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

In respect of the death of a woman

BDHR 2013-14-04

Report produced by Birgitta Lundberg

Independent Chair and Author

November 2017

CONTENTS

GLOSSARY

ACPO: Association of Chief Police Officers

BCC: Birmingham City Council

BSCP: Birmingham Community Safety Partnership

CCG: Clinical Commissioning Group

CPS: Crown Prosecution Service

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

DHR: Domestic Homicide Review

GP: General Practitioner

HCPC: Health and Care Professions Council

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

MAPPA: Multi-Agency Public Protection Arrangements

1. INTRODUCTION

1.1 Summary of the circumstances leading to the Review

The victim was aged 47 at the time of her sudden death. She had according to her partner of 13 years been found by him in the downstairs hallway in their home in November 2013 early in the morning. The partner called an ambulance and gave an explanation stating that the victim must have fallen down the stairs. There was no other person living or staying in the household at the time. The victim had a child, now adult, by her first marriage with whom she was in contact. The victim was in longstanding employment at the time of her death and had friends and work colleagues as well as extended family in another part of the country.

The outcome of the initial post mortem examination the following day was that the victim was believed to have sustained injuries consistent with an accidental fall. It was noted that she had a fracture to her cheekbone and also the orbit of her eye, which the pathologist queried. As a result the coroner's office requested that the police investigate further.

The perpetrator's mother and another person cleaned and tidied the house on the same afternoon of the death of the victim. At that point the assumption by the police and the partner's family was that the death had been an accident.

A week after the death a work colleague and friend called the police with information about long standing domestic violence in the couple's relationship. The police records revealed previous contacts in 2003 and 2004 of domestic violence call outs:

- In 2003, the police had received a report of a violent argument between the victim and her partner but no formal complaint was made to the police. The victim told the police officer attending that she had previously been a victim of physical violence and had talked to her G.P about this.

- In 2004 there was a further incident when the perpetrator was arrested and cautioned for assault on the victim and for possession of cannabis resin. The perpetrator was described as having pulled the victim down the stairs by her hair but the victim told the police that she did not want to make a formal complaint. The police recorded that the perpetrator was abusive and he was subsequently arrested to prevent a Breach of the peace.

A second forensic post mortem was now arranged and this revealed evidence of an assault having taken place. As a result the victim's partner was charged with her murder 11 days after her death.

The criminal trial took place in February – March 2015. The perpetrator was acquitted of murder but convicted of manslaughter and sentenced to a 5 year prison term.

After the trial and sentencing the Judge noted that the victim was "*hard-working, successful and well respected by her professional colleagues. She was loved by both her friends and family."*

He added: "*There must have been some disagreement between you which caused you to lose your temper. You delivered a significant punch to the right side of her face. The blow caused her to fall backwards and strike her head against a table*.

"*You thought of nobody but yourself. Rather than trying to help her or call the emergency services you left her lying on the floor of the hallway. You then waited for approximately two-and-a-half hours before dialling 999. Your behaviour was utterly selfish and betrayed a complete lack of remorse. You showed a callous disregard for your victim."*

The Detective Inspector representing the police noted that "*the perpetrator initially deceived the authorities into believing that the victim died as a result of a tragic accident. He nearly got away with it."*

He went on to comment in relation to the work colleague coming forward that*: "This crime was discovered as a result of community vigilance and courage. This goes to show that the police need the active cooperation from the community to eradicate the evil that is domestic abuse and bring offenders to justice."*

1.2 The Domestic Homicide Review Process

The Birmingham Community Safety Partnership (BCSP) was notified of the death of the victim on the 28th November 2013**.** On the 8th January 2014 the BCSP Domestic Homicide Review Steering Group reviewed the circumstance of the case against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews. The

Steering Group recommended to the Chair of Birmingham Community Safety Partnership that the case met the criteria and a DHR should be undertaken.

The Chair approved the decision to commission a Domestic Homicide Review on the 27th January 2014 and the Home Office was notified on the 29th January 2014.

The date for the conclusion of the Review has been changed as the criminal process was extended in to 2015. It was not possible to interview relevant family members and close friends and/or colleagues while the criminal process continued. Similarly, the DHR Panel was not able to approach the employing organisations for both the victim and the perpetrator to request information, which could contribute to the learning of this Review.

The final report was delayed due to unforeseen circumstances and was concluded in March 2016. Learning from the review process has been implemented in the intervening time as expected by the participating agencies.

The aim of the Domestic Homicide Review is to:

- 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 victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and

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

In addition:

- The Review will consider agencies contact with the victim and alleged perpetrator, including relevant contacts with family members, friends and neighbours.

- The Overview Report will consider relevant research and learning from previous relevant Domestic Homicide Reviews, both nationally and locally.

- The Panel will consider how, when and the most appropriate method of securing family members, friends or neighbours involvement with the DHR process being mindful of the criminal investigation process. The Panel Chair will be responsible for arranging liaison with the family with the support of a West Midlands Police Family Liaison Officer.

- Birmingham will notify Solihull Community Safety Partnership. No other Community Safety Partnerships are involved.

- Birmingham Community Safety Partnership will obtain legal advice as necessary.

- Birmingham Community Safety Partnership will notify the NHS England Area Team.

- Relevant information to emerge from criminal proceedings will be taken into account by the DHR panel. The police representative on the panel will be responsible for liaising with the Crown Prosecution Service and keeping the DHR panel updated as appropriate.

