THE EXECUTIVE SUMMARY

‘Chiman’

May 2019

PETER MADDOCKS
INDEPENDENT AUTHOR

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The review process

1. This summary outlines the process undertaken by the Stoke-on-Trent City Partnership [1] in reviewing Chiman's death who lived in the city.

2. To protect the identities of Chiman and the respective family members the following pseudonyms are used in this domestic homicide review (DHR); Chiman for the 32-year-old subject of the DHR and Jamal for her 35-year-old estranged husband. Professionals are referred to by their roles such as GP, police officer or social worker for example. Chiman and Jamal had four children who were aged 8, 6, 4 and 3 years old respectively when Chiman died. In addition to her children, Chiman is survived by her parents who live in Iraq and a brother and a sister who were both living in the UK when Chiman died. Chiman's family are from Iraq and identify as Arab. Jamal is from an autonomous region in northern Iraq. Their language of communication was Surani one of the more common Kurdish dialects. Their faith was Islam until Chiman converted after she and Jamal separated when he was deported from the UK. Jamal and Chiman had both sought asylum in the UK. Jamal was the subject of deportation orders on more than one occasion. Chiman was granted humanitarian protection to remain temporarily in the UK in 2018[2].

3. Jamal was convicted of murdering Chiman and is serving a life term of imprisonment with a minimum term to be served.

4. The first meeting of the DHR panel was in October 2019. One further meeting of the panel was held in March 2020 to discuss the draft overview report just before the COVID-19 restrictions were implemented by the HM government. The panel had membership from organisations in East Anglia, Greater Manchester, and Staffordshire as well as from the Home Office (UK asylum seekers and immigration service).

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[1] The community safety partnership set up under the Crime and Disorder Act 1998.

[2] Humanitarian protection (HP) was introduced in April 2003 to replace the policy on Exceptional Leave to Remain. HP is designed to provide international protection where it is needed, to individuals who do not qualify for protection under the Refugee Convention. It covers situations where someone may be at risk of serious harm if they return to their country of origin but they are not recognised as refugees because the risk is not of persecution for a reason covered by the Refugee Convention. Those who qualify for HP are normally granted limited leave for five years and any children who are under 18 and dependent on the claim will be granted leave in line with the main claimant.

1.1 Contributors to the review

5. Seventeen of the more than 30 agencies contacted as part of the initial scoping for the review in Stoke-on-Trent and East Anglia confirmed that they had varying levels of contact with Chiman, Jamal or their children and provided information. All were asked to provide chronological information. Most of the organisations were required to complete an individual management review (full report) that required analysis of their contact whilst other organisations who had less significant involvement provided a short report.
6. The following organisations in Stoke-on-Trent provided an individual management review (IMR)(full report):
    a) Concrete (formerly Arch) North Staffordshire Refugee and Asylum Seeker service[3] who first saw Chiman in late February 2018 for support in settling in Stoke-on-Trent;
    b) Staffordshire North and Stoke-on-Trent Citizen's Advice Bureau provide the local Refugee, Asylum Seeker and Migrant Support Service and saw Chiman five days after her move to Stoke-on-Trent to help with accommodation issues; there was further contact in March and April 2018 after Chiman had been granted humanitarian protection and needed help with making claims for welfare benefits;
    c) Staffordshire Police as part of the MASH (multi-agency safeguarding hub) received information in June 2017 initially received email information from the West Midlands Police about the high risk of HBA[4] to Chiman and Noor (who sought refuge and help from Chiman in fleeing an abusive relationship) and had subsequent involvement in risk assessment and criminal investigation of Chiman's death;

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[3] A charity working to prevent domestic abuse, homelessness and promote social inclusion in North Staffordshire.

[4] The term honour-based abuse is problematic with the inherent suggestion that the violence is the product of behaviour that has offended codes of ethics or moral standards; it implies that it is the responsibility of the victim to behave differently or more respectfully to those who are being offended. It is why some people and organisations will always preface any reference to HBA with 'so-called' honour-based abuse. To minimise unnecessary repetition the report uses the term HBA with the understanding that it refers to so-called honour-based abuse.

