North Worcestershire
Community Safety Partnership

NORTH WORCESTERSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Case No: DHR 7

Executive Summary

Under Section 9 of the Domestic Violence Crime and Victims Act (2004) in respect of the death of a 21 year old woman on 16th March 2014

Report produced by Malcolm Ross M.Sc.
Independent Chair and Author

7th April 2016

LIST OF ABBREVIATIONS

AAFDA	Advocacy After Fatal Domestic Abuse
ADHD	Attention Deficit Hyperactivity Disorder
BSMHFT	Birmingham and Solihull Mental Health Foundation Trust
CCTV	Close Circuit Television
DASH	Domestic Abuse Stalking & Harassment & Honour Based Identification Risk Assessment
DHR	Domestic Homicide Review
DRR	Drug Rehabilitation Requirement
DVPN/O	Domestic Violence Prevention Notice/Order
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
NHSFT	National Health Service Foundation Trust
NWCSP	North Worcestershire Community Safety Partnership
RAID Team	Rapid Assessment Intervention and Discharge Team
YOT	Youth Offending Team

Introduction

For the purposes of this report and to protect the identity of those involved a key will be used throughout the report as follows:

Victim	Born 1993	Female – Aged 21, Mother of S1, Partner of Perpetrator
Perpetrator	Born 1983	Male – Partner of Victim, Father of UBC and S1 and S2, Ex-Partner of PFP
PFP	Born 1983	Perpetrator's Former Partner and Mother of S1 and S2
S1	Born 2007	Child of Perpetrator and PFP
S2	Born 2009	Child of Perpetrator and PFP
P1		Former Partner of Victim and Father of S3
S3	Born 2011	Male – Son of Victim and P1
M		Mother of Victim
F1		Victim's Father and Previous Partner of MGM
F2		Partner of MGM and Father of S4 and S5
S4		Male – Child of MGM and F2 Step Bro. of Victim
S5		Male – Child of MGM and F2 Step Bro. of Victim
UBC		Male – 13 weeks, Unborn Child of Victim and Perpetrator

The Terms of Reference, details of the Domestic Homicide Panel membership etc. are contained in Appendix A to this report.

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 21 year old woman in hospital on 16th March 2014 after being attacked the previous day in her home. The woman's partner, the Perpetrator, was arrested and charged with her murder. In September 2014, the Perpetrator appeared before the Crown Court and initially pleaded Not Guilty to the charge of murder. After four days of trial, on 29th September 2014, he changed his plea to one of guilty. He was sentenced to Life Imprisonment, with the Judge's recommendation being he should serve 19 years.

The Victim

The Victim was 21 years old when she died. She already had a son by a former partner who was Asian. The former partner has not been seen since she became pregnant. Her son was of dual ethnicity. She and her son lived with her mother and her partner and two younger step brothers.

At the time of the death of the Victim, there was no agency involvement with the family, although it is known that S5 had been diagnosed with ADHD.

It appears that the Victim and the Perpetrator had known each other for some time as casual friends. The Victim, her son, Mother and two step brothers together with her Mother's then current boyfriend went to Spain on holiday in December 2011, intending to stay for only two weeks. Whilst in Spain her Mother's boyfriend suffered a heart attack and was hospitalised, causing the family to stay for longer than expected. Once the boyfriend was fit enough he was transported back to the UK, but the family remained in Spain for just over 12 months. It was during this time that the Victim struck a relationship with the Perpetrator via Facebook.

In 2013, the Victim and her family returned to England and the she started a relationship with the Perpetrator. The Perpetrator had ongoing problems with his own family concerning his use of drugs and they asked him to leave the family home. It was then that the Victim took him in and they lived together in the same house with her mother, mother's partner and step brothers,

The Victim was unemployed at the time of her death. Her son was 3 years of age.

There is relevant information about the Perpetrator's life before he associated with the Victim and was with PFP, which although quite extensive, is important information about his lifestyle, and especially the missed opportunities for agencies to protect PFP and her children and to take assertive action with regard to the Perpetrator.

