BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP
WORKING TOGETHER FOR A SAFER CITY

Domestic Homicide Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

Overview Report

BDHR2014/15-02

November 2017

Report into the death of

Anna

1972 – 2014

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CONTENTS

1. INTRODUCTION

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

This domestic homicide review was commissioned by Birmingham Community Safety Partnership following the death of a Birmingham resident, Anna. She died from compression to her neck. Her estranged husband was subsequently found guilty of her murder and the attempted murder of their two children. He was sentenced to a minimum term of 25 years' imprisonment for his wife's murder and 20 years each for the attempted murder of their children. The terms are to run concurrently. This report examines the contact and involvement that agencies had with Anna, her estranged husband and their children between January 2011 and the time of her death in June 2014.

The chair and author of this review is a freelance consultant. She is independent of, and has no connection with, any agency in Birmingham. She specialises in safeguarding children and vulnerable adults with a particular focus on domestic abuse.

The review panel would like to express their condolences to the family following Anna's death. The panel also wishes to thank all those who have contributed and assisted with this review.

1.1. Timescales

The Birmingham Community Safety Partnership was notified of Anna's death at the end of June 2014. The domestic homicide review team reviewed the circumstances of the case against the criteria set out in the multi-agency statutory guidance for conducting domestic homicide reviews and recommended to the Vice Chair of Birmingham Safety Partnership that such a review should be undertaken. The Vice Chair ratified the decision to commission a domestic homicide review on 28 July 2014 and the Home Office was notified on 28 July 2014.

The police investigation and subsequent criminal proceedings delayed the commencement of the review, which was therefore not completed within the six months as recommended in statutory guidance. The review was concluded on 28 October 2015.

1.2. Confidentiality

The findings of this review remained confidential and were only available to participating professionals, their line managers and members of the domestic homicide review panel until the report was approved for publication by the Home Office Quality Assurance Group.

To protect the identity of the family members their names have not been used and the following terms have been used throughout this review:

- Anna – aged 42
- Estranged husband/perpetrator – aged 42

} Age at the time of Anna's death

- Son
- Daughter

Anna, her estranged husband and their children are all of white British origin.

1.3. Dissemination

In addition to the organisations contributing to the review (listed at 2.3), the following will also receive a copy of this report for learning within their organisations.

- Birmingham Community Safety Partnership
- Birmingham Health and Wellbeing Board
- Birmingham Safeguarding Children Board
- West Midlands Police and Crime Commissioner

2. THE REVIEW PROCESS

The review has been conducted in accordance with statutory guidance under s. 9 Domestic Violence, Crime and Victims Act (2004). Individual management reviews (IMRs) or information reports were sought from all agencies, organisations or departments that had any recent involvement with Anna, her estranged husband or their children between January 2011 and the end of June 2014. The panel decided on this timeframe as it covered the couple's separation and the period leading up to it. The agencies involved were asked also to consider any relevant information before the period under review that might have had an impact on the case.

2.1. Purpose and terms of reference of the review

The aim of the review is to:

i. Establish what lessons can be learned from Anna's death about the way in which local professionals and organisations work individually and collectively to safeguard victims.

ii. Identify how and within what timescales those lessons are to be acted on, and what is expected to change as a result.

iii. Apply these lessons to service responses including changing policies and procedures as appropriate.

iv. Prevent domestic homicide and improve the way services respond to all victims of domestic abuse, and their children, through improved intra and inter-agency working. [1]

2.2. Key lines of enquiry

The review considered both the "generic issues" set out in the multi-agency statutory guidance for the Conduct of Domestic Homicide Reviews (2013) and the following specific issues identified in this particular case:

- What knowledge/information did your agency have that indicated Anna and her children might be victims of domestic violence, and how did your agency respond to this information?

- What knowledge/information did your agency have that indicated the estranged husband was a perpetrator of domestic violence and how did your agency respond to this information?

- What opportunities and services did your agency offer and provide to meet the needs of Anna 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 any children were at risk of significant harm or children in need of a service?

- Did the son's history of Asperger's syndrome and attention deficit hyperactivity disorder (ADHD) have an impact on the support offered to the family?

- Were there issues of capacity or resources within your agency that had an impact on your agency's ability to provide services to Anna, her estranged husband or their children? Did capacity or resources have an impact on your agency's ability to work effectively with other agencies?

[1] Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts

- Identify any lessons learnt and implemented during the review process.

Specific issues for the son's GP

- Was he formally diagnosed with Asperger's and ADHD and if so, when?
- Was any specific support offered to him or his family following his diagnosis?

Specific issues for schools, the school nurse and the special educational needs co-ordinator

- Was the son given the opportunity to talk about his home life and if so, what were his thoughts?
- Were there any patterns to his behaviour that might indicate that things were difficult at home? For example, did his behaviour change following holidays or weekends?
- Did the daughter disclose any information about her home life?
- What support and opportunities were provided to Anna?
- Did the parents play an equally active role in the son and daughter's schooling e.g. attend any additional SENCO (special education needs co-ordinator) meetings about the son?
- Was the son subject to a statement of educational needs?
- As part of any assessments, were any home visits undertaken? If so, were both parents present?
- Why did the son cease to attend his secondary school in 2012, and what school did he attend following this time?

Specific questions for the neighbourhood office

- Did Anna disclose domestic abuse or indicate that she was a victim of domestic abuse?
- Is this question routinely asked when claiming for any benefits?

2.3. Contributors to the review

In all, individual management reviews and chronologies were requested from:

- Heart of England NHS Foundation Trust
- Birmingham Community Healthcare Trust
- Birmingham Children's Hospital NHS Trust
- GP
- Schools
- Stepping Stones Family Support Project

Information reports and chronologies were requested from:

- Neighbourhood Advice and Information Service
- West Midlands Ambulance Service

The individual management reviews, information reports and chronologies covered the period between January 2011 and the end of June 2014. The panel decided on this timeframe as it covered the couple's separation and the period leading up to it.

