Domestic Homicide Review

Imran

November 2020

Sheffield Community Safety Partnership

Final Version 6

Stephen Cullen
Independent Author
16th February 2024

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

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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
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

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

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

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

79. 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.

80. 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

81. 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 2020.

82. 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.

83. In addition to agency involvement the review will also examine the past, to identify any relevant background, or trail of abuse, before the homicide. Further, whether support was accessed, with agencies and within the community, and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

CIRCUMSTANCES LEADING TO THE REVIEW

84. 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 Hassan, Imran's brother.

85. 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.

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

87. 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.

88. 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.

89. 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?".

90. Hassan was subsequently charged with the murder of Imran.

91. 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.

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

93. 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.

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

DHR PROCESS - TIMESCALES

95. It is recognised reviews should be completed, where possible, within six months of the commencement of the review.

96. In this case, the DHR was initially delayed due to the SYP murder investigation, which commenced in November 2020, and the subsequent criminal trial.

97. The Home Office were notified, on 18th February 2021, of the intention to carry out a DHR.

98. On 19th May 2021 a Multi-Agency 'Terms of Reference' meeting took place, chaired by Sheffield City Council (SCC).

99. On 9th June 2021 the Independent Author was appointed by SDACT.

100. On 26th July 2021, the Independent Author chaired a Multi-Agency IMR 'authors briefing'.

101. On 18th October 2021, the Independent Author chaired a Multi-Agency IMR 'themes' meeting.

102. On 18th January 2022 the first draft of the DHR was submitted to the DHR Panel.

103. On 21st January 2022, the Independent Author presented the initial draft report to the DHR Panel.

104. On 12th April 2022, following feedback, the Independent Author presented Version 2 of the draft report to SDACT.

105. On 6th June 2022, following further feedback, the Independent Author presented Version 3 of the final draft report to SDACT.

106. SDACT submitted Version 4 of the report to the Home Office on the 7th February 2023.

107. SDACT received feedback from the Home Office on the 20th September 2023.

108. The Independent Author responded to the feedback and resubmitted final Version 5 to SDACT on the 15h November 2023.

109. SDACT submitted final Version 5 of the report to the Home Office on the 1st December 2023.

110. SDACT received further feedback from the Home Office on the 13th February 2023.

111. The Independent Author responded to the feedback and resubmitted final Version 6 to SDACT on the 16th February 2024.

112. SDACT submitted final Version 6 of the report to the Home Office on the 27th February 2024.

CONFIDENTIALITY

113. The findings of the review should be regarded as 'Restricted' as per the Government Protective Marking Scheme (GPMS) until the agreed date of publication. Prior to this, information should be made available only to participating professionals, and their line managers, who have a pre-declared interest in the review. It may also be appropriate to share these findings with family members as directed by the Chair.

114. Pseudonyms have been used in the report to protect the identity of the individual(s) involved.

PURPOSE OF DOMESTIC HOMICIDE REVIEW

115. The purpose of the Domestic Homicide Review is to:

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

- Identify clearly what those lessons are, both within and between agencies; further, how, and within what timescales, they will be acted upon 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 and homicide and improve service responses for all domestic violence victims, and their children, through improved intra and inter-agency working.

- Contribute to a better understanding of the nature of domestic violence and abuse.

- Highlight any good practice.

TERMS OF REFERENCE

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?

SCOPE of DHR

116. The scope of this Review is from 1st January 2018 until November 2020**.**

117. 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

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

119.	Imran	Victim
120.	Hassan	Perpetrator
121.	Rashid	Father of victim and perpetrator
122.	Tahira	Mother of victim and perpetrator
123.	Shabana	Sister of victim and perpetrator
124.	Saqib	Brother of victim and perpetrator
125.	Olivia	Victim's ex-partner (mother of victim's son)
126.	Azra	Victim's ex-wife
127.	Asif	Victim's child

128. Note - There has been no way to confirm Imran and Azra were indeed married. Azra stated it was a Muslim wedding under Sharia Law but has not given any further information such as where, when and who performed the ceremony. Sharia law marriages are not legally recognised in the UK. Further, due to her hesitance to give SYP any further information, there is no way to confirm if this is true, as Imran is now deceased.

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

130. Emily – Perpetrator's ex-partner

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

132. 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.

METHODOLOGY

133. The Criteria for a Domestic Homicide Review (DHR) is detailed within the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016).

134. The guidance is issued as statutory guidance under section 9 (3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act).

135. The Act states: (1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

A. A person to whom he was related or with whom he was or had been in an intimate personal relationship

B. A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death

136. 'Intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexual orientation.

137. A member of the same household is defined as:

C. A person is to be regarded as a 'member' of a particular household, even if s/he does not live in that household, if s/he visits is so often and for such periods of time that it is reasonable to regard him / her as a member of it;

D. Where a victim lived in different households at different times, 'the same household' refers to the household in which the victim was living at the time of the act that caused his / her death.

138. In this case, after consideration, the recommendation was a DHR should be undertaken, for the following reasons:

- The guidance confirms the requirement to undertake a DHR where a death has occurred, and the 'person' is related;
- The death of the victim resulted from a violent knife attack and there were historical knife related incidents;
- The victim was a perpetrator of domestic abuse;
- Both the victim and the perpetrator have been convicted of violent offences in the past.

LIMITATIONS /PARAMETERS OF THE DHR

139. There are a number of limitations or parameters around the DHR:

- The main focus of the DHR is on learning. The DHR is not an investigation, nor something which seeks to attribute blame
- 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. We accept this may have affected the quality and accuracy of the review which is likely to be enhanced by family, friends, and wider community involvement
- The Independent Author was provided with information as requested throughout. However, given the scale and complexity of the issues, there may be key material not brought to the attention of the Independent Reviewer
- Therefore, not every issue or incident experience by Imran and Hassan is the subject of reflection, but a sufficient amount of insight was gathered to arrive at an informed assessment.

FRATRICIDE

140. Fratricide is the act of killing one's brother (from Latin: fratricidium, from the Latin words frater "brother" and the assimilated root of caedere "to kill, to cut down") is the act of killing one's brother.

INVOLVEMENT OF FAMILY, FRIENDS AND OTHERS

141. The aforementioned Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews is clear regarding the involvement of family, friends, work colleagues, neighbours, and the wider community.

142. Whilst recognising participation in the DHR is voluntary, the Sheffield Domestic Abuse Co-ordination team (SDACT) and the Independent Reviewer have consistently sought to 'reach out' and engage with the family, as well the victims ex partner(s), the perpetrator, and the perpetrators ex-partner. However, all have elected not to engage with this review.

143. In 'reaching out' to the family, the particular sensitivities, arising out of a situation where one brother has murdered another, were carefully considered.

144. Further, given the family were British Asian, any cultural and faith considerations were also taken into account.

145. The fact that Imran's ex partners and Hassan's ex-partner may have been victims of domestic abuse was also carefully considered.

146. A summary of contact with the family is detailed as follows:

- SDACT and the Independent Reviewer initially engaged with the SYP Family Liaison Officer (FLO).
- SDACT and the Independent Reviewer initially made contact, by letter, with Rashid (victim and perpetrator's father), Tahira (victim and perpetrator's mother) and Shabana (victim and perpetrator's sister).
- Contact was also made with Olivia, Azra, and Emily.
- A letter was sent to the preparator Hassan in prison, but no response was received.
- All parties were provided with the Home Office DHR Leaflet and directed to the Home Office website.
- Recognising how daunting a DHR can be for loved ones, the SDACT also signposted the family and ex partners to AAFDA (Advocacy After Fatal Domestic Abuse) service. They were also encouraged to consider the Victim Support Homicide Service (VSHS).
- At the conclusion of Draft Version 3 of this DHR, communication was forwarded Rashid, Tahira, and Shabana informing of the fact that the review was completed.

CONTRIBUTORS TO THE REVIEW

147. 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)

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

- Crown Prosecution Service (CPS)
- Citizens Advice Bureau (CAB)

149. **REVIEW PANEL MEMBERS:**

150. Hester Litten Head of Safeguarding	151. Sheffield Health & Social Care (SHSC)
152. Christina Blaydon Head of Safeguarding	153. Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
154. Dan White Head of Health and Targeted Services	155. Sheffield City Council Youth Services (SCCYS)
156. Joanna Abdulla Head of Advice	157. Citizens Advice Bureau (CAB)
158. Susan Brook SY ICB Designated Nurse Safeguarding Children and Young People (Sheffield 159. Amy Lampard Designated Doctor for Adult Safeguarding, Sheffield place	160. Sheffield Clinical Commissioning Group (CCG)

South Yorkshire Integrated Care Board	
161. Joanna Stevens Advanced Customer Support Senior Leader	162. Department of Work and Pensions (DWP)
163. Maxine Stavrianakos Head of Community Safety & Safer Neighbourhoods	164. SCC – Community Safety, Communities
165. Meeta Palawan Named Nurse & Community Safeguarding Service Lead 166. Sheila Gomez Safeguarding Nurse Specialist, Community Safeguarding Team	167. Sheffield Children's NHS Foundation Trust (SCFT)
168. Sally Adegbembo Head of Probation	169. National Probation Service (NPS) 170. Probation Service Yorkshire and the Humber Region
171. Patrick Chisholm Service Manager, Legal Services	172. SCC – Legal Services
173. Donna Taylor Assistant Director Children and Families	174. SCC – Children's Social Services
175. Carl Mullooly Head of Service - Neighbourhood Intervention and Tenancy Support	176. SCC - Housing & Neighbourhood Services
177. Roberta Beasley Detective Inspector 178. Gary Thompson. IMR Author	179. South Yorkshire Police (SYP)
180. Samantha Goulding Regional Manager	181. IDAS
182. Simon Richards Head of Service. Quality and Assurance	183. SCC

184. 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.

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

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

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

AUTHOR OF THE OVERVIEW REPORT

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

189. 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.

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

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

PARALLEL REVIEWS

192. There was a murder investigation carried out by South Yorkshire Police into the death of Imran.

193. Hassan was found guilty of Imran's murder and sentenced to life imprisonment with a minimum of 15 years on the same date.

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

EQUALITY AND DIVERSITY

195. The Equality Act 2010 defines the following characteristics as protected characteristics:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

196. Race, religion and belief, and sex are all areas under consideration in this DHR.

197. Both Imran and Hassan were British born. The victim and the perpetrator self-defined as British Asian. The perpetrator described himself to Probation / CRC as a Muslim. It is possible that the deceased was also a Muslim.

198. Professionals should understand and respect equality and diversity issues and ensure that assumptions about people's beliefs, values, gender identity or sexuality do not stop them from recognising and responding to domestic violence and abuse.

199. The Review considered the brothers' ethnicity, religion, and sex and examined whether these factors resulted in any barriers to accessing services in addition to wider consideration as to whether service delivery was impacted. This is commented upon further within the Terms of Reference, item E.