To summarise the Perpetrator's life with PFP:

The Perpetrator is a man with numerous previous convictions for possession and possession with intent to supply illegal drugs. PFP had two children by the Perpetrator and it is known that during that relationship there were significant episodes of Domestic Abuse but there was never a conviction as the PFP did not make a formal complaint to the Police about any of the Domestic Abuse.

The Perpetrator was offered drug intervention programmes but declined or failed to attend. In August 2010, he was arrested and fined for possession of cannabis.

On 8th October 2010, PFP went to the Police Station to complain that the Perpetrator was constantly texting and harassing her and his friends were following her around. She was concerned for the safety of her children as the Perpetrator had access to the children but would frequently be late returning them to her mother. There does not appear to have been an officer available so PFP left the station with a 'diary appointment' to be seen at her house. This was changed yet again and an officer visited her at her Mother's house on 19th October 2010.

The Officer was asked by PFP to inform the Perpetrator that she intended to seek legal action to stop him harassing her. The Officer attempted to complete the necessary risk assessment form (DASH) but PFP declined to cooperate. The Officer did however submit a referral form to Children's Social Care in respect of the children. This matter should have been recorded as harassment as the offence was made out and the Perpetrator should have been seen. He was not seen by the Police. An examination of the records also show that the incident had been recorded under PFP's Mother's address so any future attendance for domestically related incidents at PFP's address would not show a true record.

On 28th November 2010, an Ambulance attended at PFP's address where it was reported that a man had stab wounds to his stomach. They found the Perpetrator there with scratch marks to his abdomen but he was taken to hospital in any event. In view of the minor nature of the injuries Officers did not submit a referral form which is correct procedure, but had the address of the previous incident been indexed correctly there would have been a link to this address.

In a later statement to the Police, PFP's version of these events is that the Perpetrator arrived at her flat, walked into the kitchen and grabbed a knife. He held the knife to her throat saying 'tell me you're going to get back with me'. She said she wasn't going to and he stabbed himself in the stomach.

In December 2010, the Perpetrator's Father rang his son's GP concerned about his drug usage. The GP saw the Perpetrator and advised him to find a job and he was referred to the Drug and Alcohol Team.

On 15th January 2011, the Perpetrator called the Police saying that he was being followed by a man with a gun. Armed Response Officers attended and identified a member of the public who was searched and found to have nothing to do with the Perpetrator's call, which was a false call made after he had smoked a considerable amount of cannabis.

In March 2011, PFP reported to West Midlands Police that the Perpetrator continued to harass her but again her complaints were dealt with in a less than positive manner in that an Officer gave her a case number but nothing was recorded to the effect that this was a domestically related incident.

In April 2011, the Perpetrator was arrested for drug offences and for possessing a CS gas canister.

In May 2011, her GP confirmed that PFP was pregnant.

In July 2011, the Perpetrator was again arrested and charged with possession of cannabis with intent to supply for which he was sentenced in December 2011, at Crown Court to 52 weeks imprisonment suspended for 12 months. He was also given a Drug Treatment and Testing Order for 6 months which included a 19 day participation in Thinking Skills Programme.

In September 2011, the Victim gave birth to a baby boy. Details of the father are unknown.

In November 2011, the Perpetrator was referred to the Mental Health Trust by Probation. He was assessed and his primary problem was misuse of cocaine and his secondary problem was misuse of cannabis. He was in debt and living with his parents. He stated that his children were living with their Mother, PFP.

The Order imposed on the Perpetrator in December 2011, had little positive outcomes. He continued to use drugs throughout December and into the New Year, which was confirmed by his Father.

His failure to comply with the requirements of his order resulted in breach action being taken by Probation and the order was returned to Court for enforcement on the 2nd August 2012. He failed to attend Court for his breach hearing on the 30th August 2012 and a Warrant was issued. He finally appeared before the Court on the 18th January 2013 when a 12 week stand-alone curfew order was imposed.