- Public and media enquires will be handled by the Chair of the Community Safety Partnership

- At the conclusion of the Domestic Homicide Review, agencies will debrief those staff involved in the case and BCSP will disseminate the key learning from the case through a series of targeted seminars.

- BCSP will inform the Coroner that a DHR Review is being undertaken and will liaise with them as required.

The Review Panel met on three occasions to commission Individual Management Reviews (IMRs) and Information Reports, to receive those reports and to examine the integrated Chronology produced from agency records.

The Independent Chair of the DHR Panel together with the DHR Coordinator provided a briefing to IMR authors in preparation of the IMR process. The authors were requested to focus on an analysis of their agency involvement and the specific issues detailed in the Terms of Reference and broader domestic violence factors illustrated by relevant research.

1.3 Terms of Reference

The Terms of Reference require that the review should address both the 'generic issues' set out in the Statutory Guidance and the specific key lines of enquiry identified in this particular case.

Generic issues identified in Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2013):

Were practitioners sensitive to the needs of the victim and perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- Did your agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

- Did your agency comply with domestic violence protocols as agreed with other agencies?

- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions or risk management plans fit with this assessment and decisions made? Were appropriate services offered or provided or relevant enquiries made in the light of the assessments, given what should have been known at the time?

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

- What was known about the perpetrator? Were they being managed under MAPPA?

- Had the victim disclosed domestic violence to anyone and if so, was the response appropriate?

- Was any information shared and recorded appropriately?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim/perpetrator and their families? Was consideration for vulnerability and disability necessary?

- Were senior managers or other agencies and professionals involved at the appropriate points?

- Are there questions that may be appropriate and could add to the content of the case?

- Are there ways of working effectively that could be passed on to other organisations or individuals?

- Are there lessons to be learned from the case relating to the way your agency works to safeguard victims and promote their welfare, or the way that it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

- How accessible were the services for the victim and perpetrator?

- To what degree could the homicide have been predicted?

Key Lines of Enquiry to be addressed by all agencies:

- What knowledge/information did your agency have that indicated that the victim might have suffered Domestic Violence? Was there anything about the victim's presentation that indicated she was distressed or suffering abuse? If so, how did your agency respond to this information?

- Did your agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective?

- Were practitioners sensitive to the needs of the victim and perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- Is it possible to identify any specific occasions when the victim disclosed domestic violence or when practitioners had the opportunity to intervene, to meet the needs of the victim and if they did intervene were the services offered accessible, appropriate, empowering, supportive and understanding to the risk the victim faced?

- Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to the victim and alleged perpetrator- what lessons has your agency learned from undertaking this review? And how have these lessons been implemented?

- Were there any factors relating to the alleged perpetrator's mental health that indicated he was a perpetrator of domestic violence and were there any signs that he presented a risk to others? If so how did your agency respond and what support or intervention was put in place?

Additional specific terms of reference to be addressed by the West Midlands Police:

- What knowledge or information did your agency have that indicated that the alleged perpetrator was a perpetrator of domestic violence, and how did your agency respond to this information?

- Were there opportunities to seek evidence from other agencies, families, friends and neighbours that the victim was suffering domestic abuse? How, when and why did your agency share information with others and what was its significance and relevance?

Time Period

The DHR should focus on events from the first recorded evidence of domestic abuse in March 2003 up to the date of the arrest of the alleged perpetrator. In particular in relation to the General Practitioner consideration should be given to any disclosure of domestic violence and abuse prior to this date.

The review should also consider relevant information relating to agency contact with the victim and alleged perpetrator outside that time frame as it impacts on the assessments in relation to this case.

1.4 Independent Chair and Overview Author

The Independent Chair and Overview Author is Birgitta Lundberg, who has compiled the Overview Report, the Executive Summary and coordinated the integrated Action Plan. She is a qualified and Health and Care Professions Council registered social worker with thirty-six years' experience of social work practice and management in local authority social care services including twelve years as the manager of child protection/safeguarding and reviewing services. In the past six years she has been working as an independent social work consultant producing Serious Case Review Overview Reports, chairing and authoring Domestic Homicide Reviews and undertaking multi-agency audits. Birgitta Lundberg is not employed by any of the agencies of the Birmingham Community Safety Partnership.

1.5 Members of the Review Panel

The agency membership of the DHR Panel was agreed by the BCSP DHR Steering Group and consisted of senior managers and/or designated professionals from the key statutory agencies. The Panel members had not had any direct contact or management involvement with the victim or the alleged perpetrator. They were not the authors of the Individual Management Review reports.

It was recognised that there were no special needs or disabilities in relation to the victim that should have been taken into account in reviewing the services delivered or any matters of equality and diversity. The Panel membership reflected the needs of the case.

The Review panel membership had senior management representation from the following agencies:

- Birmingham Community Safety Partnership
- West Midlands Police
- Birmingham and Solihull Mental Health Trust
- Heart of England NHS Foundation Trust
- Birmingham Community Healthcare NHS Trust
- Birmingham and Solihull Women's Aid
- Solihull Clinical Commissioning Group
- NHS England Area Team
- Aquarius
- Solihull Metropolitan Borough Council

The Domestic Homicide Review Team Administrator attended all meetings, taking minutes, coordinating meetings and all correspondence.

Birgitta Lundberg attended all meetings as the independent Chair of the Review.

