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

BDHR2013/14-03

Report produced by Peter Maddocks
Independent Chair and Author

November 2017

1. Summary of the circumstances and processes of the review

1. This domestic homicide review concerns the murder in June 2013 of a 27 year old woman (the victim) by her 37 year old estranged husband (the perpetrator) at her home in Birmingham. She died as a result of strangulation.

2. The police were initially contacted by a family friend (Adult 6) to report that the victim had not collected her two children from school the previous afternoon. The children were at Adult 6's address together with the perpetrator who had collected them. Later in the evening there was a further call to the police from the victim's aunt (Adult 3) to report that she was missing and that she feared for her niece's safety. Seven hours later in the early hours of the 14th June 2013 the police forced an entry to the victim's property and discovered her body.

3. A police investigation resulted in the perpetrator being charged with murder for which he was convicted and sentenced to life imprisonment with a requirement to serve a minimum of 15 years.

4. The Birmingham Community Safety Partnership was notified of the victim's death on 19th June 2013. On 28th June 2013 the Domestic Homicide Review Steering Group reviewed the circumstances of this case against the criteria set out in the *Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews* and recommended to the chair of Birmingham Community Safety Partnership that a domestic homicide review should be commissioned.

5. The chair of the Community Safety Partnership ratified the decision on the 19th July 2013 and the Home Office was notified the same day with an initial target of completion in January 2014.

6. The period of the review was from May 2008 when the victim made the first disclosure of domestic abuse to the police until June 2013 when the victim was murdered. All agencies were asked to check their records from the date of the pregnancy with Child 1; this decision was informed by research evidence that pregnancy and child birth can be triggers for domestic abuse.

7. This domestic homicide review was completed using the methodology and requirements set out in government national guidance that applied at the time of the review being commissioned and completed[1].

[1] The guidance was refreshed and reissued in June 2013 to apply to domestic homicide reviews notified after the 1st August 2013.

8. Terms of reference guided the conduct of the domestic homicide review and covered the recognition and understanding about domestic abuse, knowledge about the perpetrator's abuse and violence, the services provided and the capacity of local services.

a) What knowledge/information did agencies have that indicated the subject might be a victim and how did they 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 the victim's emotional or physical safety or of her children?

b) What knowledge/information did agencies have that indicated the subject might be a victim and how did they 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 the victim's emotional or physical safety or of her children?

c) What knowledge/information did agencies have that indicated the subject's husband was a perpetrator of domestic violence and how did agencies respond to this information.

d) What opportunities and services did agencies offer and provide to meet the needs of the victim 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?

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

9. A review panel was convened of senior and specialist agency representatives to oversee the conduct of the review. The panel agreed case specific terms of reference that provided the key lines of enquiry for the review and were additional to the terms of reference described in national guidance.

10. National guidance issued by the Home Office provides discretion to the Community Safety Partnership about whether to postpone the domestic homicide review until a criminal prosecution has been completed.

11. In this case, the Community Safety Partnership decided to proceed with the domestic homicide review in order to identify any learning as quickly as possible but postponed completion of the review and publication of the domestic homicide review overview report until an outcome was known in regard to the criminal process and of the investigation by the Independent Police Complaints Commission (IPCC).

12. The referral to the IPCC followed an initial internal review by the West Midlands Police of the police contact with the victim and the perpetrator prior to the murder. That investigation is separate to the domestic homicide review and to any of the other processes associated with this case. The domestic homicide review was granted interested party status which facilitated liaison between the IPCC and the domestic homicide review. The police individual management review author was unable to speak with several officers who had contact with the victim and the perpetrator. This limited the scope of analytical discussion regarding some aspects of the police involvement[2].

13. The domestic homicide review panel met on five occasions between January 2014 and September 2014. The initial chronology of services involvement was completed by January 2014. The first draft of the agency reviews were completed in March 2014.

Role or position	Agency
Lead Nurse Complex Mental Health Joint Commissioning	Mental Health Joint Commissioning
Associate Director of Safeguarding	Birmingham Community Health Care Trust (BCHCT)
Practice Director at a medical practice	Birmingham South Central Commissioning Group (CCG)
Head of Safeguarding	Heart of England NHS Foundation Trust

[2] The IPCC oversees the police complaints system in England and Wales and sets the standards by which the police should handle complaints. It is independent, making its decisions entirely independently of the police and government. It is not part of the police. The IPCC may decide to investigate cases referred to it either by the police or by a third party independently, manage or supervise the police force's investigation, or return it for local investigation. The investigations can result in disciplinary action against officers.

