BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP
WORKING TOGETHER FOR A SAFER CITY

Executive Summary

Domestic Homicide Review
under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of a woman in November 2012

'Khaista'

BDHR2012/13-05

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Independent Chair and Author

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Contents

1 The review process

1. This summary outlines the process undertaken by the Birmingham Community Safety Partnership domestic homicide review panel in reviewing the homicide of Khaista who was a resident in their area.

2. The pseudonyms Khaista and Shab have been in used in this review for the victim and perpetrator respectively to protect their identities and those of their family members.

3. Khaista was 33 years old when she was murdered in her home by her 37 year old estranged husband. They were both Muslims and had a Pakistani heritage. Khaista was born and brought up in the West Midlands; Shab had come to the UK when the marriage had been arranged. Shab was convicted of murder in May 2013 and is serving a minimum life sentence of 20 years.

4. The process began with an initial meeting of the Community Safety Partnership on the 18th December 2012when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with (victim/perpetrator) prior to the point of death were contacted and asked to confirm whether they had involvement with them.

5. Eight of the 45 agencies contacted confirmed contact with the victim and/or perpetrator and children involved and were asked to secure their files.

1.1 Contributors to the review

6. The following eight organisations provided a chronological and analytical account of their contact:

   a) Birmingham City Council Children's Social Care (had seven contacts between 2003 and August 2012 of which two related to allegations of domestic abuse involving the victim);
   b) Birmingham City Council Pupil and School Support Service (provided an individual management review in respect of the five schools attended by the children during the timeframe for the domestic homicide review which included three schools that are independent);
   c) Birmingham and Solihull Mental Health NHS Foundation Trust (who provided assessment and ongoing contact and support to the perpetrator in regard to his mental health following the first diagnosis of depression and a psychotic episode);
   d) Birmingham and Solihull NHS Central Commissioning Groups in relation to the two GP practices that provided general medical services to the family; the family registered with the second GP practice after they had moved house in 2011;
   e) Birmingham Community Healthcare Trust (provided school nursing dental health services and one enuresis clinic appointment);
   f) Birmingham Children's Hospital (provided treatment to the children when they were presented for various ailments);
   g) Heart of England NHS Foundation Trust (HEFT) (provided medical treatment to the victim on eight occasions in the emergency department and seven times in

outpatients; treated the perpetrator in the emergency department on six occasions during the timeframe of the domestic homicide review, four treatment episodes to Child 1 of which three were referrals to ENT, three treatments to Child 2 in emergency service and one fracture clinic, and the remaining three children each attended at the emergency department on one occasion);

h) West Midlands Police; five contacts prior to the murder and the subsequent criminal investigation.

7. These services provided an individual management review which was completed by a senior person with no direct involvement or responsibility for any of the services provided directly to either the victim or the perpetrator. In addition to the eight individual management reviews information was also provided from other services.

8. Information was received from the regional ambulance service[1], the schools attended by the children (that subsequently led to commissioning an individual management review from the education service), the revenue and benefits service and Birmingham and Solihull Women's Aid[2].

9. Information was also sought from the Islamic Judiciary Council in regard to the request that the victim had made for a divorce under Sharia law.

10. Information was also sought from the solicitors who were instructed by the victim in the non-molestation orders and civil proceedings in regard to the separation and divorce proceedings. The solicitors provided access to information for the purpose of assisting the prevention of similar crimes and to support learning and improvement through the domestic homicide review.

1.2 The review panel members

Role or position	Agency
Peter Maddocks	Independent Chair and Author
Safeguarding Named Nurse for Children and Young People	Birmingham & Solihull Mental Health NHS Foundation Trust
Lead Nurse Complex Mental Health Joint Commissioning	Mental Health Joint Commissioning
Associate Director of Safeguarding	Birmingham Community Healthcare Trust
Practice Director at a medical practice	Birmingham South Central Clinical Commissioning Group

[1] The ambulance service provided an emergency response on two occasions in November 2012 when the perpetrator took an overdose.

[2] As per the MARAC protocol in Birmingham, Birmingham and Solihull Women's Aid receives the MARAC (multi-agency risk assessment conference) referrals from the West Midlands Police and makes contact with women to offer specialist domestic violence support and represents the woman's voice at the MARAC meeting. Birmingham and Solihull Women's Aid received a MARAC referral for the victim on the 2nd November 2012 via fax and although spoke with her by telephone and arranged appointments to see her they had not had a face to face discussion with the victim in spite of follow up and attempts to see her.

Head of Safeguarding	Heart of England NHS Foundation Trust
Superintendent	West Midlands Police
Senior Service Manager Violence Against Women	Birmingham City Council, Equalities, Community Safety and Social Cohesion Service
Designated Nurse Safeguarding Adults and Children & Mental Capacity Act Lead	Solihull Clinical Commissioning Group
Operations Manager	Birmingham & Solihull Women's Aid
Assistant Director - Safeguarding and Quality Assurance	Birmingham City Council Children's Services
Minute taker	Birmingham City Council, Equalities, Community Safety and Social Cohesion Service

11. All of the panel members were independent of any involvement or decision making in regard to the events and people concerned with the circumstances examined by the review.

