DOMESTIC HOMICIDE REVIEW

Into the death of Helio
2017

EXECUTIVE SUMMARY

Report Author

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The Review Panel and the Oxford Safer Communities Partnership would like to express their sincere condolences to the victim's wife and children for their loss of a much loved husband and father. Our thoughts are also with the victim's family in his home country. We cannot replace the loved one who has been so cruelly taken from them, but we hope that the contents of this report might answer the questions they raised at the beginning of the review or perhaps in the future, and may help towards a sense of healing for them.

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DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

1 The Review Process:

1.1 This summary outlines the process undertaken by the Oxford Safer Communities Partnership Domestic Homicide Review (DHR) Panel in reviewing the murder of a resident in the Oxford area.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

The victim: Helio - 35 years of age at the time of the fatal incident.

The perpetrator: Paulo - 27 years of age at the time of the fatal incident.

The victim's wife: Brigida

The perpetrator's former partner and sister-in-law of the victim: Rosa

All the parties above were of Asian ethnicity.

1.3 Criminal proceedings were completed in mid 2017 when the perpetrator was found guilty of murder and sentenced to life imprisonment with a minimum term of 20 years 10 months.

1.4 The review process began with an initial meeting of the Community Safety Partnership on 24 March 2017 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with the victim and or the perpetrator prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.5 Four agencies confirmed contact with the victim or the perpetrator, and their family and were asked to secure their files.

Contributors to the Review

1.6 The following agencies and the nature of their contributions to this review are:

- Thames Valley Police - Chronology and Independent Management Review (IMR).
- GP Practice - Chronology and IMR for the perpetrator.
- Oxford Health (Health Visiting & Mental Health) - Chronology and IMR.
- Oxfordshire Children's Services - Chronology and IMR

1.7 The authors of agency Independent Management Reviews were independent of the case, had no management responsibilities for the frontline staff who provided services to the parties involved, nor did they have personal contact with the parties to this review.

The Review Panel Members

1.8 The following were members of the DHR Panel for this review:

Name	Job Title	Agency Represented
Gaynor Mears	Independent Chair & Report Author	
Liz Jones	Domestic & Sexual Violence Strategic Lead	Oxford City Council
Ian Brooke	Head of Service, Community Services	Oxford City Council
Karen Diver (1st 3 panels) replaced by Becci Seaborne	Service Manager	A2 Dominion, Domestic Abuse Service (voluntary sector)
Felicity Parker	Chief Inspector	Thames Valley Police
Lucien Champion	Head of Investigations	NHS England South
Shaun Hanks	Interim Safeguarding Manager & Principle Social Worker	Oxfordshire Children's Services
Jayne Harrison	Children's Safeguarding Lead Nurse	Oxford Health NHS Foundation Trust
Fran Liles	Serious Incident Investigations Lead	Oxford Health NHS Foundation Trust
Dr Meriel Raine	Named GP for Safeguarding	Oxford Clinical Commissioning Group
Abi Wycherley	Violence Against Women & Girls Coordinator	Oxfordshire County Council
Claire Siddle	DHR Administrative Support	Oxford City Council

The Author of the Overview Report

1.9 The chair and report author for this review is independent DHR chair and consultant Gaynor Mears OBE. The author holds a Masters Degree in Professional Child Care Practice (Child Protection) during which she made a particular study of domestic abuse and its impact, the efficacy of multi-agency working and the community coordinated response to domestic abuse. The author holds an Advanced Award in Social Work in addition to a Diploma in Social Work qualification, and it was her experiences of cases of domestic abuse as a Children and Families Team senior practitioner which led her to specialise in this subject.

1.10 Gaynor Mears has extensive experience of working in the domestic abuse field both in practice and strategically, including setting up and managing an IDVA service, and roles at county and regional levels. She has experience in undertaking Domestic Homicide Reviews, and research and evaluations into domestic violence services and best practice. Gaynor Mears has experience of working in crime reduction as a community safety manager, with Community Safety Partnerships, and across a wide variety of partnerships and agencies, both in the statutory and voluntary sector. She has also served as a trustee of a charity delivering accredited community perpetrator programmes. Gaynor Mears is independent of, and has no previous connections with, any agency in Oxfordshire.

1.11 Terms of Reference for the Review

The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- To seek to establish whether the events leading to the homicide could have been predicted or prevented.
- This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for the coroner and the criminal court.

Specific Terms of Reference for the Review:

1. To identify and examine agency contact with the victim and the perpetrator between February 2016 when significant agency involvement commenced in relation to the perpetrator, and the date of the victim's death in 2017. Agencies with information prior to this timeframe are asked to provide a brief synopsis of their involvement.
2. Agencies that had contact or involvement with the victim, perpetrator, their partners, or children to assess:

   a) whether there were any indications or signs that tensions existed between the victim and the alleged perpetrator or any other family members which might lead to violence or domestic abuse taking place?
   b) whether there were opportunities to enquire about any family disputes or domestic or honour based abuse, if so did this take place? If not why not?

