SAFER SANDWELL PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

under Section 9 of the Domestic Violence, Crime and Victims Act, 2004.

Case Number SSP/2012/01

EXECUTIVE SUMMARY

Author: Alan Ferguson

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Author's Details

I am a qualified Social Worker and registered with the General Social Care Council.

In March 2009, I retired from the post of Service Development Manager (Safeguarding & Quality Assurance) within Worcestershire County Council after a career in child care stretching back 35 years.

Within that role, I had extensive experience of the Serious Case Review process having written numerous Management Reviews on behalf of Children's Services as well as Overview Reports on behalf of the Local Safeguarding Children Board.

Since retirement I have become the Director of an Independent Social Work Consultancy offering a range of services including consultancy related to Serious Case Reviews and, more recently, Domestic Homicide Reviews.

Over the last three years I have served on numerous Serious Case Review Panels as both Panel member and Chair and, in recent months, have taken advantage of Regional and National events to further extend my knowledge in this area and to keep abreast of recent developments. At the time of commencing this report, I had written nine Overview Reports for various LSCBs in the West Midlands Region.

The Home Office Regulations and Guidance in respect of Domestic Homicide Reviews only came into force on 13th April 2011, so this is the first such Review conducted by the Safer Sandwell Partnership and the first such Overview Report written by the Author.

I have no professional or personal connections with the Safer Sandwell Partnership or its partner agencies.

Alan Ferguson
Director
Three Towers Consultancy Limited

1. THE REVIEW PROCESS

1.1. In 2011, a 29-year-old woman died from stab wounds. A 39-year-old man, the woman's former partner and the father of her child was subsequently arrested and later convicted of her murder.

1.2. As her death appeared to meet the criteria for a Domestic Homicide Review (Section 9.3 of the Domestic Violence, Crime and Victims Act 2004) the matter was referred by West Midlands Police to the Safer Sandwell Partnership i.e. the Local Community Safety Partnership.

N.B. to preserve the anonymity of the families involved, the victim in this case will be referred to as Adult 1 throughout this report, her child as Child 1 and her ex-partner as Adult 2.

1.3. In the above legislation and associated guidance, a Domestic Homicide Review is defined as:

'A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

a) a person to whom he was related or with whom he was or had been in an intimate personal relationship; or
b) a member of the same household as himself.

1.4. The guidance goes on to describe the purpose of a Domestic Homicide Review i.e. to:

- establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals work individually and together to safeguard victims;

- identify clearly what those lessons are both within and between agencies, how and within what timescale they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to policies and procedures as appropriate; and
- prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.5. Following notification of this incident, the Community Safety Team collated a range of information from partner agencies which suggested that domestic abuse had been a feature of Adult 1's relationship with Adult 2 for some time. In addition, it became clear that:

- Child 1, had previously been made subject to a Child Protection Plan under the category of Emotional Abuse as a direct consequence of the violent and abusive relationship between Child 1's parents;
- Adult 2 had a history of involvement in mental health services dating back to at least 1999 (including one compulsory admission to hospital);
- Adult 2 had previously been involved in an abusive relationship with another woman which had led to her moving out of the local area;
- He was well known to Police as a consequence of his violent behaviour and, at the time of Adult 1's death, he was on Police bail following another incident where he had allegedly threatened and harassed her (the bail conditions included a requirement that Adult 2 should have no contact with Adult 1); and
- a referral had been made to SOADA (Sandwell Organisations Against Domestic Abuse) by Probation Service 4 working days before her death asking for help in safeguarding Adult 1 (e.g., by finding her accommodation outside the local area), but this had not been actioned by the time of her death.

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1.6. The information from partner agencies was shared with the Chair of the Safer Sandwell Partnership who, in September 2011, decided that the criteria for holding a Domestic Homicide Review under the above legislation was clearly met and directed that such a Review be carried out into the circumstances surrounding the death of Adult 1.

1.7. This summary outlines the process undertaken by the DHR Panel appointed by the Safer Sandwell Partnership in reviewing the murder of Adult 1 (see paragraph 1.16 for details of Panel membership).