200. In order to inform this DHR, advice and insight was sought from Dr Mohammed Idriss and Meena Kumari. It is important to note that whilst the insight provided by Dr Mohammed Idriss and Meena Kumari is invaluable on occasions they have offered a view based on their experience and understanding of cultural issues, as they have not had the opportunity to rely upon direct evidence from family or friends.

201. There is no evidence identified of any discriminatory practice that affected the service and treatment that Imran, Hassan, or any of the agencies included in this report.

RECORD KEEPING

202. All agencies were directed to thoroughly review all their records to ensure all interactions with Imran and Hassan were identified and included within the chronologies.

203. Agencies recorded Imran and Hassan names, date of births and ethnic origins in different ways at different times. On a number of occasions, ethnicity is not recorded at all. This may indicate that questions may not have been asked, details may not have been recorded accurately. On occasions Imran and Hassan elected not to provide any details.

204. The reasons for this are complex and include:

- A lack of professional curiosity.
- The understanding of professionals of the importance of recording personal details and protected characteristics.
- A potential lack of confidence by professionals to ask personal questions.
- A misunderstanding of the detail provided and limited attention to detail. However, there is no suggestion within agency records to suggest that language was a barrier in terms of communications with Imran and Hassan.
- A lack of trust and engagement from the service user.
- The service user providing different details at different times to different agencies.

205. **Recommendation / Learning 1**

206. **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.**

207. **DISSEMINATION**

208. All agencies engaged in this DHR, together with the Home Office, and the Office of the Domestic Abuse Commissioner will receive copies of this review.

BACKGROUND INFORMATION (THE FACTS)

209. In November 2020 a call was received by South Yorkshire Police (SYP) from a passer stating that a male was on the floor outside the home address of Hassan.

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

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

212. 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.

213. 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.

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

215. Hassan was subsequently charged with the murder of Imran.

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

217. The murder trial attracted significant attention within the local media.

COMBINED CHRONOLOGY

August 2018

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

219. 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’.

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

221. 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.

222. 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.

223. 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.

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

225. 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.

226. 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.

227. 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.

228. Hassan was arrested and interviewed in relation to this matter. During interview he answered ‘no comment’ to all questions.

229. 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.

230. 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.

231. 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

232. 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.

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

19th January 2018

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

26TH January 2018

235. 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)

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

25th February 2018

237. 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.

238. 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.

239. 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.

240. 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

241. 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.

242. 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.

243. 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

244. **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

245. 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

246. 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

247. 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

248. 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.

249. 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 that 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

250. 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.

251. 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

252. 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

253. 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

254. 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.

255. 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.

256. 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

257. 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 was bleeding from the head and vomiting blood.

258. 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.

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

260. It is possible these incidents are connected.

OVERVIEW

261. SYP have a significant number of incidents involving Imran and Hassan during the scoping period. In addition to the incident, which was very similar to the murder, there are other incidents recorded which involve serious violence and the use of weapons.

262. It appears there was an escalation in animosity between the brothers throughout 2018. It is also of note that there no reported incidents in 2019.

263. The reasons for this are not known.

264. There was limited engagement with STHFT.

ANALYSIS

265. This part of the report will examine how and why the events occurred.

266. The Human Rights Act 1998 places positive obligations on police officers to take reasonable action, which is within their powers, to safeguard the following rights of victims and children:

- Right to life (Article 2 ECHR)
- Right not to be subjected to torture or inhuman or degrading treatment (Article 3, ECHR)
- Right to and respect for private and family life (Article 8, ECHR)

267. The requirement for positive action in domestic abuse cases incurs obligations at every stage of the police response. These obligations extend from initial deployment to the response of the first officer on the scene, through the whole process of investigation and the protection and care of victims. Action taken at all stages of the police response should ensure the effective protection of victims, while allowing the criminal justice system to hold the offender to account.

TERMS OF REFERENCE - ANALYSIS

268. The analysis will specifically address the agreed Terms of Reference as follows:

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

5th March 2004

269. Imran and Hassan first came to the attention of SYP on the 5th March 2004 having allegedly committed a robbery involving a push bike. Imran was 12 years of age, and Hassan aged 14 at the time.

270. Records relating to any early offending by Imran or Hassan are no longer available. It is not therefore known what attempts at early intervention were made with Imran and Hassan.

271. It is clear that despite frequent chances of reform and reluctance to give an early custodial sentence both brothers continued to offend even when given suspended sentences

7th July 2011

272. The interventions put in place were not successful and on the 7th July 2011, Imran was sentenced to a Young Offenders Institution (YOI) for a period of 45 months for a robbery committed during the period when he was on suspended sentences.

273. Later in his life Imran would be arrested for rape, domestic abuse, and other serious violent offences. He was also arrested for drug misuse, and various other offences over time.

5th March 2014

274. Imran's first custodial sentence to adult prison was on 5th March 2014, when he was convicted of assault and sentenced to a period of 4 months detention.

275. Hassan had a similar criminal history. As a young person various convictions were initially dealt with by way of referral orders and community orders in an attempt to rehabilitate Hassan and not to criminalise him at an early age.

18th October 2010

276. However, Hassan's behaviour continued to escalate with subsequent arrests for various offences and eventually on 18th October 2010, he received his first custodial sentence to a Young Offenders Institution (YOI), for a period of 12 months for burglary.

277. Later in his life, Hassan would also be arrested and convicted for offences such as domestic abuse, other serious violence offences, the misuse of drugs, as well as acquisitive crime including burglary and taking vehicles without consent.

22nd September 2011

278. Hassan first custodial sentence to adult prison was on 22nd September 2011, for a period of 16 months. He subsequently received a number of suspended sentences for offences relating to weapons and assaults before receiving his second custodial sentence on 20th April 2016, this time for 6 months for various driving offences.

20th April 2016

279. Hassan's second custodial sentence on 20th April 2016, this time for 6 months for various driving offences.

November 2005 to April 2014

280. SCCYS worked with Imran between November 2005 & February 2010. The initial involvement was within school, where the service offered careers guidance support.

281. Upon leaving school the service provided Not in Employment, Education or Training (NEET) to Employment, Education or Training (EET) support. Imran was supported in to training around numeracy/literacy and on to 'CTS Training' until September 2009, where he then moved to Driving Ambitions from February 2010.

282. Imran attended Youth Provision within their local community sporadically, with a recorded 12 attendances between April 2012 and April 2014.

283. SCCYS worked with Hassan between May 2004 & February 2009. The initial involvement was within school, the service offered was personal development sessions with regards to career planning. Sessions ran from May 2004 until October 2005.

284. Upon leaving school Hassan attended Sheffield College to undertake Foundation Studies. SCCYS service had no further contact until May 2007.

285. SSCYS service involvement was to provide careers guidance pre and post 16 to Imran & Hassan. Both brothers had periods of non-engagement and unemployment and, with Imran in particular, often missing appointments and disengaging with the provision.

286. Dr Idriss, an academic from Manchester Metropolitan University, offers the view:

A. 'Having a history of criminality can be damaging for the family's reputation. In some instances of my own research, criminal men may be sent home back to Pakistan 'to

put them on the straight and narrow', often by the patriarchs of the family or senior members of the community'.

B. He continued 'This does not look like it happened here, and on the facts, Adults TF and TM appear to be elderly and powerless. But not wishing to inform police of incidents from 2018+ may suggest that the parents were embarrassed by their sons behaviour and so did not want to disclose any further issues so as to tarnish their family's reputation even further.'

287. When exploring young people and criminality, it is important to recognise the establishment of the Youth Justice System in 1998 was a response to a growing sense youth offending was not being dealt with in a systematic way, and that locally no one was taking responsibility for children involved in crime.

288. In 1998 the Crime and Disorder Act outlined the principal aim for Youth Justice was the prevention of offending. It established multi-agency local Youth Offending Teams (YOT) which were set up across the four districts of South Yorkshire. The local YOTs are imbedded within the local community and, therefore, have knowledge of the young people and families, in the area, who may be at risk or causing problems with their behaviour, or actions, within the community. This enables SYP to identify, refer and discuss with local partners a systematic approach to helping the young person.

289. As a consequence, a range of orders were introduced with the aim of preventing the criminalisation of young people, and to attempt to deter them from criminal behaviour. This was, and still is, a multi-agency approach focusing on early intervention and family engagement.

290. It is clear both Imran and Hassan were involved in criminality from a young age. It is also clear agencies sought to apply a range of interventions to try to prevent both brothers entering the criminal justice system.

291. Despite this support there was an early pattern of escalation in the seriousness and frequency of offending.

292. In later years, there is evidence of the escalation of violence and the use of weapons by both brothers.

293. There is a plethora of evidence linking youth criminality to escalation and violence in adulthood, which can have a devasting and lifelong impact.

294. For example, in an analysis of indicators of serious violence 'Findings from the Millennium Cohort Study and the Environmental Risk (E-Risk) Longitudinal Twin Study Research Report 110' Victoria Smith and Edward Wynne-McHardy July 2019, they found:

‘both the MCS and E-Risk analyses showed strong associations between other types of risky/anti-social/criminal behaviour and SVLBs. Those who reported impulsivity, gambling or having a high appetite for risk, along with those who self-reported minor theft and/or violence, were consistently more likely to also report SVLBs’. Further, the respondents who took part in research who had engaged in SVLBs ‘reported previously committing minor violence or starting fights more than respondents who did not report engaging in SVLBs (67% compared with 38%)’.

295. The delinquency shown by Imran and Hassan was not helped by a lack of their engagement with support agencies. This was also evident when the brothers were adults.

296. Saqib, an older brother of Imran and Hassan, was known to SYP. Saqib is currently serving a custodial sentence for murder. SYP records confirm Saqib was heavily involved in criminality from 2003 until 2014, when he was sentenced to 20 years for murder.

297. There is very limited information from agencies around the circumstances that led to the conviction of Saqib for murder.

298. The National Probation Service state Saqib experienced a turbulent childhood as his father also served time in custody and was violent towards him. The assessment also states that he was assisted by family members (does not specify who) to hide from police when charged with murder. It is not known if either Imran and / or Hassan played any part in this.

299. The impact on the family, and influence of negative behaviour by an older sibling, is an important factor to consider when exploring Imran and Hassan’s upbringing. Older siblings are often seen as role models. However, given the limited information available, the influence (if any) Saqib may have had on his younger brothers is not known.

300. Dr Idriss, an academic from Manchester Metropolitan University provides some insight as follows:

‘Also, on the perceived ‘honour’ of the family’s reputation. Hugely embarrassing to have Saqib in prison in the first instance; and now Hassan. Possible explanations for non-involvement with state agencies and their subsequent silence’.

301. Further, it is not clear what adverse influence Hassan, as the older brother to Imran, may have had on his younger brother. Based on his own early criminality, Hassan is likely to have been a poor role model for his younger brother.

302. There is less known around the environment Imran and Hassan grew up in, and the example their parents and older sibling were providing to them during this important time in their development.

