Sheffield First

SAFER AND SUSTAINABLE COMMUNITIES PARTNERSHIP

Domestic Homicide Review

Executive Summary

REPORT INTO THE DEATH OF ADULT E JUNE 2013

Report produced by Linda Gregory

Date: June 2014

EXECUTIVE SUMMARY

1.0 Introduction

The Domestic Homicide Review (DHR) examined the response and support given by agencies to Adult E prior to her sudden death in June 2013. The incident occurred whilst Adult E was staying at the flat of the perpetrator. A member of the public called the ambulance service after seeing the perpetrator, outside the building, naked, bleeding heavily and appearing to have a “mental breakdown”. An ambulance crew and police attended. On entering the perpetrator’s flat the officers and paramedics found Adult E lying on her back on the floor with serious stab wounds. They pronounced Adult E dead at the scene. At Sheffield Crown Court on 17 April 2014 the perpetrator was convicted of murder and sentenced to life imprisonment with a minimum term of 20 years to be served.

2.0 Process

A DHR was recommended and commissioned by the Safer and Sustainable Communities Partnership (SSCP) in line with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. A Consideration Report was sent to the Decision Panel and subsequently the Home Office was informed on 2 July 2013 of the intention to conduct a Domestic Homicide Review. The Overview Report was not prepared in accordance with the usual timescale; this would have required a submission to the Home office by 4 January 2014. It became clear early in the review process that the report would be delayed as the trial date for the perpetrator was set for the w/c 24 March 2014 and was then adjourned to April 2014. On 8 October 2013 the DHR Review Team contacted the Home office with this information and an extended deadline was permitted. The Overview Report was completed in May 2014.

The Review Panel first met on 31 July 2013 when Linda Gregory was commissioned as the Independent Chair and Overview Author for the process. A Review Team was established within the Domestic Abuse Co-ordination Team (DACT) to co-ordinate the process. The Review Team commissioned Individual Management Reviews (IMRs) in accordance with DHR procedures and together with the Overview report author provided oversight, support and quality assurance to agency representatives completing those reviews. There were meetings with the IMR authors on 4 October 2013 and 26 November 2013 with the majority of IMRs being submitted as a final version by January 2014. As a result of the information received in the review further information was sought from out of area agencies and received by 26 November 2013. The Review Panel met on 12 February 2014, then 6 March 2014 to consider the draft Overview report and finally on 21 May 2014 to consider the final report.

2.1 Agencies participating in the review:

Sheffield City Council:

Children, Young People and Families Service
Housing Service
Housing Solutions, Care and Support

Health Services:
Sheffield teaching Hospital NHS Foundation Trust;
Sheffield Clinical Commissioning Group – General Practice.

Education:
Sheffield College;
Rotherham College.

Charities:
Sheffield Futures;
The Children's Society.

Multi Agency:
Sexual Exploitation Service

Community Safety:
South Yorkshire Police
ISIS Sexual Assault Referral Centre

Agencies provided chronological accounts of their contact with Adult E prior to her death. In line with the Terms of Reference the DHR has covered the period from December 2009 until June 2013, except for the Children, Young People and Families Service and General Practitioners who provided information from June 2008. Each agency's report includes the following:

- A chronology of interaction with the victim and/or their family;
- Whether internal policies and procedures were followed;
- Conclusions and recommendations from the agency's point of view;
- A view from the IMR author on each of the questions raised in the terms of reference.

The IMRs were analysed for themes and concerns by the overview author. There were discussions between the overview author, the Review Team, and IMR authors, to clarify issues, discuss discrepancies and gaps in information, and to agree final recommendations at the meeting on 21 May 2014. Action plans which listed the actions agreed in relation to these recommendations were also discussed with any minor changes required made following the meeting.

3.0 Family Involvement

Adult E's mother (Adult EM) and brother (Adult EB) agreed to be interviewed by members of the review team and their views have been reflected in the overview report.

In addition, the Review Team had the advantage of being able to view the statements given to South Yorkshire Police by family members Adults EM, EB, EU, Child ES and also those given by family friends. These perspectives were incorporated into the Review and are described in the full Report.

4.0 Profile of Adult E

Adult E was born in [redacted] in Sheffield to a family of Pakistani origin and was brought up in the east of the city. Unfortunately her father died in 1998 prior to the birth of her sister in 1998 - this left her mother as a single parent of three young children with her eight year old brother feeling that he was now the male head of the household, although the family were well integrated within the community and did receive support from other family members.

Adult EM told us of Adult E "she was nice, she got along with everyone". Adult E wanted to go to University after doing her college course she was taking Health and Social Care. Adult EM said "she didn't argue with anyone, she was really kind, well-mannered and well behaved. She helped everyone and always liked to be involved in the community. She had a good sense of humour and she was always on time, she never wanted to miss college, she never wanted to miss out on anything at all."

Adult E's brother told us that she was a "bright, clever girl who had lots of friends; she was a young woman who had plans for the future". She had been looking at Universities and wanted to do an access course. Adult E was conscientious and often got her college work in before the due date, she took pride in her work. She presented as happy and enjoyed college.

Adult E was described by professionals in Sheffield who knew her in the following terms:

The [redacted] Family Project knows the whole family well and knew Adult E from being a small child. Staff described Adult E as being "caring, quiet, calm, friendly, bright and outwardly creative". She attended community events from a young age and whilst initially shy, she enjoyed joining in play and exploring the toys and games on offer. As she grew up she attended the after school club where her creative side was more evident, enjoying jewellery making, painting and porcelain design. Over time she became a young helper volunteering to help out at holiday play schemes and arranging activities for other younger children.

Adult E is described as being conservative in her dress, always clean and smart and taking a pride in her appearance and hair. Staff felt she was “genuine, caring and had an encouraging nature”. They were devastated by her death.

