



# **NORTH WORCESTERSHIRE COMMUNITY SAFETY PARTNERSHIP**

## **DOMESTIC HOMICIDE REVIEW**

**Into the circumstances**

**of the death of a woman aged 21 years**

**on 16<sup>TH</sup> March 2014**

**Case No: DHR 7**

**Independent Author:**

**Malcolm Ross M.Sc.**

**Date 7<sup>th</sup> April 2016**

## LIST OF ABBREVIATIONS

<b>AAFDA</b>	Advocacy After Fatal Domestic Abuse
<b>ADHD</b>	Attention Deficit Hyperactivity Disorder
<b>BSMHFT</b>	Birmingham and Solihull Mental Health Foundation Trust
<b>CCTV</b>	Close Circuit Television
<b>DASH</b>	Domestic Abuse Stalking & Harassment & Honour Based Identification Risk Assessment
<b>DHR</b>	Domestic Homicide Review
<b>DRR</b>	Drug Rehabilitation Requirement
<b>DVPN/O</b>	Domestic Violence Prevention Notice/Order
<b>IDVA</b>	Independent Domestic Violence Advisor
<b>IMR</b>	Individual Management Review
<b>MAPPA</b>	Multi-Agency Public Protection Arrangements
<b>MARAC</b>	Multi-Agency Risk Assessment Conference
<b>NHSFT</b>	National Health Service Foundation Trust
<b>NWCSP</b>	North Worcestershire Community Safety Partnership
<b>RAID Team</b>	Rapid Assessment Intervention and Discharge Team
<b>YOT</b>	Youth Offending Team

## CONTENTS

	<b>Page</b>
Introduction	4 - 10
Purpose of a DHR	4 - 5
Process of the Review	5
Independent Chair and Author	5 - 6
DHR Panel	6
Parallel Proceedings	6 - 7
Time period	7
Individual Management Reviews	7
Terms of Reference	8 - 9
Individual Needs	9 - 10
Lessons Learned	10
Media	10
Family Involvement	10
Subjects of the Review	10 - 11
Genogram	12
Summary of Key Events	13 - 29
The Victim	13
The Perpetrator and PFP	13 - 24
The Perpetrator and the Victim	24 - 28
Views of the Family	28 - 29
Comments made by Drug Specialist	29
Analysis and Recommendations	29 - 37
Disclosure of Criminal Antecedents of Perpetrator	32 - 35
Domestic Violence Prevention Notices/Orders	35 - 37
Conclusions	37 - 38
List of Recommendations	39
Bibliography	40
Action Plans	41 - 53

# **NORTH WORCESTERSHIRE COMMUNITY SAFETY PARTNERSHIP**

## **DOMESTIC HOMICIDE REVIEW**

### **into the circumstances**

### **of the death of a woman aged 21 years**

### **on 16<sup>TH</sup> March 2014**

#### **1. Introduction**

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 21 year old woman on 16<sup>th</sup> March 2014. The woman's partner, the Perpetrator, has been arrested and charged with her murder. In September 2014, the Perpetrator appeared before the Crown Court and initially pleaded Not Guilty to the charge of murder. After four days of trial, on 29<sup>th</sup> September 2014, he changed his plea to one of guilty. He was sentenced to Life Imprisonment, with the Judge's recommendation being he should serve 19 years.

#### **1.2 Purpose of a Domestic Homicide Review**

1.2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance<sup>1</sup> on 13<sup>th</sup> April 2011. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —*

*(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

*(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death"*

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse<sup>2</sup>, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

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

---

<sup>1</sup> Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011  
[www.homeoffice.gov.uk/publications/crime/DHR-guidance](http://www.homeoffice.gov.uk/publications/crime/DHR-guidance)

<sup>2</sup> Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

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

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

1.2.5 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.

### **1.3 Process of the Review**

1.3.1 West Mercia Police notified North Worcestershire Community Safety Partnership (NWCSP) of the homicide on 22<sup>nd</sup> March 2014. The Worcestershire Forum against Domestic Abuse and Sexual Violence acting on behalf of the Community Safety Partnership convened a DHR sub group meeting and considered the circumstances as known at that stage, and decided to hold a domestic homicide review. A letter was sent to the Home Office to this effect on 15<sup>th</sup> July 2014.

1.3.2 An independent person was appointed to chair the DHR panel and to be the author of the overview report.

1.3.3 Home Office Guidance<sup>3</sup> requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

### **1.4 Independent Chair and Author**

1.4.1 Home Office Guidance<sup>4</sup> requires that;

*“The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant”, and “...The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review.”*

1.4.2 The Independent Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police

---

<sup>3</sup> Home Office Guidance 2013 page 15

<sup>4</sup> Home Office Guidance 2013 page 11

and has many years' experience in writing over 80 Serious Case Reviews and chairing that process and, more recently, performing both functions in relation to Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

## **1.5 DHR Panel**

1.5.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Members of the panel and their professional responsibilities were:

Martin Lakeman	Worcestershire County Council Health Domestic Abuse Co-ordinator
Damian Pettit	West Mercia Police
Tom Currie	National Probation Service West Mercia
Ellen Footman	Designated Nurse for Safeguarding Worcestershire
Sarah Cox	Worcestershire County Council Quality & Safeguarding Services Manager
Lyn Mills	Worcestershire County Council Health and Wellbeing (Administrator)

1.5.2 None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

1.5.3 The Panel was supported by the DHR Administration Officer, Lyn Mills. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.5.4 On 3<sup>rd</sup> September 2014, at a Panel meeting, the Chair invited a Specialist from the Pathway to Recovery Drug Advisory Service, to inform the Panel of the effects on a person who takes a significant amount of cocaine in a relatively short period of time. It was clear at that stage that the Perpetrator had taken up to three lots of cocaine in the few hours prior to the death of the Victim. A summary of the Specialist's opinion is contained after the section on the Views of the Family later in this report.

## **1.6 Parallel proceedings**

1.6.1 The Panel were aware that the following parallel proceedings were being undertaken:

- The DHR Panel Chair advised HM Coroner on 21<sup>st</sup> July 2014 that a DHR was being undertaken, and the Coroner has been updated on a regular basis
- Because of recent contact with the deceased by the police, the Independent Police Complaints Commission have been notified and will conduct an investigation
- The review was commenced in advance of criminal proceedings having been concluded and therefore was conducted with awareness of the issues of disclosure that may arise.

## **1.7 Time Period**

1.7.1 It was decided that the review should focus on the period from 16<sup>th</sup> June 2012 (the date the Victim returned from Spain) to the date of the Victim's death on 15<sup>th</sup> March 2014.

## **1.8 Scoping the review**

- 1.8.1 The process began with a scoping exercise by the panel to identify agencies that had involvement with the Victim and Perpetrator prior to the homicide. Where there was no involvement or significant involvement by agencies the panel were advised accordingly. The scope will also include any relevant information regarding the former partner of the Perpetrator, about her relationship with the Perpetrator with respect to domestic abuse and safeguarding issues for other members of the family commencing from 1<sup>st</sup> January 2009.
- 1.8.2 Agencies were asked to identify any other significant information that may add to an understanding of the quality of dynamics of the relationships within the family before and after the time period.
- 1.8.2 The purpose of the extended period is to examine and identify what opportunities were available for agencies to intervene or challenge decisions that were made in respect of the Perpetrator and victim's siblings where concerns may have been escalated by agencies.

## **1.9 Individual Management Reviews**

- 1.9.1 The following agencies were requested to prepare chronologies of their involvement with the Victim and her family, carry out individual management reviews and produce reports.
- West Mercia Police
  - West Midlands Police
  - Warwickshire Police
  - Probation including Birmingham – National Probation Service Midlands Division, Birmingham, Coventry and Solihull
  - Worcestershire Health and Care Trust (Health Visitors)
  - NHS England Arden Area Team (Worcestershire and Warwickshire GPs)
  - NHS England Birmingham and The Black Country Team (GP)
  - Worcestershire Acute Hospitals NHST
  - Birmingham & Solihull Mental Health NHS Foundation Trust (Drug treatment provider)
  - Solihull CCG – Birmingham School Nursing (re previous relationship)
  - Birmingham Health Visiting Services (re previous relationship)
  - South Warwickshire NHS Foundation Trust (re victim)
  - Birmingham Children's Social Care
  - Worcestershire Children's Services (WCC)
  - Heart of England NHS Foundation Trust

## **1.10 Terms of Reference**

- 1.10.1 The Terms of Reference for this DHR are divided into two categories i.e.:
- the generic questions that must be clearly addressed in all IMRs; and
  - Specific questions which need only be answered by the agency to which they are directed.
- 1.10.2 The generic questions are as follows:
1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?

2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
5. Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the victim's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the victim should have been known?
13. Was the victim informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?
16. Had the victim disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the victim and the perpetrator?
25. To what degree could the homicide have been accurately predicted and prevented? Were there opportunities to escalate concerns through single or multi agencies?
26. In light of the concerns in respect of the Perpetrator's former partner and their/the children, what considerations were given to the future safeguarding of any children the Perpetrator may live with or father and risk assessment of future partners and their children? (This may involve West Midlands Police,



Birmingham Women's Aid, Birmingham Children's Services and Birmingham Mental Health services).

27. Was/should the Perpetrator have been considered a Person Posing a Risk to Children?

28. Was this case considered in MARAC or MAPPA?

29. Should alerts about the Perpetrator have been shared across agencies boundaries?

1.10.3 In addition to the above, the following agencies are asked to respond specifically to individual questions:

- Mental Health - Was there conformity to the Care Programme Approach throughout?
- Warwickshire Police, West Midlands Police and West Mercia Police - Should the Police or any other agency have considered a disclosure of the Perpetrator's violent history to the Victim? To protect that person and her children.

## **1.11 Individual Needs**

1.11.1 Home Office Guidance<sup>5</sup> requires consideration of individual needs and specifically:

- "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the Victim, the Perpetrator and their families? Was consideration for vulnerability and disability necessary?"

1.11.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.11.3 The review gave due consideration to all of the Protected Characteristics under the Act.

1.11.4 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

## **1.12 Lessons Learned**

1.12.1 The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as Child Protection and Adult Safeguarding reviews and appropriate and relevant research.

## **1.13 Media**

1.13.1 All media interest at any time during this review process will be directed to and dealt with by the Chair of the North Worcestershire Community Safety Board.

---

<sup>5</sup> Home Office Guidance page 25

## 1.14 Family Involvement

### 1.14.1 Home Office Guidance<sup>6</sup> requires that:

“members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim’s experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator’s networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances”,  
and:

“Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.”

1.14.2 The views of the family members and any family friends identified by the family will be taken into consideration. The family members will be invited to participate in the review process. (See section Views of the Family later in this report)

1.14.3 These Terms of reference will be considered a standing item on Panel Meetings agendas and will be constantly reviewed and amended according as necessary.

## 1.15 Subjects of the Review

1.15.1 The following genogram identifies the family members in this case, as represented by the following key:

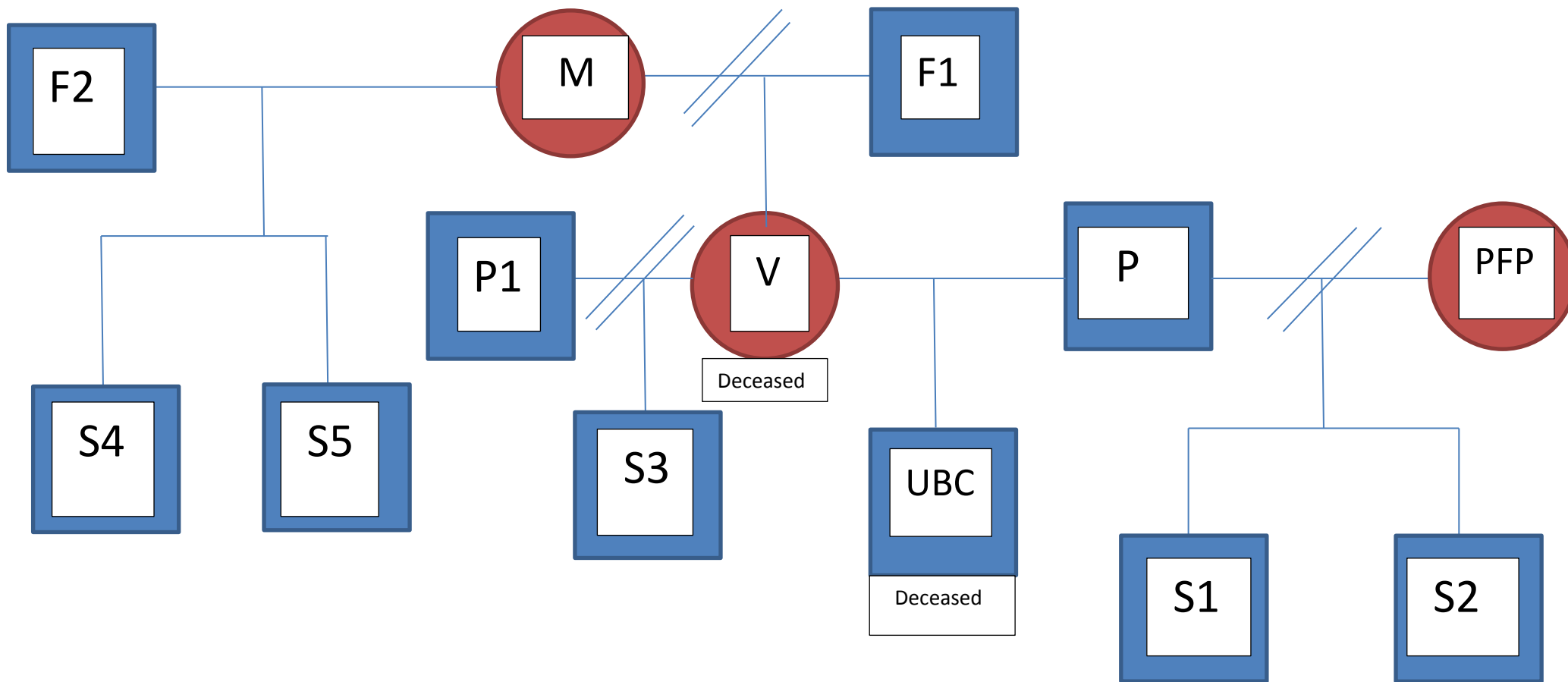
Victim	Born 1993	Female – Aged 21, Mother of S3, Partner of Perpetrator
Perpetrator	Born 1983	Male – Partner of Victim, Father of UBC and S1 and S2, Ex-Partner of PFP
PFP	Born 1983	Perpetrator’s Former Partner and Mother of S1 and S2
S1	Born 2007	Child of Perpetrator and PFP
S2	Born 2009	Child of Perpetrator and PFP
P1		Former Partner of Victim and Father of S3
S3	Born 2011	Male – Son of Victim and P1
M		Mother of Victim
F1		Victim’s Father and Previous Partner of MGM
F2		Partner of M and Father of S4 and S5
S4		Male – Child of M and F2 Step Bro. of Victim
S5		Male – Child of M and F2 Step Bro. of Victim
UBC		Male – 13 weeks, Unborn Child of Victim and Perpetrator