1.3 Author of the overview report

12. Peter Maddocks is the independent chair and author of this domestic homicide review and was commissioned in January 2013. He has over thirty-five years' experience of social care services, the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and is registered with the Health and Care Professions Council. He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has undertaken agency reviews and provided overview reports to several local safeguarding children boards in England and Wales. In compliance with national guidance he has used the online toolkit and online learning provided by the Home Office. He has also participated in training in relation to serious case reviews including the use of systems learning as developed by Social Care Institute for Excellence in regard to serious case reviews and master class training sponsored by the Department for Education.

1.4 Terms of reference for the review

13. The national guidance describes generic terms of reference that provide a context for the development of more case specific key lines of enquiry and learning that are described.

Recognition

i. What knowledge/information did agencies have that could have identified the possibility of domestic abuse and how did agencies respond to this information. Were there opportunities to seek the views, wishes and feelings of any of the children about their

parents' relationship and any evidence of domestic abuse? What information was sought or provided from within the extended family in regard to any evidence of a risk to Khaista's emotional or physical safety or of her children?

Knowledge about Shab as a perpetrator of domestic abuse and violence

ii. What knowledge/information did agencies have that indicated Shab was a perpetrator of domestic abuse and violence and how did agencies respond to this information?

Services provided

iii. What opportunities and services did agencies offer and provide to meet the needs of Khaista 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 the children were at risk of significant harm or children in need of a service?

The capacity and resources of services

iv. Were there issues in relation to capacity or resources in any single agency that impacted on the ability to provide services to Khaista and her children, Shab or any to other members of either family and also impacted on the agency's ability to work effectively with other agencies?

14. Each of the key lines of enquiry was accompanied by additional prompts for the agencies and their authors to consider when undertaking their agency review. For example, authors were asked to consider whether any information known to their services should have led to a different response and to consider the significant contributory factors that influenced how people made their decisions at the time.

1.5 Summary chronology

15. Khaista had initiated divorce proceedings through the Sharia law in mid-October 2012. A letter dated seven days before Khaista was killed was sent on behalf of the Islamic Judiciary Board to Shab to inform him that Khaista had requested a divorce. This was a significant factor identified during Shab's trial in the final escalation of violence by Shab who it is now known had been abusive and violent in his relationship with his estranged wife from when they had their first child in 2000. There are five children, aged 7 to 14 years of age, who also experienced abuse from Shab, either by witnessing or being subjected to direct assaults.

16. Khaista had first made a disclosure about abuse to the police in September 2008. She described coercive and controlling behaviour by Shab. According to information recorded by children's social care when the police subsequently passed information on to them, she was being 'pressurised' to have sexual relations. The police do not have this detail in their information system. Shab threatened to remove the children from the UK if she left him. A marker was placed on the address in the police information system as being the

home of a victim of domestic violence although no other action was taken other than to pass an information report to children's social care.

17. It was August 2012 when Khaista next contacted the police (or any other service) about the domestic abuse and told the police about the physical violence being perpetrated on herself and her children. The police advised Khaista to seek legal advice regarding a divorce and to seek guidance about what was appropriate child chastisement (this was in regard to the father's physical punishment of the children). The couple separated in late August 2012 although Shab continued to make contact with Khaista either directly or through relatives. The police received three further calls during October 2012 in relation to threats made to Khaista.

18. A non-molestation and occupation order was made in early September 2012 ex-parte (on the sole application of Khaista without the presence of Shab). The order cannot be enforced by the police and the judicial system until it is served in person as described in a specific protocol for process servers published by the Family Justice Council.

19. The orders were not served on Shab and this was significant in how the police responded to at least one of the further reports of violent and threatening behaviour by Shab in 2012. As part of their contact with Khaista and Shab, the police completed DASH (domestic abuse, stalking and harassment) assessments none of which had graded Khaista at more than medium risk. An assessment of high risk would have resulted in a referral to a MARAC (multi-agency risk assessment conference).

20. Seven referrals were made to children's social care between 2006 and September 2012 (although one of those referrals is a duplicate). There was also a joint domestic violence screening assessment that had concluded that the level of risk to the children was at level 4 indicating a highest level of risk. The subsequent social work core assessment concluded that Shab's behaviour was 'inappropriate chastisement'. There were plans to close the involvement of children's social care when the murder took place. Children's social care had concluded that Khaista had taken steps to protect herself and her children.

21. A referral on 2nd November 2012 to Birmingham and Solihull Women's Aid was followed up by an initial telephone risk assessment that recorded the risk of domestic abuse to be high. Khaista did not subsequently attend a scheduled appointment on the 14th November 2012. The 14th had been the earliest time that Khaista could attend. A follow up call was made on the 16th November 2012 but Khaista was not available.

22. Shab had intermittent contact with mental health services since 2004 although the first symptoms of depression had, according to Khaista's statement in support of the non-molestation order, begun in 2000. Although he had experienced depression and some episodic psychotic symptoms, from 2004 this was managed with medication. No depressive or psychotic symptoms had been evident during the routine psychiatric consultations.

23. There was a significant break down in how the non-molestation order was managed after it had been granted in 2012 and this highlights a potentially significant and systemic weakness in giving protection to the victims of domestic abuse.

