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

BDHR2012/13-04

Report produced by Birgitta Lundberg

Independent Chair and Author

December 2014

GLOSSARY

AAFDA: Advocacy After Fatal Domestic Abuse

ACPO: Association of Chief Police Officers

BCC: Birmingham City Council

BSCB: Birmingham Safeguarding Children Board

BSCP: Birmingham Community Safety Partnership

CCG: Clinical Commissioning Group

CPP: Child protection plan

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

ICPC: Initial child protection conference

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

MAPPA: Multi-Agency Public Protection Arrangements

PPU: Public Protection Unit of West Midlands Police

SCR: Serious Case Review

Contents

1. INTRODUCTION.

1.1. Summary of the circumstances leading to the Review

1. The tragic death of the victim in August 2012 was notified to the Birmingham Community Safety Partnership (BCSP) on the following day.

2. At the time of her death, the victim was 22 years old and had three young children under the age of 5 years, who were all subject of child protection plans under the category of emotional abuse in relation to the domestic violence and abuse being experienced by the victim from their father, the perpetrator. An unborn sibling was originally subject to the same child protection plan and the services, which were being provided to the family. However, a termination of this pregnancy had taken place a few days prior to the victim's sudden and violent death.

3. An Initial child protection conference had taken place in June 2012 following section 47 child protection enquiries and assessment carried out by Children's Social Care. The core group of agencies, in this case, Children's Social Care, the health visitor and maternity services were working to the child protection plan and the oldest child was attending a nursery at a children's centre.

4. The victim and the children had been staying with the victim's mother and her family following the Initial child protection conference, although the accommodation arrangements were in flux at the time of the death. A number of agencies were working with the victim, the children and the perpetrator in addition to the core agencies. The police became involved again subsequent to the Initial child protection conference.

5. The perpetrator was charged shortly after the event and convicted of the murder of the victim in January 2013. The victim was stabbed twenty-nine times both in the front and back of her body. The perpetrator was sentenced to life, with a minimum of twenty-two years imprisonment.

6. The perpetrator had been involved in eleven documented offences and had come to police notice on twenty-five occasions prior to the murder of the victim. This included four assaults on a previous partner, two allegations of criminal damage to the ex-partner's property, one verbal

domestic dispute, one 'threat to kill' and two harassment offences against the maternal grandmother of the ex-partner because the perpetrator had a child in that relationship.

7. The offences committed by the perpetrator did not only involve the ex-partner but included offences, as a teenager, of violence against his own extended family. The victims were mainly, but not only, female victims. The reported incidents demonstrated patterns of behaviour where the risks to the victims increased at times of pregnancy, separation and contact to children. The injuries caused were mainly to the head and face as well as the neck following attempts to strangle the victims. A number of the incidents involved finds of substances in the perpetrator's possession such as crack cocaine and cannabis as well as weapons such as knives and a report to the police at one point that the perpetrator had acquired a gun.

8. The background history of the perpetrator was known to the agencies in connection with the victim and the children since late August 2010. The agency involvement and services provided will be explored in this Review in section 3 and 4.

9. The victim's immediate family have contributed to the Review supported by a representative from the National Homicide Service and a representative from Advocacy After Fatal Domestic Abuse (AAFDA). The perpetrator was invited to contribute but no response has been received at the time of writing. The victim's father was invited to contribute but declined.

10. During the review, children's services were providing safeguarding services to the children in line with their procedures at the time.

1.2 Terms of Reference

11. The BCSP Domestic Homicide Review Steering Group recommended in August 2012 to the Chair of BCSP that a review should be undertaken as the criteria set out in Section 9 of the Domestic Violence, Crime and Victims Act (2004) had been met:

12. The Act states that a Domestic Homicide Review (DHR) should be 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 person to whom she was related or with whom she was or had been in an intimate personal relationship with ; or

- a member of the same household as herself,
  and be held with a view to identifying the lessons to be learnt from the death.

13. The Chair of BCSP approved the recommendation and the Home Office was notified of the decision to hold a DHR in August 2012. It was acknowledged that the timescale to conclude the review would be dependent on the criminal processes.

14. **The Terms of Reference** were drawn up and were subsequently reviewed by the DHR Panel and its independent Chair in November 2012 as set out below:

    The aim of the DHR 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 the 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.

15. The scope of the Review was agreed as:

- The Review will consider agencies contact with the victim and alleged perpetrator, including relevant contacts with the children.
- The Overview Report will consider relevant research and learning from previous relevant Domestic Homicide Reviews, both nationally and locally.
- The Panel will consider how and when family members should be invited to become involved with and to contribute to the Domestic Homicide Review process, being mindful of the criminal investigation process. The Panel Chair will be responsible for arranging liaison with the family, where necessary through a designated advocate.
- There are no other Community Safety Partnerships involved.

- BCSP will obtain legal advice as necessary.
- BCSP will notify the Strategic Health Authority[1] and the Coroner that a Domestic Homicide Review is being undertaken and will liaise with them as required during the Review.
- Relevant information to emerge from any 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.
- The Independent Panel Chair and BCSP will liaise regularly with the Senior Investigating Officer, West Midlands Police, to address all matters in relation to the disclosure of information in view of the criminal process and the Review.
- Public and media enquires will be handled by the Chair of the Domestic Homicide Steering Group.
- 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.

16. Individual Management Reviews (IMRs) were requested to be undertaken including a comprehensive chronology of each agency's involvement with the identified family members. Family members were informed of the Review and the details of the process including information gathering.

17. A number of **Key Lines of Enquiry** was set out to be addressed in the IMRs:

- **What knowledge/information did the agency have that indicated domestic violence and how did the agency respond to this information?**

  Consider the following:

- Whether practitioners were alert to potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?

- Whether the agency has policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies considered effective? Was it reasonable to expect staff, given their level of training and knowledge to fulfil these expectations?

[1] Now NHS England April 2013

- 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 and in keeping with organisational and multi-agency policies and procedures?

- How, when and why, the agency shared information with others and its impact?

- Was the supervision and management of the case in the agency effective and did it follow agency policies and procedures?

- To what degree did the victim's understanding of the risks she faced impact upon decision making?

- Should the information known to the agency have led to a different response?

- Was it reasonably possible without the benefit of hindsight to predict and once predicted work to prevent the harm that came to the victim?

- **What services did the agency offer to the victim including meeting the children's needs? Were they accessible, appropriate, empowering and empathetic to all their needs?**

  Consider the following:

- 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?
- Whether practitioners were sensitive to the needs of the victim?
- How accessible were the services for the victim?
- 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?
- 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 and supported to make informed decisions?
- Were there identified needs unmet, or conflict identified between her needs and the needs of others.

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

  Consider the following:

- Are there lessons to be learned from the case relating to the way the 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?

- Do any of the agency's policies or procedures require amending or do new ones need establishing as a result of this Domestic Homicide Review, including those covering risk assessment?
- Identify good practice where responses may have been over and above the required standards.
- Whether or not the agency feels there are any gaps in their current provision, including skills, knowledge and/or ability to respond effectively to the needs of the victim.

- **Identify any lessons learnt and implemented during the Review.**

Give evidence of any changes that have already been acted on in the light of the Review:
- explain the expected outcomes of the changes
- how will the lessons acted on be maintained/embedded

Additional specific issues were to be addressed by West Midlands Police, Children's Social Care and Women's Aid as set out below:

- **West Midlands Police:**

- Whether the perpetrator's previous violent history impacted upon decision-making in the reports of domestic violence made by the victim.
- An evaluation of the outcome of the Police investigation into alleged assaults and the outcome of charging decisions on 09.08.10 and 14.01.12

- How risk to the victim and the children was assessed and responded to as a result of these and historic police reports, including consideration of whether thresholds were reached for making a disclosure.

- **Children's Social Care:**

- The nature of the assessment and response to the risks and needs of the three children and how the safety of the victim featured in these assessments and responses.
- An evaluation of the assessment undertaken on 02.08.12 when it was discovered that the alleged perpetrator had discovered the victim's temporary accommodation and was considered to be under the influence of a substance when visiting the temporary accommodation. Whether information was shared with other agencies at this time?
- Whether a referral to MARAC was considered?

- **Birmingham and Solihull Women's Aid:**

- The victim was reported to have been on the waiting list for several months before obtaining a service. What is the context to this waiting list? How did the organisation manage its waiting list and mitigate against disengagement with service users? Was there capacity for prioritising according to risk and was that done in this case? Did this wait for services impact upon engagement with the victim?

1.3 The Domestic Homicide Review Process

18. Once the death of the victim had been notified to the Birmingham Community Safety Partnership and the Domestic Homicide Review Steering Group had recommended that a Review should be undertaken on the 21st August 2012, the decision was made and the Home Office was notified on 29th August 2012.

19. Draft terms of reference and the scope of the Review were drawn up and the BCSP made arrangements to appoint an independent Domestic Homicide Review Chair and Author, Birgitta Lundberg, who was appointed by the 10th September 2012.

20. The BCSP notified the the Coroner of the Review and confirmed that any liaison required would take place during the Review. It was confirmed that no other local authority areas were involved and that the BCSP had access to legal advice, if required.

21. As the children of the victim were subject of child protection plans at the time of their mother's death, the independent Chair of the DHR requested that the BSCB Serious Case Review Sub group should formally consider whether the criteria for a Serious Case Review had been met or whether the agencies, that had been involved with the children, would participate in and contribute to the DHR.

22. The Birmingham Safeguarding Children Board Serious Case Review Subgroup decided on the 16th November 2012 that there would not be a separate Serious Case Review under Regulation 5 of the Safeguarding Children's Board Regulations 2006. The Overview Report and Action Plan from the Domestic Homicide Review would be presented to the Birmingham Safeguarding Children Board (BSCB) formally at the conclusion of the Review for consideration and any relevant learning and actions to be implemented. Any learning or actions of a more urgent nature identified by one of the participating agencies that might become apparent during the Review process should be implemented without waiting for the conclusion of the Review.

23. All member agencies of the BCSP and BSCB were notified of the death and were asked to examine their records to establish if they had been approached by or provided any services to the adults in the family or to the children during the time frame set by the Terms of Reference.

24. The time period to be reviewed was agreed to be from April 2008, a point prior to the birth of the oldest child of the family, up to the time of the victim's death in August 2012. As the offending history of the perpetrator was known at the point of the Review being initiated, the West Midlands Police were asked to consider their involvement from 2003 with the perpetrator as well. Any significant information, which might come to light during the Review outside the set timeframe, should be agreed by the DHR Panel for inclusion if determined to be of relevance.

25. It was agreed that the review should give due consideration to all of the protected characteristics under Section 149 of the Equality Act 2010. In particular the review should proceed with awareness of the victim's gender, young age and repeated pregnancies. In respect of the mixed heritage of the perpetrator and the children, IMR authors should be asked to comment on whether their services were accessible and sensitive to the ethnic, cultural, linguistic and religious identity of the family.

26. By the middle of October 2012, the invitations to agencies to nominate members for the DHR Panel, which would conduct the Review, had been sent out. Requests for Individual Management Reviews (IMRs) to be undertaken by the agencies, which had been involved with the family, had also been issued.

27. The first DHR Panel meeting took place on 5th November 2012 for half a day. The Officer in Charge of the criminal investigation and the Disclosure Officer, West Midlands Police, advised the Panel of matters relating to the disclosure of information and it was agreed that liaison arrangements would be established through the Panel Chair and BCSP representative with the Senior Investigating Officer as needed.

28. The second half of the same day was set aside for the briefing for the IMR authors, which was well attended. The appointment of IMR authors had not been finalised in all agencies due to resource constraints and availability of suitably trained authors independent of the case. In one voluntary agency, the Panel member was also the manager of the nominated IMR author but in view of the agency remit and the expertise provided to the DHR Panel, it was agreed that this would be acceptable.

29. All agencies were asked to provide a chronology of their contacts with the victim, the perpetrator and the children as a matter of priority so that work could be started on drawing up an integrated chronology to track the journey of the victim, the perpetrator and the children through the available records to assist in establishing the facts of the case.

