Domestic Homicide Review

Imran
November 2020

Executive Summary
Final Version

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Independent Author
15th November 2023

1. Note: Imran is a pseudonym used for the victim, and Hassan is a pseudonym for the perpetrator for the purposes of this Report.

LIST OF CONTENTS PAGE

GLOSSARY

ACE Adverse Childhood Experience
ADHD Attention Deficit Hyperactivity Disorder
AAFDA Advocacy After Fatal Domestic Abuse
AFV Adult Family Violence
ASB Anti-Social behaviour
CPR Cardio Pulmonary Resuscitation
CPS. Crown Prosecution Service
CRC Community Rehabilitation Company
CSP Community Safety Partnership
DA Domestic Abuse
DASH Domestic Abuse Stalking and Honour Based Violence
DARA Domestic Abuse Risk Assessor
DNA Did Not Attend
DWP Department of Work and Pensions
DHR Domestic Homicide Review
ECHR European Court of Human Rights
ED Emergency Department
EET Employment, Education or Training
FLO Family Liaison Officer
GMC General Medical Council
GP General Practitioner
GPMS Government Protective Marking Scheme
HBVA Honour Based Violence and Abuse
HIT Health inclusion Team
IDVA Independent Domestic Violence Advisor
IMR Independent Management Review
IPV Intimate Partner Violence
MARAC Multi Agency Risk Assessment Conference
NEET Not in Employment, Education or Training
NHS National Health Service
NPCC National Police Chief Council
OIC Officer in Case
PTSD Post Traumatic Stress Disorder
SPOC Single Point of Contact
SOP Standard Operating Procedure
VAWG Violence Against Women and Girls
YOI Young Offenders Institution
YOT Youth Offending Service

NOTE OF CONDOLENCE AND GRATITUDE

55. As the author of this Domestic Homicide Review (DHR), I offer my sincere condolences to Imran's family for their loss.

56. To lose a son, brother, father, and partner at such a young age and in such circumstances is a tragedy.

57. It is recognised the conviction and imprisonment of Hassan, for the murder of his brother, will have caused considerable distress to the family.

58. Despite extensive efforts by the Sheffield Domestic Abuse Co-ordination Team (SDACT) and the Independent Author, Imran's family and ex-partner(s), the perpetrator, as well as the perpetrator's ex-partner have all elected not to engage with this DHR. We respect that this is their right.

59. Professionals, of the agencies involved, co-operated fully with this DHR. The Sheffield Domestic Abuse Co-ordination Team (SDACT) provided helpful co-ordination and administrative support.

INTRODUCTION

This Domestic Homicide Review (DHR) examines agency responses and support given to Imran, a resident of Sheffield, prior to the point of his death in November 2020.

The key purpose for undertaking a DHR is to enable lessons to be learned from homicides, where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned, as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide; and most importantly, what needs to change, in order to reduce the risk of such tragedies happening in the future.

CIRCUMSTANCES LEADING TO THE REVIEW

In November 2020, a call was received by South Yorkshire Police (SYP) from a person passing by, stating a male was on the floor outside the home address of his brother Hassan.

Police officers attended and located the male, Imran (victim) who was unresponsive, and had a puncture wound to his back. CPR was administered and Imran was taken to the Northern General Hospital by ambulance.

Despite continued attempts at resuscitation in the ED, CPR was discontinued, and Imran was pronounced dead.

When staff examined Imran in the resuscitation bay, a 1cm stab wound was observed to the centre of his back to the left midline. There were a further two smaller, superficial, stab wounds noted to his left arm.

CCTV footage from the scene showed Imran, emerging from the flat taking a few steps, and slumping to the ground. He had sustained a fatal knife wound.

Hassan (the victim's brother) was arrested on suspicion of murder and taken to Police custody. Of note, upon arrest, Hassan (perpetrator) allegedly said "My brother is dead. What am I going to say to my dad?".

Hassan was subsequently charged with the murder of Imran.

