DUDLEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW INTO THE DEATH OF 'Nezha' IN MARCH 2022

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

REVIEW PERIOD

1st of JANUARY 2017 to MARCH 2022

EXECUTIVE SUMMARY

Independent Author: **John Doyle**

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Preface

The Chair and the members of the Domestic Homicide Review Panel offer their sincere condolences to the family and friends of Nezha for their loss. The Chair and the members of the Panel would also like to extend thanks to those services who participated in the Review and assisted the Panel in its work.

The circumstances leading to the murder were that, on a day in March 2022, Ahmad contacted West Midlands Police (WMP) via 999, stating that: "he was being intoxicated by a female from Syria." A woman was heard in the background, stating that she was dying. Ahmad could be heard to say that he had "got her." He sounded confused and explained that he had been poisoned and that they were both dying of intoxication.

Officers arrived at the address in the West Midlands and found the front door of the property open. The bodies of Nezha and Ahmad were located in the living room area. Nezha was seen to have a gunshot wound and Ahmad also had a bullet wound. A shotgun was located across Ahmad's body and spent cartridges were nearby.

The working hypothesis of the West Midlands Police was that that Ahmad murdered Nezha before taking his own life.

There was no recorded history of domestic abuse with Nezha. There were allegations of domestic abuse from previous partners – but these were not substantiated no prosecuted. Ahmad was a licensed firearms holder.

The Panel recognised, of course, that this Review concerned a homicide and a suicide. The precise circumstances leading to the deaths of Nezha and Ahmad were determined by the Office of the Coroner in July 2022. In these circumstances, and when the Community Safety Partnership decided that a DHR will be completed, it would be usual to work with the specialist Family Liaison Officer (FLO) so that contact could be made with the family, friends and/or colleagues of the subject of the case and also with the family of the Perpetrator.

The Chair/Author and the Panel formed an excellent working relationship with the Family Liaison Officer (FLO) and they supported the Panel to complete its work.

However, due to the circumstances surrounding the investigation, the independent Author, the Commissioning Officer (from Dudley MBC), the FLO and a representative from the Professional Standards Department (PSD) of the West Midlands Police met in December 2022 to decide upon the best course of action regarding contact with the family of Nezha and the family of the Perpetrator, Ahmad. Taking account of the contact between the families of Nezha and Ahmad, the Family Liaison Officer and the PSD, it was decided – and confirmed in discussion with the Panel – that the Review should not make contact with any member, friend or associate of the family. Additionally, it was agreed by the Panel that any contact made by the family and/or friend(s) of Nezha and/or Ahmad must be facilitated via the FLO and their colleague from the Professional Standards Department (PSD) of the West Midlands Police Service.

It should be stressed that both the FLO and the PSD provided support to the Panel and, as efficiently and effectively as they could, provided answers to any of the questions raised by the Panel. The FLO and PSD also provided some context to the circumstances leading to the critical incident.

Further details of the work of the PSD are described in the section addressing ‘parallel reviews’.

Section One
The Review Process

1.1 Incident leading to the Domestic Homicide Review

On a day in March 2022, Ahmad contacted West Midlands Police (WMP) via 999, stating that:
"he was being intoxicated by a female from Syria."

1.1.1 A woman was heard in the background, stating that she was dying. Ahmad could be heard to say that he had 'got her.' He sounded confused and explained that he had been poisoned and that they were both dying of intoxication.

1.1.2 Officers arrived at the address in the West Midlands and found the front door of the property open. The bodies of Nezha and Ahmad were located in the living room area. Nezha presented with a gunshot wound and Ahmad with a bullet wound. A shotgun was located across Ahmad's body and spent cartridges were also nearby. The working hypothesis is that Ahmad murdered Nezha before taking his own life.

1.1.3 There was no recorded history of domestic abuse with Nezha, but there were incidents of alleged domestic abuse with previous partners. Ahmad had 4 passports (UK, Ukrainian, Turkish, USA) and was a licensed firearms holder.

1.1.4 Ahmad was the sole tenant of the property, but there were suggestions that Nezha also stayed at the address.

1.1.5 There were no recorded convictions for assault and/or common assault.

1.2 The time period under Review

1.2.1 At the initial meeting of the Domestic Homicide Review Panel, held virtually in September 2022, it was agreed that the timeframe for the Domestic Homicide Review should cover the period from the 1st of January 2017 to the date of the incident in March 2022. The panel decided on this time frame because this is the date that Nezha moved to the address where the incident occurred. However, the Panel was very clear in their communication with the agencies involved in the Review and requested that if any agency had any relevant information outside of this period, then this information should be included in the individual management review and chronology.

1.2.2 The parameters of the formal scope were effectively removed because a number of agencies did hold records from 2010-2014 concerning a number of subjects of this Review.

1.3 The Proposed timescale

1.3.1 The first meeting of the DHR Panel was held on the 1st of September 2022. The Panel met again in November 2022, January 2023, March 2023, April 2023 and in May 2023.

1.3.2 At the first meeting in September 2022, the Panel agreed an outline timetable of objectives and actions and this set the course for the completion of the Review and the production of the Report. This was achieved in compliance with the efforts made to respond to the Coronavirus – the completion of the Review being achieved via remote working and teleconference.

1.3.3 At the second meeting, the Panel began the process of scrutinising the submissions received from participating agencies. The Panel also discussed the involvement of the family.

1.3.4 At the third meeting, the Panel continued to consider and scrutinise the submissions and clarifications from participating agencies; the draft integrated chronology, the abridged chronology, the responses to the key lines of enquiry, the combined narrative, etc.

1.3.5 At the fourth meeting, the Panel considered a first crude draft of the Overview Report – a composite of the submissions structured in a format close to that required by the Home Office to ensure that all members of the Panel had a copy of all of the information submitted. The Panel also considered a number of emerging themes, and a number of the lessons learnt identified by the Agencies involved.

1.3.6 At the fifth meeting of the Panel, held in April 2023, the Panel considered a number of clarifications submitted by Agencies invited to submit and considered the first full draft of the Overview Report.

1.3.7 At the sixth meeting of the Panel, held in May 2023, the Panel considered the second draft of the Overview Report and committed to making comments and amendments by the beginning of July. The final draft was then submitted for consideration by the Community Safety Partnership and Domestic Abuse Boards.

1.4 The use of pseudonyms and involvement of the family of Nezha

1.4.1 As noted in the Preface, the Chair/Author and the Panel formed an excellent working relationship with the FLO and they supported the Panel to complete its work. Due to the circumstances surrounding the investigation, the Panel was advised that any contact with any member, friend or associate of the family, must be facilitated by the FLO and the Professional Standards Department (PSD) of the West Midlands Police Service.

1.4.2 Both the FLO and the PSD provided support to the Panel and provided answers, where they could, to any of the questions raised by the Panel and provided context to the circumstances leading to the critical incident.

1.4.3 Consequently, the Review Panel decided to use pseudonyms for the subjects of this case and these were all chosen by the Panel.

1.4.4 The pseudonyms chosen by the Panel – and used throughout the Overview Report – are described in the table below:

Name (Pseudonym)	**Relationship**
Nezha	Partner of the Perpetrator
Ahmad (Perpetrator)	Partner of Nezha at the time of the critical incident
Faisal	Child of Ahmad and Ayesha
Ayesha	Previous Partner to Ahmad and Mother of Faisal
Jameela	Previous Partner to Ahmad

Section two
Background information – the facts

2.1 A pen picture of Nezha and Ahmad – the focus of this DHR

2.1.1 Taking account of the nature of the contact with the families of Nezha and Ahmad – described in the Preface and parallel review sections of this Report – the Panel garnered as much information about Nezha as it could, whilst being cognisant of these necessary constraints.

2.1.2 We know that Nezha was born in Syria – in the city of Aleppo – in April 1982.

2.1.3 The Syrian civil war is an ongoing multi-sided civil war in Syria fought between the Syrian Arab Republic (which is led by the Syrian president Bashar al-Assad and he is supported by a number of domestic and foreign allies) and various domestic and foreign forces that oppose both the Syrian government and, in a variety of combinations, each other.

