



SHEFFIELD FIRST SAFER AND SUSTAINABLE COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Executive Summary

Report into the death of Adult I April 2016

Independent Author: Dr Russell Wate QPM

Date: November 2017

REVIEW PROCESS

1. This report of a domestic homicide review (DHR) was conducted by the Sheffield First Safer and Sustainable Communities Partnership (SFSSCP) and examines the homicide of a 22 yrs old female in Sheffield on the 12th of April 2016. It was conducted in line with the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (This guidance was updated in December 2016, subsequent to the commencement of the review).
2. The primary purpose for undertaking DHRs is to allow lessons to be learned where a person is killed as a result of domestic violence. Professionals need to be able to understand what happened in each homicide, in order for these lessons to be applied as widely and fully as possible. Special emphasis in this report is placed on the changes necessary in order to reduce the risk of such events happening in the future.
3. The victim is known for the purpose of this review, as Adult I. Her family have specifically asked that this review does not use her proper name, but are content for this naming convention to be used in this review. She moved to the UK in 2005 from Zimbabwe aged 12 years old, with her mother, Adult IM, and settled in Sheffield. Adult I suffered from the condition scoliosis, otherwise known as curvature of the spine¹. It is evident that this impacted on her life in terms of pain, but her family told the Review that this was self-treated by her through commercially available pain relief.
4. The perpetrator of the homicide is identified for the purpose of this review as Adult IP, a man of Black Minority Ethnic (BME) of 37 years of age. This man had been in a relationship with the victim and was a previous boyfriend of Adult I. Adult IP had three children with a former partner referred to as Adult IPCM. While the murder took place in Sheffield, Adult I met and conducted her relationship with Adult IP primarily in Nottingham but also in Essex. She returned to her family area to become a resident of Sheffield prior to her death.
5. Adult IP was arrested by the Police on the day of the murder after he handed himself in at a Manchester Police Station. He was charged with and pleaded guilty to murder. He was sentenced to life imprisonment on 19th December 2016 with a recommendation to serve a minimum of 26 years.
6. Sheffield First Safer and Sustainable Communities Partnership (SFSSCP) informed

¹ Scoliosis is the abnormal twisting and curvature of the spine. Back pain is common in adults with scoliosis. Young people with scoliosis may also experience some discomfort but it's less likely to be severe.(NHS Choices)

the Home Office on 14th June 2016 that the death of Adult I met the criteria for a DHR and oversaw the creation of a Review Panel. As a result, agencies known to have had contact with the victim, perpetrator or his previous partner and children were identified and required to contribute to the Review.

7. All of the agencies contacted and asked to confirm such contact responded positively to the Review Panel's request to secure their files and relevant information. Thirteen separate agencies supplied Individual Management Reviews (IMRs) and others provided chronologies and supplied relevant information as requested.

CONTRIBUTORS TO THE REVIEW

8. An Independent Chair with a professional background as a retired senior police detective experienced in the investigation of homicide was appointed to steer and author this review. The Chair is an independent practitioner who has conducted previous DHR's, Child Serious Case Reviews and Multi Agency Public Protection Reviews. He is independent of any agency within the Nottingham, Essex and Sheffield area. Three panel meetings were held where there was positive attendance and contribution throughout the Review.

The following agencies submitted IMR's

- South Yorkshire Police (SYP)
- Sheffield Department for Work and Pensions
- Nottingham City Care Partnership
- Essex Police
- Nottingham Trent University
- Nottinghamshire Police
- East of England Ambulance Service NHS Trust
- Nottingham City Council Adult Social Care
- Colchester Hospital University NHS Foundation Trust (CHUFT)
- Nottingham University Hospitals NHS Trust
- Nottinghamshire Healthcare NHS Foundation Trust (NHCFT)
- NHS Nottingham City Clinical Commissioning Group (NCCCG)
- Shelter

In addition the views and insights of key members of the family of Adult I were carefully collected and noted during the review process and consideration of the findings and conclusions. Similarly, Adult IP was asked if he wished to participate or contribute information but he declined to participate.