A college lecturer described Adult E “as a highly motivated student who excelled in her course work. She took pride in the quality of her work and pleasure in submitting course work prior to any deadline dates. She very rarely missed any lectures and had exceeded the 80% attendance required to complete the course.”

5.0 Terms of Reference

The purpose of this Domestic Homicide Review was to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case;

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children;

- 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; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

In addition the following areas, specific to this case, were addressed in the IMRs and the Overview Report:

- The perpetrator was a Looked After Child in the city. The Review will consider whether the support he was offered in leaving care (and during care for specific agencies) adequately identified, assessed and managed risks to others that he may have posed;

- The victim had made allegations of rape, sexual exploitation and risk of forced marriage. The Review will consider whether these allegations were responded to appropriately by agencies and whether appropriate action was taken to safeguard the victim in the face of identified risks;

- A particular focus will be the management by agencies of the interaction between the victim and alleged perpetrator;

- The perpetrator was initially an Iraqi Kurd asylum seeker, and the victim was a British Asian. The Review will consider how awareness and understanding of relevant cultural issues and consideration of equality duties impacted on interventions.

The IMR authors were asked to consider these important issues that may lead to lessons to be learnt:

- Was there a lack of appropriate information sharing between agencies?
- Did information "travel with" the subjects when they moved areas or agencies, and / or was information requested by new agencies as necessary?
- Were allegations made to agency staff about subjects followed up appropriately?

6.0 Key issues arising from the review and findings in relation to the terms of reference.

6.1 The perpetrator was a Looked After Child in the city. The Review will consider whether the support he was offered in leaving care (and during care for specific agencies) adequately identified, assessed and managed risks to others that he may have posed.

The perpetrator was a 'Looked After Child' in the city from June 2008 to January 2011 when he became a care leaver. The Local Authority and its partners are deemed to be "corporate parents"; this was underpinned by statute in the Children Act 2004 whereby Section 10 places a duty on the local authority and its strategic partners, such as, health and police to secure the welfare of children.

During the time the perpetrator was a 'Looked After Child' there were no indicators that he posed a significant risk to others. The perpetrator's time in care presents as stable with the perpetrator accessing all relevant support services. His placements within foster care were appropriate, given his age assessment and he received consistent social work support. At the time of the case transferring to the Leaving Care Team the perpetrator was assessed under the 'RAG' system and assessed as green – this equates to low risk, routine visits of one every six weeks and six month review of Pathway Planning.

It is of concern that whilst CYPF teams knew that the perpetrator had been suspended from College for fighting In January 2011 and had run in to issues with the young person he shared accommodation with, there is no review of his 'RAG' rating. This assessment of 'low risk' was not reviewed and following reallocation in March 2012 remained as green. There does not appear to have been a review meeting held or

consultation with the NSPCC or College, Police or housing department for independent feedback of the perpetrator's situation or presenting behaviour. This meant no assessment of risk or how to manage any risks posed was completed.

The Housing Service was not made aware of any needs or risks when the perpetrator was allocated his property. They did seek to manage the risks they were aware of relating to his anti social behaviour which started in June 2011 and shared information with the Police, particularly relating to an incident where a neighbour reported that they thought a woman was being injured in May 2012. The Police accepted this as "noisy love making" although with hindsight we do know that the perpetrator was physically abused by the perpetrator on a number of occasions, this may well have been what happened.

In June 2011 The Children's Society project 'Embrace' were informed directly by the perpetrator that he was indulging in "risky behaviour". He confided that he had sex with an underage girl; that he had been the subject of a rape allegation (not by Adult E); that another girl was pregnant and it could have been him or one of five of his friends; he had been stopped for driving dangerously and thrown out of a public house for his behaviour. He acknowledged to the Volunteer Co-ordinator that his life was spiralling out of control. Unfortunately the concerns that were evident were not shared with CYPF, The Children's Society made contact with the perpetrator's P&TC support worker in September 2011 so that they could verbally inform them about the issues and risks raised by Adult E but were informed he no longer worked with him. It could be that this individual no longer worked with him but the case was still open to CYPF, the information should have been formally recorded. It would have been helpful for The Children's Society to put their concerns in writing.

It is the view of the IMR author that had a meeting been pulled together that included Housing, his support worker and the college, chaired by the team manager then this could have led to increased attempts to re-engage the perpetrator in accessing support from the PTC team around his view that his life was becoming out of control. The sharing of information between Housing and PTC around the increased anti-social behaviour that was not known to PTC team may have led to more involved discussions with the perpetrator around his lifestyle choices. This may have led him to be linked into positive community voluntary groups or broader discussions around his aspirations for the future and how to get back on track. However the difficulty would have been that as an adult the perpetrator could not be forced to engage only encouraged and supported.

An issue connected to this is that the perpetrator's age was disputed by a previous Local Authority who did not believe that he was under 18 years of age in 2007 when he sought asylum. It was legally decided that he was, however the "age discrepancy" has played a key part in how the perpetrator was viewed whilst Sheffield CYPF accepted him as an unaccompanied asylum seeking child and indeed met their duty of care until his "official" 18th birthday, the expectation was then that he could manage on his own. The CORAM report states that nearly half of all applicants presenting as

separated asylum seeking children in 2005 had their age disputed. Age is fundamental as to how someone is treated and enabled to participate in society. If there is doubt and disbelief about someone's age it is bound to effect how an agency works with them. Adult E's brother also believed that the perpetrator was older than his stated age and this was a major concern for him with regard to his relationship with Adult E.

6.2 Adult E had made allegations of rape, sexual exploitation and risk of forced marriage. Were these allegations responded to appropriately by agencies and was appropriate action taken to safeguard her.

The Police's initial handling of the rape allegation and their subsequent referral to children's services; the service provided at the SARC and the referrals made by the medical examiner; the GUM service and their referral to the Sexual Exploitation Services were examples of good practice and the allegation of forced marriage was dealt with in an exemplary manner.