1.8. It is a requirement of the statutory guidance referred to in 1.3 above that the DHR Panel be chaired by 'an experienced individual who is not directly associated with any of the agencies involved in the Review'. The Independent Panel Chair is also responsible for providing the final Overview Report which details the Review findings and, where appropriate, makes recommendations to improve local practice. Details of the Chair appointed to this Review can also be found later in this section.

1.9. The Chair and the DHR Panel are first required to 'scope' the Review i.e. agree what appear to be the most important issues to address in this specific homicide and set down the time period that is to be addressed by partner agencies when researching their records. The timeframe established for this Review is September 2005 to July 2011.

1.10. Once the Terms of Reference had been agreed, all partner agencies of the Safer Sandwell Partnership were written to and asked to complete a detailed chronology of their agency's involvement with the family in the designated period and an Individual Management Review (IMR) which asked them to consider and analyse that involvement in the context of their own statutory responsibilities and local arrangements for safeguarding vulnerable people.

1.11. The purpose of the IMR is stated in guidance and is to:

- allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made;
- to identify how those changes will be brought about; and
- to identify examples of good practice within agencies.

1.12. The agencies participating in this Case Review are:

- **Sandwell MBC**: Children's Social Care – there were four periods of intervention by Children's Social Care between April 2010 and the death of Adult 1 in July 2011. Perhaps the most significant period is when a Social Worker was monitoring Child 1's safety and welfare via a Child Protection Plan that was in place between October 2010 and January 2011.

- **Sandwell Primary Care Trust (GPs)** – both Adult 2 and Adult 1 accessed universal GP services extensively throughout the period of this Review.

- **Sandwell and West Birmingham Hospital NHS Trust – 1)** for Health Visiting Services – this Trust provided universal health visiting services to Child 1 and Mother from December 2009 to April 2011.

- **Sandwell and West Birmingham Hospital NHS Trust – 2)** for Acute Hospital Services – This Trust provided routine medical services to Adult 1 between February 2006 and January 2010. In May 2010 Adult 1 self-referred with chest pains advising staff of a history of assault. Adult 2 was seen at the Emergency Department of this hospital on at least four occasions in the period set for this Review. Three of them were linked to his mental health (including overdoses) and one in respect of an injury to his right hand.

- **Black Country Partnership NHS Foundation Trust** – this Trust provided mental health services intermittently to Adult 2 throughout the period of this Domestic Homicide Review although he frequently chose not to engage once a precipitating crisis was over. These services included access to a Consultant Psychiatrist (through the outpatient system), the Primary Care Liaison Team (PCLT), the Crisis Resolution Home Treatment Team (CRHT) and the Criminal Justice Mental Health Liaison Team.

- **West Midlands Police** - this Police force had numerous contacts with Adult 2 and Adult 1 throughout the period set for this review, mostly as a consequence of Adult 2's violence and aggressive behaviour towards his ex-partner.

- **Staffordshire and West Midlands Probation Trust** - Adult 2 was subject to statutory supervision by this Trust at the time of Adult 1's murder (as part of his sentence for an earlier assault upon her in April 2010) and was attending the Integrated Domestic Abuse Programme (IDAP), a programme designed for male offenders who commit violent offences against their partners.

- **Sandwell Organisations against Domestic Abuse (SOADA)** – this organisation had two periods of involvement in this case although only spoke with her on one occasion. In April/May 2010 they attempted to offer support to her following the assault by Adult 2 and, in July 2011 they again attempted unsuccessfully to contact Adult 1 following an incident of harassment at her home.

1.13. Four agencies who had limited contact with the family provided helpful reports i.e:

- Sandwell Homes;
- Surestart Children's Centres;
- West Midlands Ambulance Service; and
- Dudley Group of Hospitals NHS Trust.

1.14. Two agencies reported that they had had no contact with the family in the period designated for this Case Review i.e:

- Adults Services (Sandwell Metropolitan Borough Council); and
- CAFCASS

Domestic Homicide Review Panel

1.15. Statutory guidance requires that the DHR Panel be comprised of 'individuals across a broad spectrum of both statutory and voluntary agencies'.