303. SYP records do not show any recorded domestic abuse related incidents between Rashid and Tahira.

304. Although STHFT health records had some indication in relation to Imran's brother having some vulnerability as there is an alert on his record which indicates that they were known to Paediatric Liaison service, Information was not shared to STHFT in relation to any ACE's or any disclosures made by both brothers to STHFT Health Care professionals.

305. It is not therefore unknown whether either brother suffered adverse childhood experience or trauma within the home setting.

306. In this case it is accepted more evidence is needed to establish if there was violence, or trauma, in the home when the brothers were growing up; which may have resulted in their youth offending, and escalation into violence.

307. In broader terms, it is worthy of note the Local Government Association (2018) found an emerging body of robust evidence for a link between experiencing family violence, and subsequent participation in youth offending.

308. There is a substantial body of evidence from large-scale quantitative studies and meta-analyses to suggest a link exists between child maltreatment, ACEs, and youth offending.

309. The report highlights specific links between sub-types of family violence, including sibling violence.

310. This review defines childhood as birth to 11 years, and adolescence as 12 to 17 years.

311. The evidence showed:

- The more risk factors, for example, adverse childhood experiences (ACEs) experienced by young people, the greater the likelihood of participation in youth offending
- There are links between a specific sub-type of family violence and involvement in youth offending, for example, between youth offending and experiencing: sibling violence, violence against women and girls (VAWG), childhood physical abuse, child to parent violence and witnessing domestic violence
- Timing of experiencing family violence matters in terms of likelihood of youth offending. Stewart et al. (2008) reported a consistent finding young people, whose maltreatment persists from childhood into adolescence, or that starts in adolescence, are much more likely to be involved in the youth justice system than those whose experience of maltreatment was limited to their childhood

312. In considering what agencies should take into account and what protective measures should be put in place, the report suggests that decision-makers should consider focusing on addressing family violence more broadly, as opposed to one specific form of family violence.

313. Further, professionals should consider risk factors that are correlated with an increased likelihood of offending among young people with experience of family violence: for example, running away from home, low school attainment and association with delinquent peers.

314. Finally, the review advocates partnerships should commission, and fund, interventions which aim to prevent and/or reduce offending among children and young people with experience of family violence. The review cites four interventions: Functional Family Therapy (FFT), Family Nurse Partnership, The Sexual Abuse: Family Education and Treatment Program, and the Big Brothers Big Sisters community-based mentoring programme have had evaluations that demonstrate success in reducing offending among young people with experience of family violence.

315. However, further research is needed to assess how appropriate and effective all four programmes are in reducing offending among young people whose families are currently, or previously, dealing with issues of serious violence and abuse.

316. Given the accepted links between adverse childhood experiences and criminality it would have been helpful to understand if Imran and Hassan suffered these during their formative years. This would have helped develop some insight into their pathway into criminality.

317. In terms of broader learning, it is important professionals look beyond the offence, particularly at an early age, and seek to identify and understanding what adverse experiences may be driving the delinquency.

Recommendation / Learning 3

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

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: the 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.

319. Adult family violence is a priority for the Sheffield Community Safety Partnership (SCSP), and its partner agencies.

320. When we explore the data across Sheffield for 2020/21 it identifies 703 victims who were victims of domestic abuse perpetrated by a family member (not including partners):

1. 20% of victims are male, in comparison to 12% for the whole service.
2. 32% of perpetrators are female, in comparison to 14% for the whole service.
3. 37% of victims have children, across the whole service 59% of victims have children.
4. 33% of victims are BAMER, 29% for the whole service.
5. 48% of victims are over the age of 40 in comparison to 29% for the whole service.
6. 16% over the age of 60 in comparison to 6% for the whole service.
7. Average age is 42 in comparison to 36 for the whole service.
8. 4% of victims are LGB in comparison to 3% for the whole service.
9. 52% have a disability compared to 48% for the whole service.
10. 40% have more than one perpetrator in comparison to 26% for the whole service.
11. 40% live with the perpetrator in comparison to 30% for the whole service.

321. SYP had significant contact with Imran and Hassan, primarily due to their criminality, over time. As a result of attending numerous incidents SYP had a raft of information to indicate hostility and violence between the brothers and the risk factors associated with it.

322. However, different officers will have attended the range of incidents involving the brothers and therefore they may not always have had an extensive knowledge and understanding of the complex relationship between Imran and Hassan and the dynamics within the wider family. Whilst Police officers will have had access to intelligence and criminal records to inform their risk assessment, a full and complete understanding of the complex relationship between the brothers would not have been known to individual officers, responding to different incidents at different times.

323. It is also important to note on many occasions when the Police were called, the brothers were on a number of occasions hostile, reluctant to engage and provided limited, ambiguous, or even false information. Imran and Hassan also lived transient lifestyles and family members, and partners, were often reluctant to engage with services.

324. However, overall Police and other agencies did not view the incidents between the brothers from a domestic abuse lens, which arguably reflects a mind-set around adult family violence when the victim and perpetrator are siblings. It may be professionals more readily recognise domestic abuse when it is taking place within an intimate personal relationship. Further, on the information presented to this DHR, it appears insufficient regard was given to the history, and contextual factors, to inform any ongoing risk assessment.

325. All this meant SYP and other agencies had gaps in their knowledge and understanding of the risk presented by Imran and Hassan.

326. SYP have made significant investment to raise the awareness and understanding of Domestic Abuse.

327. To build on the College of Policing / Safe Lives Domestic Abuse (DA) matters campaign and training programme, launched by SYP in 2020, the force has created 200 roles for DA

Champions from all ranks, grades, and departments across the organisation. These DA champions receive additional training to become Specialist Domestic Abuse Single Point of Contact (SPOCs) for the force, who are there to support, and advise, staff affected by domestic abuse, as well as providing advice on domestic abuse investigations.

328. The role of a DA Champion is to promote the DA Matters training alive across the force, to act as a role model and provide specialist support to colleagues in terms of dealing with DA incidents.

329. Of relevance to this DHR, specific training has been given to the DA champions around the barriers male victims may face in reporting abuse and to give them the tools to overcome these barriers.

Recommendation / Learning 4

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

331. Dr Idriss, an academic from Manchester Metropolitan University states that 'this should also extend to male victims of domestic abuse. Professionals may simply focus on intimate partner violence, as VAWG. But in this case, do professionals require training on spotting the signs of male victims of domestic abuse in general. These gaps in knowledge may led to incidents being missed or misinterpreted'.

332. This suggestion is taken forward at Recommendation 16.

333. STHFT say they held very little information in regard to the relationship between the brothers other than awareness they both had partners. There was limited information known to STHFT about Imran and Hassan's relationships with the wider family.

334. The presentations of Imran and Hassan at different times at the ED did not suggest domestic violence or abuse. When injuries were noted, the brothers would either provide false, or limited, information around how the injuries were caused.

335. Domestic Abuse is a priority for STHFT and they have policies and procedures for staff to follow should they identify or become aware of safeguarding concerns.

336. SFHFT use selective enquiry within the Emergency Department to identify any concerns relating to Domestic Abuse.

337. Routine enquiry is a well-established process within Maternity Services and is documented a minimum of three times in maternity records with midwifery care.

338. However, there is no evidence to suggest selective enquiry was used with either Imran, or Hassan, when they attended the ED. This is partly due to the how Imran and Hassan presented, but also potentially reveals an absence of professional curiosity.

339. Selective enquiry is a method for identifying domestic abuse where a practitioner uses their knowledge and training to recognise the signs of domestic abuse to trigger the asking of more direct questions to look to confirm the situation.

340. Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family, rather than making assumptions or accepting 'service users' versions of events or disclosures at face value. In essence it is 'asking the 'second question' or 'seeing beyond the obvious'.

341. If selective enquiry had been adopted when the brothers presented at ED, it may have subsequently led to the completion of the Domestic Abuse Communication Form (Approved shortened version of a DASH Risk assessment used in ED) and referral to other agencies. Health professionals are directed to complete this form should domestic violence or abuse be identified or suspected, including inter family violence.

342. Professionals can also contact the STHFT Safeguarding Team or a more senior member of staff for additional support and advice if needed.

343. It is accepted how people present should not be taken at face value by professionals. Professionals need to demonstrate the 'respectful uncertainty' in order to probe further and consider triangulation with information held by other professionals.

344. The STHFT Safeguarding Team raise awareness of domestic abuse through the delivery of the mandatory safeguarding levels 2 and 3 training and through the Safeguarding Champions, which have recently been established across the Trust. Safeguarding Champions access additional safeguarding training and act as a point of contact for staff within their own departments.

345. Further, the 'Think Family' approach and professional curiosity is now embedded into levels 2 and 3 safeguarding training at STHFT.

346. The 'Think Family' Approach is a concept designed to ensure services support whole families, not just individuals. Whilst it can be acknowledged there may be situations creating barriers to this approach, for example patients may be reluctant to offer information or may be aggressive, they may lack mental capacity or have compromised health needs; every effort should be made to obtain information and document this with the patient. This is considered good practice.

Recommendation / Learning 5

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

348. Although STHFT liaised with the GP, it is accepted there were missed opportunities to report knife incidents to the Police when both Imran and Hassan attended ED.

349. The Emergency Department 'Standard Operating (SOP) for releasing information to the Police' references the GMC Guidelines and states there is an obligation to contact the police whenever dealing with a patient who is the victim of a gun or knife crime.

350. The SOP was implemented in 2017 and is accessible for all staff via a SharePoint site.

351. The lack of referrals was not in accordance with the STHFT policy and guidance and is considered to be a standard below STHFT expectations.

Recommendation / Learning 6

352. **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

353. **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.**

354. SCCG GP Practice will say they had no awareness of inter-family domestic abuse and violence involving Imran and Hassan.

355. There was a history of a lack of engagement or missing appointments by both brothers. This reduced the opportunity to understand any underlying issues and risk.

356. Whilst the demand on GP Practices is recognised, particularly during the pandemic, Sheffield CCG may wish to consider whether they have the capacity to review where patients demonstrate a consistent lack of engagement.

357. There is an ongoing review of 'Did Not Attend' strategy and policies.

Recommendation / Learning 8

358. **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.**

359. SCCG consider domestic abuse to be a priority. They state they have in place specific training sessions and communications to highlight adult family violence, but they were not considered for Imran or Hassan.

360. There were some missed opportunities from SCCG regarding Imran and Hassan, to utilise a better degree of professional curiosity to enquire, challenge and elicit pertinent information to identify underlying issues that Imran may have experienced in terms of domestic abuse. In most interactions with the brothers, professionals focused their efforts on the 'presenting need' and further enquiry could have been undertaken to consider possible indicators of abuse, and the interplay between multiple presenting factors (e.g., potential injuries, depression and anxiety, alcohol use etc.)

Recommendation / Learning 9

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

362. Dr Idriss, an academic from Manchester University states this should include 'male victims of domestic abuse in particular and/or HBVA in general. Need a more coordinated understanding of why men may be victims and the barriers to reporting'.

363. This is taken forward at Recommendation 16.

364. When exploring financial issues, Imran was known to DWP from 16th December 2016. Hassan was known to DWP from 20th July 2016.