In December 2011, the Victim and her family went to Spain to return some 15 months later. It was while she was in Spain she struck up a Facebook relationship with the Perpetrator.

Until May 2012, the Perpetrator continued to use drugs and tested positive for drugs on several occasions.

On 17th May 2012, PFP called the Police to say that she had moved from her Mother's address but the Perpetrator was making threats to her family over the telephone. Officers eventually went to the address and recorded that there were no threats made and PFP was advised to change her telephone number and the case was closed. The Police IMR author states that this was contrary to the original call made by PFP.

Later in May 2012, the Perpetrator's Father called the Probation Service expressing real concern about his son's drug misuse and the effects it was having on the rest if the family. His Father requested more stringent conditions to be attached to the Court Order. He was told that the Court had made the order and there was nothing more that could be done.

On 11th June 2012, the Perpetrator's requirement to attend for drug rehabilitation ceased and there is nothing to indicate that he was referred back to Mental Health Services for drug rehabilitation after that date.

Later in June 2012, the Perpetrator found accommodation in a hostel, having been sleeping rough in a sub-way. He had left his parents' address.

From June 2012, to April 2013, the Perpetrator had spasmodic contact with the Probation Service and he was arrested in January 2013, for failing to appear in Court. His suspended Sentence was extended.

In June 2013, the Perpetrator was admitted to hospital saying that there were men after him. He was in a 'drug induced paranoia'. Police Officers who dealt with him on this occasion recorded the incident as a 'non crime incident'.

Later in June 2013, Police Officers were called to his parent's house where, under the influence of drugs, he was being aggressive. An ambulance was called and he was taken to hospital. Officers decided that there was no risk and left him there the ambulance log however indicates that there was a suggestion that he had a knife and was damaging furniture. It is recorded that he had cuts to his legs. It appears that a newly implemented Health Trust Self Harm Policy (2013) was not adhered to.

On 25th June 2013, the Perpetrator overdosed on drugs whilst at his parent's house. His children were there at the time. His Father said that he was going to send his son to Pakistan to 'sort him out'. Police Officers who attended made a referral to Children's Social Care regarding the presence of the children at the time.

In July 2013, the Victim and her family had returned from Spain and were living in accommodation in Warwickshire.

The Perpetrator and the Victim

In December 2013, Police were called to an address in Shirley, Birmingham, where it was reported that the Perpetrator had been in a taxi and had been attacked by men with guns. On arrival of the Police he admitted taking a significant amount of drugs. The following morning an Inspector attempted to contact the taxi company first mentioned in this incident to estimate what the threat had been the previous night, but the Inspector found that the telephone number for the taxi was incorrect. The Police log was closed indicating that the Perpetrator did not wish to complain. There is nothing to suggest that he was asked about the circumstances for his original call and although he had provide the address in Warwickshire where he said he had been living with the Victim, no enquiries were conducted with regard to the address.

On 16th January 2014, a home visit by a Health Visitor took place and the youngest child was seen. The Health Visitor was told that the family had returned from living in Spain. Although there was no record of any 2 year check, the Victim assured the Health Visitor that this had been done and announced that the family were moving to Redditch, Worcestershire on 1st February 2014.

On 28th January 2014, PFP contacted West Midlands Police saying that she was at her mother's house in Birmingham and the Perpetrator had left a message on her mother's answer phone to the effect that he had found out where she lived. She stated that she and her two children were now too scared to return to their address in Warwickshire.

She disclosed that she was five and a half months pregnant and the Perpetrator was not the father of the unborn child. A DASH[1] Risk Assessment was completed, which was assessed as medium risk. She enquired about a Non-Molestation Order but the Officer rightly explained that there needed to be a recent incident of molestation. The Victim was reluctant to discuss any previous domestic abuse history. She stated that she was seeking legal advice and would move to an address that the Perpetrator would not know.

In February the Victim registered at a different GP surgery in Redditch, Worcestershire where they had recently moved to.