2.4. Involvement of family and friends

The Chair wrote to Anna's family via the police family liaison officer to explain that a domestic homicide review was taking place. The family were provided with information leaflets from the Home Office and AAFDA (Advocacy After Fatal Domestic Abuse). Nevertheless, because of the on-going investigation and the impending criminal proceedings, the Chair was unable to make direct contact with the family until after the conclusion of the trial. At this point, Anna's mother and sisters kindly agreed to be involved, despite clearly struggling to come to terms with her death. By this time, Anna's children were living with one of her sisters, her sister's husband and their two children and this was having a huge impact on their family life.

Anna's family described her as a devoted mother who adored her children. She was a quiet, private person, who enjoyed the company of a few close friends. Once she had separated from her husband, Anna really enjoyed doing things for herself – she relished her independence including being financially independent.

During her relationship, she did not have a job although she did voluntary work for a charity supporting families affected by autism. She also did a college course and gained work experience at a local garden centre.

Her family provided a wealth of information to suggest that Anna's estranged husband had been obsessed by her, which was demonstrated by his controlling, obsessive and smothering behaviour. He also exhibited signs that he had been stalking her both before and after their relationship ended. None of the family had any indication that the perpetrator was violent and they had never considered that his behaviour might place Anna at risk of harm.

Anna's family were visited during the review process and again on completion of the overview report. Examples of the perpetrator's behaviour, as described during the trial and by her family and friends, are used throughout this report.

The perpetrator was approached but he declined to take part in the review.

2.5. The review panel

The review panel consisted of:

- Eleanor Stobart – Independent Chair and Overview Report Writer
- Assistant Director Quality Assurance and Safeguarding, Birmingham City Council Children Social Care
- Deputy Head of Nursing, Child and Adolescent Mental Health Services (CAMHS)
- Detective Inspector, West Midlands Police
- Domestic Homicide Review Coordinator, Birmingham Community Safety Partnership
- Head of Safeguarding, Heart of England NHS Trust
- Lead Nurse Safeguarding Adults, Birmingham Community Healthcare Trust
- Operations Manager, Birmingham and Solihull Women's Aid
- Partnerships and Project Manager Quality Assurance and Safeguarding, Birmingham City Council Children Social Care
- Safeguarding Officer, Birmingham City Council Education and Commissioning

2.6. Parallel reviews

Apart from the criminal proceedings and the inquest, there were no parallel reviews taking place. The Birmingham Safeguarding Children Board considered undertaking a serious case review but the circumstances did not reach their current thresholds.

On 1 July 2014, Birmingham Safeguarding Children Board advised the Birmingham Domestic Homicide Review team that there would not be a serious case review undertaken in respect of the children, as their injuries were not considered to be life threatening. This decision was challenged at the Birmingham Domestic Homicide Steering Group meeting on 24 September 2014. The Domestic Homicide Review team contacted the Birmingham Safeguarding Children Board on 25 September 2014 to ask them to reconsider their decision not to proceed with a serious case review. On 26 September 2014, Birmingham Safeguarding Children Board informed the Domestic Homicide Review team that the decision to not to undertake a serious case review remained the same. The perpetrator was subsequently charged with the attempted murder of the children and therefore the panel agreed that the issue of a serious case review should be raised again with Birmingham Safeguarding Children Board. Ultimately, they declined and thus the Birmingham Safeguarding Children Board was asked to contribute to the review as a panel member. In addition, the terms of reference for the domestic homicide review were shared and agreed with the Birmingham Safeguarding Children Board serious case review sub-group.

3. THE FACTS

Anna was born in 1972 and she was 42 years old at the time of her death.

On a day in late June 2014 at 07:25, the police received a call from ambulance control stating that they had been called to an address in Birmingham where a man had found his 42-year-old wife dead at ten o'clock the previous night. He had subsequently called the ambulance at 07.17 the following morning because he was concerned for his children.

When police officers and paramedics arrived at the house, they found Anna dead at the scene. Her son and daughter had both sustained life threatening injuries. The son had a stab wound to his chest whilst the daughter had injuries consistent with strangulation.

The perpetrator, aged 42, was arrested on suspicion of the murder of his estranged wife and the attempted murder of their two children. In December 2014, he was found guilty of her murder and guilty on two counts of attempted murder. He was sentenced to a minimum prison term of 25 years for Anna's murder and 20 years for each of the attempted murders of his children. The sentences are to run concurrently.

4. BACKGROUND

Following the initial scoping for this domestic homicide review, there appeared to have been little known about any of the family members. There had been no calls to police concerning domestic abuse; the children were not known to children's social

care, and there were no specific contacts with health regarding domestic abuse. The only on-going contact that the family appeared to have with agencies was through their son. He had some behavioural issues and at the age of six, he had a statement of special education needs. He also had contact with the special educational needs co-ordinator and an education psychologist. He subsequently diagnosed (aged eight) as having autistic spectrum disorder (Asperger's Syndrome) and attention deficit disorder. As a result, he had (at times) regular appointments with child and adolescent mental health services (CAMHS).

The family lived in an affluent area of Birmingham and the perpetrator worked full-time as an IT engineer to support the family. Anna looked after the children and did voluntary work. She had a close relationship with her mother and two sisters (she was the middle child). During the period under review, her father died.

Approximately 18 months before her death, Anna asked the perpetrator for a separation. According to the Judge's summing up at his trial, the perpetrator was "very hurt and puzzled" by this request. However, following the separation, to keep things as "normal as possible", he continued to visit the family home to see the children. In fact, the perpetrator, Anna and their children continued to go on family holidays together.