However there were also several responses that were inappropriate or not made in a timely manner – the referral by SARC to the ISVA was either not made and/or picked up by the Barnsley ISVA service; no assessment was made by CYPF of Adult E following the Police safeguarding referral and the Sexual Exploitation Service meeting; the SES meeting was set for three months ahead; the GP did not enter the information regarding the alleged rape on to Adult E's patient record and did not check whether she had been referred to safeguarding; the College Lecturer who Adult E spoke to in October 2011 did not ensure that a safeguarding file was set up; due to a member of staff being off ill at the College the invitation to the SES meeting is not opened and the college do not attend; the SES had no direct contact with Adult E and after the SES meeting deemed Adult E to be at risk, no direct support is offered by the service; the Police officer did not feel it was part of their role to attend the review SES meeting; the SES review meeting does not take place and her case is closed in February 2013 without consultation with any agencies or Adult E herself.

From information given to the Review it starts to become evident that Adult E was subject to coercion and control by the perpetrator. Prior to the allegation of rape made by Adult E in October 2011, the Police had been called to Adult E's home in July and August 2011 as she felt intimidated and harassed by the perpetrator and his friends. Only in May 2011 a previous girlfriend of the perpetrator had contacted the Police to state she was being harassed by the perpetrator. There is also previous information on the perpetrator stating that he might resort to violence, for example, his suspension from college for fighting and a report to the Police in June 2011 about a road traffic accident where the other driver complained that the perpetrator had assaulted him.

The report from the medical examination following the rape allegation states "A number of bruises were noted to Adult E's right clavicle area, below the left jaw, right elbow and back of the right hand. Her neck area was also painful to the touch, Adult E had an area of [redacted], which was

painful to the touch". This suggests that the perpetrator, as a minimum, did employ physical force during sexual intercourse with Adult E.

Following the incident Adult E was visibly upset within college and did tell a member of staff that a "bad thing had happened with a boy".

Whilst she does retract her allegation Adult E did attend the SARC for examination and did complete attendances at the GUM, suggesting as a minimum that she was ambivalent about what had occurred.

From the Review we know that the perpetrator frequently went to the college even when he was not a student and would therefore have the opportunity to intimidate Adult E by his presence. Adult E reported that she had been approached by the perpetrator at college prior to attending the GUM clinic; he had taken her mobile phone and been verbally aggressive. Adult E admitted that she was scared.

Research carried about the Girl Guides in 2013 concluded that too many girls are ready to accept controlling behaviour and see it as a normal part of a "caring" relationship, for example, two-fifths of girls believe it is acceptable for a partner to make you tell them where you are all the time. They felt that "too many girls tolerate behaviour rooted in jealousy and lack of trust, tending to reframe it as a genuine care and concern for their welfare".

The Police state that Adult E was naïve and vulnerable but neither them nor CYPF question the retraction of her rape allegation and consider whether she may have been coerced or subject to abuse. There does not seem to have been any consideration of previous information regarding the perpetrator's behaviour and how this might have affected Adult E's decision making.

Whilst the minutes of the SES meeting in February 2012 allude to the perpetrator being controlling and violent this does not inform further work with Adult E.

6.3 Management of the interaction between Adult E and The perpetrator

Some of the agencies, the Children's Service, NSPCC and Housing Services only had contact with the perpetrator. The SARC only works with the alleged victim, in this case Adult E. Sheffield Futures do know both but they would have no reason to cross reference them and they would not have interacted whilst accessing their service. Housing Solutions did have contact with both but under quite defined circumstances; the allocation of a tenancy to the perpetrator and responding to forced marriage concerns with regard to Adult E, again they would not have interacted whilst accessing the service.

STFHT predominantly interacted with them individually but within the review timescale it appears that Adult E and the perpetrator attended SCASH for contraceptive advice as a couple. Adult E was always seen alone and asked about non-consensual sexual

intercourse, and other partners. At the same time Adult E was accessing care at GUM reporting that she was separated from the perpetrator. At the time these 2 areas had just become part of the same organisation so they had very separate confidential recording systems that at the time were not accessible by the other area. These areas are now part of a single integrated sexual health service and in the future information sharing may be possible.

The agencies that should have been aware of the relationship between Adult E and the perpetrator and sought to manage the relationship, on many occasions failed to make the connection. There appears to have been some confusion with CYPF believing that when the rape allegation was made by Adult E that the address given for the perpetrator was out of the city and therefore made no check on their data bases. In reviewing the referrals and the information provided by Adult E into who EA was the Police referral gives the perpetrator's address as being in Rotherham and when completing the Initial Assessment, following the forced marriage referral, Adult E reported that the perpetrator was living in Leeds.

The perpetrator's name was mentioned on Adult E's CYPF case file; however, checks on the CYPF database were not completed. CYPF did not make any checks with the College and again a chance to link Adult E with The perpetrator was missed.

The name of the perpetrator's girlfriend was not known to the P&TC workers and they did not seek to identify her when they became aware of the rape allegation and then retraction in March 2012. This was a missed opportunity to make a direct link between Adult E and The perpetrator and for the Leaving Care Team to make a link of the perpetrator becoming an increased risk.

This lack of liaison between social workers, the P&TC workers and the Police means that several opportunities were missed to link Adult E and The perpetrator and therefore plan what interventions could be made to manage any interaction. The Police were aware of the connection between the two and attended on several occasions in 2011 to manage the relationship between them. However each incident appears to have been dealt with in quite an isolated manner with little reference to the harassment complaints when dealing with the rape allegation or the concerns about "grooming".

Sheffield College linked the two when they picked up the Sexual Exploitation meeting minutes in May 2012 and they sought to manage the interaction between them. They tried to avoid contact between them on College premises and sought advice from the SES on how they might be able to exclude the perpetrator from the college due to safeguarding concerns. Although the SES did not undertake any checks to see if the perpetrator was known to them as a potential perpetrator or to Social Care.