2.1.4 Unrest in Syria began in March 2011, as part of the wider 2011 "Arab Spring" protests that arose from discontent with the Syrian government. This escalated to an armed conflict after protests calling for Assad's removal were violently suppressed. The war is currently being fought by several factions: the Syrian Armed Forces and its domestic and international allies represent the "Syrian Arab Republic" and the Assad regime; opposed to it is the "Syrian Interim Government", which is a 'big-tent' alliance of pro-democratic, nationalist opposition groups whose defence forces consist of the Syrian National Army and the Free Syrian Army.

2.1.5 From this conflict, in 2011, Nezha made a visa application from Aleppo and later in 2011 Nezha arrived in Staffordshire in the UK.

2.1.6 We know that Nezha has two siblings – a younger Sister (born in May 1986) and a Brother – though his date of birth is not known. The Panel were informed that Nezha's Sister lived in Sadat City, Egypt when the critical incident occurred and the Family Liaison Officer did establish contact with her. However, during the process of the Review, Nezha's Sister changed her address and has not yet informed the FLO of her new address. Subsequently, communication has been maintained with Nezha's Brother, who lives in Germany.

2.1.7 The FLO confirmed that Nezha's Sister has received contact details for the Independent Author of this Review – though no contact has been made (information has been shared with Nezha's Sister that Arabic interpreters can be made available).

2.1.8 Nezha's Sister and Brother informed the FLO that Nezha's parents were deceased.

2.1.9 The Panel was told that, following the incident, Nezha's Sister and Brother informed the FLO (and the Office of the Coroner) that a friend of the family – who, at the time, was living in Swansea, Wales – was acting as the next-of-kin

for Nezha. The family friend was invited by the family to assist with all necessary arrangements in the UK, including the collection of Nezha's body and the burial. However, as time moved on the FLO was informed that the relationship between Nezha's Sister and Brother and the friend of the family broke down and all communication between them ceased after the burial of Nezha's body. Contact between the FLO and the friend of the family has also ceased – at the request of Nezha's Sister and Brother.

2.1.10 In June 2011, Nezha commenced her post-graduate studies at the University in the United Kingdom. Her PhD was in Life Sciences.

2.1.11 The costs associated with her study were met – in the first year – by the Syrian Government and after the first year was complete, the University in the United Kingdom waived further tuition costs.

2.1.12 During her studies at the University in the UK, the Panel learnt that Nezha engaged with the University – on a contractual basis – to undertake a variety of work, including as a laboratory demonstrator, an invigilator, and a casual tutor for undergraduate students.

2.1.13 In August 2015, Nezha was renting a property in Newcastle-under-Lyme. Nezha was registered as a sole occupant of the Property. Nezha's studies at the University in the UK were progressing very well. She had passed 6 (out of 9) modules concerning the study of English for Academic Purposes and was only 12 months – or thereabouts – from completing her PhD. This was awarded to her in October 2016.

2.1.14 In November 2018, Nezha's status as a refugee ceased, but she had received 'leave to remain' as resident in the UK.

2.1.15 When Nezha left the University in the United Kingdom – in 2021 – after completing her studies, it is likely that her income reduced significantly and this may explain why she was residing (in September 2021) in a House of Multiple Occupation (HMO).

2.1.16 Ahmad was born in February 1982 in Khorramabad, the city of the Lorestan Province in Iran. In 2009 – or thereabouts – Ahmad met his future wife (referred to in this Report as Ayesha). They married in 2009 in Istanbul, Turkey.

2.1.17 The Panel learnt that Ayesha sponsored Ahmad's visa application and they both moved to the UK in early 2010.

2.1.18 Ahmad commenced his post-graduate studies at the University in the United Kingdom in September 2015.

2.1.19 Ahmad had received his first degree from a University in Iran in 2005. From the application he made to the University in the United Kingdom, the Panel learnt that Ahmad had spent time working at three Hospitals in Tehran (between 2004 and 2010) – as an under-graduate and also when he received his first degree in biochemistry.

2.1.20 Ahmad then received his Masters Degree from a University in the United Kingdom (different to the one he attended with Nezha). He studied there between September 2014 and September 2015. Following his post-graduate qualification, Ahmad submitted to the University in the United Kingdom that he had worked in the NHS as a biochemist and as a senior biochemical scientist. This information has not been confirmed for the Panel.

2.1.21 Whilst at the University in the UK, Ahmad received a quarterly stipend and worked for the University as a laboratory demonstrator and a senior laboratory demonstrator. It is assumed by the Panel that Ahmad and Nezha met whilst at the University in the United Kingdom.

2.1.22 Ahmad's PhD programme was in clinical biochemistry. Ahmad's PhD career was not entirely successful. He pursued a programme of 'English for Academic Purposes' but did not pass the one module that he commenced in 2016 and he did not complete his MA in Learning and Teaching in Higher Education module that he commenced in September 2017. Ahmad did not complete his PhD prior to the critical incident.

2.1.23 In contrast, as noted, Nezha's academic career was more successful. Aside from the completion of her PhD and the modules listed above, Nezha commenced a MA in 'Learning and Teaching in Higher Education' and was awarded Post-Graduate credits by the Senate in October 2018 (though not the full MA) and she commenced a MA in 'Higher Education Practice' in September 2018 and was awarded Post-Graduate credits by the Senate in October 2020 (though not the full MA).

2.2 Contributors to the Review

2.2.1 The agencies invited to make submissions to the Review are listed below:

Agency	**Submission**
Staffordshire and Stoke-on-Trent ICB	Individual Management Review and Chronology
Staffordshire Police	Individual Management Review and Chronology
University in the United Kingdom	Individual Management Review and Chronology
Black Country Healthcare NHS Trust	Individual Management Review and Chronology
Dudley Children's Services	Individual Management Review and Chronology
University Hospitals of North Midlands NHS Trust	Individual Management Review and Chronology
Black Country ICB	Individual Management Review and Chronology
Dudley Integrated Health and Care NHS Trust (DIHC)	Individual Management Review and Chronology
West Midlands Police	Individual Management Review and Chronology
West Midlands Ambulance Service	Individual Management Review and Chronology

2.3 Review Panel Members

2.3.1 Following the notification of the death of Nezha and Ahmad, the Dudley Community Safety Partnership informed the Home Office that they would undertake a Domestic Homicide Review and to commission this Review under the auspice of Dudley Council.

2.3.2 The Panel received reports from agencies and dealt with any associated matters such as media management and liaison with the Office of the Coroner.

2.3.3 The Commissioning Authority (Dudley Council) appointed an independent Author, John Doyle, to oversee and compile the Review. John has extensive experience in public health management and has acted as author in several DHRs. John has completed the Home Office training concerning the completion of DHRs. John spent thirty years in public service and, having achieved registration at Consultant level with the UK Public Health Register, left the NHS in 2013. John had no connection with the subjects of the Review, no connection with any of the agencies involved in the review and no connection with the Commissioning Authority.

2.3.4 Panel members were appointed based on their seniority within relevant and appropriate agencies and their ability to direct resources to the review and to oversee implementation of review findings and recommendations.

2.3.5 The views and conclusions contained within this overview report are based on findings from documentary submissions and transcripts and have been formed to the best of the Review Panel's knowledge and belief.