1.15.2 S4 and S5 are children from F2 and M. It is known that S5 suffered with ADHD and both of the boys were known to Birmingham Children’s Services and Education. S5 had been excluded from school, and had contact with Education Social Welfare, Educational Psychologists, YOT and CAMHS.

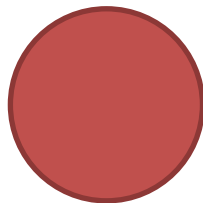
1.15.3 Attempts were made to allocate the boys a school during their stay in Warwickshire. Once the family moved to Worcestershire they were found a school in Redditch, but S4 did not attend school for a continuous period of 8 months which should have generated a referral to Children’s Services. It is thought that overall S4 had not attended school for some 2 years in total. If this information had been shared with Children’s Services it may have triggered a Child and Young Person’s Assessment. The family have moved again, to the Home Counties

<sup>6</sup> Home Office Guidance page 15

### GENOGRAM



Male      Female      Unborn Child      Separated/Divorced



## **2. Summary of key events**

### **2.1 Introduction**

- 2.2 This Domestic Homicide Review concerns that death of the Victim at the hands of the Perpetrator, who has since been dealt with at Crown Court and convicted of the offence of murder. The Victim was 13 weeks pregnant with a male child at the time of her death and it is suspected that the Perpetrator was the father of that child.
- 2.3 The Victim and her family, PFP and her family are all white British with no known religious beliefs. The Perpetrator is a Pakistani Asian man and details of his religious beliefs are unclear.

### **The Victim**

- 2.4 The Victim was 21 years old when she died. She already had a son by a former partner who was Asian. He has not been seen since she became pregnant. Her son was of dual ethnicity. She and her son lived with her mother and her partner and two younger step brothers.
- 2.5 There is no record of agency involvement with the Victim and her son, although there is an historic involvement with S4 and S5 regarding complaints of neglect where Children's Social Care were involved with the family. At the time of the death of the Victim, there was no agency involvement with the family, although it is known that S5 had been diagnosed with ADHD.
- 2.6 It appears that the Victim and the Perpetrator had known each other for some time as casual friends. The Victim, her son, Mother and two step brothers together with her Mother's boyfriend went to Spain on holiday in December 2011, intending to stay for only two weeks. Whilst in Spain her Mother's boyfriend suffered a heart attack and was hospitalised, causing the family to stay for longer than expected. Once the boyfriend was fit enough he was transported back to the UK, but the family remained in Spain for just over 12 months. It was during this time that the Victim struck a relationship over Facebook with the Perpetrator.
- 2.7 In 2013, the Victim and her family returned to England and she started a relationship with the Perpetrator. The Perpetrator had ongoing problems with his own family concerning his use of drugs and they asked him to leave the family home. It was then that the Victim took him in and they lived together in the same house with her mother, mother's partner and step brothers,
- 2.8 The Victim was unemployed at the time of her death. Her son was 3 years of age.
- 2.9 There is relevant information about the Perpetrator's life before he associated with the Victim and was with PFP, which although quite extensive, is important information about his lifestyle, and especially the missed opportunities to protect PFP and her children and to take assertive action with regard to the Perpetrator. The first section of this summary of events therefore concerns the Perpetrator and his life with PFP. The second section details the relationship between the Perpetrator and the Victim.

### **The Perpetrator and PFP**

- 2.10 The Perpetrator is a man with numerous previous convictions for drug offences, both possession and possession with intent to supply. He had been in a previous relationship with a woman (PFP) who had two children by the Perpetrator and it is known that during that relationship there were significant episodes of Domestic

Abuse between the PFP and the Perpetrator but there was never a conviction as the PFP did not make a formal complaint to the Police about the Domestic Abuse she was subjected to.

- 2.11 The history of the Perpetrator goes back before the terms of reference for this Review. He and PFP had two children, S1 born in 2007 and S2 born in 2009. His criminal convictions for drug offences from 2003 have resulted in fines, Community Service Orders, Supervision Orders, and 15 months imprisonment.
- 2.12 During that period of time he was offered a custody referral to the local drugs workers<sup>7</sup> but he declined that assistance. Later, in January 2008, whilst in custody for theft and related matters, the Perpetrator was required to take a mandatory Drugs Intervention Programme<sup>8</sup> (DIP) test, which resulted positive for cocaine.
- 2.13 It was March 2009, whilst in custody that the Perpetrator was subject of a referral from the CARAT<sup>9</sup> service in Prison. He was assessed in July 2009 prior to his release and a follow up appointment was scheduled with BSMHFT.
- 2.14 During July and August 2009, the Perpetrator failed to attend a Drug Intervention Programme and despite an Outreach Worker visiting his home address and leaving messages for him, he failed to make contact. A final visit resulted in the Perpetrator's father stating that his son no longer lived at that address and expressed resentment that the Outreach Worker was bothering the family. The case was closed but there is no evidence that any other agency, such as GPs were informed.
- 2.15 The BSMHFT IMR Author makes an interesting comment in the IMR:

‘after he was released from [Prison] he was not compelled to engage with treatment as far as the author can tell i.e. there is no evidence from the

---

<sup>7</sup>West Midlands Police employs specially trained Arrest Referral Workers, who are based in police custody suites. Arrest Referral Workers are essential to the success of drugs programme because they form the vital link between drug-misusing offenders who are in police custody and the drug treatment services, which they so desperately need rapid access to. Arrest referral uses the point of arrest as an opportunity for drug workers to make that vital contact, independent of the police. This is a voluntary service and offenders are not obliged to go into treatment. However, a willingness to participate in drug treatment is noted in the records that follow an offender to court. Arrest referral is available in all police forces and enhanced arrest referral is in place at police stations where mandatory drug testing takes place as part of the Drug Intervention Programme. Enhanced arrest referral combines a case management approach and other best practice to better plug the gap between referral and treatment.

<sup>8</sup> D.I.P. is the Drugs Intervention Programme it was founded in 2004 as part of a 10 year Home Office Drugs Strategy. It was identified that there is a relationship between drug misuse and offending behaviour. DIP was developed nationally to break this chain by offering routes out of crime and into treatment. D.I.P Testing. The test is conducted in the custody block by trained staff and screening is for Class A Drugs. The test will only reveal the presence of a Class A drug, it does not provide how much or more specifically what they have taken. Analysis is available to determine more specific information (i.e. if detained person disputes the result) but is not done routinely. Only one drug test can be taken in any one period of detention. The result will either be positive or negative. In the event of a positive drug test, the detained person will be subject to a Required Assessment. If a negative result is recorded the detained person can take a Voluntary Assessment. The Required Assessment is a two-step process. The Initial Required Assessment is carried out by a trained Drugs worker whilst in the Custody Facility following a positive drug test. It is a screening process to identify the detained person's drug misuse. The worker will also look at any issues the detained person has to signpost them in the direction of help. The Follow On Required Assessment is a more in depth assessment and looks at treatment strategies. These are usually carried out in a Treatment Centre local to where the detained person lives and are carried out by trained Drug Worker. The process is the important first step into getting a drug misuser into treatment and out of crime.

<sup>9</sup> CARAT is a multi-disciplinary, specialist support and advice service providing – ‘Counselling, Assessment, Referral, Advice/information and Throughcare – for all prisoners who require it; it is the key non-clinical gateway drug treatment service in prisons for prisoners aged over 18. The two key aims of CARATs are to provide treatment management and treatment provision in order to reduce the harm caused by any drug classified under the Misuse of Drugs Act 1971

available care record for [the Perpetrator] that a court order had been put in place at the time of his release from prison; however, the assessment record appears to show that he was subject to a Home Detention Curfew for three months (under the scheme, the offender is required to stay in their home, or approved premises, for the duration of the curfew; an electronic tag is attached to the ankle of the offender); the assessment record does not include, however, any specific detail of the curfew arrangements.

- 2.16 On 20<sup>th</sup> August 2010, the Perpetrator was again arrested and charged with possession of cannabis for which he was fined £65.
- 2.17 On 8<sup>th</sup> October 2010, the Perpetrator's Previous Former Partner (PFP) went to West Midlands Police regarding her ex-partner, the perpetrator, harassing her. Although they never lived together, she had two children with him. The children were then 2 years old and a baby. She had split up with him a few months before but he was constantly texting her, climbing over her garden fence to see if she is in the house, throwing things at her if he should meet her in the street.
- 2.18 The Enquiry Office Assistant (EOA) that spoke to her recorded a considerable amount of information which included that PFP had stated that the Perpetrator was threatening her brother, and the Perpetrator's friends were following her around. She also stated that she was to seek legal advice from a Solicitor because when he had access to the 2 year old; the perpetrator often does not return the child to the mother.
- 2.19 The log that was created for this complaint indicated that there was no free officer to see her whilst she was at the Police Station, and that she had left to go to her mother's house with the children. A Diary Appointment<sup>10</sup> was made for 1500 hours on 19<sup>th</sup> October 2010, (some 11 days later), however due to 'resource commitments' the Police cancelled that appointment and an alternative time was arranged for 1930 on the 19<sup>th</sup> October 2010.
- 2.20 A Police Officer visited her at her mother's house and recorded that she wanted the Perpetrator told that she was going to a Solicitor about the child care issues and that she had had enough of him harassing her. The matter was recorded as a 'Non Crime' incident in line with West Midlands Police procedures and the officer attempted to complete a DASH<sup>11</sup> Risk Assessment form, but it is stated that the PFP refused to assist in this process.
- 2.21 West Midlands Police DASH Policy<sup>12</sup> indicates that by using the process as outlined officers would be able to obtain:  
'information about the circumstances of the victim, information about the perpetrator, the history of any abuse and information about any children/dependants who may be affected by the abuse. Information to help identify risk may also come from Police information systems, witnesses, other agencies and people close to the perpetrator and victim.'

---

<sup>10</sup> West Midlands Police operate a Diary Appointment System for non-urgent incidents. The aim of the Diary Appointment System is to provide a timely and professional response to non-urgent incidents, which cannot be dealt with over the telephone to the point of conclusion. Such incidents will include those that require evidence capture (statements, photographs, CCTV), or where the presence of an officer is required.