Whilst some of the information provided on the perpetrator on occasions was not entirely accurate, particularly regarding his address, by the time of the SES meeting in February 2012, his name and address were accurate. As reported if there had been

more interaction between key agencies, such as, social care, P&TC workers and the College, the relationship between the two would have been more apparent and would have led to more opportunities to manage the interaction.

6.4. **The awareness and understanding of relevant cultural issues and consideration of equality duties on interventions**

When considering cultural implications, agencies tend to concentrate on the ability to communicate with the individuals concerned, however the review has considered wider implications concerning the impact of Adult E and the perpetrator's ethnicity and cultural heritage on the ability of agencies to engage with them. The overall response from agencies is that they had little difficulty in communicating with Adult E who was born and raised in the UK. Agencies also report that they offered the perpetrator appropriate support, such as, interpreting services but that he usually refused them. The experience of agencies is generally that - In all the interventions, face to face, in writing or by telephone, there is no mention of any language or cultural barriers, offending history or immigration status which could have impacted on access to services.

The SARC does report that it did not explore cultural issues, such as, forced marriage in its risk assessment with Adult E, consequently they are changing the assessment. Whilst CYPF did assess Adult E following the concerns about forced marriage, there is no comment on whether the social worker had particular knowledge or experience in this area. CYPF comments that the reason for retraction (of the rape allegation) given by E was plausible based on E and the perpetrator's cultural and ethnic differences. The college felt that they had met with Adult E's cultural needs by providing access to a lecturer of the same gender and ethnic background when in March 2013 she wanted to discuss being in a relationship with someone of a different culture.

Although no one appears to have explored with Adult E what the cultural and ethnic differences were that allegedly were causing problems with the family accepting the relationship. There was a lack of forums where a young Asian woman could discuss issues of this nature.

In considering cultural factors, it was decided that expert advice would be sought from the Muslim Women's Network, we decided to contact them following reading their 2013 report "Unheard voices" (The Sexual Exploitation of Asian Girls and Young Women). From discussions with them, it has become apparent that the loss of virginity is an issue within Muslim communities. The concern is that if the young woman loses her virginity outside of marriage, it can impact on her and her family's honour. It can bring shame on the family and mean that no one will ask for her hand in marriage.

Men understand this. Young Muslim women are brought up to believe they will only sleep with one man, if he is abusive they still feel that they are going to end up with him anyway, they have to put up with it. This can be a tension for young Muslim

women brought up in Britain where this is not the prevailing norm and she may wish to have the “best of both worlds”.

Shaista Gohir, Chair of the Muslim Women’s Network UK explained that men will use a sexual relationship, including rape, to pressurise the young woman in to remaining silent and not reporting or disclosing and to continue or start an abusive relationship.

In cases where the sexual relations have been voluntary, the men may use this to pressurise the girl to continuing with it even if she does not want to - then it becomes rape but the girls/women don’t really recognise this as rape. This scenario could also result in an exploitative relationship. In every scenario the concept of shame and honour is used to control girls and women. Men purposefully exploit this vulnerability.

The challenge for agencies is to recognise this cultural aspect and to think about how to pose questions to vulnerable young women so that they are able to understand the risks of continuing in an abusive relationship.

6.5 Was information shared appropriately between agencies?

There are information sharing protocols between agencies, for example, Housing Services and the Police which in the main work well but it tends to be around the sharing of “soft” information where there are gaps. Housing Services conclude that the information sharing protocol and the police liaison meetings enable some information to be shared. However the incident on 15th July 2011 (a woman is seen hobbling across the car park having come from the perpetrator’s flat) was not passed onto police which may have been useful intelligence to them. The neighbour told us that the Police visited the property on 12th October 2011 which coincides with the alleged rape of Adult E. There is no evidence that details of this were shared with SCC Housing Services.

With regard to Adult E*;* following her alleged rape there was no information from Safeguarding Children received by the GP. This may have led to missed opportunities to safeguard Adult E from further harm and support her following the alleged assault. Consultations with SCASH, the contraception services are private and as such the information is not shared with the G.P. However the GP can see that Adult E has accessed the service and can request further information. Previously this information was not available to GUM who we know were receiving different information from Adult E about her relationship with the perpetrator. Had GUM been aware of the number of requests for emergency contraception due to “failed condoms” reported to SCASH they could have informed the Sexual Exploitation Strategy meeting in February 2012 of potential risky behaviour.

Following the experience of the SES and Sheffield College when they requested support in dealing with the perpetrator, the sexual exploitation service concluded that it is a multi-agency team, however officers from individual agencies working as part of

the team would benefit from an over-arching service information sharing protocol, which would benefit all parties.

There are also issues of information interrogation within agencies, for example, the Police do not appear to have linked the fact that the perpetrator already had an anti harassment order against him when Adult E reported him for harassment. CYPF did not fully explore their systems to see if they knew the perpetrator and consequently make the link between Adult E and the perpetrator.

It is possible that, on occasions, the perpetrator may have sought to make information sharing more difficult by giving different addresses; not sharing information with agencies, for example, telling his support worker about the rape allegation and being somewhat economical with the truth.

In conclusion there was a lack of appropriate information sharing between agencies which appears to have hampered:- a revised and updated risk assessment of the perpetrator being made by CYPF in 2011; a timely assessment being made of Adult E following the rape allegation; potential safeguarding measures being put in place in relation to Adult E; a follow through on what actions were taken after the SES meeting in February 2012; referrals to agencies, such as, Sheffield Futures who may have been able to engage with the perpetrator.

6.6 Did information "travel" with Adult E and the perpetrator between agencies?

In the main this was not an issue as Adult E lived at the family home and had not moved or changed agencies, except moving from school to College.

The Housing Service comments that officially the perpetrator resided in the same property throughout, but they are fairly sure that he was staying elsewhere some of the time, he never confirmed this. The same area team managed the tenancy from the beginning so there are no issues of information being lost when he has moved.