2.3.6 The members of the Panel are described in the table below:

Role	**Agency**
Community Safety Officer	Dudley MBC Community Safety Team Representing Safe and Sound, Dudley's Community Safety Partnership
Head of Safeguarding	Black Country Healthcare NHS Trust
Director of Student Services and Success	University in the United Kingdom attended by Nezha and Ahmad.
Temporary Chief Inspector (at the time of the Review).	Public Protection Department, West Midlands Police
Director of Community Services	Black Country Women's Aid
Assistant Designated Nurse for Safeguarding, Black Country Integrated Care Board (Dudley)	Black Country Integrated Care Board (Dudley)
Chief Executive Officer	Churches Housing Association of Dudley District (CHADD)
Head of Safeguarding	Dudley Integrated Health and Care NHS Trust
Head of Safeguarding, Practice and Quality Assurance	DMBC Children's & Young People Safeguarding & Review

Professional Standards Investigator	West Midlands Police (PSD)
Deputy Designated Nurse for Safeguarding Adults	Staffordshire and Stoke-on-Trent ICB
Lead for Safeguarding in Education	Children's & Young People Safeguarding & Review
Head of Safeguarding	Dudley Integrated Health and Care NHS Trust
Designated Nurse for Safeguarding Adults	Black Country Integrated Care Board
Team Manager	Dudley MBC Children's & Young People Safeguarding & Review - Professional Practice
Lead Nurse for Vulnerable People	North Midlands Partnership NHS Foundation Trust
Head of Adult Safeguarding & Principal Social Worker	Dudley MBC Adult Safeguarding / Adult Social Care
	Independent Author

2.4 The Author of the Overview Report

2.4.1 The Commissioning Authority, Dudley Metropolitan Borough Council (MBC), appointed an independent Author, John Doyle, to oversee and compile the Review, in accordance with the Home Office Guidance. John has extensive experience in public health management and has acted as author in several DHRs. John has completed the Home Office training concerning the completion of DHRs and had no connection with the case or with any of the agencies involved in the review.

Section three

3.1 The Terms of Reference

3.1.1 The Panel approved these specific terms of reference and key lines of enquiry at its initial meeting and agreed to keep them under review as the process evolved. This was to ensure that they could be amended in order to capture any additional information revealed as a part of the Review process.

3.1.2 The Panel also noted that the over-arching purpose of a Domestic Homicide Review (DHR) which is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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;
- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity; and
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

3.1.3 The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

3.2 The Key Lines of Enquiry

3.2.1 In order to undertake a critical analysis of the submissions made, the Panel approved these key lines of enquiry:

a. **To establish what contact agencies had with Nezha and/or Ahmad**

This required agencies to consider these issues:

1. What contact did your agency have with Nezha and/or Ahmad? Please describe these contacts for each subject of the Review
2. Did any agency know or have reason to suspect that Nezha and/or Ahmad were subject to any form of domestic abuse at any time during the period under review?
3. Had any mental health issues been disclosed by Nezha or Ahmad, or any mental illness diagnosed by an agency in contact with them?
4. Were there any complexities of care and support required by Nezha or Ahmad and were these considered by the agencies in contact with them?
5. Were assessments of risk and, where necessary, referrals to other appropriate care pathways considered by the agencies in contact with Nezha and Ahmad?
6. Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with Nezha and Ahmad?

b. **To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for Nezha and Ahmad.**

This required agencies to consider these issues:

7. What actions were taken to safeguard Nezha and were the actions appropriate, timely and effective?

8. What happened as a result of these actions?
9. What actions were taken to reduce the risks presented to Nezha (and/or Ahmad) and were the actions you took appropriate, timely and effective?
10. What happened as a result of these actions?

c. **To establish whether there were other risks or protective factors present in the lives of Nezha or Ahmad.**

This required agencies to consider these issues:

11. Were there any other issues that may have increased the risks and vulnerabilities of Nezha or Ahmad?
12. Were there any matters relating to the safeguarding of other adults at risk, or children that the review should take account of?
13. Do you know if Nezha disclosed any domestic abuse to their family or friends? If so, do you know what action they took?
14. Did Ahmad make any disclosures regarding domestic abuse to their family or friends? If so, what action did they take?

d. **To establish whether agencies have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.**

This required agencies to consider these issues:

15. Were effective whistleblowing procedures in place within agencies to provide an effective response to reported concerns about ineffective safeguarding and unsafe procedures. Briefly describe these procedures.

e. **To identify clearly what the lessons to learn are and how they will be acted upon.**

This required agencies to consider:

16. What, (if anything), in your view should change as a result of the themes that are emerging from this Review and the production of a multi-agency action plan

f. **To recommend to organisations and partners of all agencies any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.**

g. Events and incidents may have occurred during the attempts to manage the COVID Pandemic. We would like to understand the impact of the COVID-19 Pandemic and address any improvements to service delivery.

This required agencies to consider:

17. What impact did the management of the COVID-19 pandemic – including the restrictions associated with it – have on the planned delivery and provision of the services offered to Nezha and Ahmad by the agencies in touch with them
18. What impact did the COVID-19 pandemic – including the restrictions associated with it – have on both Nezha and Ahmad individually, and as a couple.

h. The Perpetrator was a licensed shotgun holder and his certificate was registered with the West Midlands Police. The Panel is not aware of any

information to suggest that the Perpetrator's ownership of a shotgun was anything other than lawful. He was granted a license to own and use a shotgun because of the nature of his hobby and pass-time.

This required agencies to consider:

19. Was your agency involved in the assessment for, or granting of, the license for Ahmad to have a shotgun? If so, can you briefly describe the nature of your responsibility in this respect?
20. Is your agency aware of any prior information or intelligence to suggest that the ownership of a shotgun posed a particular risk to Nezha and/or Ahmad?
21. If so, please describe this information and/or your perspective on the risk.

Section four
Summary chronology

4.1 Outside the formal scope of the Review, but pertinent

Outside scope

Between **2010** and **2017**, a number of events and incidents occurred and these were considered by the Panel. In brief, these events included:

In 2010, Ayesha reported that bruising and scratches to her upper body were caused by her husband, Ahmad. They also informed West Midlands Police that they had not been allowed to leave the home address for the last eighteen months. Officers arrested Ahmad. Ayesha told officers that Ahmad had punched her to the head, face,

arms and upper body resulting in bruising. The investigation did not yield the evidence to pursue a prosecution and, coupled with this, Ayesha withdrew her complaint.

In August 2011 Nezha took a break from her studies. The Panel presumed this may correspond with the death of her parent.

In November 2012, Ayesha filed for divorce and cited 'due to violence'.

In May 2014, a family court report was made whereby Ayesha made numerous allegations of violence perpetrated by Ahmad. The Judge concluded that Ayesha had fabricated the allegations to prevent Ahmad from having contact with their child.

In May 2015, Ayesha called WMP and reported that Ahmad had assaulted their child. During her call, Ayesha divulged that Ahmad had made threats to her over the previous five months but she had not reported these to police. Ayesha advised that she and C1 were uninjured and safe at a family address not known to Ahmad but was 'traumatised' by his behaviour. A statement was obtained from Ayesha and enquiries conducted. A DASH was completed. Ahmad was voluntarily interviewed and he denied the allegations, suggesting that Ayesha was making false claims in order to assist her in the on-going family court case. The investigation was conducted on a 'single agency' basis by WMP. A harassment offence was recorded in relation to the comments made by Ahmad to Ayesha.

A short time later, Ahmad commenced a programme of post-graduate study (a PhD programme) at the University in the United Kingdom.

In mid-January 2016, in the early hours of the morning, Ahmad called West Midlands Police via 999 and reported that he had been assaulted outside a nightclub in Birmingham. West Midlands Ambulance Service attended the scene. Enquiries were conducted at the scene and these enquiries suggested that Ahmad had inappropriately touched a woman. Ahmad could not point out the offenders. Ahmad was transported to the QE II Hospital in Birmingham.

In February 2016**,** Ahmad called 999 reporting that his ex-girlfriend (W2) was outside his property making threats to kill him. They had recently separated and W2 had left some of her belongings at Ahmad's flat. She had attended to collect them and when Ahmad refused, an argument ensued. Ahmad stated W2 had not actually threatened to kill him. Ahmad agreed to allow W2 inside to collect her things whilst officers stayed and supervised.

In March 2016, Ahmad's GP noted that he was 'argumentative' in a consultation.

In June, Nezha's GP recorded that Nezha was not fit for work. A statement was issued referring to depression, and hearing loss. This was the first documented incident that Nezha attended an appointment with her partner, Ahmad.

In late July, Nezha's GP recorded low mood during a consultation. The GP also noted that:

> "Father died suddenly in Syrian war; has had counselling in the past. Not wanting further counselling but clear she wants further medication. Feels

unable to work. Combination of mood and also ongoing left sided hearing loss. Seen with partner".

In August 2016, West Midlands Ambulance Service (WMAS) attended an incident whereby Ahmad has called reporting chest pain. WMAS transported Ahmad to the Royal Stoke Hospital.

