BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP
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Domestic Homicide Review
under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of a woman

BDHR2013/14-03

Report produced by Peter Maddocks
Independent Chair and Author

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Glossary

AAFDA: Advocacy After Fatal Domestic Abuse

ACPO: Association of Chief Police Officers

BCC: Birmingham City Council

BSCB: Birmingham Safeguarding Children Board

BCSP: Birmingham Community Safety Partnership

BSMHFT: Birmingham and Solihull Mental Health Foundation Trust

CCG: Clinical Commissioning Group

CPS: Crown Prosecution Service

DARIN: West Midlands Police Domestic Abuse Risk Indicator Notification

DASH: Domestic Abuse, Stalking and Honour Based Violence risk identification, assessment and management model

DOMESTIC HOMICIDE REVIEW: Domestic Homicide Review

DVRIM: Domestic Violence Risk Identification Matrix: assessing the risks for children from male to female domestic violence, commonly known as the Barnardo's Model

Flints: West Midlands Police Intelligence system.

GP: General Practitioner

HEFT: Heart of England NHS Foundation Trust

IMR: Individual Management Review – reports submitted to review by agencies

IPCC: Independent Police Complaints Commission

MARAC: Multi-Agency Risk Assessment Conference (for domestic violence)

MASH: Multi-Agency Safeguarding Hub

NHS: National Health Service

OASIS: West Midlands Police Command and Control incident logging.

PPU: Public Protection Unit of West Midlands Police

RAID: Rapid Interface and Discharge Service of Birmingham and Solihull Mental Health Foundation Trust

SAD: SAD assessment tool for self-harming patients

SCR: Serious Case Review

WC392: West Midlands Police Vulnerable and Intimidated Witness investigation log

Contents

1. Introduction and background to the review

1.1 Summary of the circumstances leading to the review

1. This domestic homicide review concerns the murder in June 2013 of a 27 year old woman (the victim) by her 37 year old estranged husband (the perpetrator) at her home in Birmingham. She died as a result of strangulation. Her body was discovered after the police forced entry to her home after she had been reported missing by members of her extended family.

2. The police had initially been contacted by a family friend (Adult 6) to report that the victim had not collected the children from school. The children were at Adult 6's address together with the perpetrator who had collected them. Later in the evening there was a further call to the police from the victim's aunt (Adult 3) to report that she was missing and that she feared for her niece's safety. Seven hours later in the early hours of the 14th June 2013 the police forced an entry to the victim's property and discovered her body.

3. A police murder investigation resulted in the perpetrator being charged with murder for which he was convicted and sentenced to life imprisonment in January 2014 with a requirement to serve a minimum of 15 years.

4. The Birmingham Community Safety Partnership was notified of the victim's death on 19th June 2013. On 28th June 2013 the Domestic Homicide Review Steering Group reviewed the circumstances of this case against the criteria set out in the *Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews* and recommended to the chair of Birmingham Community Safety Partnership that a domestic homicide review should be undertaken.

5. The chair of the Community Safety Partnership ratified the decision to commission a domestic homicide review on the 19th July 2013 and the Home Office was notified the same day with an

initial target of completion in January 2014.

6. National guidance issued by the Home Office provides discretion to the Community Safety Partnership about whether to postpone the domestic homicide review until a criminal prosecution has been completed.

7. In this case, the Community Safety Partnership decided to proceed with the domestic homicide review in order to identify any learning as quickly as possible but postponed completion of the review and publication of the domestic homicide review overview report until an outcome was known in regard to the criminal process and of the investigation by the IPCC (Independent Police Complaints Commission).

8. The referral to the IPCC followed an initial internal review by the West Midlands Police of the police contact with the victim and the perpetrator prior to the murder. That investigation is separate to the domestic homicide review and to any of the other processes associated with this case. The domestic homicide review was granted interested party status which facilitated liaison between the IPCC and the domestic homicide review. The police individual management review author was unable to speak with several officers who had contact with the victim and the perpetrator. This limited the scope of analytical discussion regarding some aspects of the police involvement[1].

1.2 Reason and purpose for conducting a domestic homicide review in this case

9. The circumstances under which a domestic homicide review 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 relevant national guidance is described in *Multi-agency statutory guidance for the conduct of domestic homicide reviews.*

10. A domestic homicide must review the circumstances in which the death of 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

been a member of the same household as themselves.

11. The purpose of a domestic homicide review as stated in the statutory guidance is to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard the victims;

b) 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;

c) Apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) Prevent domestic violence homicide and improve service responses for all domestic violence victims through improved intra and inter-agency working.

12. Domestic homicide reviews are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts respectively to determine as appropriate. Domestic homicide reviews are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a domestic homicide review indicating that

[1] The IPCC oversees the police complaints system in England and Wales and sets the standards by which the police should handle complaints. It is independent, making its decisions entirely independently of the police and government. It is not part of the police. The IPCC may decide to investigate cases referred to it either by the police or by a third party independently, manage or supervise the police force's investigation, or return it for local investigation. The investigations can result in disciplinary action against officers.

disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separately to the domestic homicide review process. Alternatively, some domestic homicide reviews may be conducted concurrently with (but separate to) disciplinary action. The rationale for the review process is to ensure agencies are responding appropriately to the victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions.

1.3 The terms of reference and key lines of enquiry

13. The national guidance describes generic terms of reference that provide a context for the development of more case specific key lines of enquiry and learning that are described.

Recognition

i. What knowledge/information did agencies have that indicated the subject might be a victim and how did they respond to this information. Were there opportunities to seek the views, wishes and feelings of any of the children about their parents' relationship and any evidence of domestic abuse? What information was sought or provided from within the extended family in regard to any evidence of a risk to the victim's emotional or physical safety or of her children?

Knowledge about the perpetrator as a violent the perpetrator

ii. What knowledge/information did agencies have that indicated the subject's husband was a perpetrator of domestic violence and how did agencies respond to this information.

Services provided

iii. What opportunities and services did agencies offer and provide to meet the needs of the

victim and her children? Were they accessible, appropriate, empowering and empathetic to their needs and the risks they faced? What action was taken to identify whether the children were at risk of significant harm or children in need of a service?

The capacity and resources of services

iv. Were there issues in relation to capacity or resources in any agency that impacted on the ability to provide services to the victim and her children, the perpetrator or any to other members of either family and also impacted on the agency's ability to work effectively with other agencies?

14. Each of the key lines of enquiry was accompanied by additional prompts for the agencies and their authors to consider when undertaking their agency review. For example, authors were asked to consider whether any information known to their services should have led to a different response and to consider the significant contributory factors that influenced how people made their decisions at the time.

15. Although domestic homicide reviews are a relatively recent statutory obligation and therefore only a limited number have been completed nationally, the panel have taken account of other sources of learning such as any relevant serious case reviews that have identified learning relevant to the domestic homicide review.

1.4 The methodology and scope of the review

16. A review panel was convened of senior and specialist agency representatives to oversee the conduct of the review. The panel was chaired by an appropriately senior and experienced person. The same experienced and independent person has also provided this overview report and an executive summary.

17. The panel established the identity of the services that had contact with the family during the timeframe agreed for the review. For five services that had significant involvement, they were required to provide an individual management review and they are listed in paragraph 24. These reports were completed by senior or specialist professionals in their organisations who had no direct involvement or responsibility for the services provided to either the children or their parents.

18. The prime focus for the domestic homicide review was from May 2008, when the first recorded report of domestic abuse was made to the police, through to the date of the victim's death in June 2013. Agencies were asked to review their records from the date of the first pregnancy in 2005; this was on the basis that research evidence and information from previous domestic homicide reviews show that domestic abuse is often under reported by victims who will have suffered previous abuse before making a disclosure or report and that pregnancy and the birth of children are also trigger points for abuse.

19. All information known to a service providing an individual management review was reviewed by the individual management review authors. Any information regarding involvement prior to the period of the detailed chronology and analysis was summarised in the individual management review.

20. Individual management reviews were completed using the Community Safety Partnership template and were quality assured and approved by a senior officer of the reviewing agency.

21. The following agencies have provided an individual management review that was to be completed in accordance with *Multi-agency statutory guidance for the conduct of domestic homicide reviews* and any associated local guidance and relevant procedures including those of the LSCB where appropriate.

    a) Birmingham NHS Clinical Commissioning Group in respect of GP practice that provided general medical services to the family
    b) Birmingham Community Health Care Trust (BCHCT) who provided school nursing dental health services and one enuresis clinic appointment

c) Birmingham Neighbourhood Advice and Information Service who provided advice and information to the victim and the perpetrator between 2010 and May 2013 in regard to housing and council tax and other benefits before and after the separation

d) Heart of England NHS Foundation Trust (HEFT); in the main limited to provision of maternity services to the victim, between December 2005 and September 2008

e) West Midlands Police (the individual management review was subject of some delay due to the referral to and subsequent investigation by the independent police complaints commission (IPCC) of how aspects of the police response to the victim and the perpetrator was managed in 2012).

22. Information was also received from the regional ambulance service[2], the schools attended by the children (that led to commissioning an individual management review from the education service) and the early years' service (a children's centre).

1.5 Membership of the review panel and access to expert advice

23. The case review panel that oversaw this review was independently chaired by the author of this report and comprised the following people and organisations;

Role or position	Agency
Lead Nurse Complex Mental Health Joint Commissioning	Mental Health Joint Commissioning
Associate Director of Safeguarding	Birmingham Community Health Care Trust (BCHCT)
Practice Director at a medical practice	Birmingham South Central Commissioning Group (CCG)
Head of Safeguarding	Heart of England NHS Foundation Trust
Detective Chief Inspector	West Midlands Police
Senior Service Manager Violence Against Women and Domestic Homicide Coordinator	Birmingham City Council, Equalities, Community Safety and Social Cohesion Service
Operations Manager	Birmingham & Solihull Women's Aid
Assistant Director - Safeguarding and Quality Assurance	Birmingham City Council Children's Services

Minute taker	Birmingham City Council, Equalities, Community Safety and Social Cohesion Service, Domestic Homicide Review Team

[2] The ambulance service provided an emergency response on two occasions in November 2012 when the perpetrator took an overdose.

24. The panel had access to legal advice from a solicitor in the council's legal service.

25. Written minutes of the panel meeting discussions and decisions were recorded by a member of the Domestic Homicide Review team.

1.6 Independent author of the overview report and the chair of the review panel

26. Peter Maddocks is the independent chair and author of this domestic homicide review and was commissioned in November 2013. He has over thirty-five years' experience of social care services, the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and is registered with the Health and Care Professions Council. He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has undertaken two other domestic homicide reviews in Birmingham and has also completed domestic homicide reviews with other Community Safety Partnerships in England. He has undertaken agency reviews and provided overview reports to several Local Safeguarding Children's Boards in England and Wales. In compliance with national guidance he has used the online toolkit and online learning provided by the Home Office. He has also participated in training in relation to serious case reviews including the use of systems learning as developed by the Social Care Institute for Excellence (SCIE) in regard to serious case reviews.

