Sandwell Partnership
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Safer Sandwell Partnership
Local Police and Crime Board

Safer Sandwell Partnership

Domestic Homicide Review

The murder of AB

Overview Report

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Section One – Introduction

1.1 What this review is about

1. All of those involved in this review and the Safer Sandwell Partnership pass their condolences to the family, friends and colleagues of AB. Our thoughts remain with you.

2. The use of pseudonyms in this report was discussed with AB's family. They preferred to use initials instead of pseudonyms.

3. This report of a domestic homicide review examines agency responses and support given to AB, a resident of Sandwell prior to her death in 2017.

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

5. AB was 26 years old at the time of her death and BB was 30 years old.

   In 2017, the police were called to an address in Sandwell local authority area, in the West Midlands. On arrival at the address, police officers were made aware that a deceased male had been found hanged and a woman, also found in the premises, was deceased having received head injuries. Neighbours had gone in to the house and found the bodies of AB and BB. They removed the children to another property whilst waiting for the ambulance and police to arrive.

6. Police established that the male (known for the purpose of this review as BB) was the husband of the female (known for the purposes of this review as AB). The police have established that BB had assaulted AB causing significant head injuries, resulting in her death. BB had then taken his own life by hanging himself. These events had occurred during the previous 15 hours.

7. The review will consider agencies' contact and involvement with AB and BB from 2006 until AB's death in 2017. This period covers all relevant contact AB had with agencies and the relationships in which she was engaged and enables the review panel to draw all possible learning from this tragic case. 2006 was the earliest date when there was information relevant to the review.

8. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide and, most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2 Timescales

9. This review began on 25th October 2017 and was concluded in February 2020. An initial report was presented to the DHR review panel on 8th February 2018. A report was received by the Safer Sandwell Partnership on 19th April 2018 and then forwarded to the Home Office for consideration. The DHR panel had previously made several attempts to make the victim's and perpetrator's families aware of the DHR report. It later transpired that the family of AB

had not been made aware of the final report and following liaison through Advocacy After Fatal Domestic Abuse (AAFDA) asked to meet with the reviewer. Following the involvement of the family, the Home Office Quality Assurance Panel considered an amended report on 22 May 2019 and provided feedback to Sandwell in July 2019. Following a period of further engagement with the family to confirm they agreed with the final amendments made, the report was finalised in January 2020 and re-submitted to Safer Sandwell Partnership which approved it in February 2020, prior to re-submission to the Home Office.

1.3 Terms of reference

10. The full terms of reference are inserted below:

Domestic Homicide Review in respect of AB
(Terms of Reference)

Relevant Family Members
[REMOVED TO MAINTAIN CONFIDENTIALITY]

1. Introduction

1.1. [FIRST SECTION REMOVED TO MAINTAIN CONFIDENTIALITY]

1.2. The information from partner agencies was shared with the DHR Standing Panel and Chair of the Safer Sandwell Partnership who, on 18th September 2017, decided that the criteria for holding a Domestic Homicide Review under Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004) was clearly met and directed that such a review be carried out into the circumstances surrounding this case. The Chair of the Safer Sandwell Partnership Board confirmed this on 18th September 2017.

1.3. The legislation requires that '**a Review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship'** should be held, with a view to identifying the lessons to be learnt from the death'.

1.4. The purpose of a Domestic Homicide Review is set out in section 2.7 of the statutory guidance issued by the Home Office to support the legislation (i.e., the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – December 2016). Primarily the purpose of a DHR is to 'establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims'.

2. Specified Time Period

2.1. All chronologies should cover your agency's involvement with the relevant family members in the period from 2006 until AB's death in 2017.

2.2. However, if during the course of your work you find relevant information outside of that timescale, you should highlight this and include it in your chronology/IMR.

3. Agencies Involved

3.1 Helpful reports are requested from the following agencies:

- West Midlands Police
- Kaleidoscope

4. Terms of Reference

4.1. The Terms of Reference for this DHR has a number of generic questions that must be clearly addressed in all reports.

4.2. The generic questions are as follows:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?
- Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator?
- Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse?
- Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?
- Did the agency comply with domestic violence protocols agreed with other agencies, including any information sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case?
- Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and the decisions made?
- Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered?
- Is it reasonable to assume that the wishes of the victim should have been known?
- Was the victim informed of options/choices to make informed decisions?
- Were they signposted to other agencies?
- Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been in place?
- Had the victim disclosed to any practitioners or professionals and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
- Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
- Were senior managers or agencies and professionals involved at the appropriate points?
- Are there other questions that may be appropriate and could add to the content of the case?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it

identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

- Did any staff make use of available training?
- Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?
- How accessible were the services for the victim and the perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?
- How has your agency implemented the West Midlands Domestic Violence Standards (link) and the Rape & Sexual Violence Standards?

5. DHR Panel

5.1. In accordance with the statutory guidance, a DHR Panel has been established to oversee the process of the review. An independent person has been appointed to Chair the Panel and to write an Overview Report that will be submitted to the Home Office at the conclusion of this review.

5.2. It is the responsibility of the DHR Panel to 'quality assure' all reports submitted, and authors should understand that their reports may be returned for further work if the Terms of Reference are not adequately addressed or if they fall below the required standard in other areas.

5.3. Subsequent versions of the reports should be clearly marked Version 2, Version 3, etc., with the date of the latest submission.

6. Disclosure and Criminal Proceedings

6.1 There are no ongoing criminal proceedings in respect of any persons in this case. It is therefore not necessary for this DHR to address the issues of 'third party material' as defined in the Code of Practice accompanying the relevant legislation i.e., The Criminal Procedures and Investigations Act (1996) and there are no obstacles to proceeding with all aspects of the DHR.

7. Involving of Family Members/Friends

7.1. The Safer Sandwell Partnership is fully committed to enabling relevant family members and friends to participate in this DHR, believing that their intimate knowledge of the victim and alleged perpetrator can only enhance the panel's knowledge about the circumstances surrounding AB's death and thus improve their chances of identifying any lessons that will improve safeguarding services as a consequence.

7.2. The Chair of the DHR Panel will identify relevant family members and friends and write to them, advising that this review has been established and that they will be invited to participate at the appropriate time.