30. The second Panel meeting took place on 12th December 2012 and the first drafts of the IMRs were presented by the IMR authors attending the meeting. The Panel members were able to discuss the progress of the review reports and request further clarification and additional material, where needed. The quality assurance role performed by the Panel of the IMR reports was implemented. A number of IMR reports were amended to ensure that the process had been thorough and robust in reviewing the agency involvement with the family and that the relevant learning had been highlighted and recommendations had been made. All Panel meetings were minuted and all actions agreed have been tracked and signed off.

31. Further Panel meetings took place in January, February, April and May 2013. Some agencies struggled to provide the IMRs in the time requested and Children's Social Care encountered delays in providing a final IMR, which the Panel was able to approve. This led to the overall Review process being longer than originally anticipated. The BCSP DHR Steering Group was kept informed of progress.

32. The victim's family and the perpetrator were informed of the DHR taking place by letter with leaflets and advice included at the end of November 2012.The letters were delivered by hand via the Police Family Liaison Officer. The family were advised that the Chair would contact them again as soon as the criminal proceedings had concluded and it would be possible to meet with them to enable them to contribute to the Review.

33. Further letters were delivered in January 2013 as the criminal trial ended in January. The meeting with the victim's mother and aunt took place at the beginning of February 2013.

34. Additional letters were sent to the perpetrator in prison but no response was received. The victim's father declined to participate in the Review stating "that it was too late".

35. The final Overview Report was shared with the family at a meeting in July 2013 for comment. The report was updated following the family meeting and was presented to the BCSP DHR Steering Group and BSCB Serious Case Review Sub Group prior to submission to the Home Office.

1.4. Independent Chair and Overview Author

36. 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 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 five years she has been working as an independent social work consultant producing Serious Case Review Overview Reports and undertaking multi-agency audits. Birgitta Lundberg is not employed by any of the agencies of the Birmingham Community Safety Partnership or the Birmingham Safeguarding Children Board.

1.5 Members of the Review Panel

37. The agency membership of the DHR Panel was agreed by the BCSP DHR Steering Group in October 2012 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 family of the victim. They were not the authors of the Individual Management Review reports with the exception of one agency, the Birmingham Women's Hospital NHS Foundation Trust. The Panel accepted this arrangement after discussion. In addition, the Panel member for the Birmingham and Solihull Women's Aid held management responsibility for the IMR author for that agency. In view of the size of the agency staff compliment it was agreed that the arrangement could stand.

38. It was recognised that there were no special needs or disabilities in relation to any family member that should have been taken in to account in reviewing the services delivered to the family. The family reflected a diverse ethnic background and there were different religious beliefs represented in the grandparents' generation. It had been reported by the victim according to agency records that there were tensions in this respect between the two family groups. The Panel membership encompassed expertise in diversity and equality matters in order to be able to consider all aspects of the services provided to meet the needs of the victim and the children.

39. The DHR Panel members were:

- Birgitta Lundberg, Independent Chair and Overview Author
- Senior Service Manager for Violence Against Women, Birmingham Community Safety Partnership
- Detective Chief Inspector, West Midlands Police
- Head of Safeguarding[2], Birmingham and Solihull NHS Cluster[3]
- Assistant Chief Executive, Birmingham and Solihull Women's Aid
- Lead Nurse/ Midwife Safeguarding Children and Adults, Birmingham Women's NHS Foundation Trust
- Senior Service Manager, Homelessness and Pre-Tenancy Service, Birmingham City Council
- Associate Director Safeguarding, Birmingham Community Health Care NHS Trust
- Senior Service Manager, Early Years, Childcare and Children's Centres, Birmingham City Council
- Manager, Child Protection and Review Service, Birmingham City Council
- DHR Administrator, Birmingham Community Safety Partnership

[2] Head of Safeguarding, Birmingham and Solihull NHS Cluster, now superseded by Clinical Commissioning Groups (Panel member- Designated Nurse Safeguarding Children & Adults at Risk, Solihull CCG) and NHS England
[3] Now superseded by the Clinical Commissioning Group

1.6 Individual Management Review Reports (IMRs)

40. When the agencies involved had been identified, reviews and reports were requested in line with the BCSP guidance and the Home Office DHR Guidance from the following:

- West Midlands Police
- Birmingham City Council – Children, Young People and Families Directorate
- Birmingham and Solihull Women's Aid
- Birmingham City Council Homeless and Pre-Tenancy Service (to incorporate the full homeless pathway including Neighbourhood Advice and Information Service)
- Birmingham Community Healthcare Trust
- Birmingham Women's Hospital Foundation Trust
- Birmingham and Solihull NHS Cluster and relevant GPs
- A Nursery and Children's Centre

1.7 Agencies with nil returns

41. The 41 agencies, which had been contacted when the DHR letters originally went out on 20th August 2012 responded and of those 28 agencies returned the information that the family members had not been known to them. One brief information report was received from the West Midlands Ambulance Service and the Panel determined that there was no need for any further review to be undertaken by them as the contacts related to routine calls.

1.8 The definition of domestic violence

42. 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.*

43. The previous definition was as above without the added age range of 16 years and the elements of controlling and coercive behaviour described above. The Home Office definitions, past and present, have been followed in the BSCB safeguarding children policies and procedures.

44. It should be noted in addition, that Local Authorities are required to take account of the definition provided in section 177(1A) of the Housing Act 1996 in the context of housing needs, homelessness and domestic violence as well.

2. THE SURVIVING FAMILY

2.1 Family involvement in the Review

45. The family members were approached by the police Family Liaison Officer, who hand delivered letters from the independent Chair. They were advised in the accompanying leaflets about advocacy and victim support services.

46. The victim's mother, who was caring for the children of the victim and the perpetrator, expressed an interest in meeting the Chair and in contributing to the Review supported by two organisations: the National Homicide Service and AAFDA (Advocacy After Fatal Domestic Abuse). The victim's aunt was also present at the meeting, which took place in the family home at their request in February 2013. The Senior Service Manager from BCSP attended and took notes of the meeting on behalf of the Chair.

2.2 Information from the family

47. The victim's mother and aunt described their concerns for the victim when she attended the child protection conference and subsequent core group meeting as the perpetrator was present at those meetings. They questioned the wisdom of this arrangement as they believed that the victim would only say what she felt that the perpetrator would allow her to say. Their view was that he controlled and intimidated her and they feared for her safety arriving and leaving the meetings, which was why they accompanied the victim to the venues, when possible. At one of the meetings the aunt queried whether the perpetrator had been carrying a knife and stated that she asked the social worker to check this. There were no police present and she recalled informing the social worker that the victim needed protecting as did the oldest child, who the victim's family believed was at risk of being abducted by the perpetrator. The response was reportedly that, 'if the victim was fearful she must report this herself to the professionals'. The family considered that their views had been ignored by the professionals and they had difficulty understanding why the perpetrator had been invited to attend the meetings as he was no longer living with the victim at that time.

48. The members of the victim's family described their surprise at some of the information about the perpetrator's history in relation to domestic violence and a previous partner and child, which they had not been aware of prior to the criminal trial. The family expressed the view that if that information had been explained to the victim, it might have assisted her to make a more informed decision about her relationship with him, thus preventing some of what had happened. They were surprised that the agencies involved with the victim had been aware of the same information all along, yet had not shared some of it with the extended family.

49. At the child protection conference and in the child protection plans there was an expectation that the victim's mother would contact Children's Social Care or the police, if she and the children were in contact with the perpetrator. The victim's mother adhered to this request and stated that she had tried to report incidents. Yet, she expressed the view, that when she had contacted Children's Social Care and the allocated social worker was unavailable; the duty officer had not known what to do. As a result the family had phoned the police and reported their concerns in order for the matter to be followed up.

50. The family reported that the victim had thought that the perpetrator had been monitoring her movements and had broken into the home. The victim had described thinking that he had read

through her post and followed her. The family members had also encountered the perpetrator watching their homes and when challenged he had behaved in a threatening manner. This behaviour of harassing the family members had been a pattern with the previous partner and her family which was known to the agencies. However, this information was not shared by the professionals with the victim or the extended family.

51. The victim's mother described her relationship with the victim as close and supportive but there had been periods of time when the perpetrator had stopped the victim from contacting her family and stopped the victim's mother from seeing her and the children. The victim, according to agency records, reported that the perpetrator would often attempt to stop her seeing or calling family or friends by confiscating her mobile and keeping her within the accommodation at the time.

52. The victim's mother and aunt were particularly distressed as they considered that some information, which had been revealed in the criminal court, had linked an incident some days before the death of the victim to the perpetrator's defence explanation for his action to stab the victim twenty nine times. This was widely reported in the media as well and has been subject of a complaint investigation. (See details in section 3.3 and 4.1)

53. The family had understood that the victim has asked the professionals not to let the perpetrator have any information at all about her intention to have a termination of the pregnancy of the unborn baby, who was also subject of a child protection plan. The termination had taken place and the victim had informed the social worker of this by text.

54. The victim and the children were subsequently accommodated by the Homeless and Pre-Tenancy Service in a hotel pending a move to another property. This was assessed as a change of the child protection plan agreement and led to the social worker with a colleague visiting the victim and the children at the hotel. During the visit it became clear that the perpetrator was present and he was asked to leave the premises. The allocated social worker enquired about the victim's condition in view of the termination and this was overheard by the perpetrator, who had re-entered the building. The victim became very fearful and the victim and the children returned to stay with the victim's mother, although the household was now overcrowded. This incident took place four days prior to the victim's death. The family's views were that the information about the termination had been badly mishandled and had increased the risk to the victim and the children significantly.

55. Redacted – sensitive information

2.3 Family views and wishes

56. In conclusion, the victim's family expressed the view that the agencies had not taken the threat that the perpetrator posed to the victim seriously. Professionals had not listened to the victim or her family members, who had spoken out, and as a consequence had failed to act decisively in accordance with good practice, when the victim had reported instances of violence and abuse to her.

57. The victim's family expressed their grief at the loss of a young daughter and the loss for her children of their mother. They hoped that any findings of the Review would assist in preventing any other woman going through the same process from being harmed.

58. The most important message from them was that the police and Children's Social Care should focus less on the victim as just the mother of the children but see the picture as a whole and focus their work on controlling the perpetrators of violence and abuse. The victim was a young woman in a relationship where the family had had concerns about her welfare all along yet they felt that their concerns had been minimised and they had not been listened to.

59. They accepted that the victim did not tell them everything but both the victim's mother and aunt considered that agencies should have listed to the victim and should have protected her because she was frightened.

3. THE FACTS

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

61. When the records were merged in to the integrated chronology, patterns of contacts and services emerged. Specific key episodes were revealed where the opportunity had been missed by agencies in various ways to ensure that the victim's safety and the children's welfare and wellbeing were promoted effectively. The key episodes illustrated what lessons

should be learnt to improve practice for the future and the details will be examined in the Analysis section.

62. The sections below were based on the information from the integrated chronology, the IMRs, including staff interviews, and the information from the maternal family and are the Independent Overview Author's view of significant information and events about the victim and the children.

3.1 The victim's family history and community context

Designation	*Age at the time of the death*	*Ethnic origin*
The victim: victim and mother	22 years	White British
The perpetrator: ex-partner and father	28 years	Asian/white British
Child of above	3 and a half years	Mixed heritage
Child of above	2 years	Mixed heritage
Child of above	11 months	Mixed heritage

63. The victim was under the age of 18 years when she met the perpetrator and they began a relationship. Initially they stayed with the victim's maternal great grandmother in sheltered accommodation until presenting as homeless to the local authority. Since 2008, the Homelessness and Pre-Tenancy Service had recorded nine different moves. The longest settled period was in 2011 to 2012 in a three bedroom house. In addition to these recorded moves the victim and the children stayed for different periods of time with extended family members of both families. As a result of this unsettled lifestyle, the children had experienced many different carers as well as homes. Most of the accommodation moves were within a geographical area, which was described by Health reports as having 'a culture of extended family support in the community including households, which often contain several generations'.

64. The area has a high rate of recorded unemployment, social housing and deprivation with the associated impact on family life, general health and wellbeing. The demography of the area is diverse although with a predominantly white British ethnic and cultural population of mixed ages.

65. The records demonstrated that the victim felt under pressure by the perpetrator's father and her own father, who both disapproved of the relationship between her and the perpetrator but

for different reasons of culture, religion and ethnic origin. There were reports at different points in time by the victim to housing services of tensions between the two families and between the victim and her father and the perpetrator and his father leading to the involvement of the anti-social behaviour officers from the local authority's Landlord Services.

