Sheffield First

SAFER AND SUSTAINABLE COMMUNITIES PARTNERSHIP

Domestic Homicide Review
Executive Summary

REPORT INTO THE DEATH OF ADULT G ON 4th March 2014

Independent Author: Kate Mitchell, M.A., CQSW

Date: 10th March 2015

THIS REPORT HAS BEEN REDACTED FOR PUBLICATION IN ACCORDANCE WITH THE SHEFFIELD CITY COUNCIL REDACTION FRAMEWORK FOR DHR: 10th September 2015

CONTENTS **Page**

SUMMARY OF RECOMMENDATIONS

Agency recommendations:

General Practitioners:

1. Sheffield CCG to share the learning from this review, specifically around the link between child neglect and domestic abuse, with lead GPs for safeguarding (adults and children), and for the lead GPs in turn to increase domestic abuse awareness within their practices.
2. Sheffield CCG to re-issue the recently developed template safeguarding policy developed for primary care, with practice lead GPs for safeguarding (adults and children), for them in turn to consider adopting within their practices.
3. Sheffield CCG to recommend to practices that GP and health visitor records should be shared where clinical systems allow but concerns should be communicated directly.
4. Sheffield CCG to encourage practices to display domestic abuse posters in GP practices to promote community awareness of the issue and encourage disclosures.

STHFT:

1. When using interpreters to ask women for sensitive personal information such as in routine enquiry, the gender of the interpreter must be considered. A male interpreter could have an impact on the response.

SCHNHSFT Health Visiting Service:

1. Raise awareness amongst HVs of the need to discuss challenging cases with safeguarding children supervisors, so that HVs are supported to manage appropriately situations where an assessment of domestic abuse is difficult. For example, where a mother is accompanied by her husband or family.

SCHNHSFT School Nursing Service:

2. Raise awareness amongst school nurses and health visitors of the need to liaise and share information appropriately where there are safeguarding concerns relating to children in the household - school aged and pre-school children.

Children, Young People and Families:

1. Chair's Recommendation: MAST to complete a case study evidencing that following the restructure and redesign, the opportunities to engage with this family would not recur. Present to the Local Safeguarding Board Operational Sub-Group, by April 2015.

2. Incorporate the findings from this Review into training and supervision for workers in order to help them to identify domestic abuse in working with migrant families.

Housing Solutions:

1. Implement the new ICT system being developed to eliminate the issue of archived paper records not being available at interview.
2. Quality checking of decisions by officers is now completed by a more senior officer. It is recommended that this is good practice.
3. The use of Supported Family Accommodation for families with a history of a former failed tenancy is recommended as good practice.
4. Housing Solutions Officers to receive training to increase knowledge and awareness of:
   - Homeless Legislation and Security of Tenure
   - Interviewing different cultural groups including using direct questioning

   This is to be assessed in Individual Performance Reviews and supervision.

Housing Services:

1. Procedures will be updated to include the expectation that missed contact between agencies is followed up to ensure that relevant information is shared.

Asylum Seeker and Refugee Services:

1. Implement a more individual client focused electronic record keeping system which reflects the individual diverse client's needs instead of a generic housing related system.
2. Review Support Planning and Risk Assessment training to take account of the lessons learned and potential improvements in practice that have been identified in this Report, particularly in terms of follow up where withdrawal from support occurs. Review to be completed by December 2014.
3. In working with other services working with refugees and diverse cultures, Metropolitan will encourage community groups and activities to display domestic abuse advice prominently.
4. All languages & dialects spoken in the area will be reflected in any literature and pictograms used to demonstrate social and cultural laws, particularly with regard to safeguarding and abuse.

Police:

1. It is recommended that Atlas Court (police call centre) reviews its procedures for 999 and 101 calls involving non-English speakers, and:
   a. Where a call is made by a child, an adult should be spoken to in all cases to confirm that police attendance is not required
   b. Where appropriate "Language Line" will be utilised to assist in communication
   c. Where welfare cannot be established satisfactorily during the call, a police officer should be deployed to conduct a welfare check

Chair's recommendations:

These recommendations reflect the overall findings, having analysed all the IMRs for themes and discussed these with the Review Team, with individual agencies, and the Review Panel. These recommendations relate both to findings where opportunities for interventions were missed, and to where I have identified that services can be further developed to help prevent similar situations in the future.

1. The Domestic Abuse Strategic Board to monitor the impact of the FCAF on the assessment of domestic abuse in families, by receiving a monitoring report from the CYPF member of the Board, in September 2015 and March 2016.

2. The Domestic Abuse Strategic Board to require all agencies to review systems in place to evidence that:
    a) routine domestic abuse inquiries are made of women in migrant families,
    b) supervision and support to complete the task is in place, and used, where practitioners find it difficult to do so,

    and to put an action plan in place to address any gaps, by July 2015.