1.16. For this particular Review the Panel members (identified by agency and designation only) were:

- Head of Corporate Affairs, NHS Midlands and East Cluster of SHAs
- Social Care Director, Black Country Partnership NHS Foundation Trust
- Divisional Manager, Referral and Assessments & Care Management, Children and Young People's Services, Sandwell MBC
- Divisional Manager for Safeguarding, Children and Young People's Services, Sandwell MBC
- Designated Nurse Safeguarding Children/Head of Service, Sandwell PCT
- Community Safety & DV Manager, Sandwell MBC
- Detective Chief Inspector, West Midlands Police
- Head of Sandwell Probation, Staffordshire & West Midlands Probation Trust

1.17. The Independent Chair of the DHR Panel and Author of the Overview Report is Alan Ferguson, a Director of Three Towers Consultancy Limited. A summary of his career can be found at page 2 of this report.

2. KEY ISSUES ARISING FROM THE REVIEW

2.1. This section of the report will identify the learning that has been derived from undertaking this review, agency by agency, and will highlight some of the challenges facing the partner agencies of the Safer Sandwell Partnership in developing and maintaining high quality services for victims of domestic abuse.

West Midlands Police

2.2. The Custody Sergeant who authorised the release of Adult 2 on bail in July 2011 did so without access to a range of concerning information suggesting that it was unsafe to do so. West Midlands Police need to review their systems to ensure that Officers charged with that responsibility have the capacity to make informed decisions, and access to systems that quickly provide relevant information from Police records.

2.3. The programme of training for custody staff regarding the safeguarding implications of bail decisions did not influence the outcome of the Custody Sergeant's decision in July 2011. West Midlands Police need to review this training programme, firstly to clarify that all relevant staff have accessed it and secondly to identify its impact upon operational decisions.

2.4. The IMR author for West Midlands Police rightly points out that information sharing between Police and Mental Health Services in respect of offenders known to both agencies could and should be better. The Action Plan attached to the IMR makes a robust recommendation on this issue that the DHR Panel would fully support.

2.5. Although not a direct factor in the death of Adult 1, the failure of West Midlands Police to engage in the child protection process (i.e., by not attending either of the Child Protection Conferences held in respect of Child 1), could prejudice the safety of vulnerable children and young people in Sandwell. This needs to be addressed.

Staffordshire and West Midlands Probation Trust

2.6. In the opinion of the DHR Panel there are three key learning points for the Probation Trust arising from this review i.e:

- the need for clear guidance in respect of the circumstances in which offenders are withdrawn from IDAP, i.e., where they do not appear to be making any significant progress in addressing their abusive behaviour and attitudes or, as in the case of Adult 2, his harassment and violence appears to be increasing;
- the need for clearer guidance to inform professional judgements in respect of the circumstances in which it is appropriate not to confront an offender about deteriorating behaviour towards his victims; and
- a re-statement of the need to liaise with the Mental Health Trust when undertaking risk assessments of offenders.

2.7. The first two bullet points are addressed fully in the analysis section of this report and will be the subject of a recommendation from the DHR Panel.

2.8. It is a matter of concern to the DHR Panel that there was limited liaison between the Probation Trust and the Mental Health Trust in order to inform the assessment undertaken by the Offender Management. Adult 2 was well known to the Mental Health Trust, although this engagement was very inconsistent, but none of the available information was accessed by the Offender Manager after December 2010. Good information sharing should have revealed that Adult 2 was prescribed anti-psychotic and anti-depressant medication but had stopped of his own volition in March/April 2011.

2.9. The implications of this decision are explored elsewhere in this report but are likely to have been of great significance to:

- his general mental health i.e., risk of withdrawal syndromes and rapid relapse;

- his capacity to engage in and benefit from the IDAP; and
- as a consequence of the above, an enhanced level of risk to Adult 1.

2.10. However, a failure to maintain liaison with the Mental Health Trust meant that this information was not accessed or taken into account in Probation assessments, notably their decision to allow Adult 2 to continue on IDAP. The existing guidance in this area needs to be reviewed and reinforced to Probation staff.

Black Country Partnership NHS Trust

2.11. While there is a Domestic Abuse policy available within the Trust it has been established in this Review that it does not reflect latest research/current best practice and that it is not accessed consistently by clinicians or other practitioners in the Trust. The policy needs to be up dated urgently and re-launched to all practitioners with a strong message from Senior Managers as to their expectations in this area.