d) Stoke-on-Trent City Council Children and Young People's Services are parties to the MASH that received information in June 2017; also, the school contacted CYP regarding the information about CIN and child protection plans while the children were in Norfolk that had been included in school files transferred to Staffordshire; an assessment in the summer of 2018 was followed by CIN plans being agreed;
e) Stoke-on-Trent City Council Housing Services provided housing after Chiman was given humanitarian protection status to remain in the UK;
f) Stoke-on-Trent Clinical Commissioning Group (CCG)[5] provided primary health care for Chiman and the children through the GP service; the primary care records for Chiman had not been transferred before her death (complicated by the fact that Chiman registered at three different GP practices due to change of address during her time in Stoke-on-Trent) and was not available for the preparation of the CCG IMR;

7. The following organisations in other local authority areas provided an individual management review (full report).
    a) Cambridgeshire Community Healthcare provided services under the Healthy Child Programme through health visiting and community health services that included participation in three CIN meetings between November 2015 and March 2016
    b) Greater Manchester Police had responsibility for risk assessment and management of Jamal as a registered sex offender when he moved into Greater Manchester from May 2018 until the homicide[6];
    c) National Probation Service (NPS) Norfolk and Suffolk Area; Jamal was convicted in March 2013 of two offences of sexual activity with a child under 13 and served a 15-month prison sentence and was registered as a sex offender; the probation service had two contacts with Jamal to prepare a pre-sentence report (PSR); the PSR identified Jamal as a medium risk sex offender who was in denial about his offending and made a

[5] The Staffordshire and Stoke-on-Trent Integrated Care Board replaced the CCG from July 2022 after the DHR had been completed. The ICB has taken responsibility for the actions ascribed in the report to the CCG.
[6] Offenders required to comply with the notification requirements set out in Part 2 of the Sexual Offences Act 2003 (SOA 2003) are often referred to as being on the "Sexual Offenders' Register."

referral to the local children's service in Suffolk where the family were living at the time; the NPS saw Chiman on two occasions;

d) Norfolk County Council Children's Services; completed an initial assessment between January and April 2014 resulting in a CIN plan until August 2014 when a child protection plan (CPP) was implemented in response to concerns about Jamal's sexual offence history and his stated intention to return to the family; involvement ended in March 2016 by which time Jamal had been deported;
e) Norfolk Constabulary was a party to child protection plans in 2014, responded to information about so-called honour-based violence in 2015 which included the implementation of risk assessment and protection plans as well responding to information about Noor regarding further HBA;
f) Norwich Clinical Commissioning Group[7] provided primary health care for Chiman and the children through the GP service;
g) West Midlands Police received notification from Norfolk Constabulary in May 2017 when Chiman and Noor were moved to emergency accommodation in Birmingham but had not convened a MARAC before both women had left the city; Chiman was moved to Stoke-on-Trent; West Midlands Police forwarded the information to Staffordshire Police in June 2017.

8. The following national organisations provided an individual management review (full report).
    a) Home Office (UK Visas and Immigration Service and Immigration Enforcement).

9. Information was also provided by the Midlands Partnership NHS Foundation Trust in respect of contact with Chiman via the Asylum and Refugee Health Team between July 2017 and January 2018 primarily in respect of a respiratory infection. The North Staffordshire Combined Healthcare NHS Trust had two contacts in response to a referral to the Healthy Minds Service for low-level mental health talking-based support for Chiman's low mood and the stress of parenting four young children. She saw a psychological well-being practitioner with an interpreter in September 2018 when she talked affectionately about her children, and did not identify any risks to herself or the children. She was already receiving support from the Asylum Seeker and Refugee

[7] The NHS Norfolk and Waveney Integrated Care Board replaced the CCG in July 2022.

Health Team and was signposted to Sanctus[8] for ongoing support regarding her asylum application. The University Hospitals of North Midlands NHS Trust provided assessment and treatment to Chiman in response to a GP referral for a respiratory infection. The Red Cross in Norwich also had contact with Chiman between January 2014 and June 2017 providing her with advice and help such as finding sources of legal advice and sorting repairs to her property. Red Cross was never told of or had evidence of, Chiman being subjected to threats of violence.

1.2 The review panel members

10. A suitably experienced and independent person chaired the panel; details are provided in section 1.3. All of the panel members were independent of any involvement or decision-making regarding the events and people concerned with the circumstances examined by the review. The membership of the panel is listed below.