In October, the Senate (at the University in the UK) conferred the award of PhD on Nezha.

In mid-December 2016, the MASH Team Manager recorded that Ahmad alleged that Ayesha had attended his place of work with their child (at the University in the UK). Ayesha reportedly said they were homeless and under financial pressure, and therefore she was seeking reconciliation with Ahmad.

Within scope
2017

On the 9th of January, Nezha's GP recorded a consultation with Nezha and her partner. The review concerned deteriorating hearing (after effects of a road traffic accident the year before). The GP noted in the consultation that:

'*patient attended with partner, who did most of the talking'.*

An MRI and CT scan was arranged, along with a referral to audiology for a hearing assessment and hearing therapy. The information discussed was included in a letter to Nezha's GP including Nezha experiencing depression as a result of hearing loss.

In mid-August, Staffordshire Police recorded an incident concerning Ahmad. It was reported that a neighbour had kicked the door, thrown a bottle at Ahmad's head and made threats. The neighbour was arrested, interviewed and issued with a Conditional Caution (S4 Public Order Act).

In mid-October, Ahmad attended his GP. He wished to lose weight, but declined a referral to weight management service. Ahmad reported insomnia. It was noted that Nezha attended on the same date, also requesting weight advice. The GP recorded that they advised that Nezha was not overweight .

In early November, Staffordshire Police recorded an incident involving Ahmad. It was alleged that a neighbour was shining a laser through the window as Ahmad drove away in his car and had shone it into his eye. Personal Nuisance was recorded.

2018

In late January, Ahmad visited his GP and reported insomnia; anxiety at night and stress with work/PhD. It was noted that Ahmad enquired about medication for Nezha in his consultation.

In mid-March, Staffordshire Police recorded an incident concerning Ahmad. It was alleged that a male had broken the CCTV camera owned by Ahmad. Criminal Damage

was recorded; the incident was Cross Referenced as a repeat victim of ASB. Intelligence checks were conducted on the suspect. Ahmad Declined to Prosecute

In early April, Ahmad attended the Urgent Treatment Centre Out of Hours Service (OOH) and requested anti-depressants and an opioid because he stated he had run out of medication. Medication was not issued by the OOH.

In early May, Staffordshire Police recorded an incident whereby Ahmad reported an issue with a friend of the neighbour who had nearly reversed into his wife (Nezha). The purpose of the call was to log the incident. The Police recorded Personal Nuisance. An ASB TAG was added to the Incident Report for Local Policing. It was also noted that Ahmad was a repeat victim of ASB.

In mid-July, the Black Country ICB recorded that Nezha requested co-codamol (opioid) and noted that 100 tablets had been issued only 6 days ago.

In October, Ahmad requested a break in his studies from the University in the UK. The break lasted until August 2019. Ahmad cited 'health reasons' for the request.

At the end of November, NHS 111 received a call from Ahmad on behalf of Nezha. Ahmad reported breathlessness, which was worsening. Nezha made her own way to A&E. Nezha was diagnosed with a lower respiratory tract infection and was discharged the same day with a course of antibiotics.

On the 1st of December, NHS 111 received a call from a person calling themselves XX (this was Ahmad using an alias) stating that Nezha had shortness of breath. It was recorded that the patient was with her husband, and her condition was worsening. An Ambulance was despatched. It was documented that Nezha had an anxiety disorder. Nezha was 'left in the care of her partner with advice for any future episodes'. A letter was sent to her GP.

2019

Towards the end of March, Staffordshire Police note an Incident Report. Ahmad stated that his car windows had been smashed. The crime was recorded as Criminal Damage. An investigation commenced. It was recorded that the Complainant Declined to Prosecute.

In early June, the GP received a letter from the Dudley out of hours (OOH) service. Ahmad had attended with his partner and stated that he was due a GP appointment on that day but an accident on the M6 had caused a delay and he missed the appointment. Ahmad requested opioid and anti-depressant medication. It was good practice from the OOH to check Ahmad's appointment, liaise with the Practice in order to limit prescribing.

In Mid June, Ahmad's GP was asked to review a 'not fit for work' letter. Ahmad reported back problems. The duration of the letter was set for the 1st of October 2018 to the 21st of June 2019. Nezha had a GP consultation on the same day. The GP recorded panic attacks, a prolapsed disc, and knee pain.

2020

At the end of January**,** WMP received an application for a firearms and shotgun licence from Ahmad. Ahmad stated that he wished to shoot clay pigeons at a Midlands rifle club. He recorded on his application that he had previously held a firearms certificate in Iran between 2002 and 2006 and had two years military service**.** Two referees were listed – one a colleague and the other a neighbour and friend of six years from the Staffordshire area. The required checks were initiated and forms sent out to Ahmad's GP.

In early February, Ahmad's GP received a request for Consent to Release Medical Information. The request was from the Staffordshire & West Midlands Police Firearms Licensing Unit and it was asking for information regarding medical history. A letter was sent to Ahmad requesting consent to release, with an invoice for the fee (for private work, payable to the GP). There was no further record of this on EMIS system and no consent to disclose was received.

Note: Following a discussion with the GP, there was no further contact from Ahmad for consent to release information and no contact from the Police around this. No medical information was shared. Hence, Ahmad's GP Practice were unaware that a firearms licence had been granted. Therefore, there was no documentation or safeguarding oversight of this request on EMIS

In late February, Ahmad requested a break in his studies from the University in the UK. The break lasted until October 2020. Ahmad cited COVID as the reason for the request.

On the 10th of February, Staffordshire Police recorded an Incident whereby Ahmad was arrested at his home address regarding an incident involving Controlled Drugs (an allegation of illegal importation). Ahmad was arrested and held in custody under his alias name. His registered property and linked property were searched.

'Special Branch' noted that there was no relevant intelligence to share from their point of view and remarked that from the details in the (Staffordshire) log, there was nothing to support any 'CT-LASIT[1] ideology which may lead to any activity at this time'.

Staffordshire Police provided the custody reference number under the name of the alias used. There was no direct contact between WMP and Ahmad. It could not be proven that Ahmad had imported Heroin. Ahmad was released with no further action for that offence.

Later in May, Nezha attended her GP for a medication review. It was noted that Nezha was still taking anti-depressants; taking co-codamol daily for knee and back pains. The GP recorded a 'shortness of breath'. Nezha's Partner stated that Nezha almost chokes in her sleep at night.

On the 1st of June, Ahmad attended his GP for a telephone consultation. Ahmad requested an opioid prescription. A short time later, Ahmad called the Practice to enquire about the the prescription for the opioid medication. The issue was refused by

[1] Counter-Terrorism Left-wing Anarchist Single Issue Terrorism

the GP – they were awaiting Ahmad's regular GP to return. It was recorded that Ahmad:

> 'wasn't happy. Took my name. Said it was neglect and to remember this conversation in case someone rings back to pursue it.'

This was good prescribing practice.

At the end of July, Ahmad met with the Firearms Licensing Officer (FO1) to consider the firearms application. The rifle club confirmed that Ahmad was a member and had passed a probationary period. FO1 recorded that in their opinion, Ahmad could 'be permitted to possess a firearm without danger to public safety or the peace'.

On the 12th of August, Staffordshire Police noted an Incident where Ahmad called to state that his Partner had been assaulted by a neighbour and was bleeding and needed an Ambulance. On investigation, it was recorded that the incident was an assault between neighbours. Both parties had been aggressive toward each other. A Community Resolution and advice was given to both parties. The incident was recorded as 'Violence Against the Person'. WMAS attended the scene and noted that Nezha did not wish to go to A&E. Nezha's partner was happy to look after Nezha.

2021

In mid-January, West Midlands Ambulance Service were called. Ahmad advised the call handler that they had muscular pain in left side. Ahmad was not conveyed to Hospital. Ahmad stated that they would visit their GP. A short time later, Ahmad called stating that the chest pain had worsened. Ahmad was deemed to have capacity and refused transport to hospital. Ahmad was left in the care of his partner who was recorded as next of kin.

A little later in January, Ahmad called for an Ambulance and reported ongoing chest pain for 8 days, which was gradually worsening. Once again, after the attendance, Ahmad was left in the care of his partner.

