JOINT REVIEW

BDHR/2013-14/02

DOMESTIC HOMICIDE REVIEW, SERIOUS CASE REVIEW & MULTI AGENCY PUBLIC PROTECTION ARRANGEMENTS SERIOUS CASE REVIEW

In respect of the death of a woman and her child

Child died 31.05.2013
Woman died 31.05.2013

May 2017

Report by:

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GLOSSARY

BCSP	Birmingham Community Safety Partnership
BSCB	Birmingham Safeguarding Children Board
CAF	Common Assessment Framework
CALM	Controlling Anger & Learning to Manage it
DHR	Domestic Homicide Review
HMIC	Her Majesty's Inspector of Constabulary
IDAP	Integrated Domestic Abuse Programme
IMR	Individual Management Review
IMS	Intelligence Management System (West Midlands Police)
IPCC	Independent Police Complaints Commission
LAC	Looked After Children
LACCP	Looked After Child Care Plan
MAPPA	Multi Agency Public Protection Arrangements
NACRO	National Association for the Care & Resettlement of Offenders
OASys	Offender Assessment System – Probation risk assessment tool
ROSH	Risk of Serious Harm
PNC	Police National Computer
PPRC	Person Posing a Risk to Children
SARA	Spousal Assault Risk Assessment
SCR	Serious Case Review
SMB	Strategic Management Board
VISOR	Violent & Sex Offenders Register
VOO	Violent Offender Order

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1. Introduction

1.1 In June 2013 police officers picked up a text message from a mobile phone which had been sent by the perpetrator to the effect that he had killed his girlfriend. Police officers attended the home address of the Woman and found both her and her Child deceased. The Child was found in a cot and the Woman was found in her bed. Both had died as a result of pressure to the neck. A criminal investigation commenced and the perpetrator was traced and arrested at another address. He was subsequently charged and convicted of the murders of the Woman and the Child. He was sentenced to life imprisonment to serve a minimum of 29 years.

1.2 The case was subsequently discussed at the Serious Case Review Sub-Group of Birmingham Safeguarding Children Board (BSCB), the Domestic Homicide Review Steering Group of the Birmingham Community Safety Partnership (BCSP) and at the West Midlands Multi Agency Public Protection Arrangements (MAPPA) Strategic Management Board. It was concluded that a joint review should commence as this case met the following criteria:

Working Together to Safeguard Children March 2013

'A serious case is one where: (a) abuse or neglect of a child is known or suspected; and (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.'

Domestic Violence, Crimes and Victims Act (2004) Section 9(3)

Requires that a domestic homicide review be undertaken in 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 s/he was related or with whom s/he was or had been in in intimate relationship, or
a member of the same household as her/himself, held with a view to identifying the lessons to be learnt from the death

The Criminal Justice Act 2003

As the perpetrator was subject to MAPPA oversight at Level 2 there is a requirement under MAPPA guidance for a mandatory serious case review.

2. Purpose, Scope and Terms of Reference

2.1 The purpose of this joint serious case review, domestic homicide review and MAPPA serious case review is as outlined in government documents 'Working Together to Safeguard Children', 'DHR statutory guidance' and 'MAPPA guidance'. The aim being to:

- review the circumstances leading to the incident that caused the deaths of the Woman and her Child, establish why professionals took the decisions they did and establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and across the system to safeguard domestic violence and abuse victims and promote the safety and welfare of children.

- 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. To apply these lessons to service responses including changes to the policies and procedures as appropriate.

- improve intra and inter-agency working and better safeguard and promote the welfare of children.

- prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

2.2 It was determined that this joint review should focus on the period between the beginning of February 2013 which was two weeks prior to the perpetrator being released from prison until the death of the Child and the Woman, and it should include contact with extended members of the family and any other significant persons only in so much as it is relevant to the decision making and safeguarding of the Child and the Woman. However it was stipulated that should agencies identify information from an earlier date which is relevant to the findings of the SCR then that should be included. Hence the review has included information about the childhoods and previous relationships of the Woman and the perpetrator.

2.3 The most important issues to be addressed by agencies, in trying to learn from this case were identified in the Terms of Reference as:

<u>Generic Terms of Reference</u>

- What information/ knowledge was known that indicated that this woman and her children may be at risk?
- Were agencies aware of the relationship between the woman and the alleged perpetrator?
- Were practitioners aware of and sensitive to the needs of the woman and her children and in their work, and knowledgeable both about potential indicators of domestic violence, abuse or neglect and about what to do if they had concerns about their safety and welfare?

