BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP

WORKING TOGETHER FOR A SAFER CITY

Domestic Homicide Review

Executive Summary

BDHR 2014/15-02

November 2017

Report into the death of

Anna

1972 – 2014

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EXECUTIVE SUMMARY CONTENTS

1. THE REVIEW PROCESS

To protect the identity of the family members, their names have not been used. Instead, throughout the review (with the agreement of her family), the pseudonym "Anna" has been used for the victim and the term "estranged husband" has been used for the perpetrator.

This domestic homicide review was commissioned by Birmingham Community Safety Partnership to enable lessons to be learnt from the death of a white British woman, Anna, who died at her home in Birmingham in June 2014. Her estranged husband was found guilty of her murder and the attempted murders of their two children. In December 2014, he was sentenced to a minimum prison term of 25 years for her murder and 20 years for each of the attempted murders of their children. The sentences are to run concurrently.

The review followed the statutory guidance for conducting domestic homicide reviews. An initial scoping meeting of the Birmingham Domestic Homicide Team was held on ** where the decision was taken to undertake a domestic homicide review. All agencies that may have had contact with any member of the family up to the point of Anna's death, were contacted to establish whether they had had any involvement with any family member.

A total of 32 agencies were contacted, of which eight confirmed that they had had contact with either Anna, her estranged husband or either of their two children. They were instructed to secure their files.

2. CONTRIBUTORS TO THE REVIEW

In all, individual management reviews and chronologies were requested from:

- Heart of England NHS Foundation Trust
- Birmingham Community Healthcare Trust
- Birmingham Children's Hospital NHS Trust
- GP
- Schools
- Stepping Stones Family Support Project

Information reports and chronologies were requested from:

- Neighbourhood Advice and Information Service
- West Midlands Ambulance Service

The individual management reviews, information reports and chronologies covered the period between January 2011 and the end of June 2014. The panel decided on this timeframe as it covered the couple's separation and the period leading up to it.

All the individual management review authors and information report authors were independent of the case i.e. they had no involvement in the case or line management responsibility for any practitioner involved in the case.

3. THE REVIEW PANEL MEMBERS

All the panel members were independent of the case. No panel member had management or line management responsibility for any member of staff involved in the case. After an initial scoping meeting, the panel met four times. The domestic homicide review panel comprised:

- Independent Chair and Overview Report Writer
- Deputy Head of Nursing, Child and Adolescent Mental Health Services (CAMHS)
- Assistant Director Quality Assurance and Safeguarding, Birmingham City Council Children Social Care
- Partnerships and Project Manager Quality Assurance and Safeguarding, Birmingham City Council Children Social Care
- Operations Manager, Birmingham and Solihull Women's Aid
- Safeguarding Officer, Birmingham City Council Education and Commissioning
- Head of Safeguarding, Heart of England NHS Trust
- Lead Nurse Safeguarding Adults, Birmingham Community Healthcare Trust
- Detective Inspector, West Midlands Police
- Domestic Homicide Review Coordinator, Birmingham Community Safety Partnership

4. AUTHOR OF THE OVERVIEW REPORT

The chair and author of this review has been a freelance consultant for 17 years. She specialises in safeguarding children and vulnerable adults with a particular focus

on domestic abuse and working with minority ethnic families. During this time, Eleanor has been appointed to undertake projects for a wide range of organisations including (amongst others) the Department of Health, The National Police Chiefs Council (formerly the Association of Chief Police Officers), Interpol, Forensic Science Service, Amnesty International, National School of Government, Home Office Immigration Enforcement (formerly UK Border Agency), ECPAT UK and the British Medical Association.

Examples of her work include being commissioned (2000 – 2011) to research, develop and write the national statutory and multi-agency guidelines for practitioners handling cases of forced marriage for the Forced Marriage Unit (Foreign & Commonwealth Office and Home Office Unit). The NSPCC appointed Eleanor to develop a service model and accompanying manual to assist NSPCC practitioners working with South Asian children and families. Following the death of Victoria Climbié, the Department of Education commissioned Eleanor to investigate the scale and extent of child abuse linked to a belief in "spirit possession" and "djinns" in the United Kingdom.

Eleanor has also undertaken research on domestic abuse for Community Safety Partnerships and conducted audits and practice reviews for Safeguarding Children Boards. She has chaired and authored over 15 serious case reviews/domestic homicide reviews. Eleanor has a Master of Business and Administration (MBA) from Bradford University School of Management (2000) and a Master of Laws (LLM) in Child Law from Northumbria University (2011).

Prior to her work as an independent consultant, Eleanor managed services within the NHS caring for people with life limiting illnesses. She has extensive experience of working with bereaved families.

She is independent of, and has no connection with any agency in Birmingham; she has never worked for any agency in Birmingham.

5. TERMS OF REFERENCE FOR THE REVIEW

The aim of the review is to:

i. Establish what lessons can be learned from Anna's death about the way in which local professionals and organisations work individually and collectively to safeguard victims

ii. Identify how and within what timescales those lessons are to be acted on, and what is expected to change as a result.

iii. Apply these lessons to service responses including changing policies and procedures as appropriate

iv. Prevent domestic homicide and improve the way services respond to all victims of domestic abuse, and their children, through improved intra and inter-agency working. [1]

6. KEY LINES OF ENQUIRY

The review considered both the "generic issues" set out in the multi-agency statutory guidance for the Conduct of Domestic Homicide Reviews (2013) and the following specific issues identified in this particular case:

- What knowledge/information did your agency have that indicated Anna and her children might be victims of domestic violence, and how did your agency respond to this information?