66. As the victim moved within a geographical area the links with health professionals, in particular the Health Visiting Service and to some extent the GPs and the Walk in Centre were consistent. Given the health needs of three young children and a young mother, the contacts with health professionals were frequent. Most of the home visits and clinic contacts with the Health Visiting Service had noted in the records that the perpetrator was present at the time of any visit, particularly in 2012. The health facilities and the nursery were accessible locally.

67. All descriptions of the home on visits by health visitors were always of a reasonably well-kept home with suitable toys and equipment for the children, who were described as well dressed and clean. There were no concerns expressed by any agency of the practical day to day care provided by the victim to the children.

3.2 Key Episodes based on the integrated chronology of agency involvement

I. Key information from police and GP records of contacts with the perpetrator prior to 2010

68. The first recorded contact with the perpetrator and the police was in August 2000 and was categorised as a domestic incident which involved two siblings being injured by the perpetrator, then 16 years of age. As the victims did not wish to make complaints the matter was closed.

69. Three years later (2003), the perpetrator was arrested and subsequently cautioned on Crown Prosecution Service (CPS) advice for assault in a domestic incident involving a partner. A year later (2004), the perpetrator was reported to have threatened to kill the same partner, now pregnant. No action was taken as the victim was thought by the police to be unwilling to engage according to the records.

70. In the same year an extended family member of the ex-partner was attacked. At the time of his arrest, the perpetrator was found to be carrying a knife. Although he denied any assault, the perpetrator was formally cautioned for 'carrying an offensive weapon'.

71. In 2005, a quantity of illegal substances was found in the perpetrator's flat but no charges were brought. In the same year four complaints were made to the police and three of those involved injuries constituting assaults. One involved threats and criminal damage. The ex-partner had taken steps to protect herself and the child including a civil injunction. The Crown Prosecution Service were advised of the full history including the undertakings and concluded that they would not prosecute as there was "*insufficient evidence to take the case any further*".[4]

72. In 2006, the perpetrator was arrested for "threats to kill" his ex-partner and her family and for 'possession of a controlled drug'. It was reported to the police that the perpetrator had bought a gun in 2005. The perpetrator was fined for the "possession of drugs"; no other action was taken. Six hours after the arrest for these offences, while on police bail, the perpetrator assaulted an extended family member and was again found in possession of cannabis. The perpetrator was subsequently convicted of 'common assault' and 'possession of a controlled drug'.

73. During the second half of 2006, the family of the ex-partner reported several incidents of threats and harassment which were never fully followed up. The family expressed their concerns, according to police records, that their complaints were not taken seriously.

74. From the end of 2006 to April 2008 there were no further reports recorded by the police and it was understood that the ex-partner had taken significant steps to move away to avoid the harassment. In April 2008 a new report of harassment and intimidating behaviour was reported by the ex-partner again. At this point, the perpetrator had started his relationship with the victim.

75. During 2008, the perpetrator was again charged and pleaded guilty to "possession of cannabis".

76. A serious incident of harassment and criminal damage took place in a public place in the second half of 2008 where the ex-partner and child were terrified by the perpetrator's violent

[4] West Midlands Police IMR

behaviour. As a consequence, a warrant was issued for the arrest of the perpetrator on the national police computer system. The arrest in relation to this incident did not take place until two years later.

77. Between this incident and August 2010 there were no reports of the perpetrator to the police and no complaints made to any other agency have been found in the records.

78. The perpetrator had been treated by the GP service regularly for depression and sleeping difficulties since 2003. The attendance tailed off in 2010 and the last appointment offered was in July 2010. This was not taken up. There was a gap in treatment for 18 months subsequently.

79. The substance misuse history was known to the GP service throughout the period according to the records. No referrals had been made by the GPs in relation to this either to specialist substances services for treatment for the perpetrator or to Children's Social Care in relation to concerns about 'the potential impact on his parenting capacity' which should have led to a referral for family support services. Similarly there was no consultation by the GPs about the perpetrator's health issues, and their impact on the children, with the Health Visiting Service for a consideration of Common Assessment Framework (CAF) services or 'children in need' services[5], which might have offered support to the family.

II. The first key episode: August to October 2010

80. At the point of the first contact with the police and Children's Social Care in August 2010, two of the victim's children had been born and were receiving regular health visiting services. The Landlord Services records noted that the perpetrator had been living in the household since March 2010. In August, when the referral was made to the police by the victim, she stated that they were separated but the perpetrator had weekend contact.

81. The referral was made by the victim to the police mid-afternoon. The allegations reported by the victim were that the perpetrator had hit her on the previous night causing injuries to her neck and a cut to her face. She was allegedly punched to her head, grabbed by her throat and her head was banged up against a window. The victim reported that she had been held against her will and that the perpetrator had removed their two children, who were still with him

[5] Section 17 Children Act 1989

at his father's address. The victim claimed that the perpetrator would not return them to her care and had threatened to run away with them.

82. A Domestic Abuse, Stalking and Harassment (DASH) form was completed with the victim, which assessed her as being at 'medium risk', which did not require a referral at the time to the Multi-Agency Risk Assessment Conference (MARAC). The form records that the victim reported that this was not the first incident of domestic violence as there had been previous incidents of his trying to strangle her, holding her against her will and preventing her from contacting her family. The victim was not willing to make a formal statement of complaint to the police according to police records.

83. The police contacted the Emergency Duty Team (EDT) Social Care out of hour's service for consultation about the children. The children had been reported by the victim to be asleep at the time of the incident. Subsequent to the incident, the perpetrator had removed the children to his father's home address, which due to past history in respect of other children was not deemed to be suitable as a placement by the EDT social worker and manager. There was a disagreement between the police and the EDT staff about the best course of action for the young children, who remained with the extended family and were not returned to the victim until the following day. The perpetrator had made counter allegations about the victim's care of the children and the police were reluctant to move them in the night again back to the victim. The EDT staff had been aware of other background history, which led them to conclude that it was not appropriate to leave the children in the care of the perpetrator's father. An arrangement for the supervision of the children was agreed overnight.

84. Two days after the reported incident, the perpetrator was arrested and interviewed about the alleged offences against the victim and about the incident in 2008 against the ex-partner and the child. The background history of the perpetrator had been noted by the police and the outstanding warrant for his arrest had been acted on.

85. The perpetrator denied the allegations and made counter allegations about the victim's parenting skills and behaviour, which were said to have been witnessed, although this was not confirmed by the witness on enquiry. The outcome of the investigations was a decision in respect of both matters not to proceed to prosecution. The police supervising officer judged that there was "no chance of a conviction" without further evidence and the cooperation of the victim. The matter was not taken to the CPS but was filed as "undetected."

86. The referral from the Police to the EDT Social Care team had been passed on to the Children's Social Care Referral and Advice Team. Internal agency records checks were made but checks with Health Visiting or the GPs involved with the children were not undertaken. The referral was passed on to the Duty and Assessment Team for the area, in which the victim lived, for a follow up initial assessment to assess the needs of the children. There was a delay in allocating this assessment and the victim was not seen by the social worker until the next month. The delay appeared from the records to have been related to difficulties initially in staffing levels and then in making contact with the victim.

87. The home visit to undertake the Initial assessment took place in the presence of the perpetrator and the overall assessment of the interactions with and presentation of the children by the victim were recorded as positive. There was no assessment or exploration of the reported domestic violence, which was noted as an "argument".

88. There was no evidence in the assessment that there had been any information sharing with the GP or health visitor, nor with the extended family, which the victim had stated were providing support. There was no evidence in the records that the social worker undertaking the assessment had contacted the police officers, who had been involved in the investigation, to check or discuss any of the information provided in the police referral documentation. Similarly there were no checks undertaken with Landlord Services, although the victim had mentioned the wish to move to another area.

89. The outcome of the initial assessment was a recommendation by the social worker for a child in need plan. The team manager noted three tasks to be followed up:

- A support letter to housing to support a request for a move;
- A working agreement about the perpetrator's contact arrangements with the children
- Checks to be made with the GP.

90. There was no evidence in the records of the tasks having been concluded and the case was subsequently closed by the team manager a month later. There were no further contacts with the victim and the family until February 2012 by Children's Social Care.

91. The services by the health visitor and GPs continued to be delivered as a universal service unaware of the concerns that had been reported by the victim and investigated by the police and assessed by Children's Social Care. The third child was born during 2011.

III. The second key episode: January to April 2012

92. In mid-January 2012, the victim reported an assault by the perpetrator to the police and recounted another one a few days previously. The victim reported that the couple had been separated since August 2010 and described a history of domestic abuse including being assaulted when pregnant with the children. The victim explained that the perpetrator had turned up five months ago and she had been too afraid to make him leave. She described his controlling behaviour: removing her mobile phone; locking her in; preventing her from seeing her family and being aggressive and threatening towards her relatives and friends. The physical attacks were serious involving strangulation and head butting causing injuries and loss of consciousness. The victim explained that if she spoke of separation, the perpetrator became threatening to her and said that he would remove the children or 'blow up' the house.

93. The police officers, who responded to the report, undertook a DASH[6] assessment and concluded that the level of risk was 'medium' for the victim. The DASH form noted the previous incident in August 2010 and that the victim stated that the perpetrator had mental health problems. The investigating officers failed to check the background history on all available police information systems with the result that the full information relating to the history with the ex-partner was not taken in to account at this stage.

94. The officers did not follow up the concerns that the victim had expressed about the children, although the perpetrator had made threats in respect of them as well and they had been present at the time of the incidents. This should have led to a referral to Children's Social Care about safeguarding concerns for the children in line with the interagency Birmingham Safeguarding Children Procedures.

95. A few days later, the victim stated that she did not wish to pursue a formal complaint. As a result, the standard service to a person assessed as 'medium' risk was provided .This consisted of a referral for the victim to Women's Aid and the provision of a contact number to the police Public Protection Unit for future use. In contrast to the original report by the victim, the retraction statement by the victim stated that she was no longer fearful of the perpetrator and that he had now left. The police Public Protection Unit was routinely notified of the

[6] Domestic Abuse, Stalking and Harassment (DASH)

incident. The police officers interviewed the perpetrator at the end of January 2012 and decided that no further action would be taken.

96. However, the police Public Protection Unit processed the notifications simultaneously and following a Multi-Agency Joint Screening meeting[7] in relation to the children, the background history was noted. The Barnados Screening Tool was used to assess the needs and risks arising for children exposed to domestic violence and references to the background history were picked up, which led to a referral to a Children's Social Care Area First Response Team at the beginning of February 2012. The referral information contained the police logs giving full details of what had been reported by the victim about the two incidents in January 2012.

97. The case was allocated for an initial assessment to a social worker with a number of tasks, set by the team manager, to be followed up; this included statutory checks, reading background history and a home visit to see the victim and the children. Some guidance about the assessment was given by the team manager and focussed on assessing the "*mother's ability to take suitable action to protect the children and herself*".[8] The tasks included 'a need to determine, if safeguarding action, such as a Section 47 Enquiry, would be required to protect the children'.

98. The safeguarding nurse informed the health visitor of the referral and liaison with the GP took place. The health visitor reviewed the care plan with the victim the following day and noted that the plan was "*in respect of the victim's support needs as a victim of domestic abuse and in her role as a parent of three young children, whose welfare relied on her actions and understanding of the impact of domestic abuse on children*". [9]

99. There was a delay in the social worker undertaking the initial assessment, which was partly related to workload pressures as well as recorded difficulties in making contact with the victim. The assessment took place three weeks later, when the victim was seen at home without the perpetrator present. The perpetrator was reported by the victim to be living with his father as the couple had now separated.

100. The victim was advised by the social worker that, if any further incidents of domestic violence took place, the result would be a child protection conference. Although a referral by the health visitor for a nursery place for the older child had been made and the referral by the

[7] Barnados Screening Tool BST ;a meeting involving police, social care and a BCHC Safeguarding nurse.
[8] Children's Social Care IMR
[9] BSH Health visiting IMR

police Public Protection Unit was waiting to be allocated by Women's Aid for services, there was no evidence of any attempt by the social worker to make a referral to the Integrated Family Support Service for early help services to support the victim.