Organisation	Job title or role
Concrete - Refugee and Asylum Seeker service	Sarah Forshaw – Operations Manager
Cambridgeshire Community Services NHS Trust	Lorna Hughes – Deputy Named Nurse
Greater Manchester Police	Brian Morley – Detective Inspector, Sex Offender Management Unit
Home Office (UK Asylum and Immigration Service and Immigration Enforcement)	Eddy Montgomery, Director of Immigration Compliance and Enforcement Teams North, Midlands and Wales and South West
National Probation Service Norfolk and Suffolk Area	Charlotte Belham – Senior Operational Support Manager
Norfolk County Council Children's Services	Sally Sinclair – Head of Children's Services Social Work (Norwich)
Norfolk and Waveney Clinical Commissioning Group	Gary Woodward – Adult Safeguarding Lead Nurse
Norfolk Constabulary	Bruce Clark – Detective Inspector

[8] Sanctus St Mark's is a support group for refugees and people who are seeking asylum in the UK.

Organisation	Job title or role
Staffordshire North and Stoke-on-Trent Citizen's Advice Bureau	Jude Hawes, Specialist Services and Equalities Team Manager
Staffordshire Police	Mark Harrison – Major Crime Police and Review Team Loleita Higgins – Hate Crime Team
Stoke-on-Trent City Council Children and Young People's Services	Anthony Morrisey – Strategic Manager
Stoke-on-Trent City Council Housing Services	Dawn Cooke – Housing Options Lead
Stoke-on-Trent Community Safety Partnership	Nathan Dawkins – Commissioning Officer Community Safety
Staffordshire and Stoke on Trent Clinical Commissioning Group	Kim Gunn – Designated Nurse Adult Safeguarding Rachael Fitton – Senior Nurse Adult Safeguarding
Specialist advisors	
IKWRO Women's Rights Organisation[9]	Nazira Mehmari
Stoke-on-Trent and Staffordshire Safeguarding Children Board	Ros Negrycz

1.3 Author of the overview report

11. Peter Maddocks wrote this report and chaired the review. He has never worked for any of the organisations that have contributed to this review and nor has he held any elected position in Stoke-on-Trent or Staffordshire. He is not related to any individual who either works or holds an elected office in Stoke-on-Trent or Staffordshire.

1.4 Terms of reference

12. The timeline for the DHR is from November 2015 until October 2018. It was apparent from the information provided at the scoping panel that there was evidence of so-called honour-based abuse from 2015[10].

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[9] Iranian and Kurdish Women's Rights Organisation

[10] The term honour-based abuse is problematic with the inherent suggestion that the violence is the product of behaviour that has offended codes of ethics

Jamal had also been convicted of a child sex offence and was subject to registration and supervision as a sex offender. Chiman and Jamal initially lived in East Anglia in 2015. Jamal was deported although re-entered the UK illegally. Chiman remained in East Anglia until she was moved in 2017 to Stoke-on-Trent following threats of HBA against Chiman and Noor. Jamal was living in Greater Manchester and was subject to deportation procedures when Chiman was murdered.

13. Agencies contributing reports or information to the domestic homicide review used the terms of reference set out in national guidance with additional general areas arising from the particular circumstances under which Chiman died.

    a) The extent to which the immigration status of either Chiman or Jamal had an impact on how the various agencies responded to the needs of the adults or of the children who were the subject of statutory children's services involvement when living in East Anglia and Stoke on Trent;

    b) The extent to which information and evidence of so-called honour-based violence was recognised and responded to; the first record was in November 2015 and was associated with Jamal's conviction for child sex offences in 2013;

    c) The extent to which Jamal's status as a convicted child sex offender was appropriately managed within the context of HBA;

    d) The quality of risk assessments including the language and terminology and whether there were opportunities to understand the potential for escalation of threat levels to Chaman;

    e) The extent to which the reliance on interpretation services to assist communication with Chiman was appropriate and sensitive to particular risk factors such as represented by so-called honour-based abuse;

    f) Establish the reasons and circumstances under which Chiman was moved to the West Midlands in May 2017 for one week through

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or moral standards; it implies that it is the responsibility of the victim to behave differently or more respectfully to those who are being offended. It is why some people and organisations will always preface any reference to HBA with 'so-called' honour-based abuse. To minimise unnecessary repetition the report uses the term HBA with the understanding that it refers to so-called honour-based abuse.

arrangements made by the Home Office and was then relocated to Stoke on Trent;

g) The quality and appropriateness of information-sharing regarding asylum seekers who are vulnerable to abuse and violence.