On the 13th of February, West Midlands Ambulance Service were called by Ahmad who advised that he had:

> "….gone into fridge that morning to get a bottle of Pepsi. A friend had put approximately 30-30ml of methadone in the fridge and he had accidentally consumed it".

There was no evidence of analysis around who the methadone belonged to, or if there were other residents in household.

Towards the end of February, Staffordshire Police noted an incident involving Nezha. It was reported that Nezha had suffered the loss of £9,351.65. The incident was recorded as a complaint of theft. Nezha named a suspect as an Egyptian National who, over the last four months, had lived at the address and had now left. An appointment was made for a Police Officer to attend Nezha's home address. Nezha was recorded as having COVID symptoms and was awaiting an appointment for a test and requested the Police call when she was better. Over the following 3-4 weeks, several attempts were made to confirm appointment times and dates. The matter was reviewed and a short time later filed as 'Nezha declined to engage'.

On the 5th of May, Ahmad requested an urgent appointment with his GP. Ahmad reported that since having the AstraZeneca vaccine, he had chest pain, oedema (swelling), and inflammation. The GP reviewed the matter and noted:

> *"Looking back patient was having these pains before the vaccine, spoke to him in January about this and that he Did Not Attend two double appointments with the GP. Ahmad stated that he had blood samples taken 2 days after speaking to the GP in January, but there were no results on the system".*

On the 14th of June, Staffordshire Police received an anonymous call concerning Ahmad and Nezha's property. The Housing Association had changed the locks on the property following the previous Police visit. The caller stated that a man had returned to the property, called the Housing Association who did not give them keys or codes to the key safe. The man returned with a woman (presumed to be his partner and presumed to be Nezha). The call was made to the Police because they think they have broken into the property and were not sure if the Police needed to know.

Police Officers attended and spoke to Ahmad and Nezha outside the property. They had been away for 30 days in Birmingham and returned to find the door to the flat had been forced open due to the council forcing entry after serving a notice on the property.[2]

On the 8th of September**,** Nezha reported she had returned to her room within a Home of Multi-Occupancy at which she was residing, to find an unknown person had entered by unknown means and stolen jewellery and mobile phones.

The incident log was later passed to an officer within the Initial Investigation Team to make further contact with Nezha and on the 11th of September, they attempted to speak with her on the phone. Nezha did not answer. Three further calls were made over the next two days but Nezha did not answer or respond to texts sent asking for a call back. Nezha failed to return any messages and the matter was filed on the 14th of September pending any further information coming to light.

Towards the end of September, the University in the United Kingdom agreed (via appeal) another extension to Ahmad's PhD submission deadline (6 months).

2022

On the 7th of January, Ahmad reported an incident (an offence of taking without consent – TWOC) that actually occurred on the 26th of August 2021. Ahmad reported this offence using an alias. When asked why he did not report the matter at the time, he informed he was unaware that he had to do so. His insurance company had since advised him to contact the police. Ahmad was advised to contact his insurance company and the log was closed.

[2] The Panel noted that Nezha's employment at the University in the UK ceased in 2021. She had reported the theft of approximately £10,000 and could not pay her rent to the Housing Association. The Housing Association issued notice to vacate the property and were operating under the assumption that Nezha had returned to Syria (the reasons for this were not clarified for the Panel)

Three days later, Ahmad contacted WMP. He requested the log number and explained that the offender had collided with a parked car prior to returning the vehicle to his address.

Ahmad was advised that an officer would contact him within approximately twenty four hours for further details. The second log reference was generated and provided to Ahmad. Contact staff called Ahmad for further information

The matter was recorded as a crime and the reference number sent to Ahmad along with notification that the matter would be sent to the Investigation Hub to progress. An officer from the hub attempted to contact Ahmad several times and after the third failed attempt, the report was filed.

Towards the end of March, there was a text message exchange between the Social Worker and Ahmad (the Social Worker was appointed for the Child of Ahmad and Ayesha). Ahmad sent a text message back to the Social Worker, requesting that Ayesha (mother of their child) to contact him due to a "very urgent matter."

A little later, the University approved a final extension to the deadline for Ahmad's PhD submission.

Later in March, the Social Worker confirmed with the school Safeguarding Lead that they had passed Ayesha's number to Ahmad, and Ahmad's number to Ayesha.

A short time later, the critical incident occurred.

Section five

Key issues arising from the Review

5.1 The incidence of traumatic events in adolescence and early adulthood

5.1.1 The 'pen-picture' generated by the Panel from the submissions made by the agencies in contact with Nezha and Ahmad and from the information provided by the Family Liaison Officer, indicated that Nezha arrived in the UK seeking asylum and fleeing conflict in her country of birth. For Nezha, the Panel believes that she left Syria in 2010, or thereabouts.

5.2 Was there a formal recognition of disability

5.2.1 The Panel received submissions concerning the gradual loss of hearing endured by Nezha. There was no evidence to suggest that Nezha was formally registered as being disabled.

5.2.2 The Panel noted that, on reviewing the records from the Black Country ICB, there appeared to be a little inconsistency. In 2017, the GP Practice noted that Nezha's 'husband' said Nezha was unable to work. On the 29th of September 2017 at Nezha's new patient health check with her new Practice, Nezha said that she spent most of her time at work standing or walking. It was noted, however, that in 2019, a GP from the same Practice wrote a supporting letter to the Department for Work and Pensions for a home visit assessment due to Nezha's back pain, stating that she was spending most of the day lying down and needed a wheelchair.

5.2.3 The Panel did not receive any information to suggest that Ahmad was formally registered as disabled. He did not access the services offered to him by his employer when he referred to his disability (this is clear from the submission received from the University in the UK).

5.3 Hearing the voice of Nezha

5.3.1 In 2017, Nezha's new patient health check referred to a statement made in correspondence from the University Hospitals of the North Midlands NHS Trust that Nezha's main language was English and that Nezha's English was: "reasonable when she engages".

5.3.2 There were occasions when – in a literal sense – Nezha's voice was not heard. The Panel received submissions noting that Ahmad would 'do most of the talking' when joint visits to the GP were made. It is noteworthy, of course, that joint visits to the GP were the most frequent mode of contact for Nezha.

8.3.3 The Panel noted that – as time moved on – Nezha's voice became less obvious. The opportunities available to her to, perhaps express concern and to 'tell her story' diminished significantly. At the same time, it appears from the accounts received (particularly from healthcare providers and from Staffordshire Police) that Ahmad became more visible and more dominant.

5.4 Knowing the full history of Ahmad

5.4.1 There was a history of notifications for Ahmad, including detail of Domestic Violence with his ex-partner, Ayesha.

5.4.2 The Staffordshire Police arrested a person (who was in fact Ahmad, using an alias) on suspicion of importing heroin. For evidential reasons, no prosecution occurred – but the use of the alias had implications.

5.4.3 Medicines Management records for Ahmad noted that he was over-ordering an opioid medication. The Panel noted that Ahmad's attempt to order repeat prescriptions for pain-relief medication – including a request at a NHS Walk-In Centre – were clearly identified by his GP Practice and the requests were denied. The Panel worked on the assumption that Ahmad may have been preoccupied with attempting to receive this form of medication, but that his

behaviour did not demonstrate a dependency on opioid medication and none of the submissions indicated that Ahmad was addicted to any prescribed or illicit substances.

5.4.4 The consideration and management of potential opioid dependency would have been applicable for Ahmad and also for Nezha.

5.5 The Taking With-Out Consent incident reported in January 2022.

5.5.1 In light of Ahmad's apparent reluctance to engage, the lack of available information about the offender and loss of potential CCTV, the decision was taken that there was insufficient information for WMP to pursue the investigation any further and the matter would be filed pending any future contact from Ahmad. The author of the submission from WMP noted that, because the TWOC was aggravated by the fact the offender crashed the vehicle, the matter required further investigation.