- What information was known that the alleged perpetrator was a perpetrator of domestic violence or a risk to others and how did your agency respond, both individually and with other agencies?
- Were assessments and decisions made using information from all agencies involved and were the actions identified appropriate? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- What role did your agency play in relation to MAPPA meetings and what contributions did your agency make. Did your agency do what it was asked to do?
- When, and in what way, were the woman and child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of services? Was this information recorded?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for working during normal office hours and others providing out of hours services?
- Where relevant, were early help services to a child in need, CAF or family support services provided following appropriate assessments?
- Were, where relevant, the proper processes for identification, referral, child protection investigation, assessment and service provision followed?
- Were, where relevant, appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- Was practice in agencies sensitive to considerations of age, disability, marriage, pregnancy and maternity, race, religion and belief, sexuality and gender in relation to the family, and if relevant, how were they explored, recorded and responded to?
- Were the staff involved with the family supervised and supported by their managers and given the chance to exercise reflective practice?
- Was there sufficient senior manager accountability or other organisations and professionals involved at points in the case where they should have been?

- What constraints were staff operating under, if any, and were there issues in relation to the capacity or resources in your agency that impacted on the ability to provide services to the woman and her child/ren or the alleged perpetrator?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Did those agencies with significant involvement with the family and the alleged perpetrator work effectively together to put into place a programme of early help and intervention?
- Did agencies' practice in terms of assessment, intervention and decision making focus on the presenting circumstance of each intervention or did it also take account of known history and previous agency involvement?
- How was information shared between the different Local Areas in managing the perpetrator and any risk he posed to adults or children?

<u>Additional specific terms of reference to be addressed by Wales and Staffordshire & West Midlands Probation Trusts:</u>

- What is known about the alleged perpetrator as a child protection risk?

- Was the standard of risk assessment, risk management and offender management of the alleged perpetrator sufficient in this case?

<u>Additional specific terms of reference to be addressed by MAPPA</u>

- For both Wales and West Midlands MAPPA SMBs does a review of the minutes show that all relevant agencies were actively engaged in assessing and jointly planning for the release of the mother's partner with appropriate safeguards in place?
- Were disclosures fully documented and appropriate?

3. Process

3.1 Notification of this joint review was sent to agencies who were asked to undertake a management review of any contact with the Child, the Woman and the perpetrator. The agencies were requested to look critically and openly at individual and organisational practice to ascertain whether changes could and should be made and, if so, how this should be achieved. It was requested that a senior member of staff who had no involvement with the case, complete the management review. Guidance notes which included a template for the review report were provided to each agency. It was requested that upon completion, each individual management review (IMR) be agreed by that organisation's senior managers who would be responsible for ensuring that their single agency recommendations are acted upon. If agencies had no contact with the Child, the Woman, the perpetrator or the family they were asked to complete a 'nil' return. Those agencies which had minimal involvement provided an information report.

3.2 A Serious Case Review panel was established to actively manage the serious case/domestic homicide/MAPPA review processes and to obtain all relevant information from agencies and any parallel processes. The panel's role was to ensure robust analysis of IMRs and that the overview report accurately reflected agency contributions and met the 'Working Together', Domestic Homicide Review guidance and MAPPA serious case review requirements. The panel was set up with an Independent Reviewer/Chair, an Independent Reviewer/Author and representatives from a range of agencies relevant to this case.

3.3 A briefing session was held for IMR authors which was facilitated by the independent reviewer (chair) and the independent reviewer (author). The requirements of up to date 'Working Together' guidance, Domestic Homicide Review guidance and MAPPA guidance was disseminated to all of those present to ensure that IMR authors were aware of the developments in review processes, particularly focusing on establishing why actions were or were not taken by professionals.

3.4 At the first meeting of the Serious Case Review panel, the terms of reference provided by the BSCB Serious Case Review Sub Group, Domestic Homicide Steering Group and MAPPA Strategic Group, were reviewed and agreed.

3.5 Upon receipt of IMRs from agencies, a composite chronology of events was produced. The IMRs and integrated chronology were discussed by the review panel and any discrepancies or need for further information was resolved by either written communication and/or invitation to a learning event. As a result amended final IMRs were received from the agencies as indicated in section 5.

3.6 The independent reviewer/author and two members of the review panel examined the minutes of Multi Agency Public Protection (MAPP) meetings held in respect of the perpetrator as well as the VISOR (Violent & Sex Offenders Register) record pertaining to the perpetrator. The purpose was to ascertain whether MAPP arrangements were effectively applied.

3.7 The Review Panel met on eight occasions to consider all of the IMRs, information reports and to progress the Overview Report.

3.8 The Overview Report and Action Plan was presented to and agreed by the respective Boards.

4. Serious Case Review Panel Members

4.1 **Independent Reviewer/Chair:** Anne Binney

The chair of the serious case review panel is independent of all the local agencies and professionals involved in the case, and of the BSCB, the BCSP and the MAPPA SMB. She has over 40 years experience in Children's Social Care, thirteen of these as a senior manager responsible for children's social care services. She was previously chair of an Area Child Protection Committee and a Local Safeguarding Children Board prior to retiring from full

time work early in 2010 and has since then been author or independent chair of a number of Serious Case Review across the Midlands. She has never been employed by any of the agencies in Birmingham and had no knowledge of this case prior to taking on the role of independent panel chair.