Whilst she was in Spain with her family she had struck up a relationship over the Internet with the perpetrator. On her return to the UK the relationship developed and the Perpetrator moved in with the Victim and her family. On the GP registration form, the Victim described herself as being in a relationship and she was living with her son, her mother, her step father, two brothers and her boyfriend (the Perpetrator). GP records indicate that she was pregnant and she was advised to book antenatal appointments.

On Saturday 15h March 2014, West Mercia Police received a telephone call from the Perpetrator at 07.36. He said there were people at his address and he needed the Police. The operator could hear someone saying 'get off me' before the line went dead. Attempts to recall the number were made but the line went to answer phone. A check revealed that the number was that of the Victim. Officers were dispatched but there was some delay in them finding the correct address as the area was a new estate. Whilst the officers were searching for the correct address, the Perpetrator contacted the Police and said he no longer needed them, it was people being stupid and he had to leave.

When they arrived the Officers spoke to the Perpetrator and the Victim who said he had been taking cocaine and drink and he had been hallucinating. The Officers told him to 'sleep it off' and no further action was taken. There is nothing to indicate that the Victim was spoken to on this occasion or who else was in the house.

Just after 11am the same day the Perpetrator again called 999 for the Police saying there was a man outside his house in the boot of the Perpetrator's car. Almost immediately he called again saying there was someone at the door of his house and he felt threatened. The call taker heard the caller (the Perpetrator) say 'she has opened the back door' and a female shout 'get off'.

Again Officers were despatched but armed with this information and that of the previous call that morning, an ambulance was summoned as well. On arrival they saw the Victim on the kitchen floor covered in blood and they saw the Perpetrator standing nearby in blood stained clothes holding 3 kitchen knives.

A further call was received almost immediately from a neighbour saying that a 12 year old boy (the Victim's brother) had run to the neighbour's house after witnessing his sister being threatened by the Perpetrator and the Perpetrator stabbing himself with a knife in his hand.

The Perpetrator was arrested and taken into custody.

[1] Domestic Abuse, Harassment and Stalking Risk Assessment Tool used to assess the risk involved

Forensic post mortem was conducted and the Victim was found to have suffered multiple stab wound and other injuries. It was confirmed she was 13 weeks pregnant at the time of her death. The fatal wound was to her carotid artery to the left side of her neck.

The Perpetrator was charged with the Victim's murder and HM Coroner for Worcestershire opened an inquest on 27th March 2014.

On 25th September 2014, the Perpetrator appeared before the Crown Court and after initially pleading not guilty to murder. On 29th September 2014 he changed his plea to one of guilty. He was convicted of murder and sentenced to life imprisonment with the Judge's recommendation that he serves 19 years.

Views of the Family

In accordance with Home Office Guidance, the Chair/Author of this Domestic Homicide Review has had contact with the mother of the Victim on several occasions. She spoke in detail about the relationship of her daughter with the Perpetrator and how contact had been made whilst her daughter and her family when in Spain. The Perpetrator and Victim apparently knew each other from school days. On the family's return to the UK, the victim and Perpetrator commenced the relationship. The mother was aware that the Perpetrators family had sent him back to Pakistan for an arranged marriage but he had returned without a wife.

The Victim's mother knew the Perpetrator had 2 children with a former partner and there was animosity between the former partner and the Perpetrator. According to the Victim's mother, his former partner was stopping him seeing his two children and would do anything to prevent him having access. His former partner was demanding more money for the care of their children which he couldn't afford. The Victim's mother initially thought the Perpetrator was a very kind person who cared for her daughter and her daughter's young son. When her daughter became pregnant by the Perpetrator, the mother stated that she thought he (the Perpetrator) was happy.

There were, however a couple of occasions that made the Victim's mother think otherwise. One was an argument between the Perpetrator and the Victim in the early hours of one morning when the Perpetrator returned home after drinking heavily and taking drugs and he was demanding sex from the Victim which she refused. The Victim's mother warned him that if this behaviour continued then he would have to leave and she stated this was the first time she knew of his drug misuse.