- What knowledge/information did your agency have that indicated the estranged husband was a perpetrator of domestic violence and how did your agency respond to this information.

- What opportunities and services did your agency offer and provide to meet the needs of Anna and her children? Were they accessible, appropriate, empowering and empathetic to their needs and the risks they faced? What action was taken to identify whether any children were at risk of significant harm or children in need of a service?

- Did the son's history of Asperger's syndrome and attention deficit hyperactivity disorder (ADHD) have an impact on the support offered to the family?

- Were there issues of capacity or resources within your agency that had an impact on your agency's ability to provide services to Anna, her estranged husband or their children? Did capacity or resources have an impact on your agency's ability to work effectively with other agencies?

- Identify any lessons learnt and implemented during the review process.

Specific issues for the son's GP

- Was he formally diagnosed with Asperger's and ADHD and if so, when?

- Was any specific support offered to him or his family following his diagnosis?

Specific issues for schools, the school nurse and the special educational needs co-ordinator

[1] Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts

- Was the son given the opportunity to talk about his home life and if so, what were his thoughts?

- Were there any patterns to his behaviour that might indicate that things were difficult at home? For example, did his behaviour change following holidays or weekends?

- Did the daughter disclose any information about her home life?

- What support and opportunities were provided to Anna?

- Did the parents play an equally active role in the son and daughter's schooling e.g. attend any additional SENCO (special educational needs co-ordinator) meetings about the son?

- Was the son subject to a statement of educational needs?

- As part of any assessments, were any home visits undertaken? If so, were both parents present?

- Why did the son cease to attend his secondary school in 2012, and what school did he attend following this time?

Specific questions for the neighbourhood office

- Did Anna disclose domestic abuse or indicate that she was a victim of domestic abuse?

- Is this question routinely asked when claiming for any benefits?

7. SUMMARY CHRONOLOGY

There was little known about any of the family members. There was no chronology of events, as there were no calls to police concerning domestic abuse, the children were not known to children's social care, and there were no specific contacts with health regarding domestic abuse. The only on-going contact that the family appeared to have with agencies was through their son. He had some behavioural issues and had a statement of special educational needs. He also had contact with the special educational needs co-ordinator and an education psychologist. He was subsequently diagnosed (aged eight) as having autistic spectrum disorder (Asperger's Syndrome) and attention deficit disorder.

The family lived in an affluent area of Birmingham and the perpetrator worked full-time as an IT engineer to support the family. Anna looked after the children and did

voluntary work. She had a close relationship with her mother and two sisters (she was the middle child).

Approximately 18 months before her death, Anna asked the perpetrator for a separation. However, following the separation, to keep things as "normal as possible", he continued to visit the family home to see the children. In fact, the perpetrator, Anna and their children continued to go on family holidays together. Nevertheless, Anna described to family and friends (before and after the separation) that she felt "smothered" by her estranged husband.

During the course of the review, family and friends disclosed that the perpetrator was possessive and controlling – it also became apparent that he stalked Anna before and after their separation.

8. KEY ISSUES ARISING AND LESSONS LEARNT FROM THE REVIEW

There were occasions when professionals could have used opportunistic questioning to ask Anna about her relationship with her estranged husband. Despite these potential opportunities, Anna never recognised her relationship as abusive. In fact, she and her family thought her estranged husband was over-attentive but caring. Hence, no amount of questioning would have elicited a disclosure about coercive controlling behaviour. Therefore, the review concluded that both victims and practitioners required a better understanding of coercive controlling behaviour. The report also highlighted the need for practitioners to recognise the effect of domestic abuse on children. Other key issues that arose concerned the dangers of separation, and stalking and harassment.

9. CONCLUSION

In conclusion, it was evident that the perpetrator had been controlling throughout their relationship and subsequent marriage. Despite this, the panel felt that this domestic homicide was neither predictable nor preventable. However, the panel thought that if Anna had a better understanding of coercive control or had professionals questioned her further about her relationship, she may have understood better that his behaviour was controlling. She may then have sought help, which could have led to her seeking an injunction such as a non-molestation order.

10. RECOMMENDATIONS FROM THE REVIEW

The recommendations from the review are:

i. The Home Office should consider raising awareness of coercive controlling behaviour by launching a campaign around the legislation that criminalises patterns of coercive, controlling and psychological abuse.

ii. Birmingham Community Safety Partnership (in conjunction with the Birmingham Violence Against Women Steering Group) should consider raising awareness locally of coercive, controlling and psychological abuse to coincide with the introduction of the legislation (and the Home Office campaign). The campaign should be aimed at the general public.

iii. Birmingham Community Safety Partnership should request that the Violence Against Women and Children Steering Group should set out the learning outcomes for all domestic abuse training provided by agencies working with children and families. Training must be targeted at both strategic and operational levels and be in line with Birmingham domestic abuse standards. The learning outcomes from domestic abuse training should be embedded in all agencies' commissioned training arrangements.