Having been found guilty of the murder of his brother, Hassan was sentenced to life imprisonment with a direction to serve a minimum of 15 years.

HM Coroner has directed no inquest will take place into the murder of Imran unless Hassan appeals against his sentence.

73. It is of note, there was a ‘mirror’ incident involving the two brothers in August 2018. There also appears to be an escalation in violence and animosity between Imran and Hassan in 2018.

74. **SIGNIFICANT INCIDENT ASSAULT ON IMRAN BY HASSAN ON 14TH AUGUST 2018.**

75. The tragic events in November 2020 mirror an incident that took place between Imran and Hassan in August 2018. Indeed, at the Crown Court murder trial, the incidents were described as ‘strikingly similar’.

76. During the early hours, Imran attended a third-party address covered in blood stating Hassan had stabbed him for unknown reasons.

77. Imran was taken to Sheffield Teaching Hospitals Emergency Department (ED) via Ambulance. At this point, Imran stated to staff he had been assaulted by an unknown male whilst getting out of a taxi. Staff in the ED had no obvious reason to question the explanation provided by Imran.

78. Imran sustained injuries to his lower back and chest. Imran developed a small haemothorax (blood in the chest cavity). It is documented ‘slash’ wounds were observed to his left arm and wrist. Imran also sustained a fracture to his right rib. A chest drain was inserted.

79. Imran was then transferred to a cardiothoracic ward at the Northern General Hospital where he was given antibiotics, observed, and monitored. Imran was later discharged to his home address the same day. It is documented, within his health record, Imran declined all family contact. There is no further detail pertaining to his reasons for declining family contact.

80. SYPs response to this incident and subsequent investigation was diligent.

81. A third party reported the brothers had been drinking vodka and an argument had ensued. Blood and a broken glass bottle were found outside Hassan's home address.

82. However, when officers spoke to Imran, he refused to answer any questions about the incident. Imran stated he could not remember how the injuries happened and would not engage with the Police.

83. SYP made numerous attempts to engage with Imran, but he would not answer phone calls. Officers attended his known and previous addresses (14 in total) but again received no response. It is believed Imran was actively avoiding officers during this

time and may have moved addresses. During these visits officers left cards at all the addresses requesting Imran contact them, but he never did.

84. Hassan was arrested and interviewed in relation to this matter. During interview he answered 'no comment' to all questions.

85. No charges, or any other action, were brought against Hassan, primarily due to Imran refusing to support a prosecution, and there being insufficient evidence to take the investigation to the CPS.

86. Eventually, after all avenues and attempts were made to progress the case and gather evidence, the conclusion was to close the investigation pending any further evidence coming to light.

TERMS OF REFERENCE

87. The Terms of Reference, as detailed below, will be specifically addressed within this DHR:

A. The brothers had histories of criminality from young ages – does the case provide any learning regarding agency responses to young people and criminality?

B. Are agencies in Sheffield able to identify adult family violence and the risk factors associated with it?

Standing Together identified key risk factors in their review of DHRs in 2016 – these include:

- **History of the perpetrator – family history (complex and intergenerational experiences of abuse)**
- **Previous violence against women**
- **Pattern of previous criminality**
- **Antisocial behaviour**
- **Sense of entitlement, including to financial resources**
- **Addiction issues**

C. There appears to be indications of coercive control from Hassan towards Imran – if this was the case, are agencies able to recognise and respond to coercive control between family members?

D. **Is there any learning in relation to agency responses regarding the similar Incident in 2018 where it also appears that Hassan stabbed his brother Imran?**

E. **The victim was male – are agencies in Sheffield able to identify and respond to male victims of domestic abuse?**

F. **Processes for case flagging and information sharing in relation to known perpetrators of domestic abuse – are these processes as effective in relation to perpetrators as they are for victims?**

G. **Were there any opportunities to address substance misuse that were missed? For either the alleged perpetrator or the victim.**

H. **What consideration was given by agencies to the negative impact the COVID restrictions may have had on the relationship between Imran and Hassan and did this inform practice? At the time of Imran's death COVID-19 restrictions were in place in Sheffield.**

I. **Was a trauma informed approached used with either brother in their contact with agencies? Were opportunities missed to use this approach?**

88. **SCOPE of DHR**

89. This DHR will consider agencies contact and involvement with Imran and Hassan from 1st January 2018 until 15th November 2020.