365. Both brothers were sometimes in receipt of benefits from DWP during the scoping period, but during other periods did not receive any financial support. It is clear that at different times Imran and Hassan may have experienced financial challenges, which may have been one of the motivators behind their criminal offending.

366. Imran and Hassan were in the universal credit group intensive work group, meaning they would have been contacted regularly to undertake activities to secure employment. There was limited evidence of either brother taking up any regular employment.

Multi Agency Working

367. Other than SYP, a number of other agencies were unaware of the entrenched criminality of Imran and Hassan. Further, a number of agencies were not sighted of any potential inter-family domestic abuse and violence involving Imran and Hassan.

368. This invites a question around multi-agency working and information sharing.

369. Multi-agency working is challenging, but critical. It is recognised there is always a raft of competing demands on agencies. The pandemic would have presented additional challenges for professionals in the months leading up to Imran's death. However, effective multi-agency working can provide an enhanced response and protection to individuals with multiple and complex needs.

370. It appears a number of agencies may have engaged with Imran and Hassan in isolation, as opposed to recognising the interdependencies, highlighting the importance of information sharing and the added value of coming together to agree a coherent response. Whilst it is evident professionals had on occasions sought to engage with both brothers, this was often with limited understanding of what information and support other agencies may have held, and what support they may, or may not, have been providing.

371. Professionals, even when acting as part of a joint team, need to be aware of the necessity to make appropriate referrals to allow consideration of further actions and notifications to be made to other parties.

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

373. When faced with a complex set of circumstances and associated risk, a more coherent approach was required. There would have been significant benefits in a calling for partners to come together in order to share information, identify clear 'ownership' and collectively agree a way forward. Adult family violence cannot be addressed by a single agency alone, and it is only by working together the level of risk can be properly assessed, and a layer of support interventions put in place.

Recommendation / Learning 10

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

375. It is acknowledged that SDACT co-ordinated a partnership workshop as part of Adult Safeguarding Week in November 2021 on Adult Family Violence.

376. SDACT have plans to develop a local briefing to build upon previous professional development for partner agencies. This briefing may include case studies and local data to support professionals in assessing risk.

377. The briefing seeks to also build upon the Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) report.

378. Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) states “While both forms of violence are gendered, there are clear differences in the dynamics and motivations underpinning Intimate Partner Violence (IPV) and Adult Family Violence (AFV)”.

379. The analysis goes on to say “Adult Family Violence (AFV) thus falls within this definition and the remit of its associated legislative instruments, governmental policy, and professional guidance and practice. It has been recognised, however, that there is a dearth of research into AFV (Sharp-Jeffs and Kelly, 2016).

380. The report goes on to say, “the lack of research means that most of the existing practice guidance and tools in responding to domestic abuse are geared towards intimate partner violence (IPV) and potentially unsuitable for dealing with AFV”.

381. The report highlights “the most frequent risk factors for perpetrators of adult family violence, to emerge from this analysis are mental health issues, alcohol or substance misuse and previous criminality. Several review reports have also noted that perpetrators of adult violence displayed patterns of threatening behaviour towards women and had also committed some other form of violence against women”.

382. Alcohol or substance abuse misuse, previous criminality and violence and threatening behaviour towards women are clearly evident when we examine the history, and lived experience, of both Imran and Hassan. Further, whilst mental health was never clinically diagnosed with either brother, it is possible one or both may have suffered with their mental health.

383. Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) was instrumental in highlighting some distinctive features of homicide committed by family members.

384. “Between April 2014 and March 2017, the Home Office Domestic Homicide Index recorded 400 domestic homicides, of which 114 were adult family homicides (28% of all domestic homicides) (Office for National Statistics, 2018). It is, therefore, safe to say at least a quarter of domestic homicides involve family members and thus deserve much more attention”.

385. Some key features relating to dynamics and risk factors have consistently emerged from Adult Family Homicides and are particularly relevant in this case:

1. Gender - Similar to IPV, AFV is gendered both in terms of victimisation and perpetration, albeit with a more pronounced gender split in the latter (at least 90% of perpetrators of adult family homicides are men).

2. Mental health issues. Mental health issues are the most common feature of the majority of perpetrators of AFV, including depression, self-harm, psychosis, and paranoid schizophrenia.

3. Substance misuse issues. Drug and alcohol issues are a common feature of the majority of perpetrators of AFV."

4. Caring responsibilities. Not considered relevant to this DHR.

5. Instability, dependence, and social isolation. Research into Adult Family Homicides has shown a high degree of instability in the lives of those who committed the murders: inability to sustain employment due to mental health and associated issues, lack of stable, long-term relationships, high degree of transience due to lack of housing options or difficulties in sustaining independent living; breakdown of intimate relationships; work-related stress etc. This in turn increased financial and emotional dependence on their parents and other family members, which was evidenced by the fact most of the adult children were living with their parents. Social isolation was an additional poignant feature in the lives of perpetrators.

6. Lack of a clearly defined 'primary' victim. Abusive behaviours most often take place within a wider context of family violence, with the perpetrator offending against other family members and siblings in particular; as well as displaying patterns of threatening behaviour towards intimate partners. Therefore, risk needs to be considered for all family members living in the home. As an example, responding to an incident involving two brothers, or a brother and a sister, officers should always take into account other family members; especially if elderly or vulnerable parents are present. Inversely, it is quite common for parents to be relied on to provide bail addresses for perpetrators of IPV. Their safety and any risk concerns (such as mental health, substance misuse, and history of criminality) should be fully considered.

7. Absence of 'visible' high risk and lack of engagement. Due to complex family relationships, caring responsibilities, and perceived support needs of the perpetrators, as well as lack of suitable options, family members affected by abusive behaviours are often less likely to engage in support with police, prosecution, or IDVA. They are more likely to minimise their safety concerns and less able to formally articulate their experience as 'abuse'. This could in turn reinforce assumptions made by key professionals, such as police and CPS, about their level of risk, thereby increasing victims' isolation and barriers to their help-seeking and access to support.

386. When we examine what happened between Imran and Hassan over time, we can see substance abuse, instability, and lack of engagement with agencies are clearly evident.

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

‘It could also be ‘honour’-based issues that prevent them from discussing or engaging with the authorities. Might be particularly relevant in South Asian communities and families whose children who have a history of criminality and drug abuse - unIslamic behaviour’.

388. Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) summarises the risk factors that need to be identified in family violence cases:

- Family – complex and intergenerational
- Caring for someone/being cared for by somebody linked to mental health, suicidality, depression
- Suicide and homicidal thoughts
- History of perpetrator – previous violence against women, pattern of previous criminality, antisocial behaviour
- Sense of entitlement, including to financial resources
- Addiction issues
- Social isolation of victim

389. The report offers the following guidance to professionals in seeking to reduce risk of harm:

1. Never equate victim(s) lack of engagement with an absence of risk
2. Consider all key risk factors mentioned above (mental health, substance misuse, caring relationships, history of violence towards partners and other family members, and various aspects of instability) when assessing risk
3. Look beyond the ‘primary’ victim in the incident for risk to other family members, especially if there is a vulnerable adult in the family
4. Always consider risk and safety when bailing perpetrators of IPV to their parents’ address
5. Always offer the support of an IDVA
6. Always consider an Adult Safeguarding referral and provide information on mental health and substance misuse support

Recommendation / Learning 11

390. **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.**

Imran and Hassan as perpetrators of Domestic Abuse towards women

391. It is known that over time both Imran and Hassan were perpetrators of Domestic Abuse towards their female partners.

392. **Imran / Olivia / Asif**

393. Imran, his ex-partner, Olivia and their son, Asif were briefly known to the Health Inclusion Team (HIT) as part of Sheffield Children's NHS Foundation Trust (SCFT). They were known to the service due to homelessness and rent arrears.

394. Four visits carried were out by the HIT to review the health and development of Asif between December 2016 – August 2017, following the family becoming homeless. Imran was only present during the first contact. Imran and Olivia had separated by 31st January 2017 but remained in contact and noted to be on amicable terms, and Imran was having regular contact with his son. During enquiries, regarding domestic abuse and coercive control in the relationship, Olivia denied this had been a factor and there were no recorded concerns about interactions during the initial visit on 21st December 2016.

395. Imran was seen on 17th November 2016 by a Health Visitor, at a pre-arranged home contact, for the new birth visit of Asif. Both Imran and Olivia were seen with Asif, along with the maternal family. At this time Imran, Olivia and Asif were temporarily living at the maternal family home. It would seem, from the documentation in the health record, the Health Visitor was unable to make enquiries about domestic abuse, parental alcohol, or substance misuse due to extended maternal family members being present.

396. A Health Visitor action plan was made to follow this up at the next contact for the 6–8-week home visit. As the family had moved by this time professionals did inform and note that this was outstanding as an action plan.

397. Olivia was moved into the Health Inclusion Team and the plan was clearly transferred over and the Heath Inclusion Team did discuss the plan with the Imran's partner.

398. It can take courage for victims of Domestic Abuse to find the confidence to report what may be happening to them. This can arise from a whole range of reasons, including fear of reprisals. Professionals should seek to create a safe space such that vulnerable victims feel able to disclose what may be happening in confidence.

399. It is recognised that STHFT and other agencies have policies in place to support vulnerable victims to disclose domestic abuse. A number of agencies also have access to interpreters where there are language barriers.

400. The key is how widely and consistently is this applied in practice. Whilst there is evidence of Health Visitors seeking out the opportunity to discuss domestic abuse, overall health services could have taken the opportunity to undertake routine enquiry more consistently, leading to where appropriate to selective enquiry. Whilst health professionals do apply routine, the evidence from this case would indicate it is now as consistently embedded as agencies would like.

401. For example, in this case potentially more could have been done with Imran and Hassan's mother, including the use of an interpreter, to try and understand whether she was suffering from domestic abuse.

402. IDAS had no contact with Imran within the scoping period. However, Olivia and Azra were both referred to IDAS, in the related time period, with Imran named as the alleged perpetrator by both.

Recommendation / Learning 12

403. **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 vulnerable victims opportunity to disclose what may be happening in confidence.**

404. **Hassan / Emily / Abid**

405. The Health Visiting service transferred the care of Emily and Abid on the 18th April 2016 to the Health Inclusion Team (HIT) hosted by the Sheffield Children's NHS Foundation Trust (SCFT).

406. The allocated Social Worker informed the Health Visitor that Emily and Abid fled due to domestic abuse. It was acknowledged that Abid was also a victim of the domestic abuse due to being present when the incidents occurred.

407. An analysis of the health records highlighted the chronology of key significant events (KSE) in the health records were kept up to date. This is important and in line with best practice, as up to date significant events in health records enable practitioners to identify and respond appropriately to vulnerabilities and risks.

408. There were earlier indications, within Emily's maternity records in 2014, Hassan had recorded offences for causing knife related injuries. There is no evidence of an alert being placed on the patient record. However, this could be due to them being reviewed and removed, or the fact maternity services use a different electronic patient record system.