2.12. Partly as a consequence of the point above, no risk assessment was ever undertaking by Mental Health Trust into the safety of Adult 1 or any other partner that Adult 2 had or may have in the future, despite significant evidence of his tendency to extreme jealousy and his propensity for violence. Not even the attendance of Trust staff at the MARAC in May 2010 prompted consideration of such an assessment, as the information from that meeting did not reach the clinicians responsible for the day to day management of Adult 2's case. The above review of Domestic Abuse policy should incorporate guidance on when/how to undertake such risk assessments.

2.13. Adult 2 persistently failed to keep pre-arranged appointments with Mental Health professionals and there is evidence from this review that not all staff were aware of, or familiar with, the Trust policy for managing patients who do so, a policy that emphasises the need to risk assess so that patients who can safely opt out of involvement with Mental Health Services can be differentiated

from those who may pose a risk to themselves or others and where non-engagement needs to be robustly followed up.

2.14. It also became clear that the DNA policy was due for review in September 2010 and that this had not taken place. The DHR Panel expects that the Mental Health Trust will undertake this review and take appropriate action to ensure that the updated version is widely shared with clinicians/practitioners, whereby it becomes embedded in practice.

2.15. **Children's Social Care**

2.16. The IMR author has identified that there were weaknesses in the handling of the referral to Children's Social Care in April/May 2010, but puts this in the context of wide-ranging failures within that Department at that time as reported upon by Ofsted in their inspection of December 2009. As a consequence of that inspection, and a subsequent improvement notice, the performance of Children's Social Care has been upgraded to 'adequate'. Given this, and the fact that failings by Children's Social Care at this time had no obvious impact upon the circumstances leading to the death of Adult 1, the DHR Panel will make no further recommendations in this respect.

2.17. Of more concern to the Panel is the fact that Child 1 was made subject to a Child Protection Plan in October 2010 and that plan was discontinued in January 2011 without Children's Social Care ever accessing information about Adult 2 from the Mental Health Trust.

2.18. Adult 2 was a source of risk to Child 1, both directly as a consequence of Child 1 getting caught up in an assault on Mother (as actually happened in March 2010) or indirectly by exposure to the domestic violence and harassment suffered by Mother at Adult 2's hands. His mental health was of great significance in assessing the risks to Child 1 and the DHR Panel finds it almost incomprehensible that these basic agency checks were not undertaken.

2.19. Had they been done then the decision to discontinue the Child Protection Plan in January 2011 may not have been taken and Children's Social Care would still have been in touch with Adult 1 at the time of her death. The implication of this is that they may have been in a position to support her relocation in the days/weeks prior to that event as Adult 2's harassment and her fear of him grew.

2.20. The DHR Panel is also concerned at the decision of Children's Social Care not to instigate an initial assessment in July 2011 in the face of two Police referrals and one Probation referral which indicated escalating violence and harassment from Adult 2. The Probation Officer making the referral is advised that Children's Social Care is **'satisfied that Adult 1 is taking all the necessary steps to protect her child'**.

2.21. It is not clear upon what basis this judgement was made as no attempt was made to contact Adult 1 and clarify what steps she was taking. It can only be assumed therefore that the Social Worker who made this statement based it upon the situation as known to Children's Social Care in March 2011 when they last closed the case.

2.22. The IMR author for Children's Social Care has speculated that 'even if an initial assessment had been undertaken, it was unlikely that the threshold for a child protection enquiry was met'. Having had access to a range of information from other agencies, the DHR Panel would challenge that assumption but the real concern is that the judgement not to undertake an initial assessment in the first place without getting updated information was flawed.

2.23. There were legitimate reasons for believing that Adult 1 was at serious risk of physical harm and emotional distress as a consequence of Adult 2's renewed actions and, by association, Child 1 was clearly at risk of being caught up in this. Not least was Adult 1's decision to terminate Adult 2's contact with Child 1 which should have been recognised as a significant risk factor. As stated above, it is not clear what the Social Worker believed were the protective steps being taken by Adult 1 but they certainly did not include obtaining a Restraining

Order or Injunction, nor did they include Adult 1 relocating with Child 1 (although both were on her mind when she discussed the situation with the Probation Service's Women's Safety Worker).