4.2 **Independent Reviewer/Overview Author:** Gill Baker OBE

The author of the overview report is a retired police officer and is independent of all the local agencies and professionals involved in the case and of the BSCB, BCSP and the MAPPA SMB. During the last ten years of her thirty year police service she was a Detective Inspector specialising in child protection, domestic violence, sexual offences, sex offender management and vulnerable adult protection. Within her role she was responsible for compiling police individual management reviews and was a member of many serious case review panels across the West Midlands area. She was involved in the development of local, national and international multi-agency projects and initiatives as well as policy and procedures for the police service. Her work in this field was recognised when she was awarded an OBE in 2006 for services to the police. Since retirement she has been independent chair and/or author of several serious case reviews, domestic homicide reviews and MAPPA reviews.

4.3 The members of the panel are senior managers from the key statutory agencies who had no direct contact or management involvement with the case and were not the authors of Individual Management Reviews. Additionally in accordance with MAPPA guidance a Lay Adviser, who is a member of the Strategic Management Board (SMB), was included as a member of the panel. The Lay Adviser role is a voluntary and unpaid one, and has a valuable part to play in the MAPPA SCR process and is included as a member of the panel to:

- provide an independent voice to the panel
- ensure that any community issues are addressed
- act as a critical friend to the professionals.

4.4 Panel Members:

Assistant Chief Executive – National Probation Services, Wales
Designated Nurse for Safeguarding Children & Young People – NHS Birmingham South Central
Detective Inspector – Public Protection - West Midlands Police
Head of Child Protection & Review Service – Birmingham City Council
Head of Public Protection – Staffordshire & West Midlands Probation Trust
Head of Safeguarding – Birmingham & Solihull Mental Health Foundation Trust
MAPPA Lay Adviser – member of the Strategic Management Board
Operations Manager – Birmingham & Solihull Women's Aid
Safeguarding Adult Lead – Birmingham South Central CCG
Senior Service Manager – Violence Against Women, Equalities, Community Safety & Cohesion, Birmingham City Council

5 Individual Management Reviews

5.1 Agencies were asked to provide an IMR, an information report or a nil return, i.e. no contact with the Child, Woman or the perpetrator. As a result IMRs were received from the following agencies:

Birmingham Children's Hospital NHS Foundation Trust
Birmingham City Council – Children & Young People & Families (Social Care)
Birmingham Cross City Clinical Commissioning Group
Birmingham Women's Hospital NHS Foundation Trust
Birmingham Community Healthcare Trust
North Wales Police
Wales Probation Trust & Staffordshire & West Midlands Probation Trust
West Mercia Police
West Midlands Police

5.2 **Information Reports**

Due to a minimal involvement with the Child, the Woman and/or the perpetrator information reports were obtained from the following agencies:

Birmingham City Council Adults & Communities Directorate
Birmingham City Council Legal & Democratic Services
Birmingham Children's Social Care Integrated Services
Birmingham & Solihull Mental Health Foundation Trust
CAFCASS
Caernarfon Children & Family Support, Wales
Cornwall Children's Services
Heart of England NHS Trust
HM Prison Service
Moseley & District Housing Association
NHS Direct
Sustain Housing
West Midlands Ambulance Service
Worcestershire Children's Services
Wrexham County Social Services
Youth Offending Service

5.3 Independent Management Reviews/Information Reports

Process

Agencies reviewed their computer and paper records, details of which are itemised within their respective IMRs. Each of the agencies, with the exception of West Midlands Police in view of a parallel misconduct investigation, conducted interviews of their staff to enhance the quality of their IMRs and to try and get an understanding of not only what happened but why something did or did not happen. Contextual information relating to volume of work, staff turnover, training, sickness, organisational change management and supervisory practice is contained within each IMR. Available for agencies is a leaflet issued by BSCB which explains the reason, process and what can be expected when a professional is asked to contribute to a serious case review.

Guidance was also provided to IMR authors regarding the interviewing of staff.

5.4 The Panel robustly scrutinised and quality assured each IMR and information report. Specific issues in written form were raised with each of the IMR authors, which resulted in amendments and additions. There was a timely response from all of the agencies involved to the issues raised.

5.5 A 'Learning' event facilitated by the independent chair and the independent author was intended to be held for practitioners who were directly involved with the Child, the Woman and the perpetrator. The purpose was to provide practitioners with an opportunity to maximise and share learning to contribute their perspectives of the case with a view to understanding practice from their viewpoint. Unfortunately, it was felt inappropriate to pursue this as practitioners involved in the management of the perpetrator were subject to, or involved in an ongoing investigation by the Independent Police Complaints Commission (IPCC). However a learning event was held for IMR authors which was facilitated by the independent chair and the independent author during which the SCR panel were in attendance. This learning event served to increase an understanding of not only what happened but why actions were or were not taken in an effort to identity any systemic failings.

5.6 A total of twenty one single agency recommendations were contained in the IMRs, which were scrutinised by the Panel and are considered appropriate. Agencies were requested to progress their single agency recommendations in a timely manner prior to the publication of the serious case review.

6. Background

Agency contact with the Child and with the Child's half-sibling was limited apart from universal services, e.g. maternity/health visiting, and hence there is little information from professionals about what life was like for them in their family setting.