1.6 Individual Management Review Reports (IMRs)

All agencies that had had contact with the victim or the perpetrator were required to complete a comprehensive chronology based on their records held by the agency. Each IMR author was commissioned to ensure that all the issues stated within the Terms of Reference and Key lines of enquiry would be addressed, and consider significant events that occurred, the decisions made and actions taken, or not taken.

The IMR authors must address what professional judgements were made or actions taken, that indicate that practice and/or management/supervision could be improved, to understand not only what happened but **why and how** it happened in these individual circumstances.

IMRs and chronologies were requested from the following agencies:

- West Midlands Police
- Solihull Clinical Commissioning Group

Information reports were required from:

- Birmingham Community Healthcare NHS Trust
- Heart of England Foundation Trust
- Employers

Both the victim's and the perpetrator's employers were interviewed through telephone conversations by the Domestic Homicide Review Coordinator after the trial had been concluded and the notes were provided to the Independent Chair.

1.7 Agencies with Nil Returns

- Allen Croft Project
- Anawin
- Aquarius
- Ashram
- Birmingham & Solihull Women's Aid
- Birmingham City Council, Adults and Communities

- BCC Legal Service
- Birmingham Women's Hospital
- Roshni
- Gilgal
- Birmingham City Council, Homelessness and Housing
- Jan Foundation
- RSVP
- Salvation Army
- Sandwell and West Birmingham Hospital
- Shelter
- Trident
- WAITS
- The Royal Orthopaedic NHS Foundation Trust
- Citizens Advice Bureau

1.8 The Definition of Domestic Violence

The Home Office definition, which sets the standards for agencies nationally, was updated on the 31st March 2013 in order to send a clear message to victims about what constitutes domestic violence and abuse. The definition was extended to include young people aged 16 and 17 years of age and to capture the notion of coercive control:

"Any incident or pattern of incidents of controlling, coercive or 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. This can encompass but is not limited to the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour *is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and*

capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

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

**This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.*

2. THE SURVIVING FAMILY

2.1 Family, Friends and Work Colleagues Involvement in the Review

Contact with the family of the victim took place at the beginning of the review process with a letter informing the family members of the Review including a leaflet about DHRs. The Independent Chair wrote to the victim's adult child from her first marriage, who lives overseas, and a sister, who lives in the United Kingdom. The Review Panel has subsequently been informed of a brother as well. The letter to the victim's family members provided information of the Domestic Homicide Review process including leaflets and contacts. The letter also contained an invitation to participate in and contribute to the Review process and the potential learning for agencies. The letters were delivered, where possible, by the Police Family Liaison Officer in person to allow for any questions or queries.

The Independent Chair also wrote a letter, which was distributed subsequent to the trial to some of the key witnesses, who were former work colleagues and friends. As a result two witnesses were interviewed in person and some per telephone.

2.2 Information from Family, Friends and Work Colleagues

The picture, which emerged about the victim, was one of a well-liked colleague, who worked hard and supported the team she supervised. The relationship with the perpetrator, who was thirteen years younger, was partly the cause of the breakup of the victim's first marriage. The victim had one child from the marriage and the child remained with the other parent. However, the victim stayed in touch with the child and was reported by friends and

relatives as very proud and fond of her child. The victim's own extended family lived quite some distance away, which made support to her more difficult.

The context for the victim and the perpetrator was a longstanding relationship, where they lived together and both worked within the same large company but in different parts of it. The perpetrator's family lived within the area and there was regular contact with the perpetrator's family.

The work colleagues and a friend described the victim as quite short whereas the perpetrator was quite tall and physically towered over the victim. The couple liked to socialise at times with other colleagues and were described as liking to drink quite a bit of alcohol on such occasions. However, no one expressed the view that either adult had any serious alcohol dependency problems. There were indications of past cannabis use by the perpetrator but there was no evidence that it played any specific part in the death.

The victim's friends and colleagues reported the victim as stating that she paid most of the household costs and that the perpetrator did not contribute equally to the household expenses.

Both colleagues gave examples of feeling very uncomfortable with the perpetrator, who had a habit of speaking to the victim in ways to '*belittle her'*. They expressed the view that over the time of the relationship the victim's presentation became more '*invisible*' as she dressed in a '*dowdy way covering her body up'*. One of them, who was a more longstanding friend, was aware that the victim was sometimes covering up bruises on her arms and legs.

The two colleagues had spent some time trying to support the victim especially in 2003 and 2004 but also subsequently to try to convince her to end the relationship. The support included assisting her to call the employers Helpline for advice and offers of a place to stay temporarily. They believe that the opportunity for the victim to act to leave the perpetrator was lost in 2004.

It is not clear from any records or family, friends and colleagues how the perpetrator convinced the victim to remain with him. The victim was reported on more than one occasion to have said that "*she had to return as the perpetrator would not manage without her*".

What was clear was that from that time onwards, the couple arranged to buy a house together as the first house had belonged to the victim. Friends advised the victim to be careful not to lose her investment and to put in place a legal agreement. It is not known what action the victim took as she became more reluctant to speak about her situation and only confided in one person occasionally.

After 2004 there were no further call outs to the police by the victim, or anyone else, nor was there any mention by the victim to the GP of any issues or injuries.

The victim spoke to the helpline available in the employing organisation, at the time, at length. It is not known, if she ever contacted the helpline or any other helpline after 2004.

