BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP

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Domestic Homicide Review

Executive Summary of the report into the death of a woman

B-DHR2012/13-04

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GLOSSARY

AAFDA: Advocacy After Fatal Domestic Abuse

ACPO: Association of Chief Police Officers

BCC: Birmingham City Council

BSCB: Birmingham Safeguarding Children Board

BSCP: Birmingham Community Safety Partnership

CCG: Clinical Commissioning Group

CPP: Child protection plan

CPS: Crown Prosecution Service

DASH: Domestic Abuse, Stalking and Honour Based Violence risk identification, assessment and management model

DHR: Domestic Homicide Review

GP: General Practitioner

HCPC: Health and Care Professions Council

ICPC: Initial child protection conference

IMR: Individual Management Review – reports submitted to review by agencies

MAPPA: Multi-Agency Public Protection Arrangements

PPU: Public Protection Unit of West Midlands Police

SCR: Serious Case Review

1. Summary of the circumstances leading to the Review.

1. The tragic death of the victim in August 2012 was notified to the Birmingham Community Safety Partnership on the following day.

2. At the time of death, the victim was 22 years old and had three young children under the age of 5 years, who were all subject of child protection plans under the category of emotional abuse in relation to the domestic violence and abuse being experienced by the victim from their father, the perpetrator. An unborn sibling was originally subject to the same child protection plan and the services which were being provided to the family. However, a termination of this pregnancy had taken place a few days prior to the victim's sudden and violent death.

3. An initial child protection conference had taken place in June 2012 following section 47 child protection enquiries and assessment carried out by Children's Social Care. The core group of agencies, Children's Social Care, the health visitor and maternity services were working to the child protection plan and the oldest child was attending a nursery at a Children's Centre.

4. The victim and the children had been staying with the victim's mother and her family following the initial child protection conference, although the accommodation arrangements were in flux at the time of the death. A number of agencies, including the Homelessness and Pre-Tenancy Service and Birmingham and Solihull Women's Aid were working with the victim, the children and the perpetrator in addition to the core agencies. The police became involved subsequent to the initial child protection conference.

5. The perpetrator was charged shortly after the event and convicted of the murder of the victim in January 2013. The victim was stabbed twenty-nine times both in the front and back of her body. The perpetrator was sentenced to life, with a minimum of twenty-two years, imprisonment.

6. The perpetrator had been involved in eleven documented offences and had come to police notice on twenty-five occasions prior to the murder of the victim. This included four assaults on a previous partner, two allegations of criminal damage to the ex-partner's property, one verbal domestic dispute, one 'threat to kill' and two harassment offences against the maternal grandmother of the ex-partner because the perpetrator had a child in that relationship.

7. The offences committed by the perpetrator did not only involve the ex-partner but included offences, as a teenager, of violence against his own extended family. The victims were mainly, but not only, female victims. The reported incidents demonstrated patterns of behaviour where the risks to the victims increased at times of pregnancy, separation and contact to children. The injuries caused were mainly to the head and face as well as the neck following attempts to strangle the victims. A

number of the incidents involved finds of substances in the perpetrator's possession such as crack cocaine and cannabis as well as weapons such as knives and a report to the police at one point that the perpetrator had acquired a gun.

8. The background history of the perpetrator was known to the agencies in connection with the victim and the children since late August 2010.

2. The Domestic Homicide Review process – in brief

9. The Birmingham Community Safety Partnership Domestic Homicide Review Steering Group recommended in August 2012 to the Chair of Birmingham Community Safety Partnership that a Review should be undertaken as the criteria set out in Section 9 of the Domestic Violence, Crime and Victims Act (2004) had been met:

10. The act states that a domestic homicide review should be 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 person to whom she was related or with whom she was or had been in an intimate personal relationship with ; or
    - a member of the same household as herself,
    - and be held with a view to identifying the lessons to be learnt from the death.

11. The Chair of Birmingham Community Safety Partnership approved the recommendation and the Home Office was notified of the decision to hold a domestic homicide review in August 2012. It was acknowledged that the timescale to conclude the Review would be dependent on the criminal processes.

12. The terms of reference were drawn up and were subsequently reviewed by the Domestic Homicide Review Panel and its independent Chair in November 2012; the full version can be seen in the main report.