90. Any significant and relevant episodes prior to 1st January 2018 were also be considered, as they are deemed necessary for the purpose of the DHR.

SUBJECTS of DHR

91. The Subjects of the Review are detailed as follows:

92. Imran Victim

93. Hassan Perpetrator

94. Rashid Father of victim and perpetrator

95. Tahira Mother of victim and perpetrator

96. Shabana Sister of victim and perpetrator

97. Saqib Brother of victim and perpetrator

98. Olivia Victim's ex-partner (mother of victim's son)

99. Azra Victim's ex-wife

100. Asif Victim's child

101. Following discussions, the subjects within the terms of reference for this review was later amended to also include:

102. Emily – Perpetrator's ex-partner

103. Abid – Perpetrator's child (now adopted)

104. Given the family elected not to engage in this DHR, the panel have chosen the pseudonyms using publicly available information regarding names commonly in use for people from the British Pakistani community.

CONTRIBUTORS TO THE REVIEW

105. The following agencies were identified and contributed towards the DHR:

- South Yorkshire Police (SYP)
- Sheffield City Council Domestic Abuse Co-ordination Team (SCC DACT)
- Sheffield City Council Children's Social Care (SCCCSC)
- Sheffield City Council - Youth Services**,** (SCCYS) formerly delivered by Sheffield Futures)
- Sheffield City Council - Housing & Neighbourhood Services (SCCHNS)
- Sheffield Children's NHS Foundation Trust (SCFT)
- Sheffield Domestic Abuse Co-ordination Team (SDACT)
- Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
- Sheffield Clinical Commissioning Group (SCCG)
- Yorkshire Ambulance Service (YAS)
- The National Probation Service (NPS) (on behalf of South Yorkshire Community Rehabilitation Company SYCRC which is now defunct)
- Sheffield Youth Justice Service (SYJS)
- Department of Work and Pensions (DWP)
- Independent Domestic Abuse Services (IDAS)

106. The following agencies also took part in the initial Terms of Reference Meeting:

- Crown Prosecution Service (CPS)

- Citizens Advice Bureau (CAB)

107. **REVIEW PANEL MEMBERS:**

108. Hester Litten Head of Safeguarding	109. Sheffield Health & Social Care (SHSC)
110. Christina Blaydon Head of Safeguarding	111. Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
112. Dan White Head of Health and Targeted Services	113. Sheffield City Council Youth Services (SCCYS)
114. Joanna Abdulla Head of Advice	115. Citizens Advice Bureau (CAB)
116. Susan Brook SY ICB Designated Nurse Safeguarding Children and Young People (Sheffield 117. Amy Lampard Designated Doctor for Adult Safeguarding, Sheffield place South Yorkshire Integrated Care Board	118. Sheffield Clinical Commissioning Group (CCG)
119. Joanna Stevens Advanced Customer Support Senior Leader	120. Department of Work and Pensions (DWP)
121. Maxine Stavrianakos Head of Community Safety & Safer Neighbourhoods	122. SCC – Community Safety, Communities
123. Meeta Palawan Named Nurse & Community Safeguarding Service Lead 124. Sheila Gomez Safeguarding Nurse Specialist, Community Safeguarding Team	125. Sheffield Children's NHS Foundation Trust (SCFT)
126. Sally Adegbembo Head of Probation	127. National Probation Service (NPS) 128. Probation Service Yorkshire and the Humber Region
129. Patrick Chisholm Service Manager, Legal Services	130. SCC – Legal Services
131. Donna Taylor Assistant Director Children and Families	132. SCC – Children's Social Services
133. Carl Mullooly Head of Service - Neighbourhood Intervention and Tenancy Support	134. SCC - Housing & Neighbourhood Services
135. Roberta Beasley Detective Inspector 136. Gary Thompson. IMR Author	137. South Yorkshire Police (SYP)
138. Sam Goulding Regional Manager	139. IDAS