Nevertheless, Anna described to family and friends (before and after the separation) that she felt "smothered" by her estranged husband. She had planned another holiday but she asked him not to come with them. Despite this, he appeared to "harbour thoughts and hopes that there would be some sort of reconciliation".[2] Following their separation, Anna re-kindled a relationship with a past boyfriend. Then sometime at the beginning of 2014, her estranged husband became suspicious that she was seeing someone else. Therefore, he "hacked" into her Facebook account and by June, he considered buying a tracker to put in her car.

A few days before her death, she told friends that her estranged husband had "locked" her in the garage for three hours and confronted her about this new relationship. She then phoned her "boyfriend" and told him that her estranged husband now knew about their relationship. On the morning of her murder, the perpetrator visited the family home to drop off their daughter. He went into the house and looked round while everyone was out. He found that all the photos of him had been removed from Anna's bedroom. He then went to the chemist and bought a packet of sleep remedy tablets. When Anna and the children returned, he put the tablets into her tea without her knowledge. She then went upstairs to lie down. According to Anna's family, he told the children to put their headphones on. When Anna had fallen asleep, he strangled her. Afterwards he put tablets in the drinks of both children and later attempted to murder them.

[2] Extract from the Judge's summing up at the trial

5. SUMMARY AND ANALYSIS OF AGENCY INVOLVEMENT

5.1. Heart of England NHS Foundation Trust

Both Anna and the perpetrator had various appointments and in-patient episodes that fell outside the scope of this review. None of these appeared to be relevant to this review. For example, Anna accessed maternity services and the perpetrator had two in-patient episodes for hernia repairs. He also had three outpatient appointments relating to these admissions.

During the period under review, Anna was seen at the emergency department twice. The first time was in January 2013 with an injury to her right shoulder and arm. She told staff that she had hurt herself whilst ice-skating. She was discharged with a "collar and cuff". The second occasion was following a bang to her nose. She said she banged it against a dog's teeth. She had sustained a superficial laceration to her nostril and felt unwell with pain in her lower jaw and face. She was given a tetanus booster, antibiotics and reassurance.

The couple's daughter presented twice to the emergency department. The first occasion in 2006 was not within the period under review. The second visit to the emergency department was in January 2013 when she had fallen awkwardly whilst playing on a large ball. She had injured her neck and had local tenderness. She was diagnosed with a sprain and given pain relief. No follow up was required.

When the son was three years old, he was reviewed by a paediatrician on three occasions. There were reports from home and his nursery that he displayed aggressive behaviour and had poor concentration. Things appeared to calm down once he started attending nursery full-time.

In March 2011, when he was 12 years old, he was seen in the emergency department with a "punch" injury. His hand was swollen and bruised. He had fractured his fifth metacarpal neck (the knuckle above his little finger). He was given pain relief and a splint. He returned for an outpatient appointment a few days later. On both occasions, he was accompanied by his mother.

Heart of England NHS Foundation Trust analysis of involvement

Heart of England NHS Foundation Trust has a domestic abuse policy. It was launched in August 2013, which is about the same time as Anna attended the emergency department having banged her nose against the dog's teeth. However, her description of what had happened appeared plausible and nothing about her presentation indicated that she was a victim of domestic abuse. Nor were there any disclosures that the children were experiencing domestic abuse within the household or that their father was a perpetrator of domestic abuse.

Nevertheless, the son's presentation could potentially have been linked to witnessing domestic abuse. Young children experiencing domestic abuse can display a range of signs and symptoms including aggression and poor concentration. This was not explored at the time. Equally there was no evidence in the records that following his punch injury any discussion took place about the circumstances of the punch i.e. what he had punched or why. There was also no evidence that any alternative coping strategies were discussed.

Since April 2015, to improve the response to victims of domestic abuse, Birmingham Solihull Women's Aid has been providing a point of contact within the emergency department and maternity unit. The aim of this service is to ensure victims of domestic abuse are referred appropriately to organisations that can offer help, support and advice.

5.2. Birmingham Community Healthcare Trust

Birmingham Community Healthcare Trust reviewed the records of the health visitors, the school nurse and the dental hospital. Much of the information was outside of the period under review and was not relevant to the review. However, although it was apparent that the daughter received universal health visiting and school nurse services, the son required greater input around some behavioural issues. He had additional support from the school nurse because of his behaviour and he was given a statement for special educational needs in 2005 at the age of six. He was also referred to the community paediatrician due to concerns about his behaviour. Ultimately, following a number of appointments with the community paediatrician and CAMHS, he was diagnosed with developmental co-ordination disorder in association with attention deficit disorder (aged eight) for which he required medication.

Birmingham Community Healthcare Trust analysis of involvement

There were no disclosures of domestic abuse by Anna or her children to any of the services provided by Birmingham Community Healthcare Trust. However, throughout his early years, the son displayed behaviour consistent with the type of behaviour that might be exhibited by a child living in a household where domestic abuse is a feature. He was described as having difficulties with language and development; he had poor concentration and enuresis. His behaviour was considered "aggressive and challenging". However, despite this, the question of domestic abuse does not appear to have been explored by any of the professionals involved in his care.

5.3. Birmingham Children's Hospital NHS Foundation Trust

Both children were seen at Birmingham Children's Hospital but the majority of the involvement took place outside the timeframe for this review. The daughter was seen at the emergency department in 2007 having swallowed an Ibuprofen tablet. She was accompanied by her mother. She did not require any active treatment and she was discharged the same day. Her second attendance was in June 2014 following the death of her mother. She was seen for her neck injuries and admitted to the hospital.