<sup>11</sup> Domestic Abuse Stalking and Harassment and Honour Based Violence Risk Identification and Assessment Checklist used by UK Police Forces

<sup>12</sup> West Midlands Police DASH Policy – Domestic Abuse, Stalking and Harassment and Honour based Violence 2011

- 2.22 The fact that a DASH form was not submitted due to the PFP's reluctance to assist in this process is concerning, but the Officer did submit a WC392 referral form to Public Protection Unit for onward transmission to Social Services regarding the involvement of children within this domestic abuse complaint.
- 2.23 Because the PFP and the Perpetrator lived at separate addresses the assessment of risk recorded in these circumstances was Standard, which would have been filed by the Public Protection Unit. The West Midlands Police IMR Author is unable to clarify if the WC392 referral form was sent to Social Services. It is the IMR Author's opinion that these circumstances should have resulted in the Perpetrator being seen and, at the very least, warned about his future conduct and that any future incidents of this nature would be dealt with in a more positive action. The matter should have been recorded as Harassment and the circumstances clearly satisfied the offence of Harassment under Section 1 and 2 of Protection from Harassment Act 1997.
- 2.24 The West Midlands Police IMR Author also discovered that the incident had been recorded under PFP's mother's address and not her own address, so any incident reported at her own address would not have received such an urgent response as her address would not have been known on Police systems.
- 2.25 There is nothing to suggest that the Perpetrator was ever seen about this incident.
- 2.26 On 28<sup>th</sup> November 2010, the Ambulance Service Control informed West Midlands Police that they were attending at an address where a 26 year old man had self-inflicted stab wounds to his stomach. The address was the PFP's address. Officers attended and were told by an unknown female that the injured person had found his own way to hospital and he had small stab wounds to his stomach area. No details of the female were taken and no questions asked about the cause of the injury or the circumstances in which they were inflicted. The woman gave the Police the man's name, the Perpetrator.
- 2.27 Officers went to the Hospital and found the Perpetrator who had scratches to his abdomen. The incident was closed by the Police and it was recorded that:
- 'Male is OK – he has slight scratch to his stomach. No need for 392'.
- 2.28 In these circumstances, West Midlands Police Force Policy on Safeguarding Vulnerable Adults from Abuse would consider this to be such an incident that did not require a referral of form WC392 and that the Perpetrator in these circumstances was not deemed to be vulnerable.
- 2.29 However, the West Midlands Police IMR Author, correctly questions as to whether it was correct procedure to close the log without knowing all of the circumstances of the incident. It would have been expected that the officers who attended would have made sufficient enquiries about the circumstances and the relationship between them. The log does however, indicate that the Resource Allocator Despatcher (RAD) did carry out a VSI Check<sup>13</sup>, but the previous incident reported in October would not have been highlighted due to a different address being recorded on that occasion. Had the correct details been entered on Police records in October and had more information been sought from the female who requested an ambulance, who in fact was PFP, and had a more in depth questioning of the Perpetrator been conducted at the hospital, there would have been identified opportunities to safeguard PFP and

---

<sup>13</sup> A VSI check is View Summary Incident check which allows the RAD to view the previous 18 months OASIS Log history at a specified address

her children. Comment is made in the West Midlands Police IMR to the effect that the author considers the act of self-harming was yet another opportunity to cause further distress to PFP.

- 2.30 The medical records of this incident indicate that the Perpetrator firstly stated that he had self-harmed with a kitchen knife because he was feeling low. He then changed his mind and stated that it was an accident but he didn't expand on that story. The wound was described as being 0.5 cm deep by 1-2cm in length and only involving the subcutaneous fat layer. It was cleaned and sutured and he was discharged, presumably being able to have further access to PFP and her children.
- 2.31 In a statement to the Police, PFP's version of these events is that the Perpetrator arrived at her flat, walked into the kitchen and grabbed a knife. He held the knife to her throat saying 'tell me you're going to get back with me'. She said she wasn't going to and he stabbed himself in the stomach.
- 2.32 On 17<sup>th</sup> December 2010, the Perpetrator's father rang his son's GP asking for help with his drug habit, which had consisted of cannabis smoking for a few years and cocaine for the last 6 months.
- 2.33 A GP saw the Perpetrator on 20<sup>th</sup> December 2010, and recorded details of his drug usage and the fact that he had limited access to children as a result of which he got bored, had no job or hobbies but was fit to look for work. He was advised to attempt to find himself a job which would help with his boredom and thereby assist with limiting his drug use. He was referred to Birmingham Drug and Alcohol Team (DAT).
- 2.34 The letter to DAT refers to the 'waiting time of social services' but it's not clear what that context was. There is no other information contained within his records that indicate there have been any contact from social services and/or other services in respect of the following:
- Impact of his drug addiction on others, or
  - his behaviours towards PFP, or
  - part of a core assessment and in particular, assessing parenting capacity i.e. his ability to meet the need of children and impact of behaviours on child development and welfare and/ or,
  - Assessing risk posed in regard to his children or risk to others.
  - There are no entries or copies related to child protection conferences, plans or core group meetings. Nor Multi-Agency Risk Assessment Conferences (MARACs) or Multi-Agency Public Protection Arrangements (MAPPAs) or scanned copies or electronic or paper entries indicating these documents existed.
- 2.35 On 15<sup>th</sup> January 2011, the Perpetrator made two calls to West Midlands Police. The first was at 1039 hours when he reported that there was a man after him with a black gun in Warwick Road, Acocks Green, Birmingham. This of necessity was responded to immediately as a Firearms Incident as a firearms incident in a public place poses significant threats to the general public.
- 2.36 The Perpetrator was located and stated that he had been to a flat to buy and use drugs. He had snorted about £80 worth of cocaine and he had seen a man with a shopping bag outside and panicked, ran into the bathroom, locked himself and called the Police. He did not mention a gun in his rambling explanation but pointed out a member of the public standing nearby. That man was searched by a PCSO and no



gun found. It was clear to the Officers that the Perpetrator was suffering delusions from the effects of drugs. He was taken home and left in the charge of his mother

- 2.37 The second call he had made to the Police was at 1040, one minute after the first call and clearly before the arrival of the Police. The 999 Operator who took the call noted the location of the call (the Perpetrator's address) but was unable to understand the caller and the call was terminated as a nuisance call. The Operator was a different person to the one who took the first call and the two calls were not connected to each other.
- 2.38 The West Midlands Police IMR Author makes comment about the PSCO searching a member of the public, which is beyond the PCSO's powers, and that matter is dealt with adequately within the recommendation of that IMR. The Author also questions whether a person in such a drug induced state should have been left with his mother. There is no evidence of his mother being assessed as to her capability to care for her son while he was in such a state.
- 2.39 On 17<sup>th</sup> February 2011, the Victim was seen by the Community Midwife in a routine appointment regarding her pregnancy. This was her first child (S3). She was asked directly about domestic abuse within her relationship and she made no disclosure whatsoever. This was the first of three occasions she was asked about domestic abuse which is in line with maternity policy. It has to be noted that the Victim was not with the Perpetrator at this stage of her life.
- 2.40 On 1<sup>st</sup> March 2011, PFP contacted West Midlands Police on two occasions reporting that the Perpetrator was harassing her again in the street shouting and swearing and being generally abusive towards her and the children in public. An appointment was made for PFP to see a Police Officer the following day. She explained that she as going through a separation and has sought advice from a Solicitor who had told her to call the Police each time the Perpetrator acted badly towards her or caused her distress. The Officer advised her to seek a Restraining Order in respect of the Perpetrator.
- 2.41 The West Midlands Police IMR Author, rightly points out that this was the third time that PFP had been harassed by the Perpetrator and more positive steps should have been taken. This inaction was aggravated by the fact that the initial address of PFP was incorrectly recorded which resulted in a delay in her being spoken to. The report is finalised by the Officer recording that PFP had been given a case number and she was 'happy with that'. There was no reference to the fact that this was a domestic related incident and therefore was not dealt with in line with West Midlands Police Domestic Abuse Policy.
- 2.42 On 21<sup>st</sup> March 2011, the Victim attended at the Maternity Unit for her booking assessment. It is recorded that she denied any family history of medical or mental issues and that although she smoked a few cigarettes per day she denied using drink or drugs. She was asked about domestic abuse and her response is recorded as negative. Her partner, although not named, is described as being Asian (Pakistani). This was her first child and the father was not the perpetrator. She gave her mother's details as being the next of kin. The Victim stated that she lived with family and friends and considered herself well supported. It was noted that her family had been involved with Social Services, which was later ascertained as being in relation to her siblings, but the case had been closed for some time.

- 2.43 On 3<sup>rd</sup> April 2011, the Perpetrator was arrested following an execution of a drugs warrant at his home address, and CS gas was recovered. No further action was taken as the CS gas could not be attributed to the Perpetrator.
- 2.44 On 10<sup>th</sup> May 2011, it was ascertained that PFP was 20 weeks pregnant. It is noted that her contact with antenatal services were spasmodic
- 2.45 On 27<sup>th</sup> July 2011, the Perpetrator was again arrested and charged with possession of cannabis with intent to supply for which he was sentenced in December at Crown Court to 52 weeks imprisonment suspended for 12 months. He was also given a Drug Treatment and Testing Order for 6 months which included a 19 day participation in Thinking Skills Programme.
- 2.46 In September 2011, Social Services stated that the case with the victim's siblings had been closed and they did not see a need for any involvement with victim now. She was receiving support from her family and she was to live with her mother and have her own bedroom once the child was born.
- 2.47 On 16<sup>th</sup> September 2011, the Victim attended at the local hospital concerned that her membrane had been ruptured, which proved not to be the case. There is nothing to suggest why she thought that may be the case.
- 2.48 On 25<sup>th</sup> September 2011, the Victim gave birth to a healthy boy child (S3). Her Mother was with her when she gave birth. There are no records of the father being present at the birth.
- 2.49 On 14<sup>th</sup> November 2011, the Perpetrator was referred from West Midlands Probation Trust to Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) albeit for a low level of assessment, during which he stated that he had child care issues, but had no mental health or other major risk issues.
- 2.50 The Perpetrator was assessed by Senior Court Liaison Worker on 22<sup>nd</sup> November 2011, where he stated that his primary problem was substance misuse with cocaine and his secondary problem was cannabis. He identified the negative consequences of his drug use as being loss of contact with his children, his family not being happy about him using drugs (he was living with his parents), he was in debt and resorting to crime. Records indicate that his children lived with their mother (PFP) and there was no child care or health involvement at that time. He was awaiting a Crown Court appearance for possession with intent to supply.
- 2.51 On the same day the Perpetrator was assessed as being suitable for a 6 month low intensity drug rehabilitation order
- 2.52 On 9<sup>th</sup> December 2011, the Perpetrator appeared before Birmingham Crown Court for the offence of possession with intent to supply cannabis. He was sentenced to a 12 month suspended sentence order with a number of requirements. The requirements included 12 months supervision, 6 month drug treatment and testing order and a thinking skills programme.
- 2.53 He was supervised by probation staff with regards to this order for a period of 7 months from December 2011 until his final contact with the service on the 17<sup>th</sup> July 2012. At the time probation records show that he was living at his parent's address.
- 2.54 The Order imposed on the 9<sup>th</sup> December 2011 produced little positive outcome or engagement from the Perpetrator. Case records document that he missed a number

- of appointments and was still engaged in regularly misusing drugs. The Perpetrator admitted taking cocaine and cannabis throughout December 2011. This was also confirmed by his father in a call to the office on the 30<sup>th</sup> May 2012 where he reports that his son regularly came home in the early hours and his attitude and continued drug misuse was upsetting to his parents.
- 2.55 During the course of the order the Perpetrator went on to miss a number of appointments and his Offender Manager took appropriate enforcement action in line with agency policy and procedures at the time.
- 2.56 His failure to comply with the requirements of his order resulted in breach action being taken and the order was returned to Court for enforcement on the 2<sup>nd</sup> August 2012. He failed to attend Court for his breach hearing on the 30<sup>th</sup> August 2012 and a Warrant was issued. He finally appeared before the Court on the 18<sup>th</sup> January 2013 when a 12 week stand-alone curfew order was imposed.
- 2.57 On 28<sup>th</sup> December 2011, the Victim, her family and her mother's boyfriend went to Spain for a two week holiday, but whilst there her mother's boyfriend suffered a heart attack and was hospitalised. His recovery was slow so all of the family stayed in Spain for what eventually was a period of almost 15 months. They returned to the UK in the early part of 2013. It was whilst she was in Spain she struck up an internet/Facebook relationship with the Perpetrator, who she had known for some years in Birmingham.
- 2.58 During January 2012, the Perpetrator stated that he had stopped using cocaine but continued to use cannabis, which was confirmed by daily drug tests. He said that by staying away from drug users and stopping using cocaine his relationship with PFP and the children had improved. However on 31<sup>st</sup> January 2012, he tested positive for cocaine.
- 2.59 On 7<sup>th</sup> February 2012, he stated that he had 2 children but he didn't have any contact with them. The children were with their mother (PFP) and he was living with his mother at that time.
- 2.60 During March 2012, the Perpetrator expressed his desire to find employment. He admitted that he was still using cannabis and on 23<sup>rd</sup> March 2012, he was assessed as being no risk to his partner (PFP) or children. There then followed two unexplained missed appointments with his Drug Rehabilitation Requirement (DRR) and on 17<sup>th</sup> April 2012, he tested positive for both cannabis and cocaine. He stated that this was a 'one off' event which occurred due to boredom.
- 2.61 He was seen by a DRR worker on 1<sup>st</sup> May 2012, and again tested positive for cocaine. He stated that he was using cocaine two or three times per day. There is nothing to indicate that this had resulted in an updating of communication with the Probation Officer, or indeed a re-assessment regarding his risk to PFP and/or the children.
- 2.62 On 8<sup>th</sup> May 2012, a week later he had a 3 monthly review, where he stated that he had not used illicit drugs for over a week but had used cannabis, but not as a replacement for cocaine. He had used cannabis as a way of relaxing. He also stated that living at home with his parents was stressful as they objected to his drug use. He tested positive for cannabis and cocaine.
- 2.63 On 15<sup>th</sup> May 2012, the Perpetrator had an appointment with DRR and was seen by his Drug Worker. He appeared to be over active and made an excuse for not giving a

urine sample for examination. He opted to give a mouth swab but had rinsed his mouth with water just prior to giving the swab. He denied illicit drug taking but admitted using cannabis. The test proved negative for cannabis and cocaine. It is thought that the test was unreliable due to the mouth rinsing and his refusal to give urine was to prevent a positive result for cocaine testing.