101. The outcome of the assessment, based on one visit, was that the social worker recommended that the case could be closed as the perpetrator has now left and because "the victim will be undertaking preventative work". This placed the responsibility on the victim to deal with the behaviour of the perpetrator unsupported. The team manager's recorded closing comments reinforced the view that there was no role for Children's Social Care but the responsibility to manage was firmly with the victim backed up by services from Women's Aid (which had not yet been provided) and a proposal that the health visitor could undertake a CAF (Common Assessment Framework) service, although this had not been discussed or agreed with the health visitor nor with the victim for her agreement.

102. The nursery service at the Children's Centre had commenced for the older child in February 2012. The staff in the nursery had not been informed of any of the history about the domestic violence towards the victim by any agency as the information provided by the health visitor in the application form had not been passed on to them from the Locality Resource Office dealing with funding and applications. The social worker had not contacted them to inform them or share information as a part of the initial assessment either.

103. During March 2012 the Health Visiting Service contacted the social worker as the perpetrator had been seen at the home when they were visiting. After consultation with the team manager, the social worker telephoned the victim to discuss his whereabouts and was told that the perpetrator had been doing some work in the home. Telephone discussions took place with Women's Aid to establish when the service would be provided. It was confirmed that the victim was on a waiting list for an outreach worker but due to staffing pressures and shortage of resources, no timescale was available for when the service might start.

104. The Children's Social Care team manager closed the case during March 2012 without any consultation or strategy discussion with partner agencies having taken place or any referrals for support services having being actioned. The closing letter to the victim was copied to the health visitor.

105. The letter was lengthy and sent by a social work assistant rather than the social worker, who had dealt with the case. The victim was "advised to engage with all professionals to prevent further intrusion from Children Services and the Police" and "if Children's Services receive

any further referrals regarding domestic abuse in the near future it will be viewed as a matter of child protection and Children's Services will commence procedures to ensure that the children are safe and well." There was no mention of the perpetrator's responsibilities in relation to the children or to the victim.

106. Shortly after the letters had been sent and the case had been closed, the health visitor made a referral to the social worker again. The District Nursing Service was visiting the home three times a day in connection with one of the children requiring regular treatment after a hospital discharge. The perpetrator was reported to be present each time, as was a strong smell of cannabis and the victim was reportedly pregnant again. A miscarriage was reported to the health visitor shortly afterwards.

107. At the end of April 2012 the social work records indicated that a strategy discussion was requested via email by the social worker to the team manager in order to address the new information from health agencies. A strategy discussion over the telephone was noted in the police IMR on the first of May 2012 where it was decided that the Section 47 Enquiry would be a single agency, e.g. Children's Social Care enquiry, not a joint enquiry with the police. This discussion was not recorded in the social work records.

108. A further strategy discussion took place towards the end of May 2012 according to the Children's Social Care records; however, other agency records do not have any information about this discussion. The discrepancy in the dates may reflect late recording practices. The discussion was chaired by the team manager with the police and social worker included and the police information about the perpetrator going back to 2005 was shared with Children's Social Care. Whether the strategy discussion took place at the beginning or the end of May 2012, it set the remit for the subsequent Section 47 Enquiry and assessment.

IV. The third key episode: May to August 2012

109. During the end of May and beginning of June 2012 the social worker undertook the assessment work preparing for an Initial child protection conference (ICPC), which took place on the 11th June 2012. There was evidence in the social work case records that health visiting, specialist domestic violence midwifery professionals and the nursery manager had been invited but there was no trace of an invitation or request for a report from the police. On interview, the social worker confirmed that the GP, housing and the police had not been

invited. The social worker was not able to provide a specific explanation why this was the case on interview for the Review.

110. Both the victim and the perpetrator were invited to attend in separate letters but both letters were sent to the victim's address, in spite of the victim telling the social worker that they were living separately. There was no evidence in the records that the perpetrator had been assessed by the social worker in any way, or of any discussion by the social worker with the police to check for updates about him.

111. There was no evidence in the records that the assessment undertaken as a part of the Section 47 investigation included the use of any assessment tools other than the one home visit to talk to the victim. The social worker reminded the victim of the meeting nearer the time and asked the victim to remind the perpetrator of the time, which was quite inappropriate in view of the circumstances of the case.

112. The social work report was signed off on the day of the conference and provided just before the meeting, which meant that the independent Chair of the conference had not had time to read it and prepare for the meeting. The expected standard was that a report should be provided forty-eight hours in advance. The parents and the professionals received the social work report at the same time.

113. The conference was attended by the victim and by the perpetrator; both of them were present throughout. The outcome of the conference was that all the children including the unborn child became subject of child protection plans in the category of emotional abuse. The criteria were deemed to have been met in relation to the impact on the children of the domestic abuse by the perpetrator towards the victim and the need to safeguard the children from further risks of harm.

114. Child protection plans for the children were drawn up setting out sixteen tasks to be undertaken by the victim and the perpetrator as well as the professionals. Six of the tasks had been for the victim to address herself in order to protect the children from the impact of the perpetrator's behaviour while there had been four tasks for the perpetrator to address. The child protection plans placed the responsibility on the victim to take action to prevent and report any violent and abusive behaviour by the perpetrator. The planning was based on the assumption that the victim was in a position to act on her own behalf .The victim had not been given the opportunity to address the conference meeting without the perpetrator

present and all information up to this point had demonstrated that the victim was vulnerable to pressure from the perpetrator.

115. The first core group meeting date was set to take place within the required timescale in order to review progress.

116. The day after the initial child protection conference, the working agreement, which had been recommended as a part of the child protection plan, was drawn up in a meeting with the victim, the perpetrator and the victim's mother. The agreement reflected the child protection plan and set further tasks to be undertaken to achieve the outcome that had been specified as: "the parents must ensure that the children do not witness any further domestic violence and further assessments are required of both the victim and the perpetrator".

117. The child protection plan and the working agreement stipulated that the perpetrator should not reside in the family home and when he attended ante natal appointments with the victim, the children should not be present. The expectation was set that the victim would consider taking out an injunction if the perpetrator was violent again and that she must report any domestic violence to the police. The working agreement included the request that the victim's mother should report any contact that the perpetrator had with the victim and the children. The victim's mother also agreed that the victim and the children could reside at her home.

118. Both parents were advised to attend a range of courses in different agencies that had not been represented at the Initial child protection conference or the following meeting: for example, the perpetrator was required to attend an anger management course; the victim was required to attend a domestic violence for victims' course and both of them were advised to attend a 'promoting happier parenting' course. The availability or suitability of any such courses had not been assessed. It was recorded that the victim and the perpetrator had maintained to the Initial child protection conference that they were separated.

119. The contingency plan stipulated that legal advice should be sought in respect of the children and care proceedings, if the victim and the perpetrator failed to engage in the child protection plans and the Agreement.

120. Three days after the meeting to sign the working agreement, the social work case was transferred to the Safeguarding and Support Team and another social worker was allocated. There was no record of any transfer case meeting or discussion between the team managers and there was no transfer discussion with the new allocated social worker. Twelve days later

a home visit to meet the victim, her mother and the children took place by the new social worker with a senior colleague, who advised the victim that supervised contact would be arranged for the perpetrator to see the children.

121. The core group meeting set for the following day was cancelled and reset by the social worker for mid-July 2012 at the nursery. A week prior to the core group meeting, the perpetrator contacted the police making allegations about the victim's care of the children. The police officer contacted Children's Social Care and this was the point where the police first became aware of the fact that a child protection conference had taken place and the children were subject of child protection plans. No minutes or notifications had been received by the police of the outcome of the Section 47 Enquiry and the subsequent child protection conference. The police visited the victim and determined that the allegations by the perpetrator were false.

122. The core group meeting took place and was attended by the perpetrator, who made demands to tape record the meeting, which was denied. The perpetrator stated that he was being harassed by the victim's family. The police were called and the perpetrator calmed down. It was agreed to continue the plan as it was.

123. Three days after the meeting the victim's mother contacted the social worker to explain that due to changes in the household they were now overcrowded. The victim was moving back to her own home. The family were concerned as they believed that the perpetrator had keys to the property and had been in and caused damage to kitchen equipment. Police officers visited the premises and the victim was advised to go to the housing office, if she felt unsafe to stay at the house.

124. Two days later, the social worker saw the victim at her mother's home and was informed that a termination of the pregnancy was due but the appointment had been moved. The victim had discussed the termination with the heath visitor, midwife and GP.

125. The victim was still living in her own home and her mother expressed concerns about the children and the victim. In a phone call from the victim's mother to the social worker subsequently, she reported that the perpetrator was blocking her from seeing the children. A day later, the victim reported to the social worker that the termination had taken place and she was not feeling very well.

126. A few days later, the victim cancelled the supervised contact meeting for the perpetrator with the children and the perpetrator complained to the social worker stating that he would seek legal advice. Later the same day, the victim's mother reported to the social worker that the victim and the children were somewhere unknown with the perpetrator. She explained that she wanted to have custody of the children for their safety.

127. The victim approached the Neighbourhood Office and was interviewed by a homeless officer at length on the last day of July 2012; she was offered a referral to Women's Aid but she had already met a support worker from Women's Aid on two occasions earlier in July. Temporary accommodation was provided by the homeless officer in a hotel. The victim and the children left the hotel accommodation five days later after a visit by the social worker and a colleague. They returned to stay with the victim's mother after the social work intervention.

128. The visit by the social workers to the hotel followed from their visit to the victim's mother after she had reported them missing. She had subsequently found that they were in the hotel. The social workers went to the hotel and found the perpetrator on the premises and asked him to leave the building. The children were present. The victim explained that the perpetrator had searched for them by listening at doors for the children. The social worker asked how the victim was feeling after the termination. The perpetrator had re-entered the hotel and overheard this conversation.

129. The family were returned by Children's Social Care to the victim's mother's address at this point after consultation with the EDT manager. The victim's mother agreed to supervise the children and report any attempt to remove them from her care.

130. A new working agreement was signed between the victim, her mother and the social worker to confirm the arrangements. The social worker explained that there would be a consultation with a supervisor and legal advice would be sought to clarify whether care proceedings would be needed. There was no evidence that consideration was given to recalling the core group or convening an early review conference as the plans were not working and the agreement was being renegotiated without the full multi-agency participation.

131. The health visitor met the victim, her mother and aunt with the children in early August by chance outside a shop at which point the victim reported that "everything was back to normal" and the children were staying with her at her mother's home.

132. The following day was the perpetrator‘s birthday and it is not known from the records when and how the victim came to spend it with him. However, from the police investigation and the criminal trial it became known that the time had been spent at the home of an extended family member of the perpetrator’s. The police records noted that the victim’s mother had tried to persuade the victim not to meet with the perpetrator but she had nevertheless decided to go. The witness statement to the police of a family member of the perpetrator recounted that there had been an argument about the termination of the pregnancy during the evening. The victim was killed in the morning travelling back to her mother’s address in a taxi with the perpetrator.

3.3. Summary and Findings

133. The facts as outlined related to specific points where the agencies had been in contact with the victim and the children. During the whole period of time, from 2008 onwards, there were contacts as noted with:

- Health agencies including GPs, health visitors, the Walk in Centre and maternity services, planned and unplanned, in connection with the usual need for services for pregnancies, minor child hood illnesses and immunisations of children.
- Housing services in relation to requests for moves and support when harassment was reported from the extended families.
- The Children’s Centre Nursery, where the older child attended from February 2012.
- Women’s Aid services had placed the victim on their waiting list in January 2012 and after many attempts at making contact there were two direct meetings with the victim in July 2012 where she was provided with support in relation to pursuing a civil injunction as well as risk assessment work.

134. There were no records of the victim telling any of the health professionals about the domestic violence she was experiencing until it was reported to the police in January 2012. The records demonstrate that the questions about domestic violence expected to be addressed by health visitors and midwifery services with the victim had not been followed up as the perpetrator was recorded as present. To ask the question then would not have been appropriate for her safety. However, there was no record of a proactive attempt to arrange to meet the victim on her own to explore the issue and no record of a discussion about this obstacle to assessing the victim’s circumstances in the Health Visiting safeguarding supervision.

135. The GP service and the Walk in Centre had no records of the victim disclosing any information about domestic violence and abuse and were not contacted by other agencies with the information. One GP practice had a notification form from the police involvement in August 2010 placed on file. The health visitor informed the GP of the concerns reported in February 2012 following the Multi-agency Joint Screening meeting although no further liaison between them took place.