    All member agencies of the Birmingham Community Safety Partnership and Birmingham Safeguarding Children Board were notified of the death and were asked to examine their records to establish if they had been approached by or provided any services to the adults in the family or to the children during the time frame set by the terms of reference. All agencies involved in the Review were required to undertake an Individual Management Review (IMR report) of the case against the specified terms of reference and a briefing was provided to the senior managers undertaking the

internal reviews. Once the agencies involved had been identified from the 41 agencies contacted originally, the reviews and reports were requested in line with the BCSP guidance and the Home Office DHR Guidance from the following:

- West Midlands Police
- Birmingham City Council – Children, Young People and Families Directorate
- Birmingham and Solihull Women's Aid
- Birmingham City Council Homeless and Pre-Tenancy Service (to incorporate the full homeless pathway including Neighbourhood Advice and Information Service)
- Birmingham Community Healthcare Trust
- Birmingham Women's Hospital Foundation Trust
- Birmingham and Solihull NHS Cluster and relevant GPs
- A Nursery and Children's Centre

13. As the children of the victim were the subject of child protection plans at the time of their mother's death the Birmingham Safeguarding Children Board Serious Case Review Subgroup decided on the in November 2012 that there would not be a separate Serious Case Review under Regulation 5 of the Safeguarding Children's Board Regulations 2006. The Overview Report and Action Plan from the Domestic Homicide Review would be presented to the Birmingham Safeguarding Children Board formally at the conclusion of the Review for consideration and any relevant learning and actions would be implemented.

14. The time period to be reviewed was agreed to be from April 2008, a point prior to the birth of the oldest child of the family, up to the time of the victim's death in August 2012. As the offending history of the perpetrator was known at the point of the Review being initiated the West Midlands Police were asked to consider their involvement from 2003 with the perpetrator as well.

15. It was agreed that the review should give due consideration to all of the protected characteristics under Section 149 of the Equality Act 2010. In particular the review should proceed with awareness of the victim's gender, young age and repeated pregnancies. In respect of the mixed heritage of the perpetrator and the children, IMR authors should be asked to comment on whether their services were accessible and sensitive to the ethnic, cultural, linguistic and religious identity of the family.

16. A Domestic Homicide Review (DHR) Panel was set up to include senior managers independent of the case to review the IMR reports and drive the review process on to its conclusion to ensure that a robust examination of all aspects of the case was undertaken. The Domestic Homicide Review Panel met between November 2012 and May 2013 on six occasions. The membership of the DHR Panel was:

    - Senior Service Manager Violence Against Women , Birmingham Community Safety Partnership
    - Detective Chief Inspector , West Midlands Police
    - Head of Safeguarding ,Birmingham and Solihull NHS Cluster now CCG and NHS England
    - Assistant Chief Executive ,Birmingham and Solihull Women's Aid
    - Lead Nurse/ Midwife Safeguarding Children and Adults, Birmingham Women's NHS Foundation Trust
    - Senior Service Manager, Homelessness and Pre-Tenancy Service, Birmingham City Council
    - Associate Director Safeguarding, Birmingham Community Health Care NHS Trust
    - Senior Service Manager, Early Years, Childcare and Children's Centres, Birmingham City Council
    - Manager, Child Protection and Review Service, Birmingham City Council
    - DHR Administrator , Birmingham Community Safety Partnership
    - Birgitta Lundberg ,Independent Chair and Overview Author

17. The victim's family and the perpetrator were informed of the Domestic Homicide Review taking place by letter with leaflets and advice included at the end of November 2012. The letters were delivered by hand via the Police Family Liaison Officer. The family were advised that the Chair would contact them again as soon as the criminal proceedings had concluded and it would be possible to meet with them to enable them to contribute to the Review.

18. Further letters were delivered in January 2013 as the criminal trial ended in January. A meeting with the victim's mother and aunt took place at the beginning of February 2013 .The final Overview Report was shared with the family at a meeting in July 2013 for comment. The report has been updated following the family meeting and was presented to the Birmingham Community Safety

Partnership Executive Board and Birmingham Safeguarding Children Board prior to submission to the Home Office.

19. The victim's immediate family have contributed to the Review supported by a representative from the National Homicide Service and a representative from Advocacy After Fatal Domestic Abuse (AAFDA). The perpetrator was invited to contribute but no response was received. The victim's father was invited to contribute but declined.