In conclusion I think the issues are more about information sharing than information "travelling" as both Adult E and the perpetrator stayed predominantly within the city; they did not change services, such as, their GP on a regular basis; they accessed main stream health provision and in Adult E's case attended College on a regular basis.

6.7 Were allegations followed up appropriately?

When the rape allegation was made the Police did respond appropriately to the allegation, Adult E was medically examined appropriately and an Early Evidence Kit was utilised to secure any early forensic opportunities. Procedures were correctly followed in that she was taken to the appropriate location which is a special unit set up to deal with victims of rape. She was examined by a specialist in this field of work.

Her account of what had occurred was taken from her by specially trained officers and Scenes of Crime were quickly dispatched to secure evidence from the scene. The officers investigating this allegation were thorough. They visited College staff, examined their CCTV, interrogated phone records and Facebook, spoke to associates of main witnesses and quickly secured the perpetrator's arrest. Adult E was provided with a pathway to GU Med, which is clearly good practice in terms of her physical well-being.

However I do feel that the Police and CYPF were too ready to accept her retraction and this has been discussed previously.

At GUM Adult E made further allegations - The possibility that Adult E had been groomed and sexually exploited was identified by GUM who referred Adult E appropriately to the Sexual Exploitation Service. A telephone referral was followed by a written referral and the referrer ensured the referral was acted upon informed of the referral and resulting meetings. Whilst GUM acted appropriately and promptly there was no coordinated response to Adult E's allegations.

The response to the allegation of perceived forced marriage made by Adult EM was conducted in a professional and thorough manner. Police officers reacted promptly and appropriately in ensuring the safety of Adult E and her family. A place of safety was quickly secured and they were taken there without delay. They returned to their home address of their own will but safety work that was subsequently carried out was thorough.

With regard to the perpetrator the police did respond to allegations made about harassment but appear to deal with each episode in a separate manner and not connect up that he was subject to an anti harassment order.

The Housing Service did follow up allegations appropriately except the comment made by the neighbour that he threw a woman down the stairs on 15th July 2011. There is not a specific requirement in the anti-social behaviour procedure to state that this must be done and Housing Services are not entirely sure how they would refer this, but it could have been raised at the weekly liaison meeting and the South Yorkshire Police could have decided what to do with the information.

In conclusion the majority of allegations were responded to in an appropriate manner; the response to the forced marriage allegation was professional and thorough. Whilst the rape allegation was initially dealt with in an appropriate way by the Police, Adult E's subsequent retraction and delay in CYPF picking up the Police referral meant that further response was limited and minimal. Adult E's allegations made to GUM were also not followed through in a timely and satisfactory manner. This area also highlights the difficulties of dealing with "soft" information and allegations that are made when the "alleged victim" is unknown.

7.0 Lessons to be learnt

Children, Young people and Families

- A step by step guide to be produced for all social workers who move into screening teams to enable them to have a clear understanding of the processes following contact.

- There is a need for a clear understanding of child exploitation and how social workers and managers ensure that workers are able to recognise and respond to indicators of child sexual exploitation.

- It is evident from reviewing this case, that agency checks were not completed at point of contact in October 2011 and that there was a significant delay in the information being actioned by social care within agreed policy and procedure.

- In May 2012 the referral to social care led to the completion of an Initial Assessment. Outcome of the assessment was not shared with relevant agencies.

- Ensuring that accommodation providers are made aware that the care leaver has a support worker and need to make contact should concerns relating to the young adult or their actions place the tenancy at risk.

- There is clear correlation between contact with the perpetrator becoming problematic and his behaviour becoming more erratic and risky, with information not being interrogated or followed up on and changes in both worker and team manager due to workers/team managers leaving or being off work due to illness.

Housing Services

- The names and contact details of social workers and other support workers are recorded in OHMS using the 'Awareness' code system. These codes are immediately obvious as they show up in red type in every module. If the CYPF support worker had been attached to an awareness code the information would not have been overlooked by staff when they carried out their OHMS checks.

- It is recognised that a suitable protocol is required to enable housing staff to pass on reports and concerns about potential domestic violence where the victim is not known. Advice on how to do this should be sought from the Domestic Homicide Review panel.

- It is suggested that a formal protocol be set up between the Council Housing Service and CYPF- Permanence and Through Care team to enable information about how care leavers are managing in their council tenancies to flow between

the two agencies. This will aid both departments' fulfil their corporate parenting responsibilities.

- It is also suggested that consideration is given to a protocol between CYPF and other housing providers to aid the transition into independent living for care leavers.

Housing Solutions

- This case has identified that there may be case for the rehousing of care leaver's referrals procedure to be reviewed with referring agencies and Housing Solutions managers to discuss the importance of passing all information to Housing Solutions Officers for a correct assessment of housing needs and support.

- The current procedure for Housing Solutions Officers to notebook for rehousing purposes where an applicant is a Care Leaver and has the support from the Permanence and Through care Team was followed and the Support Workers name and contact details were available to Council Housing Services. However this is only a notebook entry which isn't a flagged code. If this was flagged on the person's details then this would be more obvious for Council Housing Services if any issues arise in the future.

- In situations where a customer fleeing Domestic Abuse is referred by another agency to the Out of Hours service and that customer is placed in accommodation, the Housing Solutions service will contact the referrer on the next working day to advise; whether the customer stayed in the emergency accommodation; whether the customer has approached Housing Solutions for further assistance.

- In situations where customers fleeing Domestic Abuse are referred by another agency to the Out of Hours service and do not take up their offer of accommodation, the Housing Solutions service will contact the referrer on the next working day to advise that the customer chose not to take up the accommodation.

STHFT

- Performing a pregnancy test during Adult E's attendance in A&E is good clinical practice, the documentation relating to indications and consent is not evident and that A&E guidance is produced which covers the indications for and consent to perform pregnancy tests.

- A review of the recording systems within SCASH and to assess possible improvements in information sharing and identification of high risk triggers

- A more robust pathway of referral to children's social care and SES is needed.