1.5 Summary chronology

14. Chiman lived in Norfolk until May 2017 when she was moved, with Noor, to a refuge in the West Midlands where she remained for less than a week until being relocated by the Home Office to a property in Stoke-on-Trent. The reason for Chiman being relocated away from Norfolk was because of elevated concerns about the safety of both women from so-called honour-based abuse (HBA) after Noor had left her husband alleging domestic abuse.

15. Chiman was separated from her husband, Jamal, after his deportation from the UK following his release from prison. Jamal had been convicted of two offences of sexual activity with a child under 13 years of age and served a 15-month prison sentence and was subject to registration and supervision as a sex offender upon his release. Jamal planned to return to the family home in Norfolk which triggered an initial referral to the local children's services that was followed by a child protection plan being put in place in August 2014 that was stepped down to a CIN plan in December 2014 when it was judged that Jamal could return to the family home without risk to his children. Jamal was still the subject of proceedings to be removed from the UK. He was detained under this process in July 2015 and was deported in September 2015. Children's services became involved with Chiman and her children again to provide support under a CIN plan until March 2016.

16. In November 2015 Chiman told her social worker that Jamal's brother who lived in the UK was blaming Chiman for Jamal being convicted and deported. Chiman reported receiving threatening telephone calls and feeling vulnerable because of her uncertain residency status in the UK and of being returned to Iraq. Jamal's brother was threatening to remove her children from the UK. Chiman was scared because of the specific threats being made to her as well as the wider violence and social disruption in Iraq.

17. The social worker referred the information to the police and a prompt strategy discussion resulted in two joint visits being made to speak with Chiman. Although Chiman spoke three languages this did not include English. The only translation service available to the police officer and social worker was telephone-based which was followed up by the

police completing a DASH assessment. Although the DASH assessment was high it was not referred to the MARAC. A safety plan was developed by the police in consultation with children's services under child safeguarding protocols that included placing a marker on Chiman's address for priority response and giving Chiman advice; for example, disabling the location information on her smartphone. The HBA assessment identified three men including Jamal's brother. The men were residents of Greater Manchester, France and Iraq; it did not establish what Jamal's role was. The police discussed relocation with Chiman and the Home Office. Chiman declined when it appeared that she could be moved to the East Midlands where there were concentrations of Kurdish community with links to the extended family in Iraq.

18. By January 2016 children's services concluded that Chiman's circumstances were stable and no further threats had been disclosed. Chiman was participating in parent support activities and was learning English. In March 2016 Chiman advised her social worker that Jamal's brother had gone back to Iraq. The social work assessment that was completed in early 2016 focusing on the health and well-being of Chiman's children was positive. The assessment described Chiman and her children as being well-rooted in her local community in Norfolk.

19. In late 2016 Chiman's application for asylum was rejected. Following submissions by the Norfolk police officer who had supported Chiman since the first disclosure of HBA, describing concerns about HBA, Chiman's application was again declined but she was granted access to a tribunal appeal hearing.

20. In April 2017 Noor fled to Norfolk alleging domestic abuse from her husband. A DASH assessment at the medium level was completed; which described threats from the family in the UK and based in Iraq. Chiman and Noor were still subject to immigration controls while they sought approval to remain in the UK.

21. Jamal illegally re-entered the UK in May 2017 and was subsequently arrested and detained in early June 2017.

22. By late May 2017 the Norfolk Constabulary was concerned about the level of risk for both women; Noor for making an allegation about domestic abuse and leaving her husband and Chiman for providing shelter and support for Noor.

23. Following a strategy meeting involving children's services and health, the police organised through the Home Office for Chiman and Noor to be moved to a refuge in Birmingham. A week later Noor returned to her husband after she withdrew her allegations. Chiman was moved to

Stoke-on-Trent into accommodation arranged through the Home Office (UK asylum and immigration service).

24. Norfolk Constabulary emailed information including the two risk assessments to the West Midlands Police who forwarded the information to the Staffordshire Police almost three weeks after Chiman had moved to Stoke-on-Trent when there was a further delay of six days in processing it with the MASH in Staffordshire.

25. Two weeks after being moved to Stoke-on-Trent Chiman phoned the MASH in Norfolk to report receiving calls from her family in Iraq and that she did not feel safe. The Norfolk Constabulary and MASH did not know that Chiman had been moved to Stoke-on-Trent but sent information about the telephone call to the West Midlands Police who confirmed that the information would be forwarded. Staffordshire Police nor the MASH have any record of the information being received.