136. Similarly the nursery had not been informed by the victim and became aware of the concerns when informed by the health visitor in March 2012. The victim was not approached about the matter by nursery staff and did not raise it herself with staff according to the records.

137. The agency that had records of the victim providing information about the domestic violence and the harassment was the Homeless and Pre-Tenancy Service. Requests for housing moves and assistance on three occasions, when there had been incidents and damage, came from the victim and contained the information as one of the reasons for her requests.

138. There were no records that the housing officers had considered making a referral or consulted with other agencies such as Children's Social Care or the police about safeguarding issues relating to the victim or the children prior to being invited to the core group meeting, when they became aware of the child protection plans.

139. After the victim had left the hotel accommodation, the homeless officer contacted her mother to establish the victim's whereabouts and discussed the situation with the victim, who confirmed that she wanted to stay with her mother. The homeless officer expressed concerns about the arrangement but did not contact Children's Social Care to discuss the decision or to request a review of the case.

140. The recorded facts relating to the use of substances by the perpetrator in both police records and GP records over the full period of time point to a regular use of illegal substances by him. There was no evidence in any agency records that this had been assessed or considered when assessing risks in relation to the children or the victim. There was no evidence that there had been any referrals to or consultation with specialist services for substance misuse to understand the impact on the perpetrator's behaviour and his capacity to care for young children.

141. Similarly, there was no evidence in any agency records that the fact, that the perpetrator had been treated over a number of years by the GP services for 'depression', had been taken in to account when assessing the risk that he posed to the victim and the children. This was surprising since the records demonstrated that the victim had provided that information on more than one occasion when referring to the police. The presence of a cluster of problems including substance misuse, mental health concerns and violent behaviour, in relation to the perpetrator, was not picked up and his circumstances were never assessed adequately at any point by the agencies.

142. The key episodes referred to above demonstrated that there were three referrals leading to intervention by the police, Children's Social Care and partner agencies. Two of those referrals were made by the victim herself to the police after serious incidents of violence and abuse, where the children had also been present in the home. The third referral was by the health visitor when the case had just been closed by Children's Social Care in March 2012.

143. The interventions that followed on from the referrals in August 2010, in January 2012 and March 2012 led to decisions and actions, which involved the core agencies; Children's Social Care, the police and health agencies. There were practice standards in place relating to domestic violence and child protection, which were set out in policies, procedures and guidance at the time in accordance with national statutory guidance such as Working Together 2010 and in legislation such as the Children Act 1989 and 2004.

144. So for example, there were clear expectations of timescales for undertaking work as well as for actions to communicate and undertake information checks with agencies including GPs. The initial assessments, strategy discussions, Section 47[10] Enquiries, initial child protection conference and core groups were subject to clear timescales, which were not met in any of the instances recorded in this case. The first core group had been set to take place within the required timescale but as it was cancelled by the social worker due to a requirement to cover other duty work. The rearranged meeting was significantly outside the expected timeframe. There was no explanation in the records for the delays and on interview the team manager and social worker recalled heavy workloads as the likely reason.

145. The lead agency to undertake the assessments and investigations when there were concerns about the children was Children's Social Care. Where the focus was on the victim

[10] Section 47 of the Children Act 1989

as an adult subject of domestic violence the police were the lead agency in respect of following up risk assessments, criminal investigations and crime prevention safety work.

146. The integrated chronology illustrated that there had been involvement at different times from 2003 onwards with the perpetrator and the police with a long history of incidents recorded on agency record systems. There had been no prosecutions and therefore no convictions of a domestic violence offence in relation to the ex-partner or the victim. The pattern of reported incidents demonstrated an escalating repeat offender behaviour which, when passed on from one victim to another, had become serial offender behaviour as well. The substance misuse offences should also have alerted the police to the increasing risks.

147. Children's Social Care had received three referrals, which were followed up with assessments by a social worker in August 2010 and another social worker in February and March 2012. The decision was taken in April /May 2012 by the team manager in Children's Social Care and the police Detective Sergeant that the child protection enquiry (Section 47 of the Children Act) would be carried out by Children's Social Care without further joint work with the police. This decision was not in accordance with Birmingham Safeguarding Children Board interagency safeguarding policies and procedures at that time in relation to domestic violence, as a joint enquiry should have taken place in the light of the full information about the perpetrator's offending history and the young ages of the children.

148. The outcome of this decision was that the police were not invited to the initial child protection conference and therefore were not aware that it had taken place. Without an invitation, there was no request for a report from the police and they were not provided with the minutes of the outcome of the conference and in particular therefore remained unaware that the children had been made subjects of child protection plans. The child protection conference had been provided with the information about the perpetrator's background history of domestic violence through the social work report to conference, which had been provided at the last moment.

149. Throughout the agency records there were comments by the victim and her mother stating that the perpetrator was threatening them, was controlling their contacts with one another, was preventing the victim from communicating with others and keeping her, and the children, locked in doors. The perpetrator was described by the victim's family as controlling what the victim said to professionals and influencing the contact by professionals with the victim by being present at visits and meetings. The victim was described by others and by her own observation as frightened of the perpetrator.

150. At the same time the records and the chronology demonstrated that some professionals believed the victim to be unreliable and "not truthful" about the relationship between her and the perpetrator and whether they were together or not. The repeated pregnancies were interpreted as a sign of a relationship rather than explored by the social worker, health professionals or the police as possible sexual violence and control.[11]

151. There was no evidence in the records or interviews with staff that direct work had taken place to explore in depth with the victim the significance of the impact on the children of witnessing the perpetrator's behaviour towards her except by the health visitor. The worker from Women's Aid had discussed a non-molestation order with the victim in two meetings in July 2012 and sought to empower the victim by providing emotional support.

152. The effect of the different perceptions of the dynamics of the relationship on how the services were delivered and the lack of inter-agency collaborative working will be addressed in the Analysis section.

153. Throughout the period from the birth of the first child midwifery and health visiting services had been provided and the children had according to the records been immunised, had developmental checks and been taken by the victim for treatment when needed. The referral for a nursery place for the older child had been made following concerns by both parents about some of the child's behaviours. There was no evidence in any of the records that the concerns about the child's behaviour were assessed at any point in the context of the impact on the children of the domestic violence and abuse taking place.

[11] See page 10 and 11 of 'Who does what to whom? Gender and Domestic Violence Perpetrators'. M. Hester June 2009

4. ANALYSIS

4.1 Analysis of services provided

154. "*The key question in evaluating the service response is whether it addresses the perpetrator's violence and whether it increases the safety of women and children living with domestic violence as well as responding to the separate needs of children and their mothers. In particular, how the divide is bridged between domestic abuse (usually woman abuse) and child abuse will be the barometer of the success of multi-agency working*."[12]

155. It has emerged during this Review that the quality of the interactions and relationships between the services focused on children and those focused on adults were an important issue, which had an impact on the outcomes in this case. Services focussed on children and safeguarding have a structural underpinning in legislation with accompanying regulations and statutory guidance. When assessing the risks to the children and/or the victim, the agencies focussed on one or the other according to their remit. It is a significant learning point that there should have been more effective collaboration between the agencies with a better understanding of each other's roles and services. All the agencies should have been working towards a shared aim with the victim and the children to stop the violence and to prevent further domestic abuse and violence from taking place.

156. The Birmingham Safeguarding Children Board (BSCB) and its partner agencies have guidance and procedures in relation to when and how services should be provided to safeguard children. The national, statutory guidance for safeguarding children, Working Together 2013[13], sets out the requirement for inter-agency collaboration in sharing information in a meaningful way and taking action jointly to analyse, assesses and deliver those services. At the time of the events the local BSCB procedures for domestic violence were in place (dated 2008) and were accessible online. These have now been updated (March 2013) to address the new definition of domestic violence and abuse as set out at the beginning of this report.

157. The domestic violence guidance for the police, as the lead agency for reports of domestic violence, has undergone several updates since 2005 when ACPO[14] guidance was in place.

[12] Multi-agency and multi-disciplinary work : Barriers and opportunities N .Stanley and C. Humphreys 2006
[13] Working Together to Safeguard Children 2010 was in place during the time period for this Review.
[14] Association of Chief Police Officers

In 2009 a new protocol including the notion of "victimless prosecution" was adopted. In the West Midlands Police force area, the Public Protection Units (PPU) were developed in 2008 to respond to vulnerable people. They have undergone organisational changes and Multi-Agency Risk Assessment Conferences (MARACs) have been introduced to deal with high risk victims of domestic violence and are overseen by the PPUs. The PPUs were well established by 2012 with one Detective Inspector responsible for adults and one for child abuse investigations. The majority of investigations of domestic violence were managed by investigation teams supervised by a Sergeant on Local Policing Units (LPU). The initial response to domestic violence was by the Response teams supervised by Sergeants and Inspectors.

158. The Birmingham Community Safety Partnership is a joint partnership between Birmingham City Council, West Midlands Police, West Midlands Fire Service, Staffordshire and West Midlands Area Probation Trust and the Third Sector Assembly, who work together to reduce and prevent crime and anti-social behaviour. It worked with the Birmingham Violence Against Women Board, which provided multi-agency standards for agencies to deliver services to women, young people and adults where there is domestic violence and abuse.

159. The agencies' Individual Management Review reports were all robust in examining the involvement of their agency and scrutinising the reasoning behind decisions made and actions taken. Where the records needed clarification the professionals were generally able to expand and explain their reasoning for why and how they had proceeded as they did in the interviews with the IMR authors.

160. The IMRs for the agencies, where the services had been provided primarily to the adult victim, reflected the focus on the victim, but had considered the responses that should have been made in relation to the children by those agencies. The IMRs by the agencies delivering services primarily to the children had focussed on the impact on the children of the service delivery. They had considered the consequences for the victim of the way in which they had provided the services and drawn the lessons to be learnt.

161. The services provided to the perpetrator were examined in the IMRs across the board. They considered the responses to his behaviour towards the victim by their agencies as well as the responses to his behaviour in relation to the impact on the children.

162. The IMRs have all made recommendations for learning and improvement where short falls or gaps have been identified. Some of the learning from the IMRs has wider application and all

the recommendations and actions taken to progress the learning can be viewed in the Action Plan attached to this report.

163. The police responded to the referrals by the victim by assessing the risks using the tools available at the time of the incidents e.g. the DASH format. On both occasions the outcome of this risk assessment placed the victim as a 'medium risk'. The consequence of this assessment was that there was no referral to the MARAC[15] , which could have triggered a plan to manage the perpetrator's behaviour and safety planning for the victim. The 'medium' level of risk did not meet the criteria for the MARAC process.

164. The limitations of the use of the DASH format, or any other similar format, were that the risk to the victim was assessed but the danger presented by the perpetrator was not assessed explicitly. The known background history of the perpetrator demonstrated a steady accumulation of patterns of behaviour, which posed a danger to any partner, children and extended family member. The background history was available on different police record systems but was not effectively accessed by the officers each time.

165. The police decision making about the actions to take in relation to the reports of domestic violence was flawed in the first two incidents reported and did not demonstrate any urgency in responding by seeking to question the perpetrator and hold him to account. The police IMR identified that the choice to pursue a 'victimless prosecution 'could have been made in January 2102 had the investigators been more thorough in their approach. It concluded that the interventions should have included proactive work on behalf of the police and Crown Prosecution Service (CPS) in dealing with the perpetrator and managing his behaviour to prevent an increase of the abuse.

166. It was unclear from the IMRs and interviews with the professionals why the joint decision by the police and Children's Social Care in the strategy discussions in May 2102 concluded that the matter could be pursued as a single agency Section 47 enquiry. The records may indicate a sign of the lack of urgency afforded to this case as there were discrepancies in the recording in the two agencies leaving it unclear when the strategy discussions took place as the police had a record for May 1st and Children's Social Care for May 23rd 2012. The significance of this relates to the Working Together 2010[16] requirement that an Initial child protection conference should take place within fifteen working days of the last strategy

[15] Multi-Agency Risk Assessment Conference
[16] This requirement remains the same in Working Together to Safeguard Children 2013.

discussion. The reason for a timescale to be adhered to is that in all cases the decision to hold an Initial child protection conference should reflect serious concerns about the risk of significant harm to the children. Whichever date the strategy discussion took place on, or if both events took place as the records refer to named staff (who are unclear in their recollections), it still did not fit in to the required timescale for a child protection conference.