24. Khaista sought a non-molestation and occupation order under the Family Law Act 1996 Part IV in September 2012[3]. The application included a detailed history of the relationship and of dates of incidents of domestic abuse. This was a private application without advice or support from any agency other than a private law partnership of solicitors.

25. Although Khaista initiated a legal process to secure court protection from Shab, important legal requirements were not complied with to make the orders enforceable. It remains unclear if Khaista fully understood the significance; the result was that having taken action against Shab in a civil court she had not secured the legal protection she was looking for. Several professionals working with Khaista did not know that the orders were unenforceable until the errors were identified after Shab's arrest and overnight detention by the police in October 2012.

26. The court application was made without Shab being present at court (referred to as a 'without notice application' or ex-parte). This order was made on the 6th September 2012 with a requirement for both parties to attend a further court hearing, which is usual practice.

27. The second hearing listed for the 21st September 2012 was so that Shab could attend that hearing once he had been personally served with the papers in order to either contest or to agree to a final order being granted. That hearing was not attended by either party.

28. The solicitor acting for Khaista was required to arrange the serving of the application, the interim court orders and the Notice of Hearing for the 21st September 2012. The solicitor did not have the address for Shab and wrote to Khaista on the 10th September 2012 asking for that information. Khaista responded on the 23rd September 2012 saying that she knew that Shab was living with his sister but that she did not know the address.

29. A letter dated 31st October 2012 from the solicitor to the court states that legal representation would not be provided due to Khaista not providing financial information to the Legal Services Commission (for the administration of legal aid[4]).

30. The same letter confirms that Shab had not been served with papers and requested an adjournment. It therefore seems that neither Khaista nor her solicitor were at court on the 21st September 2012. A further hearing was listed for the 4th January 2013. The solicitor attended court on that date to advise the court that Khaista had died on the 19th November 2012.

[3] The non-molestation order can forbid the respondent from molesting the applicant or a relevant child. Molestation can include, for example, violence, threats, pestering and other forms of harassment. The Court can forbid particular acts of the respondent, molestation in general, or both. The occupation order indicates who can live in the family home and can direct another person to leave the home. The court can make an order initially ex-parte although will set a further date for the respondent and applicant to be in court to allow evidence from both parties before a final order is granted. The police have now been given powers to issue Domestic Violence Prevention Notices (DVPN) that for example can remove a perpetrator from a family home; these were not available at the time of the events examined in this DHR.

[4] Access to publicly funded legal aid is available to victims of domestic abuse subject to means assessment.

31. A letter was sent to Khaista on the 25th September 2012 to confirm that an order had been made; it was not served. The solicitor had made several attempts to contact Khaista for the address where Shab was living but without success.

1.6 Key issues arising from the review

32. The extent to which domestic abuse was a longstanding issue in this 17 year marriage which became clearer after the death of the victim. The initial disclosure occurred four years after the perpetrator had first been diagnosed with depression; the co-existence of mental illness with domestic abuse created additional complexity for the victim who did not talk to other professionals about the abuse. Significantly, the mental health professionals had no information about domestic abuse.

33. The response that a victim receives when making a first disclosure of domestic abuse will be influential in how confident a victim feels about further engagement and securing help. There are many factors that inhibit disclosure and are complicated further when factors such as mental illness and caring for children are considered. Additional inhibitors arising from cultural tradition exacerbated the difficulties facing the victim.

34. In the first contact with the police there appeared to have been disclosures about the control and sexual coercion that the perpetrator was exerting although different detail was recorded by the police and children's social care. On more than one occasion the victim was asked whether the perpetrator physically assaulted her or the children; there was less apparent understanding about inquiring into and evaluating evidence about other forms of abuse. For example there is evidence that the victim was worried about the perpetrator using the children to exercise control; this was not well enough understood at the time.

35. The way that the victim and the perpetrator interacted with professionals at key moments influenced how inquiries and assessments were followed through. For example, incidents when the police officers were summoned did not involve ongoing physical or verbal confrontations.

36. The views, wishes and feelings of the children were absent from the record of inquiries and assessments that were completed. The schools remained largely outside the information sharing and assessment.

37. The influence of organisational factors included implementation of new working arrangements designed to achieve greater efficiencies. The delivery of training and development that relies on e-learning and briefing provided limited exploration and understanding, for example in regard to purpose and application of key aspects of practice in regard to risk identification and assessment.

1.7 Conclusions and lessons to be learnt

38. The domestic homicide review highlights underlying patterns that are identifiable from research and knowledge about the pattern of domestic abuse. The panel have had to resort to using hypothesis for some aspects of the analysis in this case.

39. The key findings in the final chapter of the overview report chapter are framed using a systems based typology developed by Social Care Institute for Excellence (SCIE).

    a) Cognitive influences and bias in processing information and observation about domestic abuse;
    b) Family and professional contact and interactions;
    c) Responses to incidents and information about domestic abuse;
    d) Tools to support professional judgement and decision making in regard to risk;
    e) Management and agency to agency systems to protect victims and manage perpetrators.

Cognitive influence and bias in processing information and observation about domestic abuse:

Understanding that domestic abuse is about coercion and control and implications for processing observation and information about victim and perpetrator behaviour and disclosure; ensuring that language to describe incidents does not minimise abuse including sexual as well as emotional abuse; cultural influence on how domestic abuse is recognised and disclosed; separation/flight to safety when leaving a controlling and coercive relationship creates increased levels of risk for a victim and children risk and implications for risk assessment and management; working cultures that compartmentalise and prevent the bigger picture being seen.