Clinical Commissioning Group – GP

- Sheffield CCG should suggest that each Practice Lead GP for Safeguarding Adults/Safeguarding Children consider how practices will READ code sexual assault.

- Sheffield CCG should suggest that each Practice Lead GP for Safeguarding Adults/Safeguarding Children discusses how the practice will ensure referrals to domestic abuse and safeguarding have been made when the GP is not the initial contact. This is to remind GPs that they should not presume that appropriate referrals have been made by other agencies.

- Sheffield CCG to increase awareness that referrals to domestic abuse services for over 16 year olds are made following the Domestic Abuse Pathway but a referral to Safeguarding should also be considered.

Sheffield College

- There is the need for informal procedures to be fully documented and for staff engaged in the disciplinary procedures to be proactive in ascertaining why a sudden and marked change in behaviour and attitude has occurred.

- There is a clear need to review the implementation and understanding of key policies, procedures and associated protocols namely:

  Safeguarding Policy and Procedure
  Disciplinary Policy and Procedure
  Data Protection Policy and Procedure

- There is also a requirement for individuals to acquire or improve their professional knowledge and skills with regard to these three important areas.

Sheffield Futures

- Adult E would have benefited from a structured programme around relationships delivered in a safe, single gender environment

- The perpetrator would have benefited from structured programmes around independent living, rights and responsibilities, relationships, anti-social behaviour, realistic career aspirations and appropriate learning opportunities

Children's Society

- It should be noted that the Programme involved no longer has any funding and is now closed. The recommendations and learning from this review will be cascaded across The Children's Society in order for organisational learning to take place.

- In a previous file records indicate that the perpetrator had been showing signs of requiring further support and it would have been good practice in the first instance to discuss these concerns with a Line Manager within The Children's Society and possibly refer these signs/concerns on to Social Care. (Child Protection & Safeguarding Policy 2013).

- The disclosure made by the perpetrator regarding sex with under age girls and his life "going out of control" should have been formally shared in writing with CYPF

- There was no Risk Assessment on file for the perpetrator, this had been recognised by a senior manager on the 3rd October 2011 during a file audit and had been noted but follow up was not evident. Risk assessments must be completed for all lone working with children & young people.

- There was no evidence of agreed actions being signed off by a Senior Manager following a case file audit where it had been noted that there was no risk assessment on file for the perpetrator.

- There was no clear action plan on file.

- Domestic Violence Training was not accessed.

Sexual Exploitation Service

- The SES should ensure that information regarding the sensitivity of communication with clients and family members should be clearly flagged on records to ensure all staff are aware of any issues.

- The SES should consider alternative methods of contacting clients, including via third parties such as other professionals or agencies, where appropriate.

- The SES should develop an information sharing protocol regarding child sexual exploitation for use across Sheffield. This should draw on existing information sharing protocols within Sheffield and national guidance and best practice. This will assist agencies to share information appropriately to safeguard vulnerable young people and share dangers associated with individuals of concern.

- The SES should ensure staff have appropriate awareness of domestic abuse and are clear about referral pathways.

South Yorkshire Police

- Domestic abuse training should link to other relevant areas of training and development, for example investigative practice, working with vulnerable people, and developing communication skills, including a specific focus on empathy with victims

- Work should be under-taken to ensure that CSE Teams and officers have clearly defined roles and purpose.

Sexual Abuse Referral Centre

- There is a need for detailed and accurate documentation.

- There is the need for a documentation quality assurance processes,

- There is the need to enhance the risk assessment process of all SARC clients through improved risk assessment forms and record keeping.

- There is a need for written joint working protocols to identify referral mechanisms and service expectations.

8.0 Conclusions

8.1 Overall

The ultimate aim of the review is to consider 'what might have made a difference' in this case and what therefore is the learning from this Review that would make a difference in the future.

This Review has identified good practice, but has also identified areas were the practice of health and social care services which had contact with Adult E especially around the time of the rape allegation in October 2011, could be improved. Had opportunities been recognised and worked with, Adult E may have been provided with advice, guidance and support, and could have been helped to plan for her own safety and perhaps permanently break off the relationship with the perpetrator. If responses had been more coordinated with regard to the perpetrator it might have been possible to recognise that his behaviour was becoming more risky and out of control.

It has highlighted the issue of young people and domestic abuse, the Ministry of Justice quotes the 2009/10 British Crime Survey finding that young people are more

likely to suffer domestic abuse than any other age range. This is where the disputed age of the perpetrator is possibly a factor, as research by the NSPCC and the Muslim Women's Network UK show that girls with an older boyfriend were more likely to be abused. Further that an older boyfriend of more than a year is commonly linked to increased levels of sexual coercion.

The NSPCC research and the report from Girlguiding found that too many girls tolerate behaviour rooted in jealousy and lack of trust, tending to reframe it as genuine care and concern for their welfare. Many sought to stay in a relationship by limiting the significance and impact of their boyfriend's actions on them. The Girlguiding report also found that girls preferred to talk about relationships with others of their own age in a girl only environment.

To help determine the level of risk of domestic violence a young person may be facing, CAADA is bringing out a young person's version of the 'Risk Identification Checklist' and guidance. This could be an extremely useful tool when assessing a young person, such as, Adult E, many of the risk factors identified in the guidance were apparent in her situation, for example, – perpetrator turning up unannounced and/or loitering around work/home/school; calling/texting/emailing; threats to kill; threats to expose sexual activity; threats to post pictures on line. They also state that attempts to end a relationship are strongly linked to intimate partner homicide for adults, it is believed that when Adult E attempted to end the relationship in October 2011 is when she was subject to the rape and physical force. As the Review author I would support the review of local risk assessments and how they could be informed by the young person's checklist and that training subsequently reflects this.