26. The Staffordshire Police and children's services in Stoke-on-Trent had made a prompt visit to Chiman when the information was received in the MASH a week after Chiman's phone call to the Norfolk MASH. Chiman told the social worker and police officer that she was in no danger from any family member and that the only reasons she had been moved to Stoke-on-Trent were because of the threat of violence to Noor when she had left her husband but had now returned to him. Chiman did not mention the phone call that she had made to the police officer in Norfolk.

27. In the summer of 2017 and early autumn, Chiman told Staffordshire Police about incidents of bullying and theft of property from her garden.

28. In November 2017 Chiman provided statements to support her appeal to the Tribunal for asylum which described Chiman's fear that she would be murdered by Jamal in an honour-based killing if she was sent back to Iraq. This was the only record of Chiman making an explicit allegation against Jamal in respect of HBA and there is no record of Chiman talking about her fear of HBA with any of the people or organisations that she came into contact with in Stoke-on-Trent.

29. Chiman's application for asylum was dismissed based on 'disbelieving her factual account' although Chiman was granted humanitarian protection and leave to remain in the UK for five years. This was granted based on the prevailing conditions in Iraq rather than the threat of HBA.

30. The granting of humanitarian protection allowed Chiman to begin accessing local services and gave her entitlement to claim benefit income and apply for locally provided housing.

31. Jamal was released from detention in late May 2018 due to concerns about his health. He was monitored via an electronic tag and also had to register with his local police service as a registered sex offender. He located himself in Greater Manchester. He continued to seek legal challenges to his deportation from the UK. This included trying to persuade Chiman to resume the marriage or for Jamal to secure the custody of the four children. This involved applications to the Family Court and the court appointment of a children's guardian in late 2018.

32. In June 2018 the two older children moved to a different school in Stoke-on-Trent. As part of this, the school sought information from their previous school in Norfolk. This included information about the involvement of children's services in Norfolk and the support given through child protection and CIN plans. Chiman had also spoken to the school about the challenge of parenting four young children on her own. The school made a referral to the children's service in Stoke-on-Trent completed an assessment and a CIN plan was agreed upon.

33. By August 2018 Jamal had exhausted his legal options to challenge his deportation from the UK although it was postponed because of safety concerns.

34. In September 2018 Jamal was told that Chiman would not resume their marriage and that the local authority in Stoke-on-Trent would not support the making of a contact order or for Jamal to have the children living with him.

35. In the last visit by the social worker before Chiman died, she reported having frequent telephone calls from Jamal but had not given him the address. Later the same day the police in Greater Manchester were alerted that Jamal had removed his tag and had left the property in Greater Manchester.

Key issues arising from the review

36. Chiman was identified as being at risk of honour-based abuse (HBA) and this was a predominant factor in her death. The nature, extent and implications of HBA was not sufficiently recognised, understood and therefore enquired into and responded to.

    a) Some of it reflected several agencies outside of Norfolk Constabulary having insufficient knowledge and understanding about HBA;
    b) some of it reflects safeguarding policies and procedures not being applied thoroughly enough, especially in respect of transferring information between different areas;

c) some of it reflects not enough guidance such as the use of national information and data systems;
d) some of it reflects not enough professional curiosity; some of it is also probably a by-product of Chiman being isolated and trying to cope with the parenting of four young children, erosion of her sense of self-identity and being subjected to several different sources of abuse and the insecurity of only temporarily living in the UK.

37. Things that could have made a difference include;

a) Using DASH more consistently across different services although acknowledging the limitations of the template in HBA;
b) a relationship with a trusted person; in Norfolk, Chiman had confided in the specialist police officer who remained a consistent point of contact until Chiman left Norfolk;
c) use of MARAC that included specialist advice about HBA when the high risk from HBA was identified to support a coordinated multiagency response and action plan;
d) ensuring that detailed information about HBA risk was included in plans and shared when decisions about safeguarding and residency status were being determined;
e) Using national information and intelligence systems to record evidence and source of risk; ensuring double entry and linking of information on victim and perpetrator records.