3. The definition of domestic violence

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

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

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

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

*Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."**

**This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.*

21. The previous definition was as above without the added age range of 16 years and the elements of controlling and coercive behaviour described above. The Home Office definitions, past and present, have been followed in the Birmingham Safeguarding Children Board Safeguarding Children policies and procedures.

22. It should be noted in addition that Local Authorities are required to take account of the definition provided in section 177(1A) of the Housing Act 1996 in the context of housing needs, homelessness and domestic violence as well.

4. Family views and wishes

23. The victim's family shared information with the reviewers and expressed the view that the agencies had not taken the threat that the perpetrator posed to the victim seriously. Professionals had not listened to the victim or her family members, who had spoken out, and as a consequence had failed to act decisively in accordance with good practice, when the victim had reported instances of violence and abuse to her.

24. The victim's family expressed their grief at the loss of a young daughter and the loss for her children of their mother. They hoped that any findings of the Review would assist in preventing any other woman going through the same process from being harmed.

25. The most important message from them was that the police and Children's Social Care should focus less on the victim as just the mother of the children but see the picture as a whole and focus their work on controlling the perpetrators of violence and abuse. The victim was a young woman in a relationship where the family had had concerns about her welfare all along yet they felt that their concerns had been minimised and they had not been listened to.

26. They accepted that the victim did not tell them everything but both the victim's mother and aunt considered that agencies should have listened to the victim and should have protected her because she was frightened.

5. **Summary and Findings of the Key Episodes identified in the case:**

27. The Overview Report sets out the facts of the case in a number of Key Episodes based on the information provided in the IMRs, the integrated chronology of all agency involvement and the Panel sessions, which included the IMR reviewers attending as well. A summary of the Key Episodes was as follows:

- August to October 2010.

- January to April 2012.
- May to August 2012.

28. Each Key Episode involved referrals to agencies, information sharing and recording activity by agencies, assessments undertaken, risk assessments using DASH[1] undertaken and direct contact by agencies with the victim, the perpetrator and the children.

29. The **Key Episodes** are explored in detail in the **Overview report** followed by a Summary and Findings.

30. The facts outlined in the report related to specific points where the agencies had been in contact with the victim and the children. During the whole period of time, from 2008 onwards, there were contacts as noted with:

- Health agencies including GPs, health visitors ,the Walk in Centre and maternity services, planned and unplanned, in connection with the usual need for services for pregnancies, minor child hood illnesses and immunisations of children.
- Housing services in relation to requests for moves and support when harassment was reported from the extended families.
- The Children's Centre nursery, where the older child attended from February 2012.
- Women's Aid services had placed the victim on their waiting list in January 2012 and after many attempts at making contact there were two direct meetings with the victim in July 2012 where she was provided with support in relation to pursuing a civil injunction as well as risk assessment work.

31. The Key Episodes referred to above demonstrated that there were three referrals leading to intervention by the police, Children's Social Care and partner agencies. Two of those referrals were made by the victim herself to the police after serious incidents of violence and abuse, where the children had also been present in the home. The third referral was by the health visitor when the case had just been closed by Children's Social Care in March 2012.

32. The interventions that followed on from the referrals in August 2010, in January 2012 and March 2012 led to decisions and actions, which involved the core agencies; Children's Social Care, the police and health agencies.

33. There were practice standards in place in the agencies relating to domestic violence and child protection, which were set out in policies, procedures and guidance at the time in accordance with

[1] DASH: Domestic Abuse, Stalking and Honour Based Violence risk identification, assessment and management model

national statutory guidance such as Working Together 2010 and in legislation such as the Children Act 1989 and 2004.

34. So for example, there were clear expectations of timescales for undertaking work as well as for actions to communicate and undertake information checks with agencies including GPs. The initial assessments, strategy discussions, Section 47[2] Enquiries, initial child protection conference and core groups were subject to clear timescales, which were not met in any of the instances recorded in this case.

35. The lead agency to undertake the assessments and investigations when there were concerns about the children was Children's Social Care. Where the focus was on the victim as an adult subject of domestic violence the police were the lead agency in respect of following up risk assessments, criminal investigations and crime prevention safety work.

36. The integrated chronology illustrated that there had been involvement at different times from 2003 onwards with the perpetrator and the police with a long history of incidents recorded on agency record systems. There had been no prosecutions and therefore no convictions of a domestic violence offence in relation to the ex-partner or the victim. The pattern of reported incidents demonstrated an escalating repeat offender behaviour which, when passed on from one victim to another, had become serial offender behaviour as well. The substance misuse offences should also have alerted the police to the increasing risks.