3. All agencies represented in the DHR process to monitor the gender of interpreters in domestic abuse inquiries (face to face and by telephone) with migrant families, during 2015/16. The Domestic Abuse Strategic Board to receive these data 6 monthly in October 2015 and April 2016 and to develop an action plan to address any gaps.

4. The Domestic Abuse Strategic Board to organise a workshop with the women-only Focus Group (from this DHR) in order to develop a guideline for services working with migrant families to be able to ask appropriate questions about domestic abuse. The guideline to include:
    a) A model script for staff, and guidance as to when this might be appropriate, i.e. when it is necessary to be flexible and culturally aware;
    b) Guidance on preparing and using interpreters in domestic abuse inquiries, including ensuring the gender of the interpreter is the same gender as the service user.

5. Sheffield City Council to review the information on its website regarding City of Sanctuary and migrant communities and ensure that up to date demographic information is provided about asylum seeker and refugees currently seeking sanctuary in the City. This should be a resource for staff and the public providing up to date information about new migrant groups, by September 2015 and ongoing.

6. Sheffield City Council to work with City of Sanctuary to develop a plan for improving the welcome to Sheffield for migrant families. In addition to meeting the

SCC's own aims of reducing exclusion, this project should demonstrate meeting the key aim from this DHR, of reducing the isolation of women in migrant communities in order that they may feel safer. This will include provision of information about domestic abuse, information and support for women to access English classes. To consult and involve community, voluntary and faith groups in this process. Report on this plan to the Domestic Abuse Strategic Board by September 2015.

7. The Domestic Abuse Strategic Board to task a meeting with faith leaders to discuss the issues raised in this case and invite participation in the recommendations and the action plan. Of interest in this regard is the current work by the Metropolitan Police Service in developing a women-only initiative with local mosques to address domestic abuse in South Asian communities.

8. The Domestic Abuse Strategic Board to receive a report from those tasked with actions from the DHR for Adult D which are relevant to Adult G, to ensure these have been progressed, namely to report how migrant women can be referred for support for domestic abuse. It is recognised this wouldn't have helped in this case. However, for future assurance, how will vulnerable people from migrant communities be supported in relation to domestic abuse?

9. The Domestic Abuse Strategic Board to task an audit of voluntary, community and faith groups to assess awareness of, and compliance with, the domestic abuse pathway, and develop an action plan to address any gaps, by October 2015.

10. The myth of acceptable abuse is to be robustly challenged in all services, immediately and ongoing:
    - IMR authors in debriefing within services will promulgate the message from this Review that domestic abuse is unacceptable and illegal regardless of the faith or culture of service users; and
    - In training and supervision, staff will be encouraged to be curious about faith and culture, and their access to resources will be facilitated in order that they can research the background and needs of migrant families, and ensure families are aware of the services and support available for domestic abuse.

SUMMARY OF THE REVIEW

1.1 Introduction

This is the Report of a Domestic Homicide Review (DHR) following the death of G[1] on 4th March 2014. It provides an independent overview of the service provided by agencies which had contact with the family by analysing the services provided, discussing lessons learned, and making recommendations with the aim of improving the service provided to victims of domestic abuse in Sheffield.

Agencies completed Individual Management Reviews (IMRs) during the summer of 2014 and the Overview Report was drafted and put on hold in October 2014 pending the outcome of the criminal justice process. It has been updated and completed during February 2015.

The timescale for this DHR is the period from the arrival of G's husband in the UK on 19th October 2010 until the date of G's death on 4th March 2014.

1.2 Subjects of the review

The Review was concerned with G and her immediate family: her husband (the perpetrator) and four children; her mother-in-law who was resident in the household at the time of the incident; G's sister who lives nearby, and is married to the perpetrator's brother. The perpetrator's sister and other brothers are referenced but not included. G's husband had three other wives at various times, none of whom are resident in the UK and as such they are not subjects of this Review.

G and her family came to the UK from Kuwait although various members of the family have lived in other Arabic countries, and extended family members continue to reside in Jordan, Iraq and Syria. The husband's family is known as 'bidoon', an Arabic word meaning 'without', or in this context, 'stateless'. It is not clear whether G was also 'bidoon'; however once married to her husband she would have become 'bidoon', whatever her status previously. As little is known about this group of refugees, information is included in the main report for the purpose of context.

1.3 Agencies preparing Individual Management Reviews (IMRs)

General Practitioners
Sheffield Teaching Hospitals NHS Foundation Trust
Sheffield Children's NHS Foundation Trust - Community Wellbeing and Mental Health Services Division
CYPF Prevention and Intervention, Multi-Agency Support Team
CYPF Children's Social Care
CYPF Education
SCC Housing Services

[1] Parties are anonymised in the Review. The victim is identified as 'G' and 'Adult G' interchangeably; GH is G's husband, the perpetrator.