3. Agencies who had contact with the alleged perpetrator, the victim, their partners, or children to assess what risk assessments took place:

   a) what action was taken as a result of risk assessments?
   b) was the action taken in line with agency policy and procedures?
   c) were there any opportunities to assess risk that should have been taken which were missed,

4. Did the services involved with the alleged perpetrator at the time he was seen after a self inflicted injury in December 2016, consider his admission to a mental health hospital? If not why not, and what services were offered and accessed following his discharge into the community?

5. When the family reported to agencies posts on the alleged perpetrator's Facebook profile which were threatening towards them, what action was taken, and was it in line with risk assessment and procedures?

6. Examine the effectiveness of single and inter-agency communication and information sharing both verbal, written, and via IT systems.

7. Whether the assessments, decision making, and practice by agencies was sensitive to the ethnic, cultural, linguistic and religious identity of either the victim, alleged perpetrator, their partners, or children.

8. Had the staff who had contact with the victim, alleged perpetrator, or family members received training on domestic abuse, DASH risk assessment, honour based violence, and safety planning, and whether they felt the training was in sufficient depth to undertake and assess risk?

9. To determine whether there were any barriers which may have affected the victim, alleged perpetrator, or their family members' ability to disclose abuse or to seek advice and support, and how accessible were services to them?

10. Was there any restructuring or pressures within agencies during the period under review which had an impact on the quality or availability of services?

11. The Chair will be responsible for consulting with family members and involving them in the Review.

2. Summary Chronology:

2.1 It is easy to read the summary chronology of events which follows and forget that the victim who tragically lost his life is Helio. The very limited mention of Helio in agency records makes it feel as though he is on the periphery of this review. His wife Brigida says the events which overtook their family, and which arose from Helio's sister-in-law Rosa's relationship with Paulo the perpetrator of the crime, were not viewed with any real sense of anxiety by Helio, indeed his wife Brigida describes him as an easygoing man; a man for whom 'everything was always alright'.

2.2 Facebook posts by Paulo which are reported in the chronology were mainly believed by Rosa and Brigida to be aimed at them, but they also mentioned Helio on occasions. When Helio learnt from a friend at work that Paulo wanted to fight him he did not take it seriously. Helio did not think anything would happen to him to the extent that when Brigida said they should do something he said to show the Facebook postings to the Police and let them deal with it.

2.3 The victim Helio, and the perpetrator Paulo, first came to the notice of agencies in 2015 for separate reasons. Both they and their family members originate from Asia. Helio arrived in the UK in approximately 2008 and Paulo came in 2012. They all hold European Union passports.

2.4 Helio and his family came to the notice of agencies following a routine home visit by a health visitor in the summer of 2015. The involvement of health visitors was consistent throughout this review and the staff involved had gained extra knowledge of the Asian community due to their own studies and the high numbers of their cases in which domestic abuse or child protection issues featured within that community. It is of note that one of the health visitors, unusually, had previous experience as an Independent Domestic Abuse Advocate.

2.5 The first agency records relating to the perpetrator Paulo relate to a report by him to the Police in April 2015 that he had been a victim of assault, however there were no lines of enquiry or supporting evidence to enable the Police to pursue the matter.

2.6 Helio's sister-in-law Rosa had arrived in Britain to join the family in 2014. In the Spring of 2015 Rosa met Paulo and unbeknown to her sister Brigida and Helio, she commenced a relationship with him. In the autumn of 2015 Brigida discovered that her sister Rosa was pregnant. At first she denied that Paulo was the father. Paulo learnt of the pregnancy from Brigida, and in keeping with their culture Rosa moved in to live with Paulo and they were considered man and wife. This brought Paulo into Helio's family relationships. Brigida reports that Helio had urged her to help her sister following the discovering of her pregnancy.

2.7 As the pregnancy was concealed a pre-birth risk assessment took place at which Rosa and Paulo stated that the pregnancy was planned. During a health visitor antenatal visit before the birth Rosa was asked via an online translation tool about domestic abuse as is routine. It was noted that there was no term for domestic abuse in her language. Rosa had limited English, but denied any domestic abuse was taking place. As a precaution the health visitor gave Rosa an information card containing contact details of domestic abuse services, and helped Rosa add these to her mobile phone. This was good practice.

2.8 Rosa gave birth in early 2016 and shortly afterwards she disclosed to Brigida that she had become pregnant after being raped by Paulo. A hospital social worker was informed and Rosa also reported that Paulo had been abusive when she was living with him. She stated that Paulo had threatened her with a knife, and during an argument had threatened to kill himself. An interpreter was brought in, but could not speak the same dialect and no other interpreter was available, therefore Brigida acted as interpreter for her sister. When Paulo came to the hospital he was reported to be aggressive; shouting and swearing 'she is my wife, I'm taking her'. It is thought that he knew nothing of the rape allegation at that stage. The Police were informed of the rape allegation and enquires started. Hospital security were alerted should Paulo attend.