The son's first referral to Birmingham Children's Hospital was in 2006 following a referral by his GP to CAMHS. The referral had been requested by the educational psychologist/school due to concerns about his "worsening behavioural problems". He was referred twice more to CAMHS, once in November 2006 and again in 2011. The referrals all related to his "challenging" behaviour. In 2007, at the age of eight, he was diagnosed by CAMHS as having autistic spectrum disorder (Asperger's Syndrome) and attention deficit disorder. As part of his care, he was regularly reviewed and these appointments were well attended by him and his mother.

Following his referral in June 2011, he was seen by the Tier 3 community-based CAMHS.[3] At this time, he was identified as needing one-to-one psychological intervention to address his difficulties with managing anger and aggression. Although he did not have an appointment until January 2012, a support plan was implemented which included advice and various support strategies. A number of referrals were also made to other support services including Autism West Midlands, Stepping Stones Family Support Project [4] and the communications and autism team (CAT Team).

As part of the routine CAMHS process of collating information following the son's referral in 2011, the CAMHS clinician contacted his school. The special education needs co-ordinator from the school stated that the son had concerns about his mother and father because they argued and "mum got cross and there were difficulties with family stresses". The special educational needs co-ordinator indicated that she was not sure if this was true or not, as the son could become "upset and fixated on things" which turned out not to be that "big a deal".

The final contact the son had during the period under review was in 2014 following the death of his mother. He had a stab injury to his chest, which was reviewed in the emergency department. He was admitted to the hospital to have his wound surgically repaired.

[3] Tier 3 community-based CAMHS is a multi-disciplinary team or service working in the community mental health clinic or child psychiatry outpatient service. It provides a specialised services to children and young people with more severe, complex and persistent disorders

[4] This charity undertakes one-to-one work with young people with autism and provides support to their families

Birmingham Children's Hospital NHS Foundation Trust analysis of involvement

The son was regularly reviewed, and his family were given appropriate support and advice and referrals made to other appropriate agencies for further support and intervention.

As part of the individual management review, an interview was held with the clinician who received the information from the special educational needs co-ordinator. The clinician stated that, at that time, she had concluded his misunderstandings at home fitted with his diagnosis of autistic spectrum disorder and his coping mechanisms. During the follow up visits with CAMHS, the clinician did not explore the son's comments. Equally, the clinician did not pick up any clues from the son or his mother, nor did the clinician receive any further information from school. Thus, the issue of domestic abuse does not appear to have been investigated any further by CAMHS.

Anna tended to accompany her son to his appointments. The perpetrator only attended two appointments. The reason for this could have been that he was working and therefore Anna took the lead in attending appointments. Nevertheless, the perpetrator remained “silent” during CAMHS involvement. There did not appear to be any examination about his role within the family, or how he supported and cared for his son. This meant there was very limited opportunity for CAMHS to gauge the father's involvement or his views about his son’s diagnosis.

Although the individual management review identified that all the members of staff received child protection training, it was not clear to what extent this covers domestic abuse. Inevitably, some children witnessing domestic abuse within their family may exhibit some of the signs of aggression that the son was displaying. Therefore, it is important that the subject of domestic abuse is included in training for practitioners.

The CAMHS pre-assessment parent questionnaire included some probing questions about stresses within the family. However, again it did not explicitly ask about domestic abuse. Anna was seen alone, which would have provided an ideal opportunity to ask her about domestic abuse. However, this did not happen and domestic abuse does not appear to be a subject for routine questioning.

5.4. General Practitioner

During the period under review, the family were all registered with the same medical centre. Anna was seen at the practice on nine separate occasions.

In September 2011, she was seen for "emotional problems". She told the GP (S) that her son had Asperger's, her father had died recently and she had stopped smoking

and gained weight. She said she felt tearful and anxious but was sleeping well. Although she felt down, she said she was not depressed. The GP prescribed her anti-depressants.

In October 2011, her medication was reviewed by a different GP (M). She described feeling brighter on the medication. She said her husband had also commented on this. The GP prescribed her a further three months of anti-depressants.

Anna's next appointment at the medical centre was in March 2012 with GP (X). On this occasion she described having palpitations for the past month. She was asked whether she was stressed or anxious, and whether she was sleeping and eating normally. She did not report any concerns. She was seen by the same GP the following week for a blood test.

In October 2012, she visited the medical centre complaining of lower back pain. She saw GP (J) and explained that the pain had come on suddenly when she bent to pick up the post that had come through the letterbox. She was diagnosed with muscle spasm and was treated with muscle relaxants and pain relief. The GP advised her to return if her back did not improve within two weeks.

Anna was next seen at the medical centre in January 2013. She had fallen whilst ice-skating the previous week and had been to A&E. At A&E, she had been diagnosed with a strain and given pain relief. However, she was still in pain and had restricted movement. The GP (D) prescribed her some stronger pain relief and referred her to a physiotherapist. A subsequent letter from the physiotherapist dated May 2013 said that Anna had responded well to treatment, and had therefore been discharged.

On 5 June 2014, Anna presented with a sore throat for which she was prescribed antibiotics. Then two weeks before her death, she requested emergency contraception. She was seen by GP (A) and explained that she was not in a "regular relationship". The doctor recalled, when interviewed for the individual management review, that she was "well dressed and appeared happy in herself".

The perpetrator was seen twice by the GP during the period under review; once in 2011 for gastroenteritis following a holiday; then in 2013 having stood on a rusty nail. On this occasion, he was advised to attend A&E.