409. However, other than the DASH (Domestic Abuse, Stalking, Harassment, and 'Honour' Based Abuse) risk assessments resulting in the above MARAC referrals, there was no indication a DASH risk assessment was undertaken, or considered by agencies involved, including the Health Visitors. This is an area where work is ongoing to promote appropriate use of the DASH risk assessment tool, to assess and respond to domestic abuse, whenever it is first identified or is ongoing.

410. It is important to note since the Health Visiting service was involved with Hassan, Emily and Abid, there have been significant developments and improvement in practice; including practitioners undertaking and documenting routine domestic abuse enquiries in health records. The Health Visiting Service has developed a specific care package covering support where domestic abuse is identified, or ongoing, and the completion of a DASH risk assessment where appropriate. The care package enables cross reference to be made, by practitioners, with other vulnerability factors such as alcohol/substance misuse or mental health. Some of the practice changes within the Trust and within Sheffield have been prompted by recommendations of Sheffield Domestic Homicide Reviews and Serious Incident Reviews to improve identification, assessment, and response to domestic abuse.

Recommendation / Learning 13

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.

411. The perpetrator's partner Emily and their son Abid were known to the Health Inclusion Service during 2016 due to homelessness. Hassan was never seen by the HIT as he was serving a six-month custodial sentence for a driving offence.

412. Emily suffered a significant Domestic Violence incident on the 15th July 2015, by Hassan and this was clearly recorded on the initial contact.

413. Abid was subject to a Child in Need Plan at the time. The incident was assessed as 'medium risk' by the Police.

414. There was a further high-risk domestic abuse incident on 26th September 2015 and the case was discussed in Sheffield Multi Agency Risk Assessment Conference (MARAC) on 8th December 2015.

415. The MARAC notes are replicated as follows:

- Social Care – ongoing assessment regarding Abid – currently shows that Emily and Hassan are engaging and meeting expectations in caring for the child.

- No recent physical incidents of abuse but threats to harm – she is viewed as vulnerable due to having no family support – she also states he has violent criminal history and is violent when in drink.
- June 2015 – bruise on Emily's eye and July 2015 – Hassan was seen hitting Emily.
- 26th September 2015 Hassan drove into back of unmarked police vehicle with Emily and child present – was tested positive for DUI – impending charges.
- Housing noted £996 arrears outstanding, they are looking at evicting her from tenancy because of this and there are complaints of Anti-social behaviour (ASB) at the address – it is thought this is due to her brother coming over
- They have a MAST intervention worker & engaging well with health visitor

416. The agreed actions are replicated below:

Risks highlighted: victim minimises abuse, offender alcohol abuse, threats to harm, offender history of violence, offender criminal history,		
Actions	**Action Owner**	**Completion date**
Make the victim aware of the outcome of the MARAC	Social Care	
Discuss arrears and rehousing	IDVAS	10.12.15
Make contact with victim via Social Worker	IDVAS & Social Care	10.12.15
Re-risk assess – complete another DASH	IDVAS	10.12.15
Amend address tag	SYP	10.12.15
Ensure agency files are tagged	All Agencies	

417. The family was discussed again in MARAC on 19th April 2016.

418. The MARAC notes are replicated as follows:

- DASH – on 31.3.16 Emily was punched in the eye by Hassan and given a black eye – Emily fears the reaction of Hassan and his family to her disclosing the latest incident – specifically his brothers who would shout at her and intimidate her. Emily reports that incidents happen when Hassan has been in drink. SC suspect there are further incidents of violence occurring which Hassan is not disclosing to professionals, due to fear, and are concerned about the safety of the son in the family home.
- SC – Emily states she had no contact with Hassan since the latest incident and is now in safe accommodation.
- GP witnessed the bruise on Emily face caused by Hassan punching her – IDVAS spoke to her on 8.4.16 and she stated it was the first time she'd been subject to physical abuse. She denied being isolated, however, she told SC that Hassan stops

her going out when she has injuries. Emily is now in long term supported accommodation. They plan to see her face to face.

- MAST – there was a worker involved – a referral to Power to Change has been completed. The case was closed on 22.3.16.
- Housing – the case is now closed as Emily has gone to long term supported accommodation - it was noted she experienced DA with a different perpetrator in 2012.
- HV – Emily informed the HV she had moved into the new accommodation.
- NPS – Hassan is being sentenced tomorrow for unrelated driving offences – he will be managed by CRC

419. The agreed actions are replicated below:

Risks highlighted: repeat MARAC, child contact, physical abuse, historic DV, isolation, victim minimises abuse,		
Actions	**Action Owner**	**Completion date**
Make the victim aware of the outcome of the MARAC	Children's Social Care	
Attempt to contact victim at new accommodation	IDVAS	
Update supported accommodation re: MARAC	IDVAS	
Encourage engagement with IDVAS	Health Visitor	
Update victim and children's social care post perpetrator's court appearance	IDVAS	
Ensure agency files are tagged	All Agencies	

420. It would appear, from the MARAC records, there was evidence of effective multi-agency working, with the appropriate support put in place for the victim and her child.

421. It is clear agencies were seeking to adopt a supportive coherent response to reduce the risk to Emily and her son.

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?

422. Coercive control is defined by the Government as follows:

> "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".

423. Coercive & controlling behaviour is the strongest indicator of risk. But it is often missed as the focus is on the severity of single incidents, rather than considering the pattern of behaviour.

424. Identifying coercive and controlling behaviour between male siblings can be challenging for professionals.

425. Lancer (2020) ‘Sibling Bullying and Abuse: The Hidden Epidemics’ states “sibling abuse is the most common but least reported abuse in the family”.

426. The reports highlights “sibling abuse prevalence is higher than spousal or child abuse combined with consequences well into adulthood similar to parent-child abuse. Up to 80 percent of youth experience some form of sibling maltreatment; yet it’s been called the “forgotten abuse.” Therapists also frequently overlook it. Usually, the perpetrator is an older child (often the eldest) exploiting the emotional dependence and weakness of a younger sibling”.

427. Lancer states “under-reporting is predominantly due to societal denial of the seriousness of the problem. There is no definition of sibling abuse or laws governing it (except for some sexual abuse laws.) Resources for families are also lacking. Parents have no support and are misinformed. Many expect sibling conflict and fighting. Hence, they typically overlook abuse and confuse it with sibling rivalry. When they don’t protect the victim, it constitutes a second wound – first inflicted by the sibling, then by the parent”.

428. Sibling rivalry and abuse are different. Squabbles, jealousy unwillingness to share and competition are normal sibling behaviours. Fighting between equals can be, too. Rivalry is reciprocal and the motive is for parental attention; versus harm and control. Rather than an occasional incident, abuse is a repeated pattern where one sibling takes the role of aggressor toward another, who consistently feels disempowered. It’s often characterized by bullying. Typically, an older child dominates a younger or weaker sibling, who naturally wants to please his or her sibling. Unlike rivalry, the motive is to establish superiority or incite fear or distress. Intent and the degree of severity, power imbalance, and victimization element are all factors to be considered. Inappropriate parental discipline or ineffective attempts to respond to rivalry or abuse can compound the problem by the lack of consequences or by targeting one child. When parenting is toxic, such as when it's overly strict or abusive, the perpetrator often vents his or her rage on the younger sibling.

429. Abuse may be physical, psychological, or sexual, and can be expressed through seemingly benign behaviours, including ordering, manipulation, poking, or tickling. It’s damaging when there is persistent emotional abuse, teasing, denigration, or physical harm by one sibling on another”.

430. A review of STHFT records has shown they held no information in relation to any coercive control between Imran by Hassan.

431. Whilst there is limited information around their upbringing and relationship, it is clear Imran and Hassan had a complex sibling relationship.

432. There is a clear history of violence, and particularly the use of weapons, between the brothers as adults.

433. Based primarily on SYP records, this violence and use of weapons is particularly prevalent during 2018, where the Police were called on numerous occasions.

434. It is significant that when exploring the mirror incident in August 2018, and the murder itself, Hassan was clearly the perpetrator.

435. However, there are other occasions where Imran may have been the perpetrator. For example, on 4th October 2018, 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. No further details are recorded relating to the injury.

436. Further, on 25th February 2018, Hassan attended the ED with an injury to his middle finger. Hassan sustained a dislocated finger whilst allegedly 'play fighting with his younger brother'. It should be noted that Hassan did not explicitly name Imran or anyone else to health care professionals.

437. There is limited information documented within the health records and a lack of professional curiosity or further probing of the circumstances. Treatment was offered to Hassan, and he was discharged home. This attendance was not seen by ED staff as a domestic incident and no referrals were made.

438. It would also appear that both brothers may have on occasions a challenging relationship with their parents, Rashid and Tahira.

439. SYP have records on 17th July 2018 regarding an incident where it appears both brothers may have assaulted their mother, Tahira.

440. Whilst there was a lack of co-operation from Tahira, this could have been viewed as domestic abuse and the appropriate referrals made. This was a missed opportunity.

441. During the scoping period, Imran made an allegation of assault against his father, Rashid; whilst Hassan suggested his mother, Tahira, assaulted him with her walking stick. Again, a more holistic view of what may have been happening within the family could have been taken.

442. There are limitations around what is known about the relationships of Imran and Hassan with their parents, but the following may be relevant:

443. “When parents lack a stable value system by which to settle sibling disputes, or when their principles are capricious, bizarre, or arbitrary, the sibling relationship can become chaotic or even murderous.” (Bank and Kahn, ‘the Sibling Bond 1997’)

444. These events show the complexities and transient nature of the lives of Imran and Hassan, and a potentially violent, or at least fractious, relationship between each other and with their parents.

445. The events reported to the Police were attended and investigated by SYP, but no convictions or charges were ever brought; primarily due to the lack of witnesses or corroboration, and the refusal of both brothers, and their parents, to engage with the Police. Despite the best efforts from those officers involved with the family, this pattern continued up until the death of Imran.

446. In the process of investigations, where violence was a suspected factor, between both Imran and Hassan, and their parents, they would either ‘downplay’ the violence, state injuries were caused by way of an accident or that an unknown third party had caused the injuries. This lack of cooperation made it extremely difficult for SYP to investigate any possible offences and thereby explore, in more detail, the relationship between Imran and Hassan, and their parents.

447. It is also of note, there are a number of references to alcohol misuse during these incidents. The use of alcohol and drugs within the brother’s relationship appears to have exasperated the violence and the use of weapons by both.

448. Research has highlighted a comprehensive understanding of the prevalence of sibling abuse, and violence, remains a challenge.

449. Further, coercive control is difficult to identify without the engagement of the involved parties and/or wider family circle.

450. Lancer (2020) states “Sibling abuse is a symptom of a dysfunctional family in an environment of family stressors, such as marital conflict, financial stress, family disorganisation and chaos, and lack of resources. Parents are unable to manage their own emotions and model appropriate communication and behaviour. They can’t be present for their children’s needs and feelings”.