40. The extent to which the victim's presentation as a confident, competent and articulate woman gave no indication that she might be a victim of abuse and appears to have been influential in how enquiries and assessments were completed. She was not regarded as being in need of additional professional help; when she sought advice, for example in regard to separating from the perpetrator or seeking non molestation orders, this was taken as evidence of a woman with the confidence to make appropriate arrangements for herself and for her children.

41. Police officers along with other professionals for example from children's social care, had a difficulty in understanding domestic abuse and the implications for victim behaviour and interaction with them. The victim's reluctance to talk with police officers, her decision to retract her statement of complaint were clearly frustrating; only one of the police officers appeared to know about the policy of taking a retraction statement from a victim although was doubtful it was ever done in a service trying to meet other demands.

42. The initial disclosure in 2008 was not defined and understood as an incident of domestic abuse or alleged sexual offences by the police officers who spoke with the victim. It is because of such cultural and cognitive problems associated with understanding coercive and abusive behaviour that the definitions of what constitutes domestic abuse have been more clearly defined in national guidance and law that now make clear any form of coercion is abuse.

43. Evidence from research and from the work of reviews such as this consistently show that there is a long delay before the victims of domestic abuse and sexual violence seek help. It is for this reason that improving the opportunity to identify potential indicators of abuse and creating the opportunity for adults and children who are living with domestic abuse to speak out is so important. Victims and perpetrators often show an equal reluctance (although for different reasons) to disclose information especially to statutory services such as the police and children's social care.

44. The written record of that first contact uses non-specific language such as 'controlling behaviour' and a 'jealous husband' rather than more specific description about his behaviour and incidents and the impact on the victim and children. In the record of the information held by children's social care there is reference to the perpetrator 'pressurising' the victim to have sexual relations that is not included in the police's original record.

45. West Midlands Police, along with other services, has developed new policies since 2008 although these can be undermined unless their purpose is properly understood and professional staff develop the cognitive understanding about victim and perpetrator behaviour.

46. Professionals who either are offered a disclosure of information or have reason to believe that they may be dealing with the victim of domestic abuse need to have the confidence and sensitivity to ask questions that can help identify the patterns of behaviour that include economic, emotional and physical coercion and assault as well as sexual and psychological attacks.

47. There is reference to the perpetrator threatening to remove the children from the country. Fear of losing her children held the victim back from making disclosures as described in her statements supporting divorce and court orders. The reference to sexual relations without willing consent is not viewed as potential evidence of coercion, sexual assault or rape.

48. The cultural traditions and religious belief of the family and their community is another cognitive factor that had an influence on how the family and professionals were processing information. Reference is made in the overview report about the particular challenges that arise from customs, culture and beliefs within South Asian communities. At its heart is a belief in the family being able to resolve difficulties, in supporting couples to maintain their marriages for the sake of their children and a patriarchal view about the role and status of husbands and has implications for how wives and children should behave.

49. The fact that some professionals shared the same cultural and religious traditions may have discouraged the victim from speaking with them about the abuse that she was suffering in the marriage. For professionals who were not of the same traditions, there was probably an absence of understanding about the significance and influence of such traditions for the victim and how she spoke about her circumstances.

50. The marriage was made under Sharia Law. The divorce proceedings required the couple to attend for counselling and for both parties to put their point of view. The process is based on an important principle of Islamic faith that seeks reconciliation as a first step.

51. Reference is made in the overview report about the research evidence that shows the inappropriateness of mediation and reconciliation in responding to coercion and abusive intimate relationships.

52. An additional aspect to come from this case is the danger of any person believing that when the victim of an abusive partner or spouse leaves the relationship that the danger has diminished. This tragic case along with others that have been the subject of domestic homicide reviews has demonstrated that rather than the danger becoming diminished, it can escalate the severity of risk. The killing of partners at the point of leaving relationships is often a trigger for an escalation of abuse that can result in a fatal assault. It is therefore necessary when conducting assessments to ensure that this enhanced level of risk is recognised and that continuing help is provided to secure the safety of the adult and any dependent children. Unless this is understood there is a bias towards closing professional involvement at the point of greatest threat.

53. The mental health problems that the perpetrator had over the course of several years included a psychotic condition. Untreated psychosis can represent a source of risk to the patient as well as to other people that they for example live with. This risk was recognised in the process of ongoing reviews that took place.

Family and professional contact and interaction

Importance of 'victim less' led assessment, investigation, inquiry and prosecution when dealing with domestic abuse; understanding why adult and child victims of domestic abuse are reluctant to disclose information; understanding that children's behaviour and emotional or physical health can be indicators of living with domestic abuse.

54. Professionals cannot rely on the victims of domestic abuse being able to disclose and then support ongoing inquiry and investigation by the statutory services; the onus has to be on professionals having the capacity to conduct effective enquiries and assessment to have a fuller understanding about the circumstances. The impact of domestic abuse on children can be profound and yet did not feature significantly in the risk assessments. An assertive approach has to be taken throughout in respect of collating evidence and information; the focus has to upon the behaviour of the perpetrator and removing responsibility from the victim from stopping their continued victimisation and preventing future abuse.