- 2.64 Two days later, on 17<sup>th</sup> May 2012, PFP contacted the Police reporting that she had moved out of her mother's address but the Perpetrator was there threatening her mother and other members of her family, saying he wanted to see his children. Officers attended but the perpetrator had gone from the scene before the Police arrived. The Officer recorded the incident as a domestic incident and noted that the Perpetrator had been violent towards PFP on previous occasions. It is recorded that due to operational commitments, the Police were unable to send an officer to see PFP. She was seen however the following day and an answer phone message sent by the Perpetrator to PFP was listened to by the Officer, who concluded that there were no threats made. The officer advised the mother to change her telephone number, if the Perpetrator comes anywhere near her, to call the Police.
- 2.65 The comment that he made no threats is contrary to the log created at the time. There is a lengthy examination of the details of this incident by the author of the Police IMR who concludes that it would have been beneficial to have a transcript or indeed more detail of the recorded conversation to assess if a threat was made as the Officer has closed the incident stating that there were no Police Offences committed.
- 2.66 On 22<sup>nd</sup> May 2012, the Perpetrator failed to attend at his DRR appointment and there is nothing to suggest that Probation were made aware of this, nor is there an explanation from him to explain his absence.
- 2.67 On 29<sup>th</sup> May 2012, the Perpetrator attended at his DRR appointment. He stated that nothing was moving forward in his life and admitted using cannabis and cocaine the previous day. He was frustrated at PFP for not letting him see his children. There is nothing to suggest that anything was done about this and there is no record of any checks being made as to whether the children had been made subject to a child safeguarding plan.
- 2.68 The following day, 30<sup>th</sup> May 2012, the Perpetrator's father telephoned the Probation Offices reporting that he was very concerned about his son's drug taking and that he thought that his son was not taking his current Court Order seriously. His son was regularly misusing drugs and he wanted a more stringent order made for his son. It was explained that there could be no conversation about his son's case and the Court imposed orders and they could not be changed. It was clear that the Perpetrator's father was distressed and concerned about the effect that his son's drug taking was having on the rest of the family.
- 2.69 On the same day there is an entry in the chronology from Probation to the effect that there needed to be communication with the Police about the Perpetrator's possession of forged £20 bank notes. It was agreed that Probation would challenge him about this the following day. A call was made to Stetchford Police Station Birmingham about the forged notes for 'intelligence purposes'. There is nothing to indicate the source of this information or what was done about it by the Police.
- 2.70 On 5<sup>th</sup> June 2012, the Perpetrator cancelled his last appointment with DRR. Two days later he attended the Probation Offices saying that he had not received the letter about his appointment as his family had 'kicked him out of the house' and he

was now homeless. He was given a new appointment and warned that a further failure to attend would result in breach action being taken.

- 2.71 By the 8<sup>th</sup> June 2012, he had found accommodation in a hostel. He later attended at the Probation Offices and denied that he had been seen with forged bank notes and that he was drug dealing again. He had been sleeping rough in a sub-way and had been attacked. He had stopped taking drugs because he could not afford them now in his present situation.
- 2.72 On 11<sup>th</sup> June 2012, the Perpetrator's compulsion to attend drug rehabilitation ceased and any further attendance would have been voluntary. There is nothing to suggest that after this date was the Perpetrator referred back to BSMHFT for drug rehabilitation.
- 2.73 On 13<sup>th</sup> June 2012, the Perpetrator's GP practice received a letter from ARCH to the effect that he had been discharged from the Community Drug Team and all medication from the Centre had stopped, but support was available if required. For drug users like the Perpetrator, further drug rehabilitation support is voluntary and cannot be enforced unless they re-offend and a further Court Order is put in place by Crown Court.
- 2.74 On 19<sup>th</sup> June 2012, the Perpetrator contacted the Probation Offices saying that he was too ill to attend that day. He was advised to seek a medical note to that effect. He then stated that he felt OK to attend but failed to do so. A telephone message was left for him. He again failed to attend on 2nd July 2012.
- 2.75 On 10<sup>th</sup> July 2012, the Perpetrator attended the Probation Offices and stated that he was getting a lot from the TSP programme and appeared motivated to complete the programme as instructed. He enjoyed living at the hostel and the management was assisting him with his finances and he was keeping off drugs and looking for work.
- 2.76 On 11<sup>th</sup> July 2012, the Perpetrator attended the Emergency department of a local hospital after being involved in a Road Traffic Collision (RTC) with pain to his lower back. He was assessed and discharged with pain relief.
- 2.77 On 17<sup>th</sup> July 2012, he attended at the Probation Offices too late for his appointment. He said that he had been in hospital the previous night after he had taken 10 ecstasy tablets and lost consciousness and had woken up in hospital. He told the Probation Officer that there had been no discharge paperwork completed at the hospital and that he didn't know that ecstasy tablets were harmful. He added that the Doctors had to repeatedly bring his back to life. He was not believed.
- 2.78 On 1<sup>st</sup> August 2012, a Probation Officer attempted to contact the Perpetrator by telephone only to be told by his brother that the Perpetrator had gone to Pakistan two weeks earlier after making a sudden decision to do so. He had left the hostel a week and a half before. The following day, advice was sought from the Crown Court about arranging a warrant for his arrest should he come back into the country.
- 2.79 On 30<sup>th</sup> August 2012, West Midlands Police received intelligence to suggest that the Perpetrator was linked by his telephone numbers to women who had reported being sexually exploited but there is no further information regarding that contained in the West Midlands Police IMR.
- 2.80 On 3<sup>rd</sup> September 2012, the Perpetrator was arrested for an outstanding warrant, the details of which are unclear. Later that month Police learned that he was living at a hostel for homeless people in Birmingham.

- 2.81 Nothing of consequence was noted until 17<sup>th</sup> January 2013, when the Perpetrator was again arrested on an outstanding warrant for not attending Court. It is recorded that he had been out of the country in Pakistan.
- 2.82 On 18<sup>th</sup> January 2013, the Perpetrator appeared before Birmingham Crown Court for breach proceedings, where his suspended sentence was extended until May 2013 and a curfew imposed for 12 weeks between the hours of 1900 and 0600. He was urged by his Probation Officer to keep his appointments.
- 2.83 On 23<sup>rd</sup> January 2013, Health records indicate that the Perpetrator attended hospital with chest pains. He explained that he had just undertaken a long haul flight from Pakistan. There were no obvious signs of trauma and he was discharged.
- 2.84 On 7<sup>th</sup> February 2013, he again complained of shortness of breath and he was referred to an Out of Hours GP clinic. He explained that he had just arrived back from Spain.
- 2.85 On 2<sup>nd</sup> April 2013 he again complained about neck and back pain and he was referred to a musculoskeletal clinic for treatment. He was also referred for physiotherapy but he did not attend and it was left that the patient should make contact with the clinic for a further appointment.
- 2.86 On 16<sup>th</sup> April 2013, Police were called to the Perpetrator's parent's address where he had attended with a friend in a drunken condition and was refusing to leave. Officers attended and recorded that no offences were committed and the two men left the address. Intelligence checks may well have shown that the Perpetrator was known and linked to this address and its occupants for a series of incidents of harassments.
- 2.87 In May 2013, the Perpetrator failed to keep his musculoskeletal appointment, but there was no subsequent follow up.
- 2.88 On 4<sup>th</sup> June 2013, the Perpetrator dialled '999' for the Police stating that there were people outside his parent's house where he was at that time. Officers attended and found him to be in a drug induced state. The Officers called for the assistance of an ambulance and he was taken to hospital under police escort. The matter was recorded as a non-crime incident. The West Midlands Police IMR Author suggests that the officers who attended may have considered this as a 'vulnerable moment' for the Perpetrator as intelligence would have shown that there had been previous incidents recorded against the Perpetrator where he had suffered drug induced paranoia.
- 2.89 From the medical assessment of this admission, the Perpetrator was suffering from the side effects of cocaine use. He was with his mother who stated that he had been out all night and was acting in a strange manner on his return, stating that there were people outside the house and a fire on the carpet. Observations showed that he had a raised temperature and a high pulse rate. Before the medical staff could complete a full assessment, the Perpetrator discharged himself from hospital, thus preventing any questioning or information seeking about his access to children and while the Health IMR Author considers this to be a missed opportunity, it is appreciated that he compromised the ability for staff to complete the assessment.
- 2.90 On 15<sup>th</sup> June 2013, the Police were called to his parent's address where the Perpetrator had taken cocaine, was self-harming and was damaging property within the house. Officers attended and due to the Perpetrator's violent behaviour they called for assistance and restrained him. He was transported to hospital where he calmed down. He was assessed as not being a risk and officers left him there. The ambulance log indicates that there was a suggestion that at the time the Perpetrator

was in possession of a knife, he was self-harming and damaging property in the household. He had cut wounds to his arms and legs incurred when he resisted arrest.

- 2.91 The Police correctly recorded the incident as a non-crime incident and placed a warning marker on his mother's address, where there had been several incidents of the Perpetrator becoming overcome by the effects of cocaine.
- 2.92 The Health IMR however indicates that the newly enacted Trust Self Harm Policy (2013) was not implemented.
- 2.93 On 25<sup>th</sup> June 2013, he again took an overdose at his mother's house. The Police and an ambulance were called but he had gone by the time they arrived. The family declined to help the officers with details of the whereabouts and the Police log was closed to the effect that the Perpetrator's family wished to deal with his situation. Officers were however, asked to return to the house later as there were concerns that the Perpetrator's mother was still upset by the episode. They were told that his father was going to send him to Pakistan to 'sort himself out'. The log did indicate that this was the fourth incident of this nature at this address. It is also recorded that a worker from SMART (Substance Misuse Arrest Referral Team) attended with the Police. SMART are able to provide advice, support, leaflets and signposting as well as assisting in referrals for support and services.
- 2.94 On their initial call to the house they found no one in and they subsequently received a message from the Perpetrator's father saying they appreciated the involvement of SMART and the Police but they wished for no further contact. A referral was made to Children's Services about the presence of PFP's children at the time of this incident.
- 2.95 In July 2013, medical notes indicate that the Victim and her family moved to an address in Warwickshire, although it appears that the Perpetrator stayed with his parents in Birmingham.

#### **The Perpetrator and the Victim**

- 2.96 In Birmingham, on 13<sup>th</sup> December 2013, Police were called to an address in Shirley, Solihull, where it was reported that there was a burglary in progress. Officers were despatched to the scene. Within two minutes another call was received by the Police from the Perpetrator who stated that he was being beaten up and the offenders had a shot gun.
- 2.97 The location was noted but it was misheard and the wrong address entered into the system. Attempts were made by the Police Control Room to contact the Perpetrator on his mobile, which at first failed, but eventually contact was made and the correct location noted, which, it was realised, was the location of the reported burglary in progress.
- 2.98 The Perpetrator reported to officers on their arrival that he had been in a taxi and had been assaulted. He was taken to the local Police Station where he said that he was living with the Victim in Warwickshire. (The Victim had by now returned from Spain and was living in Warwickshire). He admitted taking a considerable amount of cocaine and was paranoid. He had a graze to his knee and he was offered hospital treatment, but he declined.
- 2.99 The Duty Inspector told the Perpetrator to:
- 'go home and get some sleep and once he had rested to make contact with West Midlands Police'.