2.9 Paulo was arrested following the rape allegation, but due to the lack of an interpreter no formal interview could be held at that time. He was released on bail with conditions not to contact or go near Rosa, their child, or Helio and Brigida's home where Rosa was then staying. The officer issuing the bail conditions used different methods for explaining the conditions and felt that Paulo understood. Rosa and Paulo were formally interviewed later when an interpreter was present; Rosa twice during March 2016 and Paulo in mid April 2016. Brigida was also interviewed and stated that at first she had not believed her sister as Paulo had appeared to be 'a good man' and he was going to antenatal appointments with Rosa. However, she had seen Rosa giving Paulo money which she thought odd.

2.10 Following Paulo's arrest Rosa reported to the Police in early 2016 that he was posting 'unpleasant' things on Facebook about her and accusing her sister and Helio, of being responsible for the breakup of his relationship with her. Paulo posted one message with the comment 'You think I don't have family in the UK, wait and see'. This information was only known to the Police.

2.11 A Strategy Meeting took place in early 2016 due to a number of concerns. This included Rosa's pregnancy being as a result of alleged rape; that she was being controlled and exploited financially by Paulo due to his gambling debts. There is no record that the Facebook postings were discussed at this meeting. It was noted that Rosa was no longer in a relationship with Paulo, and Helio and Brigida's address was flagged by the Police as a precaution. Children's Services acknowledge that the risk posed by Paulo was unknown at this time. The Strategy Meeting was followed by an Initial Child Protection Case

Conference after which the child was placed on a child protection plan. The Police submitted a report, but did not attend this or subsequent conferences as they had no prior record of involvement with the family members, and there were capacity issues for the officer covering that area of work. They were sent minutes of all the child protection conferences and these are held on file. However, the review revealed that these were not read.

2.12 During a Core Group in March 2016 it was reported that Rosa was scared to go out (scared of Paulo), and Brigida explained that Paulo was posting threatening messages on Facebook daily. Brigida believed the posts were aimed at herself and Helio and blamed them for ending his relationship with Rosa and ruining his life. Paulo was said to be of the view that he had a good relationship with Rosa and after the birth he had given her his cards and passport and promised not to gamble again. Brigida reported that Paulo was threatening "that if he sees them in the street, he will run them over and he does not care if he goes to prison", and threatening messages were also coming from Paulo's family abroad. It was noted that Rosa had been responding to Paulo by text, but this breach of his bail conditions was not noted as such, nor was the breach or Facebook postings reported to the Police. Rosa and Brigida were advised by a social worker not to respond to posts or messages and to block Paulo on their social networks. The meeting heard that if such a situation arose in their country of origin things would become very violent and people would kill one another.

2.13 During a home visit in March 2016 a health visitor was told that Paulo had expressed disapproval of children being raised in 'the western way'; the social worker was aware of his comments. The health visitor also learnt that in their culture Paulo would be killed for what he had done, but the family would not take action, however Paulo had been trying to bait Helio into a fight. The health visitor had anecdotal information that fights took place in a park at night. The health visitor reported this information to the Police via 101 on 12 May 2016 (but no specific details were passed so there was little action they could take), and it was shared at a Core Group that day, and at a Child Protection Case Conference on 25 May 2016. At the Child Protection Conference consideration was given to moving Rosa and the child away from the area due to the incitement by Paulo to engage Helio in a fight.

2.14 On 26 April 2016 a Children's Service's social worker held a meeting with Paulo. No interpreter was available; an online interpreter was used. Paulo is noted as having cried throughout the two hour long meeting. He explained the situation between himself and Rosa. His understanding of rape was explored and he demonstrated an appreciation that sex needed to be by mutual consent. The social worker attempted to explore Paulo's bail conditions, however, he did not understand what was meant by 'bail' and it took the social worker about an hour to explain. Eventually Paulo produced a signed statement from his bag which stated that he was to have no contact with Rosa or their child. He stated that the Police would be contacting him on 7 July. The social worker discussed his comments on Facebook, and he explained that he wanted to share with his family what had been happening. He said that Brigida had also replied with 'nasty messages'. Paulo said that they were liars. He was advised to seek legal advice regarding contact with the child.

2.15 After a period of support by Brigida and Helio, Rosa moved into her own accommodation with her child. However, she began incurring debts and she had no recourse to public funds due to her immigration status. At one point she returned to work, but learnt that Paulo was working at the same place and she was advised to leave to avoid contact with him; by whom she was advised has not been substantiated. There is no record that Rosa was advised or signposted for support concerning her 'no recourse' situation. Children's Social Care and the Health Visiting Service continued to have significant involvement with Rosa and her child during 2016 and into 2017 and this involved ongoing contact with Brigida and Helio.

2.16 At the beginning of December 2016 at 11:45hrs the Police received a call from the Ambulance Service requesting assistance as they were attending an address in which an incident had occurred where a knife had been used. Police officers attended Paulo's address where paramedics were already in attendance. Paulo was found lying on a bed with a self inflicted stab wound; a kitchen knife remained in his stomach. He explained to officers that he had been re-reading a letter received from the Police three weeks before informing him that rape charges had been dropped due to lack of evidence; his bail conditions were cancelled. This, along with not seeing his child, had upset him and he had stabbed himself in a desperate act. He was taken to hospital where his wound was found to be superficial. A mental health assessment was arranged.