167. The unintended outcome of the decision to pursue a single agency Section 47 enquiry led to the police being left out of the loop by the social worker and the team manager, which led to the lack of a police presence at the Initial child protection conference. The police should have been present to share their information about the background history of the perpetrator fully and to assist the conference members to understand the risks that he posed to the children and the victim.

168. One of the purposes of making a child subject of a child protection plan is to provide an alert to all agencies that might come in to contact with the child, that there are concerns which they need to be aware of. The fact that this information was not shared with the police because they had not been invited and therefore did not receive the outcome and the minutes of the conference, meant that the major agency for dealing with reports of domestic violence were unaware of the on-going concerns about the children, the victim and the perpetrator.

169. The professional tasked with identifying who should be invited to a child protection conference is the social worker undertaking the Section 47 enquiries and assessment guided through supervision by their line manager. The invitations are then distributed by the Independent Conference Service. The social worker and team manager involved from February 2012 to July 2012 were the same ones. The Children's Social Care IMR has identified that the standards of good practice in inter agency and collaborative working had not been followed during that period as the expected checks and information sharing with different agencies had not taken place. So, for example, the social worker had not communicated with the GP or the housing professionals, who should have been considered for invitations to the initial child protection conference. The lack of information sharing was not just about informing them of the current circumstances but to access additional background information to ensure that the decision making was based on accurate and up to date information. The issue of the perpetrator's substance misuse and reported mental health difficulties might have been addressed, if the relevant professional, for example the GP, had been involved.

170. The social work report had been signed off by the team manager and was provided by the social worker to the conference members and the family on the day of the meeting, which was poor practice. The effect of this late presentation meant that the victim and the perpetrator had not been able to consider the information and issues to be addressed in the meeting in full and had not had the opportunity to ask questions about the recommendations and information in the report.

171. The independent Chair of the conference had read the draft report in advance but had not taken action to speak to the social worker or team manager to discuss how to manage the meeting in view of the domestic violence concerns. The lack of preparation by the Chair demonstrated a failure to exercise their authority to manage the meeting safely for the victim and the children. Action should have been taken to exclude the perpetrator from all or parts of the meeting. This should always be an option where there are concerns about domestic violence and abuse and about the controlling behaviour of the perpetrator of the abuse.

172. The conference therefore proceeded to treat both the victim and the perpetrator as equal participants in relation to the children and as responsible parents underpinned by the ethos of child protection work about working in partnership with parents (Children Act 1989). The responsibility was placed on both parents to recognise the impact on the children and to reduce the domestic violence. Without a clear recognition of the dynamics of the relationship between the two adults, including the control by the perpetrator of the situation, the conference led to the outcome that child protection plans were drawn up. The child protection plans were unbalanced in the tasks set out for the victim and the perpetrator. The outcome of the conference was not supportive to the victim and did not empower her to work towards an understanding of how to safeguard the children and be safe herself.

173. The assessment work carried out by the social worker supervised by the team manager from February 2012 to July 2012 demonstrated a lack of understanding of the dynamics of domestic violence and abuse. In particular, the social worker interpreted the behaviour of the victim as uncooperative and reluctant because she presented as vague and ambivalent about her relationship with the perpetrator. Information was provided by the victim and her mother on more than one occasion that the perpetrator was in control of what the victim said to the professionals even when he was not present himself .It was said that he threatened the victim with removing the children and reporting her as a bad mother and threatened her that the agencies would remove the children, if she said anything. As a consequence when the social worker on the first visit at the end of February 2012 recorded that it had been explained to the victim " that child protection action might have to be taken, if she did not

protect the children" the social worker was confirming to the victim what the perpetrator had said. Although social workers should be clear with families what their role and authority consists of, the approach was not sensitive to the victim's situation and served to reinforce the oppression by the perpetrator.

174. The letter sent out in connection with the case closure in April 2012 by the social work assistant set out similar wording referring to 'child protection conferences as a next step' if there were any further incidents of domestic violence reported. Research indicates that "*Such letters, even when they include information about agencies which might be helpful, reinforce women's worst fears about social work intervention in relation to their children and may therefore close down help seeking and reinforce the abuser's power and control within the family*." [17]

175. It was noted in the Children's Social Care IMR that the social worker undertaking the work from the referral in February 2012 till the transfer of the case responsibility in July 2012, after the child protection conference had taken place, had not received or sought any training in domestic violence and abuse. The importance of the supervision from a line manager, when a social worker is inexperienced in a field of work such as domestic violence, becomes more acute. The supervision should have challenged the attitudes of the social worker and should have made room for the worker and manager to reflect on the details of the case as well as the requirements of the procedures, such as timescales and inter agency working, current at the time.

176. The effect of the shortfalls in the social work interventions led to an Initial child protection conference that arrived at decisions about the risks to the children without the benefit of the full information and without the full range of agencies participating. The outcome was that the perpetrator retained some control and the victim was burdened with expectations that she would control and report on his behaviour in order to protect the children.

177. The victim left behind a letter of complaint about the services which indicated that she did not fully understand the rationale for the child protection plan and perceived that the services were mainly a threat that she might lose the children. Her decision to terminate the pregnancy was explained by her to health professionals in this context and the decision was made knowing that the perpetrator would be opposed to it. The victim had requested that the

[17] Humphreys et al 2001

information about her decision would not be communicated to the perpetrator as she feared his reaction.

178. The exposure of the information about the termination to the perpetrator is still under investigation and is not the subject of this Review. The case highlights the need for a full understanding by professionals of the importance of handling information safely in cases of domestic violence throughout the process of working with a woman and her children.

179. The agency most consistently involved with the victim and the children from the first child's birth onwards was the Health Visiting Service. The health visitor had consistently been one professional with some gaps as the victim moved, in some of the brief periods of moving, in to the hostel. If the health visitor was not available, the health visiting team covered. The service to the children demonstrated good consistent practice and recognised the needs of a young mother with small children. It was noted in the IMR that a level of trust had developed between the victim and the health visitor and this was subsequently commented on by the victim's mother as well.

180. If the police and social work intervention and assessment in August 2010 had followed the practice guidance and procedures in place at the time the social worker should have spoken to the health visitor at that time in view of the presence of young children. In the event, the police sent out some notifications but no proactive inter agency work or information sharing took place. As a result the health visitor remained unaware of the emerging concerns and the history of the perpetrator which was noted at the time by the police.

181. The Health Visiting Service was notified of domestic violence issues in relation to the victim in May 2011 when the victim and the children moved in to a hostel "having fled domestic violence" according to the records. A form with this information was passed on to the receiving Health Visiting Service when the family moved out again. However, when the family returned to their previous locality and were visited in connection with the third birth, the information was not addressed as it had not been seen by the health visitor. The family presented in September 2011 as well and settled.

182. The Health Visiting policies and procedures include the expectation that a question should be asked of a woman on contact, if she is experiencing domestic violence and abuse. The guidance includes that where the partner or possible perpetrator is present at the visit or meeting, it would not be safe to ask. The records in this case indicated that the question had been considered by the health Visitor at each contact but because The perpetrator was

always present, it was never asked. The IMR concluded that it would have been good practice for the health visitor to have considered arranging a meeting in clinic to see the victim on her own or to consult with the GP to jointly arrange for a GP surgery visit without the perpetrator present. The perpetrator had been able to control the victim's contacts with health professionals quite successfully and the victim never volunteered any information to them.

183. Once the information was passed to the health visitor in February 2012, the domestic violence was discussed with the victim and the impact on the children was explored with her.

4.2 Analysis by theme

184. A number of themes emerged as the information was examined during the review process. Many of these themes have been noted and addressed in Domestic Homicide Reviews and Serious Case Reviews nationally and have been reported on in the various research and Department for Education publications analysing the learning from such Reviews.

185. Some of the themes will be explored in relation to the victim and the children in order to ensure that the learning from her tragic death can be implemented effectively to promote improved services to women and children:

186. Themes to be covered:

- Safe information sharing; managing and proactively sharing information
- Multi-agency working; decision making
- Recognising risks and danger and assessment of the perpetrator
- Domestic violence and abuse: policies, procedures, training and supervision
- Responses to the victim by agencies
- How the behaviour of the perpetrator could be addressed
- Recognising substance misuse and mental health problems as a cluster of issues

4.2.1. **Safe information sharing; managing and proactively sharing information**

187. The policies and procedures guiding professionals in exchanging information about domestic abuse and child protection work were in place and were in line with the requirements of the Data Protection Act 1998 and other relevant legislation. The approach to domestic violence

services have changed and developed during the period covered by this review. The responses by the professionals were made within the remit at the time.

188. There were several points where information systems should have been checked within agencies and the relevant information should have been shared across agencies in order to maximise the ability of the professionals to analyse and assess the risks posed by the perpetrator to the victim and the children. Some of the particular points were:

- At points of receipt of referral
- Management / supervisory consultation
- When making decisions about what action to take
- Arresting and charging
- Joint screening mechanisms
- Initial assessments
- Case closure
- Strategy discussion
- Child protection conference
- Core group

189. The IMRs and integrated chronology illustrated that there had been points at which professionals had not been thorough in accessing their agency information systems, for example, when the police were responding to the referral by the victim in January 2012. The outcome was that they missed the previous history of the perpetrator and based their decision making on a lack of understanding of the risk posed by him to the victim. As a consequence his behaviour was not addressed effectively as there was no decision or action taken to charge him, which might have served to limit the danger he posed.

190. Their poor practice was to some extent balanced out by the joint screening mechanism, which subsequently picked the case up and actioned a referral to Children's Social Care for an initial assessment. However, the outcome was that the focus moved from the risks posed by the perpetrator to the victim and on to the safeguarding issues relating to the children.

191. The social worker should have undertaken a range of information checks with other agencies such as the GPs and housing services in line with the Children's Services and safeguarding procedures in place. These checks were not carried out at either of the initial assessments in August 2010 or February 2012, which demonstrated poor practice and poor management oversight.

192. The crucial point, where the information sharing processes should have merged and ensured that the analysis of the perpetrator's behaviour and the risks he posed to the victim and the children took place, was the child protection conference. As previously noted the preparations by the social worker and supervising manager had not been in accordance with expected guidelines and the outcome was that the attendance by agencies and participation in the discussion was limited and ineffective.

193. The fact that different professionals were less than thorough when responding to the three identified referrals in checking, analysing and sharing information led to a serious misunderstanding of the dangers posed by the perpetrator and affected the decision making.

194. The additional outcome was that there was no urgency in the safe management of the case. There was no clear statement about how to handle contacts, meetings and communications safely in view, for example, of the information that the perpetrator was in the habit of carrying a knife and had made threats to the victim and the children.

195. The victim's family were adamant that had they been more aware of the information about the perpetrator's past history they might have been able to support the victim more effectively and she might have made different choices. It was noted in records that the victim had some of the information but it was not clear where she had come by this and what she had shared with her family. The decisions about what information to share, when and how, in relation to extended family members should be well informed and taken with the safety of the person in mind. Given that the victim's mother was present at the core group some of the information would have been shared with her, if it had it been used by the agencies in the assessments properly.

4.2.2 **Multi-agency working and decision making**

196. "*The two terms used here are 'multi-agency working 'which describes work which occurs across and between different agencies and 'multi-disciplinary working' which refers to work between different professionals, some of whom may be located in the same agency or others in different organisations. A continuum of work can be identified with minimal cooperative*

relationships at one end, moving to coordination of work towards a common goal, through to active collaboration at the other extremity." [18]

197. The national and local guidance and procedures in both the adult focussed domestic violence and abuse services and the child focussed safeguarding children's services requires that professionals and agencies work together. This usually refers to multi-agency and multi-disciplinary working and in all of the core agencies; the police, health and children social care, the professionals will be located in a range of different services and in different roles within those. It requires an understanding of each other's organisations, values, roles and responsibilities to work in collaboration with each other to deliver a service, which is responsive to the needs of the service users. In particular where the safety of an adult, usually the woman, and her children are the focus, the collaboration requires good planning and safe communications.

198. If the professionals are unclear about their roles and authority the service users, who are vulnerable, will find it difficult to navigate through the services and in particular to understand the aims of the different professional interventions. For example, the independent Chair of the child protection conference did not act with the authority the role provides in the interest of the children or the victim in the way in which the conference was managed, as the perpetrator was allowed to remain throughout.