Both the children were seen at the medical centre during the period under review. The daughter was seen for an ear infection in 2011 and tonsillitis in 2014. The son was seen in 2011 for inflammation of his throat. In March 2011, the medical centre received a letter from Good Hope Hospital to confirm that he had attended A&E having sustained a "punch injury fracture". There was no explanation as to whom or what he had punched. In May 2011, Anna phoned the GP (P) to ask whether her son could be referred to CAMHS. She was concerned because he was being aggressive at school. The notes recorded that initially he had been aggressive towards pupils but now he was throwing things (computer monitors). She was informed that the

referral would be made. He went to his first two appointments with CAMHS and ceased to attend when the psychologist offered to work with him around safety and talking to other people. In July 2011, he was seen by the GP (P) for a blood pressure check – this was requested by CAMHS. At the appointment, he disclosed that he had pain in his hand. It was noted that he had previously fractured his fifth metacarpal and it had healed. However, he had since punched someone, which had caused a recurrence of the pain.

In February 2012, Anna asked GP (R) for a note so that her son could be kept at home until his new school placement was available. The GP declined to provide a note.

GP analysis of involvement

The individual management review stated that none of the members of staff at the medical centre had ever received training on domestic abuse.[5] Although Anna did not disclose any information that might lead the GPs to think she might be a victim of domestic abuse, she did present with emotional problems. During the consultation she divulged a number of problems at home including her son's Asperger's and her father's death. Both of these were plausible reasons for her emotional problems. During her following consultation, her records stated that her husband had commented on her improved mood. The GP could not recall if Anna's husband accompanied her to the appointment or if this was information that she had volunteered. Whichever, it is not usual practice for GPs to record whether adult patients are accompanied to appointments. Inevitably, being constantly accompanied to appointments may be an indication of domestic abuse, as perpetrators often try to prevent victims from disclosing information. Therefore, GPs should document whether patients are accompanied – especially in a medical centre with a large number (or rapid turnover) of GPs, as victims may be seen by a different GP on each occasion.

When Anna visited the GP with palpitations, the GP did consider anxiety and stress as a cause. However, she denied these causes. During her other visits, there was no reason for the GP to think that the explanation of her back or shoulder pain was anything suspicious.

The only other incident of note was when the son went to the GP with a sore hand having "punched someone". The GP records do not state whether this was explored further even though it indicated that his condition was not as well controlled as previously. Things were clearly deteriorating, as Anna later asked for a "note" to keep her son at home until his new school placement was available. The cause of the deterioration in the son's condition is not certain. It may have been that as he

[5] A toolkit produced by the Royal College of General Practitioners, IRIS and CAADA (now SafeLives) is being rolled out across Birmingham to help General Practices respond effectively to patients experiencing domestic abuse. For further information see www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx – accessed online 10 September 2015

grew older, his medication ceased to be as effective at controlling his symptoms. Alternatively, he could have been witnessing events at home that unsettled him. Whatever the case, there was no evidence to suggest that this was explored in greater depth.

Anna was seen nine times at the medical practice during the period under review. During those visits, she saw seven different GPs and a nurse. Thus, only once did she see the same GP twice. This lack of continuity makes it harder for victims to build any sort of trust or relationship with their GP and makes it difficult to disclose issues such as domestic abuse. This lack of continuity also demonstrates the importance of accurate record keeping.

5.5. Schools

The individual management review author had access to the children's school records, common assessment framework (CAF) paperwork and the son's special educational needs assessment documents. The head teachers of the infant and junior schools were interviewed as well as a team manager from the Early Help Brokerage and Support Service [6] and a member of the special educational needs assessment and review team.

The son attended senior school from 2009 until 2012 when he took up a place at the education centre. There was limited access to records from the education centre as it closed down in 2014 but the principal was interviewed as part of the individual management review.

It was clear from the individual management review that the son had some behavioural problems from an early age. When he was six years old, he received a statement of educational needs. This was reviewed annually.

The senior school appeared to offer the son support, and appropriate actions were taken to manage his behavioural needs. These included providing him with access to the study centre, adjusted lessons and a "red card" so he could leave class early if needed. He was also allocated a teaching assistant who supported him with the transition from primary to secondary education. He formed a bond with his teaching assistant and was upset when she was promoted and she could no longer directly support him.

By the time he was in Years 8 and 9, there were several incidents of fighting, arguing and damage to property. This resulted in a "fixed-term" exclusion of two days. The school attributed his behaviour to his condition and his inability to get along with the majority of his peers.

[6] The Early Help Brokerage and Support Service (EHBSS) offers support and advice to all organisations completing a Family Common Assessment (FCAF) or CAF

When the son was 13 years old, a common assessment framework (CAF) assessment was undertaken by Stepping Stones Family Support Project. The documentation does not record whether both parents were present during the assessment. However, the assessment recorded that both parents had concerns about their son (thus implying they were both present). The records stated that "the family was stable and enjoyed good family relationships" but struggled with their son's behaviour, and this sometimes had a "negative impact on family dynamics". The records also stated that there was "no domestic violence, family separation or breakdown" – although, again, it is unclear whether these questions were asked with both parents present. The assessment mainly focussed on the son's educational provision and the views of his parents and the practitioner completing the assessment. It did not fully explore the son's opinions. The CAF was later judged inadequate, as the son's voice was not represented.

At the request of his parents, his statement provision was reviewed. His parents (supported by the senior school) felt that a mainstream school was no longer able to meet the son's needs. In 2012, his statement was amended and he was enrolled at the education centre. Once he settled at the education centre, the principal stated that he "flourished" and his attendance rose to 98.7%.

The daughter also attended the same infant school from 2008 until 2012 and then went to the same junior school that her brother had attended. She had no additional needs. She was described as a cheerful, social girl who tried her best and mixed well with her peers. A "friendship" issue was highlighted in early 2014 by the perpetrator. The issue was resolved by the school and the perpetrator appeared appreciative of the school's intervention in the matter.

Members of staff at the infant school were aware that Anna and the perpetrator had separated and the head teacher offered Anna access to a counselling service. However, she declined the offer. From the available records, it was not possible to establish whether members of staff had enquired how she was, or gave her the opportunity to talk about the separation.