140. Simon Richards Head of Service. Quality and Assurance	141. SCC

142. The Review Panel members detailed below were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

143. Given the protected characteristics of Imran and Hassan, advice and insight were sought from the following:

144. Dr Mohammed Mazher Idriss, an academic from Manchester Metropolitan University who is the author of a book entitled 'Men, Masculinities and Honour'.

145. Meena Kumari from H.O.P.E Training and Consultancy specialising in Domestic Abuse, Sexual Violence and Safeguarding.

AUTHOR OF THE OVERVIEW REPORT

146. The Independent Author is a recently retired Chief Police Officer who has no previous connection with the Sheffield Community Safety Partnership.

147. The Author is a former Head of Public Protection and Senior investigating Officer with West Mercia Police, and therefore, has the required knowledge and understanding to undertake this DHR.

148. The Author has undertaken the accredited Advocacy After Fatal Domestic Abuse (AAFDA) Programme

149. The Author is also an associate with Safe Lives, a national charity supporting partners to reduce Domestic Abuse.

COMBINED CHRONOLOGY

August 2018

150. **SIGNIFICANT INCIDENT ASSAULT ON IMRAN BY HASSAN**

151. The tragic events in November 2020 mirror an incident that took place between Imran and Hassan in August 2018. Indeed, at the Crown Court murder trial, the incidents were described as 'strikingly similar'.

152. In August 2018 during the early hours, Imran attended a third-party address covered in blood stating Hassan had stabbed him for unknown reasons.

153. Imran was taken to Sheffield Teaching Hospitals Emergency Department (ED) via Ambulance. At this point, Imran stated to staff he had been assaulted by an unknown male whilst getting out of a taxi. Staff in the ED had no obvious reason to question the explanation provided by Imran.

154. Imran sustained injuries to his lower back and chest. Imran developed a small haemothorax (blood in the chest cavity). It is documented 'slash' wounds were observed to his left arm and wrist. Imran also sustained a fracture to his right rib. A chest drain was inserted.

155. Imran was then transferred to a cardiothoracic ward at the Northern General Hospital where he was given antibiotics, observed, and monitored. Imran was later discharged to his home address the same day. It is documented, within his health record, Imran declined all family contact. There is no further detail pertaining to his reasons for declining family contact.

156. SYPs response to this incident and subsequent investigation was diligent.

157. A third party reported the brothers had been drinking vodka and an argument had ensued. Blood and a broken glass bottle were found outside Hassan's home address.

158. However, when officers spoke to Imran, he refused to answer any questions about the incident. Imran stated he could not remember how the injuries happened and would not engage with the Police.

159. SYP made numerous attempts to engage with Imran, but he would not answer phone calls. Officers attended his known and previous addresses (14 in total) but again received no response. It is believed Imran was actively avoiding officers during this time and may have moved addresses. During these visits officers left cards at all the addresses requesting Imran contact them, but he never did.

160. Hassan was arrested and interviewed in relation to this matter. During interview he answered 'no comment' to all questions.

161. No charges, or any other action, were brought against Hassan, primarily due to Imran refusing to support a prosecution, and there being insufficient evidence to take the investigation to the CPS.

162. Eventually, after all avenues and attempts were made to progress the case and gather evidence, the conclusion was to close the investigation pending any further evidence coming to light.

163. Dr Idriss, an academic from Manchester Metropolitan University, offers the view 'this could be linked to 'honour'-based issues - not disclosing the real perpetrator so as to avoid Hassan being arrested, convicted etc in order to save the family from being

‘dishonoured’ in the eyes of the wider family and/or community? It may also explain his actions further below in seeking to avoid the police.’