8. Timescales

8.1. Timescales for submission of the IMR's and the helpful reports will be set out in these Terms of Reference and these dates must be adhered to as far as possible. The target for completion of the DHR is February 2018 as set out in the statutory guidance i.e., six months after the date of written notification from West Midlands Police to the Chair of

the Safer Sandwell Partnership. It is imperative that submission dates are adhered to as any delay in receiving reports and chronologies from agencies runs the risk of compromising our ability to meet the timescale.

Any changes to the timescale will be notified to partner agencies.

1.4 Methodology

11. The circumstances under which a Domestic Homicide Review (DHR) must be carried out are described in legislation and national guidance. The relevant legal requirement is the Domestic Violence, Crime & Victims Act (2004) Section 9, that came into force on the 13th April 2011. The national guidance is described in *Multi-agency statutory guidance for the conduct of domestic homicide reviews* that was revised in 2013.

12. A domestic homicide review must analyse the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were or had been in an intimate personal relationship, or a member of the same household as themselves.

13. The circumstances of the victim's death in this case, were referred to the DHR Standing Panel of the Safer Sandwell Partnership, following notification of the incident by West Midlands Police. The DHR Standing Panel made a recommendation to the Safer Sandwell Partnership that the circumstances of this case met the criteria for a domestic homicide review to be undertaken. They agreed and initiated the DHR process.

14. The review has been conducted in a manner that ensures:

    - A proportionate approach is taken to the DHR;
    - it is independently led;
    - professionals who were directly involved with the case are fully engaged with the review process;
    - families, friends and colleagues are invited to contribute.

15. The agencies listed in 1.6 were asked for any contacts with the subjects in this review and a chronology was produced. Given the limited contact any agency had with AB and BB agencies were not asked for Individual Management Reviews (IMRs), however West Midlands Police and the Kaleidoscope Plus Group provided helpful reports.

16. These documents were analysed and used as basis for the report.

17. The review also refers to interviews conducted with friends, neighbours, work colleagues and family members.

18. Research was conducted in specific areas.

1.5 Involvement of family, friends, work colleagues, neighbours and wider community

19. The reviewer spoke directly to the mother of BB who had requested very limited engagement with the review process.

20. AB's family had the benefit of an advocate provided by AAFDA. Unfortunately, due to an administrative error, letters for AB's mother were sent to an incorrect address and as a result

AB's family were interviewed late in this process. The reviewer has explained this issue to the family who understand the position. The family of AB were very helpful in providing an insight into the life and circumstances of AB and we are very grateful for their engagement.

21. All of those involved in the process have received the relevant Home Office literature.

22. Contributors have been able to become involved in the case in whatever way they wished and all those affected are aware of support they might access.

1.6 Contributors to the review

23. The DHR Panel asked for details of agency contact with either AB or BB from the following agencies:

Organisation	**Summary report requested & submitted on agency's contact with victim, perpetrator and family**	**Detailed report requested & submitted**
West Midlands Police	✓	✓
Sandwell & West Birmingham Clinical Commissioning Group	✓	
Sandwell and West Birmingham Hospitals Trust	✓	
Birmingham Women's and Children's NHS Trust	✓	
Black Country Partnership NHS Mental Health Foundation Trust	✓	
Sandwell Metropolitan Borough Council Education Department	✓	
Birmingham Community Healthcare Trust (Sandwell School Nursing Service)	✓	
Sandwell MBC Children's Social Care	✓	
Black Country Women's Aid	✓	
Kaleidoscope Plus Group		✓

24. It was established that there was limited contact with most of these agencies and IMRs would serve no useful purpose in this case. However, further reports were requested from and prepared by the following agencies:

- West Midlands Police submitted a report detailing their investigation and contact with AB and BB;
- Kaleidoscope Plus Group submitted a report detailing contact with AB prior to 2014.

1.7 The review panel members

25. A DHR Panel was formed, chaired by Stephen Ashley. It consisted of the following membership:

Independent Chair and Author
Domestic Abuse Team Manager - Sandwell MBC

Executive Director - Black Country Women's Aid
Designated Nurse Child Death - Sandwell and West Birmingham CCG
Domestic Abuse Incidents Review Coordinator - Sandwell MBC
Head of Adult Safeguarding - BCPFT (Mental Health Trust)
Domestic Abuse Team Administrator - Sandwell MBC
Safeguarding Children Lead Nurse - Sandwell and West Birmingham Hospitals NHS Trust
Detective Inspector - West Midlands Police
Divisional Manager Adult Services - Sandwell MBC (Observer)

The panel members had no connection to the case and were independent.

The panel met on 4 occasions.

1.8 Chair/Author of the overview report

27. The Chair and author of this review was Stephen Ashley who was entirely independent of agencies in Sandwell. He has extensive experience in the compilation of high-level reports into safeguarding issues, having been a senior police officer in Merseyside and Lancashire for thirty years working as a senior investigating officer and for Her Majesty's Inspectorate of Constabulary with responsibility for inspections relating to vulnerable adults, children and domestic abuse. He has conducted several serious case reviews and is the independent chair of two safeguarding children boards and an adult safeguarding board.

28. Mr Ashley is entirely independent of Sandwell and the agencies involved in this review and has not been employed by any agency in Sandwell or the West Midlands region.

1.9 Parallel reviews

29. A police investigation was undertaken, and a report presented to the coroner. The documents obtained in that investigation were used by the reviewer.

1.10 Equality and diversity

30. The review considered the nine protected characteristics under the Equality Act 2010 (age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation). AB was female, and BB was male. AB and BB were married to each other. Data shows that two women per week are murdered by their current or former partners in England and Wales. AB was mixed race and BB was White British. It is not known whether they had a religious faith and there was no evidence that religion was a relevant factor in this case. AB was 26 years old at the time of her death and BB was 30 years old, neither had any known disabilities.

1.11 Dissemination

31. The full final draft DHR was shared with the victim's mother at her request and her comments were welcomed and incorporated into the final document. Once agreement for the final report has been given by the Home Office Quality Assurance Panel, the DHR report will be available on the council website. The DHR report will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 1998.

32. All organisations involved with the review will receive a copy of the DHR report. The Safer Sandwell Partnership and Domestic Abuse Strategic Partnership are committed to

disseminate the learning and recommendations in learning forums with other partner agencies involved with responding to domestic abuse.