2.17 A Police review of the NICHE[1] record states that partner agencies were aware of this incident therefore no further action was required. It is not stated in Police records which partner agencies were aware or how they were informed. Children's Social Care were not informed despite there being a child protection plan in place. A Police visit took place to inform Rosa of the incident, which in light of the previous bail conditions was good practice. Her sister Brigida interpreted via the phone. However, Rosa appears to have misunderstood what was said as it became clear later that she believed Paulo had succeeded in taking his life and was dead. No domestic abuse risk assessment was undertaken. It was 6 days later during a meeting with Rosa that the childcare social worker was mistakenly told that Paulo was dead.

2.18 An Emergency Duty Psychiatric Team Foundation Year 2 doctor undertook an assessment of Paulo overnight on 2 and 3 December 2016. No interpreter was available and it was agreed with Paulo and the senior registrar with whom the doctor conferred, that his aunt would act as interpreter. Paulo said his aunt "knew everything anyway". The assessment acknowledged Paulo's 'complex social situation'; the accusation of rape and the dropping of the case by the Police; Children's Social Care's involvement with his child, and his lack of access which he hoped to regain. He had no prior history of mental ill-health. Paulo expressed his anger with the Police for their lack of contact with him and that it had taken 10 months to decide to end the case. He became tearful when speaking of how much he missed seeing his child. Paulo said he felt better having spoken to the doctor; he regretted his actions and felt more optimistic. The assessment concluded that there was no risk of self-harm, harm towards others, or from others at that time. The assessment plan was to refer to the Community Adult Mental Health Team. This was discussed and agreed with the on-call specialist registrar and a copy of the assessment with a covering letter was sent to Paulo's GP on 3 December 2016.

2.19 The plan for Paulo rightly recorded under the 'safeguarding issues' heading that he had a child known to Social Services, but that he did not have contact with the child. However, Paulo's case, in particular his lack of contact with his child, separation from his partner, Children's Social Care involvement, and self harm attempt, did not trigger concerns of a safeguarding nature or the possibility of domestic abuse being a component. No safeguarding enquiries or information sharing with Children's Services took place.

2.20 The Adult Mental Health Team accepted the referral on 3 December 2016 and telephone contact made with Paulo who said he was well. The following day two community psychiatric nurses visited him at home and undertook a further assessment. Risk levels remained the same as the before; no further risks were identified and a plan was made for further contact with Paulo later in the week. However, Paulo returned to work and it was not possible to reach him. His aunt was contacted and assurance received that he was well and she would pass on a message. When further attempt to contact Paulo was

[1] Thames Valley Police information data system in use since 2012.

unsuccessful a 14 day opt in letter was sent as per policy. This was sent to Paulo and his GP on 20 December 2016. Paulo did not respond and his case was closed.

2.21 During a joint home visit to Rosa on 8 December 2016 by a health visitor and a social worker she talked about her belief that Paulo had died by suicide. Rosa said she felt okay now, but had been scared before as she said he was acting crazy, and her brother-in-law Helio had called her to tell her to go home in case Paulo saw her whilst she was out with her child. Rosa reported that Brigida and Helio were being really helpful and she felt excited by the thought of a plan to go home to see her friends and parents in her home country. The social worker was unaware up to this point of the incident involving Paulo stabbing himself, and that Rosa's perception that he had died was incorrect. No immediate checks were made with Police or Health to establish the facts of the incident.

2.22 On 13 December 2016 Paulo contacted Children's Services and requested contact with his child, thus establishing that he was not dead as Rosa thought. He confirmed that he had attempted to harm himself. At a Core Group meeting on 15 December representatives present were informed that Paulo was alive and was requesting contact with his child. Rosa wished for a social worker to supervise any meeting.

2.23 Also on 15 December 2016 Helio's wife Brigida called the Police to report that she and her family had been threatened by Paulo via comments on Facebook saying that he would come and find them. An officer attended and spoke to Brigida; her child was with her during the visit. Brigida reported that Paulo's bail conditions had been lifted and he had made the Facebook posts asserting his innocence and making reference to false allegations. Screenshots were shown to the officer which had been sent to Brigida by a friend as she and Rosa were not 'friends' with direct access to Paulo. The officer asked Brigida to translate the post which she did; it is recorded that it read that he could prove his innocence and those who did not believe him would regret it. Brigida said she wanted to report it in case the situation escalated. The officer noted that Brigida appeared calm and did not come across as concerned. The officer advised that the friend should block Paulo, and said contact would be made with Paulo to give him words of advice. It was noted that no direct contact had been made with Brigida (messages came via a third party) nor offences committed. When the officer called Paulo there was no answer; a message was left asking him to be more careful about what he posted on Facebook. A DOM5[2] risk assessment was not completed as the incident was not considered to be domestic abuse, however, Brigida was advised to call 999 in an emergency.

2.24 A meeting took place with Paulo at the Children's Social Care office on 16 December 2016, when he was informed that an assessment would be necessary and contact would need to be supervised. He returned to the office on 22 December stating that he was upset about the rape allegations which he denied. He again requested contact with his child. It was agreed that contact could occur after Christmas, but would be supervised.