2.3 Lessons to be learnt from Family, Friends and Colleagues

The family, colleagues and friends, who have contributed information to the Review, were all distressed by the information that emerged at the trial about the extent of the controlling and coercive behaviour and violence that the victim had suffered in silence over a long time.
The main learning, which was drawn out for them, was that, which research repeatedly confirms:

"Domestic abuse is a largely hidden crime, occurring mainly in homes behind closed doors. As such, it can be difficult to record the context in which abuse is being perpetrated, or accurately measure the impact of the abuse on those who experience it.

Women are often afraid or unable to report or disclose domestic abuse to the police and may under-report domestic abuse in surveys, particularly during face-to-face interviews"[1]

The family, friends and colleagues, who were aware to some extent that there was violence and abusive behaviour towards the victim, felt restrained by her refusal to end the relationship and take action to plan for her own safety. The opportunity in 2004, when the victim had taken some steps to plan for an end to the situation, was not followed through by her. Colleagues and friends offered support and advice but the victim eventually withdrew and took steps to avoid a colleague, who had been quite proactive in offering support.

[1] (Women's Aid, 2016)

Knowledge about domestic violence and the services available to support women have changed since 2004 as have the responses by public services such as the police. There have been developments to ensure that employers offer services to support employees in circumstances where they may be the victims of domestic violence.[2]

See the Home Office document: 'Ending Violence against Women and Girls Strategy 2016-2020' Annex A. **Action Plan**: The government intends to:

70. Support the development of Bystander Programmes such as that developed by UWE and PHE, and disseminate good practice.

71. Continue to raise awareness of domestic violence and abuse in the private sector and encourage employers to develop robust workplace polices to support employees who may be victims of domestic abuse, violence or stalking.

72. Continue to encourage organisations and private sector companies to sign up to the Domestic Abuse Responsibility Pledge.

Similarly, public awareness of domestic violence and abuse from campaigns at local and national levels as well as the exposure of domestic violence in popular drama has led to more advice to friends and relatives being readily available.

A local authority research report speaking to women, who had experienced domestic violence and abuse, noted that:

The initial response women received from a service was crucial to them having sufficient trust to continue their engagement. Women needed reassurance and a believing attitude from those placed to help them.[3]

However, in this case the victim died after a period of nearly ten years where there had been no reports to the police or health agencies. The likelihood that the victim was ready to take action or to allow someone else to do so on her behalf can only be speculated about but what is known is that bruises and injuries had been observed over that period of time.

[2] (Home Office, 2016) (Provided by Solihull MBC, 2016)
[3] (Provided by Solihull MBC, 2016)

Learning point:

The overall lesson for everyone involved has been that this event could not have been predicted or prevented based on the information that was known, but that with hindsight, more might have been possible to do to support the victim to end the relationship and for action to be taken to keep her safe.

There must be more information and advice made easily available about **what to do and how to do** it for families, friends and colleagues in local areas and through national awareness campaigns. The language used to describe domestic violence and abuse must relate to real life experiences.[4]

3. THE FACTS

3.1 Key Episodes based on the integrated chronology of agency involvement

The key episodes below emerged based on the information from the integrated chronology, the IMRs, including staff interviews, and the information from the family, friends and colleagues and are the Independent Overview Report Author's view of significant information and events about the victim and the perpetrator.

The intention in this section is not to reproduce the full integrated chronology of agency contacts but to draw out significant events and provide an account of what was known in agency records about contacts with the victim and the perpetrator. Some comments will be made to highlight specific issues.

A. The Incident of Domestic Violence In 2003

The first recorded information about an incident of domestic violence in March 2003 can be found in the GP records. The GP's examination provided specific measured details of bruising all over the body. The victim stated that the bruises related to an event seven days earlier where she had been the subject of a sustained assault and verbal threats. The

[4] (ibid.)

format of the GP notes was such that should they be required for any future opinion for court, they provided evidence of an assault. On reflection during the process of this review the GP's reading of the notes suggested that the victim had been advised by someone to present to her GP for the injuries to be officially recorded.

There was no further follow up contact by the victim with the GP about this event although a referral for stress counselling had been made. The victim had been receiving counselling previously but those records were separate to the GP surgery records and no longer available. See Analysis section below.

Two days after the GP visit the victim called the police in the evening stating that "*her 'husband' was being abusive and that he had abandoned her approximately five miles away to make her own way home. He had then called her to say he did not believe she had walked home and told her to call the police. It was noted on the log that she was very upset."*

The police followed up with a home visit, where only the victim was present. The police log noted that the victim talked about a history of unreported domestic violence but was reluctant to provide details. The victim said that she was in contact with a solicitor and trying to obtain an Occupation order.

An Occupation order is an order issued by the court which sets out who has the right to stay, return or be excluded from a family home. An occupation order does not change the financial shares in a home. It is usually a short-term measure and the length of time that it lasts will depend on the circumstances.[5]

The attending police officers provided advice but as no offence had been committed and the victim did not want to provide any other details there was no further follow up.

B. The Incident of Domestic Violence In 2004

In March 2004, a year later, a 999 call was made from the home address in the evening and sounds of a disturbance could be heard before the phone was disconnected. The call handler noted the previous domestic violence callout at the address and police officers were sent out to investigate.

[5] (Citizens Advice, 2016)

Both parties were present and the victim was distressed but no obvious injuries were noted although the disorder and the phone pulled out from the socket were observed.