OTHER SIGNIFICANT INCIDENTS REPORTED TO SYP INVOLVING IMRAN AND HASSAN DURING THE SCOPING PERIOD

164. There are a range of other significant incidents reported to SYP involving Imran and Hassan within the scoping period. There are also two incidents involving their parents, Rashid, and Tahira.

165. A summary of these incidents is detailed as follows:

19th January 2018

166. Police were informed Imran turned up at Olivia's address banging on the door. No crime identified. No further action taken.

26TH January 2018

167. Imran called SYP stating his brother, Hassan is a “fucking pisshead” and would not give him his wallet back. He demanded officers attend immediately and continued to swear at the operator. Imran called a second time and said his brother had locked the door and had his wallet, and that he 'hated him and wanted him dead'.

Sheffield Teaching Hospital Foundation Trust (STHFT)

168. STHFT records detail two significant incidents involving Hassan within the scoping period.

25th February 2018

169. Hassan attended the ED with an injury to his middle finger. Hassan sustained a dislocated finger whilst allegedly ‘play fighting with his younger brother’. No further details are recorded relating to the injury.

170. Co-incidentally, or otherwise, records show Tahira attended the ED on the same day reporting chest pain. There is no indication she was accompanied during this attendance nor was an interpreter used during the assessment.

171. Although both Hassan and Tahira attended the ED on the same day, at different times, it would have been difficult for ED staff to identify the relationship between the two patients and link the attendances.

172. Hassan and Tahira may not have been aware of each other's attendances at the ED. Furthermore, Hassan or Tahira are not recorded in each other's records as related people.

4th October 2018

173. Hassan attended the ED with a facial injury. Records indicate the injury was sustained by a knife, resulting in a 4cm laceration to the left side of his chin. Of note, a member of staff had concerns when completing an initial assessment and recorded 'yes' to the question on the ED documentation,' *Does this presentation raise issues of child safeguarding or vulnerable adult?'.* It is not clear if this refers to a child of Hassan.

174. There is no documentation to suggest any actions were taken once the staff member had identified a potential vulnerability or concern which is not in line with STHFT policy and guidance. There is no evidence to suggest a child safeguarding referral was made, or if the member of staff explored if Hassan had contact with his, or any other, children. Hassan was given health advice and signposted to attend his GP for a review.

175. Given there is no evidence of a Child Safeguarding Communication Form being completed, this would appear to be a missed opportunity to refer a child (or vulnerable adult) for further assessment of risk and to share information.

Recommendation / Learning 2

176. **STHFT should ensure there are effective monitoring and audit arrangements in place to provide reassurance that where a child safeguarding (or vulnerable adult) referral is raised that safeguarding concerns are noted during initial assessment.**

Other significant incidents involving SYP and Imran and Hassan are detailed as follows.

28th May 2018

177. Imran reported Rashid pushed him. It was noted Imran was clearly on drugs. Imran wanted his passport, but Rashid refused him entry to the home. Imran was verbally abusive to Officers and would have been arrested had he not walked away.

5th May 2018

178. Imran and Hassan had been arguing. Hassan contacted police as he wanted Imran to be removed. No new damage to any property was identified and no injuries were sustained. Imran was taken to his parents' house.

6th July 2018

179. Tahira has been living with Hassan for two days and they have had a ‘falling out’. Tahira was told to leave and as a result hit Hassan with her walking stick. Hassan suffered no injury and refused to engage with officers stating he only wanted her removing from the address**.**

17th July 2018

180. Tahira and Rashid were staying with Hassan and Imran. Tahira stated Imran and Hassan had been drinking and an argument ensued. Imran and Hassan dragged Tahira into a bedroom and assaulted her. It was dark and there were no light bulbs in the property. Tahira stated she didn't know which one cut her, and which one hit her on the head. The suspects both gave matching accounts that Tahira was not telling the truth. Tahira and Rashid then failed to respond to any contact from officers and would not support any prosecution. A crime report and a DASH assessment was submitted. The risk was assessed as medium, which was later confirmed by the DARA. Primarily due to the lack of support from Tahira, no further action was taken.