Since the day of the death of the Victim her mother has discovered that her own young son had witnessed the Perpetrator snorting cocaine in his bedroom and also that the CCTV system at the house had captured images of a person clearly delivering drugs to the Perpetrator at the house at 2.15am of the morning of the murder.

At the beginning of this review process, PFP and the Perpetrator's family were written to and invited to contribute to the review. Nether replied at that stage. Following the conviction of the Perpetrator, the Police Family Liaison Officer contacted PFP and asked if she was able to help with the review process. She indicated that she would think about it, but subsequent contact by the FLO was met with a determined decline to take part. A similar situation arose with the father of the Perpetrator, who tried so hard to get his son help with his drug misuse. The Author spoke to a brother of the Perpetrator who spoke on behalf of his Father. He said that there is no doubt at all that his Father would not contribute and the family wanted to move on from this awful event. He stated that the Father would not speak to the Author, even to say that he did not wish to take part.

Advice from Independent Drug Specialist

During the earlier processes of this domestic homicide review, the Review Panel invited a Specialist Drug Advisor from The Pathway to Recovery Service to address the panel on the signs, symptoms and consequences of drugs, particularly cocaine. That input was well received and was very informative and addressed many issues that had arisen, and have arisen since, in this review.

Analysis and Recommendations

Prior to the Victim's family returning from Spain, there was very little known about the Victim and her child. Children's Social Care in Birmingham had been involved with the Victim's mother and the Victim's half siblings some years earlier.

It is quite clear that looking at the history of the Perpetrator's life that during the time of his relationship with PFP, there was a great deal of drug and alcohol abuse and significant domestic abuse and harassment. There were occasions when opportunities to consider action under harassment legislation and/or public order offences were missed, so to were opportunities missed in relation to his drug abuse. There were occasions when Officers attended various addresses to be told by either the Perpetrator or other people that drug had been used by the Perpetrator but there is no evidence that any assertive action such as arresting, searching or considering Child Protection in respect of any children present was taken.

The Perpetrator was offered various intervention programmes and similar support but he either failed to attend or his attendance was spasmodic. He breached his home detention order and there does not appear to be any evidence of him being questioned about his domestic circumstances or the possibility of domestic abuse within his relationship with PFP.

With regards to Warwickshire Authorities, it is known that S4 did not attend for 8 months due to the Warwickshire and Spanish Education Authorities being unable to exchange the necessary documentation proving the child received education in Spain. If a referral had been made to Warwickshire's Children Missing Education Team it is possible that a Child and Young Person's Assessment may have been triggered which may have highlighted the Perpetrator's presence in the family.

On one of his encounters with the Police, the Perpetrator volunteered information that he lived in Warwickshire with his girlfriend but there was no expansion of this information as to who his girlfriend was or details of his family makeup.

Disclosure of Criminal Antecedents of the Perpetrator

The implementation of the Domestic Violence Disclosure Scheme emanating from Clare Wood, a murder victim from 2009 in Greater Manchester raised national attention to the issue of disclosing information about an individual's history of domestic violence. Home Office Guidance of 'Clare's Law' indicates there are 3 options to a disclosure:

> Option 1: continue current arrangements under existing law where the police already have common law powers to disclose information relating to previous convictions or charges to A where there is a pressing need for disclosure of the information concerning B's history in order to prevent further crime.
>
> Option 2: a "right to ask" national disclosure scheme which enables A to ask the police about B's previous history of domestic violence or violent acts where the police would undertake full checks to inform a risk assessment and disclosure. A

precedent upon which suitable adaptations could be made exists with the Child Sex Offender Disclosure Scheme;

Option 3: a "right to know" national disclosure scheme where the police would proactively disclose information in prescribed circumstances to a relating to B's previous history of domestic violence or violent acts (as envisaged in the ACPO report of 2009).

As can be seen from the above the Police already have a common law power to disclose information relating to details of previous convictions where there is a pressing need to disclose in order to prevent further crime. Any member of the public can ask the Police for information about a third party's violent history, and the Police have discretion whether to disclose this information if there is a further need of further crime.