2.24. It is the view of the DHR Panel that Children's Social Care should review their response to the three contacts in July 2011 as part of their ongoing quality assurance work, with a view to establishing whether this was an isolated example of poor practice or whether further remedial work is required across Duty and Assessment Teams.

General Practice

2.25. It became evident in the course of this review that Adult 2 voluntarily (i.e., without appropriate medical advice) stopped taking prescribed anti-psychotic and anti-depressant medication in March 2011 and that the prescribing GP failed to notice or respond to this situation. It is also clear that Adult 2's behaviour towards Adult 1 deteriorated significantly from this point on and, although it cannot be conclusively said that the two issues are linked, systems within GP practices need to be sufficiently robust to identify and address such situations in patients with 'enduring long term conditions'.

2.26. The IMR author makes an appropriate recommendation in this respect which the DHR Panel expects will be implemented urgently.

2.27. The IMR author goes on to make recommendations about including domestic abuse case presentations in future training for GPs. Again, the DHR Panel believes that such an action can only enhance the safety of potential or actual victims of domestic abuse in Sandwell.

Sandwell and West Birmingham Hospitals NHS Trust (Health Visiting)

2.28. The IMR produced on behalf of Health Visiting raises an issue that features regularly in Serious Case Reviews concerning children who have died or have suffered significant injuries i.e., the fact that the role (and sometimes the

presence) of fathers to those children or subsequent male partners of the child's Mother, are overlooked in Health Visitor assessments. Most notoriously this was highlighted in the case of Baby P (Haringey 2007), but despite this the IMR author comments that 'the focus for delivery of services primarily remains with the Mother'.

2.29. The DHR Panel have asked the Trust to raise the profile of this issue among Health Visitors but are not making any formal recommendations in this review as the matter is not directly relevant to the death of Adult 1.

2.30. Other lessons learnt in the course of this review include:

- the need for Health Visitors to consider the mental health of women who are victims of domestic abuse;
- the need to identify and, if necessary, address issues relating to the ethnicity of children and their parents when conducting Health Visitor assessments; and
- the need to ensure case files include a written record of any meeting held to promote the safety and welfare of children.

2.31. In these respects, the IMR author has made appropriate recommendations.

Sandwell and West Birmingham NHS Trust (Acute Hospital)

2.32. In the context of the death of Adult 1 the Acute Hospital Trust have indicated no key learning points, but have identified a number of areas where practice can be improved. In summary, these are:

- a lack of communication between the GP and Community Nurses in relation to hand held nursing records that were unavailable for scrutiny by the IMR author;

- a lack of professional curiosity into the causes of chest pains experienced by Adult 1 in the wake of an assault by Adult 2 three weeks earlier; and
- the failure to implement self-discharge processes when Adult 2 left the hospital against medical advice in July 2010.

2.33. The DHR Panel is satisfied that these issues are addressed within the IMR and appropriate recommendations made.

Sandwell Organisation Against Domestic Abuse (SOADA)

2.34. A significant and final opportunity to safeguard Adult 1 from further assault at the hands of Adult 2 was missed when staff at SOADA failed to respond with due urgency to the referral from Probation in July 2011. This referral was made initially by telephone in July and followed up the same day with written confirmation about the need for urgent support and advice.

2.35. The telephone call is made by the Women's Safety Worker allocated to Adult 1 and expresses her grave concern i.e., 'immediate dangers: harassment, verbal and physical abuse'. The WSW requests that urgent support be provided to help Adult 1 in obtaining an injunction but, perhaps more importantly, given Adult 2's persistent flouting of legal sanctions, to give advice on relocation options.

2.36. There is no evidence in SOADA case records that the IDVA (Independent Domestic Violence Adviser) receiving the telephone call from the WSW took any action in response apart from asking that the referral be put in writing. However, in interview with the IMR author, the IDVA claims that she made two telephone calls to try and contact Adult 1 the same day, but these were not answered.

2.37. The IDVA also says that had she been in work that week she would have made further attempts to contact Adult 1 including trying to arrange a joint visit with a Police Officer, however she was due to go on annual leave the following day and by the date of her return to work Adult 1 was dead.