Metropolitan Housing - Asylum Seeker and Refugee Services
South Yorkshire Police

In addition, information was received from:
Arches Housing
Sheffield Association for the Voluntary Teaching of English (SAVTE)
Northern Refugee Council
Family Development Project
Immigration Service

2.1 Summary of the case

The incident occurred at the family home in Sheffield. Information received by the police led to the discovery of G's body and her husband, Adult GH, was subsequently charged with murder. Adult GH pleaded not guilty to murder but guilty to manslaughter on grounds of diminished responsibility. This plea was not accepted by the prosecution and the case was tried in January 2015. Psychiatric assessments supported a diagnosis of psychosis, which was contested by the prosecution, and the jury found the perpetrator guilty of murder. He was convicted and sentenced on 9th February 2015, to life imprisonment with a tariff of 23 years.

2.2 A Profile of Adult G

Adult G grew up in a large family which moved between Jordan, Syria, Iraq and Kuwait. The family is of the Shia Muslim faith. She was particularly close to her sister who is just a year younger, especially after the two women came to the UK and knew only one another. She married at age 17. Following her death, the Family Liaison Officer completing a victim-focussed report noted that little was known about Adult G's lifestyle in the UK. She owned very little, having no toiletries, handbag or personal belongings that would be expected, and few clothes other than soiled and stained items.

The lack of information about Adult G is indicative of one of the significant factors of this case. Adult G's isolation from the world outside her home was, by the time of her death, complete. Few people met her and fewer people knew her as an individual personality. When professionals came into the home, it was rare for Adult G to be unaccompanied by either her husband or mother-in-law. At GP appointments she was invariably accompanied. She was not known to neighbours who reported only that they occasionally saw a figure in the garden, always covered. During the Review, the Police reflected that, had the family done as the perpetrator asked and helped to conceal the body, her death could have gone unremarked outside the family.

2.3 Information from Adult G's Family and Friends

Adult G's brother in Iraq reported that the family knew he was violent and would beat her. In Kuwait, G had the support of her brothers, which the family believes was to her advantage in deterring her husband from violence, but once in the UK her family worried for her safety. The family was in the process of requesting a divorce for G, with the aim of bringing her home.

We met Adult G's sister and her husband who is the perpetrator's brother (i.e. the two sisters married the two brothers). We heard that Adult G was assaulted on a daily basis, both in their own country and in the UK. In Kuwait, there were controls on his violence due to the presence of their brothers. However, once they came to the UK, his violence escalated. She related incidents when he had kicked G; and when he pulled out her hair and Adult G hid the hair (this was subsequently found by the police investigation). The perpetrator threatened to kill her, then the children, then himself, and she believed he would do this, that he was 'all-powerful', if she tried to divorce him or to resist his abuse. As his behaviour escalated during the autumn and winter of 2013/14, he took away her mobile phone and [*redacted]* told the sister and her husband to stay away. She thought if she complied with this, her sister might be safer. The sisters last had contact around the end of the year, 2013.

Her sister believes that Adult G was aware of the law but would not have asked for help, because of the shame. The shame would have affected her family here in the UK, and also in their home country. The sisters did not know where one another lived, did not know their address; the children were taken to school by their husbands and they were taken to visit one another by their husbands, and therefore neither could have found their way to the other's home independently. Adult G asked her sister not to tell anyone about the abuse. She was confident that, had she told anyone outside the family about the abuse, that G would have denied it for all these reasons.

The family pointed out that asylum seekers generally struggle to feed their family and keep them warm as there would be difficulties with benefits and finding work, and the sister expressed concern that there were no services specifically understanding and working with refugee families, and this meant many could be living in hardship and isolation. She felt the school had not been sympathetic with the children's experience as refugees, and had not attempted to make a relationship with them prior to the murder of their mother. Following the murder, the school staff gave good care and support to the children, and she believed that had school staff got to know the children before the incident, the children would have disclosed abuse and something might have been done. Her concern was that this could be happening in other refugee families, and she thought schools could do more.

The perpetrator's brother was concerned about his brother's mental health and continues to believe that this ultimately caused the homicide. He believed health

services could have done more to recognise and treat his condition. He said that when GH's mental health worsened prior to the incident, GH had not gone to the GP but had sought support from the Mosque where he believed GH was encouraged to address the issue through prayer.

Adult G's sister was very clear that no woman in her culture would disclose domestic abuse to a man, whether a GP, or a member of the family, and they would never disclose via an interpreter who was male. She felt it could be possible to disclose to a health visitor or midwife.

Her sister related that Adult G's relationship with her volunteer English tutor was important to her. She looked forward to the visits and welcomed the gifts that the tutor brought. It was significant that she chose to show her bruise to her tutor; she would never have admitted abuse, but did want her to know that she was hurt. Adult G's sister felt let down by the organisation which the family believed could have done more to act on the information the tutor passed on.