The Domestic Abuse Disclosure Scheme of 2013 was implemented across West Midlands Police Force area in March 2014. However, the major caveat in this case is the fact that the Perpetrator had not been convicted of a domestically related offence. He had been charged but PFP withdrew her complaint and the case did not proceed to court. Therefore the Perpetrator was not subject of a Multi-Agency Public Protection Arrangement (MAPPA) under which there is an opportunity for previous convictions to be disclosed to potential Victims.

With regard to the Common Law Power to disclose, PFP did not ask for disclosure and the Officers were therefore constrained by the Data Protection Act preventing them disclosing without any request being made. However, there is evidence that PFP feared for her safety on several occasions and is considered that West Midlands Police may have referred her to a Multi-Agency Risk Assessment Conference (MARAC) as a high risk victim. Here information can be shared on the highest risk domestic abuse cases and from that discussion a co-ordinated action plan is created where disclosure could have taken place through an Independent Domestic Violence Advisor (IDVA).

It is also the case that if the Perpetrator or Victim had been referred respectively to MAPPA or MARAC the Perpetrator ought to have been monitored as he moved between Birmingham, Warwickshire and Worcestershire and his presence in the Victim's family may well have been identified.

The Overview Report also mentions the creation of Domestic Violence Notices and Orders which came into effect in March 2014, 7 days before the death of the Victim. The DVPO's provides protection to Victims enabling the Police and Magistrates to put protection in place in the immediate aftermath of a domestic violence incident and the DVPN is a notice served at the time of the incident indicating that the order is likely to be enforced. A recommendation has been made in another Worcestershire DHR regarding the implementation of DVPN's and DVPO's.

On the day of the attack on the Victim, Officers from West Mercia Police had an opportunity to check intelligence held about the Perpetrator. Records would have shown he had a propensity to self-harm. At the initial call at 07.57 they left the Perpetrator assuming he was going to sleep off the effects of the drugs, and there is no evidence that the Officers considered the welfare of anyone else in the house at that time. Intelligence may have indicated that he had previously made threats to PFP.

West Mercia Police IMR contains a number of recommendations but this report makes a recommendation for both West Midlands Police and West Mercia Police regarding checking intelligence following a report of domestic abuse.

The Perpetrator presented at a hospital in June 2013 after self-harming and took his own early discharge. This meant the relevant assessment paperwork was not completed. The hospital trust however, one month before implemented a self-harm policy which requires a much more detailed history of the patient. Since this incident hospital staff have been alerted to the policy and more details are now obtained from self-harming patients.

The Probation Service indicate that in their experience offenders who misuse substances often lead chaotic lifestyles which makes engagement with agencies and the keeping of appointments difficult. The Probation Service have suggested a recommendation to try and co-ordinate by joint interventions and meetings a more structured approach to information sharing with such people.

Conclusions

The Perpetrator had significant substance and alcohol misuse problem which affected not only himself but PFP and their children, his own family and ultimately the Victim and her family. He failed to comply with conditions of his drug treatment programme.

There were missed opportunities for the Police to take action with respect to his harassment of PFP.

There was no consideration by the West Midlands Police to pursue a victimless prosecution on behalf of PFP and her children, all of whom were at risk. She withdrew her complaints, no doubt in fear of the consequences from the Perpetrator should she have continued to court.

Information known about the Perpetrator was not shared with other agencies or fellow Police forces which resulted in the holistic picture of his drug and alcohol problem and the effect that had on PFP and more recently the Victim and their respective children was not recognised.

S4 was absent from school for 10 months and this was not identified as a problem worthy of investigation. This was a missed opportunity for Education to flag to Children's Social Care that S4 may have been at risk during his absence from school.

There was no joint thinking and a lack of professional curiosity judgement among professionals. No one agency had the full facts because of the lack of a comprehensive overview and information exchange.