37. Children's Social Care had received three referrals, which were followed up with assessments by a social worker in August 2010 and another social worker in February and March 2012. The decision was taken in April/May 2012 by the team manager in Children's Social Care and the police Detective Sergeant that the child protection enquiry (Section 47 of the Children Act) would be carried out by Children's Social Care without further joint work with the police. This decision was not in accordance with BSCB interagency safeguarding policies and procedures at that time in relation to domestic violence as a joint enquiry should have taken place in the light of the full information about the perpetrator's offending history and the young ages of the children in the family. The outcome of this decision was that the police were not invited to the initial child protection conference and therefore were not aware that it had taken place. Without an invitation, there was no request for a report from the police and they were not provided with the minutes of the outcome of the conference and in particular therefore remained unaware that the children had been made subjects of child protection plans.

38. Throughout the agency records, there were comments by the victim and her mother stating that the perpetrator was threatening them, was controlling their contacts with one another, was preventing

[2] Section 47 of the Children Act 1989

the victim from communicating with others and keeping her, and the children, locked in doors. The perpetrator was described by the victim's family as controlling what the victim said to professionals and influencing the contact by professionals with the victim by being present at visits and meetings. The victim was described by others and by her own observation as frightened of the perpetrator.

39. At the same time the records and the chronology demonstrated that some professionals believed the victim to be unreliable and "not truthful" about the relationship between her and the perpetrator and whether they were together or not. The repeated pregnancies were interpreted as a sign of a relationship rather than explored by the social worker, health professionals or the police as possible sexual violence and control.[3] The effect of the different perceptions of the dynamics of the relationship between the parents may have impacted on how the services were delivered.

6. Conclusion and Findings of the Analysis of the Key Episodes

40. The information gathered from all agencies and from the family meeting in February 2013 as set out in the Key Episodes was analysed and explored in depth by the DHR Panel and the Overview Author. The purpose of the analysis was to bring out the lessons to be learnt from this case, which then led to the recommendations which are set out in the integrated action plan. Each agency IMR report set out internal agency recommendations, where lessons had been identified and these are represented in the individual IMR's and the integrated Action plan.

41. The analysis noted a number of themes, which are explored in the report:

- Safe information sharing; managing and proactively sharing information
- Multi-agency working; decision making;
- Recognising risks and danger and assessment of the perpetrator
- Domestic violence and abuse: policies, procedures, training and supervision
- Responses to the victim by agencies
- How the behaviour of the perpetrator could be addressed
- Recognising substance misuse and mental health problems as a cluster of issues
- There are references to research and the particular themes were drawn from the case.

42. The **conclusion** and findings of the Overview Report analysis section was as follows:

[3] See page 10 and 11 of 'Who does what to whom? Gender and Domestic Violence Perpetrators'. M. Hester June 2009

43. In the light of the information available to this Review from the IMRs, the integrated chronology, the discussions in Panel meetings and the meeting with the victim's family it has emerged that, if the work had been carried out across the agencies in accordance with good practice and the requirements in place in agencies at the time, it might have been possible to prevent the death of the victim, and thus the loss of their mother for the children. This statement is not made with just the benefit of hindsight but with the knowledge arising from the Review, that there were a number of missed opportunities and that some decisions made about the service delivery to the victim were seriously flawed. It is however not possible to know how the victim might have responded to a different set of services aimed to support her.

44. The outcome might have been different if the risk assessments had been based on the full background information about the perpetrator from the first report by the victim in August 2010 and if the social work assessment had been undertaken in collaboration with other agencies such as the GP and the health visitor. From this point onwards the responses to the victim missed the overall picture and failed to understand the dynamics of the domestic abuse and violence carried out by the perpetrator.

45. The volatile and controlling nature of the perpetrator's behaviour was not fully understood at any point in the interventions by the agencies. As the risk assessment had been flawed, they were not able to predict the level of risk and danger that the perpetrator posed to the victim and the children. Although it could not have been predicted that the perpetrator would kill the victim, it could have been predicted that he would carry on to behave violently and abusively and in view of his past history and established domestic violence research evidence, it is very likely that the behaviour would have escalated further.