Detective Chief Inspector	West Midlands Police
Senior Service Manager Violence Against Women	Birmingham City Council, Equalities, Community Safety and Social Cohesion Service
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

14. A family liaison officer was the first point of contact with the victim's family who had delivered a letter from the chair of the panel. A letter was delivered to the victim's mother, uncle and aunt advising them of the domestic homicide review, offering information about sources of support and advocacy and offering them an opportunity to meet with the chair and author for the domestic homicide review. The letter also invited contact or information by other means such as post or email.

15. The family were also given information about sources of additional information and support that included Advocacy After Fatal Domestic Abuse.

16. None of the family responded to the contact which was subsequently followed up. The family were offered further contact to discuss the report and the findings of the domestic homicide review.

17. Forty-five agencies were contacted at the start of the domestic homicide review and asked for any information about contact or involvement with either the victim or the perpetrator.

18. Five organisations who had significant contact or knowledge of either the victim or the perpetrator participated in the review providing a chronological and analytical account of their contact in an individual management review and were:

    a) Birmingham NHS Clinical Commissioning Group in respect of GP practice that provided general medical services to the family;

b) Birmingham Community Health Care Trust (provided school nursing dental health services and one enuresis clinic appointment)

c) Birmingham City Council Neighbourhood Advice and Information Service (provided advice and information to the victim and the perpetrator between 2010 and May 2013 in regard to housing and council tax and other benefits before and after the separation)

d) Heart of England NHS Foundation Trust; in the main limited to provision of maternity services to the victim, between December 2005 and September 2008;

e) West Midlands Police (the individual management review was subject of some delay due to the referral to and subsequent investigation by the Independent Police Complaints Commission (IPCC) of how aspects of the police response to the victim and the perpetrator was managed in 2012).

19. Information was also received from the regional ambulance service[3], the schools attended by the children (that led to commissioning an individual management review from the education service) and the early years' service (a children's centre).

20. The perpetrator had first moved to the UK in 1998 before returning to Bangladesh for an arranged marriage to the victim in 2004 or 2005. After the marriage the perpetrator returned to the UK while the victim remained in Bangladesh until she came to the UK in October 2005 on a two year spouse visa sponsored by the perpetrator; she attained indefinite leave to remain in the UK in October 2007. Neither the victim nor the perpetrator had English as their first language.

21. The perpetrator worked as a chef; the victim was never in paid employment. There is no evidence of mental illness, substance misuse or disability in regard to either adult. They had two children who attended the same primary school at the time of the murder.

22. The first record of domestic abuse was by the police in May 2008 when the victim was six months pregnant with Child 2 and Child 1 was just over two years old. The victim reported being assaulted and dragged by the hair by the perpetrator and that the perpetrator had tried to take her passport. She also asked for help to deal with 'financial pressures' although these are not detailed in the record of the contact. It is now thought that this may refer to the perpetrator demanding money from the victim's account and there was also a dispute over a loan to purchase property in Bangladesh that was not

disclosed at the time. A referral was made to children's social care services; no further action was taken by either service.

23. In June 2012 the victim contacted the police to say that she was being prevented from leaving the perpetrator who was also 'withholding money'. It is known from the police criminal investigation into the murder that the perpetrator had made several threats to the victim although none of the information including reports of bruises being observed by relatives was disclosed to the police. The victim's mother had talked with her about her concerns although told the police that the victim did not believe that her life was in danger. According to a record in children's social care the victim and perpetrator had separated in November 2012 although the source of the information is unknown.

24. The police were told by the victim in February 2013 that there was a threat to her life from the perpetrator who was at the time visiting Bangladesh. She told the police that she was separated from the perpetrator. The fact that the perpetrator was not in the country led the police and children's social care to take no further action in the absence of an immediate threat being carried out.

25. The next contact with the police was in June 2013 when the victim was reported as missing after she failed to collect her children from school. It was several hours later when a police officer made a visit to the victim's home that her body was found.

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

1.1 Key issues arising from the review

26. The extent of the domestic abuse was not known by any of the services until after the victim was murdered. Research and domestic homicide reviews demonstrate that the first disclosure is likely to only occur after several incidents. National guidance emphasises that coercion and control in all its forms constitutes abuse.