451. Lancer (2020) offers the following risk factors for professional to consider. These are factors that make sibling abuse more likely:

- Spousal / intimate partner abuse or child abuse (physical or emotional, including criticism and shaming).
- Cultural norms that condone abuse of power.
- A hierarchical family structure, where one spouse controls the other, and older siblings mimic that authoritarian behaviour and attitude toward younger siblings.
- Gender and birth order matter. First-born children are more likely to be offenders. Younger females are more often victims. Siblings close in age, or an older brother-younger sister pair are risk factors.
- An older child overseeing a younger sibling breed to resentment, boundary confusion, and abuse of power.
- Parental neglect or lack of supervision.
- Parental normalization of abuse by ignoring or minimizing it. Silence is taken as assent.
- Parental inability to resolve sibling conflict or respond appropriately.
- Parental favouritism toward one child or comparing siblings.
- Coercive parenting.
- A parent taking sides, blaming the victim, or shifting responsibility to the victim, e.g., “Don’t play with him, then.”
- Substance abuse by a parent or the abuser.
- Children with a conduct or mood disorder or ADHD are more predisposed to violence.
- The offender has experienced abuse, has an aggressive temperament, lacks empathy for victims, has lower or higher self-esteem than peers, or has unmet needs for physical contact.

452. “The effects of sibling abuse mirror parent-child abuse and have a long-term negative impact on survivors’ sense of safety, well-being, and interpersonal relationships. Victims of all ages experience internalized shame, which heightens anger, fear, anxiety, and guilt. Both victims and perpetrators often have low self-esteem, anxiety, and depression. Victims may engage in substance abuse, self- harm, or delinquent behaviour. Abuse causes fear of the perpetrator that may lead to PTSD and produce nightmares or phobias.”

453. As stated, SYP continues its roll out of the College of Policing DA matters training programme which is delivered by Safe Lives. The programme is heavily focused on coercive and controlling behaviour. All current officers and some support staff have, or will be receiving, this training.

454. SYP has a specific DA intranet site that all SYP employees are able to access.

455. This site is updated regularly and includes online training packages on coercive and controlling behaviour, as well as updating officers with new legislation or policy and provides advice and guidance around best practice.

456. The STHFT Safeguarding Team raise awareness in relation to the indicators of coercive control through mandatory levels 2 and 3 safeguarding training. The Trust Safeguarding Champions have been offered training from IDAS. Further training for all staff to access will be available during 2022/in the future.

457. It is accepted that STHFT (and other agencies) did not have any direct knowledge of coercive control between Imran and Hassan. However, along similar lines to recognising that domestic abuse may have been taking place between the brothers, agencies and professionals could have been open to the possibility that Hassan was coercively controlling Imran.

458. Where significant incidents happened between Imran and Hassan, most notably the incident in August 2018, there may have been opportunities to seek to encourage disclosure around the nature of the relationship between the two brothers.

459. Given that coercive & controlling behaviour is the strongest indicator of risk, 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.

<u>Recommendation / Learning 14</u>

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.

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

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

461. Imran was taken to Sheffield Teaching Hospitals ED via Ambulance. He stated 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.

462. Imran sustained injuries to his lower back and chest. Imran developed a small haemothorax (blood in the chest cavity). It is also 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.

463. Imran was then transferred to a cardiothoracic ward at the NGH 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.

464. SYP's response to this incident and subsequent investigation was diligent.

465. 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

466. 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.

467. 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 visit's officers left cards at all the addresses requesting Imran contact them, but he never did.

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

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

470. 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.

471. However, whilst this incident was classed as domestic related, a DASH risk assessment was not completed by SYP. In order to assess risk in circumstances such as this, officers are directed to use The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model.

472. DASH was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).

473. There is the non-police version of DASH which is widely used by Independent Domestic Violence Advisors (IDVAs), domestic abuse services, and a range of frontline professionals.

474. 'The First Time, Right Time' approach underpins the DASH assessment. The DASH checklist is a tried and tested way to understand risk. It is based on research about the indicators of high-risk violence and abuse.

475. The purpose of the DASH risk checklist is to give a consistent tool for Practitioners, who work with adult victims of domestic abuse, to help them identify those who are at high risk of harm; and which cases should be referred to a MARAC meeting, in order that agencies may manage the risk. DASH applies to all victims of domestic violence.

476. When completing the DASH risk assessment, it is very important that officer(s) ask all of the questions on the checklist at every incident. Officers need to consider:

- Who is at risk?
- The context of the behaviour
- How the risk factors interact with each other
- The victim's perception of risk

477. Officers should explain to the victim(s) the completion of the risk assessment allows the officer to have a clearer picture of what is happening in the relationship, and to understand the level of risk which the victim is being subjected to; this also assists in the identification of any coercive control offences.

478. Ideally, the form should reflect the victim's perspective of risk and be as comprehensive as possible.

479. The DASH assessment contains 27 questions covering key risk factors. These questions are wide ranging and inclusive of gender, race, age, and other protected characteristics.

480. The 27 questions include any previous family violence, financial problems, and addiction problems which if taken forward, may have captured some key information to assess the level of risk between the brothers.

481. It should be noted with regard to this incident Imran refused to even speak to the officers and it is thought that he was actively attempting to avoid the Police during this time.

482. However, SYP Policy and practice dictates even when the victim elects not to engage, and / or where DA is suspected as being a factor in the incident, even if this cannot be proven, Police officers should still complete the DASH risk assessment and signpost available domestic violence support agencies who can support the victim.

483. In cases where the victim is reluctant to co-operate, the DASH risk assessment should be completed by officers using the best of their knowledge and judgement, rather than being guided by specific answers from the person involved. The officer should define the risk as high, medium, or low based on the facts known to them. Even without the support of the victim, each recorded incident presents an opportunity for assessment and decision-making in order to safeguard a victim.

484. **Domestic Abuse Risk Levels:**

485. When officers(s) use DASH to assess risk, they are directed to follow the guidance detailed below:

HIGH	14 or more ticks, **OR** Professional Judgement, **OR** Repeat MARAC victim*, **OR** Honour Based Abuse, Forced Marriage, Female Genital Mutilation
MEDIUM	8 – 13 ticks, **OR** 4 Incidents or more in a 4 month period, **OR** Professional Judgement
LOW	Incidents falling outside of the above

486. Once the Police officer has completed the DASH, the risk assessment should be submitted onto the crime report or non-crime incident. The risk assessment and crime report are ordinarily then forwarded for a secondary assessment by a member of the DARA team. The DARA team will quality assure, and triage, the referral for further multi agency intervention, including a referral to MARAC.

487. Safelives are a UK wide charity dedicated to ending domestic abuse. They work with organisations across the UK to transform the response to domestic abuse.

488. Safelives describe MARAC as 'a meeting where information is shared on the highest risk domestic abuse cases between representatives of local Police, Health, Child Protection, Housing Practitioners, Independent Domestic Violence Advisors (IDVAs), Probation and other Specialists from the statutory and voluntary sectors.

489. The Officer in Case (OIC) for this incident has confirmed if a DASH risk assessment had been completed then they would have graded it as high risk thereby prompting an automatic referral to MARAC.

490. The fact a DASH risk assessment was not completed following this incident represents a missed opportunity to share information with other agencies, refer to MARAC, assess risk and potentially seek to safeguard and support Imran.

491. It is of concern DASH risk assessments were not completed by SYP having been called to the violence involving the brothers on the 12th of September and 4th October 2018. Again, these incidents represent missed opportunities.

492. This is balanced against other incidents, including on 17th July 2018, when a DASH assessment was submitted when Tahira was assaulted.

493. Dr Idriss, an academic from Manchester Metropolitan University will offer the view:

> 'A crucial point due to stereotypes and how society socially construct 'who is a victim', as you say, because society focuses attention on female victims. There is nothing wrong in this, the feminist movement has worked hard to highlight female victimisation. But an unintended consequence of this is that men are overlooked, ignored, and do not fit the stereotype of victimhood'.

Recommendation / Learning 15

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

495. Returning to the mirror incident on 14th August 2018, STHFD ED staff ordinarily follow national guidance in relation to the reporting of any injuries caused by knife or gunshot wounds to the Police.

496. However, on this occasion, there is no evidence recorded in STHFT records to suggest this incident had been reported in accordance with the usual protocol.

497. Whilst SYP were aware of the incident, via the third-party report, by not reporting the incident in line with the standard protocol, STHFT missed an opportunity to share information with other agencies, assess risk and potentially safeguard and support Imran.

498. More generally, STHFT staff could have explored in more depth the risk and, adopt a more holistic approach to the issues underlying the injuries presented when Imran and Hassan attended the ED. This may have led to disclosures of domestic violence, or inter-family violence, which could have been supported by earlier or additional interventions, timely information sharing and liaison with other agencies.

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

499. Dr Idriss, an academic from Manchester Metropolitan University provides some insight as follows:

> 'An absolutely crucial question to ask, and perhaps, one of the most important questions in this report. There is a lack of male support services and refuges nationally in general. As there may be cultural/religious/honour/shame issues involved in the case of Imran, there is an even greater lack of minority support services that serve minority men. Would the outcome of this case have been different if there was intervention by minority support services dedicated to minority male victims? I cannot answer this question, perhaps no one can, but it is something worth considering. Do we need to create more male support services in Sheffield?'

500. Imran was a British Asian man. He was believed to be of Muslim faith. He was a perpetrator of Domestic Abuse.

501. Imran may have found it challenging to recognise he may have been a victim of domestic abuse or coercive control.

502. On the one hand, given his gender and cultural heritage and the fact his brother was the perpetrator his understanding of the abusive nature of the relationship may not have been clear to him. On the other hand, he was himself a perpetrator of Domestic Abuse.

503. When we consider intersectionality, it is important to recognise people's identities can often cut across a number of protected characteristics, and they can be both a victim and a perpetrator, at the same time.

504. There can be significant challenges in men reporting domestic abuse.

505. Male victims can experience specific barriers in reporting domestic abuse. Barriers such as pressure from within the immediate, extended family and the wider community, can play a role. This, together with cultural traditions, may also prevent, or delay, male victims from reporting offences of domestic abuse.

506. Often male victims are reluctant to report domestic abuse due to gender stereotypes about what a victim of domestic abuse 'looks like'. Many support services, including advice lines and refuges, are geared towards female victims. Not all domestic abuse services work with men, and it can be difficult at times for men to access tailored support.

507. Mankind Initiative and Office of National Statistics (2021) will state '61% of men who call the Mankind Initiative helpline have never spoken to anyone before and 64% would not have called if the helpline was not anonymous'. Also 'half of male victims 49% fail to tell anyone they are a victim of domestic abuse compared to 19% of female victims'.

508. When exploring domestic abuse involving British Asian men, it worth noting a BBC article from 2013 which reported:

509. "A growing number of Asian men are becoming victims of domestic abuse by their partners and in-laws, according to a UK charity.

510. The ManKind Initiative, a national charity supporting male victims, found 9% of calls for help to its service last year were made by Asian men.

511. In 2008, the ManKind Initiative dealt with 61 callers who were from the Asian community, and in 2012 that rose to 135 - an increase of 121% in four years.

512. The Safe Project, a charity in Leicester supporting victims of domestic abuse, has also seen an upward trend.

513. Meena Kumari, from the project, states: "We are finding that Asian men tend to stay in [abusive] relationships for longer because they feel shame and are fearful to report the abuse."

514. Meena Kumari reaffirmed the importance of honour and shame within Asian families.

515. Meena Kumari offered the view that honour and shame may be a key reason around the limited engagement family, not only in the period leading up to the murder, but also in terms of engagement with this DHR.

516. Meena Kumari also stressed the importance of understanding the family's 'code', and the importance of the wider family history and migration.

517. Meena Kumari suggests an understanding of the parents lived experience may help us understand the cultural factors which may have affected the behaviour of Hassan and his brother.

518. Charities believe the rise in the number of victims from the Asian community getting help, can be partly explained by greater awareness of the issue.

519. Despite the growth, charities say the number of victims could be far higher than the figures suggest, because many men may still not be accessing mainstream services, out of fear of being identified.

520. Mark Brooks, from ManKind Initiative, said: "There is more of a cultural barrier for men from the Asian community to come forward. It can be a significant taboo for them to admit they are victims of abuse."

521. In the case of Imran, as stated previously, he may not have seen himself as a victim of domestic abuse. Even If Imran had considered that to be the case himself to be a victim of DA, he may have been reluctant to come forward for some of the reasons detailed above.

522. Dr Idriss states:

> 'There is a need to consider why Imran and Hassan declined to accept any assistance from agencies or give permission to share information. Was this due to mistrust of state agencies? Previous bad experience? Or was it due to 'honour' based issues - not wanting to associate with state agencies and police because this is a source of shame and embarrassment in front of the family and community?
>
> He continued: 'Notions of honour and shame are important in South Asian communities. Even having police knocking on the front door can be a source of shame and embarrassment because it indicates criminality and damage to the family's reputation in front of the community. Having prior convictions and a history of violence and

involvement of police probably confirms this, which may be why Imran and Hassan declined to participate. If these are the challenges, how can state agencies help overcome these issues in future, as part of recommendations?'

Dr Idriss states, 'notions of honour and shame, embarrassment and ridicule - even hinting that a man might be a victim - needs to be considered here, especially within a South Asian context'.

523. In the case of Imran, the barriers to reporting domestic abuse may have been compounded by a lack of confidence in the Police service and other agencies. Imran may already have held a negative view of the Police due to earlier dealings as a suspect from a young age. This could have been part of the reason for his consistent refusal to engage when SYP attended reported incidents.

524. The SYP website will highlight the following support agencies for victims of Domestic Abuse in Sheffield:

- National Domestic Abuse helpline
- Independent Domestic Abuse Service (IDAS)
- Domestic Abuse Coordination Team (DACT)

525. The following agencies also specifically support victims from the BAME community.

- Ashiana
- Karma Nirvana
- Sachma

526. Given the barriers and under reporting in this area, the partnership should review the support available to male victims of domestic abuse, particularly men with protected characteristics. If a gap is apparent, they should seek to address by commissioning specialist support for male victims with protected characteristics.

<u>Recommendation / Learning 16</u>

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

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?

528. The two principal forums for sharing information around perpetrators of domestic abuse are the MARAC and MATAC arrangements. This does not preclude agencies sharing information, where it is appropriate to so, outside of these forums. The importance of multi-agency information sharing is referred to previously in this report.

529. Information is shared across agencies at MARAC. A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local Police, Health, Child Protection, Housing Practitioners, Independent Domestic Violence Advisors (IDVAs), Probation and other Specialists from both statutory and voluntary sectors. Information is shared about the victim, perpetrator and any children involved.

530. After sharing all relevant information, they have about a victim and the perpetrator, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan.

531. The Sheffield MARAC Information Sharing Protocol (ISP) covers the information that can be shared, the legal authority for sharing information, including without the subject's permission, and the procedure for requesting and recording requests for information outside of the MARAC.

532. The ISP relates only to high-risk cases, agencies should have a thorough and robust approach to risk assessment to minimise the chance of medium risk cases being referred that are not covered by the ISP.

533. In addition to the above, the Partnership also follows guidance on information sharing from the following legislation and guidance:

- Data Protection Act
- Sheffield City Council Information and Data Protection Policy.
- Safe Lives (CAADA) guidance on information sharing,
- Management of Police Information Guidance

534. In this case, neither Imran nor Hassan was referred to MARAC, as DASH risk assessments were not completed for any of the incidents involving the two brothers. Agencies did not recognise the potential domestic nature of the offences between the two brothers. Therefore, the opportunity to share information was not taken.

535. Hassan was referred to MARAC as a result of assaulting Emily and key information around his actions, as a perpetrator, was shared across agencies.

536. In March 2021, the Multi-Agency Tasking and Coordination (MATAC) protocol was introduced. Regular meetings led by SYP, along with key partners, assess and plan a bespoke set of interventions to target and disrupt serial domestic abuse perpetrators and/or

support them to address their behaviour. The core objective of MATAC is to ensure agencies work in partnership to engage serial domestic abuse perpetrators and take enforcement action where required, which is a positive step towards protecting vulnerable and intimidated victims.

A perpetrator is only discharged from the process after discussion with all partners concerned. This will be based on engagement with services, victim feedback, further occurrences, and recent risk score.

This is a positive step forward to ensure information around perpetrator is shared as appropriate to inform any risk assess.

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

537. The aforementioned Standing Together Against Domestic Violence (Sharp-Jeffs and Kelly, 2016) report details clear links between adult family violence, mental health, alcohol, and drugs.

538. "Analysis of Metropolitan Police data on domestic violence homicides in 2008-09 found all six of the perpetrators who had killed family members were either suffering from mental health problems and/or were under the influence of drugs and/or alcohol (cited by Neville & Sanders-McDonagh 2014)".

539. Extensive research highlights a strong association between harmful levels of alcohol use and perpetration and victimisation and indicates alcohol may exacerbate abusive behaviour in a relationship where it already exists.

540. The misuse of alcohol and drugs was clearly evident when Police had contact with Imran and Hassan. Alcohol and drugs are known to lower inhibitions and can increase the severity of violence.

541. A number of incidents reported to SYP involved either one, or both, of the brothers having consumed alcohol and / or having taken drugs.

542. Imran was arrested twice for drug related offences, the first time on 18th September 2019, where he was found to have a small wrap of cannabis in his possession after being stopped in the street and searched. This was dealt with by way of a Police Notice for Disorder (PND). SYP would not ordinarily make a referral for substance misuse following the issuing of a PND, unless specifically requested by the person found in possession of drugs.

543. The second time was on 1st October 2020, when he was arrested for a domestic abuse incident and again found to have a small wrap of synthetic cannabis in his possession. On this occasion Imran was offered an allocated drug worker referral, as part of the custody

process. This was effective practice. However, Imran stated he had no substance issues and refused the offer.

544. Hassan was arrested on 1st May 2020 for possession with intent to supply drugs. Again, as part of the custody process, he was asked about substance misuse and stated he had no issues. When Hassan was offered an allocated drug worker referral, he refused.

545. There is always a medical professional in custody suites to assist Police in assessing those who may be struggling with alcohol or substance abuse/withdrawal, and who may experience problems whilst being held in custody. Drug workers are also located in custody suites which enables those suffering from alcohol or substance misuse problems, the opportunity to discuss options and access support services, that can assist them prior to release from custody. Police also hand out leaflets signposting, those suffering from addiction, to support services. This is part of the process of release from custody.

546. Whilst it was not taken up, the offer of a drug worker to both Imran and Hassan whilst in custody followed the guidance.

547. Where a person is arrested for a 'trigger' offence they should be subject to a mandatory drug test within the custody suite if they are over 18.

548. In the case of Hassan, it appears he was arrested for some trigger offences where he was not then subjected to a drug test. This could be seen as a missed opportunity as had a positive test been returned; he would have been required to attend a mandatory assessment with a drug referral worker.

Recommendation / Learning 17

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

550. When exploring the involvement of the brothers with drugs, it is noted Hassan was convicted of possession with intent to supply drugs on 3rd October 2019. Hassan received a suspended sentence for 12 months with one condition, to complete 200 hours unpaid work. Hassan failed to comply with the order, and it was subsequently terminated.

551. There were four intelligence reports to suggest involvement in drug dealing from an address used by both Imran and Hassan. However, these were never substantiated and, therefore, no warrants were ever issued to search the property.

552. STHFT were made aware of Imran's cannabis use and alcohol misuse when he presented at the ED on 16th May 2015. Whilst this attendance is outside the scope of this review, it is felt to be relevant in terms of understanding Imran's substance abuse over time.

553. Imran attended after vomiting blood. Imran reported a history of drinking half a bottle of vodka per day for the previous three years and smoking 20 cigarettes a day. Imran's diagnosis was cannabis related cyclical vomiting.

554. There is no evidence within his records that Imran was offered support or sign posted to services to address his alcohol or substance misuse issues on this occasion. This represents a missed opportunity.

555. Imran presented in the ED in December 2015 with abdominal pain. There is no evidence, within his record, his substance misuse or alcohol misuse were discussed with the triage nurse or doctor. Imran left the department without seeing another Doctor, therefore, the opportunity for referral was missed on this occasion. Again, this represents a missed opportunity.

Recommendation / Learning 18

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

557. Imran returned to the ED in August 2016 vomiting fresh blood. Imran was admitted for treatment and discharged home with a follow up out-patient appointment.

558. Imran was referred to a consultant for support around his substance and alcohol misuse in 2016. He was consequently offered two outpatient appointments of which he didn't attend.

559. The Consultant wrote to Imran' GP informing him of the missed appointments, and also to Imran, giving him the opportunity to contact STHFT should he require support to address his alcohol and substance misuse. This was good practice.

560. There is no evidence within the records that Imran made contact with alcohol services or his GP for additional support.

561. There is no indication, within the STHFT records, Hassan had any issues with alcohol or substance misuse. This is at odds with SYP records which indicate alcohol and drugs misuse.

562. There is no evidence to suggest substance misuse, or alcohol misuse, were explored with Hassan when he attended the ED. This is an example of the absence of 'joined up' working commented upon previously, and potentially represents a missed opportunity.

563. SCCG records will describe both Imran and Hassan as young men without any congenital or chronic physical health issues. Neither brother had been diagnosed with any mental health or substance misuse issues. They state they would not have expected his GP practice to have had any additional consultations with them. Whilst mental health was never clinically

diagnosed with either brother it is possible that one, or both, may have suffered with their mental health. They may have used alcohol and / or drugs as a coping mechanism.

564. Both Imran and Hassan failed to attend appointments with the GP practice, which reflects their inconsistent level of engagement with agencies.

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.

565. The Covid 19 pandemic affected the world, including the UK, from March 2020 and continued through the months leading up to the murder of Imran and beyond.