55. The victim described in her witness statement for the non-molestation and occupation order how she had thought about leaving her marriage several times but that she was not on speaking terms with her family and that she had felt isolated from any support. In two of the statements made to response police officers she described feeling frightened. No information is recorded about how the children felt.

56. All of the different services, and the police and children's social care in particular, describe how the children did not make disclosures about the abuse that the children were no doubt witnessing on a regular basis or even disclosing the assaults that they suffered.

57. Several of the children presented with health symptoms which appear to have become more acute from 2010 onwards. Two of the children had digestive problems in 2010, another had chest pains in 2012 and another attended an enuresis clinic on one occasion. Many of these presentations were at the hospital emergency department rather than through the GP practice which may or may not be significant. If the children had been more regular attendees at the GP there would have been more regular direct contact with the primary health professionals in a small practice.

58. Some of the children's school attendance also declined and three of the children were involved in arguments at school and showed clear symptoms of distress about their home circumstances. Some of the children had several changes of school in a relatively short period of time and this limited an overview of what might be happening.

59. There is no recorded evidence that in the contact with the children that any professional queried whether there were underlying problems that required discussion and work with other services. One of the head teachers sought clarification regarding the non-molestation order although it was left to the school to make any judgements they thought appropriate.

Responses to incidents and information about domestic abuse

Danger for the victim if professionals deal with incidents of domestic abuse as isolated episodes; having access to relevant historical evidence and intelligence and establishing context for particular incidents; managing the behaviour and threat presented from the perpetrator; investigation and protection strategies that rely on the victims cooperating or giving consent; effectiveness of referral and information sharing at multi-agency panels.

60. Identifying, investigating and recording evidence of domestic abuse is an essential foundation for effective intervention and support being provided to victims and children. It gives improved opportunity to identify for example behaviour that is intended to harass and control.

61. It is a common misapprehension that domestic abuse will be clearly evident and obvious; in truth, domestic abuse often remains hidden and especially if systems and people are passive in their approach to identifying and dealing with it. In this case for example, the majority of contacts with West Midlands Police were not categorised as domestic abuse and this had consequences in how information was recorded and subsequently processed.

62. When further contacts occurred there were no flags to alert response officers to the fact that they were not dealing with an isolated incident. Even if the information had been recorded adequately the case has highlighted potential areas for development in regard to how information is checked and processed.

63. Once a victim has made a disclosure or compelling evidence such as an injury has revealed evidence about the abuse, there is only a short window of opportunity to secure evidence for the purpose of pursuing protection and prosecution and of engaging the victim in an exit strategy from the relationship. The point has already been made that the risk of further and even fatal harm is increased very considerably at the point of separation in the relationship or marriage.

64. Professionals, particularly in the police and social care services with statutory powers and duties to adult the victims and children, need to have a very clear focus on how the perpetrator is managed and prevented from having opportunity to exert control and harm on the victim and any children. This has to take account of how vulnerable the victim parent will be and that in spite of their intent or resolve they may face difficulty in processing or dealing with issues such as legal processes.

65. There needs to be a clear understanding and an anticipation that for the victims to attempt to make an exit from the relationship will require concerted and continuing support to help them maintain their resolve. Ironically, the victims at the point of exiting the relationship may feel even more isolated and especially if it means leaving the home and community that they are familiar with and coincide with dealing with a new group of professionals such as solicitors and courts.

66. Dealing with domestic abuse is about intervening in a cycle of coercion where the perpetrator is endeavouring to exert even greater control especially if they feel under threat of losing control over the victim and can be exacerbated by a sense of lost status or authority.

67. The victim will be afraid of further the victimisation and especially if they are expected to initiate formal proceedings against their abusive partner. The victims may also have great difficulty in being able to help themselves. The emotional and physical demands and the complexity of judicial and professional systems can overwhelm and be confusing. In this case, the process of seeking the non-molestation and occupation order was undermined when the victim had been unable to supply details about where the perpetrator was living. This will not be an uncommon experience.

68. All of the response police officers described how they relied on their control and contact centre staff to update them about any relevant historical information or markers. Most described this as being given to them rather than them making a particular check for example after taking initial statements at the incident.

69. During one ongoing incident involving the police it was unclear who had an overview. The contact centre was supervised by an officer covering two locations and there was a sergeant with 13 constables available for deployment with the sergeant having to directly deal with some of the requests for a police response.

70. Following an arrest individuals are brought to the police station and are transferred to the prisoner management unit who then have responsibility for conducting interviews, making a decision as to whether there is evidence of a crime and liaising with the Crown Prosecution Service.

71. It was evident from this case that there were systemic issues at the time in regard to what information was being recorded on the WC392 and the police electronic portal system which was compounded by police officers being deployed to deal with another incident before returning to process the information which was then used in the handover package to the Public Protection Unit.

72. In this case there was a significant gap in information recorded about an allegation of assault and a knife being used when the perpetrator had been arrested with a reliance on the breach of the non-molestation order. When that was found to be unenforceable the Public Protection Unit was focussed on complying with statutory timelines for detention and the response officers' role had come to an end at the close of shift.

