JOINT

Domestic Homicide Review

Serious Case Review

MAPPA Review

Executive Summary

of the report into the death of a woman and a child

B-DHR 2013/14-02

Child died 31.05.2013

Woman died 31.05.2013

Report produced by Gill Baker OBE, BA (Hons)

Independent Reviewer/ Author

May 2017

INTRODUCTION

The purpose of a Domestic Homicide Review (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 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

A DHR is not an inquiry into how a victim dies or into who is culpable as those matters are for Coroners and criminal courts to determine. DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges during the course of a DHR which indicates that disciplinary action should be initiated then the relevant agency disciplinary procedures should be undertaken separately to the DHR process.

In production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality. The Birmingham Community Safety Partnership (BCSP) has balanced the need to maintain the privacy of the family with the need for agencies to learn lessons relating to practice identified by the case and has authorised the publication of sufficient information to enable this to take place.

A decision to undertake a Domestic Homicide Review was made in conjunction with the Birmingham Safeguarding Children Board and the West Midlands Strategic MAPPA Board. Hence a joint review was undertaken to incorporate the following:

Working Together to Safeguard Children March 2013

'A serious case is one where: (a) abuse or neglect of a child is known or suspected; and (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.'

Domestic Violence, Crimes and Victims Act (2004) Section 9(3)

Requires that a domestic homicide review be undertaken in 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 s/he was related or with whom s/he was or had been in in intimate relationship, or
a member of the same household as her/himself, held with a view to identifying the lessons to be learnt from the death.

The Criminal Justice Act 2003

As the perpetrator was subject to MAPPA oversight at Level 2 there is a requirement under MAPPA guidance for a mandatory serious case review.

It was determined that agencies would secure and review their files from February 2013 until the date of the death. Agencies were required to compile an Individual Management Review (IMR) to provide an independent, open and critical analysis of

individual and organisational practice. The IMRs identify lessons learnt by the individual agencies, highlight any good practice and include recommendations for single agencies to improve practice.

Terms of Reference

In addition to the generic terms of reference contained within the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2013),* the following issues were to be addressed:

- *What information/ knowledge was known that indicated that this woman and her children may be at risk?*
- *Were agencies aware of the relationship between the woman and the alleged perpetrator?*
- *Were practitioners aware of and sensitive to the needs of the woman and her children and in their work, and knowledgeable both about potential indicators of domestic violence, abuse or neglect and about what to do if they had concerns about their safety and welfare?*
- *What information was known that the alleged perpetrator was a perpetrator of domestic violence or a risk to others and how did your agency respond, both individually and with other agencies?*
- *Were assessments and decisions made using information from all agencies involved and were the actions identified appropriate? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?*
- *What role did your agency play in relation to MAPPA meetings and what contributions did your agency make. Did your agency do what it was asked to do?*
- *When, and in what way, were the woman and child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of services? Was this information recorded?*

- *Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for working during normal office hours and others providing out of hours services?*
- *Where relevant, were early help services to a child in need, CAF or family support services provided following appropriate assessments?*
- *Were, where relevant, the proper processes for identification, referral, child protection investigation, assessment and service provision followed?*
- *Were, where relevant, appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?*
- *Was practice in agencies sensitive to considerations of age, disability, marriage, pregnancy and maternity, race, religion and belief, sexuality and gender in relation to the family, and if relevant, how were they explored*, *recorded and responded to?*
- *Were the staff involved with the family supervised and supported by their managers and given the chance to exercise reflective practice?*
- *Was there sufficient senior manager accountability or other organisations and professionals involved at points in the case where they should have been?*
- *What constraints were staff operating under, if any and were there issues in relation to the capacity or resources in your agency that impacted on the ability to provide services to the woman and her child/ren or the alleged perpetrator?*
- *Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?*
- *Did those agencies with significant involvement with the family and the alleged perpetrator work effectively together to put into place a programme of early help and intervention?*
- *Did agencies' practice in terms of assessment, intervention and decision making focus on the presenting circumstance of each intervention or did it also take account of known history and previous agency involvement?*

- *How was information shared between the different Local Areas in managing the perpetrator and any risk he posed to adults or children?*