The victim was spoken to separately and she explained that they had been out with friends when the perpetrator decided they should go home. Once outside the pub he took a taxi leaving her to make her own way home, similar to the sequence of events the previous year. When she arrived home an argument followed where '*without warning, the perpetrator grabbed her jumper and dragged her to the landing. She resisted at which he took her by the hair and pulled her down the stairs, walking backwards down the steps as he pulled her forward. At the bottom, this assault continued; taking her by the feet and dragging her into the hall and into the lounge. Luckily, a telephone was within reach on the floor and the victim dialled '999' before the perpetrator pulled the phone cord from the socket*.' [6]

The victim did not want to make a formal complaint. The police officers decided to arrest the perpetrator for a 'Breach of the peace' and removed him to the police station. At the police station he was further arrested for possession of a quantity of cannabis. The perpetrator had been cautioned in relation to possession of cannabis in 1999 and at that time he was described as both '*aggressive and controlling'* in his interactions with the police officers.

A domestic violence incident log was created and the Domestic Violence Officer made a visit the following day, when a second statement was taken with the victim. In contrast to the first statement the victim now agreed to pursue a complaint and she provided more detailed information about incidents giving examples:

The perpetrator was concerned that they both smoked and instructed her to stop – despite continuing to smoke 20-30 cigarettes a day himself. This was corroborated by the victim's sister, who had overheard similar comments at a family funeral. The victim's failure to cease smoking was viewed by the perpetrator as a form of deceit, and provided insight into his attempts to control his partner. The victim described violence escalating from this point onwards. She described visiting London with a friend six months earlier. On her return, the perpetrator immediately became aggressive and again accused her of smoking. The victim stated that she stood up to him and he responded by hitting her, knocking her to the ground. He then dragged her whilst she was on the floor and slapped her with an open hand. She did not report this to police at the time.

[6] (West Midlands Police, 2015)

The perpetrator was cautioned for the assault in March 2004 as he fully admitted the offence. There was no other action in relation to the cannabis.

This outcome was judged by the Review panel and the Police IMR author as a missed opportunity in view of the statement, the previous incident and the documented evidence in the GP records from 2003. See Analysis section below.

C. The initial response by Agencies attending at the time of death

Early in the morning in November 2013 a 999 call by the perpetrator resulted in the Ambulance service attending the home address. The first clinicians on the scene documented in their patient report form that they had been advised by a male on scene that the victim had been drinking heavily and went to bed at approximately 00:00hrs. They were then advised by the partner that the victim was found face down at the bottom of the stairs at approximately 05:48. The attending clinicians documented that they found the victim lying on her back on the floor, feet by the radiator, head in the doorway to the living room, wearing a nightdress only. There was blood vertically across her face and there was approximately 20ml of blood on the floor.

At 05:55:01 the Ambulance officers on the scene updated the Ambulance Control that what they had found appeared suspicious based on their professional judgment and experience. Within the short space of time on the scene the attending clinicians had identified that the explanation given did not appear to be credible.

At this point the police were called out. It initially appeared to the police that the victim had fallen down a flight of stairs within the home. Police spoke with her partner, who gave a plausible account of the incident. One of the police officers took some photographs which were referred to at the trial.

The perpetrator‘s mother cleaned the house that same afternoon. She did not give evidence at the trial.

A standard post mortem examination followed the next day. The pathologist raised a query about some of the injuries and the matter was referred back to the Coroner’s office and further investigation by the police.

A week later a work colleague and friend phoned the police to ask if they were aware that the relationship between the victim and the perpetrator had involved domestic violence and abuse for a long time. As a consequence of this phone call and the past information about the incidents in 2003 and 2004, which had now been acknowledged, a second forensic post mortem was carried out.

The perpetrator was arrested and charged with murder eleven days after the victim's death.

3.2 Conclusion and Findings

The responses by the police and the GP in 2003 and 2004 were not unusual in the context of policies and procedures in place at the time. Knowledge and awareness of domestic violence and abuse and the combination with controlling behaviour and excessive alcohol drinking sometimes combined with cannabis use was not as widespread as it is at the present time. The impact on victims over time of controlling and coercive behaviour by perpetrators is now much better understood by practitioners as well as the general public and victims themselves. The Home Office definition of Domestic violence changed to incorporate controlling and coercive behaviour in March 2013 which has assisted professionals when responding to concerns. [7]

The dilemma presented to the police officers and the GP revolved around the victim's reluctance to make any formal complaint to the police or to take any action to end the relationship. A lack of confidence by professionals to follow up concerns with victims has been documented in research and past reviews, for example, the GP records show no further mention of the injuries or the situation after the consultation, where the notes were made. This would be likely to indicate that the GP did not check up at a later stage how the victim was dealing with her situation.

The friends and work colleagues, who were aware, as well as the employer's helpline felt equally constrained by the victim's reluctance to accept support.

[7] (Stark, 2009)

The evidence was available of an assault in 2003 in the GP records and the statement by the victim in 2004, as well as the perpetrator's admission, which meant that there was an opportunity to intervene by consulting with the Crown Prosecution Service. The police IMR concluded: '*that it was likely that a charge and conviction would have ensued if the CPS had been consulted*.'[8]

Learning point:

The accumulation of incidents and injuries over a long period of time in addition to the description by colleagues of the victim's appearance making her more 'invisible' as time went by is an example of the impact that coercive control has over a victim.

The services, which are in place, respond traditionally to incidents rather than an accumulation of restrictions, being cut off from family and friends, being belittled, targeted violence and unreasonable demands for example. The professionals need to be aware when responding to reports or call outs of the importance of taking account of a full history not just an incident.