Adult G's sister told us that whilst there is tolerance of domestic abuse, this does not mean it is permitted. On the contrary, she was clear that the Qu'ran does not permit assault but explained that there is often a difference in interpretation by individuals and families. Generally, within her culture, it would not be acceptable to report abuse; the shame would be attached to the woman who was being abused. She felt strongly that the one thing that could be done would be to reduce the isolation of women in refugee households. Her suggestion was that English classes should be compulsory for refugees; she believed this would take women out of the home, educate and inform them about the law and what they can do to get help; and help them to build social networks. Overall this would help women to integrate with local communities. She was very clear that it would not be acceptable within her faith to attend an event held at a church or church-owned premises.

The family's participation in the Review was remarkable for their honesty and willingness to discuss difficult matters. There were some concrete ideas that resonate throughout the Review and can be taken forward, e.g. awareness for schools working with refugee children, and specifically the need for agencies to ensure they have face to face contact with mothers in refugee households. Whilst the suggestion of compulsory English classes may not be achievable, as a constructive way of reducing isolation and increasing integration, and developing social and support networks for migrant families, the provision of English classes needs careful consideration.

3.1 Conclusions from the Individual Management Reviews

3.1.1. A**gency awareness and understanding of relevant cultural, race, religion or nationality issues, and consideration of equality duties:**

Health services:

- Adult GH moved GP practices which is said to be common among refugees who move a lot; he may not have understood that patients are registered with a specific GP practice. It is not uncommon for Arabic speaking men to register at Practice 1 where there are Arabic-speaking GPs; while the family is cared for by a practice nearer to the home.
- A lot of different practitioners were involved and no one was able to establish relationships or continuity of care. Adult GH arranged to see a different GP during a course of treatment for depression; it is not known why he did this. The family generally presented chaotically, not keeping appointments, using the walk-in service.
- The GPs caring for the family were experienced in caring for refugee families. One GP stated that Adult GH's faith allows violence towards women though domestic violence was rare in the Islamic population he cared for and more common in cultures that use alcohol. Another GP reported that his experience of Muslims is that domestic violence would be offensive and that domestic abuse is common in all cultures and religions. There was evidence of a GP using direct questioning of Adult GH in relation to his anger and domestic abuse; this demonstrates a good understanding of cultural differences and the possible impact of prior trauma on an asylum seeker.
- Staff at both practices are trained in domestic abuse and aware of the domestic abuse pathway.
- Maternity and midwifery practitioners were not aware of cultural complexities, and had this been known, the information may have influenced the care provided. For example, there may have been more emphasis on understanding the family dynamic. Efforts were made to support the family to ensure adequate food, money and accommodation was secured, however the impact of that intervention on the family is not clearly defined.
- There was a limited understanding of the cultural background of the family by the Health Visiting and School Nursing Services. More knowledge of the cultural background of this family may have influenced the way these agencies worked with this family.
- In the Health Visiting Service the IMR author concluded there was no evidence that a lack of awareness impacted on interventions. Interpreters were used. During the Review, it was raised that a health visitor did not complete 'routine inquiry' (into domestic abuse) because Adult G was accompanied; this is raised as a lesson learned. Also, it was raised during the Review that Adult G was referred to a resource in the community that was not accessible to her, and this was not understood by the health visitor. Adult G was referred to English lessons provided at home by SAVTE which was good practice.

- The School Nursing Service had minimal contact with the family and during their contact communicated with Adult GH and his brother, who collected the children from school. An interpreter was not used by the School Nurse. The Review found there was a lack of awareness of the language barrier and therefore the invitation to attend a Team Around the Child Meeting was probably not understood.

Children, Young People and Families:

- The MAST worker engaged in resolving Child GS1's school attendance problem was proactive in using interpreter services to communicate with Adult GH, and helping his attendance at English classes to fit in with school times.
- MAST staff did not meet the family other than Adult GH. The IMR author raised a number queries about the agency's awareness, understanding and consideration of cultural, race, and religious issues. The record begs questions such as: why was the worker only engaging with Adult GH and not making attempts to engage with Adult G? Why did the worker believe Adult GH needed support to work around school times, without having a conversation with Adult G who also had parental responsibilities? What assumptions was the worker making about this family that impacted on his practice? This would include a question of gender bias. Did the worker know that in this culture, as a man he would not gain access to Adult G? These issues are reflected in action plan.

Housing Services:

- The family was referred to the Refugee Service for support when they were in interim accommodation which suggests there was recognition of their refugee status and need for support, and relevant action was taken.