None of the schools involved with the children had any indication that domestic abuse featured within the household. Neither Anna nor her estranged husband gave any signs or signals that domestic abuse was an issue within the family. Although in 2011, the son told his teaching assistant that he had "concerns about his mum at home". However, this appeared to be worries about the impact his behaviour was having on his mother rather than any wider concerns about her. The incident was documented and the school telephoned Anna and told her of the conversation. The records stated that the "communication and autism team" thought that a presenting feature of the son's autism was noise sensitivity. Thus, he might perceive "normal" conversation as an argument.

From the records, it appeared that both parents were involved in the children's education. Anna appeared to attend more parents' evenings than the perpetrator but it appeared that both parents were present during the common assessment framework (CAF) assessment in 2011 and during the majority of the son's annual reviews of his statement.

Schools analysis of involvement

There were two occasions when members of staff could have scrutinised situations more closely. First, when the couple separated and counselling was offered. This would have provided an opening for staff to ask Anna how she was and give her the opportunity to talk about the separation. Then, had she indicated that domestic abuse was a feature, an appropriate referral could have been made. The second occasion was when the son disclosed to his teaching assistant that he was worried about his mother at home. From the records, it appeared that this was not explored further.

5.6. Stepping Stones Family Support Project

The Stepping Stones Family Support Project provides "*holistic integrated child and adolescent mental health services to support families with children and young people who are diagnosed or being assessed for a mental health problem or developmental condition, with the aim of strengthening emotional resilience and promoting a protective environment that will create a positive lasting impact for the family*".

During the period under review, Stepping Stones had 11 face-to-face contacts (mainly home visits) and 10 telephone contacts with Anna. The service aimed to "*implement a parenting programme with the parents who needed support in managing their son's challenging behaviour*". The key worker was a social worker with experience of supporting families with children who had been diagnosed as being on the autism spectrum.

In July 2011, a "parent initial assessment" was carried out by the key worker and a qualified play therapist at the family home. Records showed that Anna provided most of the information even though her husband was present. Two further home visits occurred during August 2011 when only Anna was present. The third visit in August involved all the family including both parents and both children.

In September 2011, the key worker initiated a common assessment framework (CAF) to establish whether a multi-agency response was required to support the family. The partner agencies involved included Stepping Stones, the GP and CAMHS. The assessment described the "*family functioning okay. There has been no domestic violence or family separations or breakdowns that would have a significant impact on the child's developmental needs*". The assessment also stated that there was no "involvement" from the father's side of the family.

There were two more visits during September 2011. One where only Anna was present and the other with both parents present. A further six meetings took place during October and November 2011. Anna was present at all of them and her husband was there for two meetings. The focus continued to be on strategies for supporting the family to manage their son's challenging behaviour.

At the end of November, a planned session was cancelled because the key worker needed to "prioritise some other work and was then going on leave for 2 weeks". Another meeting was cancelled in December and then following a final CAF meeting, the case was closed (April 2012) as the son had been given a place at West Midlands Education Centre and he was described as "a different person and enjoying school".

Stepping Stones Family Support Project analysis of involvement

As part of the initial assessment for Stepping Stones, a question was asked about the couple's relationship. The heading for the section was "Domestic Violence: previous/current relationships" and one of the sub-headings asked, "Does anyone currently, or in the past, make you feel unsafe, uncomfortable or unhappy due to their behaviours or actions?" The response was recorded as "nothing stated". It is clear from the records that both Anna and her husband were present during this assessment and there is nothing in the records to suggest that either of them were seen alone. Therefore, an opportunity was missed to discuss domestic abuse with Anna and enable her to disclose any information. During subsequent visits, Anna was often seen on her own which again would have provided good opportunities to discuss the relationship she had with her husband.

5.7. Neighbourhood Advice and Information Service

Anna visited a neighbourhood office in 2013 to ask about claiming benefits, as her "husband had left her". She asked for information about council tax, job seekers allowance and disability living allowance. She was advised to contact the service again if she required support to claim benefits. There were no other contacts recorded.

From the records, she did not appear to have been asked any routine questions about whether they had separated because of abusive or violent behaviour. Had she disclosed, it would have been an ideal opportunity to provide her with the details of local domestic abuse services that may have been able to assist her.

5.8. West Midlands Ambulance Service

West Midlands Ambulance Service is only able to search its records by address. This means that if the ambulance service were called to family members at a different address or in a public place, those contacts would not have been identified. From the review of its records, the service's only contact with the family was in June 2014 when Anna died.

On arrival, the ambulance crew found Anna dead and her estranged husband disclosed that he had injured their children. Both the children received emergency treatment and the paramedics made a joint child protection referral via the ambulance service safeguarding referral telephone number.

6. EMERGING THEMES

6.1. Recognising the effect of domestic abuse on children

It was clear from the individual management reviews that the son exhibited aggressive behaviour from an early age. In this case, it was linked to his later diagnosis of autistic spectrum disorder (Asperger's Syndrome) and attention deficit disorder, but records did not appear to consider other causes such as witnessing domestic abuse.

Children respond differently to domestic abuse depending on a number of factors including their age, gender, race, stage of development and resilience. However, research [7] describes a range of behaviour in younger children who experience domestic abuse. This might include a change in behaviour such as becoming more withdrawn or having poorly developed verbal skills, difficulties at school and increased difficultly forming relationships with peers. Children and young people who grow up in households where domestic abuse is a feature may be disruptive, find it hard to concentrate in school, and they may be aggressive towards teachers and other pupils. Older children may develop mental health problems such as depression or self-harming, or start to use drugs and alcohol. Some children, particularly boys, may model the abusive behaviour.