THE REVIEW PANEL MEMBERS

9. The Panel comprised of the following panel members who were all independent of the case:

Member	Agency
Russell Wate	Independent Chair and Author
Ian Tandy	Assistant to Chair

Standing Panel Members

Penny Brookes	NHS Sheffield CCG
Pete Horner	South Yorkshire Police (SYP)
Victoria Horsefield	Sheffield Safeguarding Children Board
Simon Richards	Sheffield City Council (SCC) Adult Safeguarding and Quality
Steve Eccleston	Sheffield City Council Legal Services
Ann Powell	National Probation Service, Sheffield

Co-opted Panel Members

Paula Bishop	Nottingham Crime and Drugs Partnership (Domestic Abuse Specialist)
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Co-ordination Team

Alison Higgins	Sheffield Drug & Alcohol/Domestic Abuse Coordination Team (DACT – Domestic Abuse Specialist)
Alison Howard	DACT
Steve Ashmore	Head of Police Investigation
Simon Finney	Strategic Commissioning Manager for Vulnerable Adults

TERMS OF REFERENCE FOR THE REVIEW

10. The purpose of this DHR was primarily to:
- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
 - Establish what lessons are to be learned from the case about the way in which local professionals and organisations work both individually and together to safeguard and support victims of domestic abuse including their dependent children.

- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

In addition there were additional terms of reference considered in undertaking this Domestic Homicide Review given the circumstances of the individuals and events involving the murder:

- Was there appropriate sharing of information geographically across areas, specifically Nottingham, Essex and Sheffield?
- Was there appropriate disclosure and sharing of information between and within agencies?
- Was there sufficiently detailed recording of information by professionals?
- Was appropriate pastoral care offered by Nottingham Trent University where Adult I was an undergraduate student?
- Was there a possible failure to signpost or refer appropriately, or failure to record signposting at the GP practice in Nottingham?
- There are similarities with other DHR's in Sheffield in that both the victim and perpetrator are migrants to the UK.
- Previous DHR's have also identified issues with GP's and Primary Care information sharing.
- Both the victim and perpetrator are BME migrants but had no language issues; the victim was disabled as a result of the condition scoliosis (abnormal twisting and sideways curvature of the spine.)
- The review will consider any other information that is found to be relevant.

SUMMARY CHRONOLOGY

11. Adult I was killed outside her mother's house in Sheffield on 12th April 2016, having been stabbed around forty times by Adult IP, who was her former boyfriend. Adult I had ended the relationship with Adult IP some time earlier and it is thought there had been no immediate contact prior to the attack on her. She had formed a new relationship with another man, Adult IP2. Adult I had returned to her family home to care for her mother, who had recently suffered a stroke but who also tragically witnessed the attack on her daughter.
12. She originally left her home in Sheffield to study first at Nottingham University in September 2012 and then later moved to Nottingham Trent University in September 2013. Whilst in Nottingham she met the perpetrator Adult IP and they had a two-year relationship. The couple did not live together, but Adult IP would stay regularly with Adult I in her shared student accommodation in the centre of

Nottingham. Later in the relationship Adult I discovered that her boyfriend had a previous partner and three children, who were living in Essex. In the past, the local police had attended this home of this previous partner twice following reports of domestic abuse involving Adult IP.

13. During her time in Nottingham, Adult I had repeated and frequent contact with both medical and policing professionals. Nottinghamshire Police were first contacted about Adult I in December 2014, when a taxi driver helpfully reported what appeared to him as a domestic abuse related assault on a woman in the street in December 2014. Adult I went on to call the police herself on a further two occasions in April and November 2015 in regard to complaints of domestic abuse by Adult IP. On each occasion, policing procedures were followed and the required assessment forms were completed. The subsequent evaluation of factors was judged as being “medium risk” and none of these events was ever seen as a “high risk” despite the pattern of events disclosed. When Adult I moved from Nottinghamshire, there was no information passed to the police in Sheffield about the domestic abuse involving Adult I.
14. There were similar repeated contacts with a range of medical services and providers during this time in Nottingham. In July 2014, Adult I was admitted to Colchester Hospital University Foundation Trust, following an apparent suicide bid involving toilet cleaner. (It is not known why Adult I was in Essex at this time other than this is the home area for Adult IP). After treatment she was discharged having refused to engage with the Mental Health Crisis Team. Soon afterwards, Adult I was seen by her GP in Nottingham, for strong headaches and a stiff and painful neck. She was referred to Nottingham University Hospital where tests were completed. There is recorded liaison with the University tutorial staff about issues that would ultimately lead to her inability to complete her university studies. In mid April 2015, she attended the Urgent Care Centre in the City for back pain and then immediately following the second reported Domestic abuse incident, a further suicide attempt on 21st April, saw her admitted to Nottingham University Hospital.
15. The remainder of her time in Nottingham was punctuated with visits to her GP, the Urgent Care Centre and the Sexual Health Service based at the City Hospital campus of NUH. On each occasion, the medical issue for which Adult I presented was addressed, but without a wider ranging evaluation or holistic check of her well-being. As an example, following a visit to her GP in October 2015, a Patient Health Questionnaire was completed resulting in a score of nineteen, which was lower than on a previous occasion. There were no discussions recorded about her partner or any relationships at this time.
16. In December 2015 Adult I confirmed to the police that she had ended the relationship with her boyfriend. There then followed a gap of four months where nothing is known by agencies about the lives of Adult I, or Adult IP. Adult I’s family said that after moving to Sheffield, she had in fact gone to London to work for a

short time, before returned to Sheffield to care for her mother. During the evening of 11th April 2016 Adult IP went to his ex-partner's address in a car that had been hired to his mother. Adult IPCM would not let him in and so he left a note for the children on his car, which read, "Has had enough of this life". He also abandoned his wallet, some identification and some spare keys. He then went and bought two knives from a supermarket in Colchester and drove to Sheffield. Once there he waited outside Adult I's home and when she came outside he stabbed her.

CONCLUSIONS – LEARNING THE LESSONS

1. A number of primary themes have been identified from the analysis of this DHR into the homicide of Adult I, which need to be highlighted. Several of these themes sadly appear regularly in Reviews of Domestic Abuse murders and have been identified in the 'Key findings from analysis of Domestic Homicide reviews' published this year by the Home Office². The themes for Adult I are as follows;

Learning Themes Adult I

- **Domestic Abuse incidents being dealt with as individual incidents**
- **Lack of professional curiosity- including believing another agency was doing something**
- **Record keeping and information sharing**
- **Self-Harm and mental health concerns as indicators of DA**
- **Lack of prevention action for perpetrator**
- **Working with student/transient populations**

2. There were repeated occasions when the number of agencies engaged with Adult I and her moves around the country, resulted in only a partial sharing of information about her circumstances and situation. This review has accordingly identified that improvements should be made in relation to information sharing. In the circumstances, however, these oversights would not have prevented the tragic death of Adult I in Sheffield on 12th April 2016. The review author is also of the belief that this tragic death could not have been predicted.
3. There were a number of opportunities to engage with Adult I in regard to the Domestic Abuse she reported in different areas and to different agencies. There was a repeated tendency for some of these reports of domestic abuse to be treated in isolation and not as part of the on-going pattern of abuse she was experiencing. This was despite the fact that on one occasion, Adult I clearly told professionals that domestic abuse was happening constantly. No one agency ever took ownership of

² Home Office (2016) 'Domestic Homicide Reviews KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS' HM Government

Adult I's case and therefore there was a lack of coordination of risk. At times her case was dealt with by simply following process without further thought for the wider picture of what life was like for her.