Refugee and Asylum Seeker Services:

- The support worker was Arabic speaking and aware of the family's culture. This is highlighted as good practice. There was discussion during the Review as to whether this is a paradox: there is experience to indicate that troubled individuals within ethnic minorities often do not wish to have workers from the same ethnic minority. They may perceive a threat to their confidentiality or a judgement by their own community on their ability to manage their lives. In the case of this family, shame was a key factor. This paradox may be reflected in knowing that although the service provided practical support and advice for a prolonged period, the worker did not get close to the family.
- Records indicate that Adult GH became less engaged with the support worker when she transferred her support from doing tasks with or for him to encouraging and enabling him to do the tasks himself. There is a file note of Adult GH becoming 'loud and upset' with the worker when she refused to carry out several tasks directly and advised him instead of the steps to do them himself, in June 2012. Gender bias may have been a feature in the relationship between support

workers, who were female, and Adult GH; there could be a risk of underplaying the significance of gender given the complexities of culture, race and religion.

- Adult GH disengaged from this service by telling the worker they were moving to Manchester. No such plan has been reported elsewhere. The disengagement supports the view, expressed elsewhere, that Adult GH may have been disengaging with all services who may have observed domestic abuse or provided Adult G with an opportunity to disclose.
- Information about the significance of the relationship between the white British tutor and Adult G supports the notion that it was easier for Adult G to develop rapport with a woman from a different faith and/ or culture.

3.1.2 **Processes for communication with non-English speakers:**

Health services:

- In GP services, most of the consultations used translators or the GP spoke Arabic. The practices used in house interpreters for consultations, phone calls and making appointments. The GP practice could reflect on the suggestion that Adult G would have found it more difficult to disclose to members of the local community, which would include the receptionists.
- In midwifery and health visiting services, interpreters and Language Line were used to communicate with Adult G, but the IMR author notes that it is not clear if Adult G was comfortable with the interpreter service that was used. It is not recorded whether the telephone interpreters were male or female or if there was a choice of gender offered.
- The School Nursing Service did not use an interpreter. There is evidence that Adult GH was able to communicate in English, as was his brother. This is conflicted by the section below which suggests there was a language barrier.

Children, Young People and Families:

- Workers have access to 'Language Line' and this was accessed.
- There were clearly communication difficulties between the school and the family, as a result of language. Interpreters were not used, although the school had concerns to discuss. There was a misunderstanding about who was collecting the child, which could have been due to communication.

Asylum Seeker and Refugee Services:

- The support worker was Arabic speaking.
- The Service uses pictograms in literature, to communicate with refugees and asylum seekers about domestic abuse.

Police:

- The police IMR identified a lesson to be learned when a 999 call is made by a child of a non-English speaking family such as happened in this case. By utilising

Language Line the Police will provide the level of service that would be offered to an English-speaking caller.

The Review found there to be a shortage of female interpreters which could impact on someone's ability to respond to questions about domestic abuse; and has become aware that interpreters sourced locally may represent the same community as the abused person, again impacting on the ability of a victim to speak freely.

3.1.3 A**ppropriate information for members of the public, including hard-to-reach communities:**

Health services:

- Practice staff was aware of the information on the Sheffield CCG website regarding domestic violence including the pathway for referral. The GPs and their staff reported that they look for the signs of domestic violence and would report it if it was suspected. Practice 2 has posters regarding the domestic abuse help line in waiting areas and consulting rooms. There were some concerns about putting up posters at Practice 1 because of fears of alienating patients who may think you are meddling in their affairs but it was accepted that this could be trialled.
- STHFT highlighted the need for targeted training and enhanced information being available to staff involved with hard to reach communities. Having a named midwife experienced in caring for vulnerable families is a huge benefit. Continuity of care was a positive factor in the care of Adult G and efforts to support the whole family were clearly evident.
- There are posters, leaflets and contact cards with all the relevant information regarding domestic abuse, including the Domestic Abuse Helpline available and accessible in the health clinics in Sheffield. The Helpline for Domestic Abuse is also on display in health settings across the city. Some information is available in a number of languages including Arabic however having posters in key languages could be considered.

3.1.4 **Agencies working together effectively to safeguard the children:**

Health services:

- The children missed a lot of appointments and were sometimes brought the next day; there is no way of knowing what could have been missed or whether it had been a minor illness which just resolved itself.
- A failed call-back due to Adult GH having another appointment is not explained and is an example of chaotic presentation which may have alerted concerns about child neglect. This concerned the baby, who was seen the next day and was noted to be well and happy.
- The baby was not brought for the one year old vaccinations and although this was followed up six months later it could have been opportunity to ask the health visitor if there were any other concerns about neglect or accessing health care.