It could be argued that the son displayed behaviour consistent with witnessing domestic abuse and yet this does not appear to have been considered by any of the agencies working with the family. At no time was his mother asked whether she was a victim of domestic abuse, even when her son disclosed that he was concerned

[7] See for example, www.womensaid.org.uk/domestic-violence-survivors-handbook.asp; www.refuge.org.uk/get-help-now/what-is-domestic-violence/effects-of-domestic-violence-on-children/ and Guy, J (2014) Early Intervention in Domestic Violence and Abuse, Early Intervention Foundation, London @ www.eif.org.uk/wp-content/uploads/2014/03/Early-Intervention-in-Domestic-Violence-and-Abuse-Full-Report.pdf, chapter 3 – accessed online 1 September 2015

about his parents arguing. Again, his concerns about arguments at home were attributed to his condition rather than viewed as his accurate observation.

Given the number of services working with children and the number of women affected by domestic abuse, it is disappointing that professionals working with families do not routinely consider domestic abuse as a cause of wider problems within families (for example mental ill health, physical illness, psychosomatic illness and behavioural problems in children).

6.2. Opportunistic questioning and speaking with individuals on their own

There were several opportunities when professionals could have used opportunistic questioning to ask Anna about her relationship with her estranged husband. The school had the opportunity to ask her how she was when it became apparent that the couple had separated. The neighbourhood office, the GP and practice nurses could have questioned her about her relationship. Indeed, Anna's GP records did not state whether she was accompanied to appointments. Inevitably, some perpetrators will accompany the victim to all appointments so that they are prevented from disclosing domestic abuse. Thus, it is important to document whether someone is seen on their own, especially in a GP surgery with a large number of staff or a high turnover of GPs. During the CAF process although their relationship was discussed, the records do not show whether they were spoken to separately. When relationships are discussed, victims must be spoken to separately to enable them to disclose domestic abuse.

Despite these potential opportunities, Anna never recognised her relationship as abusive. In fact, she and her family thought her estranged husband was over-attentive but caring. Hence, no amount of questioning would have elicited a disclosure about coercive controlling behaviour.

6.3. Coercive controlling behaviour

In December 2014, the government announced a new domestic violence law criminalising patterns of coercive, controlling and psychological abuse (s.76 Serious Crime Act 2015). This legislation is due to come into force around September 2015.[8] The legislation aims to "protect victims by outlawing sustained patterns of behaviour that stop short of serious physical violence, but amount to extreme psychological and emotional abuse".[9] Those experiencing coercive control often have every aspect of

[8] For further information see for example http://www.womensaid.org.uk/page.asp?section=00010001001000330002 and https://www.gov.uk/government/news/government-to-create-new-domestic-abuse-offence - accessed online on 1 September 2015

[9] https://www.gov.uk/government/news/government-to-create-new-domestic-abuse-offence - accessed online on 1 September 2015

life "policed" by their partner. This includes being prevented from having friendships or hobbies, having their access to money limited and having minute aspects of their everyday life monitored such as when they are allowed to eat, sleep and go to the toilet. Despite this new offence, many victims of domestic abuse fail to recognise their experience as "controlling or coercive behaviour".

In this review, there were aspects of the perpetrator's behaviour that were controlling. Anna told friends that she felt smothered. Her friends described him standing on the doorstep checking his watch when she returned from nights out. She told friends that she would go to the supermarket in the evening, just to get away from him. He appeared to use his relationship with their children as a way of maintaining contact with her after their separation and frequently returned to the family home. He "hacked" her Facebook account and researched the possibility of putting a "tracker" in her car. Clearly, he harboured thoughts that they might re-kindle their marriage.

Many victims fail to view their experience as domestic abuse, particularly those in relationships that are psychologically, financially or emotionally abusive. Many people still believe that domestic abuse must involve physical violence. Had Anna, or her friends and family, viewed her situation as domestic abuse, she may have felt more confident to seek help from organisations such as domestic abuse services. They would then have been in a position to give her advice, support and information about her options and design an appropriate safety plan.

6.4. The danger of separation

Many victims, their families and indeed professionals continue to believe that once a victim has separated from their abusive partner, the abuse will stop. However, post-separation violence and abuse is an issue for a significant number of victims of domestic abuse (and their children). One research study[10] showed that 76% of women who had separated suffered further abuse and harassment from their former partner, with child contact being a particular point of vulnerability. In fact, research shows that women are at greater risk of violence and being killed after separating from abusive partners.[11]

When Anna and the perpetrator separated, he continued to go to her house (for which he had a key). It appeared that he did this for "the sake of the children". However, when he became suspicious that she was moving on with her life and was

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[10] Humphreys, C and Thiara R, Neither justice nor protection: women's experiences of post-separation violence, Journal of Social Welfare and Family Law, Volume25, Issue 3, 2003 – accessed online 1 September 2015

[11] See for example www.womensaid.org.uk/domestic-violence-articles.asp?section=00010001002200020001&itemid=1126 – accessed online 1 September 2015

seeing someone else, he hacked into her Facebook, "pestered"[12] her about her new relationship and locked her in the garage to question her about it. He also considered buying a tracker to put in her car.

Anna had been telling her friends for some time, before and after the separation, that she felt smothered by him. The perpetrator liked to fix everything and do everything in the household, which made Anna and the children more dependent on him. In April 2014, she wanted to go to Disneyland with the children but her estranged husband insisted it was not safe for her to go without him. He stifled the children as well, especially their daughter. The family recalled occasions when he would not let their daughter run down the beach with her cousin. He even kept the dog away from other dogs, stating that the dog was stressed and needed some "chill-time". Although Anna described feeling suffocated by him, she never mentioned feeling scared of him.