Section Two – The facts of the case

2.1 Background information

33. At the time of her murder AB was living in the home she shared with her husband, BB, and their 3 children. AB and BB had been in a relationship since 2014 and married in 2017.

34. In 2017 the police were called to the home where the bodies of both AB and BB had been found by a neighbour. The children had been present in the house at the time of their parents' deaths. There were no direct witnesses to what had occurred.

35. In addition, the pathologist noted that blood tests showed that BB had used cocaine and alcohol on the evening prior to his death.

36. In the case of AB, the pathologist stated that the possibility of AB being under the influence of any such substance at the time of her death can be ruled out.

37. The Coroner later determined that AB had been murdered by BB and BB had then taken his own life.

2.2 Chronology

2.2.1 The circumstances of AB

38. AB was mixed race. There is little documentation relating to AB. AB had received counselling following a referral to Child and Adolescent Mental Health Services (CAMHS) by her General Practitioner (GP) when she was 14 years old. She felt bullied, suffered from panic attacks, had low self-esteem and suicidal thoughts. AB was prescribed anti-depressants at that time.

39. In 2009 AB was in a relationship with an Asian male (this is a relevant factor in this case) and became pregnant. At this time, she was living in the West Midlands with her mother, step-father and sister. AB stated to midwives that she had a supportive family and partner. AB gave birth to a child in 2009. The relationship with her child's father deteriorated and AB later described it as controlling and emotionally abusive. AB's only contact with the police occurred when they were called to a dispute between AB and the child's father. The police reported that the dispute did not involve physical abuse and there was no further police action. It seems that AB did not report any of the controlling or emotionally abusive elements of the relationship to the police.

40. The relationship had ended by the time AB's child was 4 years old. In 2014 AB undertook further counselling sessions. AB stated she had been bullied at school and had been in an emotionally abusive relationship. She continued to have panic attacks and a very negative view of her life. AB stated that she continued to fear her previous partner, even though he no longer had contact with her or her child.

41. After 4 months AB stopped attending counselling sessions and, despite efforts to maintain a service, she declined further sessions. It would appear this coincided with the start of her relationship with BB in the late summer of 2014. It seems they had known each other for a number of years but had not previously been in a relationship.

42. There is no evidence from agencies relating to the relationship between AB and BB, except the contact with maternity services when AB was pregnant. AB and BB married in February 2017. They lived together with the 3 children.

43. AB gave birth to a child in 2015 and another child in 2017. BB was registered as the father of both children. Both pregnancies progressed well with no extenuating circumstances. The maternity services were aware that she had previously suffered mental health issues but raised no issues in their standard documentation.

44. In both pregnancies, AB should have been asked if there were any issues relating to domestic abuse. These are standard questions contained in the ante-natal questionnaire. This question was not asked on either occasion. There is confusion as to why this question was not asked given that on one occasion AB attended with her mother and not BB. Whilst practitioners reported that this was often a difficult issue to tackle with women, it is nevertheless important that questions regarding domestic abuse are routinely asked by health professionals when women attend maternity appointments.

Learning Point One

Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth. Domestic abuse during pregnancy puts the woman and unborn child in danger. It increases the risk of infection, miscarriage, premature birth, and injury or death to the baby. It can also cause women to experience emotional and mental health problems, such as stress and anxiety, which can also affect the development of the baby. Maternity and midwifery services are well-placed to identify domestic abuse and ensure that victims receive appropriate advice and support. Sandwell and West Birmingham NHS Trust and Birmingham Women's Hospital Maternity Services use a set of 'Routine Enquiry' questions when undertaking ante-natal checks. One of these questions specifically asks about the relationship with the father, which might elicit whether domestic abuse is an issue. In the case of AB, that question was not asked in either of her pregnancies.

45. Health partners should have knowledge of, and refer to, the Department of Health learning resource: *"Responding to Domestic Abuse – A resource for health professionals"* published in March 2017. This document provides a learning resource for health professionals giving a practical insight and tools that health professionals need when speaking to women about their relationships. Section 4.3 of that document gives details of how professionals should conduct sensitive enquires, and how to ask direct questions relating to domestic abuse. Health professionals did not appear to use this guidance when speaking with AB.

Learning Point Two

The Department of Health document: "Responding to Domestic Abuse – A resource for health professionals", provides practical guidance for frontline health professionals when asking questions about domestic abuse. There is no evidence that this tool was used when dealing with AB in either of her pregnancies.

46. In both pregnancies, AB went on to have normal deliveries and was dealt with by universal services. There is no record of any relevant events that could be regarded as 'out of the ordinary'.

47. There was no reported contact with any agency, other than universal services, at any point from the birth of her second child until her murder. Police interviews with friends and family do not reveal any unusual or abusive behaviour. In fact, a number of BB's family members described BB's relationship as *"close and loving".* This was not a view shared by AB's family who had a difficult relationship with BB. In hindsight, they also considered that he was a controlling individual. Neighbours did not report any unusual behaviour or evidence of abuse. GP records do not reveal anything more than routine visits and there were no reports of issues with the three children.

48. AB worked at a local company but was on maternity leave at the time of her murder. It seems that there had been some concerns amongst work colleagues about the relationship between AB and BB. There was occasional evidence of minor bruising which AB stated had been caused by her children. AB refused to train an Asian male because she said there would be *"consequences"*, but it would be alright for her to train a white male. AB's previous partner was Asian, with whom she had a child. AB later described this relationship as controlling and abusive. It appears that BB was jealous of this relationship, even though it had ended several years previously, there was no contact between them, and AB and BB had subsequently married. Consequently, AB felt that she could not work directly with Asian men as BB would not be happy about this.

49. AB did confide in work colleagues about emotional abuse but did not describe any physical violence. AB described how BB could easily become very jealous and she was found crying and said it was because she thought BB might leave her and she would be destitute. There was some evidence of controlling behaviour by BB, as colleagues were aware that she was *"required"* to text BB on her arrival at work and at intervals during the working day. They also noted she had stopped wearing make-up and talking to men at work.

50. At no time did AB make specific allegations of abuse to her colleagues and, whilst colleagues identified that BB might be a risk, they did not receive information or see signs that would give them grounds to be more pro-active.