- Child GD1 [*redacted*] which is detailed in NICE Guidelines on child maltreatment as a feature that should prompt consideration of emotional abuse if it is persistent and unexplained. [*Redacted*.]
- Adult G and Adult GH were educated about [*redacted*]. NICE guidelines state that [redacted] should prompt consideration of neglect. This could have been a missed opportunity to raise the question of neglect with other professionals such as the health visitor or suggest a MAST referral for further support around hygiene. However, the IMR author who is a GP, does not think [*redacted*] would have triggered information sharing with health visitors.
- The Health Visiting Service took action to address the needs of the children and encourage their development. All contacts by the Health Visiting Service were with Adult G. Adult GH was seen on only one occasion.
- The Health Visitor was unaware of the concerns raised at school regarding Child GD1. Both the School and the School Nurse would have been aware of younger siblings in this family. It may have been helpful for the School Nurse to liaise with the Health Visitor as it would have given the Health Visitor an opportunity to share information regarding the younger children's health, development and wellbeing. Had the information been shared it might have prompted the gathering and analysis of further information to obtain a wider picture of this family. This could have influenced the decision making process regarding referral and support from other services including specialist services,
- It is not clear from the School Nursing Records whether there was an improvement regarding Child GD1 and whether the improvement was sustained.
- There was consistent contact with Adult G during delivery of maternity and midwifery services, including substantial contact by the midwife from the Homeless and Travellers Services, and no concerns were noted regarding possible evidence of neglect.

<u>Children, Young People and Families:</u>

- There were clear missed opportunities to engage with the family following the first referral from the community midwife. This is a gap in both inter-agency communications as the referral came from health and was passed to the Family Development Project; and in intra-agency communication, as it can be seen that MAST in one locality did not communicate effectively with MAST in another locality, on two separate occasions. It is not known what impact this had on opportunities to identify any neglect and address any safeguarding concerns.
- When MAST intervened as a result of a further referral, the wider, more complex needs of the family were not addressed and the focus of the work was centred on one child's attendance issues in isolation. There was no contact with Adult G. This has been highlighted as a significant gap in services, and improvements described in this Report.
- The School had concerns about neglect which led to a meeting being convened by the school nurse. There was confusion about who would be the lead

professional in convening this meeting, and information was not shared with other agencies, including the health visitor and children's social care. It was not clear that this was a TAC meeting. The parents did not attend the meeting and this did not lead to further action to engage with the parents. Lessons for the School to learn include clearly understanding and implementing multi-agency procedures.

- There were three key occasions when the School might have had contact with Adult G: at the pre-school visit to the family home; for discussion of concerns about the eldest daughter; and visiting the home to follow up concerns about school dinners. Yet lack of contact with Adult G did not raise a concern. The School should reflect on this practice and consider that one parent may be 'blocking' contact with another parent for a reason, and this could be escalated into a concern using the multi-agency pathways for communication.

Housing Services:

- No safeguarding issues were observed or reported during the period of contact with housing services. At the time of the homicide, the family was in privately rented accommodation.

Asylum Seeker and Refugee Services:

- There was good and regular liaison and information sharing with other agencies working with the family.
- Some areas of work were duplicated, the 'lead' agency not always being evident.
- When the tutor may have heard a child being hit, this was not shared within the agency. There is insufficient training or systems within the agency in regard to safeguarding. It is not thought that raising this incident would have led to an intervention, however, if it had been communicated back to the health visitor (who was the referrer) it may have been linked to other data and led to an unannounced visit.

3.2 Faith and Culture:

As it emerged that faith and culture were relevant to the services provided to the family, we discussed these issues with the family; met with a women-only Focus Group representing the faith and culture of the subjects in this case; and included a representative of the City of Sanctuary (a local movement which aims to build a culture of welcome and hospitality for refugees and asylum-seekers) in our discussions.

3.2.1 Faith:

The family's religion is Shia Islam. Following research and consultation which is discussed in the main Report, we are confident that there is no acceptance of domestic abuse within the faith. This is a faith that sets out the nature of gender relationships and a process for resolving disputes, and it is suggested that Adult GH did not follow the teachings of the Qu'ran by chastising his wife. Adult GH's brother

told us that in difficulty the men would seek the support and advice of the *imam* as the worship leader at their local mosque; and Adult GH did not generally do this; instead he confined his religious activities to the home although we were told he sought advice from the Mosque regarding his mental health. Adult G's sister told us that whilst domestic abuse is not permitted within Islam, it is a matter of interpretation and she is aware of the teaching having been interpreted otherwise. In this regard, there would be nothing to distinguish interpretations of Islam from interpretations of other faiths, in which perpetrators of abuse have been able to find justification for their actions. There is no suggestion that the homicide was motivated by Adult GH's faith beliefs, and although extreme religious expression may have become part of a set of delusions he experienced before the murder, any such discussion is beyond the scope of this Review.

3.2.2 Culture

This family is Kuwaiti Bidoon. The main report references discussion of the Bidoon community, a stateless group of residents facing barriers to health care, education and employment. In Kuwait, there is a relatively low level of physical violence against women. However, the experience that led to seeking asylum, and having financial hardship and social isolation in this country, may suggest the potential for domestic violence could be more significant. This would not be by virtue of being a Bidoon.