The Child

6.1 The Child was a seven month old baby, of white British ethnicity who was the second child of the Woman by her partner 2. The Child was healthy, was starting to sit up, was up to date with immunisations and was presented for health check–ups on time. Indeed the Child was voluntarily presented at the well-baby clinic at regular intervals and was seen on a monthly basis. Health visitor assessments did not identify any additional needs for the Child and hence the core visiting service was provided, The Child lived with the Woman and an older half-sibling. It was documented that the Woman had parental responsibility for the Child and the Child's father (Partner 2) was not named in health records. It is known however that Partner 2 lived with the Woman and Child until February 2013 when the Woman formed a relationship with the perpetrator. After that time Partner 2 had very limited access to the Child, mainly because Partner 2 was homeless for a period of time. It is known that the perpetrator moved into the family home and regularly looked after the Child when the Woman was at work. This was not known to health agencies involved. There is little information contained in agency records as a universal service was provided due to additional needs not being identified. Family members/friends described the Child as happy, healthy, much loved and well cared for by the Woman.

The Woman

6.2 The Woman, of white British ethnicity, was one of seven children from a family with a parental history of violence and alcohol abuse. She was taken into care at the age of 6 years, shortly after her parents parted. There were concerns of neglect and physical abuse as well as a parental failure to prevent their children coming into contact with a 'person who posed a significant risk' (PPRC). The Woman was accommodated briefly in a children's home but was later fostered and remained with the same foster carer from age 10 until 17 at which time she moved onto independent living. The Woman had difficulty maintaining contact with her siblings, all of whom were in care but in different

placements. There was little contact with her birth parents due to their unreliability and failure to attend appointments which served to leave the Woman confused and reluctant to agree contact. She commenced a relationship with partner 1 when she was 15 and he was 26. During her time in foster care and when in her relationship with partner 1, she was to achieve success academically and eventually acquired a degree in social work. During her time in care she was the subject of a Looked After Child Care Plan (LACCP) and she received After Care Support until she finished her higher education. Her final assessment by her aftercare worker, described her as –

> *'A stable young person who is focussed on her education and is very ambitious. She is open to talk about issues if they arise. She is able to reflect on her situation, her life and behaviour and deal with problems when they occur. She will seek help and advice if needed and knows how to access services. She is able to form, sustain and work on existing relationships and has a long term boyfriend. She has had counselling in the past and thought that it was very beneficial to her. It appears that she has worked through her issues and has matured into a responsible and independent young adult'.*

6.3 She gave birth to her first child by partner 1 but their relationship encountered difficulties and they parted when their child was 12 months old. The woman indicated that she wished to move to the south of England with their child and, as a result, court proceeding regarding an application for the residence and care of their child were instigated by Partner 1. During those proceeding counter allegations of domestic abuse were made but an agreement was reached between the couple and after hearing the application the court decided upon an order establishing residence of their child with the Woman and contact with the father (partner 1). Hence the Woman and her child remained in Birmingham.

6.4 After graduation, the Woman gained employment in a care home for adults with learning disabilities, challenging behaviour and mental health issues. She was employed full-time as a senior support worker. Through this employment

she met and went on to form a relationship with Partner 2. Again this relationship encountered problems and an incident of domestic abuse was reported to the police on one occasion. The Woman became pregnant with the Child and her relationship with Partner 2 broke down for a short time but was resumed after the birth of the Child. Partner 2 lived with the Woman and her two children until she formed a relationship with the perpetrator, whom she had originally met when she was 12 years old through siblings and friends who were also in the care system.

6.5 The Woman maintained contact with her long term foster carer with whom she was very close and who also helped with child care and lived close by. The Woman also kept in contact with her siblings and her mother. It is also known that the Woman and one of her female siblings continued to have some contact with the 'Person who Posed a significant risk to Children' whom she described as a family friend. The woman was described by her friends and family as someone who would always put the needs of her children first.

The perpetrator

6.6 The perpetrator, of white British ethnicity, was one of three children from a family with a parental history of violence and substance abuse. It appears that his father regularly beat his mother which was often witnessed by the children who on occasions tried to intervene. The perpetrator's father was eventually imprisoned for an assault on the perpetrator's mother at which time she left him and moved to Wales with the children. The perpetrator and one of his siblings could not settle and moved back to Birmingham to live with their father. After a short time the children were taken into care after their father was again imprisoned following an assault on a neighbour. The perpetrator was 14 when he went into care and was to live at various children's homes across the Birmingham area. The perpetrator was disruptive and challenging and was often violent towards other young people and staff. The perpetrator was described at the time as 'constantly bullying female peers and his younger sister'. Numerous incidents of criminal damage were recorded which involved the perpetrator. He had four convictions for assault and in 1999, at

the age of 15, he was sentenced to three months imprisonment in a young offender's institution. There followed more assault convictions in 2001 and 2002.