2.25 In late December 2016 a serious incident occurred involving Rosa and Paulo's child which required an investigation. In the new year Paulo was interviewed as part of enquiries. He confirmed that due to the rape allegations and bail conditions he had not seen his child for almost a year and did not know what had happened. Paulo was described as very emotional and he was crying, and as the officer in charge was aware of the previous self harm incident a welfare check was conducted; it was noted that he had no thoughts of hurting himself, he was only worried for his child.

[2] The DOM5 is as 19 question risk assessment created and used from June 2012 by Thames Valley Police to assess levels of risk in domestic abuse incidents in Oxfordshire and rolled out force wide from Spring 2013. The DOM5 replaced the ACPO DASH risk assessment in Oxfordshire.

2.26 On 27 January 2017 Children's Social Care phoned Paulo to advise him to see a solicitor and to be party to the proceedings in respect of his child. In his interview with the chair of the review Paulo said he had consulted a solicitor and was advised that it could take up to 8 months before gaining care of his child. He said he found the process confusing and had not understood the part he could have in the proceedings. During the interview with the chair Paulo was crying and distressed when speaking of his child. Paulo had his first supervised contact with his child in early 2017. He came prepared and followed advice regarding approaching the child, and the visit was noted to be positive.

2.27 Sometime later in 2017 Paulo was in a local shop at the same time as Helio. They had 'words'. In interview for the review Paulo alleged that Helio called him a rapist and a bad man, and said that his child was suffering. Paulo said this "made his head go off". During evidence at Paulo's trial it was reported that Helio had told a member of the shop staff "he wants to fight me", and Paulo had said "I have to kill him before he kills me". Paulo left the shop and purchased a knife at nearby shop. He attacked Helio in the street. He was restrained by members of the public until the Police and ambulance arrived. Sadly, Helio died of his wounds in hospital; Paulo was charged with murder and the possession of a bladed article in a public place. Paulo pleaded guilty to murder and was sentenced to life imprisonment with a tariff of 20years 10months.

3. Key Issues Arising from the Review:

Gaps in Information Sharing

3. 1 As is found in many reviews, gaps in information sharing prevented the whole picture being visible; the smallest piece of information can make a difference to judging risk levels, and decision making. A child protection plan was in place during the period under review therefore information could and should have been shared more effectively. In respect of the Police the child protection case plan and conference minutes were shared, but they were not read. This was a serious oversight for a high risk area of practice.

Language Barriers

3. 2 Interpreting services for sensitive interviews and assessments were not always available which resulted in the delay of interviews or the use of family members to interpret. Using family members at such times whilst understandable is not advisable, especially when dealing with sexual crime and domestic abuse. Confidentiality is important in such cases as feelings of individual or family shame may influence what is said, or unfamiliar phrases or concepts may be misinterpreted or influenced by cultural differences.

Risk Assessment

3. 3 An absence of risk assessment concerning the perpetrator was also a key issue in this review. Apart from mental health, no one had undertaken a risk assessment of him, and it is arguable that the assessment tools used by Mental Health Services to assess risk to others does not probe deeply enough or consider all aspects of domestic abuse. Risk to Rosa from Paulo was not revisited when situations changed, for example at the end of bail conditions or Paulo's attempted self harm. The risk he posed to Helio was not appreciated following Paulo's online postings and attempts to goad Helio into a fight. Assessment tools[3] particularly to assist practitioners in risk assessing perpetrators are absent, but the area is not alone in this.

[3] Apart from the National Probation Service who use the Spousal Assault Risk Assessment (SARA) tool.

Understanding Culture

3. 4 There are many aspects to culture and each community or individual has a culture of their own. The previous history of the parties' country of origin has been one of occupation and civil war, marked by extreme violence including massacres, torture, imprisonment, displacement, and the decimation of infrastructure. Helio and Paulo were born and grew up during this violent and tumultuous period. The impact of conflict and violence can have lasting effects including the normalisation of violence: Normal for parents to use violence as a form of discipline, to use violence to deal with conflict with a partner (gender based violence is a serious problem in the country relevant to the review), and seeing violence as a form of resolution[4], including for family feuds and conflicts. This does not excuse violence, but in certain circumstances it can help us to understand the culture in which violent actions occur, and to take steps to mitigate and challenge these damaging customs. In particular it highlights the need to consider a person's background history and culture when assessing risk and needs.

3. 5 In interview for this review Paulo denied any pre-planning to kill Helio, and as far as can be judged there did not appear to be any so-called honour motive behind the act. Nevertheless, we have learnt that in such situations as existed in this case, family conflict would have invariably taken place in their country of origin which would have been likely to end in fighting, serious injury, or death.

4. Conclusions

4.1. In considering the information within this review the fatal attack which caused Helio's death could not have been prevented by any agency. The serious risk of harm posed by Paulo to Helio was not understood; where risk was considered the focus had been on the risk he posed to Rosa his former partner. Partly because of this it has been difficult to keep the victim Helio centre stage in this review. So much was taking place within his sister-in-law's life as a result of her relationship with the perpetrator which was having an impact on Helio's own family life, and perhaps because of this he did not recognise the risk to himself and nor did services. And yet Helio appears to have supported his wife in trying to help her sister and the tragic fallout from her relationship with Paulo. The cost to Helio's wife and children is immeasurable, not just because she has lost her partner and the father of her children, but the future she had mapped out together with him and her ambition for her own future has been forced to change.