1.7 Family contribution to the serious case review

27. The victim's mother, aunt and uncle were notified of the domestic homicide review following the initial meetings of the panel in 2014 when the criminal trial had been completed and the police had provided a briefing about the criminal investigation and prosecution.

28. The chair of the panel wrote to Adult 1, Adult 2 and Adult 3 via the police family liaison officer. In that letter the chair of the panel also enclosed information about sources of support for families, which included Advocacy After Fatal Domestic Abuse (AAFDA).

29. None of the family felt able to provide any information to the review. They will be advised of the findings from the review and have been offered further contact if they wish to meet the independent reviewer or another representative of the panel.

1.8 Contact with the perpetrator

30. In compliance with Home Office guidance the chair wrote to the perpetrator after his conviction and imprisonment to notify him about the domestic homicide review. The independent chair of the domestic homicide review consulted with the prison regarding the perpetrator's attitude and ability to contribute meaningful information to the domestic homicide review.

31. An offender supervisor in the prison offender management unit met with the perpetrator on the 12th August 2014. During that meeting the perpetrator was asked to provide a response to a number of questions and queries on behalf of the domestic homicide review panel. The purpose of this was to establish if the perpetrator was able to contribute any additional information to enhance learning from the review.

32. During that meeting the perpetrator asserted that his relationship with the victim had been good in spite of the evidence put before the trial and the evidence considered by the domestic homicide review panel. He acknowledged that he had slapped her and stated his regret. The perpetrator was asked to think about how the children would have been affected by the domestic abuse; he provided little evidence of understanding the impact on the children having asserted that the age of the child who witnessed an incident was too young to remember anything.

33. The perpetrator did not feel that he required any assistance in regard to domestic abuse and has not talked about what happened. The perpetrator continued to assert that the victim had died accidentally.

34. In view of the attitude of the perpetrator and his unwillingness to acknowledge either the domestic abuse or his responsibility for the murder for which he was convicted the panel agreed that there was no value in pursuing any further contact and information with the perpetrator in regard to learning for the review.

1.9 Status and ownership of the overview report

35. The overview report is the property of the Birmingham Community Safety Partnership as the commissioning body for the review. All domestic homicide review overview reports provided to Community Safety Partnerships in England are expected to be published. This overview report provides the detailed account of the key events and the analysis of professional involvement and decision making. The executive summary provides a more accessible and shorter account of the key findings from the review.

36. The overview report is primarily written with the intention of addressing professionals involved with the design, oversight or delivery of multi-agency services although it should also provide accountability and information to other interested parties.

37. In reading this overview report, it is important to remain clear about the purpose of the review and of this overview report in particular. The domestic homicide review examines with the benefit of hindsight and other analysis, if it is possible to identify whether alternative judgements and decisions could or should have been taken, and whether different outcomes might have been achieved. The review does not investigate the circumstances of the death. That was dealt with through the criminal investigation and trial that convicted the perpetrator.

38. In doing this work, the panel are mindful about how complex or opaque some of the information and events may have looked to people involved at the time of the events.

39. The Community Safety Partnership will determine how and what further information is provided to the family at the conclusion of the review and the evaluation made by the Home Office Quality Assurance Group.

2 The Facts

2.1 Summary of the murder

40. The body of the victim was discovered by the police officer who went to the property shortly after midnight on the 14th June 2013 following the report of the victim as a missing person six hours previously after she had failed to collect her children from school. The officer eventually gained access to the property through an unsecured window to make a search of the property.

41. The summary of events in the next chapter provides an account of the initial response by the police to identify the victim as a missing person and the circumstances under which there was a delay of several hours before an officer went to the property is explored in later chapters.

42. The attack on the victim gave her no opportunity to make contact with any service or other person to request help when the perpetrator gained access to the property and strangled her. Her body was located in the hall of her home.

43. The judge, in his summing up following the conviction of the perpetrator, said that on the day of the killing the perpetrator had gone to the victim's address where she had made it plain she did not want him there. "The snapping point seems to have been that she refused to let you go upstairs." The judge said that the defendant had then held and squeezed his wife's neck for a "significant" period of time and that he was aware she was dead when he left the property.

44. The victim's two children had been waiting at school to be collected on the day their mother died. The judge said the perpetrator had played a "cool and calculated game" by pretending to look for the victim.

2.2 Details of the post mortem and inquest

45. The cause of death was strangulation. The conviction of the perpetrator at the Crown Court terminated the Coroner's inquest. No further information has been sought from the post mortem.

2.3 Members of the family and household and cultural identity

46. The perpetrator first came to the UK in 1998 before returning to Bangladesh to marry the victim in either 2004 or 2005. The marriage is believed to have been arranged by the victim's mother and uncles in Bangladesh. Following the marriage, the perpetrator returned to the UK leaving the victim in Bangladesh until she entered the UK on the 23rd October 2005 on a two year spouse visa sponsored by the perpetrator[3].

47. Neither the victim nor the perpetrator had English as their first language. The victim had a much more limited understanding of English than the perpetrator who acted as translator in some of their contact with services. The victim required the services of interpreters when she attempted to report the abuse on three occasions to the police. As will become clearer in later sections of the report, this was a significant factor in communication and interaction between the police and the victim.

48. The perpetrator worked as a chef; the victim never had paid employment in the UK. There is no information about the education of either adult or whether there was any learning difficulty or disability. There is no evidence of any mental health issues or substance misuse by either adult.

49. The victim's parents continue to live in Bangladesh. She has two sisters and three brothers. She had a maternal uncle (Adult 2) and a maternal aunt (Adult 4) who were both married and lived with their spouses in Birmingham.

50. The couple rented a property for a few weeks before moving in to live with Adult 2 and Adult 3 for a month before moving to another rented property where the victim lived until her death.

51. The victim was granted indefinite leave to remain the UK on the 29th October 2007. Both of the children were born in the UK. At the time of the victim's death, the children were attending the same primary school in Birmingham.

52. The family lived in an inner city area of Birmingham that has high levels of deprivation. It is an area that is in the ten per cent most deprived in England. The area has a large Asian population that is mainly from a Pakistan heritage originally.

53. In the West Midlands, approximately 30 per cent of those victims that report domestic abuse repeatedly report domestic violence within a year and it is thought that around 75 per cent of all domestic abuse incidents are witnessed by a child[4].

[3] A spouse visa is a visa much the same as any other visa except that it is issued on the basis of marriage. It allows a non-EU spouse to come to the UK on the basis of his relationship and it allows them the right live and work in the UK. It will only be issued if the non-EU spouse is married to a UK citizen or some who has Indefinite Leave to remain in the UK.

[4] [4] Report of the Vulnerable Children's Overview and Scrutiny Committee, 1st December 2009

54. Birmingham Safeguarding Children Board estimates that between 33000 to 40000 (equating to roughly 12-14 per cent) of Birmingham's children and young people are affected by domestic abuse. Many of these children have witnessed or heard domestic abuse, will sense that their carer is unhappy and some have been abused themselves[5].

2.4 Relationship between the victim and the perpetrator

55. There is little information about the relationship between the victim and the perpetrator although the police acquired more during the course of the criminal investigation. Information especially from Adult 4 indicates that there were far more incidents of abuse and violence and injury to the victim than were reported to the police and this would be consistent with the research and crime study analysis that domestic abuse is a very under reported and hidden crime.

56. According to Adult 4 the victim on several occasions tried to dismiss injuries as being the result of her hitting herself and she also felt unable to leave the relationship because of her concern that her mother would never have the outstanding loan of several thousands of pounds for the purchase of land in Bangladesh, paid back by the perpetrator.

57. Adult 4 provided a statement to the police during the criminal investigation that described the loans that had been arranged for two land purchases. The first loan in 2008 was around the time that the victim made her first disclosure of abuse and violence. The second purchase, according to Adult 4, occurred sometime in 2011 and involved the victim's mother raising money as a loan for the purchase but insisting that the deeds were in the victim's name rather than the perpetrator. Adult 4 also stated that she was aware that the perpetrator had taken £3000 or £4000 from the victim's account although did not know the date.

58. According to relatives who provided statements to the police during the criminal investigation although the relationship was initially 'normal', problems began to develop in relation to a dispute about a parcel of land that had been purchased in Bangladesh.

59. The combination of the victim having virtually no understanding of English and lack of employment or participation in any activities outside of the home made her particularly dependent on her husband and therefore more vulnerable to coercion within the relationship.

60. The first record of a disclosure of domestic abuse in May 2008 occurred when the victim was six months pregnant with her second child; she was grabbed by the hair and was dragged and shaken at their home. The perpetrator had threatened to send her back to Bangladesh and tried to confiscate her passport. Child 1 was just over two years old. The victim did not want the perpetrator to be arrested but did want help to resolve 'financial pressures'. It is not clear if this was a reference to the dispute over the purchase of land or was in regard to the perpetrator withholding financial support for the household, although it is clear that there was physical and emotional coercion and financial control.

[5] Report of the Vulnerable Children's Overview and Scrutiny Committee, 1st December 2009

61. There were three further reports to the police in relation to domestic abuse. The next occasion that the victim contacted the police in June 2012 was to report that she was trying to leave the relationship but was being prevented from doing so by the perpetrator. The perpetrator was also again withholding money. Adult 4's statement to the police after the murder stated that she saw the victim with injuries from being hit with a belt and scratches to the back and arm during Ramadan in 2012 (July and August) although these were not reported to the police (or any other service). The police individual management review author could not be certain if these were related to the incident that was reported in June 2012 although no injuries were observed or disclosed during that episode of police contact.

62. Adult 4 also reported overhearing threats made by the perpetrator in the presence of Adult 1 that he intended to kill the victim. Adult 1 raised her concerns with the victim who appeared not to take the threat seriously and that he was 'just saying this, nothing will happen'. The argument had arisen because the perpetrator wanted to have the parcel of land just in his name rather than as Adult 1 was suggesting, having it as a joint ownership between the perpetrator and the victim.

63. The police were not made aware of this background regarding the dispute over land or about the threats or evidence of physical injury to the victim during 2012.

64. In February 2013 the first threat to the victim's life was reported to the police. When the victim contacted the police to report that the perpetrator was threatening to kill her she described the status of their relationship as separated and that she had instructed the school not to allow either of the children to be collected by their father. The victim never consulted a solicitor and there is no record of her ever being advised by any professional to consult a solicitor.

2.5 Details of criminal proceedings and other investigations

65. The perpetrator pleaded not guilty to the charge of murder. He was sentenced to life imprisonment and is to serve a minimum of 15 years.

66. The prosecution evidence revealed an escalation of aggressive and violent behaviour over 'a long period of time'. The triggers for the escalation to murder included the ongoing dispute over the title deeds for the land purchase; the victim preventing the perpetrator's contact with the children and the victim resisting his attempts to be in the house.