6.7 The perpetrator had a number of relationships with women and often these relationships overlapped and domestic abuse was inherent. It is probable that the perpetrator first met the Woman in 2000 when he was in a relationship with one of her female siblings. He fathered three children by two women. The mother of his eldest child was subjected to serial domestic abuse by him, which was reported to the police and he was subsequently convicted of assault. The mother of his other two children also reported that he had physically and sexually assaulted her but the case was discontinued after she withdrew her statement. In 2006 his two youngest children sustained injuries which were believed to have been non-accidental. A prosecution was not pursued as it could not be ascertained who had caused the injuries. The care of the children was then undertaken by their maternal grandfather who had a Residence Order. In 2007 the perpetrator moved to Wales with the mother of his youngest children. However it is believed there was an unreported domestic abuse incident between them and she then moved to the south of England. The perpetrator was named on the birth certificate of the third child of the mother of his two youngest children but it was later discovered that he was not the father of that child. It should be noted that the mother of the perpetrator's two youngest children was convicted in 2013 of the murder of her third child (this case was subject of BSCB serious case review). In 2008 the perpetrator seriously assaulted the male ex-partner of one of his sisters. This was committed in front of children and indeed it was reported that the victim was holding one of the children when he was attacked.

6.8 The perpetrator was described in agency records as mainly compliant during his supervision but was reluctant to share information and he became more manipulative and reluctant to disclose information as his supervision neared its end. During this review and the criminal investigation it has become apparent that all known relationships of the perpetrator were abusive emotionally and/or physically.

7. Ethnicity, Diversity and Cultural Issues

7.1 Commissioning arrangements for IMR reports required agencies to specifically consider whether practice was sensitive to racial, cultural, disability, linguistic and religious identity of the child and family subject of the serious case review, and the impact on service delivery.

7.2 Birmingham has a population of 1.3 million people and 53.1% of residents are White British, compared with the national average in England and Wales of 80.5%. There are 310,198 children under the age of 19 and 56.6% of non-white ethnicity with 91 community languages spoken. There are high levels of child and family mobility in some parts of the city as well as increasing numbers of asylum seekers and refugees. The city has areas of affluence but many of considerable poverty. Indices of disadvantage are much higher than those found nationally and 30% of children are eligible for free school meals which is nearly twice the national average. *(data sourced from local authority statistics January 2012).*

7.3 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.

7.4 The review gave due consideration to each of the protected characteristics under the Equality Act 2010, paying particular attention to serial domestic abuse and violent behaviour of the perpetrator. Identified was a culture of acceptance and minimisation of violence and domestic abuse by a circle of young people who had experienced such behaviour in their childhoods and

who had become acquainted as Looked After Children.

8. Chronological Sequence of Events

8.1 Each agency was required to collate a sequence of events of their organisation's professional involvement with the family and this information was merged to create an integrated chronology to enhance learning. Primarily this concentrates upon the release of the perpetrator from prison but incudes significant information prior to that date.

8.2 In **July 2008** the perpetrator was convicted of a serious assault on the ex-partner of his sister. He assaulted the man with a hammer in the presence of the man's children, and caused a number of fractures to the man's skull. The man was said to be holding one of the children when he was attacked and as a result that child became covered in blood. The man sustained brain damage as a result of the attack. The perpetrator was also found to be in possession of two swords and a piece of Cannabis. At Pre-Sentence Report stage the perpetrator was assessed through OASys [1]as being a high risk of serious harm (ROSH) to a known adult and a medium ROSH to children, with an emerging pattern of domestic abuse. As the perpetrator was assessed as a high risk ROSH a Probation Offender Manager was required to engage in sentence planning from the start of the perpetrator's custodial sentence. A sentence plan was carried out a month later supported by an OASys assessment. There were no indications of any mental health issues, other than low mood. In view of the perpetrator's history of domestic abuse the OASys assessment should have been informed by a Spousal Assault Risk Assessment (SARA) but one was not completed. The sentence plan involved interventions to address the perpetrator's use of violence, his alcohol misuse and early identification of Probation Approved Premises as a release address where his risk could be best managed. The Probation Offender Manager informed Children's Social Care in Devon that the mother of the perpetrator's youngest children was living in their area and pregnant. Information was

[1] OASys - Offender Assessment system is a risk assessment tool utilised by Probation

subsequently passed between Children's Social Care services in Devon and Birmingham as she moved between the two areas (information regarding this is contained within BSCB serious case review. She gave birth to her third child in **December 2008** but the relationship between her and the perpetrator broke down after it became apparent that he was not the father of that child, although he had been named on the birth certificate. The perpetrator made threats against her and against the child through the use of a mobile phone. He also made threats against the victim of the serious assault. Information was exchanged between Children's Social Care, the Police and the Probation service.