Learning Point Three

If someone suspects that a family member, friend or colleague is in an abusive or unhealthy relationship, it can be difficult to know what to do. There is online guidance available on what can be done and local specialist support organisations like Black Country Women's Aid can also provide advice. This can focus on how to best have a conversation and support a friend, relative or colleague in an informed and non-judgemental way which allows the victim to make their own decisions and identify possible options and solutions. More could be done to promote the guidance available to friends and family.

51. In mid-2017, there was no information provided that suggested AB was at a high risk from BB. AB's mother is perhaps the best person to describe AB and her relationship. She believed that AB *"adored"* BB and the children. She acknowledged that AB was shy and lacked confidence and did not particularly socialise, preferring to spend her time with the family.

Whilst AB's mother had noted some issues of concern as described below she did not believe AB was at risk from BB. There was no evidence AB drank alcohol or took drugs.

52. When talking to the family of AB it became apparent that, with hindsight, there were issues that were concerning.

53. AB's mother was able to describe how AB was always immaculately dressed and would take considerable time each morning to straighten her hair and apply make-up. AB took great pride in the way she dressed and how she looked. Once the relationship with BB began there was a deterioration in this aspect of her life and AB's mother was under the impression that AB had been told by BB that he did not want her to *"dress up"*.

54. AB's mother also recalls that on one occasion AB had a number of bruises including one on her face. However, when questioned she had provided a plausible explanation. AB's mother accepts that her view is clouded by hindsight, but she looks back and feels that *"there was something not right"* in the relationship between AB and BB.

55. BB also decided that they would move from the relative closeness of AB's family and this isolated AB.

56. Following AB's death AB's mother was given letters and cards that AB had kept which had been given to her by BB. They contain an insight in to the relationship. BB sent many cards and letters apologising for his behaviour and in particular his jealousy. He also stated that he wanted to stop taking drugs. However, in many of the letters he states that to help him do this AB needed to *"stop winding him up"* and had to "*play her part".* This is another indicator of controlling behaviour.

57. As described above, work colleagues were, on some occasions, concerned about her and the relationship with BB. Minor bruising was given a plausible explanation and, whilst AB made it clear her husband could be jealous, particularly of Asian men (probably because of her first relationship), she did not provide any solid evidence of abuse. This left her colleagues in a difficult position. Ultimately, they did not have enough evidence to be pro-active and when various colleagues took time to listen and comfort her, she was not at all specific in what was occurring in the household.

58. This controlling behaviour was later supported by the police investigation that established that AB had called BB 684 times during a one-month period in 2017.

Learning Point Four

Whilst there is limited evidence that AB had been physically assaulted by BB prior to her murder there is clear evidence of coercive and controlling behaviour by BB. It is unclear whether family and work colleagues understood that this was occurring and the effect on AB. This case has identified that there is often a lack of understanding of coercive and controlling behaviour and the damage this abuse does to victims. There needs to be an increase in the awareness and understanding of this type of abuse and the ways in which it can be identified.

2.2.2 The circumstances of BB

59. There has been little information provided about BB. BB was of White British ethnicity. He was 3 years older than AB and had known her since she was 16 years old, although their

relationship did not start until 2014. BB worked as an HGV driver away from home during the week and returned home at weekends.

60. A close friend described BB as: *"a happy person, a real joker, and a fun-loving guy"*. He was not known to be violent or become angry. BB had been cautioned by the police for a criminal damage offence in 2009 but that incident had no relevance to this case, and he had no other recorded contact with the police. Another friend stated that AB and BB seemed very happy together. There is no evidence from friends or family that he posed a risk to AB. There is no relevant GP record suggesting any issues.

61. There was evidence at the scene of the murder that BB used both cocaine and alcohol, but this is not mentioned by any friends or relatives who deny knowing about the problem.

2.2.3 The circumstances of the murder of AB

62. The following information is from police information at the time of the murder investigation. In 2017 BB and his brother were at AB and BB's home playing computer games and drinking: *"a few cans".* The results of the post mortem examination also make it clear that BB was using cocaine at this point. AB was also in the house with their children. During the evening, BB's brother stated to BB that AB had received a text message which she did not show to BB. It is clear from the subsequent police investigation into the murder that this text did not exist, as there were no SMS messages sent to AB's phone that evening. At approximately 9pm AB took the children for their baths and put them to bed. At this point BB's brother states he told his brother the content of the text message which he said read: *"Can you meet me, and [AB] replied I will when he is asleep".* BB's brother got the impression this made BB: *"very angry".* Given AB was not known to socialise, she had just put the children to bed and her husband was in the house, it lacks credibility to believe that she would have left the house, without explanation, to meet another person.

63. BB's brother then left the address in a taxi. At approximately 7am the following day BB's brother received a text from BB saying: "I have hit [AB] with a hammer". He thought he was joking and replied: "knobhead".

64. At approximately 1pm on that Saturday afternoon a neighbour was alerted. Neighbours went in to the house and found the bodies of AB and BB. They removed the children to another property whilst waiting for the ambulance and police to arrive.

65. A post mortem was conducted on AB and BB and it was established that AB had received serious head injuries and had also been asphyxiated. BB had hanged himself.

66. AB was not found to have consumed any alcohol or drugs but there were concentrations of cocaine in BB's blood system and evidence he had consumed alcohol. A note was found at the scene that read: "Didn't mean to do it, sorry".

67. Police concluded that BB had murdered AB and then hanged himself.

68. During the scene examination by the police, 8 handwritten letters were recovered, the author of the letters appears to be BB, who signs some of them with his nickname. In the letters, he declares the love he has for AB, but also says he is always searching for problems and it may be: "all down to his head". In other letters, he suggests that he will not touch another drug again. He states that he is depressed and is struggling to cope, he is scared he is going to lose AB. He also states that he knows he blames AB a lot, he needs to learn to trust her, and he has turned into a "jealous control freak".

69. The letters are not dated, but in comparison with handwriting on the suicide note, it would appear that BB is the author.

70. The police enquiry considered the possible motive for the murder was that AB may have been having an affair. It is suggested that AB had text messages on her phone from a male she was arranging to meet later that night.

71. AB had an iPhone. The handset was submitted to the Metropolitan Police and the results showed AB had no text messages held in the iPhone to suggest she was having an affair. The only WhatsApp contact she had was BB.