Additional specific terms of reference to be addressed by Wales and Staffordshire & West Midlands Probation Trusts:

- *What is known about the alleged perpetrator as a child protection risk?*

- *Was the standard of risk assessment, risk management and offender management of the alleged perpetrator sufficient in this case?*

Additional specific terms of reference to be addressed by MAPPA

- *For both Wales and West Midlands MAPPA SMBs does a review of the minutes show that all relevant agencies were actively engaged in assessing and jointly planning for the release of the mother's partner with appropriate safeguards in place?*
- *Were disclosures fully documented and appropriate?*

SYNOPSIS

In June 2013 police officers picked up a text message from a mobile phone which had been sent by the perpetrator to the effect that he had killed his girlfriend. Police officers attended the home address of the Woman and found both her and her Child deceased. The Child was found in a cot and the Woman was found in her bed. Both had died as a result of pressure to the neck. A criminal investigation commenced and the perpetrator was traced and arrested at another address. He was subsequently charged and convicted of the murders of the Woman and the Child. He was sentenced to life imprisonment to serve a minimum of 29 years.

It is believed that the Woman and the perpetrator first met when they were both Looked After Children and had both been taken into care together with their respective siblings due to parental violence and substance/alcohol abuse. Their relationship began only after his release from prison in February 2013, and hence lasted less than 4 months until the murder of the Woman and her youngest Child. Fortunately the Woman's eldest child was staying with partner 1 (that child's father) at the time.

The Woman was only 6 years of age when she was taken into care, and apart from a short period in a children's home, was to benefit from being in foster care which included a long term placement with a foster carer to whom she remained close as an adult. Throughout her time in care there were no behavioural problems and the only concern raised was when her relationship with Partner 1 began as she was 15 years of age and he was 26 years of age. However she achieved good academic achievement, was hard working and was thought a stable, focused, ambitious individual by the time she had progressed to independent living. She gave birth to her first child by partner 1 but they parted when the child was 12 months of age. She later formed a relationship with partner 2 and gave birth to her second Child who is subject of this Joint Review. She was successful in her career and apart from contact with health professionals for general health matters in relation to herself and her children she had little contact with any other agencies after leaving care. Each of her relationships encountered difficulties and it is evident that domestic abuse occurred.

On the other hand the perpetrator was a teenager when taken into care and he was placed in children's homes. He was disruptive, violent and displayed challenging behaviour throughout his time in care. By the age of 17 years he had a total of 33 criminal convictions several of which involved violence. He had a number of relationships with women, often involving domestic abuse and there were concerns about non accidental injuries to two of his children. He was therefore known to a range of agencies and he usually appeared compliant whilst withholding information. There is no doubt that due to his time in children's homes, youth offender institutions and prison

that he was ‘institutionalised’ and had difficulty coping in society. The Woman and the perpetrator shared the same social circles as both kept in contact with family members and peers who had been in the care system at the same time. It is apparent that within this social circle there was a degree of acceptance and minimisation of abusive behaviour.

There was effective management of the perpetrator after his conviction of a serious assault upon an adult male who was an ex-partner of his sibling. Relationships he had formed whilst in prison and when first released on Licence were identified and prompt safeguarding actions in relation to the women and their children were undertaken. However as the end of his sentence date approached and Licence restrictions were due to cease whilst still appearing compliant, it is apparent he became more manipulative and less willing to disclose information and there was a lack of supervision or management oversight at that time.

There was a great deal of information sharing between agencies although there was some delay in record keeping, submission of MAPPA referrals and authorisation of the transfer of the case from Wales probation to West Midlands probation.

There were clear indications that the perpetrator was in a relationship and whilst there was a great deal of activity, there were missed opportunities when information was passed on which could have led to identifying the Woman at an early stage. When eventually her identity was established there was a failure to take prompt action which could have served to safeguard the Child and the Woman which seems to indicate a lack of understanding of the risk that the perpetrator posed.

FAMILY AND ASSOCIATES ENGAGEMENT

Following the completion of the criminal proceedings, the long term foster carer, partners 1 and 2, the eldest sibling of the Woman and the perpetrator agreed to contribute to this review and all were seen by the independent reviewers. Their views

are incorporated into the joint overview report.