73. Domestic abuse cannot be dealt with as a single agency matter. In this case there was tendency for services and people to work within their own silos and to conduct single agency enquiries. There were also silos within single agencies such as West Midlands Police. The case was never the subject of any multi-agency discussion; although there was a referral to the joint screening panel it was not discussed because of current involvement by children's social care. The referral to MARAC was not made. No multi-agency assessment was completed.

74. The issue of the wrongly served court order and the decision to release the perpetrator lost sight of the threat that he represented especially knowing that the police were not in a position to enforce the order. The decision to down grade the threat level because he was in custody also took no account of the real nature of the perpetrator's threat through his need to control the victim. There are new powers available to the police through the use of Domestic Violence Prevention Notices that could now be used to provide an immediate element of control.

75. The assessment by children's social care did not seek explicit evidence about the children's worries, wishes and feelings in regard to their circumstances.

76. The children's presentation of behaviour for example in school or with ailments in hospital emergency or clinical settings did not include any record of exploring the family circumstances and history to identify causes for their symptoms.

77. The effectiveness of multi-agency panels to oversee information and develop risk assessment was undermined. There was confusion whether the case had been referred to MARAC and arose through the use of a common referral form (as well as apparently an erroneous reference to a referral being intended). When the case was discussed at a screening panel there was a significant delay in information being placed on the agency recording system of children's social care and no communication between the agency representative and the practitioner directly involved with the victim and her children. The implementation of the multi-agency safeguarding hub (MASH) provides a quicker opportunity for information sharing than existed in 2012.

Tools to support professional judgement and practice in regard to risk

The availability and use of different risk assessment frameworks; clarity and understanding about the respective multi-agency risk assessment meetings;

78. Four different assessment tools were used; the DASH, the Domestic Violence Risk Identification Matrix the national assessment for children in need and their families and finally the assessment by Birmingham and Solihull Women's Aid (which was developed with the police DASH model). None of these were apparently completed as a multi-agency process and there were differences in the conclusions that were made in regard to the risk to the victim that range from standard through to high risk.

79. Under current West Midlands Police operating principles, the only multi-agency risk assessment in use currently is the joint screening between police, children's social care and health using Barnardo's joint screening tool. West Midlands Police assess risk by using the National Decision Making Model[5] in conjunction with DASH.

80. The referral that was sent to Birmingham and Solihull Women's Aid by the police shortly before the murder caused confusion; the same form that is used for seeking support from

[5] https://www.app.college.police.uk/app-content/national-decision-model/the-national-decision-model/

Birmingham and Solihull Women's Aid was the same as the one used for the highest risk victims who would be referred to the MARAC. Matters were further complicated when the police officer completing the form had begun completing the MARAC section 'out of habit'. An assumption was made in Birmingham and Solihull Women's Aid that this was a case that would be referred to MARAC which in fact was not the case on the basis of the risk assessment that had been completed by West Midlands Police.

81. The approach to assessment by both the police and children's social care revealed a focus on the immediate incident or events and showed very little curiosity. For example, both services were told about the non-molestation order but made little progress in collating an adequate history of evidence. The extent to which individual professionals have sufficient understanding about the purpose of particular tools or systems combined with heavy workloads created conditions that were not conducive to more sceptical and curious inquiries.

82. West Midlands Police had introduced new systems for recording risk and evidence that had contributed some confusion for example in regard to the completion of DASH and non-crime recording.

83. The consistency of recording and access to historical information is also a factor in how police officers and other professionals make their judgments. Many of the police officers who came into contact with the victim were not aware of the previous contact.

84. The police responding to incidents relied on being provided with relevant information by their control; there is a high reliance on what is contained in the Police National Computer although it is clear that there are other systems such as OASIS and FLINTS that are not routinely checked unless, and until, more detailed inquiries are required. The officers did not complete historic checks and this was in breach of West Midlands Police policy.

85. Response officers are not able to access systems directly except when in police stations (they have no personal or vehicle based data access) although when they do their own checks some of them appear to prefer using the local intelligence FLINTS system because it is easier to use.

86. Although there is reference to discussion at a multi-agency screening meeting there is no record of this anywhere than in the recording of West Midlands Police. It appears that because children's social care were already involved it was referred onto children's social care without any detailed multi-agency discussion or decision making. According to one of the individual management reviews the panel does not discuss cases that are already open to children's social care.

87. The establishment of the Multi-agency Safeguarding Hub in Birmingham will provide opportunity for improved and more efficient joint agency collating of information and managing enquiries and assessment.

Management and agency to agency systems

Complexity and lack of co-ordination across different organisational and professional silos dealing with civil protection; adequacy of local systems for alerting the police to non-molestation orders; reliance on e-learning and operational briefing; dangers of working cultures that are focussed on dealing with immediate need or threat and crisis management; capacity and co-ordination of local risk assessment systems; training and awareness raising in schools and education settings; engagement between solicitors and local professional safeguarding systems and networks; promoting links and understanding with local religious leaders in advice and support during divorce proceeding involving domestic abuse; developing understanding about cultural and religious traditions and their relationship with domestic abuse;

88. Several issues are highlighted by this case in regard to the arrangements for the administration and enforcing civil legal orders to protect victims. The importance of victims having access to legal advice and being able to secure legal protection is recognised in the revised arrangements for legal aid. From April 2013, the scope of services covered by legal aid were reduced significantly and legal aid support was withdrawn for the most frequently seen family disputes in courts. Legal aid funding has been limited to cases involving issues of domestic abuse or violence. Emergency legal aid remains available if the victim requires an immediate application for non-molestation or occupation orders.