4. ANALYSIS

4.1 Analysis of services provided

A. Health

Until 2007 the adults were registered at different GP practices. Both adults were treated by their GP services for periods of time for stress, related to both work and relationship issues and depression. Both were referred for GP community based counselling services. The concern about stress by the victim was accepted by the GP to be work related.

The main reference to domestic violence was the consultation by the victim in 2003 when the injuries were catalogued. There was no further follow up and there was no reference to domestic violence subsequently by either the victim or the GP practice. The call out to the

[8] (West Midlands Police, 2015)

police in 2004 may therefore not have been mentioned by the victim to any health practitioner.

As the Counselling service, which had been seeing the victim at times, did not have any records remaining and no one was available to contribute to the review, it has not been possible to assess if the victim shared any information or sought support about the abuse. It can be concluded however that, as there was no feedback noted in the GP records from the counselling service, there was no meaningful contact between the GP service and the counselling service about the victim.

During the review the GP surgeries involved with the adults have explored their domestic violence procedures and training is now in place. Recommendations have been made and implemented to ensure that staff have access to all relevant information systems and advice about how to refer to MARAC or Safeguarding leads for example. Systems have been put in place to monitor and review that practice staff are consistent in applying their procedures in relation to domestic violence and abuse.

It transpired during the review that the victim had needed treatment for serious dental problems. She suffered from a fear of dentists and had not sought treatment in time. There was no connection with injuries from any violence. The review process has led to awareness raising in the community dental health services about domestic violence and the policies and procedures which should be in place. The learning from this review is being addressed.

B. Police

The police response in 2003 was within the procedures in place at the time. However, the victim's intention to apply for an Occupation order might have alerted them to the fact that the victim was trying to take control and plan for her own safety. It was a known risk factor at that time as well that risk increases whenever an end to a relationship is being considered and the victim stated that the perpetrator was not aware of her actions. Given the victim's reference to past incidents, it would not have been possible to be confident about an assessment of risk without follow up. Information was provided about services but it was not clear from the records what the victim's response was.

The query the Review panel raised was whether the officers assumed that the victim's statement that she had seen her GP and was taking legal advice meant that she was able to deal with the situation.

The call out a year later, in March 2004, led to a number of actions by the police although there was no systematic method in place for referrals of incidents of domestic violence. The decision about what action to take was at the discretion of the individual officer.

The attending investigating officers did decide to request a follow up by the Domestic Violence Officer having taken a statement from the victim. The first statement recorded that the victim was not willing to make a formal complaint. The statement taken by the Domestic Violence Officer however noted that the victim had changed her view and was willing to proceed.

Given the previous evidence recorded by the GP from 2003, the presence of alcohol use with the same pattern of behaviour leaving the victim to walk home in the evening, the report by the victim of an escalation of violence and the presence of an admission and corroborating evidence, it was likely that a charge would have ensued, if the CPS had been consulted.[9]

The investigating officers did not take into account the statement to the Domestic Violence Officer that the victim had changed her mind about proceeding with a complaint. The perpetrator admitted the assault and the outcome was a caution. It was not clear from the records why the investigating officers disregarded the second statement where the victim had changed her view.

The use of a caution for a domestic violence offence would be unusual in today's policing response, particularly for an offence between intimate or ex-partners (except in certain exceptional situations). In context this was a widely used disposal during the early time covered by this review. Current practice would be to take positive action including a referral to the Crown Prosecution Service should the evidential threshold be met.

In 2005 the police policy changed towards domestic violence and abuse. The emphasis was now placed on recognising levels of risk and implementing safeguarding measures to minimise this. The new policy introduced the Domestic Abuse Risk Indicator Model (DARIM)

[9] (West Midlands Police ,2015)

and the use of Multi-Agency Risk Assessment Conferences (MARAC). There were four levels of risk indication in DARIM – Standard, Medium, High and Very High. The threshold for any case being discussed at MARAC was that the victim was very high risk, however when necessary high risk victims would be discussed on a case-by-case basis. Since that time there have been several organisational changes and new developments in policing and domestic violence and abuse.

If the information in place for the victim's disclosures in 2003 and 2004, including the evidence recorded by the GP, had been presented after 2005 it is unlikely that the victim would have been assessed as very high risk given the threshold criteria.

The most recent changes since 2014 has seen the formation of local designated teams who will investigate all incidents of domestic violence irrespective of the levels of risk. The teams are supported by safeguarding officers and Domestic Abuse offender managers. Extensive training has been implemented for all front line staff.

The final contact with the victim for the police was the attendance at the scene, where she was found on the floor downstairs. The attending officers accepted the perpetrator's story too readily and did not secure the scene for further forensic investigation. The scene was then cleaned the same afternoon by the perpetrator's mother. The information about the past police involvement in 2003 and 2004 was not known to the officers attending at the time as noted through the Review panel meetings. If the victim's work colleague and friend had not raised the alarm a week later, as noted by the police after the trial, it is possible that the death might have been accepted as accidental.

As a consequence of the death of this victim essential learning about the attendance at scenes of unexplained deaths, where victims have fallen down stairs for example, has been taken on board and a training video has been produced for use with front line staff. The trial included expert evidence about such circumstances and the information has formed the basis for this training.

C. The Employers

The victim and the perpetrator were both employed by a large private organisation and worked in different parts of that organisation. Requests for information after the trial about the services in place for staff were responded to, although the information relates to policies

and procedures in place rather than any personal information about the victim or the perpetrator.