Conclusions

38. HBA is different from domestic abuse; it is a system-based threat that reflects entrenched beliefs, culture and practices which represents shared values across a family and a community; this influences how victims behave and interact with professionals and represent an enhanced risk if interventions are misguided or uninformed and for example breach confidentiality; HBA is both a motivation for victims disclosing fear and information but at the same time can be a constraining factor when the victim feels and is being told that they are going against what is seen to be ‘acceptable’ or ‘honourable’.

39. Victims of HBA are at high risk of serious harm including homicide as demonstrated in Chiman’s case; it is accompanied by coercive control that is deeply embedded in systems of culture and values.

40. The role of the community in perpetrating or condoning abuse means that survivors of HBA are often unable to return to their communities even after the immediate risk has been removed. For survivors of HBA the impact on their well-being, sense of belonging and day-to-day life can be severe and long-lasting.

41. Perpetrators of HBA often extend beyond the circle of partners and family members who would be considered perpetrators of domestic abuse. SafeLives' Insights data finds that over half (54 per cent) of domestic abuse victims at risk of HBA were abused by multiple people, compared to only 7 per cent of those not identified as at risk of HBA. However, this wider network of abusers is often centred on partners or family members, and as such most victims of HBA are also victims of domestic abuse[11].

42. Risk assessment is a critical and complex process that underpins how services such as the police and social care services in their response to information and incidents. The work of Dr Jane Monkton-Smith has demonstrated that clusters of risk markers are more significant than numbers that the motivation underpinning the violence is more helpful to understand than just focussing on actions and that trying to discern patterns are more helpful than being guided by incidents.

43. HBA is not an issue for any single agency such as the police to deal with but it requires all of the statutory and other power vested in services that have a legal duty to provide protection and to detect and respond to crime.

44. HBA needs a common purpose and approach to honour-based violence that is distinct from identifying and responding to domestic abuse. HBA is motivated, orchestrated and organised and often concurrently at local, national and international levels crossing the boundaries of local authority or county areas, state boundaries and jurisdictions; it has implications for how enquiries and risk assessment need to be conducted.

45. All statutory agencies or services commissioned on behalf of statutory bodies need to have a shared definition and understanding of HBA and

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[11] Spotlight Report #HiddenVictims Your Choice: 'honour'-based violence, forced marriage and domestic abuse SafeLives p7 Available from http://www.safelives.org.uk/spotlight-4-honour-based-violence-and-forced-marriage Accessed 14th November 2019

how to respond using common appropriate risk assessment and risk management pathways for coordination and accountability.

46. People working in those services need to have the training to develop their understanding of HBA and what they are expected to do in response to it.

47. Local policing, health and well-being and community safety partnerships need to have up-to-date knowledge and understanding about individuals and groups who are residents or being placed into their areas who may be at particular risk and vulnerability to honour-based violence through a diaspora where such beliefs and codes of conduct remain influential; Adequately resourced services that include access to specialist advice and consultation, translation and refuge services; for areas such as East Anglia where there is a smaller proportion of people from a BME background the level of knowledge and understanding about HBA is likely to be underdeveloped.

48. The HMIC report in 2015[12] identified the importance of local police and other public services understanding that HBA is an under-reported crime. To have effective local strategies it is critical to have an understanding of the characteristics of the local population and in particular to identify particularly vulnerable groups. This DHR has highlighted the multiple vulnerabilities that Chiman (and Noor) faced. Although there is evidence of good and conscientious work by individuals they will not be sufficiently effective unless they work within a framework of policy and interagency working that recognises and responds to the organised threat posed by HBA.

Learning

49. The learning is summarised;

a) An understanding of Chiman's personal history and the implications of her cultural upbringing was largely absent and prevented a clearer understanding of the significance of risk factors;
b) Some services outside of Norfolk had provided insufficient training and development to their staff to help them understand

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[12] The depths of dishonour: Hidden voices and shameful crimes (2015) HMIC p50-51