Based on his antecedent history, the Perpetrator was not going to change his lifestyle. He had numerous opportunities to do so but failed each time. His drug misuse held more importance than his children or relationships but he showed a disturbing possessive nature with regard to PFP. He demonstrated this possessiveness with the Victim. He thought she was seeing someone else or contacting another. Fuelled by the effects of two very large doses of cocaine within a very short period he killed the Victim.

Whilst information sharing may have meant more positive action by the Police in respect of him harassing PFP and/or his drug abuse, his mental health was not regularly assessed. He was last seen by Mental Health on 29th May 2012. Perhaps if his contact with the Police since that date or his attendance at Emergency Department at Hospital had focused on his mental health he may have had mental health support or treatment.

The Health Visitor's IMR points out clearly that there was a lack of professional curiosity about the adults in S3's life. A routine enquiry about domestic abuse was not documented although it is not known if there was appropriate opportunity to ask questions about it. This has been identified as a learning point together with the adults taking care of the child C3

and the recording of information in the child's health records. Both of these issues have been adequately dealt with in the Health Visitor's IMR recommendations.

In all of the circumstances this review has identified and despite the short comings of various agencies in a variety of ways, the fatal attack on the Victim could not have been predicted or prevented. To reiterate the comments made by the Victim's mother about the Perpetrator a short time before the murder and before she knew the truth about her daughter's partner:

> "I thought the Perpetrator to be a very kind polite person who was very caring towards my daughter and her young son. When she became pregnant by him, he was happy".

List of Recommendations

Recommendation No 1

Warwickshire Safeguarding Children Board (WSCB) is to seek assurance that:

> **a) Children in Warwickshire seeking a school place are identified and an appropriate offer of a school place is made in a timely manner**
> **b) When children in Warwickshire are not in education relevant assessments are undertaken in relation to any identified vulnerabilities and appropriate arrangements are made to safeguard the child where required.**

Recommendation No 2

West Midlands Police to confirm with North Worcestershire Community Safety Partnership within 6 months of the date of this report that information regarding the dissemination of the use of Domestic Violence Protection Notices and Orders has been completed for all officers within the force.

Recommendation No 3

West Midlands Police and West Mercia Police examine their policies and procedures regarding action taken by officers at the reports of domestic abuse complaints, to ensure that all possible intelligence is gathered on the parties concerned and if necessary that intelligence is shared with other Police forces and agencies as deemed appropriate.

Recommendation No 4

All agencies, when working with substance misuse service users and other individuals that lead chaotic lifestyles, ensure appointments are co-ordinated resulting in joint interventions /meetings being better established. This will need a more structured approach to information sharing

Malcolm Ross

Independent Chair/Author

Appendix A

DOMESTIC HOMICIDE REVIEW

CASE No. 7

The Domestic Violence Crimes and Victims Act 2004 Section 9 (3), which was implemented with due guidance[2] on 13th April 2011, (amended in 2013) establishes the statutory basis for a Domestic Homicide Review.

Under this section a 'Domestic Homicide Review' means a review of the circumstances in which the death of a person age 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, held with a view to identifying the lessons to be learnt from the death

In compliance with the Home Office Guidance, [3] West Mercia Police notified the circumstances of the death in writing to the Community Safety Partnership (CSP) for Worcestershire. The CSP accordingly notified the Home Office of the circumstances.

The Domestic Homicide Review Panel

The review was carried out by a Domestic Homicide Review Panel made up of representatives of agencies who were involved in delivering services to the family of the victim. It included senior officers of agencies that were involved. The professional designations of the panel members were:

- Strategic Coordinator for Domestic Abuse and Sexual Violence, Worcestershire County Council
- West Mercia Police
- National Probation Service West Mercia
- Designated Nurse for Safeguarding Worcestershire
- Worcestershire County Council Quality & Safeguarding Services Manager
- Worcestershire County Council Health & Wellbeing (Administrator)

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Home Office Guidance[4] requires that;

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair*

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2011 Amended 2013 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[3] Home Office Guidance page 8
[4] Home Office Guidance 2013 page 11

should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

The panel chair and the overview report writer was Mr Malcolm Ross, a retired Senior Detective from West Midlands Police. He has 25 years' experience in conducting case reviews for local authorities in the United Kingdom and is independent of any agency involved in this case.