The organisation had a helpline for staff at the time in 2003 and 2004 and the victim did use this. What advice was given or if any support was offered is not known. There were references by the work colleagues of support from the Human Resources department to the victim and the perpetrator but it has not been possible to confirm if this was the case or what it may have involved.

The organisation has some domestic violence policies in place now and has been advised through this review process of the various national guidance available to employing organisations. The guidance has been promoted by the Home Office, Public Health England and the Welsh Office and consists of a number of good practice guides: 'Responding to colleagues experiencing domestic abuse' and 'Managing and supporting employees experiencing domestic Abuse: a guide for employers'. The current government strategy for 'Responding to violence against women and girls' includes actions for employers.

4.2 Conclusion and Findings

The victim was known to have experienced domestic abuse and violence throughout the period of the Terms of Reference for this review, which covers most of the time of the relationship of the victim and the perpetrator. One theme that runs through the information available is that the victim remained reluctant to end the relationship, to speak about what was happening to her or to draw attention to it. The only opportunity where she may have been supported to end the relationship was in 2004. After that point there was no further information noted in records by the police or health agencies.

The circumstances as uncovered by the police investigation and subsequent trial were that the victim had suffered both violence, threats and abuse as defined in the official definition as coercive and controlling behaviour all the time.

The difficulty that victims have is that society and the people around them often find it hard to recognise the effect of the accumulation of abuse. For the victim to tell the police about the perpetrator's behaviour in relation to, for example, the victim smoking as a one off story might not alert the police to the underlying behaviour by the perpetrator to control and humiliate the victim.

Learning point:

The finding of this review is that all practitioners need to be aware not only of specific incidents but to be able to put those incidents into the context of the victim's whole life. When assessments are made, the information that is gathered must consider with the victim how the perpetrator is behaving and how it affects the victim's ability to lead her life at home, at work and in social situations without being fearful.

5. LEARNING

5.1 Lessons Learnt

The learning from this review mirrors many other reviews in that it highlights that awareness and knowledge about domestic violence and abuse has changed over time. The agencies that victims come in to contact with are primarily the police and health agencies, usually at a point of crisis. The agencies have developed their safeguarding and domestic violence and abuse policies and procedures over time but this review highlights that private employers need to sign up to do the same.

The support and advice to relatives and friends, whether at local or national level, should provide advice not only about what to do but how to do it. The main concern from relatives and friends is acting against the victims' wishes. Advice about how to overcome that barrier with the victim would be the most useful help that the work colleagues, friends and family identified.

The significant lesson for the police when they attend a scene of an unexplained death, where, for example, someone has fallen downstairs, must be followed up and embedded in practice to avoid any other perpetrator trying to provide a seemingly plausible story.

5.2 Implementation of Learning

The lessons to be learnt from this Review must be followed up to ensure that systems and practice improves and where practice has already been addressed as a result, mechanisms must be in place to embed and maintain the improvements.

The IMRs and the Information Reports provided recommendations where applicable. The Action Plan will be monitored regularly by the BCSP for actions taken in response to the recommendations. The learning, where actions are planned, such as audits, has been set against clear timescales.

Each agency will feed back to their staff and the IMR authors and anyone else who was involved in the review process.

The dissemination of the learning will be targeted to the practitioners in the member agencies of the Birmingham Community Safety Partnership.

The victim's family members will be provided with the full report by the BCSP.

6. RECOMMENDATIONS

6.1. Recommendations by the Independent Overview Report Author

The recommendations by the Overview Report Author are intended to complement the recommendations in the IMRs and to address the agencies involved. The intention is to improve practice and systems where there are concerns about domestic violence and abuse and to contribute towards reducing violence against women and to promote their safety.

1. Learning point:

The review has highlighted the dilemmas that family, friends and colleagues experience when a victim is reluctant to take action to stop and prevent abuse and violence. The difficulty touches on interpretations of what is private and confidential and fears of losing touch with the victim, if the person in question does make a referral to the police.

1. Recommendation:

The BCSP should review how it produces current local material which is available to relatives, friends and colleagues and examine, if it provides information, which gives clear advice about what to do and how to do it.

2. Learning point:

When police officers attend an incident, where there has been an unexplained death, for example someone has had a fall down stairs, it is important that they access full information about any background history , before they make a decision about the explanation given by any witness. All such decisions must be subject to senior officer oversight. The particular aspects of such fatal falls must be approached with an open mind and investigated fully. The training material and guidance produced by the police arising from this review about attendance at unexplained deaths should be used.

2. Recommendation:

The West Midlands Police to undertake a review of homicide investigations covering 2015 to 2016 to determine that those investigations, where there were domestic violence related aspects, were recognised as such. The review should establish that the correct intelligence checks had been undertaken on all involved to retrieve all known background history.
The West Midlands Police will provide assurance to the BSCP agencies that management oversight is exercised in all homicide investigations and will include monitoring evidence of domestic violence and abuse.

3. Learning point:

The employers of both the victim and the perpetrator had support services in place during parts of the time period of this review but the contents and relevance of those services has not been fully available to the review. The understanding by the Review is that services were delivered to both parties. It would have been helpful if the employer could have participated more constructively in the review process to assist in the learning from the Review.

3. Recommendation:

The Birmingham Community Safety Partnership must develop a Local Strategy under the umbrella of the national Violence against Women and Girls strategy 2016-2020 to engage with private employers to promote knowledge of domestic violence and abuse and the implementation of policies and procedures to support employees.