89. In Birmingham there is no single point of oversight in respect of applications for civil orders such as non-molestation and occupation orders. There appear to be at least four routes by which a person harmed by domestic abuse can apply for a civil order. Not all of the routes are widely known either to professionals or to the general public. There are also issues in regard to ensuring that orders are administered correctly and no single point of oversight.

90. In December 2013 West Midlands Police policy changed in respect of the recording of non-molestation orders. The new policy tried to achieve engagement from the various county courts around the West Midlands area although with limited success. There appears to be a significant knowledge gap for victims obtaining the non-molestation order and what to do next. It has been suggested that a nationally produced leaflet explaining what the order means and that it must be served otherwise it gives a victim a false sense of security. This would need to be produced in a range of languages and for the courts to ensure it was promoted at the point of an order being made.

91. Once the orders are received within West Midlands Police (along with the certificate of service), a non-crime is generated which is categorised as a medium risk domestic abuse incident due to the reason behind obtaining a non-molestation order. The actual order is scanned so that it can be retrieved at any point. A marker is placed on the Police National Computer for the subject of the order and a domestic abuse safeguarding officer will make contact with the victim.

92. The provision of legal advice and representation to the victim in respect of the application for non-molestation and occupation order was through a private legal practice. As part of the routine matrimonial checklist the solicitor would have been aware of Children's Social Care being involved with the victim and her children. When the solicitor faced difficulties in

the victim providing information to secure the legal aid, and the serving of the court orders and notices, there could have been an opportunity for discussion about the lack of protection that was being achieved for the victim and for the children. There also may have been opportunity for coordinating a plan to have the papers served at a police station if children's social care and the police had been made aware of the problems with serving the orders.

93. When West Midlands Police are informed of a non-molestation order it is entered on to the Police National Computer and is the expected practice across England and Wales. The police rely on being told about an order to enforce it if required to; this is an essential element of the protection.

94. The importance of knowing about an order and having evidence that it has been served is illustrated by this case. Of the non-molestation orders that are notified to West Midlands Police (and presumably to other police services) it is not always the case that evidence of service on the co-respondent has been achieved.

95. One of the specialist sergeants has drawn attention to the recommended best practice set out in the national protocol for process servers that they should complete a statement of service under oath or affirmation so that it can be relied upon in any subsequent civil or criminal proceedings[6].

96. When the problems with serving the order had been revealed, there could have been an opportunity for the order to have been served subject to agreement and availability of a process server. This requires police officers having the knowledge and capacity to take that additional step rather than as in this case simply deciding there was no further action to be taken.

97. A significant contributory factor appears to have been the high reliance on e-learning and shift briefing to achieve sufficient understanding about relevant policy and procedural developments relevant to domestic abuse. In some services such as schools there was very little evidence of training and development in relation to domestic abuse and this had implications for how some of the contact and information was managed.

98. Unless professionals have a good understanding about what domestic abuse is and the implications for victim and perpetrator attitudes and behaviour they will treat risk assessment tools and other aspects of policy as primarily a compliance issue. The manner and method of allocating resources to incidents is also influenced by the level of understanding of both police civilian staff as much as warranted police officers.

99. Two particular incidents highlight this; firstly the lack of response to the victim withdrawing her statement of complaint after the perpetrator was in custody.

100. The importance of anticipating and understanding why victims will be reluctant to make statements and may seek to withdraw and influence decision making is critical to crime

[6] *Protocol for process servers: non-molestation orders*; Domestic Abuse Committee of the Family Justice Council; November 2011.

detection and victim protection. Some officers felt that such a policy might be good in principle but will take a lower priority in completion with more urgent calls for police help.

101. The second relates to how the issue of the non-molestation order was managed. There was no pause to consider that in spite of the problems with the order, the fact that an order had been granted was real evidence of domestic abuse and threat. Detecting and preventing crime and protecting victims should be a core purpose for the police and be supported from other services.

102. The individual management review on behalf of the Education Service has highlighted strategic issues in regard to learning and improvement for identifying and supporting children living in households where there is domestic abuse.

103. The first concerns the level of training and awareness that teaching and support staff in school are receiving across the city that can help them identify potential signs and symptoms that a child may be exhibiting but has not explicitly disclosed any evidence of domestic abuse. The Birmingham Community Safety Partnership have a strategic commitment to training being made available to the Designated Senior Person for safeguarding and teaching staff although this case has identified that some schools have not updated training for their staff in regard to domestic abuse. Four of the five schools had already committed themselves to implementing this training.

104. Of some concern, one school that is not part of the local education provision was unable to identify any learning or opportunities for improvement in spite of having been in possession of information that indicated there was potentially domestic abuse in the household. The local education service has no authority or remit in relation to this school.

105. The administration of the divorce application through the Sharia legal system is entirely separate to any other local or national systems. This case has highlighted a potential source of heightened risk for women seeking to leave a marriage where domestic abuse is the reason for the application where the emphasis is on reconciliation as a first step.