Time Period

It was decided that the review should focus on the period from 1[6th] June 2012 (the date the Victim returned from Spain) to the date of the Victim's death on 15th March 2014.

Scoping the review

The process began with a scoping exercise by the panel to identify agencies that had involvement with the Victim and Alleged Perpetrator prior to the homicide. Where there was no involvement or significant involvement by agencies the panel were advised accordingly.

Agencies were asked to identify any other significant information that may add to an understanding of the quality of dynamics of the relationships within the family before and after the time period.

The purpose of the extended period is to examine and identify what opportunities were available for agencies to intervene or challenge decisions that were made in respect of the Alleged Perpetrator and siblings by parents where concerns may have been escalated by agencies.

Individual Management Reviews

The following agencies were requested to prepare chronologies of their involvement with the Victim and her family, carry out individual management reviews and produce reports.

- West Mercia Police
- West Midlands Police
- Warwickshire Police
- Probation including Birmingham – National Probation Service Midlands Division, Birmingham, Coventry and Solihull
- Worcestershire Health and Care Trust (Health Visitors)
- NHS England Arden Area Team (Worcestershire and Warwickshire GP's)
- NHS England Birmingham and The Black Country Team (GP)
- Worcestershire Acute Hospitals NHST
- Birmingham & Solihull Mental Health NHS Foundation Trust (Drug treatment provider)
- Solihull CCG – Birmingham School Nursing (re previous relationship) Birmingham Health Visiting Services (re previous relationship)
- Coventry and Warwickshire CCD – Warwickshire Health Services (re victim)
- Birmingham Children's Social Care
- Worcestershire Children's Services (WCC)
- Heart of England NHS Foundation Trust

Terms of Reference

The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- Specific questions which need only be answered by the agency to which they are directed.

The generic questions are as follows:

1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the victim’s wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the victim should have been known?
13. Was the victim informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?
16. Had the victim disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?

23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the victim and the perpetrator?
25. To what degree could the homicide have been accurately predicted and prevented? Were there opportunities to escalate concerns through single or multi agencies?
26. In light of the concerns in respect of the Perpetrator's former partner and their/the children, what considerations were given to the future safeguarding of any children the Perpetrator may live with or father and risk assessment of future partners and their children? (This may involve West Midlands Police, Birmingham Women's Aid, Birmingham Children's Services and Birmingham Mental Health services).
27. Was/should the Perpetrator have been considered a Person Posing a Risk to Children?
28. Was this case considered in MARAC or MAPPA?
29. Should alerts about the Perpetrator have been shared across agencies boundaries?

In addition to the above, the following agencies are asked to respond specifically to individual questions:

- Mental Health - Was there conformity to the Care Programme Approach throughout?
- Warwickshire Police, West Midlands Police and West Mercia Police - Should the Police or any other agency has considered a disclosure of the Perpetrator's violent history to the Victim? To protect that person and her children.

Individual Needs

Home Office Guidance[5] requires consideration of individual needs and specifically:

- "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the Victim, the Alleged Perpetrator and their families? Was consideration for vulnerability and disability necessary?"

Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

[5] Home Office Guidance page 25

The review gave due consideration to all of the Protected Characteristics under the Act.

The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Lessons Learned

The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as Children and Adult Serious Case Reviews and appropriate and relevant research.

Media

All media interest at any time during this review process will be directed to and dealt with by the Chair of the South Worcestershire Community Safety Board.

Family Involvement

Home Office Guidance[6] requires that:

> "members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",
> and:
> "Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

The views of the family members and were taken into consideration. The family members were invited to participate in the review process.

[6] Home Office Guidance page 15

Bibliography

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
Home Office 2011 Amended 2013
www.homeoffice.gov.uk/publications/crime/DHR-guidance