67. In his summing up at the trial the judge said, "The background to the killing of your wife involves a dispute, which you took deeply to heart, about the title to land you had bought in Bangladesh." He said the perpetrator had taken an "outrageously disproportionate view" about the importance of that although he could not be certain that he killed his wife for gain.

68. The judge went on to say that "I am satisfied that a significant part of your character is a stark inability to understand that anybody who differs from your views could possibly be right. You also have a very short fuse. I am satisfied that you have resorted on previous occasions to using violence against your wife in the course of disputes, mainly about money."

2.6 The narrative overview and summary of information about the contact and involvement of services.

69. Only the most significant contacts are included in this summary. For example, there were 62 contacts with the GP during the time frame for the review of which 20 were with the victim. Other appointments were with the children or the perpetrator.

70. Later sections for the report describe the analysis and learning. For example, in regard to the GP service there are three occasions that were of particular interest in regard to domestic abuse although none of the contacts with the GP were in regard to any explicit disclosure or evidence of domestic abuse. A detailed account of the police contact is included in the next chapter that describes agency analysis against the key lines of enquiry for the review.

71. The booking appointment in 2005 for the first pregnancy with the midwifery service provides a record of the routine history taking that included social circumstances. Although the record suggests that there were 'special circumstances' affecting the victim at the time there is no detail as to what these might have been. The HEFT author acknowledges that within the context of a domestic homicide review this now takes on some significance although could have been indicating any number of issues and is not necessarily an indication of concern.

72. There were three unscheduled attendances at the hospital emergency department during the pregnancy with non-specific symptoms. Emergency attendances with vague symptoms can be a potential indicator of domestic abuse although acknowledging that symptoms during pregnancy requiring attendance at hospital that are not necessarily the result of abuse. There was no record of any routine enquiries to check about any concerns regarding potential domestic abuse.

73. In January 2008 the victim attended the hospital midwifery service to book the second pregnancy. It was noted that she was going to Bangladesh for a holiday until April 2008. She was next seen by the midwifery service on the 20th May 2008 when she was asked routine questions about domestic abuse; none was disclosed.

74. Just over a week later on the 29th May 2008 when the victim made her first contact with the police to report an assault and financial coercion by the perpetrator. Children's social care was informed by telephone on the 16th June 2008 about the contact with the police and this was followed by a police referral on the 30th June 2008. The perpetrator had already been cautioned and no further action was taken by either service; children's social care recorded that it was the first offence and no child had been present; the decision did not acknowledge that the victim was six months pregnant. The Birmingham Community Healthcare Trust safeguarding team were informed by a DARIN[6] on the 14th July 2008 and that the police had

5 This is a domestic abuse referral and information notification

graded the level of risk to be medium. There is no record of the information being received or followed up by the local health visiting team or GP.

75. The routine antenatal contact during the second pregnancy was unremarkable; there is no evidence of concern about the victim of either of her children. Both children received the required immunisations and developmental checks and were presented for appropriate consultations with the GP and health professionals.

76. In June 2009 the first of several presentations with the GP for respiratory infections was recorded for Child 1.

77. In September 2009 Child 1 started attending nursery school and remained until July 2010 and started primary school. Child 2 attended the same nursery in 2011.

78. In February 2012 Child 2 was referred to the dental hospital for the removal of ten teeth under general anaesthetic.

79. In April 2012 the victim had two molars removed at the dental hospital.

80. On the 13th May 2012 the victim consulted the GP about a sprained knee.

81. In June 2012 the second contact with the police was recorded when the victim reported that she was being prevented by the perpetrator from leaving the marriage. The police advised the victim to contact the local Citizen's Advice Bureau. The incident is not recorded as domestic abuse and no referral was made to children's social care or to any other service.

82. On the 5th July 2012 the local children's centre made a 'cold call' to the family home as part of their routine contact and offer of services to families with pre-school children. A registration for services was completed and information was left. There was no further contact or take up of services.

83. In November 2012 children's social care were told that the victim and perpetrator had separated; the source of the information is not clarified.

84. In February 2013 the third contact with the police occurred when the victim had been subject of a threat to kill by the perpetrator. He was in Bangladesh at the time and the information was treated as not representing an immediate threat of harm. Children's social care was informed but no further action was taken; the reason recorded was that the victim had withdrawn her complaint.

85. On the 5th March 2013 the victim went to the local Neighbourhood Advice and Information Service for advice about housing and other benefits; she told the staff that the perpetrator had gone to Bangladesh. She was told that she needed to bring evidence in order to transfer tenancy and benefits. She made nine phone calls from the 6-8th March 2013 but no appointments were available. Several more phone contacts occurred through March; in the last week of March there were 16 calls.

86. On the 12th March 2013 the victim consulted the GP about a viral infection as well as a pain in her elbow.

87. On the 9th May 2013 the victim attended an appointment for advice from the Neighbourhood Advice and Information Service. The perpetrator was in receipt of the family's benefit income and she had separated from him.

88. On the 17th May 2013 the victim consulted the GP about pain in both of her legs.

89. On the 12th June 2013 the victim attended the GP for treatment to shoe bite and was prescribed antibiotics[7].

90. On the 13th June 2013 the victim did not collect the children from school. Her body was

discovered at 01.00 on the 14th June 2013 when the police forced entry to her home.

91. Children's social care was informed of the victim's death via the Emergency Duty Team for out of hours. The two children were placed with Adult 4 and Adult 5.

3 Analysis of information against the key lines of enquiry

92. The purpose of a review is not to try and second guess the judgements and decisions that the various people and organisations made at the time of the events taking place. Hindsight can severely distort the clarity of information that was available to the practitioners dealing with events and information and can also underplay factors such as ,for example, the real time pressures that were a factor at some key moments.

3.1 Significant themes for learning that emerged from examining the individual management reviews and other information

93. The significant themes that are identified from looking at the individual management reviews include reflection in regard to cognitive and cultural influences that can be powerful barriers to victims making a disclosure or identification by professionals of domestic abuse; the importance of identifying particularly vulnerable and socially isolated women; recognising domestic abuse as being about control, coercion and power over a victim; the importance of checking for previous relevant history to judge the significance of an individual piece of information or incident; anticipating the escalation or enhanced levels of risk that are associated for example with disclosure of abuse or separation from an abusive and coercive relationship.

a) The disclosure of domestic abuse is fraught for victims and their children; it is frequently only made after several repeated episodes have occurred; in this case the victim did not

[7] Symptoms include bunions, hammertoes and other painful foot deformities often because of ill-fitting shoes.

receive an effective response to her first disclosure in May 2008 and it was almost four years before she felt able to again try to get help;

b) Coming from a different cultural tradition and being isolated by lack of language are significant barriers in communication;

c) Social isolation and high dependence on a spouse are latent conditions for excerpting control; lack of employment or social contacts outside of the immediate family can contribute to isolation from potential sources of advice and support;

d) Domestic abuse is frequently a pattern of behaviour that is repeated and escalates in severity;

e) Identifying and defining domestic abuse from the outset is a vital foundation for developing appropriate strategies to work with adult victims and children; recognising, defining and recording any information or evidence about domestic abuse is vital; it requires sufficient awareness of research and best practice to inform the encouragement of disclosure, detection, investigation and assessment;

f) Children living with domestic abuse often do not disclose explicit information although their emotional and psychological well-being and their behaviour will be detrimentally influenced;

94. The remainder of this chapter summarises key evidence relating to the terms of reference established for the review.

3.2 Knowledge/information that agencies had to indicate the victim might be a victim of domestic abuse and how agencies responded.

95. Domestic abuse is not about loss of anger or limited to physical and verbal assault. It is pernicious and kept secret by victims and by perpetrators and their children. Disclosure is difficult and physical signs and symptoms can be hidden, disguised or be the subject of misleading description of circumstances.

96. Government guidance describes and defines domestic abuse as any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse encompasses, but is not limited to a range of behaviour that includes psychological, physical, sexual, financial and emotional control. Its purpose is 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.

97. This was the controlling behaviour that the victim was subjected to over a period of several years. It is the police who are the focus of this review in regard to the information they had on four occasions between May 2008 and June 2013. There is an opportunity to also reflect on whether other services in contact with the victim and her children sought or understood enough information about their true circumstances.

98. In reading this part of the report, the focus is on any missed opportunity to have acted differently and to reflect on the implications for improving the awareness and practice across all services in encouraging discussion, disclosure and recognition of symptoms of domestic abuse and coercion.

99. As an under reported crime, it is increasingly understood that domestic abuse is rarely disclosed at an early stage and on average 35 incidents have occurred before a disclosure or complaint is made to the police or to another service[8].

100. In a domestic homicide review the first recorded information by an agency is unlikely to mark the onset of domestic abuse. It is also known that the problems for disclosing domestic abuse affect all communities irrespective of their cultural, economic or social circumstances

although some communities including those from a south Asian tradition have particular issues in regard to recognition and disclosure of abuse. This is discussed in the final chapter of findings.

101. The victim arrived in the UK in late 2005, was reliant for continuing residency during the first two years on the spouse visa and had little English and no apparent source of independent income. The money she did have was taken from her. She was also pregnant. These were powerful factors over and above any cultural imperatives for the victim to make the relationship work and to keep hidden any evidence or information about domestic abuse.

102. Agencies were asked to check for any information about the victim being subject to domestic abuse and whether there were opportunities to seek the views, wishes and feelings of any of the children about their parents' relationship and to identify any evidence or indication of domestic abuse.

103. With the exception of the police, there were no disclosures or other indication of domestic abuse observed or recorded; in view of the knowledge that abuse was a factor over several years, a key point for the findings in the last section of the report is the extent to which the victim and her children clearly felt unable to tell professionals about what was happening. For example, less than a week after going to the police to disclose assault and financial control, the victim was unable to speak with midwifery staff about any aspect of the domestic abuse. It is a possibility because of the information provided during the murder enquiry that the victim had sustained physical injuries that were not reported or could have been hidden by clothing.

104. The family and relatives state that evidence of domestic abuse became apparent to them when the perpetrator had purchased the second parcel of land in 2011 and there was a dispute about the registration of the deeds. As a result of the criminal investigation and the

[8] Yearnshaw, S. (1997) 'Analysis of Cohort.', in Bewley, S, Friend J and Mezey G (eds.) *Violence Against Women*, London: Royal College of Obstetricians and Gynaecologists

collation of information for this domestic homicide review it is known that although the land purchase and subsequent dispute over deeds was a trigger for the escalation in coercion and violence there was already a history of abuse at a much earlier stage in the marriage.

105. The narrative summary has described how the routine booking arrangements during both pregnancies included a check with the victim as to whether there were concerns about abuse. The individual management review acknowledges that this relies on the pregnant woman feeling able to make a disclosure and that it also requires sensitivity for example as to whether there is an opportunity to speak in private with the woman. Ensuring that primary health and midwifery practitioners are sufficiently aware of the coercive and secret nature of domestic abuse and not just relying on disclosure is an important aspect of professional development.