199. The facts noted in the integrated chronology demonstrated that the collaboration between agencies and individual professionals at the points where assessments and decisions were made was not effective. The lack of collaboration was either because an individual worker did not approach other professionals and agencies proactively or managers/supervisors failed to guide staff through the process as expected of them.

200. As a result of the lack of engagement between the different professionals the quality of the assessments and decision making was not good enough. The outcome of the child protection conference, e.g. the child protection plans, lacked a common aim to work towards supporting and empowering the victim and keeping the children safe. The experience for the victim may have served to further reinforce the perpetrator's position as the person in control. It was noticeable that so far there had been no specific assessment to address his capacity as a father or a partner.

[18] N.Frost 2005 Professionalism ,Partnership and Joined-up thinking

201. There were other agencies, which had engaged with the victim during July 2012 subsequent to the initial child protection conference such as housing services and Women's Aid. If the services had been joined together to collaborate and work across the adult and child boundaries more effectively the specialism provided by Women's Aid should have been a support to the victim alongside the core assessment, which was in progress with the social worker and should have involved the health professionals and the police.

4.2.3 **Recognising risks and danger and assessment of the perpetrator**

202. The police undertook the required assessments of risk in response to the referrals and used the tool available; the DASH[19] assessment tool. This is a well-established national tool which consists of a series of questions to the victim to assess their experience and provides a score for the level of risk to the victim. The scoring then places the risk at a level such as standard, medium or high risk. The level of risk achieved determines the next step; for example, if the score was 'high', the criteria for a referral to the Multi-Agency Risk Assessment Conference (MARAC) had been met.

203. There has been a trend to widen the use of this tool in all agencies and expand the training in the use of it. All tools to assist in making assessments of risk are useful as a guide but must be underpinned by up to date information and professional judgement taking account of all the information available and the whole picture of a case.

204. The victim's perception of their experience when asked questions about 'domestic violence ' may be different to those of the interviewer .Other Serious Case Reviews[20] and interviews with women have noted that there is not necessarily a shared understanding of what is meant by 'domestic violence and abuse' among the general public and therefore service users. For example the Health Visiting Service was expected to ask if the victim had experienced 'domestic violence'. Depending on how the question might have been asked the answer may not have provided a full understanding of the risks. The questions should explore the victim's views and experience and not merely tick 'yes' or 'no'.

205. The outcome of the interviews with the victim was that the level of risk was assessed as 'medium'. The DHR review process has revealed that the offending background history of the

[19] Domestic Abuse, Stalking and Harassment and Honour based Violence: Risk identification, Assessment and Management model.
[20] Leicester City SCR Child R

perpetrator had not been fully covered and as a result the level of danger posed by the perpetrator was not understood by the agencies.

206. The failure to effectively address the perpetrator's offending background history, the similarities in his behaviour with several victims, the continued references to substance misuse and mental health problems was compounded as the risk assessments then served to inform other services in the future. The strategy discussion in May 2012 and the subsequent child protection conference based their decision making on the previous information without an up to date, informed, new assessment of the perpetrator. The child protection plans had recommended 'core assessments' of both the victim and the perpetrator but had not requested a specific 'risk assessment 'of the perpetrator.

207. The research also points out that "*Any risk assessment is a process, which should combine static and dynamic risk factors .Static risk factors focus on the history and past behaviour of the perpetrator and the nature of the past abuse. Dynamic factors consider the changeable characteristics of perpetrator (such as attitudes) and of the context (such as separation) that can either raise or decrease the risk of further harm*."[21] In this case the pregnancies and the substance misuse added to the dynamic risk factors. The research noted that a sudden event can very quickly escalate the level of risk and can be difficult to predict. The separations between the victim and the perpetrator would have added to the risks as the perpetrator was reported by the victim to refuse to accept that their relationship had ended. The explanation of his presence at the hotel was that he had been searching for them.

4.2.4 **Domestic violence and abuse: policies, procedures, training and supervision**

208. The review found that the presence of policies, procedures and training was variable across the agencies. The Birmingham Safeguarding Children Board child protection procedures and the chapter about domestic violence and abuse, which was in place during the period for this review were dated 2008. The commitment by all partner agencies and the expectations by Working Together to Safeguard Children 2006/10/13 is that all agencies should have their own agency policies, procedures and training in place to underpin the BSCB policies.

209. The impact on service delivery of professionals, who are not trained or familiar with working with domestic violence and abuse, can be significant as they may not recognise the risks or understand the impact on the victim or the children. The additional factor may be that they do

[21] Radford et al: (2006) Domestic Abuse Risk Assessment and Safety Planning in Child Protection –Assessing Perpetrators

not recognise the signs in the first place and therefore may not make referrals where it would have been appropriate to do so.

210. The health visiting professionals had policies and procedures in place and had all had training. They were in receipt of regular supervision. Yet one aspect that had been overlooked prior to February 2012 was the fact that they were never able to ask the victim the questions about domestic violence, which they had noted in their records as a problem. This should have been raised in the regular supervision, which had been taking place, so that the matter could have been discussed and resolved and an opportunity arranged to see the victim separately.

211. A number of the IMRs have made recommendations to implement policies, procedures and training as a matter of urgency or to update current ones. The GP surgeries and the Walk in Centre involved with the victim and the children, and the perpetrator, have all made firm recommendations to implement up to date policies about domestic violence and abuse.

212. The Children's Social Care social worker from February 2012 to July 2102 had not undergone any training related to domestic violence and abuse. An outcome of this lack of understanding was poor practice in relation to the victim. The recording and assessment demonstrated little empathy with the victim and some mistrust as to her motivation and trustworthiness .The recording and the IMR demonstrated that there had been a number of missed opportunities to provide services and support to the victim and the children by the social worker, who had not followed practice guidance and procedures at the time.

213. The specific learning from the review is the need to ensure that domestic violence and abuse policies and training, whether for adult focussed services or for children focussed services, must stress the need for collaborative working across agency boundaries to meet the needs of the victim and any children and empower them to participate in shaping the services to support them.

4.2.5 **Responses to the victim by agencies**

214. The research, as noted earlier, has explored the fact that the responses of agencies can unintentionally serve to reinforce the threats by the perpetrator that "they will take the children away".

215. The ‘no further action’ and case closure letters in cases of domestic violence are a particularly risky area as the letters are sent to the victim. Where the perpetrator is exercising control by reading letters, emails and texts and restricting access to communicate with others, the letters are a possible source of information and can increase the risks and threats.

216. The effect in this case served to reinforce the pressure on the victim and placed her in a more isolated position.

217. Similarly, the management of the child protection conference and the core group meetings where the perpetrator was a full participant, served to reinforce his control and disempower the victim as she was not in a position to express her views freely.

218. Extensive research about domestic violence has established that most women have experienced a significant number of incidents of abuse and injuries before they even consider reporting their situation to the agencies. In this case, it was the victim who reported her situation to the police on two occasions giving them considerable details of the abuse. The significance of her actions had not been appreciated by the professionals, who perceived her as unreliable as they did not understand the pressure she was under from the perpetrator.

219. Given the victim’s young age, the review has noted that there had been five pregnancies recorded. The Health Visiting IMR commented on the perpetrator’s presence at all their visits and his sometimes quite inappropriate sexualised language about their relationship. His reaction to the miscarriage in March 2012 was noted to be offhand and inappropriate. The question did not seem to have been raised by any professional of the existence in the relationship of sexual violence or coercion. Instead as noted earlier in this report the social worker interpreted the pregnancies as a sign of a relationship being active when the victim said it was not and she was then thought to be ‘less than truthful’. The element of trust was not present in this case between the social work professionals and the victim, which impacted on the outcome of the interventions and services delivered.

220. The expectations that were placed on the victim to safeguard the children and thus control the perpetrator’s behaviour through the child protection plans were unrealistic. Without robust services in place to support her and to contain his behaviour, for example by police involvement, the likelihood of success was poor. The implied judgment perceived by the

victim that if she could not safeguard the children 'she was not a good mother' was reported by her family to have upset her as they all saw her as a good mother.

221. The importance of creating a safe environment to allow a victim to speak about their situation and experiences and of establishing safe ways of communicating must be reinforced in all training and supervision.

4.2.6 **How the behaviour of the perpetrator could be addressed**

222. Community Safety Partnerships under the Crime and Disorder Act 1998, including the amendments set out in the Policing and Crime Act 2009, were given the responsibility to tackle crime and reducing crime with the responsible authorities in a local area, which includes local authorities, probation services, health agencies and a number of other agencies. Since 2012, the new Policing and Crime Commissioners role will have to 'have regard' to the plans set out by the CSP and vice versa. One of the significant areas of crime relates to domestic violence.

223. The BCSP has prioritised the prevention and reduction of domestic violence in the city. The Birmingham Violence against Women Board has published a strategy for 2013 to 2015 to drive the vision to reduce domestic violence in the city forward.

224. The most effective way to hold perpetrators of domestic violence to account is identified as through the criminal justice system in the strategy. In the case of the perpetrator, this Review has noted that there were several missed opportunities to control the perpetrator's abusive and violent behaviour and hold him to account spanning a period of time from 2003 to 2012.

225. During that time frame the understanding and expertise as well as guidance and regulations had developed considerably and improved the responses in agencies to reports of domestic violence. However, the practice demonstrated in 2012 by the agencies did not meet the expected standards and failed to challenge and control the perpetrator's behaviour.

226. This Review has revealed the tension that can develop for the core agencies, Children's Social Care, the police and health agencies, between focussing on the safeguarding of the children with the victim as the mother expected to protect them and keeping the victim safe. The focus on the children moved the attention away from the perpetrator, who was not robustly challenged or investigated in relation to the original reports by the victim or assessed in relation to safeguarding the children.

227. The management of the perpetrator and the potential risks should be the central focus for the police and CPS, where appropriate. The strategy discussion should take place promptly once a report has been received from a victim, if there are children involved. A Section 47 enquiry should be undertaken jointly between the police and Children's Social Care unless there are clearly stated reasons agreed and recorded by the managers /supervisors stating why this case should be an exception.

228. All Initial child protection conferences where domestic violence and abuse are a factor should include an invitation to the police, who should attend and provide a full report of the background history.

229. Where domestic violence is a significant factor leading to the implementation of child protection plans, child protection conferences should consider, if a referral should be made to the MARAC.

230. The police IMR concluded that if the police investigations and enquiries in 2012 had been 'completed more diligently' there may have been a realistic prospect to achieve a prosecution of the perpetrator.

4.2.7 **Recognising substance misuse and mental health problems as a cluster of issues**

231. Where services are provided to an adult, the recognition that the same person is a parent with parenting duties and responsibilities, or may pose a risk to another adult, should lead to a consideration of making a referral to social care agencies or to seek advice from a designated safeguarding professional.

232. A cluster of problems had been noted for the perpetrator in his GP records and were reported by the victim to the police in her original referrals and DASH assessments e.g. mental health treatment for depression and regular substance use. This should have been considered in view of his role as a father in relation to the children as well as in the DASH risk assessment in relation to the danger he posed to the victim.

233. The impact of substance misuse when combined with mental health problems is often not recognised as noted in a previous local Serious Case Review[22]. The relationship is referred to as '*dual diagnosis*'[23] and explains how the two issues may impact on one another often in a way that can affect the persons behaviour significantly. There was no evidence in this case that the perpetrator had been assessed in relation to these issues as the GP services had not been approached by the social worker or the police in connection with the reported domestic violence.

234. Policies and training for domestic violence and abuse should include learning about the effects on the behaviour and feelings of someone, who suffers a cluster of complex problems, which may require an assessment and services to be delivered with a care plan to reduce the risks and impact on their behaviour.

235. The lack of any assessment of the perpetrator during any of the contacts by agencies with him led to some of his background history being overlooked and his overall state of mind not being recognised. The fact that he posed a serious danger to both his ex-partner and the victim was not understood.

4.3 Analysis of the review process and family involvement

236. The review process has been described in section 1 in this report and has followed the national guidance for Domestic Homicide Reviews. By and large the process has been implemented as required. The only requirement, which proved difficult to meet, was the timescale as there were delays in the production of the IMRs and in particular the Children's Social Care IMR. Two other agencies needed more time than initially planned for as well.