46. If the response had been effective and action had been taken to control the perpetrator's behaviour by the agencies, for example by charging him with offences, it is not possible to state with certainty that he would not have found another opportunity to attack the victim. His history reveals that he continued to present a risk to his ex-partner long after the relationship had ended because of the presence of his child.

47. The services provided to the victim and the children were not effective in keeping them safe and it can only be concluded that if the services had met their needs and had been provided effectively, their safety might have been achieved. The overall conclusion has to be that the victim, who had reported her fears and concerns, was not really listened to or heard by the agencies.

7. Lessons to be learnt

48. The Review has identified a number of areas where improvements could be made by implementing changes to promote good practice and a more effective response to victims of domestic violence and abuse. The learning from this Review is not limited to the agencies that were directly involved but extends to all agencies where there may be contacts with victims of domestic violence and abuse.

49. The key issues to be addressed were identified as follows:

- Finding means to remove barriers and boundaries between and within agencies to enable professionals to work together and to collaborate to provide responsive and safe services to victims and their children.

- Improving the use of risk assessments tools as one part of the work with victims; and

- Reinforcing the practice to update and review **all other** information to assist in forming a professional judgement about the whole situation a victim is experiencing in order to understand the danger posed by the perpetrator.

- Ensuring that the child protection processes are carried out as required in collaboration with other agencies involved with the victim and the children such as GPs , health visitors, housing officers, Women's Aid workers and **at all times**, where there is domestic violence and abuse , the police.

- Improving the safe management of child protection conferences to address the risks and dangers posed by perpetrators towards the adult victim as well as the children.

- Ensuring that the police investigations are rigorous in undertaking checks and following up complaints reported to them in a timely manner, including consultations with the Crown Prosecution Service about potential prosecutions.

- Addressing the lack of up to date domestic violence policies, procedures and training of front line professionals in the agencies identified in this Review so that they can intervene with confidence and a good understanding of the dynamics of domestic violence and abuse.

- The resources and roles of the third sector, such as Women's Aid, must be clarified to the agencies primarily focused on services to children: Children's Social Care, health agencies and the police; to ensure that the support that can be provided by them is effective and within their capacity and can be delivered in collaboration with the core agencies.

8. Implementation of learning

50. A number of lessons to be learnt have emerged from this Review which must be followed up to ensure that practice improves and where practice has already been addressed as a result, mechanisms must be in place to embed and maintain the improvements .

51. The IMRs have provided evidence in their reports and in the action plan, which will be monitored regularly by the Birmingham Community Safety Partnership, of actions taken in response to their recommendations. The learning, where actions are planned, such as audits, has been set against clear timescales.

52. Each agency is expected to provide feedback to their agency and the IMR authors as well as to the professionals, who were involved in the IMR process.

53. The dissemination of the key learning will be targeted to the professionals in the member agencies of the Birmingham Community Safety Partnership and the Birmingham Safeguarding Children Board and will include wider Birmingham services not directly affiliated to these partnerships.

9. Recommendations by the Independent Report Author

54. The recommendations from the Individual Management Reviews are set out in the action plan. The recommendations by the report author are intended to compliment the recommendations in the IMRs and to address the agencies collectively. The intention is to improve collaborative inter agency work in the city where there are concerns about domestic violence and abuse and to contribute towards reducing violence against women and to promote their safety and that of their children.

Learning Point 1:

55. The Review had identified the need to find means to remove barriers and boundaries between and within agencies to enable professionals to work together and to collaborate to provide responsive and safe services to victims and their children.

Recommendation 1

1.1 A working group should be jointly established by the Birmingham Community Safety Partnership and the Birmingham Safeguarding Children Board consisting of representatives from the core agencies of both. The working group should also include some domestic violence service users, and/or surviving family members, with the aim:

- To establish mechanisms to break down the boundaries and to promote collaborative working across the divide between adult focussed and children focussed services where there are concerns of domestic violence involving adult victims and children.
- To develop proposals to improve safe services for adults and children.
- The working group should report to both Birmingham Safeguarding Children Board and Birmingham Community Safety Partnership regularly.
- The Birmingham Safeguarding Children Board and Birmingham Community Safety Partnership should monitor progress and implement proposals made by the working group.

1.2 Cross representation between the Birmingham Safeguarding Children Board and the Birmingham Community Safety Partnership should be reviewed to ensure that there is an active and up to date exchange of developments, cooperation and joint working in place at all levels on both bodies.