181. Dr Idriss, an academic from Manchester Metropolitan University, states:

‘The act of drinking within a Muslim household can be very embarrassing. Muslims are not supposed to drink, and it could be Tahira and Rashid were rebuking Imran and Hassan of their Islamic duties not to drink. They may have not liked this so dragged Tahira into the bedroom and assaulted her. Again, this could be linked to ‘honour’-based issues, dishonouring the family because of their drinking habits. When the police showed up, the two brothers closed ranks’.

12th September 2018

182. A third party contacted the Police stating an unnamed male has been cut by his brother, at an address confirmed as Hassan's. The victim was bleeding from his arm and had bled on the floor in the street. A male could be heard in the background to say he was bleeding but declined an ambulance. The call handler rang back, and a male answered the phone stating this was a false call, and he was fine. Officers attended to ensure welfare due to previous incidents but could not locate an injured party.

183. A third party stated the injured male had been injured to his right hand but did not know how. There was fresh water outside suggesting blood had been washed away. The initial caller was re-contacted, who stated she cannot remember making the call and was clearly under the influence of drugs or alcohol, and that she doesn't know who they were talking about and is known to make things up whilst under the influence.

14th October 2018

184. A third party heard a commotion and saw an unknown male run away with a knife. Hassan came out of the address with a cut to his neck. Upon Police officers attending the incident, Hassan was uncooperative, stating no crime had occurred and that the injury had been caused by cutting himself whilst shaving. Hassan signed a Pocket Notebook to this effect. Hassan refused ambulance treatment. Despite the efforts of the Police, no crime was identified, no DASH assessment was considered, and no further action taken.

10th March 2020

185. Police were informed Imran has turned up at Olivia's address banging on the door. No crime identified and no further action taken.

8th November 2020

186. A third party called Police stating his friend 'Mr Ali' has been attacked by his brother and had cuts to his fingers. The address noted was that of Hassan. It could not be confirmed if this was in relation to the reported incident, so officers attended. Multiple house to house enquiries were made, but no male victim could be located. For several days following the incident, the named address was attended and calling cards left. The initial caller was re-contacted, who could provide no further information and hadn't heard from 'Mr Ali' since the incident.

187. Police attended Hassan's address on 14th November 2020. Imran answered the door and stated he had nothing to do with the reported incident, and he was just staying at the address whilst Hassan was away. He was checked over and had no injuries or defensive wounds.

188. Imran was uncooperative and would not answer any questions detailed within the DASH risk assessment or sign a Police Notebook Entry. When asked about 'Mr Ali' he stated he had no idea who this man was and could provide no more information.

8th November 2020

189. Imran had contacted Police stating he has been stabbed by his 'cousin' and hit with a baseball bat at the location. The location was confirmed as the home address of Hassan. Imran stated he is bleeding from the head and vomiting blood.

190. Ambulance and Police officers attended. Imran had a very small 1cm cut to the face but would not confirm how it has happened. Imran then proceeded to be abusive

towards the Ambulance team and walked off. Imran was heavily intoxicated and refused to clarify any details. He had not been stabbed or hit with a baseball bat.

191. Imran refused any treatment and would not provide any details to officers. No further action was taken. No crime was recorded.

192. It is possible these incidents are connected.

193. **CONCLUSION**

194. It is clear Imran, and his brother Hassan, had a difficult life. They lived chaotic, transient lives, were engaged in serious violence and criminality and there was evidence of drug and alcohol misuse.

195. The brothers appeared to have a volatile relationship with each other, which appeared to escalate during 2018. The risk of serious harm was evident in the 'mirror' incident where Hassan stabbed Imran. Tragically, he went on to murder his brother in very similar circumstances.

196. Imran and Hassan's contact with agencies and professionals was inconsistent over time.

197. There is clear evidence of both Imran and Hassan engaging with agencies on a number of occasions when in need; but then electing not to co-operate or support any further action.