8.3 In **June 2010** the Probation Offender Manager referred the perpetrator to MAPPA as a category 2, level 2 offender[2]. This was four months prior to his release date on Licence. Guidance indicates that this should have taken place six months prior to a release date on Licence. The referral was explicit about safeguarding concerns in respect of domestic abuse and non-accidental injuries to his two youngest children. At the MAPPA level 2 meeting in **July 2010,** it was evident that there had been a significant amount of safeguarding activity and information exchange regarding his children and the children of his sister. At this meeting it was felt that a return to Birmingham as requested by the perpetrator in Approved Premises would be appropriate. However at a later MAPPA Level 2 meeting held in early **October 2010** it was decided not to release the perpetrator to Birmingham as there were safeguarding concerns about the perpetrator's children who were resident there with their maternal grandfather. Hence the perpetrator was released towards the end of **October 2010,** on Licence with conditions of living in an Approved hostel in Wales, non -contact with victims, exclusion zones, offender behaviour work, drug testing, disclosure of personal relationships with women, plus additional reporting at the Approved Premises.

8.4 In **April 2011** the perpetrator was recalled back to prison after it was discovered that he had an emerging relationship with a 'vulnerable' woman

[2] **Category 2, Level 2 offender** - Violent offender with active multi-agency management where the offender poses a high or very high risk of serious harm

who had previously been a victim of domestic abuse and who had three children. He had failed to disclose this in accordance with his Licence conditions to his probation offender manager 1. Information had been exchanged between agencies and it was discovered that the youngest child of the woman had bruising to the neck which occurred on a day that the perpetrator had visited. She had shown this to a health visitor and it was thought at the time that the injury was caused by poppers on a bib. When a disclosure about the perpetrator was made to the woman in question, it was queried whether or not this was actually the cause of the injury. However it was assessed that there was insufficient evidence to substantiate concerns that the injury could have been non accidental. It was also ascertained at this time that the perpetrator was in another relationship with a woman who lived in Worcestershire and she too had a child. Again information was shared and a disclosure made in order to safeguard the child and woman in Worcestershire.

8.5 Following his recall to prison the perpetrator was the subject of further MAPPA meetings and there was considerable exchange of information between agencies particularly relating to safeguarding activity across Children's Services in Wales, Birmingham, Worcestershire and Devon. In addition the probation offender manager compiled recall reports to the Parole Board as the perpetrator's release from prison was reviewed in **September 2011.** At this point re-release was not supported as the risks posed by the perpetrator could not be safely managed in the community. The perpetrator had requested that he wished to return to Birmingham upon his release. The probation offender manager 1 engaged with Birmingham Children's Social Care and West Midlands Police in order to risk assess a move to Birmingham. The perpetrator's end of sentence date was in April 2013 when he would be free to return to Birmingham of his own accord. It was therefore felt that a managed transfer to Birmingham engaging with MAPPA and Approved premises would be appropriate so that a level of monitoring and engagement could be established to effectively manage his risk.

8.6 In **April 2012** a transfer request was therefore sent by probation offender manager 1 in Wales to Birmingham Probation. In high risk harm cases

transfer has to be endorsed by senior managers and in this case there was a considerable delay, despite a number of contacts by probation offender manager 1. In **November 2012** a MAPPA referral was made and the case was discussed at a MAPPA meeting in Wales in **December 2012** when the risk management plan and Licence conditions for the perpetrator's release was discussed. Included in this meeting were staff from West Midlands MAPPA support team and from the Approved Premises Probation team. Consideration was given to an application for a Violent Offender Order (VOO).

8.7 In **December 2012** a professionals meeting was held in Birmingham to consider the risk management plan for the perpetrator. The ROSH to children was reviewed and it was considered that it was high, rather than medium as previously assessed using OASys. This meeting was referred to as a professionals meeting rather than a MAPPA meeting due to the fact that until the offender management transfer was secured by senior management the MAPPA responsibility remained in Wales. Consideration was to be given for a Violent Offender Order.

8.8 In **December 2012,** an offender prison information sharing report was recorded on VISOR to the effect that the perpetrator had completed a CALM programme and a Thinking Skills Course and that he had received visits from the mother of his two youngest children, from the woman who lived in Worcestershire and from the sister of the Woman (subject of this review).

8.9 In **January 2013,** a final MAPPA meeting was held in Wales which confirmed Licence conditions. Those conditions subsequently approved by the Parole Board were as follows:

- Not to own or possess more than one mobile phone or SIM card and to provide details of that mobile phone to the supervising officer
- To reside at named Approved Premises
- Not to approach named people
- To comply with the supervising officer for purpose of addressing

anger problems

- Curfew between 2115 and 0915 hours daily (to be reviewed by the supervising officer on a weekly basis)
- Not to enter specified areas in Wales
- Not to enter specified areas in West Midlands
- Report to staff at Approved premises at 1200 hours and 1700 hours daily (to be reviewed by the supervising officer on a weekly basis)
- Notify the supervising officer of any developing personal relationships with women.

An application for a Violent Offender Order was not pursued as it was reported by a police officer from North Wales that the case did not meet the criteria. No further detail was recorded within the MAPPA meeting minutes but at this stage there were stringent Licence conditions agreed and hence a VOO would 'not be necessary'.