- 2.100 The following morning an Inspector attempted to contact the taxi company first mentioned in this incident to estimate what the threat had been the previous night, but the Inspector found that the telephone number for the taxi was incorrect. The Police log was closed indicating that the Perpetrator did not wish to complain. There is nothing to suggest that he was asked about the circumstances for his original call and although he had provided the address in Warwickshire where he said he had been living with the Victim, no enquiries were conducted with regard to the address.
- 2.101 The West Midlands Police IMR Author makes a valid comment to the effect that the Perpetrator's behaviour may well have been such as to consider him being removed to a place of safety under the Mental Health Act 1984. Intelligence checks would have indicated that he was known previously for identical reasons of making allegations that someone had a firearm whilst under the influence of cocaine.
- 2.102 The Perpetrator, (it is assumed) however, did contact the Police again as a result of a calling card being left in his possession. A man, (the Perpetrator) stated that he had taken cocaine and was hallucinating at the time of making the call to the Police. There is nothing to suggest that he was asked if he was accessing any services with regard to his drug use.
- 2.103 On 18<sup>th</sup> December 2013, a Health Visitor called at the Victim's address in Warwickshire for a planned home visit in relation to her Child (S3). There was no reply again, so a message was left stating that there would be another appointment made for January 14<sup>th</sup> 2014, some 4 weeks hence.
- 2.104 On 16<sup>th</sup> January 2014, a home visit did take place and the child was seen. The Health Visitor was told that the family had returned from living in Spain. Although there was no record of any 2 year check, the Victim assured the Health Visitor that this had been done and announced that the family were moving to Redditch Worcestershire on 1<sup>st</sup> February 2014.
- 2.105 On 28<sup>th</sup> January 2014, PFP contacted West Midlands Police saying that she was at her mother's house in Birmingham and the Perpetrator had left a message on her mother's answer phone to the effect that he had found out where she lived. She stated that she and her two children were now too scared to return to their address in Warwickshire. She told the Non-Emergency Contact Operator that she had been living in a refuge due to domestic abuse but now had a flat.
- 2.106 Officers went to see PFP at her mother's address and were told that she and the Perpetrator had been separated for about 4 years and they have two children. She also disclosed that she was five and a half months pregnant and the Perpetrator was not the father of the unborn child. She gave the officer the history of her domestic abuse with the Perpetrator and a DASH<sup>14</sup> Risk Assessment was completed, which was assessed as medium risk.
- 2.107 The Public Protection Unit was notified and the following day further safeguarding was considered and a referral was made for joint screening.<sup>15</sup> Joint screening was

---

<sup>14</sup> Domestic Abuse, Harassment and Stalking Risk Assessment Tool used to assess the risk involved

<sup>15</sup> Joint screening mechanism is used for domestic abuse and the impact that abuse has on the children in that relationship. In 2009 Barnardos Screening Tool (BST) was introduced to West Midlands Police. As a result of Service Transformation (STT) Project of 2013/2014 West Midlands Police are moving towards the implementation of Multi Agency Safeguarding Hubs (MASH) who will have the responsibility of MASH to joint screen cases of domestic abuse. MASH is currently operational in Sandwell and Birmingham (June 2014).



completed at a local level by officers aligned to the Child Abuse Investigation Team within the Public Protection Unit (PPU). Prior to the meeting each agency researched their involvement with the subjects of the domestic abuse incident (including children of the relationship). During the screening meeting the team reviewed the case in order to establish if there is any child protection safeguarding requirement.

- 2.108 PFP explained that she had previously made complaints but had not followed them through to the prosecution stages. She was now seeking legal advice and rather than going back into a refuge she was considering moving to somewhere where the Perpetrator did not know. She asked about a Non-Molestation Order and the Officer advised her that there needed to have been a recent incident for the courts to issue one, and as there had not been such an incident for the past 2 years, it was unlikely to succeed. She was reluctant to disclose the details of the previous domestic abuse other than to say she had been a victim for 2 years and the Perpetrator was a controlling person who did not allow her to have contact with friends or her family.
- 2.109 As a result of the Screening Meeting the matter was graded a Scale 2 incident, which states:
- ‘Scale 2 – Consider referring to a support agency, consider a CAF (Child and Families) intervention. This scale is below the level of risk where Children’s Services would be expected to make a formal intervention.
- 2.110 In February 2014, the Victim completed a new patient registration form at a GP surgery in Redditch Worcestershire. The family had by now moved from Warwickshire. During her stay in Spain she had made contact with the Perpetrator and they had formed a relationship. On her return to the UK the relationship had developed and the Perpetrator had moved in with the Victim and her family. According to the GP registration form the Victim described herself as being in a relationship and apart from herself and S3 the other people resident in the house were, her mother, her step father, (mother’s partner) two brothers and her boyfriend.
- 2.111 GP notes for 19<sup>th</sup> February 2014, indicates that the Victim had just found out she was pregnant and she was advised to book antenatal appointments.
- 2.112 On Saturday 15<sup>th</sup> March 2014, at 0736, the Perpetrator contacted West Mercia Police via 999 from his mobile telephone, saying ‘there are people at my address. I need the Police’. It is recorded that in the background to this call, Operators could hear someone saying ‘Get off me’. The telephone line then went dead and despite the Operator attempting to ring the number back, it constantly went to answerphone.
- 2.113 In view of the nature of the first call, Officers were despatched. Checks on the telephone number indicated that the subscriber to be the Victim.
- 2.114 Officers attended at the area of the address at 07.47 but as the area was a new build they had some difficulty in finding the correct address, which they did at 08.22. However prior to the Police arriving, the Perpetrator again contacted the Police stating that he no longer needed them, it was people being stupid and that he had to leave now.
- 2.115 On arrival Officers spoke to the Perpetrator and the Victim and reported back to control that the Perpetrator had been taking cocaine and drink which had led him to hallucinate and become paranoid. He thought there were people in the house trying to get him. Officers told him to ‘sleep it off’ and he was given advice about his behaviour. No further Police action was deemed necessary. There is nothing to indicate that the Victim was spoken to on her own on this occasion.

- 2.116 At 11.04 the same day, the Perpetrator again dialled 999 for the Police. The call went to Warwickshire was re-directed to West Mercia. He stated that there was a taxi outside his house with a man in the boot.
- 2.117 Almost at the same time, the Perpetrator again called 999. This time the call went to West Mercia Police. It was to the effect that there was someone at the door and he had something on him and he felt threatened. The Call Taker then heard the caller, the Perpetrator, say, 'She has opened the back door', a female then shouted 'Get off' and the call was terminated.
- 2.118 Officers en-route linked the call to the earlier attendance to the Perpetrator who was suffering from the effects of cocaine and they summoned an ambulance. On arrival they saw the Victim on the kitchen floor covered in blood. They also saw the Perpetrator nearby whose clothing was heavily blood stained. He was holding three kitchen knives.
- 2.119 The Victim had suffered multiple stab wounds and was taken to hospital by ambulance. The perpetrator was arrested on suspicion of murder and taken into custody. The Victim died from her injuries in hospital the following morning.
- 2.120 A few minutes later, Police received a call from a neighbour to the effect that a 12 year old boy, the Victim's brother was there saying he had witnessed his sister being threatened by the Perpetrator and that the Perpetrator had stabbed himself in the hand with a knife.
- 2.121 A Forensic Post Mortem was subsequently conducted by a Forensic Pathologist who determined that the Victim had suffered some 64 penetrative wounds to various parts of her body as well as 31 other injuries. The Pathologist determined that the Victim was 13 weeks pregnant at the time of her death. His conclusion was that although many of the penetrative wounds were superficial, she had suffered a wound to her carotid artery to the left side of her neck, which proved fatal. He determined the cause of death to be:
- '1a. Stab wounds complicated by haemorrhage and hypoxic/ischaemic brain damage'.
- 2.122 West Mercia Police commenced a murder investigation. The Perpetrator was charged with the Victim's murder. HM Coroner for Worcestershire opened an inquest on 27<sup>th</sup> March 2014, and adjourned to a date to be fixed.
- 2.123 During the investigation it became apparent that the Perpetrator had taken a significant amount of drugs, probably cocaine. CCTV footage showed a person delivering what is thought to be drugs to the house at 0215 hours that morning, which it is thought he used. (The Police subsequently arrested that person who was a known drug dealer). Enquires reveal that the Perpetrator had taken drugs before that, whilst he was out of the house earlier that evening.
- 2.124 On 25<sup>th</sup> September 2014, the Perpetrator appeared before the Crown Court and after initially pleading Not Guilty to murder, on 29<sup>th</sup> September 2014; he changed his plea to one of guilty. He was convicted of Murder sentenced to life imprisonment with the Judge's recommendation that he serves 19 years.

### **Views of the family**

- 2.125 Guidance requires the Chair/Author of Domestic Homicide Reviews to have significant contact with members of the Victim's family, friends and close associates, as well as the Perpetrator themselves.
- 2.126 On 21<sup>st</sup> July 2014, at an early stage in the Review process, the Chair/Author wrote to the Victim's mother explaining the DHR process and inviting her to contribute to the review. The letter was delivered by the Police Family Liaison Officer.
- 2.127 On the same day, a similar letter was written to the Perpetrator and sent to the Prison where he was on remand. The letter invited him to contribute to the Review process but made it clear that any contact he wishes to make with the Chair/Author would be after the criminal proceedings had been completed. No acknowledgment of the letter has been received and no contact has been made by the Perpetrator.
- 2.128 A similar letter of explanation was sent to the Perpetrator's solicitor, which similarly did not attract an acknowledgement. The invitation remains open to the Perpetrator.
- 2.129 On 4<sup>th</sup> September 2014, the Chair/Author met with the Victim's mother at her house in Worcestershire. She was at that time receiving support from a representative of the Charity AAFDA (Advocacy After Fatal Domestic Abuse), and she continues to have contact with that organisation.
- 2.130 The Victim's mother explained that the father of S3 was an Asian man, who left the relationship with the Victim once the Victim became pregnant by him and he has not been seen since. The Victim and her mother have brought the child up.
- 2.131 She explained that she had two other children by a relationship with F2 in the genogram resulting in two boys, S4 and S5, S5 being diagnosed with ADHD. She stated that the father of the Victim (F1) had left her some years previously and that the Victim did not have any contact with him.
- 2.132 She went into detail about the move to Spain and how during the last few months they were there, the Victim had contacted the Perpetrator by Facebook and they had started to 'talk' to each other. On the family's return to the UK the Victim and the Perpetrator started to see each other and a relationship grew. She was aware that the Perpetrator's family had sent him back to Pakistan for an arranged marriage but he had returned without a wife.
- 2.133 As far as the Victim's mother knew, the Perpetrator had two children by a former partner and there was animosity between him and the former partner (PFP). He only saw his children on the odd occasion and PFP would do anything to stop him having access. PFP was demanding more money for the care of the children, which he couldn't afford. She was aware that he had been excluded from his own family home, but was unaware of the reason behind that.
- 2.134 It was at that stage that the Victim suggested to her that the Perpetrator should move in with them. They were by that time living in Warwickshire. The Victim's mother thought the Perpetrator to be a very kind polite person who was very caring towards her daughter and her young son. When she became pregnant by him, the mother stated that he was happy.
- 2.135 She did describe one early morning not long before the death of her daughter when the Perpetrator and the Victim were arguing in their bedroom and the argument spilled onto the landing. She went to see what was happening and her daughter said that he had been out until the early hours and had come home drunk and after taking drugs and wanted sex. The Victim had refused and an argument had started. The mother said that she stopped the argument and told the Perpetrator that if this sort of

thing happened again he would have to leave. That was the first time the Victim's mother knew of his drug misuse.

- 2.136 Since the day of the death of the Victim, the mother has discovered that her own son, S4 had witnessed the Perpetrator snorting cocaine in S3's bedroom. She has also learned that CCTV had captured images of a person delivering drugs to the house at 0215 on the morning of the murder.
- 2.137 The Victim's mother questioned whether the Police had the power at that time of the incidents described above, to disclose what they knew about the Perpetrator regarding his antecedents and past criminal history. This is discussed later in this report.
- 2.138 On 23<sup>rd</sup> June 2015, the Author again saw the Victim's Mother at her home, now in the Home Counties of England. The Author went through the report with her and she highlighted some amendments, which have now been incorporated into this version of the report. She was content with the findings and recommendations. Also present was a representative of AAFDA, a support organisation for victims of domestic abuse and homicides.
- 2.139 At the beginning of this review process, PFP and the Perpetrator's family were written to and invited to contribute to the review. Nether replied at that stage. Following the conviction of the Perpetrator, the Police Family Liaison Officer contacted PFP and asked if she was able to help with the review process. She indicated that she would think about it, but subsequent contact by the FLO was met with a determined refusal to take part. A similar situation arose with the father of the Perpetrator, who tried so hard to get his son help with his drug misuse. The Author spoke to a brother of the Perpetrator who spoke on behalf of his Father. He said that there is no doubt at all that his Father would not contribute and the family wanted to move on from this awful event. He stated that the Father would not speak to the Author, even to say that he did not wish to take part.

### **Comments made by the Drug Specialist**

- 2.140 As stated earlier in this report, the Review Panel had the benefit of hearing from an expert drug advisor from the Pathway to Recovery Service. She stated that cocaine was a short term stimulant and the effects of a 'snort' would last between 15 to 30 minutes. The period of euphoria would eventually decline and in order to maintain that feeling the person would have to continually take more cocaine. The person would be unable to sleep and so paranoia would begin. Aggression is quite common through lack of sleep and the person would probably be unable to analyse situations especially if the person had paranoid personality traits. The person would be able to drink more because of their adrenalin and this would be exaggerated if the person was smoking cannabis as this would result in disinhibitions.

### **3. Analysis and Recommendations**

- 3.1 This Overview Report deals with the death of the Victim at the hands of the Perpetrator, but also illustrates the relationship the Perpetrator had with his former partner, which bore striking similarities to the relationship he had with the Victim. The evidence and information gathered during the course of this Review however, indicates that there was more known about his relationship with PFP than his relatively short relationship with the Victim.
- 3.2 Agencies were aware of the Victim's family. Children's Social Care in Birmingham had been involved with the Victim's mother and the Victim's half siblings some years earlier. Until the series of incidents concerning the Perpetrator started to unfold in

December 2013, when the Victim and her family returned from Spain and had settled in Warwickshire, there was little known about the Victim or her child, other than a brief health entry when she attended her booking in appointment with regard to her pregnancy with S3.