5.5.2 Ahmad was not home when his vehicle was taken but did provide details about what happened. It is not recorded how he knew the offender was indeed responsible. It is fair to suspect this information was provided to him by his partner who was therefore a key witness in the case. What the Panel could garner from the chronology was that, whilst the incident was reported in January 2022, it actually occurred in August 2021. In February 2021, Nezha reported the theft of approximately £9,400 and on the 8th of September 2021, Nezha reported that she had returned to her room within an HMO to find that an unknown person had entered her room and stolen property.

5.6 Subtle signs of coercion and control

5.6.1 As noted, a frequent mode of contact with General Practice was for Nezha and Ahmad to make joint visits. The GP noted that Ahmad would often lead the conversation and speak on behalf of Nezha.

6.6.2 While in isolation, the softer signs of potential safeguarding risk are less visible, but when domestic abuse and safeguarding concerns are viewed as a whole, they can provide a picture that may otherwise go unseen. Identification of these subtle signs is key.

5.7 Transferring abuse from one partner onto another

5.7.1 There was a period when Ayesha (who made allegations of abuse) would make contact with Ahmad – frequently this concerned the care and welfare of their child. Ahmad would often refer to this contact as harassment and it appeared to cause considerable distress and distraction for him.

5.8 Anti-social behaviour and discrimination from neighbours

5.8.1 Ahmad and Nezha both endured episodes of discrimination and disputes with their neighbour(s). It is not clear whether this constituted a 'hate crime'. The Panel learnt that counter allegations were made by the neighbour about Ahmad.

5.9 Nezha's accommodation and lived experience

5.9.1 Nezha was registered as a resident in one property that she shared with Ahmad. However, toward the end of the scope of the Review, there is reference to Nezha living in a house of multiple occupation. This occurred approximately six months after the reported theft of approximately £10,000.

5.9.2 The Panel noted that Nezha's employment with the University in the UK ceased in 2021. This, no doubt, had significant financial implications and the representative from the University did confirm that Nezha's income will have fallen notably from this point.

5.10 The incident of the Burglary on the 8th of September 2021.

5.10.1 It is unclear whether or not Forensic Services did eventually visit the address where the burglary occurred. There is nothing to suggest that they did and nothing relating to forensic evidence, or lack of, documented within the rationale for filing the case.

5.10.2 Despite there being an entry within the incident log that states Nezha was vulnerable (she had self-disclosed an undefined disability), this is not referenced anywhere within the crime investigation log.

5.10.3 It is subsequently not clear what Nezha's disability was or indeed her level of vulnerability. This may have been explored with Nezha on the 'phone had she answered one of the several calls made by WMP. However, because efforts to engage with Nezha failed, there is no way of knowing.

5.11 The licensing of the firearm

5.11.1 The Panel was informed that Ahmad's GP reported that they received a 'consent to disclose medical information form' and invited Ahmad to provide consent, along with a fee for payment. This was not received and the GP did not share any information about Ahmad with the Staffordshire and West Midlands Police (WMP) Firearms Licensing Unit.

5.11.2 The Enquiry Officer from the joint Firearms Licensing Unit did not identify that the incident concerning the arrest of Ahmad in February 2020 was the same Ahmad that was applying for a firearm. At the incident of the arrest in 2020, Ahmad was arrested by Staffordshire Police using one of his aliases. Had the link been made, the Enquiry Officer would have been prompted to conduct a check on the Police National Computer which would have revealed that he was actually arrested (under an alias) and was under investigation for allegedly importing heroin into the UK.

5.11.3 It was possible – though the Panel were acutely aware of the dangers associated with hindsight – that enquiries could have been made with Staffordshire officers, such as obtaining custody photos and information from the seized documents and this would have confirmed that the alias was in fact Ahmad. At the time, there was no rationale for doing so.

5.11.4 Had this been confirmed, and given the nature of the offence, WMP was clear that Ahmad would not have been granted a firearms licence.

5.11.5 The Panel also learned that the Licensing Department had – from March 2020 for around twelve months due to the management of the COVID Pandemic – frozen grant applications and this affected the application process. The application process was re-opened after intervention from both the Offices of Executives and Commissioners due to pressure from the public, the press and shooting associations. The enquiry was done by a restricted police officer as many of the licensing team were working from home under the COVID restrictions

5.11.6 As noted elsewhere in this Report, the guidance concerning the issuing of firearms licenses was amended in December 2021. If an individual has applied for a firearms license and is the subject of a PNC or PND check, it will show that they have applied for a license. The firearms licensing department are now informed if an applicant has been arrested and license holders are recorded on PNC and PND in accordance with this regulation. At least one referee must now be contacted as part of the application process. No one will be given a firearms licence unless the police have reviewed information from a registered doctor setting out whether or not the applicant has any relevant medical history – including mental health, neurological conditions or substance abuse issues. individuals are now required to provide a medical pro-forma alongside their application, filled out and signed by a registered doctor.

5.12 The effect of dominance.

5.12.1 The Panel learnt that the GP noted that Ahmad often arrived late for appointments, requested medication late, had poor compliance with medication, did not attend for some appointments and requested that his name was changed on EMIS to include the title ‘Dr.’ This may be seen as someone who wished to control their circumstances.

5.12.2 The Author of the submission made by the University Hospitals of the North Midlands considered the remark made by Ahmad during a consultation with them (that he felt that the Syrian conflict was what makes his wife: “virtually unresponsive”) to be a curious remark to make about a woman who appeared, from other accounts, to be perfectly competent and confident.

5.12.3 There was no evidence on the EMIS records for Nezha that transferrable risk from Ahmad had been considered. This was disappointing in light of Ahmad’s dominance at some appointments.

5.13 Nezha’s healthcare history

5.13.1 As noted elsewhere in the Review, Nezha presented to her GP with a variety of healthcare needs. A number of these consultations concerned advice and prescribing to tackle pain relief. There were 33 prescriptions for pain relief issued during the scoping period, although there was no evidence to suggest that there was any over prescribing.

5.13.2 As noted, Ahmad was quite involved in Nezha’s healthcare. The degree of intrusion into the healthcare record of a partner could be seen as a form of

coercion and control. The recognition and response to these less subtle indicators is specified in current training provided to healthcare professionals.

5.14 Alerts and safeguarding oversight:

5.14.1 A visible chronology of safeguarding indicators could have made a difference in this case. Consideration should be given to what constitutes a 'safeguarding incident' and the difference between 'EMIS coding' and an 'alert'. It would be beneficial to code individual incidents so that on the patient's 'summary record', an overview of the frequency and timeline of events would be evident.

5.15 Ahmad's behaviour in the 12 months prior to the incident

8.15.1 The Panel concentrated upon just three specific examples.

- In 2021, Ahmad contacted the Ambulance Service when he accidentally consumed methadone when he mistook it for a soft-drink in his fridge. Critical thinking and safeguarding oversight on receipt of this notification could not be seen. Expectations would be to invite Ahmad to the surgery, establish who the person was that prescribed the methadone and whether there was transferrable risk or drug dependency issues for Ahmad.
- Ahmad was also prescribed pain relief initially in 2017 and again in 2022. This opioid analgesic painkiller is a highly effective medication for pain relief and is a controlled drug. Analysis around the ongoing use of anti-depressants and the 'accidental' methadone overdose could have initiated a GP consultation and onward referral to mental health services and substance misuse services.
- In 2021, Ahmad contacted his GP Practice on a number of occasions reporting that he was concerned about the possible effect of his Astra-Zeneca COVID vaccination. Ahmad stated that it was having an effect on his facial hair, that he was developing enlarged breast tissue and that – on a recent trip to Germany – he had received a testosterone test and told his GP at the Practice that it was low. None of these symptoms could be confirmed by his Practice.

5.16 The incident in Plymouth

5.16.1 The Panel set aside some time to discuss the tragic incidents that occurred in Plymouth in August 2021. The Office of the Coroner held an Inquest into those events and in February 2023 the Inquest Jury returned a verdict of unlawful killing of all of the victims.