CAADA also found that young people find it difficult to identify themselves as being exploited and are reluctant to tell adults what is happening. As the Review author I would support the development of work within schools and colleges, preferably within single gender groups, to help young people understand what abuse is and what healthy relationships are.

Adult E's family have been consulted, they felt it would have been difficult for agencies to predict what happened and in general thought that agencies had responded well, Adult E's mother did have some thoughts on how agencies' responses could be improved. She also thought that there should be information at College for groups of Asian girls about relationships and what is okay and what isn't, because she thought Adult E was as open with her as she felt she could be in front of her mother but if she'd had this at College she could have told them more. Adult EM also thought that more access to counselling or relationship discussion at the college would have been helpful.

Adult EM thought that if they could have found out about the perpetrator's previous records and past this might have changed things. Adult EM stated "We didn't know the full facts about it". She particularly felt that at the time of the rape allegation made by Adult E in October 2011, if they had been given information about his previous

harassment of ex-girlfriends and rape allegation, it might have made Adult E think differently about him and the relationship.

There are a number of lessons to be learned and specific actions to be taken by agencies, which in the view of the author would help to prevent similar events in the future. It is not possible to say whether if any or all of those lessons and actions, had been applied in Adult E's situation, they could have made her safe enough.

8.2 Hindsight

In coming to conclusions about lessons learned, the author was aware that this Review was undertaken with the benefit of hindsight. No one agency had the overview that was available to the report author. A couple of indicators may have affected decision making had they been known at the time. These are:

Family and friends – From the statements of Adult E's family and friends a clear picture of domestic abuse starts to develop early in their relationship; Adult E often has bruises on her body and face following a visit to his home; burn marks are noticed by different family members and friends; she appeared scared of him; he stalked her by sitting outside in his car; he was constantly texting her and checking where she was and was verbally abusive and threatening to other family members.
Had the Police and Children's Services been more aware of the nature of the relationship between Adult E and the perpetrator it is possible that more steps could have been taken to safeguard her. However it should be recognised that Adult E may not have wanted agencies to know this information as she did, on occasion, prevent a family member from informing the police.

Critical Time Frame – From reading chronologies it became evident that the time period of October 2011 until March 2012 was critical. Adult E made the rape allegation in October 2011 and during this time period did attempt to engage with professionals about the nature of her relationship with the perpetrator. Unfortunately due to a series of issues/decisions no one professional, especially one with sufficient training and understanding of domestic abuse, gained a full picture of what was happening with Adult E and a full risk and needs assessment was not conducted.

It is worth remembering that Adult E was only 16 years old when she made the rape allegation, for services it is a time of transition, she will be considered an adult by some and a child by others. From experience it appears that this group, 16 – 18 year olds are some of the most difficult to place within services and offer an appropriate service. It is possible that Adult E may have been intimidated by the amount of agencies and professionals that she had to deal with at the time of the allegation. As in other cases, this suggests there might be a need for a lead professional to be identified in cases of multiple agency involvement.

9.0 Recommendations

Agency recommendations:

The agency recommendations are based on the information presented in the IMRs and in subsequent discussions with agencies by the Review Team and in the Review Panel.

Sheffield City Council Children, Young People and Families:

1. A step by step guide to be produced for all social workers who move into screening teams to enable them to have a clear understanding of the processes following contact.

2. All social workers will attend CSE refresher seminars on referral pathways where CSE is raised as a concern

3. A policy and procedure for staff within the Leaving Care Team where a young adult is disengaging with services. This is to include guidelines in respect of checks with partner agencies involved with the young adult.

4. Permanency and Through Care service to meet with Housing Solutions to review current policy and procedures in respect of referrals and quality of assessment provided to determine suitable accommodation and support.

Sheffield City Council Housing Service

1. It is recommended that the names and contact details of social workers and other support workers are recorded in OHMS using the 'Awareness' code system. The need to record support details as awareness codes will be in procedure guidance and staff briefings.

2. It is recommended that a suitable protocol is identified to enable housing staff to pass on reports and concerns about potential domestic violence where the victim is not known.

3. It is recommended that a formal protocol be set up between the Council Housing Service and CYPF- Permanence and Through Care team to enable information about how care leavers are managing in their council tenancies to flow between the two agencies.

Sheffield City Council Housing Solutions

1. Managers to review the information that is shared between CYPF and Housing Solutions within the Care Leavers referral procedures and circulate to staff the

importance of information regarding support needs and risks which must be forwarded to the accommodation provider in providing support or managing risks.

2. All applicants supported by the Permanence and Throughcare Team who are rehoused through Council Housing Services to be flagged on the Housing management System with the name and contact details of the Support Worker. This will stay on the system for 3 years until it is reviewed and will be shared with all Housing management staff.

3. In Domestic Abuse cases, Housing Solutions will consider their procedures regarding referring back to referring agencies to update on the situation.
    a. In situations where a customer fleeing Domestic Abuse is referred by another agency to the Out of Hours service and that customer is placed in accommodation, the Housing Solutions service will contact the referrer on the next working day to advise:-
        i. whether the customer stayed in the emergency accommodation;
        ii. Whether the customer has approached Housing Solutions for further assistance.
    b. In situations where customers fleeing Domestic Abuse are referred by another agency to the Out of Hours service and do not take up their offer of accommodation, the Housing Solutions service will contact the referrer on the next working day to advise that the customer chose not to take up the accommodation

Sheffield Teaching Hospitals (NHS) Foundation Trust

1. That A&E guidance is produced which covers the indications for and consent to perform pregnancy tests.

2. That a robust pathway for referrals to Sheffield Children's Social Care and Sexual exploitation service from GUM is formulated.

3. That the information systems used by GUM and SCASH are reviewed now that the service is integrated.

4. That SCASH review the markers for high risk behaviour and update staff and systems as necessary

Sheffield Clinical Commissioning Group

1. Sheffield CCG to recommend that each Practice Lead GP for Safeguarding Adults/Safeguarding Children consider how practices will READ code sexual assault.