LEARNING

Key Issues:

- **Acceptance/Minimisation of Abusive Behaviour**
- **Information Sharing and Record Keeping**
- **Offender Management/MAPPA**
- **Domestic Abuse**

Lessons Learnt

- Information exchange between agencies in the main was good
- Information/actions were not consistently recorded in a timely manner
- Significant safeguarding activity was undertaken but was not fully recorded which served to indicate a medium rather than high risk of harm to children
- Police and Children's Social Care missed opportunity to identify relationship and hence risk when information passed to them
- Immediate action to safeguard the Child and the Woman after her identity was established was not taken and there was a lack of supervision/management oversight at this time
- The high risk to children posed by the perpetrator was not identified at an early stage and the significance of serial domestic abuse was not recognised
- Identified was a culture amongst a group of young people who had been in the care system of acceptance and minimisation of violence, sexual offending and domestic abuse.

GOOD PRACTICE

The probation Offender manager in Wales (where the perpetrator had been

imprisoned) showed great tenacity and determination to ensure safeguarding of women and their children and appropriate disclosure when the perpetrator formed relationships. This was exceptional and a good example of the system working with excellent information sharing and disclosure of relevant information to ensure that children and women were protected.

The holding of a professional's meeting in Birmingham when there was a delay in the transfer of the case. This ensured that relevant information and actions were taken to manage the risk posed by the perpetrator. The recognition that he posed a high risk to children rather than a medium risk demonstrated a good understanding of the nature of his behaviour and at that stage deflected from a focus upon his risk to the adult male who was the victim of his index offence and an understanding of the effect upon children who were present, plus the more recent developments in the relationships he had formed with women and the risk to them and their children.

CONCLUSION

Whilst the risk posed by the perpetrator was correctly assessed as high to both known adults and children, it is apparent that when his Licence conditions ended, this was not sufficiently focused upon. This may have been due to the fact that the index offence for which he was imprisoned was a serious assault upon an adult male, but there was overwhelming evidence of the perpetrator's violent behaviour towards females with whom he had formed relationships, and in turn a risk to children, his own and those of others. Indeed whilst in prison he had made threats to the child of an ex-partner.

It was certainly predictable that the perpetrator could cause harm to others. He was a serial perpetrator of domestic abuse and it is also known from research that a critical time for a victim to be harmed is when a relationship is ended or is about to end. It appears that the Woman refused a marriage proposal from the perpetrator, and that the perpetrator believed that if given an ultimatum she would choose her children over him.

It is possible that if immediate action had been taken when the identity of the Woman was discovered and a prompt disclosure was made to her about the risk posed to her and to her children, then appropriate safeguarding measures could have been taken, and her death and the death of her Child could potentially have been prevented,

Joint Review Panel

Independent Reviewer/Chair Anne Binney

Independent Reviewer/Author: Gill Baker O.B.E.

Panel Members:

Assistant Chief Executive – National Probation Services, Wales
Designated Nurse for Safeguarding Children & Young People – NHS Birmingham South Central
Detective Inspector – Public Protection - West Midlands Police
Head of Child Protection & Review Service – Birmingham City Council
Head of Public Protection – Staffordshire & West Midlands Probation Trust
Head of Safeguarding – Birmingham & Solihull Mental Health Foundation Trust
MAPPA Lay Adviser – member of the Strategic Management Board
Operations Manager – Birmingham & Solihull Women's Aid
Safeguarding Adult Lead – Birmingham South Central CCG
Senior Service Manager – Violence Against Women, Equalities, Community Safety & Cohesion, Birmingham City Council

JOINT REVIEW RECOMMENDATIONS

1. **Raise the awareness of all Children in Care and those who care for them about what constitutes a safe and a risky relationship, with a view to supporting an outcome that all children in care enter into positive and healthy relationships.**

2. **That all police officers and staff recognise the importance of considering the safeguarding of children and young persons identified within any reported incident.**

3. **Probation Offender Managers should ensure that information about visitors to Domestic Violence perpetrators supplied by the prison service is considered at MAPP meetings and 6 weeks prior to release from prison so that any necessary enquiries regarding potential new partners can be undertaken.**