6.5. Stalking and harassment

It appeared that the perpetrator "stalked" Anna even before their relationship ended. For example, family members described him turning up uninvited when she went out with her friends or family. He would turn up to events such as camping trips organised for mums and children, and then place Anna in a position that she was not able to send him away. Research suggests that stalking can be "an extension of coercive control"[13] and it often starts before a couple separate.

After the couple separated, the perpetrator even looked around the house while she and her children were all out – which was how he found out that she had removed all the photographs of him from her bedroom (and resolved that if he "could not have her then no-one else would").[14] She told family and friends that she thought that he was accessing her text messages. As an IT engineer, he was certainly capable of tracking her through her mobile phone. In fact, her phone may have been registered to him – her house and her car remained solely in his name. She clearly thought her Facebook account was being hacked, as she told her family that he was not a "friend" on Facebook and they should not mention him on Facebook.

Although his behaviour was clearly obsessive, her family and friends (and indeed, Anna herself) had no concept that this was a form of domestic abuse and she might be at risk.

[12] Judge's sentencing remarks

[13] TK Logan & Robert Walker, Partner Stalking: Psychological Dominance or “Business as Usual”?, 10 Trauma, Violence & Abuse 247, 251 (2009) as cited in D Tuerkheimer, Breakups (2013). 25 Yale Journal of Law & Feminism 51 (2013) – see www.paladinservice.co.uk/wp-content/uploads/2013/12/Tuerkheimer-paper-on-DV-criminalisation-gap-2013.pdf – accessed online 1 September 2015

[14] Judge's sentencing remarks

7. CONCLUSION

It was evident that the perpetrator had been controlling throughout their relationship and subsequent marriage. Despite this, the panel felt that this domestic homicide was neither predictable nor preventable. However, the panel thought that if Anna had a better understanding of coercive control or had professionals questioned her further about her relationship, she may have understood better that his behaviour was controlling. She may then have sought help, which could have led to her seeking an injunction such as a non-molestation order.

8. RECOMMENDATIONS

i. The Home Office should consider raising awareness of coercive controlling behaviour by launching a campaign around the legislation that criminalises patterns of coercive, controlling and psychological abuse

ii. Birmingham Community Safety Partnership (in conjunction with the Birmingham Violence Against Women and Children Steering Group) should consider raising awareness locally of coercive, controlling and psychological abuse to coincide with the introduction of the legislation (and the Home Office campaign). The campaign should be aimed at the general public

- The campaign should (for example)
  - Help victims from all communities understand patterns of controlling and coercive behaviour.
  - Highlight the problem of stalking and harassment in order to help victims recognise inappropriate behaviour such as constant texting, the use of trackers and spyware to check where they are and what they are doing.
  - Equip victims to recognise what is "normal" behaviour and what might be unreasonable or potentially dangerous behaviour by a partner.
  - Demonstrate the consequences for perpetrators if they:
    - Stalk or use spyware to track a victim.
    - Use controlling or coercive behaviour.
  - Raise awareness of services that can offer help, support and advice.

iii. Birmingham Community Safety Partnership should request that the Violence Against Women and Children Steering Group should set out the learning outcomes for all domestic abuse training provided by agencies working with children and families. Training must be targeted at both strategic and operational levels and be in line with Birmingham domestic abuse standards. The learning outcomes from domestic abuse training should be embedded in all agencies' commissioned training arrangements and should include knowledge and skills to understand (amongst other things):

- The offence of controlling or coercive behaviour
- The importance of routine enquiry and speaking with victims on their own
- The rationale for documenting when individuals are accompanied to appointments
- Information about the use of technology in stalking

9. SINGLE AGENCY RECOMMENDATIONS

Clinical Commissioning Group

- All practice staff should receive training on domestic abuse
- The CCG should highlight to GPs that if a patient is accompanied to appointments, this should be documented

Heart of England Foundation Trust

- All acute paediatricians to be notified when they see children with problematic and aggressive behaviour which they are asked to investigate that they include inquiries in relation to domestic abuse as part of their investigation
- Documentation in relation to punch injuries presented in under 18s to the Emergency Department must include details of the precursor to the event and assessment of the young person's mood and coping strategies to enable appropriate communication with Primary Care about the event and consideration of self-harm protocols.
- Raise awareness of the Women's Aid drop-in service and audit attendance at the service. The domestic abuse flowchart should include signposting victims to the Women's Aid drop-in service, reminding staff to make a referral to Children's Social Care and informing the victim of this.

Education

- All schools (including Academies, Free and Independent Schools) must commission training on domestic abuse for all staff including special education needs coordinators and behavioural coordinators.

- Special educational needs annual review to include questions about home life.

- fCAF should still be used within schools to formalise the early help offer to children and families even when a child is subject to a statement of special educational needs .

- Closer liaison with alternative provider sites to ensure record retention policies are adhered to effectively.

Forward Thinking Birmingham (CAMHS)

- Domestic abuse within the household should be routinely considered as part of the CAMHS initial assessment.
- Training on domestic abuse for all staff.

Stepping Stones

- Ensure awareness, and application of, Stepping Stones Family Support Project Domestic Abuse Policy (2015) across the whole of the workforce (through combination of induction, online learning, supervision, face-to-face training, appropriate to role.

- A presentation to be given to the Children's Services Leadership Team (CSLT, middle managers) about the learning from our involvement in this case – for cascading to service leads and team members.

- In quarter 3 (Oct-Dec) case file audits undertaken will specifically focus on checking the explicit purpose for each visit, evidencing women (especially) are asked about Domestic Abuse at outset of work.

- Ensure the awareness of domestic abuse (zero tolerance) and promote sources of support for adults and children (Childline) across all services – suitable to the age of services users.

Birmingham Community Healthcare Trust

None

West Midlands Ambulance Service

None