- 3.3 Most of the events illustrated in this Review concern the Perpetrator and PFP, but details are included to demonstrate the Perpetrator's constant lifestyle and behaviour prior to and subsequent to his relationship with the Victim.
- 3.4 Looking at the period when he was with PFP, the Perpetrator had significant contact with the Police. This was mainly over his drug and alcohol use, but also on a number of occasions, regarding complaints by PFP about him harassing her, which the West Midlands Police IMR rightly points out is a criminal offence. Some of those complaints lacked sufficient investigation and should have resulted in more positive action by officers dealing with her complaints. There were missed opportunities to consider action under Harassment legislation and even public order offences. There were certainly opportunities missed to take action regarding his drug abuse and to link those incidents with consideration of the protection of victim's half siblings, who were often present when his drug usage became evident.
- 3.5 On 9<sup>th</sup> March 2009, BSMHFT received a referral from the Prison In Reach Worker, who had carried out an assessment prior to the Perpetrator being released from custody. It appeared that a Home Detention Order was in place following his release but the assessment did not contain any details of that Order. Nor did it contain the reasons why the Perpetrator had separated from PFP and their child, which may have opened an opportunity to consider child protection and adult protection referrals or investigations.
- 3.6 The Perpetrator was never determined to meet the criteria for treatment under the Mental Health Act 1983, so his Care was not subject to the conditions of the Care Programme Approach<sup>16</sup> (CPA).
- 3.7 His case was allocated to an Out Reach Worker with BSMHFT Drug Intervention Programme (DIP) and an appointment made which he failed to attend and there is nothing to suggest that Probation were made aware of his failure to comply with his breach of the Home Detention Order or the difficulty with his lack of engagement with BSMHFT. There appears to be no questions asked of him at any time about his domestic circumstances and whether there was any domestic abuse within his relationship with PFP, especially when his drug misuse, which including cocaine, appeared to be escalating during the period of his DRR Court Order. There was no further communication with Probation about this.

---

<sup>16</sup> The Care Programme Approach (CPA) was introduced by the Department of Health in 1991 as a framework for the assessment and management of persons with a mental health disorder, both in hospital and in the community. Since it was introduced the CPA has been revised and reinforced through a series of guidelines and circulars, the most recent of which was the 'Refocusing the Care Programme Approach - Policy and Positive Practice Guidance' published by the Department of Health in 2008. The CPA framework is designed to ensure that anyone who is referred to specialist mental health services has:

- a systematic assessment of their health and social care needs;
- the formulation of a care plan to address their identified health and social care needs;
- a key worker ( known as a care coordinator) who must keep in close contact with the service user to monitor and co-ordinate their care; and
- regular reviews

- 3.8 The role played by alcohol or drug misuse in domestic violence and abuse is poorly understood. Research has indicated that 21% of people experiencing partner abuse in the past year thought the perpetrator was under the influence of alcohol and 8% under the influence of illicit drugs<sup>17</sup>. People are thought to be at increased risk of substance dependency as a consequence of being the victim of domestic violence.<sup>18</sup>
- 3.9 With regards to Warwickshire Education and Learning, it is known that whilst S4 was registered at school in Warwickshire, he did not attend for 8 months. For some reason there was lack of information exchange between Warwickshire and the Spanish Authorities for the child's school records. Whilst it is appreciated that S4's situation was complicated by the family's movement from Birmingham to Spain, to Warwickshire and finally to Worcestershire, it remains fact that he was registered at a Worcestershire school to which he never attended. If a referral had been made to Worcestershire Children Missing Education Team, this may have undoubtedly triggered a Child and Young Person's assessment, which may have highlighted the fact that the Perpetrator was considered a member of the Victim's family.
- 3.10 There does not appear to have been any open channels of communication between local authorities and agencies. The Perpetrator and the Victim's families were known to Birmingham agencies but that information did not follow them to Warwickshire and Worcestershire, when the family returned from Spain.

#### **Recommendation No 1**

**Warwickshire Safeguarding Children Board (WSCB) are to seek assurance that:**

- a) Children in Warwickshire seeking a school place are identified and an appropriate offer of a school place is made in a timely manner**
- b) When children in Warwickshire are not in education relevant assessments are undertaken in relation to any identified vulnerabilities and appropriate arrangements are made to safeguard the child where required.**

- 3.11 It may be said that West Midlands Police were not aware of the Victim, her move to Spain or her return from Spain to live in Warwickshire. There were however, opportunities to uncover these facts by intelligence checks that were not conducted.
- 3.12 On 13<sup>th</sup> December 2013, the Perpetrator reported that he had been beaten up by men who had a shot gun. He was at this time at an address in Solihull. West Midlands Officers attended and the Perpetrator stated he had taken a considerable amount of cocaine and said he was living with his girlfriend (the Victim) in Warwickshire. He was told to go home and get some sleep. No checks were made with Warwickshire, nor was he asked about his home circumstances. A Police 'calling card' was left in his possession and later a man (presumed to be the Perpetrator) called West Midlands Police saying that he was hallucinating at the time of making the original call.
- 3.13 On 28<sup>th</sup> January 2014, PFP called West Midlands Police, She was at her mother's address in Birmingham and saying that the Perpetrator had found out where she lived and she was in fear of her safety. She gave a summary of the history behind her complaint. A DASH Risk Assessment was completed and subsequently a

---

<sup>17</sup> Homicides, firearms offences and intimate violence 2010/11: supplementary volume 2 to Crime in England and Wales 2010/11 Home Office

<sup>18</sup> Domestic Violence and Substance Use; Tackling Complexity British Journal of Social Work 35; 1303-20 Humphreys C., Regan L., River D. et al 2005

Screening Meeting was held where it was decided that the incident was below the level of risk where Children's Services would be expected to become involved. There is nothing to indicate communication with West Mercia Police where the Perpetrator now lived with the Victim.

- 3.14 Both of these incidents indicate a missed opportunity to conduct intelligence checks and to share information about a cocaine user (the Perpetrator) who repeatedly came to the notice of West Midlands Police for drug and domestic issues. There was evidence he was living in West Mercia Police area with the Victim. PFP was now complaining about him harassing her. PFP and her children were living in fear of him. None of that information was shared with West Mercia Police. There was a lack of understanding of the risks posed from stalking and harassment which were continuing almost 2 years after separation and still whilst in a new relationship
- 3.15 West Mercia Police attended at the home address of the Victim on the morning of 15<sup>th</sup> March 2014, hours before the attack on the Victim occurred. They responded to the Perpetrator who was clearly suffering the effects of drug misuse. Police Officers were told that the Perpetrator had taken cocaine, and they told him to 'sleep it off'. There was no consideration of a referral being submitted about the children that were present at that time. Nor was there any consideration for the safety of the Victim at that time, who was in the presence of a man affected by drugs.
- 3.16 The West Mercia Police IMR points out that in addition, there was no consideration about the welfare of the Perpetrator himself and as to whether he ought to have received medical assessment or indeed arresting him for drug related offences. There is nothing to suggest that the thought of conducting a search of him or the premises under drug legislation was considered.
- 3.17 The Health Visitor's IMR indicates that a Student Health Visitor saw PFP in the normal course of events at her address in Birmingham. There is nothing to suggest that the issue of domestic abuse was mentioned or whether PFP was spoken to about domestic abuse when she was on her own. There is nothing recorded to the effect that she was in company of the Perpetrator at the time and therefore questions about domestic abuse were not or could not be asked on that occasion.

#### **Disclosure of criminal antecedents of the Perpetrator**

- 3.18 The implementation of the Domestic Violence Disclosure Scheme followed the case of Clare Wood, who was murdered by her former partner in Greater Manchester in 2009, and the case brought to national attention the issue of disclosing information about an individual's history of domestic violence to a new partner. Noting that her former partner had three previous convictions under the Protection from Harassment Act 1997, the Coroner's report into the murder published in July 2011 contained the following recommendation:

"subject to appropriate risk assessment and safeguard, I recommend that consideration should be given to the disclosure of such convictions and their circumstances to potential victims in order that they can make informed choices about matters affecting their safety and that of their children."
- 3.19 The tragic case of Clare Wood follows a report commissioned by the Home Office and published in 2009 by Chief Constable Brian Moore of Wiltshire Police on behalf of the Association of Chief Police Officers (ACPO) - Tackling Perpetrators of Violence

against Women and Girls<sup>19</sup>. Chief Constable Moore set out a series of ten recommendations which included a “right to know” where he concluded that;

“whilst routine disclosure should not be common practice, following risk assessment it may be proportionate and necessary to enable a potential victim to make choices about her safety and that of her children.”

- 3.20 This led to the publication of Home Office Guidance<sup>20</sup> which suggested that there were three conditions when seeking to disclose under ‘Clare’s Law’; (A being the Victim – B being the Perpetrator)

Option 1: continue current arrangements under existing law where the police already have common law powers to disclose information relating to previous convictions or charges to A where there is a pressing need for disclosure of the information concerning B’s history in order to prevent further crime.

Option 2: a “right to ask” national disclosure scheme which enables A to ask the police about B’s previous history of domestic violence or violent acts where the police would undertake full checks to inform a risk assessment and disclosure. A precedent upon which suitable adaptations could be made exists with the Child Sex Offender Disclosure Scheme;

Option 3: a “right to know” national disclosure scheme where the police would proactively disclose information in prescribed circumstances to A relating to B’s previous history of domestic violence or violent acts (as envisaged in the ACPO report of 2009).

- 3.21 As can be seen at the time of Clare’s case the police already had common law powers to disclose information relating to previous convictions or charges to A where there is a pressing need for disclosure of the information concerning B’s history in order to prevent further crime. It therefore follows that currently:

- any member of the public can already ask the police for information about a third-party’s violent history;
- the police have discretion on whether to disclose the information if there is a need to prevent a further crime.

- 3.22 Under the Multi-Agency Public Protection Arrangements (MAPPAs), where a violent offender requires interagency management at Level 2 or Level 3 as defined by the MAPPAs criteria, the local MAPPAs panel is already obliged to consider disclosing previous convictions to potential victims every time an offender’s case is reviewed. The relevant areas of existing law are as follows:

- the common law power for the police to share information for policing purposes (for the prevention and detection of crime);
- Data Protection Act 1998;
- Human Rights Act 1998;
- Children Acts (1989) and (2004); and
- Criminal Justice and Immigration Act (2008)

---

<sup>19</sup> Tackling Perpetrators of Violence against Women and Girls Sept 2009 ACPO

<sup>20</sup> Domestic Violence Disclosure Scheme - A Consultation October 2011 Home Office



- 3.23 The Domestic Abuse Disclosure Scheme 2013, was implemented across West Midlands Police force area in March 2014, since the issues raised in this review, after PFP had separated from the Perpetrator and after the Victim had returned from Spain and moved to Warwickshire.
- 3.24 However, the major caveat in this case was the fact that the Perpetrator had not been convicted of a domestically related offence. He had been charged but PFP withdrew her complaint and the case did not proceed to Court. Therefore the Perpetrator was not subject of MAPPA criteria or classed as a violent offender.
- 3.25 Given that PFP declined to pursue any prosecution against the Perpetrator for any offence, and all of the facts were not known to West Midlands Police Officers, the implementation of the Common Law power to disclose as stated above did not arise. PFP did not ask for disclosure and the officers were thereby constrained by the Data Protection Act, preventing them from disclosing to PFP without her requesting disclosure.
- 3.26 However there is evidence that PFP feared for her safety on numerous occasions in relation to his harassment of her and on those occasions it is considered that West Midlands Police should have considered referring PFP and her children to MARAC<sup>21</sup> as a High Risk Victim.
- 3.27 A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors<sup>22</sup> (IDVAs), probation and other specialists from the statutory and voluntary sectors.
- 3.28 After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with other fora to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.
- 3.29 The focus of the MARAC is to implement a safety plan for the adult victim of abuse. However, children which are involved in the same MARAC case as an adult high risk victim will be mentioned at MARAC. This ensures that the relevant agencies that are charged with safeguarding children are informed of the children's situation. For example, Children and Young People's Services may undertake a separate

---

<sup>21</sup> Multi-Agency Risk Assessment Conference.

<sup>22</sup> The Independent Domestic Violence Advisors (IDVA) is a government initiative introduced to reduce the number of Domestic Related Homicides. IDVAs focus on high risk clients by supporting at a point of crisis, supporting them to plan appropriate safety management strategies. These pro-active responses safeguard service users and their dependents. A central part of the role involves supporting them to access and navigate through the Criminal Justice System. The Home Office initiated the development of Multi Agency Risk Assessment Conference (MARAC) and IDVA service at a local and national level to offer coordinated responses to victims of domestic abuse. Currently Local Authority funds the IDVA service. The IDVA works in partnership with MARACs to reduce the risk of harm to high risk clients. The IDVA service has continued to be central to the Multi-Agency Risk Assessment Conference (MARAC) in providing a coordinated service to women at high risk of serious harm and domestic homicide; focusing on reducing risk and safety management of women and their dependents. The IDVA sign post to other organisations when risk is reduced

assessment of a child involved in a MARAC case to determine whether or not the child requires additional support or safeguarding measures. Many vulnerable, previously 'hidden' children who are living with domestic abuse are identified through the MARAC process.