198. On a number of occasions, the brothers refused to say anything, or provide ambiguous or false information, to professionals. There is a pattern over time of both brothers missing, or electing not to attend, follow up appointments.

199. There is limited information held around Imran and Hassan's childhood. It is not known if the brothers suffered adverse childhood experiences or trauma when growing up. A greater understanding of the circumstances of Imran's and Hassan's upbringing may have prompted staff to adopt a trauma informed approach.

200. It is clear a number of agencies did not have any awareness, or understanding, of the potential domestic abuse between Imran and Hassan and / or inter-family violence and entrenched criminality.

201. The nature of the relationship between two brothers, and associated risk was not consistently identified by agencies. As a consequence, information was not routinely shared and the opportunity for multi-agency working, and a coherent response, was missed.

202. There is learning regarding how agencies communicate internally, and with each other, to ensure they ‘join the dots’ and make collective decisions on the most accurate, timely and complete information.

203. Professionals, even when acting as part of a joint team, should be professionally curious, and aware of the necessity to make appropriate referrals to allow consideration of risk.

204. Had the concerns been viewed holistically there was information, either known or available, which should have given rise to the view significant harm was at least likely.

205. In undertaking this Review there were some examples of good practice including the Multi-agency working evident at MARAC and SYP, investigating the majority of incidents involving Imran and Hassan, despite the lack of co-operation from both brothers. Further, SHHFT provided care and treatment to Imran and Hassan, on a number of occasions when then presented at ED with injuries.

206. Whilst taking into account the complex relationship between the brothers, lack of engagement and co-operation, and the context in which professionals were working, professional practice was on a number of occasions reactive, rather than a proactive in addressing the risks presented by both brothers.

207. This DHR has identified a range of learning points for agencies and professionals in supporting vulnerable people who are subjects of adult family violence.

208. This learning includes the importance of professional curiosity, recognising domestic abuse involving men and coercive control, risk assessment, multi-agency working, information sharing, and signposting specialist support.

209. Whist the review acknowledges there are some examples of good practice, it also highlights there were some missed opportunities to support and safeguard Imran. That is not to say, the murder would have been prevented; but more professional curiosity, better information sharing, and enhanced multi-agency working may have helped to identify and reduce the risk.

210. The murder of Imran by his own brother was a real tragedy for the family. There are lessons to be learned from these sad events. These lessons which may help avoid similar distress for others in the future.

211. The findings of this DHR provide an opportunity for agencies, both individually and collectively, to consider their response in light of the learning and recommendations; in order to make the future safer for others.

212. A critique of DHRs over time will identify, despite the commitment of agencies and professionals to safeguard the most vulnerable, much of the learning in this DHR are repeated themes.

213. Creating transformational and sustainable change is a significant challenge for Community Safety Partnerships. The relevant learning and recommendations from this DHR should be disseminated and monitored to support this change.

LESSONS TO BE LEARNED

214. ## MULTI AGENCY RECOMMENDATIONS

Recommendation / Learning 1

215. **All Agencies should recognise the importance of ensuring ethnicity and other protected characteristics are recorded. All Agencies should provide additional guidance and training around recording and sharing personal information, including protected characteristics.**

216. ### Recommendation / Learning 3

217. **All Agencies to consider the evidence of the links between adverse childhood experiences, family violence and youth offending and put in place strategies to mitigate the risk.**

Recommendation / Learning 10

218. **All Agencies should recognise the importance of multi-agency working and follow agreed protocols around information sharing in order to assess risk.**

Recommendation / Learning 11

219. **All Agencies to disseminate to Professionals the 'Standing Together Against Domestic Violence' (Sharp-Jeffs and Kelly, 2016) guidance, as part of their professional development strategies.**

Recommendation / Learning 12

220. **Where domestic abuse may be suspected, Professionals should seek to create a safe space (including the use of interpreters as necessary), in order to provide opportunity for vulnerable victims to disclose what may be happening in confidence.**