106. The first disclosure to the police in May 2008 was when the victim was six months pregnant with her second child and her first child was just two years old. The police were the only service that ever received explicit disclosures of domestic abuse from the victim or from any other source in spite of the routine screening. It is significant that less than 48 hours before the victim made her first contact with the police she had attended for a routine antenatal appointment at the hospital where she made no disclosure and showed no indicators to cause concern to the midwifery staff.

107. It is estimated that 30 per cent of domestic abuse commences during pregnancy (DoH, 2004; McWilliams and McKiernan 1993[9]). Pregnancy, far from being a time of peace and safety, can trigger or exacerbate male violence (Bohn, 1990; Helston and Snodgrass, 1987[10]) and especially if it is exacerbated by depression and mental illness. Although there is no evidence of diagnosed depression or mental illness, the isolation that the victim probably experienced on coming to the UK would have had some impact on her emotional and psychological condition.

108. Although many women experiencing domestic abuse can be helped if someone asks them about problems in their relationship, this case illustrates the extent to which victims of domestic abuse are reluctant to make disclosures. They may also fear the consequences of revealing abuse such as intervention by statutory services to protect the children or

jeopardising the economic and housing circumstances of the family.

109. The victim's first contact with the police via a 999 telephone call from her home at 16.04 on the 29th May 2008 was ended from the victim's end; the log of the call states that a 'foreign female mentioned her husband troubling her then cleared tried ringing back no answer. There was a baby crying in the background'.

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[9] Department of Health (2004) *Why mothers die: report on confidential enquiry into maternal deaths in the United Kingdom 2000-2002*. London. TSO; McWilliams, M, McKiernan, J. (1993) *Bringing it out into the open*.

[10]Domestic violence and pregnancy: Implications for Practice Journal of Nurse-Midwifery Volume 35, Issue 2, pages 86–98, March-April 1990

Helton AS, Snodgrass FG (1987) Battering during pregnancy: intervention strategies. *Birth*. 14:3 142-7

110. The incident was identified by the call taker as a 'Disorder' which meant that it was allocated for an immediate response by uniformed officers. By 16.30 the officers were trying to establish via the language line interpreter what had happened having found the victim in a distressed state at her home.

111. It was established that there had been an argument over 'financial issues and other problems' and the perpetrator had threatened to send the victim home to Bangladesh (although the victim had been given entitlement to remain in the UK in October 2007).

112. The perpetrator had grabbed the victim by the hair and she had been dragged and shaken with the perpetrator demanding to have her passport. No physical injuries were observed but her distress was apparent to the officers who completed a WC392[11]. The victim stated that she did not want her husband to be arrested: this is a common victim behaviour and unless the response officers adopt a suitably assertive stance at the outset it will undermine subsequent action. The officers correctly arrested him on suspicion of assault.

113. The police individual management review comments that although the documentation records that the argument had been about 'finances and other problems' and also the threat to send the victim to Bangladesh there is no detail about the issues or any evidence that this was explored during the investigation. The fact that the victim had very limited English and had required use of the language line service contributed to difficulties in communication between the officers and the victim.

114. The recording does not clarify information about the crying baby that had been heard by the call operator during the initial telephone call; there was no information where the child had been during the incident and there is no record of the child being physically checked. No contact was made with children's social care (or any other service) about the child or unborn child until several days later. The information was not referred to the specialist police officers in the public protection unit and therefore no risk assessment was completed by that team.

115. The risk assessment framework used by the police in 2008 was the DARIM (domestic abuse risk indicator model which had been introduced in 2005. Through a series of 17 questions it required a judgment to be made in regard to the level of risk to the victim ranging from low, through medium to high. According to the police individual management review the victim was graded at low level although the individual management review from Heart of England Foundation Trust states that the DARIM assessment they received was medium; the police individual management review believes that if the DARIM had been correctly applied with more attention to enquiring into the issues highlighted in the previous paragraph, the risk would have probably merited a decision of medium risk.

[11] The police INDIVIDUAL MANAGEMENT REVIEW explains that this is the vulnerable and intimidated witness log that police officers were required to complete between 2004 and 2009 which when processed correctly ensured that a unique non crime number is allocated to the incident and the type of enquiry completed and thereby allow oversight of any action in response to a vulnerable victim of domestic abuse.

116. A statement was taken from the victim later the same evening that was obtained by the

interpreter rather than the police officer; the statement was of poor quality according to the individual management review. There was no relationship history, details of Child 1 or of the pregnancy or whether there was any previous history of abuse in the relationship. There was limited account of the incident which according to the victim had lasted some 15 minutes.

117. The statement confirmed that the victim was willing to attend court and was willing to give evidence. She said that she was going to stay with her sister in Birmingham although no details were recorded about the sister or the address to allow checks to be made about any risk to the victim or to her children (including the unborn).

118. Further irregularities are identified by the individual management review in regard to the perpetrator's arrest and custody. He was given the opportunity to nominate a person for him to notify about being in police custody; the name of the nominee was an 'aunt' at the home address; it is thought by the individual management review author that this was an effort by the perpetrator to make contact with the victim whilst he was in custody and would have given an opportunity to intimidate or influence her in regard to any police action. In the event no contact was made.

119. The perpetrator made a 'no comment interview' on the advice of his solicitor. The solicitor provided a pre-prepared written statement that acknowledged that the couple had argued during which he had 'accidentally' pulled her hair and expressed 'regret' about assaulting her. The statement said that he had never raised his hand previously and would not do so in the future. He did not elaborate on the hair pulling or the 'tapping to her head'.

120. The police individual management review comments that the statement was not a 'frank admission' of guilt and 'merely' an admission to being reckless and did not assist the investigation. The inspector authorised a caution being administered. The decision was made on the basis that the incident had been a verbal altercation over the victim's refusal to hand over her passport (which does not recognise the coercion). The record of the decision refers to the victim making a statement requesting minimal action and that the perpetrator had expressed regret; this is not unusual victim behaviour. The individual management review comments that a caution was inappropriate.

121. There is no record of what the victim felt about the outcome; the perpetrator was released just after midnight.

122. There was little apparent consideration of possible history, an absence of a more thorough exploration of the circumstances and reasons for the incident and no consideration in respect of the implications for Child 1 or the unborn baby. There was no consultation with the Crown Prosecution Service regarding whether a charge would have been appropriate given his attitude and response; if he had been charged then he would have been subject to bail conditions that could have included control of his contact with the victim. Since this incident the police have been given additional powers to deal with perpetrators of domestic abuse such as the Domestic Violence Prevention Notice.

123. In his statement for the criminal investigation following the victim's murder in 2013 Adult 2 described visiting the victim and perpetrator at their home after being told about the assault. The victim told her uncle that the perpetrator was sending all his money to Bangladesh. Adult 2 could see that the house was in poor condition and that there was no food in the house. He told the perpetrator that he had responsibility for a family and was no longer single and should not be sending money to Bangladesh. There is no comment in the police information about the condition of the home at the time of their contact in 2008.

124. The police individual management review author comments that the incident in May 2008 was the victim's first contact with the West Midlands Police and possibly her first contact with any police officers since coming to the UK. It was therefore even more important for time to have been spent with the victim to explain what the police and other services could offer to her. It was with the benefit of hindsight the single most significant opportunity to provide the victim with advice and help and to have understood the nature of the abusive relationship and its implications for the victim and for the children.

125. The police had no record of any information being sent to children's social care or other services although children's social care had a note of the police contact and the Birmingham Community Healthcare Trust confirms that a copy of the DARIN was received by the safeguarding team for the two former primary care trusts on the 14th July 2008 which was six

weeks after the incident[12]. In any event, the absence of a risk assessment by the specialist police officers (who were not provided with information including the DARIN) meant that no further follow up was made by either the police or children's social care who have statutory powers and responsibilities for safeguarding.

126. Following the birth of Child 2 there was contact by midwifery, health visiting and GP service. On a presentation to the GP in May 2010 the victim had a sore 'possibly sprained knee'. There was no concern about domestic abuse (although the GP does not appear to have been aware of the incident in 2008). This was the only occasion from the various contacts that could possibly have been an injury arising from an assault until the second contact with the police in June 2012.

127. The dental referral in February 2012 for Child 2 to have ten teeth removed under anesthetic was the only significant health information in regard to either of the children. Coincidentally the victim was also receiving dental treatment although this was not the result of any physical trauma such as an assault. Significantly, the perpetrator was being used as an interpreter for some of the contacts with health professionals. Other staff acknowledged that the victim had limited English but had felt that translation was not required.

When the victim made her second call to the police (again via the 999 telephone service) in June 2012 she was using her native language which made it difficult for the English speaking call taker to decipher some of the conversation. The victim was able to make the call taker understand that she was attempting to leave her husband who was trying to prevent this from happening. The call was ended when the perpetrator returned to the home. The call was classified as 'Disorder' and allocated for uniformed officers to respond within an hour. Officers were with the victim at 15.01 (she had called at 14.14) who through an interpreter established that the perpetrator was withholding money from the victim and that she wanted to leave him. Advice was given to go to the Citizen's Advice Bureau.

[12] Primary care trusts were abolished and replaced by clinical commissioning groups (CCG) from April 2013.

128. The police individual management review explains that the policy for risk assessment was updated in 2009 and therefore this second incident should have been the subject of a Domestic Abuse Stalking and Harassment (DASH) risk assessment if the officers had recognised that the victim was the subject of coercive, controlling and abusive behaviour by her husband and was seeking help to leave the relationship and had two dependent children. In order to use the DASH the officer has to be able to identify the indicators of domestic abuse.

129. Research evidence highlights a heightened risk and incidence of violence associated with a victim leaving an abusive relationship[13]. Rather than being a move to safety, it is often a critical and dangerous development where the abuser knows they are on the point of losing control over their victim; in this case it is now known that financial coercion was a very significant issue.

130. The officers (who possibly were not aware of the evidence from research) specifically said that it was not a 'domestic incident'; the individual management review disagrees with this assessment. If the incident had been correctly recognised as domestic abuse it should have resulted in a DASH being completed and in turn this would have been the subject of a further risk assessment by specialist police officers. There is no evidence that history was checked in regard to the 2008 assault.

131. An aunt's statement to the murder investigation team recalls seeing the victim with injuries in the summer of 2012 (July/August) after the victim had been hit with a belt. No injuries were recorded as having been seen by the officers although the aunt describes these as being to the arms and back and therefore probably hidden by clothing; professionals working with the victims of domestic abuse will recognise this pattern of behaviour (by perpetrators and victims) of disguising or hiding evidence of coercion and injury.

132. The third contact with the police on the 20th February 2013 at 16.17 was again by a 999 telephone call and was the clearest and most serious disclosure by the victim of threats to her life. She again asked to speak to an interpreter and explained that she was separated from her husband who was on holiday in Bangladesh and that he had told her he would kill her if she separated from him. She told the call taker that she had two children and that she wanted to 'tell you everything'.

[13] Several studies including (Humphreys and Thiara 2002 *Routes to Safety: Protection Issues Facing Abused Women and Children and the Role of Outreach Services*. Bristol: Women's Aid Publications; Radford and Hester 2006 Radford, L. and Hester, M. (2006) *Mothering through Domestic Violence*. London: Jessica Kingsley) have established that a substantial proportion of domestic violence occurs in the course of or following separation.

133. The victim was asked if she was in danger at that moment to which she replied 'not at the moment but my husband, I am feeling bad'. The victim was advised that the local police would contact her and come to her home. The log was transferred to the contact centre at the police station which covers the area of the city in which the victim lived. The log was received by the contact centre's supervising sergeant's terminal at 16.34. A police constable made a request over the police radio for a Bengali speaking officer to make contact with call centre; there was no response.

134. At 16.41 the sergeant had spoken to the victim and ascertained that her husband had gone to Bangladesh about a month ago and she was unsure when he would be returning; they had separated about a month ago and her husband was threatening her when he returned to the UK.

135. The victim had again informed the police that she had two children and that she had asked the school not to allow their father to collect or meet them at the school. The victim was concerned that her husband planned to take the children when he came back to the UK. There was no clarification as to whether there was any order in place to restrict the father's contact.

136. The sergeant recorded that the victim's English 'isn't brilliant but I have established that there is no immediate threat'. According to the log, the victim 'appeared to want assistance and advice as when (the victim) was asked whether she wanted her husband arresting she had replied no'. The victim had mentioned having a friend who would be willing to translate and would be with her the following day at the same time (late afternoon).

137. The log was updated to say that the victim would make contact with the police again when her friend was present to 'establish exactly what the female wants and if threats have actually been made'.

138. The sergeant transferred the log back to the constable in the contact centre with the instruction to keep the log open until the victim had called back. A police staff member closed

the log instead of keeping it open. This was done without authorisation.

139. The police individual management review comments that although the initial call was correctly identified as a domestic abuse incident, the follow up was not in compliance with the police policy that requires an early response with a visit to the victim. The policy stipulates that officers are to be sent to every reported incident of domestic abuse. This did not happen and the individual management review comments that this was poor practice; was not consistent with procedure and service standards and was compounded by the closure of the log despite the instruction of the sergeant. When the log was closed a non-crime log should have been completed to record all the details including the rationale for the decision to close the log. This did not happen for a number of reasons that include insufficient understanding by all personnel about the purpose of policy and particular procedural requirements.

140. The police domestic abuse policy also states that family and friends should not be used as interpreters: this is because of concerns about minimization, difficulties in understanding dynamics and power relationships, cultural issues and traditions and the opportunity for family or friends to excerpt influence and further control over a victim disclosing abuse.

141. The victim did not make contact with the police the following day and because the log had been closed there was no follow up either by the police (when different officers would have been on shift).

142. The individual management review comments that a visit to the victim should have ascertained more clearly the nature of the threats and also when the perpetrator was likely to return to the UK and whether he had any relatives, friends or associates who could or would carry out any threats to abduct the children or cause violence to the victim and her children whilst he was outside the UK. In spite of the difficulties in regard to language and communication, the victim had provided sufficient information to indicate that she was reporting domestic abuse, that she was worried about safety for herself and for her children and that that the threats to harm her life were persistent. No checks were made on the victim or the address; the officers were therefore unaware of the incident in 2008 and that domestic abuse had been a factor for several years.

143. As part of the work on the individual management review the police author made contact with the UK Border Agency who confirmed that the perpetrator returned from Bangladesh on the 24th February 2013 and was due to go back again to Bangladesh on the 27th February 2013.

144. On the 25th February 2013 the police received a 999 call from a family friend (Adult 6) who reported that the perpetrator wanted access to the family home to collect his belongings. He was being prevented from doing this by the victim.

145. The call was graded as a miscellaneous incident with an early response and was passed to the local police station contact centre and accepted by a police constable who downgraded the response from early to routine. The 999 operator continued to update the log; at 19.01 the perpetrator and Adult 6 were making their way to the address and the victim was refusing to allow access.

146. At 19.11 the constable contacted the perpetrator and advised him to get a friend to collect his belongings which he agreed to do. The log was closed with no further action required and was incorrectly classified as a public safety/welfare civil dispute.

147. The police individual management review comments that the incident was incorrectly classified from the outset. There was enough in the in the initial call to indicate that this was potentially a situation involving domestic abuse and if checks had been made on the victim, perpetrator and/or address it would have confirmed the previous history. The advice for a friend to collect belongings would have been appropriate in an isolated incident that involved an argument or ending of a relationship without domestic abuse.

148. On the 17th May 2013 the victim consulted the GP about pain in both of her legs. The GP was unaware of the background of domestic abuse. There is no evidence or indicator either from disclosures of diagnosis that the pains were associated with domestic abuse.

149. The victim consulted the GP about a shoe bite on the 12th June 2013 and was prescribed

antibiotics. The main cause of shoe bite is wearing shoes that are the wrong size for the foot. This was a sign of the victim neglecting her own health and having very limited income. This could have been an opportunity to have enquired into the social circumstances of the victim. The individual management review from the Clinical Commissioning Group comments that the GP is very knowledgeable and up to date about research and good practice in regard to domestic abuse and that this was a general practice that aims to comply with standards of good practice.

150. The final call to the police was at 18.09 on the 13th June 2013 and was the report of the victim as a missing person from the victim's aunt (Adult 3). She told the call taker that the victim had failed to collect her two children from the school. The aunt reported that the children were with Adult 6 and the perpetrator. The 999 call operator spoke with Adult 6 who stated that she thought the victim 'was quite happy and that there were no problems between her and (the perpetrator)'. If the police logs of previous contacts had been checked this would have shown that this information was not correct.

151. The call was graded as an early response within one hour and was transferred to the local police contact centre where it was received by a police constable at 18.12 who passed it on to the resource allocator and dispatcher who downgraded the response to routine (allowing a response within 48 hours rather than the one hour). No checks were made on the system for previous contacts and the risk based questionnaire that the missing person policy required to be used was not completed either in order to establish if the victim was missing or absent.

152. The inspector, having been made aware of the case by the resource allocator and dispatcher at 18.15, requested that the questionnaire was completed by the caller being contacted again. The individual management review comments that even without contacting the caller, there was already sufficient information to indicate concern in regard to a mother failing to collect her children from school, of this being entirely out of character and if historical logs had been checked would have alerted the officers to the history of abuse that had recently been escalating with the victim's decision to leave the marriage. Adult 3 was also expressing her considerable worry in her contact with the police.

153. At 20.30 the inspector dispatched officers with a 'number of key actions' that included

ascertaining the safety and circumstances of the children, to ask the father why he had picked them up from school and when he had last had contact with the victim. The inspector also requested intelligence checks to be made and to check whether there had been any separate contact from the victim. It is of note that the spelling of the victim's name and of other relatives was recorded in several different formulations which may have been a factor in the inspector's mind to double check.

154. At 22.45 the log was allocated to a police constable starting their night shift at 22.00. The resource allocator and dispatcher updated the log at 22.47 to confirm that checks on FLINTS[14] had shown no trace; the individual management review author comments that there are several ways in which FLINTS can be used but if the address had been checked correctly it should have shown up nine logs to the address of which four related to the victim and perpetrator.

155. The constable tried to contact the victim by her mobile and landline number without success. At 00.25 the constable visited the victim's address. Entry was subsequently forced to the property and the victim's body located near the front door.

156. The contact with the police in particular was the most significant in regard to information and knowledge about domestic abuse. Children's social care and the Birmingham Community Healthcare Trust were made aware of the incident in 2008 although none of the services apparently recognised the significance of that first disclosure in terms of the well-being of the victim, Child 1 or the unborn baby. All the services missed the information about financial coercion; there was an overwhelming preoccupation with establishing whether there was a threat of immediate physical harm rather than understanding domestic abuse as coercion and exercising control.

157. The GP and the Neighbourhood Advice and Information Service had information that potentially indicated financial coercion; information that on its own was not significant enough to trigger formal protocols but could have prompted further probing and checking of information and consultation.

158. The fact that information held by the police was not managed in accordance with protocols

had implications for the way the police managed their contact and passed information to other services such as children's social care and contributed to the safeguarding and statutory assessment frameworks not being used in regard to the children's circumstances and well-being.

159. If the contact with children's social care had been managed as referrals it would have required completion of statutory enquiries and assessment and would have created the opportunity to join other services such as the GP and health visiting service into the process. They were processed as lower level information reports.

3.3 Knowledge and information agencies had about the perpetrator of domestic violence

The point has been made in the previous section that domestic abuse is about coercion and control of victims: that victims are reluctant to make disclosures and perpetrators will endeavour to disguise and hide evidence of their abuse. It is why it is so important to make sure that any indication of domestic abuse is defined and managed from the outset. The one occasion when the perpetrator was arrested and placed in custody he used his lawyer to minimise the evidence and did not co-operate with any investigation. This was control of the professionals as well as the victim.

[14] FLINTS is a West Midlands Police intelligence system that cross references with all police IT systems.

160. None of the services had much contact with the perpetrator. Of the 62 contacts the family had with the GP for example, only five were in relation to the perpetrator.

161. He should have been identified as a perpetrator of domestic abuse as early as 2008 when the victim was pregnant with their second child. That should have triggered safeguarding procedures for the children. Although information was sent to children's social care and

Birmingham Community Healthcare Trust none of the three services initiated the process in regard to Child 1 and the unborn baby. It seems that there was delay in information being sent through as well as in the processing within services.

162. According to the police individual management review the risk assessment had concluded that the level was low whereas the Heart of England Foundation Trust report states that the assessed level of risk was medium. Children's social care does not refer to the DARIM.

163. The decision to release the perpetrator with just a caution is criticised by the police individual management review. The decision may also have influenced how the other two services treated the information.

164. The threat to kill the victim reported to the police in June 2012 was not correctly defined and managed as domestic abuse by the police. This meant that information was not processed within the police in assessing risk from the perpetrator.

3.4 The opportunities and services offered by agencies to the victim and her children and provide to meet the needs of the victim and her children

165. The victim and her children were in receipt of core services such as education for the children as well as health care for them and for the victim. Following the birth of Child 2 the local children's centre made contact to tell the victim about their services with a view to encouraging her and the children to participate; this was part of the core offer of support to parents and pre-school children rather than an indication of any concern. The victim did not make any further contact with that service.

166. The information report from the service could not confirm whether it was the victim or the perpetrator who did most of the talking during the visit. Although the report describes the training and support given to staff in regard to domestic abuse and that no concerns were identified the report does not provide any information about the extent to which the victim's

vulnerability was recognised.

167. The family made use of the GP and other health services. For the most part this was routine. As part of the ante and post-natal care and contact for the pregnancies there was some evidence of routine inquiries and checks being made of the victim about abuse but it is less clear the extent to which the social support available to the victim was explored.

168. There are two particular aspects in regard to information provided in regard to health professionals contact that invite further reflection.

169. The first concerns the severe dental caries that resulted in ten teeth being extracted from one of the children.

170. The identification of neglect is seen increasingly to be important in work with vulnerable children. In a study completed in 2012[15] health visitors indicated that dental neglect is rarely an isolated issue that leads on its own to child protection referral; however poor dental health in children is a marker of broader neglect.

171. Dentists are well placed to notice signs of child abuse and neglect, yet research shows that UK dentists are unprepared for a role in protecting children at risk[16].

172. Abused and neglected children have been found to have higher levels of tooth decay than the general population (Valencia-Rojas et al. 2008[17]) therefore when primary health care workers such as health visitors are aware of the presence of dental neglect it should alert them to the potential for broader neglect and subsequent child protection and particularly in families that are resistant to professional advice and factors such as domestic abuse and substance misuse.

173. The manner in which information about the extraction of children's teeth was processed appears to reflect a degree of normalisation in regard to children living in economic and

social disadvantaged circumstances; the children lived in an area of the city that is economically and socially very deprived and the children were living in a home where it is now known whether there was inadequate food according to the evidence of relatives that was only made available as part of the murder investigation. None of the agency reports make any comment about conditions in the home.

174. Related to the issue of undiagnosed neglect, the victim went to the GP with a shoe bite in June 2013; an injury that occurs because of ill-fitting footwear. The victim had been subjected to years of financial control by the perpetrator. There is no record that over and above a prescription for antibiotics that there was any other probing about the social circumstances of the victim. This may in part because this is a part of the city where many people are living with little money and therefore this victim was not seen as particularly unusual within that context.

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[15] Health Visitors' Role in Assessing Oral Health in Children: Investigating Dental Neglect Thresholds. Bradbury-Jones. C., Taylor, J., Innes. N., Evans, D. & Ballantyne, F. August 2012

[16] Safeguarding children in dentistry: Do paediatric dentists neglect child dental neglect? J.C. Harris, C. Elcock, P. D. Sidebotham & R. R. Welbury British Dental Journal 2009:206, 465 - 470 (2009)

[17] Prevalence of early childhood caries in a population of children with history of maltreatment. Journal of Public Health Dentistry, 68(2), 94-101. Valencia-Rojas, N., Lawrence, H.P., Goodman, D. (2008)

175. The difficulties that the victim faced in regard to her lack of language skill in English were a significant barrier to more effective communication. It exacerbated her isolation and was a significant factor in her contact with the police. For some services other than the police there was either a belief that the victim understood enough words as to not require an interpreter or on some occasions the perpetrator was used to translate. The use of family and relatives is fraught with difficulty and when domestic abuse is suspected it is prohibited by the policy of services such as the police.

176. The use of interpreters was not consistent and was a significant factor in why the police, when they were contacted by the victim, failed to understand the significance and extent of the abuse in the relationship.

177. The quality of interpreters is an issue and especially in dealing with something as sensitive as domestic abuse or other intimate crime involving adults or children.

178. The failure to recognise the significance of the original report in 2008 had consequences in how other services also dealt with information. There was never any clear indication that the threat to the children from the behaviour of the perpetrator was understood. The police and school were both told about the victim's concern and effort to control the perpetrator's contact with the children.

179. A previous domestic homicide review in Birmingham collated evidence about how domestic abuse presents an additional level of stigma and social isolation that can inhibit the ability of the victims and families to disclose what is happening and can also influence the response by some professionals who either share a common cultural tradition or are unaware of the significance of different cultural systems.

180. In this case, the family were from a South Asian cultural tradition that relies on the family structure to provide support and to resolve personal problems and difficulties. It is a tradition that believes strongly in the privacy and primacy of the family and encourages family members to be loyal to the family and to not look to external people and agencies to

intervene. It is a tradition that encourages the family and its various members to take care and responsibility.

181. When the victim asked for help, the response was too often unable to provide effective enough intervention and support.

182. The physical, psychological and emotional effects of domestic abuse and violence on children can be severe and long-lasting. Some children may become withdrawn and find it difficult to communicate. Others may act out the aggression they have witnessed, or blame themselves for the abuse. All children living with abuse are under stress. There is no record of the children of what the children observed or heard in regard to the incidents of domestic abuse and no record about their views, wishes and feelings.

183. The Neighbourhood Advice and Information Service had many phone calls from the victim in March 2013. There were nine attempts over a three day period in early March to get an appointment; four attempts in a 48 hour period in mid-march and sixteen in the last week of March. A total of 32 calls were made when appointments were not available. The victim disclosed in the first contact that the perpetrator had gone to Bangladesh but no information was recorded about the circumstances.

3.5 Issues in relation to capacity or resources agencies that impacted on the ability to provide services

184. Most of the individual management review and information report authors did not identify issues in regard to capacity or resources as being factors that influenced how contact with the family was managed.

185. The Birmingham Community Healthcare Trust described historical issues in regard to staffing and vacancies in the health visiting service that had affected the city that contributed to very high caseloads of 600-700 for health visitors (as well as the action taken by that service to address these issues in recent years and nationally through the Health Visitor Implementation Plan[18]). There were also changes to organisational and accountability

arrangements that arose through health service reforms and restructuring. It was against such a background that the information about the original report to the police was made in 2008.

186. Previous domestic homicide reviews had highlighted that the introduction of new working and recording arrangements in regard to vulnerable adults had been an issue for the police. For example, the data collection form (WC392) had been created in 2010 to record crime and non-crimes generated from domestic violent incidents in order to then trigger further actions. In 2010 there was confusion and misunderstanding which was reflected by a significant fall in referrals; in 2011 staff were given training on the new procedures for DASH risk assessments. It is understood that some officers thought they had the same discretion for completing the WC392 as they had for the DASH risk assessment in managing their administrative workload.

187. Additional factors affecting the force included a change from paper reporting to a computerised 'crime portal' system. The police task and finish group for domestic violence had been exploring how to work more closely with local police units to understand how risk was being identified, assessed and recorded. Evidence was currently being examined with anticipated changes to come into effect in 2014.

188. Changes to the way that interpreter services were commissioned and provided at a national and local level have had implications for this case. Interpreter services for the police and criminal justice services in general is now provided through a national provider.

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[18] In February 2011 the government made the commitment to an extra 4,200 health visitors by 2015 and published a plan.

4 Findings of the review and recommendations

189. Any meaningful analysis of the complex human interactions and processes for information management and decision making that characterise multiagency work relating to domestic

abuse and homicide has to understand why things happen and the extent to which local systems help or hinder effective work within 'the tunnel'[19].

190. This report and all the others that are provided through a review such as this should acknowledge the complexity facing people working in those services. The benefit of the hindsight offered through a detailed review should not over simplify or devalue the skills and knowledge that the combined workforce of criminal justice, education, health and social care professionals has developed and that they deploy on a daily basis.

191. The key findings in this chapter are framed using a systems based typology developed by the Social Care Institute for Excellence (SCIE). Although the SCIE methodology has been developed specifically for serious case review rather than domestic homicide review and this review has not used systems learning to collate evidence there is value in using the following framework to identify some of the underlying patterns that appear to be significant for local practice[20].

a) Cognitive influence and bias in processing information and observation;
b) Family and professional contact and interactions;
c) Responses to incidents and information about domestic abuse;
d) Tools to support professional judgement and decision making in regard to risk;
e) Management and agency to agency systems.

192. In providing the analysis and recommendations to the Community Safety Partnership there is an expectation that the Community Safety Partnership will want to provide a response to each of the key findings as well as to the recommendations and action plans that are described in the individual management reviews.

193. The Community Safety Partnership will determine how this is managed and communicated to the relevant stakeholders.

The IPCC investigation has resulted in recommendations being made to the West Midlands Police to address improvement in regard to training of police following changes in policy, reviews of the missing person's policy and training on risk factors, call handling, the use of interpreters and use of police cautions in regard to domestic abuse. This review endorses those recommendations.

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[19] View in the Tunnel is explained by Dekker (2002) as reconstructing how different professionals saw the case as it unfolded; understanding other people's assessments and actions, the review team try to attain the perspective of the people who were there at the time, their decisions were based on what they saw on the inside of the tunnel; not on what happens to be known today through the benefit of hindsight.

[20] SCIE identify five domains of which two have been used for this domestic homicide review; the domains are innate human biases (cognitive[20] and emotional), family and professional interactions, responses to incidents, tools and management systems

4.1 Cognitive influence and bias in processing information and observation:

Victim behaviour; invisibility of emotional coercion and control; recognition of neglect in communities with high levels of deprivation;

194. In this case, there were a number of factors that influenced the processing of information. The single most significant factor was that, apart from the incident in May 2008, nobody understood that the victim was being abused and indicators of neglect were not recognised.

195. Some of this might be a process of normalisation in the context of working in areas where there are high concentrations of need. The family live in an area that is located within one of the ten per cent most deprived areas in the country. This context is significant. The nature of need within the family that was presented was not regarded as exceptional particularly it seems within the local culture and social circumstances of other families where factors such as dental caries are not uncommon. This is a process that individual professionals largely have to resolve on a case by case basis in circumstances where all the services are under pressure.

196. The approach to the three attempts by the victim to get help in regard to the domestic abuse was flawed. This reflected people departing from the expected procedures and standards; an underlying reason was a cognitive inability to understand domestic abuse and the impact it has on victims and their behaviour (combined with a lack of knowledge on the part of some about important policy requirements). The overwhelming mind-set was to look for evidence of physical and immediate threat rather than understanding the coercion and effort to control by threats.

197. Professionals who either receive a disclosure of information or have reason to believe that they may be dealing with the victim of domestic abuse need to have the confidence and sensitivity to ask questions that can help identify the patterns of behaviour that include economic, emotional and physical coercion and assault as well as sexual and psychological attacks. This has implications for how the risk assessment schedules are applied.

198. An additional aspect to come from this case is the danger of any person believing that when the victim of an abusive partner or spouse leaves the relationship or the spouse or partner is outside of the country that the danger has diminished. This tragic case has demonstrated that rather than the danger becoming diminished, it can escalate the severity of risk. The killing of partners at the point of threatening or actually leaving relationships is a trigger for heightened threat. It is therefore necessary when conducting assessments to ensure that this enhanced level of risk is recognised and that continuing help is provided to secure the safety of the adult and any dependent children. Unless that is the mind-set that is applied, there will be a high reliance on the more superficial immediate observation as to whether victims and children are 'safe and well'.

199. Given the barriers to disclosure which include fear of further violence, it is even more important to create the best opportunity for responding effectively. For example, when the victim asked the school to prevent the perpetrator from collecting the children from the school there was a focus on the legal limitations on the school of being able to do this but not enough as to the reasons and circumstances. Places like schools and health clinics can be gateways to help for victims.

Recommendation 1

The Community Safety Partnership should consider whether policy and practice guidance in relation to inquiry and assessment relating to domestic abuse gives sufficient attention to professional mind-set and victim behaviour.

4.2 Family and professional contact and interactions;

Ensuring that professional contact does not escalate risk; clarity of communication especially when language or a disability may be a factor; influence of victim behaviour and demeanour; inference given to information from non-professional sources; importance of universal and open access services to help victim's overcome social isolation.

200. The point has been made about the escalation in threat when a victim shows intent to leave an abusive relationship. In any contact between a victim and any professional, when a concern or direct disclosure is made about domestic abuse, it is vital that it does not lead to the victim being exposed to greater risk. It is the reason, for example, that midwifery and health visiting staff routinely ask about domestic abuse but do it when a private opportunity arises.

201. A significant issue for most of the services was the fact that English was not the victim's first language. This impeded communication between her and various professionals. It is not apparent that the significance was understood by professionals at the time.

202. All of the services have confirmed that they have access to interpreter services although have not been able to explain why these have not been consistently used.

203. The victim was socially isolated. This made her even more reliant on her husband and family. The importance of open access services such as children's centres are well recognised and is the reason for contact being made with the mothers of very young

children. In this case a routine contact was undertaken although the victim did not take up any offers of service. The visit was undertaken by a bank member of staff who may have had less personal investment in engaging the family. It is not clear that this contact was used as an opportunity to proactively look for indicators of vulnerability (social isolation, no friend or close family, limited language, not in work, limited income).

204. Although it is acknowledged that individuals have a right to privacy, given the known inhibitors that can discourage take up of services, the case invites some refection as to whether the offer and delivery of these types of universal provision are being appropriately assertive and proactive in reaching out and encouraging engagement and involvement with services such as children's centres. This can be an important element of giving victim's a trusted pathway to advice and help. Primary health workers such as health visitors and GPs can also be an important source of encouragement as well as identifying indicators of vulnerability. Reference for example has been made to the shoe bite that in hindsight could have been more clearly seen as something more than just self-neglect by the victim.

205. None of the professional contacts record any detail about physical conditions in the home although much of the family income appeared to be diverted to relatives in Bangladesh.

206. This is not the first domestic homicide review where evidence from family members reveals that they had concerns about the victim prior to the death. It has not been possible to speak with any of them and therefore it remains unknown what sources of help they were aware of for the victim.

207. On the day of the murder the first contact with the police was from a relative who was concerned that the victim had not collected her children from the school. The IPCC investigation and the police individual management review have both commented that in that initial call a significant volume of information was provided and the relative made clear they were concerned. The decision to seek further information for the purpose of the risk assessment questionnaire showed more of a preoccupation with process rather than recognising the significance of information that had already been acquired.

208. The IPCC and police individual management review have made recommendations in regard to how procedures in regard to missing persons are applied. The message for multi-agency learning is that with hindsight not enough inference was given to the level of concern being expressed. It was not the only occasion. It happened in contact with the police; it happened when the victim expressed concerns about the perpetrator at school. It is not just about applying protocols or procedures but also understanding their purpose.

4.3 Responses to incidents and information;

Ensuring that enquiries and assessment are based on rigorous assessment of risk to the victim and children; signposting to advice and help;

209. Domestic abuse is a generic term describing a range of controlling and coercive behaviours which are used by one person to establish and maintain control over another person with whom they have, or have had, an intimate or family relationship. It is the cumulative and interlinking physical, psychological, sexual, emotional and financial abuse that has profound and damaging impact on the victim including their children. It erodes self-confidence and identity and isolates the victim from potential sources of help and support. Treating domestic abuse as isolated incidents fails to reveal the underlying dynamic of coercion and control.

210. Victims often want to prevent the police arresting a perpetrator with whom they have or had an intimate relationship. This should be anticipated and is not a reason for not treating a call as a potential crime and subjecting it to an appropriate level of forensic and investigative enquiry. Perpetrators should not be allowed to influence the investigation and must not be allowed to minimise their attitude, behaviour and overall conduct. A consistent reinforcement of the message that the behaviour is unacceptable irrespective of race, culture or religion is essential and that victims are informed and encouraged to use specialist services.

211. Domestic abuse that involves families or households where children live or stay on a regular basis needs to be investigated not only as a potential crime but also regarded as a safeguarding issue that involves specialist police officers and children's social care.

212. The victim does not seem to have been advised to seek legal advice over and above going to the Citizen's Advice Bureau. There is no record of her making contact with the Citizen's Advice Bureau. The report has discussed the shortcomings in regard to the investigation of threats to kill. In addition to the criminal and public law frameworks that are available to help victims of domestic abuse there are private law remedies available to help victims prevent harassment and control contact from the perpetrator. Access to legal aid and to specialist lawyers should form part of the array of response available to victims of domestic abuse and their children.

Recommendation 2

The Community Safety Partnership should review the effectiveness of strategies for communicating and signposting victims of domestic abuse to specialist advice and support to respond to victims and children who have experienced domestic abuse.

4.4 Tools to support professional judgment and practice in relation to risk;

The purpose and application of risk assessment and referral pathways;

213. The application of the risk assessment frameworks did not achieve a good enough enquiry into the circumstances and background to the incidents of domestic abuse. History in regard to previous contacts was not checked leading to each incident being assessed in isolation and entirely reliant on the observations of police officers primarily.

214. Rather than being a procedure of facilitating clearer disclosure and exploration of background and underlying patterns the approach appeared to be more administrative and compliance with the letter rather than the ethos of the frameworks.

215. There was apparent confusion in the referrals that went to other services. The Heart of England Foundation Trust is clear that they received a DARIN that was indicating medium risk involving a pregnant woman who already had a two year old child. They acknowledge that they did not act on that information. Children's social care make no reference to the DARIN although were aware of a report of domestic abuse involving a pregnant mother of a

two year old child.

216. The establishment of the Multi Agency Safeguarding Hub (MASH) in Birmingham will provide opportunity for improved and more efficient joint agency collating of information and managing enquiries and assessment.

217. Information provided to the police during the murder inquiry indicates that there had been long term concern and knowledge about the perpetrator's attitude and care of his family. Although much of the contact with services was outside of the family home there were visits made as part of routines associated with health care following the birth of the children and outreach through the children's centre as well as visits by the police in response to the emergency calls.

218. None of those contacts recorded any concern about physical conditions in the home although much of the family income appeared to have been diverted to relatives in Bangladesh. The information about dental caries attracted little attention as an indicator of neglect.

219. Birmingham Safeguarding Children Board will receive a copy of this report. Birmingham Safeguarding Children Board in collaboration with NSPCC have launched a campaign to help children to be protected from neglect. This report draws attention to the role of dental practitioners and services in helping identify potential adult and child victims of abuse and neglect.

Recommendation 3

The Community Safety Partnership should ensure that information is submitted on the implementation of the action plan submitted to the domestic homicide review by the early years and education services.

Recommendation 4

The Community Safety Partnership should ensure that revisions to the S11 and S175 audit safeguarding children audit tool incorporates learning from this and other domestic homicide

reviews.

4.5 Management and agency to agency systems;

Identification and response to domestic abuse across all services; initiating domestic abuse pathways; accessibility and use of trained interpreters; capacity of services to make effective contribution to meaningful statutory reviews; sharing learning from other parallel investigations.

220. A consistent message from this and other domestic homicide reviews is that it is rare for domestic abuse to be explicitly disclosed. The inhibitions and barriers have been acknowledged and described. There is a risk when conducting a review such as this for some individual professionals to feel that their practice and decision making is being unfairly scrutinised.

221. It is clear that some professionals are still working on an assumption that they will be told about domestic abuse (by the victim, by a family member, by another professional). The truth is that domestic abuse is more likely to be revealed when professionals are vigilant and proactive about the safety of adult victims and their children.

222. A woman and children being kept in poverty may reflect the very difficult circumstances facing very many families but if it is a result of financial coercion this has different significance.

223. Some services have yet to demonstrate a sufficiently clear understanding about their role in identifying and preventing domestic abuse. Examples included the way in which the Neighbourhood Advice and Information Service received repeated phone calls regarding housing and financial advice but did not arouse enhanced curiosity about the context of the victim; asking the question about why the victim was trying to leave a relationship. Services are relying on clear disclosures of domestic abuse to trigger a response; it is not clear that

anybody was aware for example of the unusual level of telephone contact by victim with the Neighbourhood Advice and Information Service for example in March 2013. Securing a tenancy and finance for victims of domestic abuse are urgent priorities and appeared to be what was occurring in March 2013.

224. Similarly when the victim disclosed her concern about the perpetrator collecting the children from school, this did not provoke more curious and purposeful follow up. In making these comments it is not saying that it is the job of one single person or organisation to help and intervene. The point is that organisations need to ensure that their staff have sufficient awareness about domestic abuse, their role and responsibility in responding to it and have the systems in place to develop effective responses. Some of this will be procedural and some of it is about the mind-set, empathy and professional communication skills relevant to the task.

225. Having ready access to people with the right language skills and who have had sufficient training in understanding domestic abuse appears to be an issue across services.

226. Children's social care have had limited involvement in the domestic homicide review either in regard to participation in the panel meetings or providing an information report to clarify the circumstances under which the service received later notifications from the police or the robustness of response to information about threats to the victim.

227. The IPCC and West Midlands Police reports have highlighted the extent to which there was some confusion and misunderstanding about aspects of domestic abuse policy, risk assessment and recording systems. A significant contributory factor was a reliance on e-learning and shift briefing to communicate new arrangements. This provided limited opportunity to make the purpose of some significant activity and left no opportunity for officers to ask question or clarify on matters such as the use of electronic forms or the use of the missing person questionnaire. The consequence was a preoccupation with clarifying with the letter of a protocol without understanding the spirit and purpose. For example the initial contact regarding the unusual behaviour of the victim in not collecting her children.

228. The establishment of the joint screening arrangements for domestic abuse and of the

MASH should provide an enhanced ability to identify and provide advice and help to adult victims and children living with domestic abuse.

Recommendation 5

The Community Safety Partnership should ensure that the review of the provision of advice services in the city is fully sighted on the difficulties that this victim of domestic violence experienced in obtaining an appointment for advice services. Future plans arising from both the review of advice services and the review of domestic violence should secure a clear pathway for advice and support for domestic violence victims.

Recommendation 6

The Community Safety Partnership should seek further information from services regarding the availability of appropriately trained interpreters.

Recommendation 7

The Community Safety Partnership should seek further information from the statutory director for children's services regarding the capacity of the service to participate in statutory reviews.

Recommendation 8

The Community Safety Partnership should request information from agencies about the extent to which they rely on e-learning or similar strategies for raising awareness and knowledge of staff regarding domestic abuse.

