SHEFFIELD FIRST SAFER AND SUSTAINABLE COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

January 2016

Victim Adult H

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

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

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

1.3 In summer 2014 South Yorkshire Police (SYP) attended address 1 and found the body of H. She had died of multiple stab wounds. The perpetrator was arrested at the scene and was later charged with the murder of H. He pleaded guilty and was sentenced to life imprisonment and will serve a minimum of 23 years in prison.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.2 DHR Panel

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

Member	**Role/Agency**
➢ David Hunter	Independent Chair & Author
➢ Paul Cheeseman	Assistant to Chair
Standing Panel Members	
➢ Jo Daykin-Goodall	Safer & Sustainable Partnership Board
➢ Kevin Clifford	NHS Sheffield CCG
➢ Pete Horner	South Yorkshire Police (SYP)
➢ Victoria Horsefield	Safeguarding Children Board
➢ Simon Richards	Sheffield City Council (SCC) Adult Safeguarding & Quality
➢ Steve Eccleston	SCC Legal Services
➢ Zlakha Ahmed	Independent Voluntary Sector (Co-opted)
Co-opted Panel Members	
➢ Max Lanfranchi	National Probation Service Sheffield
➢ Dawn Walton	SCC CYPF education MAST
➢ Edna Asumang	Sheffield Children NHS FT (Acute)
➢ John Tolland	Doncaster Prison
➢ James Scott	Crown Prosecution Service (CPS)
➢ Chris Morley	Sheffield Teaching Hospital

➢ Ronda Ninkovic	NHS Sheffield CCG
➢ Quentin Marris	Addaction
➢ Alison Watts	Her Majesty's Courts and Tribunal Service (HMCTS)

Co-ordination Team

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

2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs.

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

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

2.4 Notifications and Involvement of Families

2.4.1 The DHR Chair wrote to the families of the victim and perpetrator on 28.02.2015 inviting them to contribute. The brothers and sister of the victim were provided with a copy of the DHR report and they gave the DHR panel a picture of their sister in their own words.

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

2.5 Terms of Reference

2.5.1 The purpose of a DHR is to;

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

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

2.5.2 Timeframe under Review

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

2.5.3 Case Specific Terms

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

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

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

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

5. Was there appropriate information sharing between agencies?

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

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

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

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

3. BACKGROUND

3.1 Victim Adult H

3.1.1 H was born in the Punjab region of Pakistan and was the eldest of seven siblings. She came to the UK in 1992 after marrying the perpetrator in Pakistan. English was not her first language and at the time of her entry into the UK GP records describe her use of English as very limited. H and the perpetrator had two sons from the marriage, HS1 and HS2.

3.1.2 The victim suffered domestic abuse at the hands of the perpetrator at various times throughout her marriage. These were never reported to the police nor any other agency. However, there is credible independent evidence that she suffered physical injuries at the perpetrators hands and there are reports that on occasions she had visible bruises. She left the perpetrator twice when she went to live with members of her family in south east England. She returned to the South Yorkshire area after six years and lived with H when he was released from his last prison sentence.

3.2 Perpetrator

3.2.1 The perpetrator was born in the UK and his parents originate from the Punjab area of Pakistan. He was educated in the South Yorkshire area. He worked for some time as a waiter although his record of work was patchy because of imprisonment. He had a significant history of offending and served periods of time in prison. The offences for which he was convicted included misuse of drugs, theft, burglary and violence against the person. As well as offending the perpetrator was known to have a history of substance misuse. At various times he used cannabis and heroin.

4. COMMENTARY

4.1 The perpetrator's history of offending grew incrementally over the years. He used violence towards others and was also subjected to violence himself. The most serious offence he was convicted of related to his possession of a handgun during a dispute with others at a wedding in 2011. He received a term of six years imprisonment. During this event the weapon was fired and a round discharged into the ceiling. Being able to procure ammunition and a handgun capable of firing live rounds is a significant risk factor. Children were present at the time. His ability to obtain, and his willingness to then carry this weapon, indicates his connections to serious criminality.

4.2 In contrast to the perpetrator H was of good character and the panel found no evidence she was involved with him, or his associates, in any criminal activity. Neither is there any evidence she misused drugs or consumed alcohol. From the limited information that was available to the panel, and the submission made by her family, H was a good mother who loved and cared for her children.

4.3 One of the important issues the panel considered was the extent to which language may have been a barrier to H reporting her experiences of domestic abuse. Accounts differ as to how well H understood and could converse in English. It appears she relied on the support of her husband and family members to help her access services. While her medical history was unremarkable the panel felt there were some presentations following injuries that begged more curiosity from her GP. While there was no direct evidence these were caused by the perpetrator there should have been more probing, particularly given the perpetrator's antecedent history of drug misuse.

4.4 The panel also heard that when the perpetrator was being considered for release on licence from prison the Offender Manager (OM) from the (then) South Yorkshire Probation Service (SYPS) visited H. While she did not disclose any information that indicated she had been the victim of domestic abuse, neither was she asked any direct questions about her experiences. This may have been a lost opportunity for more professional curiosity to have been exercised. The panel recognised that, in her contact with professionals from agencies, H's poor use of English may have created a barrier to such probing. In addition the absence of an interpreter or the use of a family member in this role may also have been a barrier.