- 3.30 Similarly, IDVAs are not typically able to offer a separate, individual service to children affected by domestic abuse, but all IDVAs have a duty to work with parents to highlight the risks to children from witnessing domestic abuse. IDVAs also have a duty to inform Children and Young People's Services if they believe that a child is at risk of harm.
- 3.31 It is clear then, that if PFP had been referred to MARAC other agencies would have been involved and the Perpetrator would have been monitored as he moved from PFP in Birmingham to the Victim in Warwickshire and Worcestershire. There would have been a more holistic inter-agency view of his involvement in both families which may have triggered more assertive action especially regarding child protection and possible domestic abuse issues.

### **Domestic Violence Prevention Notices and Orders**

- 3.32 Domestic violence protection orders (DVPOs) are being implemented across England and Wales from 8 March 2014. This follows the successful conclusion of a 1 year pilot in the West Mercia, Wiltshire and Greater Manchester police force areas.
- 3.33 Domestic violence protection orders are a new power that fills a gap in providing protection to victims by enabling the police and magistrates to put in place protection in the immediate aftermath of a domestic violence incident.
- 3.34 With DVPOs, a perpetrator can be banned with immediate effect from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim time to consider their options and get the support they need
- 3.35 Although the power to issue a DVPN and subsequent application for a DVPO lies with the police (DVPN) and ultimately the Criminal Justice Service (DVPO), the success of any such process will be reliant on the partnership work with other agencies and organisations including those that contribute to MARACs and service providers for Independent IDVAs.
- 3.36 Engagement of these agencies with the victim, at the earliest opportunity, is crucial to the success of the DVPN/ DVPO process
- 3.37 In another recent Domestic Homicide Review in Worcestershire (Case 6) a recommendation was made regarding DVPNs:

**“West Mercia Police to confirm with North Worcestershire Community Partnership within 6 months of the date of this report that information regarding the dissemination of the use of Domestic Violence Protection Notices and Orders has been completed for all officers within the force”.**

- 3.38 Whilst the same recommendation can be made in this report, it is unnecessary to repeat it as the Action Plan for Case 6 will adequately manage that recommendation.
- 3.39 However the recommendation needs to be made regarding West Midlands Police to ensure a commensurate system is in place in the neighbouring force areas.

## **Recommendation No 2**

**West Midlands Police to confirm with North Worcestershire Community Safety Partnership within 6 months of the date of this report that information regarding the dissemination of the use of Domestic Violence Protection Notices and Orders has been completed for all officers within the force.**

- 3.40 The common theme in this case is the lack of information sharing between West Midlands and West Mercia Police predominantly caused by the lack of intelligence checking. Information about the Perpetrator was contained within West Midlands Police intelligence systems, which were available to West Mercia Officers, and officers from both forces had opportunities to check the system and retrieve information that would have been useful in the overall picture of his behaviour and may well have led to positive action.
- 3.41 On the day of the murder, Officers from West Mercia Police had opportunity to check intelligence concerning the Perpetrator. They would have found that he had a propensity to self-harm. They left the house on the assumption that the Perpetrator was going to sleep off the effects of the drugs and they apparently had no concerns for the welfare of anyone else in the house. At the time of leaving the officers did not know who was in the house. Intelligence would have indicated that he had made threats to his previous partner PFP and he had been denied access to their children. The intelligence available would have provided the officers with alternative ways of dealing with this incident. It wasn't until the second call made by the Perpetrator that the officers requested an ambulance to the scene, thinking about the Perpetrator's care, but by now he had taken the life of the Victim.
- 3.42 West Mercia Police IMR contains a number of appropriate recommendations, one of which is similar to the recommendation No 3 below, but as it is only pertinent to West Mercia Police, this Overview Report widens the scope of the recommendation to include West Midlands Police as well.

## **Recommendation No 3**

**West Midlands Police and West Mercia Police examine their policies and procedures regarding action taken by officers at the reports of domestic abuse complaints, to ensure that all possible intelligence is gathered on the parties concerned and if necessary that intelligence is shared with other Police forces and agencies as deemed appropriate.**

- 3.43 In relation to Health, the Heart of England NHSFT IMR identifies that the Victim, who was a teenage mother, had an increased risk and vulnerability and the necessary Teenage Pregnancy Notification was completed in line with Trust policy and that the routine enquiry regarding domestic abuse had been used appropriately but no disclosures had been made by the Victim. However, at the time of birth of S3, there was no record of who attended with her, but at that time there was no requirement to record such information, which may have been useful. The system now has changed. Since September 2011 those details are required to be recorded for safeguarding reasons.
- 3.44 In relation to the Perpetrator, the Heart of England NHSFT IMR states that the Trust Self Harm Policy was not followed during his presentation in June 2013, which was probably due to him taking his own early discharge. However, this meant that the relevant assessment paperwork was not completed and therefore no referral to the RAID Team. The Policy was new, only having been implemented one month before. Since this incident staff have since been alerted to the Policy. Overall an assessment

made of the Perpetrator's contacts and relationships indicate that no details were obtained about his relationships and any contact with children, which given his substance misuse and self-harm propensity should have been explored in greater detail. His records did not indicate a referral or signposting to substance misuse services.

- 3.45 The Probation Service indicates that many offenders with substance misuse issues lead a chaotic lifestyle that makes engagement and the keeping of appointments difficult. In this case the Perpetrator was only able to keep a limited amount of appointments and therefore was unable to fully benefit from interventions available to him in particular his Drug Treatment Requirement.
- 3.46 In order to assist with this problem the National Probation Service suggests that co-ordination with the arrangement of appointments between agencies would be helpful.

#### **Recommendation No 4**

**Agencies that work with substance misuse service users and other individuals that lead chaotic lifestyle, ensure appointments are co-ordinated resulting in joint interventions /meetings being better established. This will need a more structured approach to information sharing.**

#### **4. Conclusions**

- 4.1 The Perpetrator was known to West Midlands Police, Probation and various Health agencies in Birmingham. His substance and alcohol misuse were also well known and a constant source of problems for himself and PFP and their children. His family attempted on several occasions to get help for his drug problem but he failed to engage with health agencies. He failed to comply with the conditions of his drug treatment programme
- 4.2 There were missed opportunities to take Police action regarding his harassment of PFP with regard to Domestic Violence Prevention Notices and to take positive action when he presented with the effects of drugs. These are adequately dealt with in both West Mercia and West Midlands Police IMR recommendations.
- 4.3 Complaints from PFP regarding his behaviour towards her especially when in public were not acted upon. She withdrew her allegation of domestic abuse thus preventing court action for the Perpetrator. She made several contacts with the Police expressing fear for her and her children's safety. There should have been consideration of a victimless prosecution as she had two children whose safety was at risk. Had that happened the Perpetrator may have been flagged as high risk. Whilst reports from the Police indicate that PFP declined to continue with her complaints against the Perpetrator, it has to be acknowledged that some victims are not in a position to continue to complain for fear of violence and retribution from the Perpetrator. Some victims are controlled by the Perpetrator to such an extent that they are unable to disclose or complain and in this case it may be that PFP was seeking a short speedy relief when she called for Police assistance knowing that she would not see her complaint through to the end.
- 4.4 Information known about the Perpetrator was not shared with other agencies or fellow Police forces which resulted in the holistic picture of his drug and alcohol problem and the effect that had on PFP and more recently the Victim and their respective children was not recognised.
- 4.5 S4 was absent from school for 8 months and this was not identified as a problem worthy of investigation. This was a missed opportunity for Education to flag to

Children's Social Care that S4 may have been at risk during his absence from school.

- 4.6 There was no joint thinking and a lack of professional curiosity judgement among professionals. No one agency had the full facts because of the lack of a comprehensive overview and information exchange.
- 4.7 Based on his antecedent history, the Perpetrator was not going to change his lifestyle. He had numerous opportunities to do so but failed each time. His drug misuse held more importance than his children or relationships but he showed a disturbing possessive nature with regard to PFP. He demonstrated his possessiveness with the Victim. He thought she was seeing someone else or contacting another. Fuelled by the effects of two very large doses of cocaine within a very short period he killed the Victim.
- 4.8 Whilst information sharing may have meant more positive action by the Police in respect of him harassing PFP and/or his drug abuse, his mental health was not regularly assessed. He was last seen by Mental Health on 29<sup>th</sup> May 2012. Perhaps if his contact with the Police since that date or his attendance at Emergency Department at Hospital had focused on his mental health he may have had mental health support or treatment.
- 4.9 The Health Visitor's IMR points out clearly that there was a lack of professional curiosity about the adults in S3's life. A routine enquiry about domestic abuse was not documented although it is not known if there was appropriate opportunity to ask questions about it. This has been identified as a learning point together with the adults taking care of the child S3 and the recording of information in the child's health records. Both of these issues have been adequately dealt with in the Health Visitor's IMR recommendations.
- 4.10 In all of the circumstances this review has identified and despite the short comings of various agencies in a variety of ways, the fatal attack on the Victim could not have been predicted or prevented. To reiterate the comments made by the Victim's mother about the Perpetrator a short time before the murder and before she knew the truth about her daughter's partner:

"I thought the Perpetrator to be a very kind polite person who was very caring towards my daughter and her young son. When she became pregnant by him, he was happy".

## List of Recommendations

### Recommendation No 1

Page 31

Warwickshire Safeguarding Children Board (WSCB) is to seek assurance that:

- a) Children in Warwickshire seeking a school place are identified and an appropriate offer of a school place is made in a timely manner
- b) When children in Warwickshire are not in education relevant assessments are undertaken in relation to any identified vulnerabilities and appropriate arrangements are made to safeguard the child where required.

### Recommendation No 2

Page 36

West Midlands Police to confirm with North Worcestershire Community Safety Partnership within 6 months of the date of this report that information regarding the dissemination of the use of Domestic Violence Protection Notices and Orders has been completed for all officers within the force.

### Recommendation No 3

Page 36

West Midlands Police and West Mercia Police examine their policies and procedures regarding action taken by officers at the reports of domestic abuse complaints, to ensure that all possible intelligence is gathered on the parties concerned and if necessary that intelligence is shared with other Police forces and agencies as deemed appropriate.

### Recommendation No 4

Page 37

All agencies when working with substance misuse service users and other individuals that lead chaotic lifestyles, ensure appointments are co-ordinated resulting in joint interventions /meetings being better established. This will need a more structured approach to information sharing

## Bibliography

**Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews -**  
Home Office 2011 [www.homeoffice.gov.uk/publications/crime/DHR-guidance](http://www.homeoffice.gov.uk/publications/crime/DHR-guidance)

**Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews**  
**Revised** August 2013 Home Office

**DASH Policy – Domestic Abuse, Stalking and Harassment and Honour based Violence**  
West Midlands Police 2011

**The Care Programme Approach**  
Department of Health 1991

**Refocusing the Care Programme Approach - Policy and Positive Practice Guidance**  
Department of Health in 2008.

**Tackling Perpetrators of Violence against Women and Girls**  
ACPO Sept 2009

**Homicides, firearms offences and intimate violence 2010/11:** supplementary volume 2 to  
Crime in England and Wales 2010/11 Home Office

**Domestic Violence and Substance Use; Tackling Complexity** British Journal of Social  
Work 35; 1303-20 Humphreys C., Regan L., River D. et al 2005

**Domestic Violence Disclosure Scheme - A Consultation**  
Home Office October 2011



## North Worcestershire Community Safety Partnership

### Domestic Homicide Review Case No. 7

#### ACTION PLAN

#### Overview Report Recommendations

Recommendation	Action Required by Agency	Implementation Lead	Target Date for Completion	Summary of Actions Taken and Date
<p><b>Recommendation No 1</b></p> <p>Warwickshire Safeguarding Children Board (WSCB) is to seek assurance that:</p> <ul style="list-style-type: none"> <li>a) Children in Warwickshire seeking a school place are identified and an appropriate offer of a school place is made in a timely manner</li> <li>b) When children in Warwickshire are not in education relevant assessments are undertaken in relation to</li> </ul>	<p>Warwickshire Safeguarding Children Board</p>	<p><b>Nigel Minns</b> <b>Head of Education and Learning, WCC</b></p>	<p>April 2016</p>	<p>WCC Education and Learning will be presenting a progress report to the Performance, Monitoring and Evaluation sub-committee of WSCB in April 2016. The report will include progress against points a) and b) of recommendation 1. WSCB will be able to seek further clarification or assurance. This report will be sent to Worcestershire County Council as confirmation of progress</p>



<p>any identified vulnerabilities and appropriate arrangements are made to safeguard the child where required.</p>				
<p><b>Recommendation No 2</b></p> <p>West Midlands Police to confirm with North Worcestershire Community Safety Partnership within 6 months of the date of this report that information regarding the dissemination of the use of Domestic Violence Protection Notices and Orders has been completed for all officers within the force.</p>	<p>West Midlands Police</p>		<p>September 2015</p>	<p>Delivered by West Midlands Police to all officers and staff as part of Operational Sentinel.</p> <p>One of the main strategic objectives of Operation Sentinel was to ensure that new legislation and policy is understood, ingrained and adhered to (Care Act 2014; Anti-social Behaviour Crime and Policing Act 2014 which includes Forced Marriage; The Crime and Security Act DVPO's and DVPN's; Victims Code and Code of Ethics).</p> <p>Training has been provided to all officers regarding DVPO's and DVPN's through Operation Sentinel, e learning NCALT training packages and Newsbeat editorials.</p> <p>The WMP Process Solution Document for</p>