27. The significant themes that are identified from the agency information include the cognitive and cultural influences that can be powerful barriers to victims making a disclosure of domestic abuse; the importance of identifying particularly vulnerable and socially isolated women; recognition of domestic abuse as being about control, coercion and power over a victim and not rely on physical indicators of harm or allegations of assault; the importance of checking for previous relevant history to evaluate the significance of an individual piece of information or incident; anticipating the escalation or enhanced levels of risk that are associated for example with disclosure of abuse or separation from an abusive and coercive relationship. There are specific issues for the police in regard to how missing person's protocols and risk assessments were applied that were the subject of the IPCC investigation. Key issues from the review are;

    a) The disclosure of domestic abuse is fraught for victims and their children; it is frequently only made after several repeated episodes have occurred; in this case the victim did not receive an effective response to her first disclosure in May 2008 and it was almost four years before she felt able to try to get help again; she did not tell the midwife about her report to the police when asked visited less than a week later; the evidence of emotional, financial and other control and coercion were not sufficiently inquired into; there was a pre-occupation as to whether physical threats or assault were imminent;

    b) Coming from a different cultural tradition and being isolated by lack of language were significant barriers in communication particularly for the victim; this has significance for contact with services that include primary health care, early years and advice services;

    c) Social isolation and high dependence on a spouse are the latent conditions for exerting control; lack of employment or social contacts outside of the immediate

family can contribute to isolation from potential sources of advice and support; the victim came to the UK on a spouse visa which made her very dependent on the perpetrator in being able to remain in the UK;

d) The perpetrator took control of all money in the household; indicators of neglect in regard to the health of the children and victim were not seen as symptomatic of abuse; this may have reflected the fact that the family lived in a materially deprived part of the city and the challenge of distinguishing between poverty and neglect;

e) Relatives and friends had concerns about the victim especially in 2012 although those concerns were not shared with any professional and may have reflected a lack of confidence in what would happen; when relatives expressed concern about the victim not collecting her children there was a delay in following protocols designed to assess risk; the history of previous contact, the fact that the victim not collecting the children was so out of character and the concern of the relative were not given sufficient attention and inference;

f) Domestic abuse is frequently a pattern of behaviour that is repeated and escalates in severity; victims and relatives may minimise the risk for a number of reasons;

g) Identifying and defining domestic abuse from the outset is a vital foundation for developing appropriate strategies to work with adult the victims and children; recognising, defining and recording any information or evidence about domestic abuse is vital; it requires sufficient awareness of research and best practice to inform the encouragement of disclosure, detection, investigation and assessment;

h) Children living with domestic abuse often do not disclose explicit information although their emotional and psychological well-being and their behaviour will be detrimentally influenced;

i) Training of some professionals relied on e-learning and shift briefing; the extent to which early years and education settings provided sufficient training and development in regard to domestic abuse has been raised and is being addressed.

28. The remainder of this chapter summarises key evidence relating to the terms of reference established for the review.

Conclusions and recommendations

29. 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.

30. The key findings in this chapter are framed using a systems based typology developed by SCIE (Social Care Institute for Excellence). Although the SCIE methodology has been developed specifically for serious case reviews rather than domestic homicide reviews and this review has not used systems learning to collate evidence there is value in using the following framework to identify some of the underlying patterns that appear to be significant for local practice.[4]

    a) Cognitive influence and bias in processing information and observation;
    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.

31. In providing the analysis and recommendations to the Community Safety Partnership there is an expectation that the Community Safety Partnership will want to provide a response to each of the key findings as well as to the recommendations and action plans that are described in the individual management reviews.

32. The Community Safety Partnership will determine how this is managed and communicated to the relevant stakeholders.

33. The IPCC investigation has resulted in recommendations being made to the West Midlands Police to address improvement in regard to training of police following changes in policy, reviews of the missing person's policy and training on risk factors, call handling, the

use of interpreters and use of police cautions in regard to domestic abuse. This review endorses those recommendations.

1.2 Cognitive influence and bias in processing information and observation:

Victim behaviour; invisibility of emotional coercion and control; recognition of neglect in communities with high levels of deprivation;

34. In this case, there were a number of factors that influenced the processing of information. The single most significant factor was that apart from the incident in May 2008 nobody understood that the victim was being abused and indicators of neglect were not recognised.

35. Some of this might be a process of normalisation in the context of working in areas where there are high concentrations of need. The family lived in an area that is located within one of the ten per cent most deprived districts nationally. This context is significant. The nature of need within the family that was presented was not regarded as exceptional particularly it seems within the local culture and social circumstances of other families where factors such as dental caries are not uncommon.