4.2. There is little doubt that this case has proved difficult and taxing for all concerned. As Rosa's health visitor said; it was one of the most difficult cases she has ever had. The complexities of domestic and sexual abuse, mental health, and child protection present a significant challenge both professionally and emotionally for practitioners. Added to this a relatively small community with its own unique culture, especially one with a history of violence and post conflict normalisation of violence, and we can see why it proved to be multi-stranded and difficult to grasp the key issues.

4.3. For someone with an in-depth knowledge of domestic abuse Paulo's actions and circumstances would have raised alarm bells, for there are significant elements which are high risk factors. Here was a man accused of a serious sexual assault on his former partner (albeit the prosecution had been dropped), with whom he had a child and with whom he wanted contact which was being prevented at that time. Here was a man who had self harmed in a violent way (albeit not life threatening), and Children's Services were

[4] Deborah Smith. *Children in the heat of war: Armed conflict around the world is affecting children in their own.* American Psychological Association. Monitor on Psychology. September 2001, Vol 32, No. 8. http://www.apa.org/monitor/sep01/childwar.aspx. accessed 08/12/17

involved. Among the high risk elements of a DASH risk assessment are threats or attempts of self harm by a perpetrator; separation (he was separated from his ex-girlfriend and his child against his wishes), conflict over child contact, allegations of behaviours of a sexual nature which hurt the victim. Overall no one agency appears to have recognised these risk indicators together in assessments or during reports connected with Paulo's online pronouncements or intimidation. Any consideration of risk posed by Paulo was in connection with his former partner, and this had not been updated; risk to Helio and the wider family was not considered.

4.4. Taking a systemic view; lines of communication between agencies did not run as smoothly as they should, particularly as child protection procedures were in place which are designed to provide ease of information sharing and partnership working. As in many cases involving domestic abuse the risk posed by the perpetrator was under appreciated, minimised or lost. Alongside this the successful use of social media by him to intimidate and make threats was under estimated, as was the cultural context of his messages and how they would be perceived as threats which might escalate by those from his cultural background. The processes available to deal with the online posts experienced by the family proved ineffective.

4.5. The gaps in information sharing whilst very concerning could not have prevented what appears to have been an opportunistic and rapidly planned attack on Helio by Paulo. However, the combined information could have thrown extra light on Paulo's volatility, the degree to which he was affected by the lack of contact with his child, and this could, and should, have informed risk assessments of him and the risk he posed to those to whom his anger was directed, namely Helio and his family.

5. Lessons Learnt

The Importance of Cultural Awareness :

5.1 There has been new learning during this review concerning the Asian culture and the influences which have shaped it. The need for cultural awareness can sometimes seem like a tick box exercise, and some critics will name such awareness as political correctness. This is not the case. True cultural awareness means an understanding of the influences of national, environmental, and family background on others' lives, both positive and negative, to inform how services are delivered to meet the requirements and safety of everyone in the community.

5.2 There is evidence of good practice within the review, namely by the health visitors who have undertaken additional study into the culture of the ethnic group to which the parties belong in order to understand and support them more effectively. The formation of a multi-agency working group which is attended by health visitors, social workers and Police staff among others, is also to be commended. However, this review has highlighted the need for further and wider understanding of the relevant Asian culture and customs, some of which are born out of living with conflict and violence over many years and the need for survival. As the research cited in the review has revealed exposure to conflict and violence can have a lasting effect on a country's population, and impact on how individuals live and react to violence.

5.3 A fuller understanding of the relevant Asian culture on women and men's lives, their relationship expectations and challenges, in addition to the cultural norms expected of, and experienced by women should also be attained, particularly by those undertaking assessments of risk or need. This should also include an awareness of the part violence can play in family conflicts, and the culture of harsh punishment practices in families which may have a significant impact on mental health and wellbeing.

Language and Interpreting Barriers

5.4 Language barriers were an issue in this case, not only in respect of individuals' full understanding of what was being said to them, but family members were used on occasion as interpreters with all the pitfalls this can bring in terms of accuracy, cultural influences, and sensitivities about what is said on both sides. For example using a family member to interpret for questioning about sexual matters or domestic abuse has the potential to result in alterations to what is said due to embarrassment or shame, or simply because there are no words in their own language for such issues as domestic abuse. Mental ill-health may also be differently perceived in another culture and lack accurate words or common understanding. Victims of abuse also face barriers when seeking specialist help if they cannot communicate themselves either face to face or via the phone.

5.5 Access to appropriate interpreting resources at crucial points formed a barrier for practitioners' when imparting information or undertaking assessments. Interviews were also delayed on occasion. The Police, Social Care, and Health often have complicated information to impart, notably concerning legal matters which can seem confusing for people unfamiliar with the process, especially for those from other parts of the world. Paulo found it very confusing to understand about bail, and about care proceedings which is of concern considering the life-changing consequences of this process for those involved.