				<p>Domestic Abuse Teams – Version 4 states that one of the identified responsibilities of the team is that they “prepare documents and lay information before a court for example, in relation to the application for civil orders such as Domestic Violence Protection Orders or financial productions orders”.</p> <p>The Offender Manager Toolkit for engagement advises offender managers regarding the use of DVPN’s and DVPO’s including non-crime incidents and upon breach of bail conditions.</p> <p>The Police Visual Handbook which is a searchable working guide for all officers and is accessible on the Uniform Training Learning &amp; Development site provides an introduction to the law regarding DVPN’s &amp; DVPO’s and outlines the guidance and powers to apply for the orders, the</p>
--	--	--	--	---

				<p>information is thorough and includes what action can be taken regarding breaches.</p> <p>Dedicated PPU staff who investigate all DA offences have received bespoke training which has included DVPN.s and DVPO's.</p>
<p><b>Recommendation No 3</b></p> <p>West Midlands Police and West Mercia Police examine their policies and procedures regarding action taken by officers at the reports of domestic abuse complaints, to ensure that all possible intelligence is gathered on the parties concerned and if necessary that intelligence is shared with other Police forces and agencies as deemed appropriate.</p>	<p>West Midlands Police and West Mercia Police</p>		<p>September 2015</p>	<p><b>West Midlands Police and West Mercia Police</b></p> <p>Toolkits are available on the Public Protection Intranet site which provide officers with guidance and advice including what information/intelligence that they should be gathering to ensure appropriate safeguarding measures can be put in place for the victim/family. Officers are given advice regarding what systems will hold pertinent information (e.g. FLINTS/CORVUS/PNC).</p> <p>MASH – Multi Agency Safeguarding Hubs discuss incidents of DA where children are</p>

				<p>involved. All agencies work together to share all available intelligence and information.</p> <p>PND (Police National Database) checks enable officers to obtain information from other forces regarding victims and offenders.</p> <p>MARAC (Multi-Agency Risk Assessment Conference). The main aim of the MARAC is to reduce the risk of serious harm or homicide for a victim and to increase the safety, health and wellbeing of victims – adults and any children. In a MARAC local agencies will meet to discuss the highest risk victims of domestic abuse in their area. Information about the risks faced by those victims, the actions needed to ensure safety, and the resources available locally are shared and used to create a risk management plan involving all agencies. The</p>
--	--	--	--	---

				meeting ensures all intelligence/information is discussed and shared; this will include other Police Forces where necessary (i.e. victim/offender known to reside outside of initial force area).
<p><b>Recommendation No 4</b></p> <p>All agencies, when working with substance misuse service users and other individuals that lead chaotic lifestyles, ensure appointments are coordinated resulting in joint interventions /meetings being better established. This will need a more structured approach to information sharing</p>	<p>The National Probation Service will ensure that reporting requirements take full account of a service user's appointments with substance misuse services in all possible instances in order to ensure the effective co-ordination, information sharing, and protection of vulnerable individuals (both adult and children).</p>	<p>West Mercia Cluster: With immediate effect</p> <p>Midlands NPS Division: By the 30.6.15 (this needs to be ratified formally by the National Deputy Director)</p>	<p>By 30th November 2015</p>	<p>Information Sharing Protocols with Providers of Substance Misuse Services will be reviewed and updated to ensure effective information sharing.</p>



**North Worcestershire Community Safety Partnership**

**Domestic Homicide Review Case No. 7**

**ACTION PLAN**

**Individual Management Report Recommendations**

**Agency: West Midlands Police**

<b>Recommendation</b>	<b>Action required by Agency</b>	<b>Implementation Lead</b>	<b>Target date for Completion</b>	<b>Summary of Action Taken &amp; Date</b>
<p><b>Recommendation No 1</b></p> <p>Vulnerable Adult guide to be amended to address the issue of closure of logs to a standard that will allow searching via the FLINTS intelligence system to recover all incidents that involve a person. The guide currently states that all actions and signposting should be recorded on the</p>	<p>For actions to be identified at HRB.</p>	<p>No Panel Rep from WMP.</p> <p>Authorising Officer DCI 4565 Dunn.</p> <p>Awaiting allocation.</p>	<p>To be allocated at HRB May 2015</p>	<p>Entered on WMP Recommendation tracker. Item No 99.</p> <p>For discussion at next WMP Homicide Review Board (May 2015).</p>

<p>OASIS Log, it should also state that before closure of the log that a PNC <b>MUST</b> be made via the integrated OASIS?PNC system</p>				
<p><b>Recommendation No 2</b></p> <p>The Vulnerable Adult Guide for Front Line Officers to have further examples provided regarding what is/is not a 'vulnerable moment' to prevent misinterpretation of what is and is not a 'vulnerable moment' to provide further clarity regarding adults who are repeatedly self-harming or suffering effects of drug induce paranoia, thus reducing the potential of missed opportunities to identify vulnerable adults and provide appropriate safeguarding, signposting and referrals.</p>		<p>No Panel Rep from WMP.</p> <p>Authorising Officer DCI 4565 Dunn.</p> <p>Awaiting allocation.</p>	<p>To be allocated at HRB May 2015</p>	<p>Entered on WMP Recommendation tracker. Item no 100.</p> <p>For discussion at next WMP Homicide Review Board (May 2015).</p>



**North Worcestershire Community Safety Partnership**

**Domestic Homicide Review Case No. 7**

**ACTION PLAN**

**Individual Management Report Recommendations**

**Agency: West Mercia Police**

Recommendation	Action required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
<p><b>Recommendation No 1</b></p> <p>Police call takers and dispatchers should be reminded to obtain as much detail as possible from a caller to enable increased intelligence research prior to arrival of attending officers. This will ultimately increase officer safety and awareness and more importantly the safety and welfare of any possible victims.</p>		DCI Pettit	November 2015	TBC. A meeting has been arranged In Mid May to educate OCC (call Centre Staff) and to work out the flow of information back to the officers attending. This fits with the wider agenda of protecting people from harm and positive action.



<p><b>Recommendation No 2</b></p> <p>Officers attending incidents such as these should be reminded to, ensure full intelligence research is carried out on the relevant nominals whilst they are in attendance. This will ensure welfare of all persons present, including the attending officers and provide police with a full intelligence picture.</p>			<p>November 2015</p>	<p>Joint Training has taken place with Women's Aid and all front line supervisors, SNT and patrol officers to ensure that DASH is understood and the requirement to perform lateral checks are undertaken. This includes explicit requirement about Child Safeguarding within the electronic DASH on CRIMES&gt;</p>
<p><b>Recommendation No 3</b></p> <p>Staff responsible for closing police message logs for incidents should ensure all relevant information has been recorded on the same and actioned as necessary.</p>			<p>November 2015</p>	<p>TBC. A meeting has been arranged In Mid May to educate OCC (call Centre Staff) and to work out the flow of information back to the officers attending. This fits with the wider agenda of protecting people from harm and positive action.</p>
<p><b>Recommendation No 4</b></p> <p>Warwickshire and West Mercia Police to consider further training input for staff with regards the side affects of cocaine/drug use.</p>			<p>November 2015</p>	<p>To be assessed as part of the wider learning needs assessment being undertaken by the PVP Strategic group. This in turn will lead to a format for delivery to all police officers and staff by way of compulsory of 'vulnerability' training.</p>



**North Worcestershire Community Safety Partnership**

**Domestic Homicide Review Case No. 7**

**ACTION PLAN**

**Individual Management Report Recommendations**

**Agency: South Warwickshire NHS Foundation Trust (Health Visitors)**

Recommendation	Action required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
<p><b>Recommendation No 1</b></p> <p>South Warwickshire NHS Foundation Trust to promote the Health Visitor Domestic Violence and Abuse Training for all South Warwickshire NHS Foundation Trust Health Visitors to ensure that all windows of opportunity to offer support to victims of domestic abuse are not missed.</p>	<p>Cascade Institution of Health Visiting Training on Domestic Violence and Abuse (supported by the DOfH) to all</p>	<p>Health Visiting Professional Development Lead for SWFT</p>	<p>September 2015 and ongoing for new staff</p>	<p>Training being cascaded out by ‘train the trainer’ Health Visitors across the Trust first sessions completed in August 2014</p>

<p><b>Recommendation No 2</b></p> <p>South Warwickshire NHS Foundation Trust to include a question in the record keeping audit tool about the significant adults in the child's life being documented in the records and for the audit plan to ensure these recording standards are maintained in line with record keeping policies.</p>	<p>Questions around carer details regularly recorded and updated in general record keeping audit tool for all children's areas in SWFT. Increase skills in professional curiosity as part of culture change</p>	<p>Professional lead Children, Young People and Families service/service managers, A&amp;E Departments and Macgregor ward.</p>	<p>Records Audit completion date September 2015.</p>	<p>Awareness raising messages underpinned in safeguarding children training currently being delivered across the Trust. Use of intermittent screensavers on Trust Intranet to raise awareness.</p>
--	---	--	--	--



**North Worcestershire Community Safety Partnership**

**Domestic Homicide Review Case No. 7**

**ACTION PLAN**

**Individual Management Report Recommendations**

**Agency: Heart of England Foundation Trust**

<b>Recommendation</b>	<b>Action required by Agency</b>	<b>Implementation Lead</b>	<b>Target date for Completion</b>	<b>Summary of Action Taken &amp; Date</b>
<p><b>Recommendation No 1</b></p> <p>To ensure that the Trust Self-Harm Policy is followed</p>	<p>Audit the application of the self-harm police to ensure that:</p> <ul style="list-style-type: none"> <li>• Relevant risk assessments are completed</li> <li>• Mental Health referrals to RAID is completed</li> </ul>	<p>Consultant Lead Safeguarding Adult ED</p>	<p>October 2015</p>	<p>Self-Harm Policy Reviewed and re-circulated to all staff</p> <p>Service Level agreement with RAID under review (February 2016)</p>
<p><b>Recommendation No 2</b></p> <p>To review the ED adult</p>	<p>Formulate a working group. Draft revised assessment documentation.</p>	<p>ED Safeguarding Lead</p>	<p>December 2015</p>	<p>Documentation of assessment is discussed during the safeguarding</p>

<p>assessment paperwork utilised when a mental health, substance misuse or domestic abuse issue is identified to ensure that the staff are prompted to:</p> <ul style="list-style-type: none"> <li>• Undertake a complete social history including all household members, contact with children or other dependants</li> <li>• Consideration of safeguarding risk to children/ dependants</li> <li>• Document onward referrals e.g., to substance misuse services</li> </ul>	<p>Seek ratification/ approval Enable IT support.</p>	<p>Consultant and Head of Safeguarding</p>		<p>training delivered to all ED clinical staff (75% compliance in Dec 2015)</p> <p>Regular audit of documentation in the ED in place</p> <p>Monitoring of safeguarding activity relating to child safeguarding issues identified in relation to adult presentations – this is reported quarterly to the Safeguarding Committee</p>
<p><b>Recommendation No 3</b></p> <p>To develop and deliver some ‘on the job’ training for ED staff focussed around adult mental health and substance misuse presentations</p>	<p>Discuss the concept with providers Develop learning outcomes and resources Scope and develop a delivery plan</p>	<p>Head of Safeguarding Safeguarding Trainer</p>	<p>December 2015</p>	<p>The Trust has delivered level 3 safeguarding training to 75% of the ED workforce. This includes information about mental health, substance misuse and 'Thinking Family in Assessments'. Plan in place to achieve 85% by June 2016</p>



**North Worcestershire Community Safety Partnership**

**Domestic Homicide Review Case No. 7**

**ACTION PLAN**

**Individual Management Report Recommendations**

**Agency: National Probation Service**

<b>Recommendation</b>	<b>Action required by Agency</b>	<b>Implementation Lead</b>	<b>Target date for Completion</b>	<b>Summary of Action Taken &amp; Date</b>
<p><b>Recommendation No 1</b></p> <p>Additional Domestic Abuse Checks should be requested by Offender Managers when significant new concerns are identified.</p>	<p>Re-issue to Probation staff guidance contained in this Domestic Abuse checklist for offender Managers. To review/record at Team Meeting and reviewed every 6 months by SPO.</p>		<p>March 2015</p>	<p>Completed by due date, and reviewed by local teams</p>
<p><b>Recommendation No 2</b></p> <p>All staff to be reminded that Home visits provide valuable information that would contribute to the management of offenders. Even when the offender is not assessed as High or Very High Risk of Serious Harm.</p>	<p>Re-issue to Probation staff guidance contained in this Domestic Abuse checklist for offender Managers. To review/record at Team Meeting and reviewed every 6 months by SPO.</p>		<p>March 2015</p>	<p>Completed by due date, and reviewed by local teams</p>