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[4] SCIE identify five domains of which two have been used for this domestic homicide review; the domains are innate human biases (cognitive[4] and emotional), family and professional interactions, responses to incidents, tools and management systems

This is something that individual professionals largely have to resolve on a case by case basis in circumstances where all the services are under very significant pressure.

36. The approach to the three attempts by the victim to get help in regard to the domestic abuse was flawed. This reflected people departing from the expected procedures and standards; an underlying reason was a cognitive inability to understand domestic abuse and the impact it has on victims and their behaviour (combined with a lack of knowledge on the part of some about important policy requirements). The overwhelming mind-set was to look for evidence of physical and immediate threat rather than understanding the coercion and effort to control by threats.

37. Professionals who either receive 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. This has implications for how the risk assessment schedules are applied.

38. 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 or the spouse or partner is outside of the country that the danger has diminished. This tragic case has demonstrated that rather than the danger becoming diminished, it can escalate the severity of risk. The killing of partners at the point of threatening or actually leaving relationships is a trigger for heightened threat. 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 that is the mind-set that is applied, there will be a high reliance on the more superficial immediate observation as to whether victims and children are 'safe and well'.

39. Given the barriers to disclosure, it is even more important to create the best opportunity for responding effectively. For example, when the victim asked the school to prevent the perpetrator from collecting the children from the school there was a focus on the legal limitations on the school of being able to do this but not enough as to the reasons and circumstances. Places like schools and health clinics can be gateways to help for victims.

Recommendation 1

The Community Safety Partnership should consider whether policy and practice guidance in relation to inquiry and assessment relating to domestic abuse gives sufficient attention to professional mind-set and victim behaviour.

1.3 Family and professional contact and interactions;

Ensuring that professional contact does not escalate risk; clarity of communication especially when language or a disability may be a factor; influence of victim behaviour and demeanour; inference given to information from non-professional sources; importance of universal and open access services to help victims overcome social isolation.

40. The point has been made about the escalation in threat when a victim shows an intent to leave an abusive relationship. In any contact between a victim and any professional when a concern or direct disclosure is made about domestic abuse it is vital that it does not lead to the victim being exposed to greater risk. It is the reason for example that midwifery and health visiting staff routinely ask about domestic abuse but do it when a private opportunity arises.

41. A significant issue for most of the services was the fact that English was not the victim's first language. This impeded communication between her and various professionals. It is not apparent that the significance was understood by professionals at the time.

42. All of the services have confirmed that they have access to interpreter services although have not been able to explain why these were not consistently used.

43. The victim was socially isolated. This made her even more reliant on her husband and family. The importance of open access services such as children's centres are well recognised and is the reason for contact being made with the mothers of very young children. In this case a routine contact was undertaken although the victim did not take up any offers of service. The visit was undertaken by a 'bank' member of staff who may have had less personal investment in engaging the family. It is not clear that this contact was used as an opportunity to proactively look for indicators of vulnerability (social isolation, no friends or close family, limited language, not in work and limited income).

44. Although it is acknowledged that individuals have a right to privacy, given the known inhibitors that can discourage take up of support, the case invites some reflection as to whether the offer and delivery of these types of universal provision are being appropriately assertive and proactive in reaching out and encouraging engagement and involvement with services such as children's centres. This can be an important element of giving victims a trusted pathway to advice and help. Primary health workers such as health visitors and GPs can also be an important source of encouragement as well as identifying indicators of vulnerability. Reference for example has been made to the shoe bite that in hindsight could have been more clearly seen as something more than just self-neglect by the victim.

45. None of the professional contacts record any detail about physical conditions in the home although much of the family income appeared to be diverted to relatives in Bangladesh.

46. This is not the first domestic homicide review where evidence from family members reveals that they had concerns about the victim prior to the death. It has not been possible to speak with any of them and therefore it remains unknown what sources of help they were aware of for the victim.

47. On the day of the murder the first contact with the police was from a relative who was concerned that the victim had not collected her children from the school. The IPCC investigation and the police individual management review have both commented that in that initial call a significant volume of information was provided and the relative made clear they were concerned. The decision to seek further information for the purpose of the risk assessment questionnaire showed more of a preoccupation with process rather than recognising the significance of information that had already been acquired.

48. The IPCC and police individual management review have made recommendations in regard to how procedures in regard to missing persons are applied. The message for multi-agency learning is that with hindsight not enough inference was given to the level of concern being expressed. It was not the only occasion. It happened in contact with the police; it happened when the victim expressed concerns about the perpetrator at school. It is not just about applying protocols or procedures but also understanding their purpose.