Recommendation / Learning 14

221. **All Agencies are encouraged to build upon the professional development to date and support professionals around identifying and supporting victims who may be subject of coercive control.**

Recommendation / Learning 16

222. **The Partnership to review the support available to male victims of domestic abuse, particularly men with protected characteristics; and reassure themselves specialist independent support is accessible to victims, who may be reluctant to come forward.**

SINGLE AGENCY RECOMMENDATIONS

Recommendation / Learning 2

223. **STHFT should ensure there are effective monitoring and audit arrangements in place to provide reassurance that where a child safeguarding (or vulnerable adult) referral is raised that safeguarding concerns are noted during initial assessment.**

Recommendation / Learning 4

224. **SYP should build upon the training to date, and support professionals in identifying and responding to inter-adult violence / domestic abuse between siblings.**

Recommendation / Learning 5

225. **STHFT should build upon the training to date and support professionals working within the Emergency Department(s) using selective enquiry or professional curiosity.**

Recommendation / Learning 6

226. **STHFT to raise awareness and understanding of professionals to ensure where domestic abuse is disclosed, within the Sheffield Teaching Hospital, A DASH should be submitted. Within the Emergency Department(s) a Domestic Abuse Communication Form should be used by health professionals.**

Recommendation / Learning 7

227. **The STHFT ED should remind all staff of the 'Standard Operating Procedure for the reporting of gun and knife crime' and ensure all staff working within the Emergency Department and Minor Injuries are made aware of their**

responsibilities for reporting such incidents to police. The SOP could include responsibilities for considering parallel safeguarding and DA referrals.

Recommendation / Learning 8

228. **As part of the ongoing review of 'Did Not Attend' strategy and policies, Sheffield CCG to consider whether they have the capacity to review the risk where patients demonstrate a consistent lack of engagement.**

Recommendation / Learning 9

229. **SCCG should build upon the training to date, and support professionals, in identifying and responding to inter-adult violence / domestic abuse between siblings.**

Recommendation / Learning 13

230. **Health Visitors (working for Sheffield Children's NHS Foundation Trust (SCFT) or Sheffield Health and Social Care Trust) should routinely submit a DASH (Domestic Abuse, Stalking, Harassment, and 'Honour' Based Abuse) risk assessment where domestic violence or abuse is identified or suspected, including inter-family violence.**

Recommendation / Learning 15

231. **SYP should ensure a DASH risk assessment is completed in all domestic abuse incidents, even when the victim is refusing to engage.**

Recommendation / Learning 17

232. **SYP should ensure any person arrested for a 'trigger' offence should be the subject of a mandatory drug test and assessment, we well as being offered the support of a drug referral worker.**

Recommendation / Learning 18

233. **STHFT should ensure patients are signposted for specialist support when they are exhibiting evidence of alcohol and drug misuse**

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13th February 2024

Dear Alison,

Thank you for submitting the Domestic Homicide Review (DHR) report (Imran) for Sheffield Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 10th January 2024. I apologise for the delay in responding to you.

The QA Panel were pleased to see that feedback had been accepted positively and the necessary changes made from the August 2023 panel. It was positive that updates had been applied to the executive summary and the overview report. It was noted that pseudonyms that were used were chosen sensitively. There was also an insightful discussion of the impacts of the COVID-19 pandemic.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- There was a lack of routine enquiry across health services and a lack of professional curiosity across health and other agencies.
- More evidence could be added around the statement that 'There is a plethora of evidence linking youth criminality to escalation and violence'.
- There are references to coercive control, but they would benefit from greater detail.
- The action plan includes 66 recommendations, but the review only has 16. The recommendations could be made clearer and more specific which would help make the action plan easier to read.

- There are still a couple of places where the text needs changing to the third person – 370: 'my understanding' and 652: 'I understand'.
- The front page of the report is missing the CSP name.
- The report gives the full date of death; this should be updated to include the month and year only.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel