BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP
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Domestic Homicide Review
Under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of a woman

BDHR 2013-14-04

Executive Summary and Learning Points

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Independent Chair and Author

Summary of the circumstances leading to the Domestic Homicide Review

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

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

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

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

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

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

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

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

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

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

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

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

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

The Domestic Homicide Review Process

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

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

The appointed DHR Review Panel met on three occasions and commissioned Individual Management Reviews (IMRs) and Information Reports, which were examined alongside the integrated Chronology produced from agency records.

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

The date for the conclusion of the Review was changed as the criminal process was extended in to 2015. It was not possible to interview relevant family members and close friends and/or colleagues while the criminal process continued. Similarly, the DHR Panel was not able to approach the employing organisations for both the victim and the perpetrator to request information, which could contribute to the learning of this Review.
The final report was delayed due to unforeseen circumstances and was concluded in March 2016. Learning from the review process has been implemented in the intervening time as expected by the participating agencies.

See the Overview report for the full Terms of reference, family involvement and details of the process.

The definition of domestic violence.

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

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate

partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

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

***Controlling behaviour** is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

***Coercive behaviour** is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."**
**This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.*

Conclusion and Findings

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

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

The difficulty that victims have is that society and the people around them often find it hard to recognise the effect of the accumulation of abuse. For the victim to tell the police about the perpetrator's behaviour in relation to, for example, the victim smoking as a one off story

might not alert the police to the underlying behaviour by the perpetrator to control and humiliate the victim.

Lessons to be learnt from Family, Friends and Colleagues

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

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

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

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

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

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

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

[1] (Women's Aid, 2016)
[2] (Home Office, 2016) (Provided by Solihull MBC, 2016)

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

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

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

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

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

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

Lessons learnt

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

The support and advice to relatives and friends, whether at local or national level, should provide advice not only about what to do but how to do it. The main concern from relatives and friends is acting against the victims' wishes. Practical advice by agencies about how to

[3] (Provided by Solihull MBC, 2016)

overcome that barrier with the victim would the most useful help and support identified by the work colleagues, friends and family.

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

Specific Learning Points:

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

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

Learning point:

The finding of this review is that all practitioners need to be aware not only of specific incidents but to be able to put those incidents into the context of the victim's whole life. When assessments are made, the practitioner must consider with the victim how the perpetrator is behaving and how the pattern of their behaviour affects the victim's ability to lead her life at home, at work and in social situations free from fear and intimidation.

Learning point:

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

The services, which are in place, respond traditionally to incidents rather than an accumulation of restrictions, being cut off from family and friends, being belittled, targeted

violence and unreasonable demands for example. The professionals need to be aware when responding to reports or call outs of the importance of taking account of a full history not just an incident.

Implementation of Learning

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

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

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

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

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

Recommendations by the Independent Overview Report Author

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

1. Learning point:

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

1. Recommendation:

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

2. Learning point:

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

2. Recommendation:

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

3. Learning point:

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

3. Recommendation:

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

4. Recommendation:

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

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