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APPENDICES

Appendix 1 – index to significant relationships

	Relationship to the subject	**Age at the time of the death**
The victim		27 years
The perpetrator	Estranged husband	37 years
Child 1	Eldest child	7 years
Child 2	Second eldest child	4 years
Adult 1	Victim's mother (Resides in Bangladesh with victim's father)	42 years
Adult 2	Victim's uncle (brother of Victim's mother) (resides in Birmingham)	43 years
Adult 3	Victim's aunt through marriage and wife of Adult 2	34 years
Adult 4	Victim's aunt sister of victim's mother) resident in Birmingham	30 years
Adult 5	Victim's uncle through marriage and husband of Adult 4	46 years
Adult 6	Family friend who initially reported that the victim had not collected her children from school	43 years

Appendix 3 - Procedures and guidance relevant to the domestic homicide review

Date	Policy or legislation	Prime agency
1990	**Home Office Circular 60/1990 Domestic Violence:** issued to all police forces in England and Wales advising police to ensure that all police officers involved in the investigation of cases of domestic violence regard as their overriding priority the protection of the victim and the apprehension of the offender. The circular emphasised the importance of multi-agency working, establishment of domestic violence units, reviewing of recording policy and ensuring that officers were aware of the power of arrest and providing support to the victim.	Police
October 1991	**Children Act 1989 implemented;** major legislation in regard to investigation and protection for children at risk of harm. Section 17 imposes a duty upon local authorities to safeguard and promote the welfare of children in need. Section 25 describes the circumstances under which a local authority can seek to restrict the liberty of a child by placing them in secure accommodation. Section 46 provides the police with powers of removal and accommodation of children in cases of emergency to take children into police protection where a police officer has reasonable cause to believe that a child would otherwise be likely to suffer significant harm. Section 47 requires a local authority to make enquiries they consider necessary to decide whether they need to take action to safeguard a child or promote their welfare when they have reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm. These enquiries should start within 48 hours. The local authority is required to consider whether legal action is required and this includes exercising any powers including those in section 11 of the Crime and Disorder Act 1998 (Child Safety Orders) or when a child has contravened a ban imposed by a Curfew Notice within the meaning of chapter	Social care and police have specific duties and powers described in the Act but implications and duty to cooperate for other services.

	I of Part I of the Crime and Disorder Act 1998. Section 31 (9) defines harm which was extended via section 120 Adoption and Children Act 2002 implemented in January 2005 that now includes 'impairment suffered from seeing or hearing the ill-treatment of another' recognising that children who witness or hear abuse suffer, or are likely to suffer, significant harm as a result.	
1995	**Home Office and Welsh Office (1995)** inter agency circular/inter agency coordination to tackle domestic violence: issued to all agencies involved in tackling domestic violence including the police.	All services
1996	**Family Law Act 1996**: changed the legal framework relating to civil injunctions in the context of family law. Part IV of the Family Law Act 1996 provides single and unified domestic violence remedies in the county courts and magistrates' courts. Two types of order can be granted: • A non-molestation order, which can either prohibit particular behaviour or general molestation; • An occupation order, which can define or regulate rights of occupation of the home.	
1997	**Protection from Harassment Act 1997**: (PHA) introduced the offence of harassment and power of the court to issue restraining orders on conviction. PHA makes it a criminal offence to pursue a course of conduct which amounts to harassment of a person. A court may issue a restraining order against someone found guilty of such an offence. Amendments to the PHA introduced by the Domestic Violence, Crimes and the victims Act 2004 will gives courts the power to issue a restraining order in certain circumstances against a defendant acquitted of a charge of harassment. In addition to the criminal offence, the PHA also creates a civil statutory tort of harassment, which enables a person to obtain a civil court injunction to stop harassment occurring and to claim damages where appropriate. This legislation can provide protection in neighbourhood disputes, cases of racial harassment and can also potentially apply in cases of domestic abuse.	Police and courts

1998	**Crime and Disorder Act 1998**: established the framework of multiagency Crime and Disorder Reduction Partnerships tasked with conducting audits of local crime and disorder and agreeing a local strategy. Section 17 of the Act requires the police (in partnership with local authorities) to exercise all their functions —*with regard to the effect on the need to prevent crime and disorder in their areas*. Domestic violence falls clearly within these duties.	
1998	**Human Rights Act 1998**: introduced positive obligations to protect life and protect the victims against inhuman and degrading treatment.	All services and courts
1999	**Youth Justice & Criminal Evidence Act 1999**: introduced special measures within a court setting, for vulnerable and intimidated witnesses.	Police and courts
2000	**Home Office (2000) Domestic Violence Break the Chain multiagency guidance for addressing domestic violence**: the guidance includes advice for the police that *"there must be no suggestion that dealing with domestic violence is in any sense second class police work*" and that specialist officers should maintain close links with other units dealing with issues such as child protection.	Police as well as other agencies
2000	**Home Office Circular 19/2000; Domestic Violence revised circular to the police**: this circular provided more specific and detailed information to the police and reflected changes in legislation since 1990 and the findings of recent research.	Police
2004	**HMCPSI/HMIC (2004) *Violence at home, a joint thematic inspection of the investigation and prosecution of cases involving domestic violence***: includes a number of recommendations relating to policing and prosecuting domestic violence cases.	Police and courts
2004	**Domestic Violence Crime and the victims Act 2004;** Civil injunctions (under Part IV of the Family Law Act 1996) offer temporary protection through non-molestation orders or occupation orders. However, breach of injunction by the perpetrator was often not effectively enforced. New provision under section 1 of the DVCVA 2004 is intended to address this issue. Until now a breach has only been punishable as a civil contempt of court. When a non-molestation order either made after July 1st 2007, or an earlier order which has been varied is breached it will be treated like any other criminal offence, meaning that the perpetrator can be arrested,	

	charged and brought before the magistrates' court. The victim, who was the applicant in the original civil process, becomes the key witness in a criminal case. As in other criminal cases, the decision whether or not to prosecute will be made by the Crown Prosecution Service (CPS) in conjunction with the police, where there is sufficient evidence and it is in the public interest to do so. The maximum custodial sentence for breaches dealt with as a criminal offence is five years. The procedure under Family Law Act 1996 Part 6 rule 12A (2)states:- Where an order is made ex parte a copy of the order.... shall be served by the applicant on the respondent personally. Enforcement of orders S20 (1A) states:- ... shall be delivered to the officer for the time being in charge of any police station for the applicant's address or of such other police station as the court may specify (1B) states:- The documents referred to above ... shall be delivered by (a) the applicant, if the applicant is responsible for serving the order on the respondent	
2004	**ACPO (2004) guidance on investigating domestic violence**: guidance includes a clear focus on the investigation of criminal offences relating to domestic violence.	
2004	**Home Office Violent Crime Unit (2004) Developing Domestic Violence Strategies – A Guide for Partnerships.**	
2005	**ACPO (2005) guidance on identifying, assessing and managing risk in the context of policing domestic violence**: includes a list of risk 313 factors and general information about the basic principles of identifying, assessing and managing risk in domestic violence cases.	Police

January 2005	**Adoption and Children Act 2002**, section 120 implemented: amends section 31 of the Children Act 1989 to include the following in the definition of harm: impairment suffered from seeing or hearing the ill treatment of another e.g. witnessing domestic violence.	Police, social care and courts
February 2005	**ACPO (2005) policy on police officers who commit domestic violence related criminal offences**: clearly establishes the principle that evidence that a police officer has committed criminal offences relating to domestic violence is not compatible with a police service that has public confidence.	Police
March 2005	**ACPO (2005) guidance on investigating child abuse and safeguarding children**: guidance includes a clear focus on the investigation of allegations of criminal offences relating to child abuse and the need to identify concerns for children which are managed in the multi-agency structure for safeguarding children.	Police
June 2005	**ACPO (2005) Practice Advice on Investigating Harassment**: this provides information on harassment including that related to domestic abuse.	Police
September 2005	**ACPO (2005) Guidance on Investigating Serious Sexual Offences:** includes specific investigative guidance on investigating domestic or intimate partner sexual offences.	Police
2005	**Home Office (2005) Domestic Violence**: **A National Report**: this developed a national delivery plan for services relating to domestic violence.	All services and courts
December 2005	**Responding to domestic abuse:** a handbook for health professionals and superseded an earlier handbook issued in 2000.	Health
2006	**H M Government (2006) Working Together to Safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children** that includes guidance on children exposed to domestic violence (superseded in 2010)	All services
2007	**ACPO (2007) Police Officers and Police Staff that are the victims of Domestic Abuse**	
2007	**Home Office (2007) National Domestic Violence Delivery Plan: Annual Progress Report 2006-2007.**	
April 2008	**ACPO (2008) Guidance on Investigating Domestic Abuse**: this revised and updated the ACPO (2004) Guidance on Investigating Domestic Violence.	
April 2009	**National MAPPA guidance v3**	
September	**Improving safety, reducing harm. Children and Young People and domestic violence**; A practical	Health

2009	toolkit for front-line practitioners	
March 2010 8th April 2010	Working Together revised and reissued The Crime and Security Act (CSA 2010) gained royal assent of which Sections 24-33 of the Act relate to Domestic Violence Protection Notices/Orders. (DVPN/O) These are legislated for under Sections 24 - 33 of the Crime and Security Act 2010 which (when fully implemented after being piloted in Greater Manchester, West Mercia and Wiltshire) will grant powers to the police in England and Wales to issues notices which immediately prevent allegedly violent partners from returning to a family home pending a formal order being issued by a magistrate. Section 33 came into effect when the Act came into force; sections 24-30 were commenced from 30th June 2011 for one year. Sections 31 and 32 have not been commenced.	All services Police
November 2010	**Call to End Violence against Women and Girls;** national action plan, vision and guiding principles for reducing violence against women and children	
April 2011	Domestic Homicide Reviews (DOMESTIC HOMICIDE REVIEWs) were established on a statutory basis under **section 9 of the Domestic Violence, Crime and the victims Act (2004)**	
April 2012	***Striking the Balance*; Practical Guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences**); Guidance intended to assist those involved in information sharing between agencies about Domestic Violence to make decisions. It identifies the underlying ethical considerations so that tensions between confidentiality and information sharing may be resolved.	Health
May 2012	**Responding to domestic abuse: Guidance for general practices;** a general guide to GP practices issued by the Royal College of General Practitioners and CAADA to help them provide effective help to patients experiencing domestic violence.	
2012	**CAADA Risk Identification Checklist (RIC) & Quick Start Guidance for Domestic Abuse, Stalking and 'Honour'-Based Violence** (this is not government guidance or legislation but is included as an important contribution to local and national arrangements	
June 2012	Government issues consultation on revised guidance for working together	
July 2012	Pilot of the Domestic Violence Disclosure Scheme begins for 12 months in Greater Manchester,	

	Nottinghamshire and Wiltshire in England and in Gwent in Wales. The scheme is commonly referred to as Clare's law; this is a reference to Clare Wood who was murdered by her ex-boyfriend in Salford in 2009. The boyfriend had a history of domestic violence that was not known to Clare Wood. The pilot scheme allows a check with police on whether a partner has a history of domestic violence.	