HBA and its significance for risk assessment and providing help and services; in Norfolk, there had been extensive training and awareness-raising since 2011 although with some notable exceptions such as the specialist police officer it was not apparent in the level of understanding and approach to risk assessment in this case; none of the services who had contact with Chiman sought specialist advice from an organisation that could have assisted;

c) The voice of Chiman's children remained largely hidden in any of the recorded assessments and information provided; the views, wishes and feelings of the children being recorded as part of assessments and plans are largely absent from accounts and analysis; this included understanding the behaviour being presented by the older child and often this being understood as a behaviour management issue or only as Chiman needing more parent support rather than a child processing traumatic experiences which included separation and disappearance of their father;

d) In general, HBA was regarded too much as a matter for the police to deal with and contributed to being dealt with in isolation from other services and planning arrangements; this has implications for ensuring that the relevant people and services have a good enough understanding of the nature of risk and their role in mitigation; examples include ensuring children were not susceptible to being collected by family or friends who may be part of HBA threats;

e) The level of understanding about HBA being a deeply embedded, transcultural system of control was insufficiently understood although individual officers in the Norfolk Constabulary had a better understanding than other services; it has implications for how crime and safeguarding enquiries are planned and acted upon; domestic abuse, intimate partner abuse and HBA can all be sources of significant risk and harm as demonstrated in this case; understanding the source of and the parties to the risk is an important part of the process;

f) The decision to remove Chiman from Norfolk in response to elevated risk assessment of dynamic and emerging information nonetheless removed her from important sources of support and was done without any up-to-date risk assessment specific to Chiman; moving a victim of HBA to a new location is at best a short-term measure of protection and carries a risk of escalating the risk and the vulnerability of the victim; it also has implications for disrupting the lives of dependent children;

g) The absence of an HBA best-practice risk assessment is a national issue; Norfolk Constabulary was the only service to use a recognisable DASH-based assessment of HBA risk; DASH and risk assessment is not a one-off activity and it is not the sole responsibility of the police; risk assessment is a dynamic process as new information comes to light or incidents happen that needs to inform judgment; the limitations of relying on risk screening rather than developing a more detailed and reflective risk assessment by other services; the DASH assessment is primarily designed to screen for risk about intimate partner violence and as such has limitations in respect of the more systemic threats represented by HBA;

h) The significance of the separation was not clarified and understood within the context of HBA or the intentions of either Jamal or Chiman regarding the marriage after Jamal was deported; none of the assessments of risk established what Jamal's knowledge and role in the HBA was at any stage; this included the initial and only HBA assessment in November 2015 that was recorded at high; not linking Jamal to the HBA and ensuring the Home Office had an understanding about the threat and that an alert system was in place in the event of Jamal re-entering the UK for example; five men were identified as being involved in the HBA but there was no follow up in terms of placing alerts or warning flags on national databases;

i) Limited opportunity for Chiman to develop a relationship of trust with a professional after being moved from Norfolk; having the capacity to develop a relationship of trust and understanding with a victim is essential along with sufficient professional curiosity; there are many reasons why a victim will provide limited, misleading or contradictory information; it is one of the reasons that risk assessments need to be treated as dynamic and evolving rather than one-off transactions;

j) The absence of a MARAC at the point of arranging Chiman's transfer to another area from either Norfolk or the West Midlands; it is recognised that if Chiman had transferred into Stoke-on-Trent under a MARAC plan it is unlikely to have changed the approach to risk management unless the threat to Noor had been assessed as part of the longer-known HBA concerns dating from 2015 but those had not identified Jamal as part of the HBA threat or a domestic abuse perpetrator;

k) A visibly frightened victim is consistently a very significant marker for concern and is why it is so important to record the nature and reason and ensure effective communication with services who need to help provide protection;

l) Warning messages on databases were not routinely checked or used and cross-referenced between potential perpetrator and potential victim; there was no entry on national computer databases used by the police to alert other services to a potential risk to the victim or threat from the perpetrator;

m) Decisions by different services to close their involvement was done without enough consultation with other interested services or people; examples included Norfolk children's services closing their involvement in March 2016; the Home Office Safeguarding Unit closing their involvement without consultation with local services in Norfolk;

n) Migrant communities with uncertain immigration status are by definition a vulnerable group; local areas need to have good enough capability in knowing who, where and how many people are living in their area and are in a position to understand the potential for HBA-related vulnerability;

o) When the MASH makes referrals to other areas, it needs to have the input of all relevant statutory services (police and children's social care services in this case);

p) Primary health care services were not in a good enough position to help identify and to respond to potential indicators of HBA or other forms of violence; there were gaps in the information provided to and managed by the GP practices;

q) The non-availability of refuge accommodation for victims with no access to public funds was a factor in the decision to move Chiman and has implications for safety planning in local areas

r) National policy concerning data sharing about victims of crime with immigration enforcement agencies could potentially provide further opportunities for victims to be coerced and controlled. Going forward Staffordshire Police will consider its approach to this informed by the NPCC response to the "super-complaint".