1.4 Responses to incidents and information;

Ensuring that enquiries and assessment are based on rigorous assessment of risk to the victim and children; signposting to advice and help;

49. Domestic abuse is a generic term describing a range of controlling and coercive behaviours which are used by one person to establish and maintain control over another person with whom they have, or have had, an intimate or family relationship. It is the cumulative and interlinking physical, psychological, sexual, emotional and financial abuse that has such profound and damaging impact on the victim including their children. It erodes self-confidence and identity and isolates the victim from potential sources of help and support. Treating domestic abuse as isolated incidents fails to reveal the underlying dynamic of coercion and control.

50. Victims often want to prevent the police arresting a perpetrator with whom they have or had an intimate relationship. This should be anticipated and is not a reason for not treating a call as a potential crime and subjecting it to an appropriate level of forensic and investigative enquiry. Perpetrators should not be allowed to influence the investigation and must not be allowed to minimise the attitude, behaviour and overall conduct of investigation and enquiries. A consistent reinforcement of the message that the behaviour is unacceptable irrespective of race, culture or religion is essential and that victims are informed and encouraged to use specialist services.

51. Domestic abuse that involves families or households where children live or stay on a regular basis needs to be investigated not only as a potential crime but also regarded as a safeguarding issue that involves specialist police officers and children's social care.

52. The victim does not seem to have been advised to seek legal advice over and above going to the Citizen's Advice Bureau (CAB). There is no record of her making contact with the CAB. The overview report discusses in some detail the shortcomings in regard to the investigation of threats to kill. In addition to the criminal and public law frameworks that are available to help victims of domestic abuse there are private law remedies available to help victims prevent harassment and control contact from the perpetrator. Access to legal aid and to specialist lawyers should form part of the array of response available to victims of domestic abuse and their children.

Recommendation 2

The Community Safety Partnership should review the effectiveness of strategies for communicating and signposting victims of domestic abuse to specialist advice and support to respond to victims and children who have experienced domestic abuse.

1.5 Tools to support professional judgment and practice in relation to risk;

The purpose and application of risk assessment and referral pathways;

53. The application of the risk assessment frameworks did not achieve a good enough enquiry into the circumstances and background to the incidents of domestic abuse. History in regard to previous contacts was not checked leading to each incident being assessed in isolation and entirely reliant on the observations of police officers primarily.

54. Rather than being a procedure of facilitating clearer disclosure and exploration of background and underlying patterns the approach appeared to be more administrative and compliance with the letter rather than the ethos of the frameworks.

55. There was apparent confusion in the referrals that went to other services. The Heart of England NHS Foundation Trust is clear that they received a DARIN that was indicating medium risk involving a pregnant woman who already had a two year old child. They acknowledge that they did not act on that information. Children's social care make no reference to the DARIN although were aware of a report of domestic abuse involving a pregnant mother of a two year old child.

56. The establishment of the MASH (multi- agency safeguarding hub) in Birmingham is intended to provide opportunity for improved and a more efficient joint agency collation of information and managing enquiries and assessment.

57. Information provided to the police during the murder inquiry indicates that there had been long term concern and knowledge about the perpetrator's attitude and care of his family. Although much of the contact with services was outside of the family home there were visits made as part of routines associated with health care following the birth of the children and outreach through the children's centre as well as visits by the place in response to the emergency calls.

58. None of those contacts recorded any concern about physical conditions in the home although much of the family income appeared to have been diverted to relatives in Bangladesh. The information about dental caries attracted little attention as an indicator of neglect.

59. Birmingham Safeguarding Children Board (BSCB) will receive a copy of this report. The BSCB in collaboration with NSPCC have launched a campaign to help children to be protected from neglect. This report draws attention to the role of dental practitioners and services in helping identify potential adult and child victims of abuse and neglect.

Recommendation 3

The Community Safety Partnership should ensure that information is submitted on the implementation of the action plan submitted to the domestic homicide review by the early years and education services.

Recommendation 4

The Community Safety Partnership should ensure that revisions to the S11 and S175 audit safeguarding children audit tool incorporates learning from this and other domestic homicide reviews.

1.6 Management and agency to agency systems;

Identification and response to domestic abuse across all services; initiating domestic abuse pathways; accessibility and use of trained interpreters; capacity of services to make effective contribution to meaningful statutory reviews; sharing learning from other parallel investigations.

60. A consistent message from this and other domestic homicide reviews is that it is rare for domestic abuse to be explicitly disclosed. The inhibitions and barriers have been acknowledged and described. There is a risk when conducting a review such as this for some individual professionals to feel that their practice and decision making is being unfairly scrutinised.