5.16.2 The Panel noted, from the press release from the Plymouth Coroner, that a comprehensive Preventing Future Deaths Report had been completed and that recommendations had been made to the Home Office. Additionally, the Panel noted that the failings highlighted by the jury's findings, which contributed to the shootings and which will likely be used to make widespread changes to UK gun laws, included:

- That Devon & Cornwall Police [Firearms and Explosives Licensing Unit (or 'FELU') made serious errors in granting Jake Davison's application for a shotgun licence and by failing to revoke it in 2020;
- Following the assault on two children in 2020, the force made an unreasonable decision to charge the assault as one of battery and to properly investigate

whether it was safe to return the shotgun and certificate, after initially seizing them;

- The force did not have robust systems in place concerning the training of FELU staff, or to ensure decisions were made at the correct level;
- Sufficient medical information was not taken in respect of the initial shotgun licence application;
- FELU (Firearms and Explosives Licensing Unit) failed to properly obtain and consider all the relevant evidence before deciding whether to grant the licence;
- A lack of national accredited firearms licensing training failed to equip police staff to protect the public;
- There was a catastrophic failure in the management of the FELU, with a lack of managerial supervision, inadequate and ineffective leadership.

8.16.3 The Independent Office for Police Conduct (IOPC) has also stated that a criminal investigation into possible health and safety breaches by Devon and Cornwall Police was underway at the time of writing this Report.

8.16.4 The Senior Coroner in Plymouth noted in his Preventing Future Deaths Report that the Home Office, and each of the 43 Chief Constables in England and Wales, should respond to his detailed examination of gun laws by the 3rd of May 2023. The Home Office has applied to the Office of the Coroner for an extension to the deadline.

Section six
Conclusions

6.1 This Domestic Homicide Review concerns the death of Nezha, who died in March 2022, and of Ahmad – who died at the same incident. The working hypothesis of the West Midlands Police was that Ahmad murdered Nezha with a licensed firearm and then took his own life. This was confirmed by the Office

of the Coroner at the Inquest held into the deaths. The Inquest was concluded in July 2022.

6.2 The Domestic Homicide Review Panel that completed this Review recognised that this was a murder, followed by a suicide.

6.3 As noted in the Preface, the circumstances surrounding the review being undertaken by the Professional Standards Department (PSD), meant that the Review Panel would not make direct contact with any member, friend or associate of the family of either Nezha or Ahmad and that all communication must go via the FLO and their colleague from the PSD. The information acquired by the Review to provide a 'pen-picture' of the subjects of the case was verified by the FLO and the Panel are grateful for their help and support.

6.4 The Panel noted that the agencies contacted in relation to this Review identified a specific diversity issue concerning Nezha. The agencies recorded and noted that Nezha was Syrian and had fled conflict in her country of birth and sought asylum in the UK. Nezha made a visa application to the UK from Aleppo and arrived in Staffordshire in 2011.

6.5 The Panel learnt that Nezha has two siblings – a Sister and a Brother. The Panel were informed that Nezha's Sister lived in Sadat City, Egypt when the critical incident occurred and the Family Liaison Officer did establish contact with her. Nezha's Sister and Brother informed the FLO that Nezha's parents were deceased.

6.6 In June 2011, Nezha commenced her post-graduate studies at the University in the United Kingdom. Her PhD was in Life Sciences. The costs associated with her study were met – in the first year – by the Syrian Government and after the first year was complete, the University in the United Kingdom waived further tuition costs.

6.7 During her studies at the University in the UK, the Panel learnt that Nezha engaged with the University to undertake a variety of work. This included working as a laboratory demonstrator, an invigilator, and a casual tutor for undergraduate students.

6.8 In August 2015, Nezha was living in a property in Newcastle-under-Lyme and she was registered as the sole occupant of the Property. The Panel learnt that, when Nezha and Ahmad formed their relationship (in approximately 2015), from time to time, Ahmad would also reside at the property.

6.9 During this period, Nezha's studies at the University in the United Kingdom were progressing very well. She had passed 6 (out of 9) modules concerning the study for a MA in English for Academic Purposes and was only 12 months – or thereabouts – from completing her PhD. Nezha was awarded her PhD in October 2016.

6.10 The Panel learnt that in November 2018, Nezha's status as a refugee ceased. However, it was noted that Nezha received 'leave to remain' and so remained a resident in the UK.

6.11 Nezha left the University in the United Kingdom in 2021. She had completed her studies. The Panel worked on the assumption that, at this point, Nezha's income reduced significantly. This may explain why Nezha was residing (in September 2021) in a House of Multiple Occupation (HMO) and it may suggest that, to some degree, Nezha was becoming financially dependent upon Ahmad.

6.12 The Panel noted that the report of assault and harassment from Ayesha was handled promptly and relevant safeguarding procedures were undertaken. Relevant referrals were made with Children's Services in both the area in which Ayesha and her child had lived when the incident occurred and the area they moved to following the incident. Contact was maintained with Ayesha throughout the investigation and her expectations managed accordingly.

6.14 The Panel learnt that Ahmad applied to West Midlands Police (WMP) for a firearms license at the end of January 2020. At this time, the WMP were using an intelligence system called FLINTS. Following discussion of the application process, it became apparent that if an intelligence log had been submitted to include Ahmad's 'aliases', this would have shown up on FLINTS. However, of course, as noted by the author of the WMP submission, the enquiry officer was unaware that Ahmad was known in Staffordshire Police because he had been arrested under an alias and this alias was completely unknown to WMP.

6.15 As a part of the licensing procedure, a letter was sent to Ahmad requesting consent to release relevant medical information. The Panel received a copy of the licensing guidance in operation at the time of the application and this element of the procedure was in accordance with that guidance. Discussion between the GP and the author of the submission from the relevant ICB, outlined that no further communication was received from Ahmad or the Police. This suggested that Ahmad's medical history was not shared with the Police. in addition, the GP informed the Author of the submission that Practice X was unaware that a firearms license had been granted to Ahmad.

6.16 As noted above, the submissions received from the agencies in contact with Ahmad tend to generate an image whereby Ahmad's behaviour, in the 12 months prior to the critical incident, can be described as unusual or at least out of character. Whilst each individual feature did not generate a concern acute enough to consider a safeguarding referral, or discussion at a multi-agency arrangement, when taken together they portray a person experiencing some degree of trauma or mental distress, the precise causes of which are not entirely clear. There may have been a strong desire exercised by him to control those elements of his life that he could control – and that included Nezha.

6.17 Throughout this Review, the voice of Nezha has been very difficult to discern. The Panel valued the information provided via the Family Liaison Officer, which, in turn, came from Nezha's Siblings. This information, coupled with the submissions received from the one or two agencies in contact with her prior to

2015, gave a clear impression of a woman strong enough and resilient enough to flee the trauma of violence in her country of birth and make a new life in the UK. However, when Nezha began her relationship with Ahmad in 2015, more agencies began to record contacts with her – including Staffordshire Police, the Ambulance Service and NHS primary and secondary care services. Nevertheless, it appeared to the Panel that as Nezha was becoming known to more services, simultaneously her presence was becoming less obvious to the extent that she seems to have lost her autonomy.

6.18 Nezha was murdered by Ahmad and the weapon used by him to kill her was a legally held licensed firearm. The Panel await the response of the Home Office to the request made by the Coroner in Plymouth to review the guidance concerning the issuing of firearms licenses.

6.19 The Panel extends its condolences to the family, friends and colleagues of Nezha.

Section seven
Lessons to be learned by the agencies submitting information.

7.1 Staffordshire Police

7.1.1 Predominantly, the response from Staffordshire Police was focused upon an ongoing dispute between Ahmad and/or Nezha with identified neighbours. As noted elsewhere in this Review, there was a mixture of attempted resolutions to these disputes but they were not entirely successful and the dispute continued.

7.1.2 The Panel did note that at least one incident involving the identified neighbours could have been coded as a 'hate crime' and that a lack of engagement with victims of such crimes can be countered by more direct (but sensitive) enquiry with them and a more assertive service directed towards the perpetrators of such crimes.

7.2 Dudley Children Services

7.2.1 Dudley Children's Services informed the Panel that there is learning in relation to the sharing of information, specifically contact numbers, between parents where domestic abuse is, has been, or may be a concern. Further, Dudley CSC noted that there is a learning opportunity in relation to the quality of support and intervention in relation to safeguarding C1. A number of referrals were received from family members, raising concerns about C1's safety. A more robust assessment of C1's care and Ayesha's parenting capacity may have led to more timely intervention.