5.6 Learning English means a reduction in isolation, self empowerment, and the ability to communicate unaided, for example to consult a GP directly and confidentially without an interpreter present, and the ability to access a range of services including emergency services. Both Paulo and Rosa's limited English skills would have held them back from independently accessing services which could have supported them.

Social Media

5.7 The role of social media in this case reveals the need for greater awareness of legislation and best practice among practitioners Because what the family perceived as threats and intimidating messages were communicated through a third party and not sent directly to the individuals to whom they were probably intended, there was no legal action which could be taken. It is highly probable that Paulo knew that in his small community the messages in his posts would get through to Helio and his family members, just as a message reportedly sent to Helio trying to goad him into a fight with Paulo was said to come via a friend at work. Although Brigida was reported not to appear anxious about the Facebook postings, she may not have wished to appear anxious or distressed in front of her children, but she was concerned enough to report them, and on the last occasion said she was reporting in case things escalated.

5.8 The advice to Rosa and Brigida to use the block feature on Facebook was clearly well meant and aimed at shielding them from Paulo's posts which they perceived as intimidating. However, this also had the result of making them unaware and unable to report any further posts which concerned them and which might have indicated any escalation in Paulo's threats and behaviour. Consideration should be given as to how to advise those viewing posts or receiving electronic communication which they find threatening or intimidating in future. This may need to be determined on a case by case basis. Advice which would maintain evidence, but offer safety is needed, for example

from Paladin a charity supporting victims of stalking and harassment[5] whose website contains advice for professionals as well as victims.

Information Sharing

5.9 A vast majority of Domestic Homicide Reviews and Serious Case Reviews identify a lack of effective information sharing between partner agencies. This review is also confirming this finding. This case required full and effective coordination to pull together all the strands of information on the various people and events involved. Despite the child protection process which facilitates and promotes information sharing this was not achieved. This was partly due to the absence of the Police from that process and their knowledge of the content of case conference minutes, and partly due to the information which was not shared between agencies to build a full picture. The exception to this is the joint working between health visitors and social workers which demonstrates good practice between them, as was the passing of information to the Police by the health visitor concerning information about fights in a local park.

5.10 There were a number of occasions when concerns, threats, or intimidating postings by the perpetrator were reported to either the Police, Children's Services or Health Visiting Service between February and December 2016, but the Police and Children's Services did not adequately share their knowledge of these events. Incidents were not considered as a pattern of behaviour because there was no overall picture and analysis of what was taking place.

5.11 Paulo's incident of self harm was not shared by Mental Health Services with Children's Social Care even though he reported their involvement, nor reported by the Police to Social Care as no connection was made between Paulo and the child who was under a child protection plan, although a welfare visit did take place to Rosa his former partner.

Risk Assessment

5.12 The initial Police DOM5 risk assessment recorded that the perpetrator's behaviour was 'problematic', but what was meant by this was not recorded. This reduced the information known about the perpetrator which had the potential to inform future contact with him and any risk assessment.

5.13 In this case the perpetrator's first alleged victim, his ex-partner Rosa, was separated from him, and we know that separation is a high risk time, especially when the separation is not of the perpetrator's choosing. Whilst for the most part protective factors worked in keeping Rosa's whereabouts from Paulo, he knew where Helio and his family lived. However, agencies were concentrating on Rosa and her child and 'took their eye off the ball' when it came to risk assessment in response to changes in circumstances or threats, particularly where the perpetrator was concerned and his animosity towards Helio and his family. The actions of Paulo directed at Helio, such as trying to draw him into a fight, and threatening to come after him and his family in December 2016, did not generate any reassessments of risk, or consideration of Paulo's behaviour.

5.14 Children's Social Care did not undertake a risk assessment or consider using the DASH risk assessment tool, and the risk assessment for use by Mental Health does not probe deeply enough to effectively establish risk to others where domestic abuse is suspected

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[5] https://paladinservice.co.uk/ - includes National Police Improvement Agency & ACPO (2009) *Practice Advice on the Investigation of Stalking Harassment.* https://paladinservice.co.uk/wp-content/uploads/2013/09/ACPO-Police-Guidance-on-Stalking-and-Harassment.pdf.
https://paladinservice.co.uk/guidance-for-professionals/

or known. All agencies would benefit from a perpetrator risk assessment tool designed exclusively to assess the risk they pose to their victim, their children, families, themselves, and the community around them which can be used alongside existing assessments and triggered when domestic abuse is suspected or in evidence. This could be similar to the system used by the Probation Service who use the SARA[6] risk assessment in such circumstances.

5.15 The welfare check on Rosa following Paulo's self harm incident and end of bail conditions was good practice. However, the opportunity was not taken to carry out a reassessment of risk in light of these changes in circumstances which had taken place since the first DOM5 risk assessment had been done earlier in the year.