61. It is clear that some professionals are still working on an assumption that they will be told about domestic abuse (by the victim, by a family member, by another professional). The

truth is that domestic abuse is more likely to be revealed when professionals are vigilant and proactive about the safety of adult victims and their children and look for signs and symptoms of coercive and controlling domestic abuse.

62. A woman and children being kept in poverty may reflect the very difficult circumstances facing many families but if it is a result of financial coercion this has a different significance.

63. Some services have yet to demonstrate a sufficiently clear understanding about their role in identifying and preventing domestic abuse. Examples included the way in which the Neighbourhood Advice and Information Service (NAIS) received repeated phone calls regarding housing and financial advice that did not arouse enhanced curiosity about the context of the victim; for example asking any questions about why the victim was trying to leave a relationship. Services are relying on clear disclosures of domestic abuse to trigger a response; it is not clear that anybody was aware for example of the unusual level of telephone contact by the victim with the NAIS for example in March 2013. Securing a tenancy and finance for victims of domestic abuse are urgent priorities and appeared to be what was occurring in March 2013.

64. Similarly when the victim disclosed her concern about the perpetrator collecting the children from school this did not provoke more curious and purposeful follow up. In making these comments it is not saying that it is the job of one single person or organisation to help and intervene. The point is that organisations need to ensure that their staff have sufficient awareness about domestic abuse, their role and responsibility in responding to it and have the systems in place to develop effective responses. Some of this will be procedural and some of it is about the mind-set, empathy and professional communication skills relevant to the task.

65. Having ready access to people with the right language skills and who have had sufficient training in understanding domestic abuse appears to be an issue across services.

66. Children's social care have had limited involvement in the domestic homicide review either in regard to participation in the panel meetings or providing an information report to clarify the circumstances under which the service received later notifications from the police or the robustness of response to information about threats to the victim.

67. The IPCC and West Midlands Police reports have highlighted the extent to which there was some confusion and misunderstanding about aspects of domestic abuse policy, risk assessment and recording systems. A significant contributory factor was a reliance on e-learning and shift briefing to communicate new arrangements. This provided limited opportunity to make sufficiently clear the purpose of some significant activity and left no opportunity for officers to ask question or clarify on matters such as the use of electronic forms or the use of the missing person questionnaire. The consequence was a preoccupation with clarifying with the letter of a protocol without understanding its spirit and purpose. For example the initial contact regarding the unusual behaviour of the victim in not collecting her children.

68. The establishment of the joint screening arrangements for domestic abuse and of the Multi-Agency Safeguarding Hub should provide an enhanced ability to identify and provide advice and help to adult victims and children living with domestic abuse.

Recommendation 5

The Community Safety Partnership should request further information from the City Council regarding the extent of understanding and use of the domestic abuse pathway by the Neighbourhood Advice and Information Service for identifying and responding to victims of domestic abuse. This should also include details on reductions in access and drop in services since 2013 and how call handling is being monitored in regard to identifying potentially vulnerable adults and children.

Recommendation 6

The Community Safety Partnership should seek further information from services regarding the availability of appropriately trained interpreters.

Recommendation 7

The Community Safety Partnership should seek further information from the director of children's services regarding the capacity of the service to participate in statutory reviews.

Recommendation 8

The Community Safety Partnership should request information from agencies about the extent to which they rely on e-learning or similar strategies for raising awareness and knowledge of staff regarding domestic abuse.

Peter Maddocks, CQSW, MA.
Independent author

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

West Midlands Police

Birmingham City Council Revenues and Benefit Service

Birmingham City Council Children's Social Care Birmingham

City Council Homelessness & Housing Needs

Birmingham City Council Neighbourhood Advice & Contact Centre

Heart of England NHS Foundation Trust

West Midlands Ambulance Service Birmingham

Community Health Care Trust

South & Central Clinical Commissioning Group/ GP

Education Services/Schools

Agencies providing a nil return to scoping

Staffordshire & West Midlands Probation Service

Birmingham City Council Adult Social Care

Birmingham City Council Neighbourhood Advice & Contact Centre

Birmingham City Council Legal Services

Birmingham Public Health (for substance misuse services)

Birmingham Women's Hospital

Sandwell and West Birmingham Hospital

University Hospital Birmingham

Royal Orthopaedic Hospital

Birmingham & Solihull Women's Aid

Anawim

Ashram

Birmingham Crisis Centre

The Salvation Army

Trident Reach the Charity

Shelter