566. It is important to acknowledge the context in which all agencies were working during the latter part of the scoping period. Alongside increased demand and finite resources, the pandemic presented a raft of challenges for agencies. The commitment displayed by professionals to safeguard and protect people across all agencies during this period was extraordinary.

567. It is recognised services faced an unprecedented situation. It is accepted, even in times of crisis, safeguarding procedures still needed to be adhered to, in fact one could argue the pressures the crisis presented, necessitated closer joint working.

568. Imran had 10 recorded contacts with SYP during the period of the pandemic, between March 2020 and his death in November 2020. Frontline officers were on duty and visible 24/7 during the pandemic.

569. Hassan had more limited contact during this period.

570. There was no obvious deterioration in service provision offered to Imran during the pandemic, as all 10 incidents involving him were attended and investigated, despite the restrictions being in place.

571. There were no reported incidents involving Hassan during the lockdown and the pandemic.

572. There is no evidence to suggest the COVID 19 pandemic adversely impacted on the care and support offered by STHFT.

573. However, of course, there is a possibility either of the brothers may have been affected by the pandemic and may have struggled to cope with the enforced restrictions.

574. Outside of the pandemic it is considered relevant to explore the transient lifestyle of Imran and Hassan and associated accommodation issues.

575. It is clear that Imran and Hassan led transient chaotic lives. There were periods where they appeared to be effectively homeless, residing with parents or living in poor conditions. Research indicates stable accommodation is a key protective factor in reducing risk and harm.

576. On the 25th February 2019 Imran signed for a 1 bed furnished flat as a sole occupant with SCCHNS.

577. On 7th January 2020 an anonymous report was received, of a young woman living in address of Imran. The Neighbourhood Officer visited, who was advised by a local resident that they had seen a young couple and they had moved all the furniture out. Despite several attempts to contact Imran he did not engage with the Housing and Neighbourhoods Service.

578. Follow up calls were made by the Neighbourhood Officer to no avail. Local residents reported seeing a male return to property about every three weeks, staying for a couple of days then leaving again.

579. During this period visiting was restricted due to Covid 19 lockdown. A Notice to Quit was served on Imran on the 2nd of October 2020. This was in line with the Housing abandonment process. However, due to the pandemic and continued lockdown the Notice to Quit was not enforced.

580. Despite several further attempts to contact Imran he did not engage at any point. Again, this reflects a lack of engagement with agencies generally.

Hassan

581. On 4th June 2018, Hassan signed for a 1 bed flat as a sole occupant.

582. On 20th February 2019 Hassan contacted Housing, advising he was unable to pay the rent, as he had been sanctioned for missing a DWP appointment. He was advised to make up missing payments, once he was in receipt of benefits again.

583. On 6th March 2019, and again on 9th May 2019, the Neighbourhood Officer contacted Hassan to arrange an annual visit. However, there was no contact, and Hassan did not engage or respond to letters, nor cards sent, or left at the property.

584. On 4th April 2019 Hassan again contacted the housing team explaining he was still unable to pay his rent due to a further sanction for not attending DWP.

585. On 9th December 2019 Hassan was advised to bring rent payments up to date. If he didn't Hassan was advised court action would be the next stage. This was in line with procedure.

586. The lack of engagement with SCCHNS, unless in times of need, is reflective of how both brothers engaged with other agencies.

587. It is clear both brothers had contact with a number of agencies, on a number of occasions, when in need; but would then refuse to co-operate and then disengage with agencies.

588. There is a consistent pattern of both brothers declining to co-operate with professionals and missing, or electing not to attend, follow up appointments.

589. The Housing and Neighbourhoods Service is in the process of developing a 'tenancy ready course' to help new tenants understand how to manage their tenancy. This will hopefully reduce incidents of non-engagement between the Housing and Neighbourhood Service and tenants.

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

590. Trauma-informed care aims to promote feelings of psychological safety, choice, and control.

591. A Trauma Informed Approach is closely aligned to Adverse Childhood Experiences (ACE).

592. There is a growing recognition across agencies of the importance of identifying and responding to adverse childhood experiences and trauma in young lives.

593. SYP offer online training to all Officers and Staff recruits, should they wish to learn about the effect of trauma on a person.

594. SYP also offer a Vulnerability CPD package which contains nine programmes, each of which focuses on how to deal with a vulnerable person. The programme contains learning such as, how to 'Look beyond the obvious', 'the neuroscience of trauma', 'the importance of the subject's story' and 'the subject's past experience of the police'.

595. There is limited information around Imran and Hassan childhood. It is unknown whether they suffered any adverse childhood experiences.

596. During SYPs early interactions with the family, Imran and Hassan would have been classed as 'children in household'. This may have provided a negative perception of the Police. This could possibly go on to explain why, in later life, on a number of occasions the brothers elected not to cooperate with SYP in any way, which made it challenging for SYP to assist them in getting the help they may have needed; or for them to accept help from other partner agencies when referred to them.

597. There is nothing documented with regard to any Adverse Childhood Experiences for Imran or Hassan within STHFT records.

598. Family Health Assessments are completed in accordance with the Common Assessment Framework during initial contact with families by a health visitor.

599. When Imran's son was seen for a new birth visit, the Family Health Assessment did not identify any adverse childhood incidents, significant incidents, or concerns.

600. Had this any adverse childhood experiences, significant incidents or concerns been identified, STHFT staff may have used professional curiosity and a trauma informed approach to gain a wider understanding of the 'lived experience' and challenges that Imran or Hassan were facing. Staff may then have been able to offer advice and support by referring on to additional agencies and services where appropriate.

601. There was very little information on the problems lists in the GP records of either brother.

602. There is some evidence, within the health records, which suggests some vulnerability in relation to Imran in his youth, as there was an alert placed on his record in 2011, which pre-dates the period of the review. The alert indicates Paediatric Liaison involvement, however, there is no further detail available. It is unlikely this information was available to staff when Imran presented to the ED in later years.

603. It should also be acknowledged that STHFT has made significant recent changes in relation to the offer of support to patients who attend with types of traumas, or where there is an indication that domestic abuse has taken place. More emphasis is being highlighted in relation to training and support offered to staff within STHFT, particularly those who work within the ED and Minor Injuries Unit.

EFFECTIVE PRACTICE

604. As stated, this DHR seeks to adopt a strengths-based approach. This was consistent with the partnership approach in wanting to recognise positive practice, where it was appropriate to do so.

Multi Agency Working

605. When we examine the multi-agency response, including MARAC meetings, to protect and support Emily, and her child, in 2015 and 2016; there is evidence of effective multi-agency working, with the appropriate support put in place for the victim and her child.

606. It is clear agencies were seeking to adopt a supportive coherent response to reduce the risk to Emily and her child from Hassan.

SYP

607. SYP attended, and sought to investigate, the majority of incidents involving Imran and Hassan, and their parents, despite the lack of co-operation from all parties.

608. With exception of not submitting a DASH, the SYP investigation into the 'mirror' incident on 14th August 2018 was broadly diligent.

609. Whilst it was not taken up, the offer of a referral to a Specialist Drugs Worker by SYP to both Imran and Hassan, whilst in custody, represents effective practice.

STHFT

610. The care and treatment Imran, Hassan and the individuals included in this review received at STHFT was of a good standard, and quality, given the resources available at the time of attendances at STHFT.

611. Treatments were offered and provided, and assessments were undertaken, with due regard for the capacity of individuals to make decisions.

612. **SHSC**

613. It is recognised that a Health Visitor action plan was made to support Olivia. with contact scheduled for a 6–8-week home visit. As the family had moved by this time Professionals did note and inform other Professionals that the action plan was outstanding.

614. Olivia was moved into the Health Inclusion Team and the plan was clearly transferred over. The Heath Inclusion Team discussed the plan with her. Health Visitors also took the opportunity to discuss domestic abuse, as part of their routine enquiry.

CONCLUSION

615. 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.

616. 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.

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

618. 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.

619. 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.

620. 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.

621. 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.

622. 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.

623. 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.

624. 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.

625. 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.

626. 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.

627. 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.

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

629. 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.

630. 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.

631. 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.

632. 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.

633. 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.

634. 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

635. ## MULTI AGENCY RECOMMENDATIONS

Recommendation / Learning 1

636. **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.**

Recommendation / Learning 3

637. **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

638. **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

639. **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

640. **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

641. **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

642. **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.**

643. **SINGLE AGENCY RECOMMENDATIONS**

Recommendation / Learning 2

644. **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

645. **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

646. **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

647. **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

648. **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

649. **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

650. **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

651. **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

652. **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

653. **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

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

655. **RECOMMENDATIONS IDENTFIED BY AGENCIES**

656. All partner agencies are committed to learning and continuous improvement.

657. Below is a summary of the learning, and specific recommendations, each Agency have helpfully identified as part of this DHR. This is evidence of reflective practice and a commitment to improve the service they offer as a result of this case.

658. Where Single Agencies have made their own recommendations from their own learning, the Partnership should receive updates regarding progress.

659. **South Yorkshire Police (SYP)**

1. Continued training packages for dealing with non-engagement, and the barriers faced specifically due to cultural differences. Training to include working alongside community leaders to enhance SYP profile and the perceptions of Police as a force to help those in need.

2. SYP have stated they will explore whether the DA Matters training could be expanded to include cultural differences.

3. Operational update / brief around the importance of completing a DASH and even submit where DA is suspected, this is regardless of whether the victim engages and assists by answering the questions.

660. **Sheffield Teaching Hospitals Foundation Trust (STHFT)**

To build upon the ongoing training as part of the safeguarding champions network awareness around the impact of ACEs and adopting trauma informed practice.

1. To raise awareness through levels 2 and 3 Safeguarding training of the 'Think Family' approach when undertaking assessments.

2. ED staff to be offered domestic abuse training to include recognition, routine and selective enquiry, use of the DASH risk assessment document and the MARAC referral process. IDAS have offered training and are wanting to link in with ED staff to raise awareness.

3. **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.**

661. A briefing by the STHFT ED was shared internally on the 15th January 2022 around gun and knife crime with signposting to other documents and linked to the Sheffield City knife crime strategy and reminded staff to report and links on how to do this.

662. **Sheffield CCG (SCCG)**

1. Sheffield CCG to encourage GP Practice staff to adapt their 'did not attend' policy to consider the impact of not accessing health care appointments on the health of adults who may lack capacity and children**.**

663. **Sheffield City Council - Housing & Neighbourhood Services (SCCHNS)**

1. The Housing and Neighbourhoods Service is in the process of developing a 'tenancy ready course' to help new tenants understand how to manage their tenancy with the help of a support worker. This will hopefully support vulnerable tenants and reduce incidents of non-engagement between the Housing and Neighbourhood Service and tenants.

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Emergency Department Standard Operating (SOP) for releasing information to the Police.

END

See below for Home Office Feedback letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Alison Higgins
Strategic Commissioning Manager
Domestic and Sexual Abuse
Domestic Abuse Co-ordination Team
Sheffield City Council
West Wing, Moorfoot Building
Sheffield
S1 4LP

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