2. Sheffield CCG to recommend that each Practice Lead GP for Safeguarding Adults/Safeguarding Children discusses how the practice will ensure referrals to domestic abuse and safeguarding have been made when the GP is not the initial contact.

3. Sheffield CCG to increase awareness that referrals to domestic abuse services for over 16 year olds are made following the Domestic Abuse Pathway but a referral to Safeguarding should also be considered.

4. Sheffield Health and Social Care FT to share the learning from this case across the whole organisation and specifically with the practices involved in the review, to include the wider primary health care team.

Sheffield College

1. That Informal disciplinary procedures are fully documented and for staff engaged in the disciplinary procedures to be proactive in ascertaining why a sudden and marked change in behaviour and attitude has occurred.

2. Review the implementation and understanding by the workforce of key policies, procedures and associated protocols and develop mechanisms for checking compliance with the following policies:

    a. Safeguarding Policy and Procedure
    b. Disciplinary Policy and Procedure
    c. Data Protection Policy and Procedure

3. That individual staff acquire or improve their professional knowledge and skills with regard to safeguarding, disciplinary procedures and data protection.

4. The Executive Director of Human Resources to ensure that protocols are developed to ensure mail; physical paper, electronic and voicemail are managed where there is long term absence of staff

5. The Local College Principal to ensure all staff understand the importance of compliance with Sheffield City College Safe by Design principles.

Sheffield Futures

1. Sheffield Futures to develop a rationale and strategy for single gender work, seek endorsement by Sheffield City Council and for it to be included in the Service Plan for Community Youth Teams from April 2014.

2. Structured programmes identified, delivered by Sheffield Futures or Partners around independent living, rights and responsibilities, anti-social behaviour, positive relationships, realistic career aspirations and appropriate learning opportunities,

Children's Society

1. All potential Safeguarding concerns to be discussed with Line Managers as per Child Protection & Safeguarding Policy (2013); For this to be recorded as per policy on case files/supervision records and via the appropriate designated referral processes where necessary I.e. Defensible Decision /Child in Need/Child in Need of Protection forms.

2. All lone working should be risk assessed and evidenced within files prior to any visits and is the responsibility of The Line Manager or Safety Officer at The Children's Society (Lone & Out of Hours Working Policy).

3. All audit recommendations following case file audits must be followed up as part of a complete process in order to ensure that all actions have been completed. These should be reviewed and signed off by a Manager on the dates set within the audit.

4. All children, young people and families should have a clear action plan on file which is kept up to date.

5. Domestic violence training should be accessed by staff when working with young adults who may be involved in aggressive relationships. The Children's Society to ensure that appropriate training is made available.

Sexual Exploitation Service

1. The sexual exploitation service should develop an information sharing protocol regarding child sexual exploitation for use across Sheffield. This should draw on existing information sharing protocols within Sheffield and national guidance and best practice. The aim being to assist agencies to share information appropriately to safeguard vulnerable young people and share dangers associated with individuals of concern.

2. The sexual exploitation service should ensure that information regarding the sensitivity of communication with clients and family members should be clearly flagged on records to ensure all staff are aware of any issues.

3. The sexual exploitation service should consider alternative methods of contacting clients, including via third parties such as other professionals or agencies, where appropriate.

4. The sexual exploitation service should ensure staff have appropriate awareness of domestic abuse and are clear about referral pathways.

5. Sexual exploitation service to be aware of cultural sensitivity in cases.

6. Sexual exploitation service to consider the number of professionals involved with young people referred to the service and ensure that young people are not confused or intimidated by the number of professionals involved with their case.

7. Sexual exploitation service to ensure any actions agreed at strategy meetings are carried out in a timely manner.

South Yorkshire Police

1. Domestic abuse training should link to: other relevant areas of training and development, for example investigative practice, working with vulnerable people, and developing communication skills, including a specific focus on empathy with victims

2. Work should be under-taken to ensure that CSE Teams and officers have clearly defined roles and purpose.

Sexual Abuse Referral Centre

1. Review and improve the SARC risk and needs assessment to make all questions clear and precise as well as creating space to record more in depth information in relation to potential risk factors and actions taken. It will also identify whether there is a risk of forced marriage.
2. Develop a joint working agreement with South Yorkshire Police Public Protection Unit to affirm responsibilities for making onward referrals for domestic abuse and/or safeguarding concerns in Police cases and follow up of such referrals.

3. Review and improve joint working arrangements with ISVA services to include referral mechanisms and feedback mechanisms and ensure subsequent action plans are implemented

4. Review and improve joint working arrangements with IDVA services to include referral mechanisms and feedback mechanisms and ensure subsequent action plans are implemented

5. Improve record keeping: Sample audits to be undertaken of records completed by staff prior to their monthly one to ones.

Chair's recommendations:

The following recommendations from the Independent Chair of the Domestic Homicide Review reflect the overall findings, having analysed all the IMRs for themes and discussed these with the Review Team and the Review Panel.

1. Sheffield will build on the work already begun on how best to support young people affected by domestic and sexual abuse through continuing to participate in the CAADA Young People's Violence Advocacy Programme (Dept of Education funded) and the MsUnderstood Peer on Peer abuse project underway in the city (started Spring 2014). A key priority will be to develop pathways and / or streamline existing pathways to support for teenage young people experiencing domestic and / or sexual abuse in their relationships including where this involves risk of sexual exploitation. This will build on existing support pathways provided by the Sheffield Sexual Exploitation Team and partners.

Learning from these projects should also be used to inform training and awareness raising for staff in relevant agencies. The learning from this DHR should be shared to inform this work.

To be led by MsUnderstood / CAADA YPVA steering group

2. Sheffield to review risks assessments in light of the development of the CAADA young person's risk identification assessment checklist. Learning should be shared and used to inform training regarding the cultural issues raised by this review in relation to barriers to accessing support / leaving abusive situations for young Asian women and how this should inform consideration of risk factors.