3.2.3 Conclusions about faith and culture:

During this Review, myths about faith, culture and domestic abuse were expressed by staff with a British heritage, and staff with an Arabic heritage. Professional staff expressed assumptions about faith and gender that may have influenced their work. For example, the lack of attempts to have face to face contact with Adult G; and the acceptance that a visit to the home would not include her. These contributed to the invisibility of Adult G from services.

The conflicting and divergent views expressed by professionals during this Review may mirror perceptions of domestic abuse within the community. The trial heard that neighbours on either side of the family house heard assaults taking place in the days leading up to the murder, and heard the murder taking place over several hours. Neither set of neighbours reported these events; one was white British, and the other was Arabic.

These myths are for agencies to address. The issue about cultural competence is that staff should be trained to be professionally curious about new groups presenting to the service in order to understand their needs and ensure equal access to the service; and in relation to domestic abuse, to ensure staff at every level is clear that domestic abuse in any language, faith or culture is not tolerated within UK law.

In our discussion with Adult G's sister, she expressed that what was most important in enabling domestic abuse was the values of the family. This applies to all families

of all faiths and cultures. In her view, the most important barrier to the disclosure of domestic abuse was in the isolation of women who are part of refugee families, their inability to communicate in English, to understand the law and how they would be helped and supported. Given that she was clear that Adult G could not have disclosed abuse in her own community, because of her isolation, and the shame and prejudice she would have experienced in her own community, her view was that only better integration with British communities would help.

Having considered the influence of faith and culture, the Review concluded that it is the migrant status of the family, and not their faith or culture *per se*, which emerged as a significant theme. The barriers to services for migrant families, given their isolation; language; financial difficulties; poor, often crowded accommodation; psychological and physical health issues arising from their experiences or lack of treatment in their home country; can create a closed and pressurised environment in which violence could either be triggered or could escalate. Added to an individual's predisposition to violence, or a family's tolerance of domestic abuse, these factors can significantly raise the risk of abuse within the household.

3.3 Migrant Families

The following issues, highlighted in this Review, are common to migrant families. Some have been raised in previous DHRs.

3.3.1 Interpreters

- A shortage of female interpreters. The gender of the interpreter would be a key influence on someone's ability to respond to questions about domestic abuse.
- Interpreters sourced locally may represent the same community as the abused person, again impacting on the ability of a victim to speak freely.
- It is often difficult to source a female interpreter when using Language Line.
- The questions used by health staff in routine domestic abuse inquiries may not be understood by people without English as a first language. For example, Arabic speakers understand and respond to direct questioning.

3.3.2 Support for migrant families

- There is no support service for refugees once they move from National Asylum Seeker accommodation, i.e. once they are granted leave to remain as a refugee, yet there is evidence of ongoing financial hardship and social isolation.
- Community resources are not easily accessible to migrant families because of the barriers of language, travel, childcare, etc., quite apart from the restrictions in some families on women being unaccompanied. Resources based in a church-owned setting cannot necessarily be accessed by people of other faiths.
- Sheffield City Council is a 'City of Sanctuary' which is an area for continuing development as it relates to diversity, community cohesion, and practical support for migrant families.

3.4 Overall conclusions

3.4.1 Good practice:

There was evidence of good practice, for example:

- The proactive approach to domestic abuse by GPs working with refugees and asylum seekers presenting as depressed and angry; the use of direct questioning.
- Primary medical services were accessible and culturally sensitive from GP practices experienced in working with refugee families.
- The level and quality of intervention and support by the community midwife.
- The level of support provided by the Refugee Support Service.
- Examples of important support being offered to new migrant families by well-trained, multi-ethnic teams; for example, in GP practices, in housing and refugee support services.

3.4.2 Missed opportunities:

The abuse experienced by Adult G was never exposed to agencies and therefore there was no opportunity for any of the agencies to assess Adult G's risk using the DASH risk assessment tool. With one exception when Adult G showed a bruise to her tutor, the abuse experienced by Adult G was hidden from the view of people outside the household and family. There were however opportunities where there could have been an intervention or other support, and these are described below and explored in detail in the main Report.

- During one episode of intervention, the Health Visiting Service did not make a routine domestic abuse inquiry.
- There were potential signs of neglect in the children, both in contact with GPs and in contact with the school.
- There were communication barriers between the school and the family.
- When Adult GH disengaged with services, or did not allow access to the house, this information was not communicated, discussed and potentially linked with other information.
- Two episodes when MAST and the Family Development Project could have intervened with the family were missed.
- In the third episode of MAST involvement, the service focussed exclusively on school attendance and did not address the family welfare issues in the referral.
- There was no contact with Adult G by children and young people's services including schools and this was not seen as unusual by any of these agencies.
- Adult GH was asked about domestic abuse by his GP; Adult G was never asked (it was a different practice).