4.5 Given the offence involving a firearm for which the perpetrator was convicted the panel looked closely at how the risk he presented was assessed when he was considered for release from custody. Based on the information then available to the Offender Manager (OM) from SYPS, they reached a conclusion that H presented a medium risk to the public and victims of the original offence and a low risk to children, staff and prisoners. There were some concerns that insufficient weight was given to the fact that one of the victims in the offence of possessing a prohibited weapon was under eighteen and also in respect of the perpetrator's criminal associations.

4.6 The panel was also concerned that other information, that was available and held by Her Majesty's Prison Service (HMP) and SYP, appears not to have been shared with the OM. These related to violence used towards, and by, the perpetrator while in prison and his possible involvement in suspected drug dealing at a time he was released into the community on a temporary licence. That information may have altered the assessment of risk and meant the perpetrator was made the subject of

MAPPA arrangements upon his release. However the panel concluded that there was a significant gulf between the possible understatement of this risk and the homicide of H.

4.7 Given the perpetrators antecedents the panel gave careful consideration to how agencies considered the risks he presented to children. They felt there were at least two lost opportunities by SYP for a multi-agency assessment of risk in respect of his children. One of these related to the perpetrator possessing drugs at home in 1997 and the second related to the possession of the firearm.

4.8 The panel felt the fact the perpetrator misused drugs for many years was an important factor that should have escalated the interest other agencies took in safeguarding. However it was only in 2009 that this information was noted on the medical record of one of his children; it was never cross referenced to the record of H.

5. CONCLUSIONS

5.1 Despite all that was known about the perpetrator's history of offending no agency had direct information that domestic abuse was present in the relationship between H and the perpetrator. While there may have been some, so called, 'soft signs' and some missed opportunities to exercise professional curiosity there were no precursor incidents that might have caused any agency to believe H was at risk of serious harm from the perpetrator. The panel therefore concluded that her homicide was neither predictable nor preventable.

6. LESSONS LEARNED

1. The Sheffield DACT needs assessment identified that 26% of individuals receiving support from DACT commissioned providers were BME; this is in comparison to an overall BME population of 19.2% of the Sheffield population. Domestic abuse is under reported generally and members of some BME communities may face additional hurdles when disclosing domestic abuse[1]. This includes language, access to interpretation and isolation to name a few. These hurdles may make it more difficult for them to disclose their experiences and then to access competent independent advice and support. These findings were also identified from a focus group held following the case of Adult G.

2. The 'toxic trio' (also referred to by organisations as the 'trilogy of risk' are three risk factors that increase the risk of child abuse; they are parental mental health issues, parental substance abuse (including alcohol) and domestic abuse[2]. In this case the substance abuse was identified but unfortunately, although present, domestic abuse was not enquired about and so the second factor of the toxic trio was not identified. Specialist substance misuse services, and GPs if they are providing treatment for misuse, should always ask questions about home circumstances when assessing patients who present with issues of substance misuse. They should be alert for signs of domestic abuse and take action as required. Addressing domestic abuse needs to have the same profile amongst specialist substance misuse services as is given to safeguarding children.

3. There is a need to develop ways in which GP notes can be shared with prison health providers and the DHR panel notes NHS England are currently undertaking work to address this.

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

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

7. SUMMARY OF KEY FINDINGS

i. H was a caring woman who suffered in silence. She never reported what happened to her however her experiences meant she was a victim of domestic abuse at the hands of the perpetrator.
ii. The perpetrator had a significant history of offending including the use of violence. He also had a long history of misusing drugs.
iii. There should have been more curiosity shown by her GP when H presented with injuries.
iv. English was not the first language of H and this may have presented a barrier to her disclosing her experiences to professionals.
v. When professionals spoke to H in the presence of a family member who acted as an interpreter this may have created a barrier for H that prevented her disclosing information about the behaviour of the perpetrator.
vi. The misuse of drugs by the perpetrator should have escalated the interest professionals took in safeguarding issues.
vii. There was information known to HMP and SYP but not by NPS which might have affected the assessment of risk that was undertaken on the perpetrator when he was released on licence from prison.
viii. When assessing risk, greater weight could have been given by NPS to the fact that a victim involved in the index offence when a weapon was discharged was under 18 years of age at the time it was committed.

While there were some 'soft signs' and missed opportunities to exercise more professional curiosity in relation to domestic abuse, no agency could have predicted or prevented the homicide of H.

8. RECOMMENDATIONS

8.1 The single agency and DHR Panel recommendations appear at Appendix B.

Appendix 'A'

Terms

Domestic Violence

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

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

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

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

   - psychological
   - physical
   - sexual
   - financial
   - emotional

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

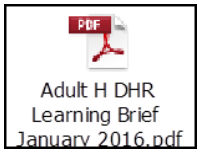
   Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

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

Appendix B

Action Plan

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

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

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

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

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

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

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

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

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14 December 2015

Dear Ms Higgins

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

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

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

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

- The Panel felt the reference in paragraph 1.2 (in both reports) allows the perpetrator to speak for the victim (in relation to her designated ethnicity) and should be removed and replaced with the ethnicity simply stated;

- The Panel recommended checking the wording in paragraphs 6.1.3 to 6.1.5 to ensure the victim's children do not consider the comments to be targeted at them;

- The action plan requires milestones, outcomes and progress to be included;

- Additionally, the Panel suggested the review panel may wish to consider including a recommendation in the action plan on how third party reporting could be improved safely.

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

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

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

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assruance Panel

End of Executive Summary