8.10 In mid-**February 2013** the perpetrator was released from prison and was transported to the Approved premises by police officers. Found in his possession by staff at the Approved premises were five Valentine cards from the sister of the Woman (subject of this review). This information was passed onto the police offender manager who saw the perpetrator the following day and this information was shared with the probation offender manager 2. Three days later the perpetrator disclosed to his probation offender manager 2 details of a personal relationship with the Woman's sister. As a result a MAPPA meeting was held the following day when the following actions were decided upon; a disclosure to be made to the sister of the Woman who was living in Cornwall, a referral to Cornwall Children's Services social care with regard to safeguarding of her child and to reclassify the perpetrator as a Category 3 'dangerous' offender (he was previously classified as a Category 2 'violent' offender). The sister of the woman was spoken to and stated that she was aware of the perpetrator's history of violence and that he had told her of his Licence restrictions and fully understood that Children's Social Care would want to undertake an assessment. She stated that she wanted to progress a

relationship with the perpetrator but if she had to choose between him and her child she would choose her child. Information regarding these actions and information was recorded on VISOR late February 2013.

8.11 In **February 2013,** the perpetrator informed the probation offender manager 2 that his relationship with the Woman's sister had ceased because he was not prepared to move to Cornwall as his own children were in Birmingham. The perpetrator was also seen by the police offender manager when it was established that the perpetrator was seeking accommodation with assistance from the National Association for the Care and Resettlement of Offenders (NACRO) due to the fact that he would have to move out of the Approved premises in mid-April 2013 when his Licence expired. Also discussed was a change of curfew arrangements and information was gleaned about the perpetrators family tree, ex-partners, their children and the children of the perpetrator.

8.12 At the end of **February 2013,** the transfer of the perpetrator's case was finally accepted by senior probation management. Until this date the management of this offender was shared between Wales and the West Midlands.

Not known by any professional or agency at the time but it is has transpired that shortly after his release from prison the perpetrator formed a relationship with the Woman. Initially the perpetrator used her address to meet up with her sister.

8.13 The following day the perpetrator's curfew time was extended until 2200 hours, as a result of discussions between the police and probation offender managers. A further visit was made to the perpetrator by the police offender manager at the beginning of **March 2013.**

8.14 In **March 2013** a meeting was held with the perpetrator, a social worker for his children and the probation offender manager 2. The perpetrator was seeking contact with his children but he was told he must be realistic regarding contact

due to his history of violence. The following day the police offender manager went to the Approved premises to check that the perpetrator was signing on as required by his Licence conditions. The perpetrator told his police offender manager that he was realistic about the length of time it may take before he would have any contact with his children. They also discussed a possible house move and reduction to the curfew restrictions. The police offender manager also visited the mother of the perpetrator's eldest child who expressed concern about the effect of the perpetrator's release upon her child. The police offender manager verbally passed on the concerns to the social worker for the perpetrator's two youngest children the following day.

8.15 In **March 2013** the police offender manager again saw the perpetrator to inform him that the maternal grandfather of the perpetrator's two youngest children was seriously ill and they were now in the care of their maternal great aunt. A special guardianship application had been made and the following day the perpetrator was seen by a social worker in the presence of the police offender manager. The perpetrator was described as frustrated and unhappy that he was not allowed to see his children but he accepted that they should be placed with the maternal great aunt. It should be noted that at this time the mother of the perpetrator's two youngest children was on trial for the murder of her third child. After this meeting the curfew requirements were altered to 2300 hours instead of 2200 hours and the requirement to sign on at the Approved premises at 1200 hours was removed. It was planned that the requirement to sign on at the Approved premises at 1500 hours would be removed at the end of March 2013 subject to compliance and behaviour. This approach is standard practice with a view to re-integrating offenders in the community. However mid**-March 2013** the perpetrator was warned about his failure to sign on the previous day. The explanation given was accepted as he stated that he had been looking for accommodation. After this the police offender manager assisted the perpetrator to view accommodation but the perpetrator was to receive a second warning from probation staff after failing to attend a morning briefing at the Approved Premises.

8.16 Late **March 2013** in the early hours**,** partner 1 received two text messages

from the perpetrator alleging that the Woman had allowed a paedophile (a Person who posed a Risk to Children (PPRC) - previously referred to as being a family friend by the Woman) to have contact with the child of Partner 1 and the Woman. Partner 1 felt that the messages may have been malicious but he was concerned about his child's safety and he later reported the matter by telephone and in person to West Mercia Police and by telephone to Birmingham Children's Social Care. He named both the perpetrator and the 'PPRC'.

8.17 On the same day in the early hours, the perpetrator sent a text message to a work's mobile telephone at the Care Home where the Woman worked as a Senior Carer. The message was picked up by a colleague of the Woman and the message read as though it was intended for the Woman and to the effect that he had enjoyed spending time with the Woman at the Care Home but he hoped no-one would find out because the Woman could lose her job as they were living together. Later that morning a further text message was received at the Care Home to the effect that the Woman was a baby killer, getting rid of a baby after 8 weeks and should a person like that be taking care of people. The member of staff contacted senior managers and also spoke with the Woman but it was felt that the messages were malicious and the Woman stated that she had received similar abusive messages. The member of staff was told by senior managers to send a text back threatening to report the matter to the police if the messages did not cease and to write down the exact content of the messages and then to delete them from the phone. No further action was taken and the police were not informed.