Expected Outcome: An improvement in the practice of agencies working together to undertake assessments and share information where there is a domestic violence victim and children; an improvement in agency attendance at key meetings, such as Child Protection Conferences, and safe management of child protection meetings for the victims.

Learning Point 2:

56. The Review identified the need to improve the use of risk assessments tools as one part of the work with victims. The risk assessment process must include the practice to update and review all other information when forming a professional judgement about the whole situation a victim is experiencing and the danger posed by the alleged perpetrator.

Recommendation 2

2.1 The use and the application of risks assessment tools such as DASH should be carefully examined by the police and partner agencies including the current linked training in the light of the findings of this Review. A regular quality assurance process should be in place.

2.2 The police should produce and disseminate a briefing for partner agencies of the purpose and best practice of using the tool in domestic violence and abuse referrals to form a professional judgement about the actions to be taken.

Expected outcome: An improvement in the practice of using the risk assessment tool by the police leading to a better decision making process to follow up prosecutions; a better understanding of risk assessment by partner agencies to inform their practice in making referrals to the MARAC.

Learning Point 3:

57. The Review found that there was a need to ensure that the child protection processes are carried out as required in collaboration with other agencies involved with the victim and the children such as GPs, Health Visitors, Housing officers, Women's Aid workers and at all times, where there is domestic violence and abuse, the Police.

58. The Review determined that there was a need to improve the safe management of child protection conferences, including the preparation for conferences and the management of the meeting, in order to manage the risks and dangers posed by perpetrators towards the adult victim as well as the children.

Recommendation 3.

3.1 A review should urgently be undertaken of the protocol between the police and the Children's Independent Conference Service to confirm that all child protection conferences, where domestic violence and abuse are a known or suspected issue, will have police representation in attendance with up to date information about the alleged perpetrator.

3.2 Regular audits should track police attendance and report regularly to the Birmingham Safeguarding Children Board. Any obstacles or gaps in attendance should be addressed within the safeguarding structure promptly by the Conference service.

3.3 The Birmingham Safeguarding Children Board and the Conference Chairing Service should review and update the current guidance and training for conference chairs in relation to the safe management of domestic abuse and violence.

Expected outcome: Child protection conferences and child protection plans should reflect the safe management of cases involving domestic violence and abuse. Police presence at child protection conferences should be taking place where there are concerns about domestic abuse and violence as a matter of routine.

Learning Point 4:

59. To improve the domestic violence and abuse training of front line professionals and supervisors in the agencies identified in this Review so that they can intervene with confidence and a good understanding of the dynamics of domestic violence and abuse.

Recommendation 4

4.1 An analysis of current domestic violence training should be undertaken by the agencies participating in this Review to establish that it addresses the issues in the findings of this Domestic Homicide Review. All the training should promote collaborative working to respond to victims and their children with sensitive and effective delivery of services.

4.2 The commissioning process for domestic violence and abuse training should be reviewed and should in future draw on the joint expertise of interagency trainers in both the fields of domestic violence relating to adults victims and the field of safeguarding children and should ensure that the training is targeted to frontline professionals and their managers.

Expected outcome: Better practice should be in evidence in assessments and decision making, such as police charging decisions, and at key meetings, such as Child Protection Conferences and should be regularly audited by the relevant agency.

Learning Point 5:

60. The relevant agencies must address the implications for practice and service delivery in relation to the updated definition of domestic violence and abuse, particularly the inclusion of 16 and 17 year olds and the recognition of coercive and controlling behaviour, and the information must be disseminated and integrated in to policies and procedures across agencies. The current Birmingham Safeguarding Children Board safeguarding children procedure on 'Domestic Violence and Abuse' (chapter 23) was updated in March 2013 to reflect the changes. The learning in relation to this Review relates to the lack of understanding that was demonstrated about the perpetrator's coercive and controlling behaviour in addition to his violence.

Recommendation 5. A briefing and 'awareness raising' launch and dissemination program should be implemented across all member agencies of both the Birmingham Safeguarding Children Board and the Birmingham Community Safety Partnership to embed the change in the definition and to underpin the learning from this Domestic Homicide Review.

Expected outcome:

That all agencies become aware of the updated definition with the inclusion of 16 and 17 year olds and that they update their own internal policies, procedures and training accordingly. The learning from this Review should drive improvement in the response by agencies to all reports of domestic abuse and violence.

For further detail see the full report and the action plan.

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