237. The main reason for the delays related to finding suitably qualified and experienced professionals available to undertake the IMRs. Two of the authors had not received any previous training and had not undertaken similar work in relation to Serious Case Reviews, which might have assisted them in this task. Although the process for this DHR included a half day briefing session for the authors at the very beginning, not all the authors had been identified at that point. The availability for the authors of advice and support in their agencies from their supervisor or signing off manager was reported as variable.

[22] Birmingham SCR Case 21
[23] Dual Diagnosis –the challenge in providing integrated services 2004.NHS

238. The Review Panel held additional meetings and met with the IMR authors to discuss their reports to facilitate the review process. The delays were taken up with the relevant managers in the agencies by the Panel representatives and, with Children's Social Care, by the Review Chair in writing. The final IMR from Children's Social Care was received in May 2013, which then enabled the Overview Report to be concluded.

239. The Panel members included a representative from a Women's Aid service, which enabled the Panel to explore the issues as they arose in depth and led to good discussions. It was noted that the Panel membership, which included agencies representing children's services, such as Early Years and Health Visiting Services as well as Children's Social Care, at times reflected the tensions noted in the Review between services focussed on the victim of domestic violence and services focussed on children. The need for barriers and boundaries between and within services to be overcome when delivering services in response to domestic violence was reinforced by the Panel experience.

240. The Panel concluded that the IMRs had reflected on the issues of ethnicity, culture and diversity in the extended family. There was no evidence that there had been any discrimination in the provision of services to the victim directly. However, the information available indicated that the fathers of the victim and the perpetrator had disapproved strongly of the relationship, which had affected the victim and had left her more isolated from family support at times. Some of the interactions by the victim with housing services demonstrated that the requests for the involvement of the anti-social behaviour officers related to tensions between the extended families. No adverse impact of tensions between the families on the services delivered to the victim and the children was apparent in the information available.

241. The process of contacting the family of the victim was facilitated by the Family Liaison Officers and worked well. As the trial took place within a relatively short time of the victim's death (six months) and the perpetrator pleaded guilty, the timeframe for the meeting with the victim's family after the trial was quite quick.

242. The victim's mother and aunt were supported by two representatives of victim support agencies, which provided a positive input to the review process. The information from the family members was helpful and added to the Review Panel's understanding of the victim's feelings and perceptions of her situation. The report and outcome of this Review was shared with them prior to final sign off. The family had no additional comments to make.

243. Several attempts were made in writing to establish contact with the perpetrator to seek his views but no response was received. It has not been possible to reach any views about the perpetrator's perceptions about the services provided. As there were no assessments undertaken of his capacity as a parent or the risks he posed to the victim and the children with him, little is known of his views. It has not been possible to assess what sort of intervention he thinks might have prevented him from killing the victim.

4.4 Conclusion and Findings

244. In the light of the information available to this Review from the IMRs, the integrated chronology, the discussions in Panel meetings and the meeting with the victim's family it has emerged that, if the work had been carried out across the agencies in accordance with good practice and the requirements in place in agencies at the time, it might have been possible to prevent the death of the victim, and thus the loss of their mother for the children. This statement is not made with just the benefit of hindsight but with the knowledge arising from the Review, that there were a number of missed opportunities and that some decisions made about the service delivery to the victim were seriously flawed. It is however not possible to know how the victim might have responded to a different set of services aimed to support her.

245. The outcome might have been different if the risk assessments had been based on the full background information about the perpetrator from the first report by the victim in August 2010, and, if the social work assessment had been undertaken in collaboration with other agencies such as the GP and the health visitor. From this point onwards the responses to the victim missed the overall picture and failed to understand the dynamics of the domestic abuse and violence carried out by the perpetrator.

246. The volatile and controlling nature of the perpetrator's behaviour was not fully understood at any point in the interventions by the agencies. As the risk assessment had been flawed, they were not able to predict the level of risk and danger that the perpetrator posed to the victim and the children. Although it could not have been predicted that the perpetrator would kill the victim, it could have been predicted that he would carry on to behave violently and abusively and in view of his past history and established domestic violence research evidence, it is very likely that the behaviour would have escalated further.

247. If the response had been effective and action had been taken to control the perpetrator's behaviour by the agencies, for example by charging him with offences, it is not possible to state with certainty that he would not have found another opportunity to attack the victim. His history reveals that he continued to present a risk to his ex-partner long after the relationship had ended because of the presence of his child.

248. The services provided to the victim and the children were not effective in keeping them safe and it can only be concluded that if the services had met their needs and had been provided effectively, their safety might have been achieved. The overall conclusion has to be that the victim, who had reported her fears and concerns, was not really listened to or heard by the agencies.

5. LEARNING

5.1 Lessons learnt

249. The Review has identified a number of areas where improvements could be made by implementing changes to promote good practice and a more effective response to victims of domestic violence and abuse. The learning from this Review is not limited to the agencies that were directly involved but extends to all agencies where there may be contacts with victims of domestic violence and abuse.

250. The key issues to be addressed were identified as follows:

251. Finding means to remove barriers and boundaries between and within agencies to enable professionals to work together and to collaborate to provide responsive and safe services to victims and their children.

252. Improving the use of risk assessments tools as one part of the work with victims; and

253. Reinforcing the practice to update and review **all other** information to assist in forming a professional judgement about the whole situation a victim is experiencing in order to understand the danger posed by the perpetrator.

254. Ensuring that the child protection processes are carried out as required in collaboration with other agencies involved with the victim and the children such as GPs , health visitors, housing officers, Women's Aid workers and at all times, where there is domestic violence and abuse, the police.

255. Improving the safe management of child protection conferences to address the risks and dangers posed by perpetrators towards the adult victim as well as the children.

256. Ensuring that the police investigations are rigorous in undertaking checks and following up complaints reported to them in a timely manner, including consultations with the Crown Prosecution Service about potential prosecutions.

257. Addressing the lack of up to date domestic violence policies, procedures and training of front line professionals in the agencies identified in this Review so that they can intervene with confidence and a good understanding of the dynamics of domestic violence and abuse.

258. The resources and roles of the third sector, such as Women's Aid, must be clarified to the agencies primarily focused on services to children: Children's Social Care, health agencies and the police; to ensure that the support that can be provided by them is effective and can be delivered in collaboration with the core agencies.

5.2 Implementation of Learning

259. A number of lessons to be learnt have emerged from this Review which must be followed up to ensure that practice improves and where practice has already been addressed as a result, mechanisms must be in place to embed and maintain the improvements .

260. The IMRs have provided evidence in their reports and in the Action Plan, which will be monitored regularly by the BCSP, of actions taken in response to their recommendations. The learning, where actions are planned, such as audits, has been set against clear timescales.

261. Each agency is expected to provide feedback to their agency and the IMR Authors as well as to the professionals, who were involved in the IMR process.

262. The dissemination of the key learning will be targeted to the professionals in the member agencies of the Birmingham Community Safety Partnership and the Birmingham Safeguarding Children Board and will include wider Birmingham services not directly affiliated to these partnerships.

6. RECOMMENDATIONS

6.1. Recommendations by the Independent Report Author

263. The recommendations from the Individual Management Reviews are set out in the Action Plan. The recommendations by the Report Author are intended to compliment the recommendations in the IMRs and to address the agencies collectively. The intention is to improve collaborative inter agency work in the city where there are concerns about domestic violence and abuse and to contribute towards reducing violence against women and to promote their safety and that of their children.

264. **Learning Point 1:** The Review has identified the need to find effective methods to remove barriers and boundaries between and within agencies to enable professionals to work together and to collaborate to provide responsive and safe services to victims and their children.

Recommendation 1.

1.1 A working group should be jointly established by the BCSP and the BSCB consisting of representatives from the core agencies of both. The working group should also include some domestic violence service users, and/or surviving family members, with the aim:

- To establish mechanisms to break down the boundaries and to promote collaborative working across the divide between adult focussed and children focussed services where there are concerns of domestic violence involving adult victims and children.
- To develop proposals to improve safe services for adults and children.
- The working group should report to both BSCB and BCSP regularly.
- The BSCB and BCSP should monitor progress and implement proposals made by the working group.

1.2 Cross representation between the BSCB and the BCSP should be reviewed to ensure that there is an active and up to date exchange of developments, cooperation and joint working in place at all levels on both bodies.

Expected Outcome: An improvement in the practice of agencies working together to undertake assessments and share information where there is a domestic violence victim and children; an improvement in agency attendance at key meetings, such as child protection conferences, and safe management of child protection meetings for the victims.

265. **Learning Point 2:** The Review identified the need to improve the use of risk assessments tools as one part of the work with victims. The risk assessment process must include the practice to update and review all other information when forming a professional judgement about the whole situation a victim is experiencing and the danger posed by the alleged perpetrator.

Recommendation 2

2.1 The use and the application of risks assessment tools such as DASH should be carefully examined by the police and partner agencies including the current linked training in the light of the findings of this Review. A regular quality assurance process should be in place.

2.2 The police should produce and disseminate a briefing for partner agencies of the purpose and best practice of using the tool in domestic violence and abuse referrals to form a professional judgement about the actions to be taken.

Expected outcome: An improvement in the practice of using the risk assessment tool by the police leading to a better decision making process to follow up prosecutions; a better understanding of risk assessment by partner agencies to inform their practice in making referrals to the MARAC.

266. **Learning Point 3:** The Review found that there was a need to ensure that the child protection processes are carried out as required in collaboration with other agencies involved with the victim and the children such as GPs, health visitors, housing officers, Women's Aid workers and at all times, where there is domestic violence and abuse, the Police.

The Review determined that there was a need to improve the safe management of child protection conferences, including the preparation for conferences and the management of the meeting, in order to manage the risks and dangers posed by perpetrators towards the adult victim as well as the children.

Recommendation 3.

3.1 A review should urgently be undertaken of the protocol between the police and the children's Independent Conference Service to confirm that all child protection conferences, where domestic violence and abuse are a known or suspected issue, will have police representation in attendance with up to date information about the alleged perpetrator.

3.2 Regular audits should track police attendance and report to the BSCB. Any obstacles or gaps in attendance should be addressed within the safeguarding structure promptly by the Conference Service.

3.3 The BSCB and the conference chairing service should review and update the current guidance and training for Conference Chairs in relation to the safe management of domestic abuse and violence.

Expected outcome: Child protection conferences and child protection plans should reflect the safe management of cases involving domestic violence and abuse. Police presence at child protection conferences should be taking place where there are concerns about domestic abuse and violence as a matter of routine.

267. **Learning Point 4:** To improve the domestic violence and abuse training of front line professionals and supervisors in the agencies identified in this Review so that they can intervene with confidence and a good understanding of the dynamics of domestic violence and abuse.

Recommendation 4.

4.1 An analysis of current domestic violence training should be undertaken by the agencies participating in this Review to establish that it addresses the issues in the findings of this Domestic Homicide Review. All the training should promote collaborative working to respond to victims and their children with sensitive and effective delivery of services.

4.2 The commissioning process for domestic violence and abuse training should be reviewed and should in future draw on the joint expertise of interagency trainers in both the fields of domestic violence relating to adults victims and the field of safeguarding children and should ensure that the training is targeted to frontline professionals and their managers.

Expected outcome: Better practice should be in evidence in assessments and decision making, such as police charging decisions, and at key meetings, such as child protection conferences and should be regularly audited by the relevant agency.

268. **Learning Point 5:** The relevant agencies must address the implications for practice and service delivery in relation to the updated definition of domestic violence and abuse, particularly the inclusion of 16 and 17 year olds and the recognition of coercive and controlling behaviour, and the information must be disseminated and integrated in to policies and procedures across agencies. The current BSCB safeguarding children procedure on 'domestic violence and abuse' (chapter 23) was updated in March 2013 to reflect the changes. The learning in relation to this Review relates to the lack of understanding that was demonstrated about the perpetrator's coercive and controlling behaviour in addition to his violence.

Recommendation 5. A briefing 'awareness raising' launch and dissemination program should be implemented across all member agencies of both the BSCB and the BCSP to embed the change in the definition and to underpin the learning from this Domestic Homicide Review.

Expected outcome: That all agencies become aware of the updated definition with the inclusion of 16 and 17 year olds and that they update their own internal policies, procedures and training accordingly. The learning from this Review should drive improvement in the response by agencies to all reports of domestic abuse and violence.

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