50. This DHR was commissioned by the Stoke-on-Trent Safer City Partnership and as the responsible body will be accountable for the implementation of the learning from this DHR. The appendix at the rear of this report includes the recommended actions identified by agencies in their management reviews. It is inappropriate and not practical for the responsible body in Stoke-on-Trent to monitor the implementation of any recommendations or action plans in other areas. It is for that reason that the following recommendations are primarily addressed to the commissioning responsible body although a distinct recommendation is included for a formal response to the learning from

the Norfolk County Community Safety Partnership for inclusion in the submission to the Home Office.

51. Staffordshire Police have 20 Investigators who have been trained about HBA by the charity Karma Nirvana[13]. This includes their expertise in HBA risk assessment. Karma Nirvana is listed in Staffordshire Police policy as a support group to which reported victims of HBA may be referred. This policy is under review.

52. The Domestic Abuse Bill 2020 is intended to bring in important new legal changes that include creating a legal definition of domestic abuse and will place a duty on local authorities to provide support to victims of domestic abuse.

Recommendations

1. The Domestic Abuse Commissioning and Development Board in Stoke-on-Trent and Staffordshire should seek assurances that local training plans include so-called honour-based abuse and includes risk screening and assessment.
2. The Domestic Abuse Commissioning and Development Board in Stoke-on-Trent and Staffordshire should seek assurances as to whether its members' respective policies and procedures are sufficiently clear in respect of so-called honour-based abuse and the implications for safeguarding practice in promoting informed professional curiosity to seek disclosures about honour-based abuse.
3. The Stoke-on-Trent Community Safety Partnership should consider whether local arrangements for DASH-based screening merit further review in providing an appropriate structure to assess and respond to the systemic and systematic risk represented by so-called honour-based abuse.
4. The Domestic Abuse Commissioning and Development Board in Stoke-on-Trent and Staffordshire should seek assurances about what arrangements are in place for specialist advice being available on so-called honour-based abuse, including through specialist IDVAs and as part of the MARAC process.
5. The Stoke-on-Trent Safeguarding Children Partnership should consider whether the absence of the child's voice and lived experiences as recorded in the case is a reflection of wider

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[13] https://karmanirvana.org.uk/about/

practice and consider what and how further improvement can be achieved.

6. The Stoke-on-Trent Health and Wellbeing Board be requested to consider the implications for public health strategies that target so-called honour-based abuse.
7. The Chair of the Norfolk County Community Safety Partnership should provide a written response to the learning from this DHR and any actions that they will be monitoring and implementing and for this to be included in the submission to the Home Office.
8. The Home Office should consider what policy and training implications are raised through the review in respect of;
    a) Level of knowledge about honour-based abuse;
    b) Provision of specialist advice about honour-based abuse to Tribunals dealing with requests for permission to remain in the UK when there are allegations about honour-based abuse;
    c) Recording and linking information about perpetrators and victims of domestic abuse and so-called honour-based abuse;
    d) Clarifying arrangements for risk screening and safeguarding oversight when responding to requests for relocation as a consequence of honour-based abuse.

National policy

1. The shortfall in emergency refuge accommodation for victims and survivors who have no access to public funds requires national leadership and action.
2. The data-sharing arrangements whereby information about victims of crime is handed over to immigration enforcement is a potential barrier to victims without secure citizen or residency status seeking help.
3. The limitations of the DASH risk screening for systemic threats represented by so-called honour-based abuse need addressing at a national level to provide a nationally accepted best practice framework.
4. Guidance on the use of recording and checking of police national databases. Routinely checking for warning messages on databases and cross-referencing between HBA perpetrator and HBA victim records that include linking records with family or associates perpetrating HBA.

5. The transfer of records between the GP practices and Primary Care Support England (PCSE) is subject to unexplained delay. It is beyond the scope of a local DHR to identify why delays occurred in this case. It is a recurring issue for other patient records.
6. The Home Office may wish to consider whether a redraft of multi-agency guidelines or work with NHS England to oversee amended procedures and training for health staff regarding matters of so-called honour-based abuse. This includes the issue of the victim's consent when there is concern about HBA where the GP is not a key partner within a safeguarding plan. The risk of inadvertent disclosure of information or information being accessed inappropriately.