- When Adult G showed her tutor a bruise, the absence of pathways and processes at this Service did not provide her with an opportunity, although we are assured by family that she would not have disclosed.

The Review heard of a number of developments since these events which would make the systems more resilient in a similar situation. These included a restructuring and new system design in MAST; and the introduction of the FCAF (new assessment methodology) which are detailed in the main Report.

3.4.3 Hindsight:

In hindsight we know that her husband had always been violent towards Adult G and that this had escalated when in the UK. Evidence presented at the trial proved that he assaulted his wife seriously prior to the homicide. However, the family's lifestyle effectively masked any opportunity for abuse to be observed or recognised as abuse. Adult G had no support and social network in the UK beyond her sister. She spoke no English. She did not know where she lived. She did not know her sister was just a short walk from her house. She was not allowed out of the home without being accompanied by her husband, and in the house she was supervised by her husband or his mother.

Adult G was not known to the school and to agencies that did not visit the home, with the exception of her visits to the GP. In hindsight there are a number of potential signs that may have alerted a worker to potential domestic abuse, such as Adult G's chaotic presentation at the GP surgery with a number of minor ailments which may be considered a 'calling card' but no injuries were ever observed and there was no reason to make the link. However, health professionals did come into the home. There were no observable signs of abuse during these contacts.

We now know that during the last year the family had very little contact with external agencies and have speculated that her husband was actively disengaging from external services or 'blocking' their contact with Adult G. There was no opportunity for agencies to observe the family during the last 6 months, and no contact with her sister for the last 3 months, of Adult G's life. Withdrawal from the observation of any professional worker or family member may have been part of a wider picture of coercion and control. As referenced earlier, the isolation of Adult G was so complete that, had a member of the family not called the police, the homicide may not have been discovered.

It is not possible to say whether any or all of the lessons learned set out below, and recommendations at the front of this summary, had they been applied earlier in Adult G's life, could have made her safe. Information from the family and from the police investigation and criminal trial, leads me to conclude that her husband's abuse of her was so persistent and determined, and the barriers against disclosing it so insurmountable to her as a migrant woman, that Adult G would never have been safe unless she had returned to Kuwait/ Iraq to be with her family. Although under

consideration by her family at the time of her death, there was no suggestion that this was an achievable option for her.

This is not the first DHR where the victim is a woman in a migrant family, and there will be other migrant families in which the adult female is in a similar situation as Adult G prior to her homicide. It is therefore very important that the following lessons are learned, the recommendations noted and the action plan implemented.

3.5 Lessons to be learned

Health services:

- It is good practice to ask about domestic abuse when patients attend with depression and especially thoughts of self-harm and anger.
- Domestic violence and child neglect are often found together.
- GPs and practice staff need to be aware of the cultural issues relating to asylum seekers and refugees.
- Failure to attend appointments and chaotic presentations can be associated with child neglect and domestic violence.
- It is good practice to record the use of interpreters and who is present in a consultation.
- Health Visitors should routinely enquire about domestic abuse when undertaking family health assessments to complete the family health profile. The presence of family members or friends does not negate this requirement.
- There must be clear documentation when an assessment/ enquiry about domestic abuse has not been possible and the need for further attempts to be made for the assessment/enquiry to be completed.
- We need to continue the inclusion of findings of DHRs, implications for practice and lessons to be learned, in training and updates for Health Visitors, School Nurses and other Community Health Practitioners.
- The findings point to the importance of preparation prior to joint visits when undertaking an assessment together with an interpreter.
- When a safeguarding or child protection issue is raised regarding a school age child, and there are younger siblings in the family, the Health Visiting Service could be contacted by the School Nurse to seek any relevant information that could contribute towards assessment or decision making.
- Health practitioners need to be more aware of the cultural background of families and understand the implications this may have on the children and the family.
- There could have been better information sharing between the GP practice and the Health Visiting Service.
- This was a vulnerable refugee family who could have been flagged up to discuss at regular meeting with the health visitors.
- The School Nursing Service should liaise with the Health Visiting Service when concerns about neglect are raised at school, to consider other siblings.
- Health visiting records need to be shared by using electronic systems, rather than handheld records.

Children, Young People and Families:

- MAST detailed a number of steps taken since 2012 that would lead to a different service being provided now. During the Review, MAST undertook an exercise to evidence these improvements.
- MAST's new systems need to evidence that information is shared between localities, when families move address.
- The lack of clarity about roles and responsibilities in the school safeguarding system should be clarified by the implementation of the FCAF.

Housing Services:

- Missed telephone calls between professionals must always be followed up.

Asylum Seeker and Refugee Services:

- When families end contact, the Service should cross-reference with other agencies to explore whether disengagement reflects difficulties within the family.