Domestic Abuse Training

5.16 In-depth domestic abuse training which includes intimate partner abuse and adult family abuse is essential for all practitioners and clinicians involved in undertaking assessments. The complexities in both types of abuse need to be fully understood and knowledge of the high risk factors associated with domestic abuse needs to be of a high enough level to enable these factors to be identified to inform risk assessment.

5.17 The impact of cultural norms and relationship expectations should be embedded in domestic abuse training to reflect the local area population. As this case has revealed practitioners need the knowledge and tools to help them with complex child protection cases where domestic abuse has been alleged and the victim has no recourse to public funds. There is no evidence to suggest that Rosa was given sources of information or support regarding her 'no recourse' situation. Practitioners need to have the knowledge of resources via training on local or national specialist services who can advise in such cases.

Working with Fathers

5.18 In interview Paulo appeared unclear about the process to assess him as a carer for his child. He reports that he acted on the social worker's advice to consult a solicitor, and was advised that it could be possible. He did not appear to understand care proceedings and his part in that process. Paulo felt there should be more professional support at such a time and help with the stress of dealing with it all. Signposting or referral to an independent service or charity would be a helpful consideration at such times, as the social worker will naturally be focussed on the best interests of the child at this time.

6. Recommendations

6.1 The recommendations below arise from the lessons learnt, the deliberations of the review Panel, and from the IMRs submitted to the review. Timescales for the achievement of the recommendations are included in the action plan which accompanies the review for governance purposes.

6.2 Recommendations 1 to 4 are the Panel's recommendations.

[6] Spousal Assault Risk Assessment is used alongside the OASys assessment when domestic abuse is identified .

National Level:

Recommendation 1:
The Home Office is asked to recommend a national domestic abuse perpetrator risk assessment tool suitable for multi-agency application which can be used alongside existing assessments[7] with the aim of providing an holistic assessment of the specific risk posed by a perpetrator of domestic and sexual abuse.

Local

Recommendation 2 :
Practitioners' knowledge and awareness of the relevant Asian culture should be informed by local information gathering, and local relevant Asian expertise. It should include the impact of post conflict and sources of violence in that region; social expectations and norms including regarding intimate relationships; community strengths, and possible areas of internal conflict, with the aim of providing holistic and well informed assessments to support service users.

Recommendation 3:
The Oxfordshire Domestic Abuse Strategic Board, when commissioning training and workforce development, should ensure good practice guidance on advising victims on how to gather evidence and keep safe online and through electronic communications is included.

Recommendation 4:
That the Oxford Safer Communities Partnership reconvene the Domestic Homicide Review Panel 12months from the completion of the review to assess the progress made and the achievement of outcomes. The victim's family member should be offered an invitation to this meeting, or if they prefer, be given a written update on progress.

6.3 The following recommendations arise from Individual Management Reviews.

Local Authority, Health Trusts and Police

Recommendation 5:
The Local Authority, Health Trusts and Police should cooperate in investigating the provision of a pool of suitably trained interpreters for the relevant Asian language to assist their staff with essential and/or sensitive interviews and assessments.

Police

Recommendation 6:
Child protection case conference minutes should be read and analysed for intelligence and crimes which need to be recorded. The successful implementation of this process should be reported to the sub-group of Oxfordshire Local Safeguarding Children Board.

Oxford Health

Recommendation 7:
A process should be embedded in practice and training that if an adult who is assessed by the Emergency Department Psychiatric Service is known to have a child who is open to Children's Social Care then information about the contact of the adult with Mental Health Services should be shared regardless of whether risk to the child is identified. If there are

[7] An assessment pathway similar to the Probation SARA risk assessment which is triggered when domestic abuse is identified during an OASys assessment may wish to be considered.

concerns about risk to a child who does not appear to already be known to Children's Social Care then these concerns should be referred to the MASH.

Recommendation 8:
Guidance clarifying information sharing processes should be provided for clinicians which states that unless there is a clear reason not to do so, information should be shared with the knowledge and consent of the patient wherever possible. If the clinician is unsure of whether the information meets the threshold for sharing, or if there are issues around consent, advice should be sought during office hours via the Oxford Health Safeguarding Children team, via the consultation line, or by 'No Names' consultation with Children’s Social Care. If urgent advice is needed out of hours, this should be sought from the senior clinician on duty. This process should be reinforced in training.

General Practitioners

Recommendation 9:
Guidance should be provided for primary care clinicians in how to seek support when interpretation services do not meet their needs in consulting and providing medical care.

Children's Social Care

Recommendation 10:
Consistent cross referencing of wider family members on the electronic recording system needs to be ensured across the service.

Recommendation 11:
The training that social workers and their managers receive in relation to domestic abuse and so-called honour based violence should be reviewed to ensure that the risks to other men in communities residing in the UK are fully recognised. This should include:

a) the possible increased risk due to care proceedings
b) the impact of no recourse to public funds for individuals from overseas and sources of specialist support
c) the need for comprehensive safety planning including for wider family members, and the consideration of inter-family conflict

The following recommendation is made by the Panel, but is relevant only to Children's Social Care:

Recommendation 12:
A referral route or signposting to a specialist service for parents whose child is subject to care proceedings should be examined to support them through this complicated process.