4. The vital importance of maintaining proactive professional curiosity has been established in a number of national publications³. There is no doubt in Adult I's case that professional curiosity is evidently absent. As an example, when Nottingham University Hospitals NHS Trust was treating Adult I, the aspects of domestic abuse in her case were not discussed in depth or enquired into. Rather there was the assumption that the police were involved and dealing with these issues. Similarly, Nottinghamshire Police became aware of the children of Adult IP being involved in previous domestic abuse, but there were no attempts to obtain their full details. Nor were there actions to notify Essex Police of the details of the domestic abuse involving a parent of these children.
5. There are clear signs of the way some healthcare professionals overlooked Adult I's mental health issues as indications and symptoms of domestic abuse. On two recorded occasions, Adult I made an attempt to self-harm by taking tablets, but also by drinking toilet cleaner. There is also mention within her conversations with health professionals in particular her GP practice of her having a low mood and being depressed. The review author feels that not enough was done to try and persuade her to engage with interventions to get to the root of her problems. These may have been triggered by her disability but were in all likelihood more due to what she described as the constant domestic abuse she was suffering.
6. Adult IP came to the attention of the police and other agencies in both Nottinghamshire and Essex. Alcohol as a trigger was also mentioned on a few of these occasions and a pattern was emerging of Adult IP as a consistent perpetrator of domestic Abuse. Nothing was done in either Essex or Nottingham to consider any interventions in relation to the offender.

RECOMMENDATIONS FROM THE REVIEW

7. When the family of Adult I was asked about any appropriate recommendations they felt were needed, they were unable to suggest any specific necessary action for the future. Nonetheless, individual agencies have made a series of recommendations within their IMR's, which they need to ensure they implement. In addition to these agency recommendations, the DHR panel has also raised a number of recommendations that will help to protect victims of Domestic Abuse in the future.

Recommendation 1

The Sheffield First Safer and Sustainable Communities Partnership (SFSSCP) should

³ House of Commons (2009). "The Protection of. Children in England: A Progress Report' Lord Laming.

request that the community safety partnership that covers the Colchester hospital areas seeks assurance from them that they are implementing their action plan and disseminating learning from this review. This CSP should also ensure the same applies for Essex police.

Recommendation 2

The Sheffield First Safer and Sustainable Communities Partnership (SFSSCP) should request that the relevant community safety partnerships within Nottinghamshire seek assurance from the agencies below that they are implementing their action plan and disseminating learning from this review and specifically request:

- i) Nottingham University Hospitals NHS Trust that they are delivering clear domestic abuse training to its staff so that a clinical enquiry is carried out when a patient discloses domestic abuse. This training must make it clear that even if there is already an agency involved then a Domestic Abuse Stalking Harassment and Honour based violence Risk identification checklist (DASH RIC) should still be completed and the relevant referrals made.
- ii) Nottingham City Council Adult Social Care should ensure that the standard letter for general DART use outlines the correct contact number and the available resources that are deemed safe and appropriate. This can always be amended according to need, risk and safety aspects. There is in place a clear protocol for record keeping which would cover when phone calls will be deemed unsafe. The records need to document why unsafe and clear rationale for this. An audit of records should assure the CSP that the recording policy is being adhered to.
- iii) The NCCCG should work with GP practices to develop a protocol that can be used by them when processing and recording DART referrals.
- iv) Nottinghamshire Police ensures that where children are recorded on the DASH RIC, Officers should be reminded of the need to obtain their full details including a current address wherever possible. This may require further enquiries and research by the Officer submitting the DASH RIC. This includes the requirement to consider safeguarding referrals for children recorded on the DASH RIC irrespective of the policing area in which they currently reside. Nottinghamshire Police Officers should be reminded that if a victim has moved out of Nottinghamshire, the person with that information must ensure that the new Policing Area and Command Unit are informed. The new address should be provided and the Policing Area apprised of the abuse and risk category of the victim.
- v) Nottingham Trent University is making sure that their staff use professional curiosity when a student informs them that they are subject to DA and

checks other agencies are actually dealing with the abuse. Particularly if a student subsequently drops out of their course or is unable to be contacted.

Recommendation 3

In order to help to disseminate learning the SFSSCP should write to the Home Office to ask them for guidance on what good practice is currently happening across the UK in relation to intervention programmes that are delivered to perpetrators. In this case it is felt that a programme could have been a preventative factor however guidance is needed on commissioning such a programme and how to achieve the maximum effect. The SFSSCP should share findings with the other CSP's involved in this DHR.