2.38. It is not explained why the IDVA did not discuss the Probation referral with her line manager whereby the degree of urgency could have been emphasised and arrangements could have been made for a colleague to follow up the concerns. As a consequence, when the follow up letter from Probation was received the next day and brought to the attention of the Senior IDVA, she decided that it could wait until the original IDVA returned from leave.

2.39. The IMR author points to a number of contextual issues that he believes demonstrate that a deteriorating management structure and changes to key personnel (largely prompted by the overall need of statutory agencies to make significant savings on expenditure) undermined the work of SOADA leaving them without strategic direction and a clear remit e.g;

- the Business Manager was made redundant and the post was deleted in March 2011;
- the Strategic Co-ordinator for SOADA took voluntary redundancy in April 2011;
- workloads for IDVAs were high, up to twice the nationally agreed figure in some cases; and
- there were no written protocols guiding the work of IDVAs so there was no guidance available to help the IDVA who received the referral from Probation.

2.40. While all this is undoubtedly true, the DHR Panel believes that two experienced IDVAs could and should have made better decisions in July. Firstly, the IDVA could have brought the Probation referral to the attention of the Senior IDVA, emphasised the risks to Adult 1 based upon the concerns of the WSW and requested that someone follow up urgently. Secondly, even without this briefing, the Senior IDVA could have taken this action herself (or directed another IDVA to do it) had she undertaken a basic risk assessment based on the available information in their own agency records and the concerns expressed in the Probation referral letter.

2.41. As stated above this was the final opportunity to intervene to safeguard Adult 1. Records show that she was not seen or spoken to by any professional from this point in time up to her death 5 days later.

2.42. The IMR author points out that three separate reviews have been carried out since April 2011 concerning the provision of domestic abuse services in Sandwell. At the point of drafting this report (April 2012) a 'Task and Finish' Group has been commissioned by the Chair of the Domestic Abuse Strategic Partnership to address the future of such services. This report will contain a recommendation to support the work of that group.

2.43. SOADA was set up in 2005 in response to the recommendations from the Serious Case Review in which two children were killed by their father in a case involving domestic abuse. The IMR quotes from an evaluation report commissioned from Wolverhampton University in 2008 which describes a '**need for a multi-agency model within Sandwell that could deal holistically with victims and survivors of domestic abuse**'. The case of Adult 1 and the volume of new referrals to SOADA gives ample evidence that such a model is still needed, perhaps more than ever.

3. CONCLUSION AND RECOMMENDATIONS

3.1. The plight of Adult 1 i.e., the ongoing threat of harassment, abuse and violence from Adult 2, was no secret to a number of agencies in Sandwell who had statutory responsibilities and duties to protect her and her child. The case records show that Adult 2 had a history of such behaviour, compounded by mental health problems dating back to at least 1999. Individually these agencies have reported to this review that they have carried out their duties to an acceptable and, in some situations, good standard.

3.2. Despite this, Adult 1 was killed by Adult 2 and as a consequence a child is left to grow up without a Mother and a family are devastatingly bereaved.

3.3. The DHR Panel has considered all submissions to this review in great detail and has concluded that the most significant feature of this case was not the good work done individually by those agencies, but their failure to work together to produce a robust risk assessment and a safety plan based upon that assessment.

3.4. Such a plan should have clearly identified the risks to Adult 1 based upon not only Adult 2's violence towards her but his history of violence, harassment and abuse towards a former partner which was well documented. It should have identified the triggers for that violence i.e., Adult 2's obsessive jealousy and any disruption to his contact with children – this again was clearly evidenced in his relationship with this former partner. The plan should have been informed by the state of Adult 2's mental health, and regularly updated by mental health professionals to reflect any deterioration in his condition or indeed any loss of contact which was an ongoing feature of his relationship with Mental Health Services. The fact that, without medical guidance, he stopped taking anti-psychotic medication and no-one noticed or followed up, appears to the DHR Panel to be a significant oversight. Such an action could only have had a negative impact upon his mental health, including potentially a rapid relapse and consequently an increased risk to Adult 1's safety.