4. **MAPP panels to consider the use of a Violent Offender Order where formal supervision is ending.**

5. **West Midlands Police and Birmingham Children's Social Care services to review domestic violence training to ensure learning from this case in relation to control, coercion and risk by perpetrators is fully incorporated.**

6. **Offender managers to set accredited Domestic Violence Programmes as an objective for custodial sentence planning, where appropriate, and encourage transfer to a prison providing that intervention where possible.**

7. **Birmingham Community Safety Partnership and Police and Crime Board to review local arrangements for the effective management of domestic violence abusers and offenders.**

8. **Those organisations that completed an IMR or information report are required to provide evidence that action has been taken to address individual and management practice which has fallen below expected professional standards.**

SINGLE AGENCY RECOMMENDATIONS

There are a total of 21 internal recommendations made by agencies to learn lessons and improve practice were progressed during this the course of the Review. These are as follows:

Birmingham Children's Social Care

- Further audit to be undertaken to determine whether there are examples of children being created on Care First but no referral opened.

- To achieve full CSC involvement at MAPPA level 2 and 3 panels.

Birmingham Cross City CCG

- All practice staff to receive training regarding Domestic Abuse.

Birmingham Women's NHS Foundation Trust

- Remind staff to consistently record the details of others who are present during a consultation i.e. partners, friends and relatives and include conversations that take place involving those individuals.

- Ensure consistency in practice in accordance with Trust guidelines for domestic abuse.

- Share appropriate contextual historical information relating domestic abuse.

Wales Probation Trust and Staffordshire and West Midlands Probation Trust

- OASys practice need to reflect current risk concerns so that appropriate risk management/sentence plans are formulated and implemented, including the use of SARA.

- Case Recording must provide a record of all activity/contacts in a supervised case.

- MAPPA practice. MAPPA panels should reflect the meeting discussion, take an overview of risk concerns and victim safety, be effectively chaired and ensure actions are communicated to those not present at the panel.

- Transfers. Risk Management and Victim Safety is maximised through clear transfer arrangements between Trusts, in particular in early agreement between ACOs/Senior Managers, in High Risk transfer cases.

- Rehabilitative Interventions.

  (i) Interventions identified to address risk should be prioritised and implemented in a custodial/community setting as part of the Sentence Planning / Review / Recall process.

(ii) Wales Probation Trust should progress offender interventions (eg Accredited Programmes, Specified Activity Requirements) in a timely, pro active manner.

West Midlands Police

- West Midlands Police to ensure that it has a policy covering the management of Category 2 violent MAPPA offenders.

- West Midlands Police should ensure that police information and intelligence on the management of violent MAPPA offenders is recorded on Visor.

- West Midlands Police should ensure that WMP policy covers the use of duty mobile phones by offender management teams (LPU and PPU), including appropriate guidance on out of hours use.

- West Midlands Police to ensure that the training provided to violent MAPPA offender managers is appropriate and tailored to their role.

- West Midlands Police to ensure that Violent MAPPA offenders are considered as a specific cohort in the current review of domestic abuse offender management.

- West Midlands Police to ensure that lessons learned through this IMR are incorporated into policy development and future staff training.

West Mercia Constabulary

- Specific advice should be given to the front counter clerk who took the initial call in regard to the lack of detail obtained and the importance of obtaining such detail.

- Generic advice should be provided to communications staff that full details *must* be obtained from callers in order to best inform the officers dealing with the incident. Once these details have been obtained then the necessary checks *must* be completed and actioned before any consideration can be given to filing the incident.

- Specific advice should be provided to the responding Police Constable detailing the importance of documenting, fully, the message result. (The facility exists for officers to input their own update rather than rely on communications staff to complete it). The officer should be advised that given the concerns of partner 1 the content of the text should have been included within the message to inform others in the event of a reoccurrence. The officer could also be reminded of the importance of carrying out fundamental checks in order to inform the situation assist those contacting the police. The officer should be advised regarding social service referrals in order to safeguard children.

- Learning and Development should ensure that all officers and staff recognise the importance of considering the safeguarding of children and young persons identified within any reported incident.