72. The call data on AB's phone was examined over the summer period and the only numbers she contacted were friends and family. The top contact in her call data is BB.

73. **There were no SMS messages sent to AB's phone during the evening in 2017 when she was murdered.**

74. Police concluded that from the examination of AB's call data, she was not having an affair.

75. There seems little doubt from his own letters and comments that BB could be jealous and controlling. BB's brother told him about an alleged text message and even in normal circumstances it is likely that BB would have become angry and jealous. This, combined with the fact that he had been using cocaine and alcohol, provoked a more extreme reaction.

Learning Point Five

The use of cocaine, especially when combined with alcohol, can cause increased levels of paranoia and violent behaviour. It is important to note, however, that AB was murdered, not because of BB's use of substances, but due to his coercive and controlling behaviour. Whilst drugs and alcohol can exacerbate abusive behaviour, the underlying reason for that behaviour is the use of power and control. Professionals need to be aware of these issues when completing risk assessments and responding to incidents of domestic abuse.

2.3 Overview

76. Agencies had very limited contact with either AB or BB, other than universal services. There was no evidence provided to the review that friends, family or work colleagues could have known that AB was in an abusive relationship.

77. It is however clear that BB did exert coercive control over AB. There is little evidence that AB was subject to physical abuse. There were no reports by anyone to the police, or any other agency, by AB or any third party that AB was suffering from domestic abuse.

78. BB was a jealous individual who often used alcohol and cocaine. When BB's brother said that he had seen a text on AB's phone, indicating she would meet a man, this appears to have been enough to trigger the jealous and controlling behaviour he had previously shown and on this occasion that resulted in a premeditated and sustained assault and murder of AB.

79. There was no evidence of any sort that AB was engaged in an intimate relationship with any individual other than her husband.

Section Three - Analysis

3.1 Learning points

3.1.1 Learning point one

80. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth. Domestic abuse during pregnancy puts the woman and unborn child in danger. It increases the risk of infection, miscarriage, premature birth, and injury or death to the baby. It can also cause women to experience emotional and mental health problems, such as stress and anxiety, which can also affect the development of the baby. Maternity and midwifery services are well-placed to identify domestic abuse and ensure that victims receive appropriate advice and support. Sandwell and West Birmingham NHS Trust and Birmingham Women's Hospital Maternity Services use a set of 'Routine Enquiry' questions when undertaking ante-natal checks. One of these questions specifically asks about the relationship with the father, which might elicit whether domestic abuse is an issue. In the case of AB, that question was not asked in either of her pregnancies.

81. The Routine Enquiry question should have been asked. The fact that in both of her pregnancies, in 2015 and 2017, this question was overlooked is of concern. It is perhaps understandable that where the partner is present it is not appropriate to ask the question around domestic abuse, which might illicit a lie or cause an issue for the pregnant partner. Tools are available to assist with this process. It is incumbent on the practitioner to find a safe way of asking this question in every case. Policies and training make it clear that this is an expectation, but supervision needs to be improved to ensure it is not overlooked.

3.1.2 Learning point two

82. The Department of Health document, "Responding to Domestic Abuse – A resource for health professionals", provides practical guidance for frontline health professionals when asking questions about domestic abuse. There is no evidence that this tool was used when dealing with AB in either of her pregnancies.

83. The Department of Health learning resource, "Responding to Domestic Abuse" is simple to use and provides the information that frontline professionals need to talk to women in an open way and discuss their relationship. There is guidance on how to acquire information in circumstances where a partner wishes to be present. Health agencies must ensure their frontline practitioners are aware of and have access to this document.

84. A previous DHR in Sandwell (published on 11 June 2019) recommended that all staff across the health economy are familiar with this document and provide evidence of the use of this guidance by health professionals and outcomes achieved. It also raised the issue of health professionals' understanding of how to ask women routine questions about their experience of domestic abuse. The local Clinical Commissioning Group undertook the following action:

"Safeguarding Training to be provided for clinicians in primary care settings on how to approach difficult topics with patients to include the toxic trio, the impact of alcohol misuse on parenting capacity and the signs, symptoms and behaviours children may display when living in a household where there is domestic abuse, and record keeping."

85. Work is underway on these actions and it is critical that these recommendations are fully implemented.

3.1.3 Learning point three

86. If someone suspects that a family member, friend or colleague is in an abusive or unhealthy relationship, it can be difficult to know what to do. There is online guidance available on what can be done and local specialist support organisations like Black Country Women's Aid can also provide advice. This can focus on how to best have a conversation and support a friend, relative or colleague in an informed and non-judgemental way which allows the victim to make their own decisions and identify possible options and solutions. More could be done to promote the guidance available to friends and family.

87. **Furthermore, employers in the area would benefit from the 'Employer's Initiative' on domestic abuse and 'Business in the Community' toolkit on domestic abuse to ensure an understanding by employees of the signs of domestic abuse and in particular the signs of coercive and controlling behaviour in relationships.**

88. In this case, there were few signs that AB may have been in an abusive relationship. Close friends and family of both AB and BB did not believe BB was abusive or that he posed a threat to AB. However, all of those interviewed believed that AB was to some extent vulnerable. She had previously suffered abuse and been in a relationship which was abusive. As an individual, AB was vulnerable and did not present as confident or mentally strong. She was on maternity leave and a reduced salary at the time of her murder as well as being a new mum. These things would have added to her vulnerability. For example, her reduced income may have made her more financially reliant/dependent on him. Also, as a new mother, she would need more support with the care-giving of the other children, given her probable lack of sleep and her need to focus more of her time to meeting the needs of a baby.

89. Work colleagues were, on some occasions, concerned about her and the relationship with BB. Minor bruising was given a plausible explanation and, whilst AB made it clear her husband could be jealous, particularly of Asian men (probably because of her first relationship), she did not provide any solid evidence of abuse. This left her colleagues in a difficult position. Ultimately, they did not have enough evidence to be pro-active and when various colleagues took time to listen and comfort her, she was not at all specific in what was occurring in the household.

90. The reviewer explored with both the mother of AB and her work manager whether there were reasons why AB did not report the abuse she suffered. In the case of her work colleagues, including her supervision, there was evidence that colleagues had shown concern and offered her the opportunity to discuss what was happening at home. It should be acknowledged, however, that many victims do not want to discuss their private life within a work setting for fear of repercussions or being treated differently or their status, reputation and authority affected. Whilst in hindsight her colleagues realised she may have been subject to abuse, they did not believe they had the evidence or confidence to broach the subject directly with her or know what to do or who to refer for help and support. It is clear that AB did not have the type of character where she wanted to proactively share personal issues with her colleagues and many of them remain traumatised by this case, knowing that AB was suffering abuse and they had not identified that soon enough.

91. The evidence is that whilst colleagues of AB and her line management were sympathetic and willing to support AB. they did not appreciate or understand the degree of coercive and controlling behaviour she was subject to. The explanation for minor injuries appeared reasonable and again there was not the evidence or confidence to ask AB direct questions about her relationship. The 'Employers Initiative' scheme would provide support for employers in Sandwell and would be a useful tool to help employers and colleagues understand signs of domestic abuse and develop ways of dealing with the issues of domestic abuse in all its forms.

92. It appears that in this case there were colleagues who lacked the confidence to raise the issue of domestic abuse with AB and a vulnerable individual who lacked the confidence to raise the issue with her colleagues or family.

93. AB's employer has undertaken staff training around domestic abuse issues. They and other employers in the area would benefit from further work with the 'Employer's Initiative' on domestic abuse and the 'Business in the Community' toolkit on domestic abuse. This may help to ensure an understanding by employers and employees of the signs of domestic abuse and in particular the signs of coercive and controlling behaviour in relationships.

94. This reluctance to discuss issues of domestic abuse extended to her immediate family. AB's mother remains confused by the fact AB never raised the issue of domestic abuse. When AB's mother started to become concerned that the relationship between AB and BB may not be entirely happy, she raised the issues with AB who reassured her that everything was fine in their relationship and AB's mother stated she "laughed off" the idea that there could be any form of domestic abuse taking place. However, it is well known that 'disguised compliance' is common, where victims may minimise the abuse they are experiencing as they are fearful of professional involvement. AB may also have been worried about disclosing the abuse to her family.

95. It is clear that for family and friends of AB the issue of domestic abuse related almost entirely to physical injury. There was a clear lack of understanding of the damage that coercive and controlling behaviour would have on a victim. Even though her family may be familiar with the physical aspect of domestic abuse, it is clear that there is a difficulty in raising the issue of domestic abuse as victims can feel embarrassed or feel judged. Whilst perpetrators attempt to isolate victims from family and friends, challenging the behaviour can cause victims to withdraw. This is a very delicate line to tread. It may also be that the victim herself did not understand that she could seek help for her family when subjected to this type of behaviour.

96. AB did not approach any services that are available to victims and survivors of domestic abuse in Sandwell. Many victims can perceive barriers to reporting domestic abuse or seeking help. These can include:
    - Many victims can feel ashamed of the abuse and wrongly feel it is their fault, which the perpetrator reinforces by blaming the victim for his behaviour
    - Many victims with children feel they have a responsibility to stay with the perpetrator for the sake of the children
    - Self-esteem can be so low that the victim believes that they are nothing outside of the relationship or believe they deserve the abuse
    - Victims can maintain the hope that the non-abusive part of their relationship is real and enduring and that the abuse is a one-off
    - The loneliness and stress of building a new home, gaining a source of income, establishing a new life for the victim and their children can be too much

    Some of these barriers may have prevented AB from seeking support.

97. There are many services available and the Community Safety Partnership, Safeguarding Adults Board and Children's Safeguarding Partnership have undertaken considerable work in this area. These are detailed on public websites and are easily accessible. Some details are outlined below.

98. The subject of domestic abuse is, and has to remain, high on the agenda for the Safer Sandwell Partnership. Domestic violence is a priority for the partnership, and they work closely with Black Country Women's Aid.

99. The Safer Sandwell Partnership has conducted a huge amount of work to inform the public about domestic abuse. In summary, they have:

- Put in place a Domestic Abuse Strategic Partnership (DASP) that analyses performance data and has in place a domestic abuse delivery plan with clear actions and timescales;
- provided significant funding for work to address domestic abuse;
- produced progress reports for the children and adult safeguarding boards;
- in May 2016 produced an analysis on MARAC outcomes which was presented to the DASP and Safer Sandwell Partnership. An updated report was presented in May 2018;
- conducted an evaluation of the use of IRIS domestic abuse intervention in GP surgeries;
- the University of Birmingham have evaluated the Brighter Futures domestic violence perpetrator programme;
- they have also conducted high profile campaigns in the local media and conducted poster campaigns including bill boarding across the area highlighting the 'This isn't love – Love shouldn't hurt' campaign;
- supported a range of events supporting White Ribbon Day 2017; 2018 and 2019;
- supported the UN's 16 Days of Action campaign against violence against women and girls
- Sandwell's Safer 6 campaign included a focus on domestic abuse, promoting support services for victims and families
- Produced an awareness raising video on domestic abuse and controlling behaviour: www.sandwell.gov.uk/TinasStory

100. In each of these areas there has been significant work to understand impact. Agencies in Sandwell have demonstrated that they take domestic abuse seriously and have consistently invested in training and campaigning. AB's employers have in place processes for staff and provide welfare and support for their staff in a personal and professional way. They are proactive in working with all partners in all sectors to improve identification and support.

101. It is essential that the work conducted by the Safer Sandwell Partnership continues with regard to domestic abuse and, in particular, this work is coordinated with both the children's safeguarding partnership and adults safeguarding board. Further work could be done to encourage local employers to engage in the 'Employer's Initiative' and use the 'Business in the Community' toolkit on domestic abuse; and to promote guidance available to friends, relatives and colleagues on what to do if they suspect domestic abuse. Recommendations 4 and 5 address this.

3.1.4 Learning point four

102. Whilst there is limited evidence that AB had been physically assaulted by BB prior to her murder there is clear evidence of coercive and controlling behaviour by BB. It is unclear whether family and work colleagues understood that this was occurring and the effect on AB. This case has identified that there is often a lack of understanding of coercive and controlling behaviour and the damage this abuse does to victims. There needs to be an increase in the awareness and understanding of this type of abuse and the ways in which it can be identified.

103. In September 2012 the Government introduced a new domestic abuse offence in Section 76 of the Serious Crime Act 2015. The offence was controlling or coercive behaviour in an intimate or family relationship and carries a penalty of up to five years in prison, as well as a fine.

104. While the previous legislative framework had failed to recognise coercive control as a form of domestic violence, the coercive or controlling behaviour offence introduced a whole new set of behaviours that could be classed as domestic abuse.

105. Coercive control is defined as ongoing psychological behaviour, rather than isolated or unconnected incidents, with the purpose of removing a victim's freedom.

106. The Government definition also outlines the following:

"Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

"Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour."

107. There is no doubt on the evidence contained in this review that BB was engaged in coercive and controlling behaviour over AB. It is also clear that whilst both AB's family members and work colleagues were in many ways uncomfortable about the relationship between AB and BB, they were unable to articulate this and did not feel there were sufficient grounds to report their concerns to any agency or organisation.

108. Whilst physical abuse is often easier to identify and is often so abhorrent to people that they will take some form of action, coercive and controlling behaviour is often a factor underpinning this behaviour but can be more difficult to identify. In this case, work colleagues offered support as did the employer. AB's mother questioned AB about minor injuries but never had enough information to take action.

109. Crown Prosecution Service guidance on this issue states:

"Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship. Prior to the introduction of this offence, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within an intimate relationship (the Statutory Guidance cites the following cases - Curtis [2010] EWCA Crim 123 and Widows [2011] EWCA Crim 1500).

110. The new offence, which does not have retrospective effect, came into force on 29 December 2015.

An offence is committed by X if:

- *X repeatedly or continuously engages in behaviour towards another person, Y, that is controlling or coercive; and*
- *At time of the behaviour, X and Y are personally connected; and*
- *The behaviour has a serious effect on Y; and*
- *X knows or ought to know that the behaviour will have a serious effect on Y.*

X and Y are 'personally connected' if:

- *they are in an intimate personal relationship; or*

- *they live together and are either members of the same family; or*
- *they live together have previously been in an intimate personal relationship with each other.*

There are two ways in which it can be proved that X's behaviour has a 'serious effect' on Y:

- *If it causes Y to fear, on at least two occasions, that violence will be used against them - s.76 (4)(a); or*
- *If it causes Y serious alarm or distress which has a substantial adverse effect on their day-to-day activities - s.76 (4) (b).*

For the purposes of this offence, behaviour must be engaged in 'repeatedly' or 'continuously'.

Another, separate, element of the offence is that it must have a 'serious effect' on someone and one way of proving this is that it causes someone to fear, on at least two occasions, that violence will be used against them. There is no specific requirement in the Act that the activity should be of the same nature. The prosecution should be able to show that there was intent to control or coerce someone.

The phrase 'substantial adverse effect on Y's usual day-to-day activities' may include, but is not limited to:

- *Stopping or changing the way someone socialises*
- *Physical or mental health deterioration*
- *A change in routine at home including those associated with mealtimes or household chores*
- *Attendance record at school*
- *Putting in place measures at home to safeguard themselves or their children*
- *Changes to work patterns, employment status or routes to work*

For the purposes of the offence X 'ought to know' that which a reasonable person in possession of the same information would know - s.76 (5)."

111. This section is worth repeating in this review because it is clear that if investigated it is likely BB would potentially have faced a charge under section 76. In this case AB suffered coercive and controlling by BB. This was evidenced by the fact that he:
    - required AB to 'check in', resulting in excessive text messaging;
    - required AB to change her lifestyle with AB by not taking time on her appearance;
    - demanded what AB could do at work;
    - made, through letters left at the scene of his suicide, an admission that he was jealous and controlling;
    - isolated AB from her family.

    Whilst this behaviour raised some level of suspicion by AB's family members and work colleagues, it was not sufficiently recognised for what it was and as a result no action was taken.

112. The problem appears to be that whilst domestic abuse is now better understood by agencies and the general public, coercive control is not well understood and can be difficult to identify. It is clear that more work needs to be done to highlight this issue.

113. In Sandwell, a previous DHR (published 6 February 2019) was conducted that considered the issue of coercive behaviour and the following recommendations were made:

    "Recommendation One
    All professionals need to develop an understanding of coercive and controlling behaviour and recognise and identify the dynamics of those behaviours as they manifest themselves,

both within a personal relationship and the family. They need an ability to challenge those behaviours as they appear and respond appropriately.

Recommendation two
To improve Community Safety, we should seek to raise awareness of the significant adverse impact of coercive control in relationships so that not only victims are better able to recognise they are experiencing this form of domestic abuse and seek help and support, but also their community, family, friends and colleagues are equipped to identify safe and effective pathways to provide that support

Recommendation Three
As part of integrated professional practice, the agencies listed should be able to demonstrate that consideration of possible coercive controlling behaviour has formed part of assessments, interventions and planning."

114. These recommendations remain relevant and the Sandwell Safer Partnership should ensure they have been implemented. Recommendation 7 in this report addresses this.

3.1.5 Learning point five

115. **AB's family firmly believe that AB's murder was pre-planned and pre-meditated, as information from the police investigation indicated that the weapons used were not readily available and would have required premeditated action to retrieve and use them. The role that BB's use of substances had on his behaviour that evening will never be fully known or understood. BB may have intended to murder AB, regardless of whether he was under the influence of cocaine and alcohol. His use of these substances may well have given him courage to carry out a murder he had already intended to carry out. It is therefore important to note that AB was murdered, not because of BB's use of substances, but due to his underlying coercive and controlling behaviour. However, it is noted that the use of cocaine, especially when combined with alcohol, can cause increased levels of paranoia and violent behaviour. Whilst drugs and alcohol can exacerbate abusive behaviour, the underlying reason for that behaviour is the use of power and control. Professionals need to be aware of these issues when completing risk assessments and responding to incidents of domestic abuse.**

116. The use of alcohol and/or cocaine is not an excuse for a perpetrator of domestic abuse. It is also not a reason to condone or justify the use of violence and abuse by perpetrators. It is clear that domestic abuse perpetrators use violence and abuse because they wish to control their victims.

117. However, there is evidence that cocaine and alcohol, especially when combined, can result in a heightened sense of paranoia and potentially an increased likelihood of the use of violence. It is important for professionals to understand the potential for substance use to exacerbate abusive and controlling behaviour by domestic abuse perpetrators and potentially increase the risk to victims. Multi-agency training on domestic abuse should reflect this.

Section Four - Conclusions

118. AB was murdered by BB. The evidence supports the view that BB was a controlling and jealous individual and that AB lacked confidence and self-esteem and was a vulnerable individual. There were no grounds to believe that AB was unfaithful to BB.

119. One evening in 2017 BB was allegedly told of a text on AB's phone by BB's brother, suggesting she was going to meet with someone without BB's knowledge. There is no evidence that the text ever existed. In response, BB - who had been drinking alcohol and using cocaine - waited until his brother left the house and the children had been put to bed. BB then murdered his wife by hitting her with a hammer and strangling her. BB then took his own life.

120. Apart from the universal services that were engaged with AB during her two pregnancies, local agency contacts with AB pre-dated her relationship with the perpetrator. None of the agencies had any relevant contact with, or knowledge of, the perpetrator. There had been no police contacts with AB whilst in the relationship with BB and there was no record of police involvement (in the West Midlands or any other police force areas) with BB as a potential perpetrator of domestic abuse.

121. Whilst BB was a controlling and coercive individual towards AB, this was not fully understood by AB's family, friends and work colleagues and as a result they were unable to support or protect AB.

122. Taking these factors into account, the DHR did not identify any direct causal links between areas where practice could have been improved upon and the homicide incident. However, there were missed opportunities and the DHR did identify five learning points, which should inform improvements to future practice.

123. The children of AB have suffered horrific trauma as a result of the actions of BB and murder of their mother. When considering this case professionals should be aware of the devastating impact on children and families. Following this review, Children's Services have confirmed that the children are living with close family and doing well.

Section Five - Lessons to be learnt

124. The key learning points from the review are summarised as:

1. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth. Domestic abuse during pregnancy puts the woman and unborn child in danger. It increases the risk of infection, miscarriage, premature birth, and injury or death to the baby. It can also cause women to experience emotional and mental health problems, such as stress and anxiety, which can also affect the development of the baby. Maternity and midwifery services are well-placed to identify domestic abuse and ensure that victims receive appropriate advice and support. Sandwell and West Birmingham NHS Trust and Birmingham Women's Hospital Maternity Services use a set of 'Routine Enquiry' questions when undertaking ante-natal checks. One of these questions specifically asks about the relationship with the father, which might elicit whether domestic abuse is an issue. In the case of AB, that question was not asked in either of her pregnancies.

2. The Department of Health document, "Responding to Domestic Abuse – A resource for health professionals", provides practical guidance for front line health professionals when asking questions about domestic abuse. There is no evidence that this tool was used when dealing with AB in either of her pregnancies.

3. If someone suspects that a family member, friend or colleague is in an abusive or unhealthy relationship, it can be difficult to know what to do. There is online guidance available on what can be done and local specialist support organisations like Black Country Women's Aid can also provide advice. This can focus on how to best have a

conversation and support a friend, relative or colleague in an informed and non-judgemental way which allows the victim to make their own decisions and identify possible options and solutions. More could be done to promote the guidance available to friends and family.

Furthermore, employers in the area would benefit from the 'Employer's Initiative' on domestic abuse and the 'Business in the Community' toolkit on domestic abuse to ensure an understanding by employees of the signs of domestic abuse and in particular the signs of coercive and controlling behaviour in relationships.

4. Whilst there is limited evidence that AB had been physically assaulted by BB prior to her murder there is clear evidence of coercive and controlling behaviour by BB. It is unclear whether family and work colleagues understood that this was occurring and the effect on AB. This case has identified that there is often a lack of understanding of coercive and controlling behaviour and the damage this abuse does to victims. There needs to be an increase in the awareness and understanding of this type of abuse and the ways in which it can be identified.

5. AB's family firmly believe that AB's murder was pre-planned and premeditated, as information from the police investigation indicated that the weapons used were not readily available and would have required premeditated action to retrieve and use them. The role that BB's use of substances had on his behaviour that evening will never be fully known or understood. BB may have intended to murder AB, regardless of whether he was under the influence of cocaine and alcohol. His use of these substances may well have given him courage to carry out a murder he had already intended to carry out. It is therefore important to note that AB was murdered, not because of BB's use of substances, but due to his underlying coercive and controlling behaviour. However, it is noted that the use of cocaine, especially when combined with alcohol, can cause increased levels of paranoia and violent behaviour. Whilst drugs and alcohol can exacerbate abusive behaviour, the underlying reason for that behaviour is the use of power and control. Professionals need to be aware of these issues when completing risk assessments and responding to incidents of domestic abuse.

Section Six - Recommendations

125. The recommendations of this review are:

1. Birmingham Women's Hospital and Sandwell and West Birmingham NHS Trust Community Midwifery Service should review the ante-natal 'Routine Enquiry' questionnaire and ensure there is clear guidance on when questions concerning domestic abuse are asked and that practitioners follow protocols and national guidance.

2. All frontline staff who engage in maternity and midwifery services should receive regular and updated training into the signs of coercive and controlling behaviour and the risk factors associated with that behaviour.

3. The Safer Sandwell Partnership should take the lead in working with other relevant Boards to ensure domestic abuse remains a priority across partnerships. This should include detailed and fact-based reviews on the outcomes of the work and training that has been undertaken; to determine its effectiveness.

4. The Safer Sandwell Partnership should undertake work to encourage employers to engage with the ‘Employer’s Initiative’ on domestic abuse and utilise the ‘Business in the Community’ toolkit on domestic abuse.

5. The Safer Sandwell Partnership should promote guidance available to friends, family or colleagues of someone they suspect is in an abusive or unhealthy relationship on how they could help them in an informed, supportive and non-judgemental way to identify possible options and solutions.

6. The Safer Sandwell Partnership should consider providing advice to frontline practitioners about the possible effects of cocaine and alcohol abuse on individuals. Multi-agency training in domestic abuse should include this information.

7. The Safer Sandwell Partnership to contact key organisations involved with this DHR and the Domestic Abuse Strategic Partnership partners and remind them of the learning from recent DHRs, in particular relating to coercive and controlling behaviour, and ensure the recommendations contained in them are implemented.