4. Recommendation:

This report should be shared with the employing organisation formally by the BCSP to enable learning to take place in the organisation. The Employing organisation should be supported to develop and implement a domestic violence policy and procedure that ensures a safe, empowering and supportive response to victims, and assists work colleagues about what to do when domestic violence and abuse is identified or disclosed.

Birgitta Lundberg,

Independent Chair and Author

7. APPENDIX 1

Single Agency Recommendations

Solihull Clinical Commissioning Group

Recommendation 1: The practice develops and puts into place a policy and procedure for domestic abuse. This policy should be linked to Solihull Community Partnership Domestic Abuse Standards, other safeguarding and relevant human resource policies and procedures.

Recommendation 2: The practice has systems in place to monitor and review that practice staff are consistent in applying the domestic abuse policies related to staff and patients.

7. APPENDIX 2

Overview Report Recommendations - Through Early Identification Victims of Domestic Violence and Abuse Are Effectively Safeguarded							
	Recommendation/ Action	**Scope**	**Lead Agency**	**Desired Outcome**	**How Will Success Be Measured**	**Target Date**	**Completion/ RAG**
1.	**Birmingham Community Safety Partnership**						
	The Birmingham Community Safety Partnership should review how it produces current local Domestic Violence and Abuse material, which is available to relatives, friends and colleagues and examine, if it provides information, which gives clear advice about what to do and how to do it.		Birmingham Community Safety Partnership	The general public, are supported by clear, awareness raising materials, to support empower and protect victims from all communities. All information must include information and signposting to a range of services available.	A major review of domestic violence is being undertaken. Communication is included as a strand of the review.	On-going 2016	
	The Birmingham Community Safety Partnership must develop a Local Strategy under the umbrella of the national Violence against Women and Girls strategy 2016-2020 to engage with private employers to promote knowledge of domestic violence and abuse and the implementation of policies and procedures to support employees.		Birmingham Community Safety Partnership	All Private Organisations have clear and consistent guidance that supports Employers to respond effectively and safely to victims of domestic violence and abuse and their children.	Included within the 2016, Domestic Violence Strategy. To be included within the Violence against Women and Children dataset.	On-going 2016	

Individual Agency Recommendations – Holding Perpetrators To Account							
	Recommendation/ Action	**Scope**	**Lead Agency**	**Desired Outcome**	**How Will Success Be Measured**	**Target Date**	**Completion/ RAG**
3.	**West Midlands Police**						
	West Midlands Police to undertake a review of homicide investigations covering 2015 to 2016 to determine that those investigations, where there were domestic violence related aspects, were recognised as such. The review should establish that the correct intelligence checks had been undertaken on all involved to retrieve all known background history. The West Midlands Police will provide assurance to the BSCP agencies that management oversight is exercised in all homicide investigations and will include monitoring evidence of domestic violence and abuse.			1.1 An improvement in the completion of intelligence checks when a homicide has occurred to ensure that if domestic abuse has taken place between the nominals involved, it is recognised as such. 1.2 To ensure that when a homicide occurs no investigative opportunities are missed or overlooked.	1.1 and 1.2 Monthly DA audits by WMP Service Improvement Team (SIT) to ensure compliance with DA policy. Weekly Homicide Review Meeting chaired by head of WMP Homicide; this includes attendance by a representative from Homicide Intelligence Team.	November 2016	
4.	**The Employing Organisation- Through Early Identification Victims of Domestic Violence and Abuse Are Effectively Safeguarded**						
	The Employing organisation should be supported to develop and implement a domestic			The Organisation has embedded the learning from this DHR, and has	Copy of the Policy to be provided with an implementation strategy.	August 2016	

	violence policy and procedure that ensures a safe, empowering and supportive response to victims, and assists work colleagues about what to do when domestic violence and abuse is identified or disclosed.			clear and consistent guidance that supports Employers to respond effectively and safely to victims of domestic violence and abuse and their children.			

Individual Agency Recommendations – Through Early Identification Victims of Domestic Violence and Abuse are Effectively Safeguarded							
	Recommendation/ Action	**Scope**	**Lead Agency**	**Desired Outcome**	**How Will Success Be Measured**	**Target Date**	**Completion/ RAG**
Solihull Clinical Commissioning Group							
	Recommendation 1: The practice develops and puts in place a policy and procedure for domestic abuse. This policy should be linked to Solihull Community Partnership Domestic Abuse Standards, other safeguarding and relevant human resource policies and procedures.		Practice Safeguarding Lead and Practice Manager	To support practice decision making and response in respect of domestic abuse.	Reporting to Solihull CCG Safeguarding Team whom will report progress on action plans into Solihull CCG Governance Committee's, exception reporting to Governing Body.	Completed by end of September 2014.	
	Recommendation 2: The practice has systems in place to monitor and review that practice		Practice safeguarding Lead and	Established in-house systems to test compliance.	Reporting to Solihull CCG Safeguarding Team whom will report	Audit Report and Reporting.	

	staff are consistent in applying the domestic abuse policies related to staff and patients.		Practice Manager		progress on action plans into Solihull CCG Governance Committee's, exception reporting to Governing Body.		

Reports with No Recommendations

1. West Midlands Ambulance Serve NHS Foundation Trust (WMAS)

2. Birmingham Community Healthcare Trust

3. Heart of England Foundation Trust

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