7.3 Dudley Integrated Health and Care NHS Trust (DIHC)

7.3.1 The author of the submission questioned the decision made to issue a firearms licence to an individual who has been reported to have been the perpetrator of domestic abuse.

7.4 West Midlands Police

7.4.1 With regard to the response provided by WMP on the day of Ahmad and Nezha's deaths, the author of the submission was not in a position to comment at the time the Review was underway (due to the Review being undertaken by the Professional Standards Department).

7.4.2 At the time of publication of this Review (June 2024), the final report of the PSD case concerning the deaths of Nezha and Ahmad was being written. The lead reviewer from the PSD confirmed that 'recommendations were being made for the force' and that these recommendations will be considered by the Appropriate Authority in the PSD.

7.4.3 West Midlands Police did identify a number of learning opportunities from their involvement with the Review, concerning specifically Ahmad's application for a firearms license. These are set out below:

- Intelligence checks conducted when processing applications for a firearms license need to be more robust and repeated prior to being issued regardless of how long the process takes.

- It is evident that the missing of information meant that Ahmad was granted a firearms licence and held a shotgun.
- Had all available information been obtained, Ahmad would not have been granted the licence.
- Background checks for applicants must be repeated at the point the applicant is deemed suitable and before the supervisor grants the license. These must include checks with an applicant's GP so that any changes are noted and considered.

7.5 UK University

7.5.1 Details are provided within the five actions described in the single agency action plan, appended to this Report.

7.6 Black Country Integrated Care Board (Dudley Place)

7.6.1 From discussion with the GP, it is understood that Nezha and Ahmad often accompanied each other to their appointments. The GP described Ahmad as polite, rational, and educated and that there were no concerns noted by the GP about the relationship dynamics between Ahmad and Nezha. Nezha and Ahmad's joint attendance at appointments was not always recorded on EMIS, therefore was not identifiable by future professionals as a possible risk factor.

7.6.2 Nezha and Ahmad both had a history of physical and mental health difficulties for which they took medication including long term anti-depressants, opioid medications and the Panel considered that it may be possible that Nezha and Ahmad lived with a degree of opioid medication dependency.

7.6.3 Discussion with the GP around Ahmad's mental health raised that Ahmad had no formal mental health diagnoses. Ahmad requested Selective Serotonin Reuptake Inhibitors (SSRIs) and low dose antidepressants were prescribed to help Ahmad with the stresses and strains of everyday life, busy work, and study.

7.6.4 Previous domestic homicide reviews have highlighted a link for victims with attending A&E, patient stress and anxiety, unexplained pain (including allegedly from a car accident), concerns about weight, stress, urinary problems, and issues with digestion (IRIS, 2022), all of which Nezha experienced. Perpetrators presented with recurrent symptoms of anxiety and depression, attended the practice more than average, reported having problems with partners and children, had access to a weapon (IRIS, 2022), all of which could be applicable to Ahmad.

7.6.5 Safeguarding checks had been completed by BCHFT (Black Country Healthcare Foundation Trust) MASH Safeguarding Nurses and documented on EMIS. As noted, these safeguarding entries do not receive GP safeguarding lead oversight and can be missed amongst consultation text. Current alert systems on EMIS could be more effective in highlighting historic safeguarding concerns. Safeguarding checks are an essential information source to highlight potential risk to staff and transferrable risk to other adults and children. In historic domestic homicide reviews, General Practice was the main professional that both the victim and perpetrator were engaged with.

Recommendations from the Review

Set out below are the Recommendations made by the Panel, accompanied by the rationale for each Recommendation.

These Recommendations are **NOT** in any order of priority.

Recommendations

1. Sharing information concerning risk and vulnerability with Higher Education institutions.

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Investigate the development of a 'disclosure form' which will require the agency making the submission to the MARAC (or other relevant multi-agency arrangement) to secure the consent of the client to disclose necessary information to other MARAC Partners prior to the MARAC submission being made. The disclosure form – with the relevant information – could then be shared securely with each Partner on the MARAC prior to the meeting taking place. This disclosure form may allow – where necessary – information to be shared with institutions of Higher Education;
- Consider whether safeguarding training could be shared across the interface with higher education services within the CSP area to help share knowledge of local agencies and their threshold for providing support;
- To consider forging links with the Staffordshire and Stoke-on Trent CSPs to share their training across the interface with the Universities within their organisational footprint.

2. Firearms Licensing

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from the West Midlands Police that the DARA[3] is applied for first responders and the use of DASH is promoted as a dynamic assessment, specific to the client, used for conducting secondary risk assessments;
- Consider the development of a multi-agency assessment of firearms applications and invites the MARAC Governance Group to act as the assessing Panel;
- Invite the West Midlands Police to apply a resolution to any GDPR issues at the point of application by explicitly informing the applicant that their application will be referred to a multi-agency forum for assessment;
- Apply due diligence to a process whereby, as necessary, applications that may have potential for risk to transfer to children, colleagues, family members, etc.

[3] the Domestic Abuse Risk Assessment (DARA) has been identified by the College Professional Committee and the NPCC as the preferred risk tool for first responders to domestic abuse. The NPCC supports forces adopting the DARA for first responders to domestic abuse. The DARA has been designed and evaluated for use by first responders. Specialist police officers and staff conducting secondary risk assessment are expected to continue using the DASH. Similarly, as the DARA has been evaluated in a frontline policing setting, partner agencies are expected to continue to use the DASH.

to be referred to the appropriate safeguarding authority and the employee alert system across Dudley MBC

3. Adverse experiences in early adulthood

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from partners that trauma informed practice is being embedded across the Borough
- Assess the development of trauma informed practice, specifically for people seeking asylum

4. Use of the Pathfinder Toolkit and NICE Guidance.

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from all Partners that they have suitable and effective domestic abuse and safeguarding training which is available to their staff

5. Suicide and the impact on family and friends

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Establish links with the Black Country Healthcare NHS Foundation Trust and supports the Trust in its endeavour to secure 'real-time-surveillance' (RTS) data on suicide and supports the Trust to develop a plan to promptly deliver support to family and friends, as appropriate;
- Seek support and guidance from the Offices of HM Coroner to deliver the ambition to secure 'real-time surveillance' data and also to drive the delivery of the recommendations from the National Confidential Inquiry into Suicides and Mental Health (NCISH);
- Deliver these particular recommendations in tandem with the Recommendations made by the Panel for DHR-9, specifically:
    - To promote the connection between suicide and domestic abuse;
    - Include domestic abuse as an explicit priority within the suicide prevention strategy;
    - Ensure that the RTS system asks specific questions about domestic abuse.

6. Prescribing practice

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seek assurance from the Pharmacy Clinical Network that systems are in place to support safe and effective prescribing, particularly for drugs that can be abused and/or may lead to dependency

7. Hate Crime, Anti-Social Behaviour and Domestic Abuse

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Seeks assurance that all officers – Police, the ASB Team, housing services and others – consider domestic abuse when receiving referrals concerning hate crime and/or anti-social behaviour and vice versa; and
- That there are clear routes into appropriate services when hate crime and/or anti-social behaviour coupled with domestic abuse is identified.

8. Placing 'alerts' onto EMIS

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Establish links with IRISi and seek clarification for the decision to step-down the use of certain READ codes, which results in them no longer being promoted on the IRIS training;
- Invites IRISi to consider supporting the re-introduction of key domestic abuse related READ codes into the training programme;
- Ensure IRISi continues to promote in its training programme specific codes for people subject to a history of domestic abuse (14XD, 14X3); domestic abuse in the household (13Wd); being a victim of domestic abuse (14XG).

9. Family Safeguarding

The Panel invites 'Safe and Sound (the Dudley Community Safety Partnership) to:

- Work with the Children's Social Care Service to support the ongoing work regarding 'Think Family' and other 'strength based' models;
- Offer particular support to the implementation of "Family Safeguarding", which commenced within the Borough from July 2023;
- Encourage partners to work together and with other Partnerships (including the Safeguarding Board) to promote and deliver a programme to support the adoption of the 'Think Family' ethos and model of delivery.