3.5. Had there been such a plan in existence in June/July 2011 then its influence on events should have been significant and different decisions should have been taken eg:

- the Probation Trust may have decided to challenge Adult 2 for his renewed harassment of Adult 1 and returned the matter to Court (although the timescales involved may not have prevented the death of Adult 1;
- SOADA would have responded more robustly to the Probation referral in July and arranged for Adult 1 to be relocated out of Adult 2's reach;
- West Midlands Police would have had sufficient information to deny Adult 2 bail in July 2011;
- the Mental Health Trust and/or the GP would have recognised that Adult 2 had stopped taking his medication and considered the implications of this for the safety of Adult 1; and
- Children's Social Care would have responded more robustly to the Probation referral in July 2011 and, in the interests of protecting Child 1, supported Adult 1's attempts to relocate.

3.6. The mechanism for establishing a Safety Plan is the MARAC process and, at this point, I make no apologies for restating the opinion of CAADA that MARAC is 'the single most important advance in protecting adult victims and their children since the introduction of refuge provision in the 1970s'.

3.7. The DHR Panel has learnt that the MARAC meeting is part of a wider process which hinges on the early involvement and support from an IDVA and the continued specialist case management that this role can offer, both before and after a meeting.

3.8 This report has earlier analysed events surrounding the MARAC held in May 2010 in which we identify a number of significant weaknesses, not least the failure to articulate a robust safety plan or to engage IDVAs in the development and monitoring of that plan.

3.8. I have also documented the demise of SOADA from innovative and dynamic in 2005 to largely dysfunctional and lacking vision in 2010 when the case of Adult 1 and Adult 2 was under consideration. While I have been critical of the actions/inactions of the two IDVAs during both the 2010 and 2011 referrals, it is clear to the DHR Panel that these were two individuals working very hard in an environment that was characterised by high workloads, poor supervision/management practices, dwindling resources, lack of clear written guidance and lack of strategic direction.

3.9. The DHR Panel has no illusions about the difficulties facing public sector finance at this present time and for the foreseeable future. However, the case of Adult 1 demonstrates beyond doubt that an adequately resourced, clearly defined and well supported MARAC process is essential for the safety of women and children in Sandwell and that SOADA (or an equivalent organisation) is equally essential to provide the specialist case management role as envisaged and promoted by CAADA.

3.10. CAADA's audited projections that every £1 spent on MARAC and supporting processes saves £6 in public expenditure needs to be clearly understood and taken into account by those managers who are currently charged with restructuring domestic abuse services locally. The cost of Adult 2's trial alone was significant, let alone the cost of keeping him in prison for 23 years.

3.11. At this point in the report I am required to consider two key issues i.e. was the death of Adult 1 predictable and was it preventable?

3.12. Most of the agencies reporting to this review consider that her death was not predictable and, on balance, the DHR Panel agrees that it would have been difficult for the practitioners involved to consider that such an event was likely. Historically Adult 2 had never been known to use a weapon (other than one occasion where he allegedly self-harmed) and, on the various occasions when he had been arrested by the Police, he was never found in possession of a knife or other means of harm to others.

3.13. However, the family of Adult 1 believe that she knew an attempt on her life was imminent and evidence this in two respects. Firstly, there is a letter written by Adult 1 in which she expresses fears for her life and that of Child 1. Secondly, Adult 5 (the sister of Adult 1) reports that when Adult 1 left Child 1 in her care the day before her death she provided enough clothes for a week, even though it was only a planned overnight stay. Adult 5 believes this to be significant in the context of Adult 1's expectations at that time.

3.14. However, these facts did not come to the attention of agencies until after Adult 1's death and, even if they had been known prior to that event, it is unlikely that either would have led any professional to think that Adult 2 was about to step up his violence and commit the ultimate crime.

3.15. However, even if the fatal assault could not have been predicted there are, in the opinion of the DHR Panel, grounds for considering that Adult 1's death could have been prevented. There are two scenarios in which prevention could have occurred i.e:

- if Adult 2 had been detained in custody as a consequence of his further harassment of Adult 1 in July 2011; and
- if Adult 1 had been assisted by SOADA to relocate away from the Sandwell area in the days immediately before her death.

3.16. The reasons why Adult 2 was not in prison in July 2011 were considered very carefully by the DRH Panel. It is clear that, the Police had little option but to release Adult 2 on bail. This position is based upon the nature of the offences that he admitted to, the regulations in respect of bail decisions and the level of information known to the investigating officers and the Custody Sergeant. However, the information taken into account was less than was known in Police and Probation records and considerably less than was known to partner agencies. These issues are addressed in the Action Plan attached to this Review.

3.17. Also considered by the DHR Panel is the background to the failure of the MARAC process and the inadequate intervention of SOADA, particularly in July 2011 when there was one final opportunity to engage with Adult 1 and help her to get away from the emerging danger that she faced.

3.18. The DHR Panel reiterates its belief that the roots of this ultimately inadequate response of agencies in both of the above respects lies in the failure of the MARAC process in 2010 to develop and monitor a safety plan for Adult 1 which would have guided the actions of the Police, Probation and SOADA as her situation visibly deteriorated in June/July 2011.

3.19. This report sets out below a number of recommendations that the DHR Panel believe will enhance the response of local agencies to women in the same position. This alone will not be adequate to safeguard victims of domestic abuse and it is the opinion of the DHR Panel that senior managers of the partner agencies in the Safer Sandwell Partnership have a grave and urgent responsibility to address the structural, strategic and resource issues required to deliver comprehensive and high quality domestic abuse services in Sandwell.

3.20. It is only through a strong multi-agency response to domestic abuse that risk assessments can be considered comprehensive and safety plans appropriately targeted. Specialist Case Workers e.g., IDVAs, must be in place (in sufficient number and appropriately trained/supported) to work with high risk victims of domestic abuse from the point of crisis, and that work should be very much focused on the MARAC process. The DHR Panel also believe that these case workers must be supervised by an experienced Manager who needs to be located with them in order to prioritise their workloads, undertake robust quality assurance measures and to guide staff when urgent referrals are received.

3.21. The DHR Panel end this review process with a profound sense of sadness that Adult 1 did not receive a co-ordinated package of support from agencies who had every reason to recognise that she faced ongoing harassment and

violence from a man whose history of such behaviour was well documented and showed little or no signs of being changed by his engagement in the IDAP.

3.22. All that can be offered to her family now is a commitment by agencies to do all within their powers to learn the lessons from this review and to use them to establish a more robust and enduring service for all victims of domestic abuse.

Recommendations

1. That the Safer Sandwell Partnership (SSP) support initiatives by CAADA to have the multi-agency risk assessment conference process placed on a statutory basis to ensure sustainable local funding and high quality intervention which supports high risk victims of domestic abuse.

2. That Safer Sandwell Partnership re-affirms its commitment to domestic abuse services locally and supports the Domestic Abuse Strategic Partnership in delivery such services by adequately resourcing the necessary activity.

3. That the Safer Sandwell Partnership review current plans to provide domestic abuse services locally to ensure that they have a clear strategic direction, are adequately resourced, are robustly managed and that operational staff are appropriate trained and supported to provide a high quality protective service.

4. That Safer Sandwell Partnership take measures to satisfy itself that the MARAC process is working effectively in Sandwell and, in particular, that robust Action Plans are routinely produced to safeguard high risk victims of domestic abuse.

5. That the Safer Sandwell Partnership undertake an audit of partner agencies written policies and procedures in respect of domestic abuse to ensure that they reflect current research and best practice, and that staff of partner agencies are familiar with those procedures whereby they know how to act when they become aware of potential victims.

6. That West Midlands Police review their training programme for custody staff to ensure that bail decisions in cases of domestic abuse take full account of all safeguarding issues.

7. That Staffordshire and West Midlands Probation Trust review their guidance regarding criteria/thresholds for withdrawing offenders from IDAP (and returning the matter to Court) where those offenders appear to be making limited progress in addressing their abusive behaviour, and to provide additional guidance in respect of circumstances where it is not appropriate to confront an offender about deteriorating behaviour towards victims.

8. That SSP put in place appropriate measures to satisfy itself that all recommendations arising from this Domestic Homicide Review i.e. including those contained in the IMRs of partner agencies are fully implemented and the lessons arising from them are embedded into procedure and practice.