106. The case has highlighted the additional complexity that strong cultural or religious traditions can represent in identifying and supporting adult the victims and children of domestic abuse to disclose information or access and accept help when women are expected to comply with cultural and religious practices and to follow the traditions of their family or community in order to be accepted into society. Culture and religion can be used as a means to control the behaviour of women and to keep them disciplined. There is such a fine line between religion and culture that it can be hard for an individual to distinguish between the two.

1.8 Recommendations

Recommendation 1

The Community Safety Partnership should review the effectiveness of communication strategies to promote awareness about domestic abuse and sources of advice across the different cultural and religious communities in the city and the extent to which they are represented in strategic partnerships.

Recommendation 2

The Community Safety Partnership should satisfy itself that all Birmingham services featured within this review have clear working definitions and policy supported by robust audit about what constitutes domestic abuse and have arrangements in place for promoting and monitoring participation in training and development. This should take account of action taken in response to a previous review (DHR2012/13-04).

Recommendation 3

The Community Safety Partnership should seek further information from the local law society as to whether accessing legal aid by victims of domestic abuse is a barrier to using civil proceedings to restrain perpetrators of domestic abuse.

Recommendation 4

The Community Safety Partnership should ensure that further discussion takes place with local courts in regard to the learning regarding the application for and processing of court orders designed to protect victims of domestic abuse.

Recommendation 5

The Community Safety Partnership should receive further information regarding the circumstances and effectiveness of local risk assessment tools and frameworks to identify risk and are able to provide effective multi-agency intervention and protection. The review should determine whether these need to be simplified into one risk assessment model.

Recommendation 6

Training for key individuals, in certain organisations, in how to use a *Risk Identification Checklist* must be in place, so that professionals can recognise high risk characteristics such as separation, training should include how to develop a robust safety plan for vicitms who are intending to have left an abusive relationship

Recommendation 7

The Community Safety Partnership should consult with the Birmingham Safeguarding Children Board about any additional contact and action that is required in regard to any schools that are independent of the local education service where there may be concerns about the policy and professional development in regard to safeguarding that includes domestic abuse.

Recommendation 8

The Community Safety Partnership should ensure that information is provided on the outcome of discussions with the local faith leaders with a view to facilitation and support of further guidance and professional support in regard to divorce or separation involving domestic abuse.

Recommendation 9

The Community Safety Partnership should initiate discussion with the local Law Society about the best approach and strategy to developing closer links between solicitors and local professional safeguarding networks to improve communication and oversight of

arrangements for the administration and enforcement of civil orders providing protection to victims of domestic abuse.

Issues for national policy

107. There is currently no professional or practice guidance for solicitors providing legal advice and representation to victims of domestic violence over and above the family law accreditation scheme that establishes minimum standards for accreditation and for continued professional development. Working knowledge about local safeguarding systems and professional relationships and cultural understanding being included in the core knowledge along with guidance could promote greater protection for victims of domestic abuse.

108. The Home Office may wish to initiate discussion with the Law Society about an agreed set of standards for practice and procedure in relation to non-molestation and other legal injunctions designed to protect victims of domestic abuse and whether these should be codified within the risk assessment framework and the national family law accreditation scheme for lawyers acting in domestic violence cases.

109. The issues highlighted in regard to the procedure for divorce under Sharia law in cases involving domestic abuse will extend across the UK and invites consideration of developing national guidance in consultation with national and local religious leaders of all faiths.

The development of Independent and Free Schools in the city are outside the system of local professional support and oversight in regard to arrangements for safeguarding children. One of the schools that is from that sector was unable to recognise any learning in regard to designating a senior lead professional for safeguarding or ensuring training and development is provided for teaching and support staff.

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Appendix 1 Details of the organisations contacted and scoped for the review

Individual Management reviews were received from

Birmingham City Council Children's Social Care
Birmingham and Solihull Mental Health Foundation NHS Trust
Birmingham Community Healthcare Trust
Birmingham Cross City Clinical Commissioning Group
Birmingham City Council School Improvement and Settings
Birmingham South Central Clinical Commissioning Group
Heart of England NHS Foundation Trust
West Midlands Police

Information Reports were received from

Birmingham City Council Neighbourhood Advice and Information Service
Birmingham City Council Revenues and Benefits Service
Birmingham and Solihull Women's Aid
Solicitor's Firm
West Midlands Ambulance Service
Schools for all five children
NHS Walk In Centre
Birmingham City Council Legal Services
- Birmingham Children's Hospital

Agencies providing a nil return to scoping

Staffordshire and West Midlands Probation Trust
Birmingham City Council Adult Social Care
Birmingham City Council Homeless and Pre-Tenancy Service
Birmingham Children's Hospital
Birmingham Women's Hospital
Sandwell and West Birmingham Hospital
University Hospital Birmingham
Royal Orthopaedic Hospital
Ashram
Allens Croft Centre
Anawim
Gilgal
Jan Foundation
Ladywood Project
Rape & Sexual Violence Project
The Salvation Army
WAITS (Women Acting in Today's Society)
Star Support (Support Time and Recovery Service)
Shelter
Freshwinds
Aquarius
Birmingham MIND