8.18 The telephone call from Partner 1 was received by West Mercia Police at the beginning of **April 2013** when he reported the text messages that he had received from the perpetrator. It is clear that he was concerned about the content of the texts and he asked to call into his local police station to discuss the matter with a police officer. This he did and after waiting for 55 minutes he saw a police officer. However it was logged that the text messages were not threatening or abusive but just unwanted. The officer asked Partner 1 to send back a polite text message asking him not to text him any more to which he

received a polite response agreeing to that. Partner 1 stated that he had reported the matter to Birmingham Children's Social Care and it is quite apparent that he was concerned about the safety of his child. System checks were made in respect of Partner 1 but not in respect of the perpetrator or the named 'PPRC', who had been referred to as a paedophile. No further action was taken by West Mercia Police and no information/intelligence was forwarded to West Midlands Police where the alleged incident took place, and no contact was made with Birmingham Children's Social Care.

8.19 The telephone call that Partner 1 made to Birmingham Children's Social Care was received at the beginning of **April 2013** when an entry was made on Carefirst computer system but no referral was opened and no further action was taken. There is no evidence that any checks were undertaken on the details given. The name of the PPRC, referred to as a paedophile, was recorded incorrectly but the perpetrator's name was correct.

8.20 On the same day that the telephone call from Partner 1 was received, the police offender manager made late recordings of information and actions in respect of the perpetrator. All previous entries were made in **February 2013**. Information/intelligence was however entered onto the West Midlands Police Intelligence Management system (IMS)[3] requesting stops or observations of the perpetrator to be reported. The entry though did not highlight the perpetrator's high risk in relation to children and domestic abuse.

8.21 The perpetrator secured accommodation which he moved into during the first week in **April 2013.** He was assisted in this move by the police offender manager. Various options for accommodation were considered, one of which was refused on the basis of the perpetrator's offending. The accommodation which was offered and accepted by the perpetrator is a facility which specialises in accepting individuals with mental health difficulties but is also a registered social landlord and will accept other tenants. This accommodation

[3] West Midlands Police IMS – purpose to receive and store information to inform patrol strategies, crime hotspots, offending behaviour, criminal links and associations and alerts officers if a particular officer/section has interest to ensure that information is passed on.

was facilitated by a dedicated NACRO support worker at the Approved Premises. Shortly after moving into this accommodation, staff raised concern that the perpetrator was in a relationship and that he had named the Care Home where she worked. He had also not stayed overnight at the accommodation the night after he moved in. These concerns were shared with the police but it is unclear and cannot be ascertained whether or not the information about the Woman's place of work was passed on. Information was shared between police and probation and the perpetrator denied any relationship to both the police and the probation offender managers on two separate occasions.

8.22 In mid-**April 2013,** the perpetrator's Licence expired which meant he was no longer subject to any conditions. However he continued to be managed as a MAPPA category 3, Level 2 status. West Midlands Police IMS system was updated to the effect that the Licence had expired and information was entered regarding safeguarding of the perpetrator's children and that access could only be granted to him with the approval of Children's Social Care. The police offender manager made attempts to contact the perpetrator unsuccessfully and it was reported by staff at his accommodation that he was not staying there.

8.23 At the end of **April 2013,** a MAPPA meeting was held in Birmingham in respect of the perpetrator. The perpetrator remained as a category 3, Level 2 offender with a high Risk of Serious Harm (ROSH) to known adults and children. Actions from that meeting were for the police offender manager to locate the whereabouts of the perpetrator, to include a search on social networking sites and a check on the Police National Computer (PNC) to ascertain if he had been stopped anywhere else in the country. A joint visit was to be made by Police and Social Care to the carers of his two youngest children with authorisation to show them a photograph of the perpetrator in case he attempted contact. The police offender manager was instructed to report back by the end of **May 2013**. A further MAPPA meeting was scheduled for the second week in **July 2013** or earlier if further risk identified.

8.24 After the meeting the police offender manager managed to contact the perpetrator by telephone. He confirmed that he was in a relationship but refused to give any further details but he did agree to meet the officer in early May 2013. On that day however he sent a text message to the officer to cancel and it appears that despite numerous attempts to contact the perpetrator these proved unsuccessful. Information was placed on West Midlands police briefing systems. Eventually mid-**May 2013,** the police offender manager did speak to the perpetrator by telephone. He was talkative, seemed happy and was due to start employment on a trial basis. He stated that he was still in a relationship and confirmed that the Woman had children. He refused however to disclose any further information. Various actions were taken by the police offender manager in an effort to trace the perpetrator and identify the Woman. These included a search of police information/intelligence systems and a search of social networking sites.

8.25 In **May 2013** the police offender manager was informed by Children's Social Care that a meeting had been arranged with the perpetrator to discuss his two youngest children. On the same day the Family Liaison Officer allocated to the ongoing murder trial of the mother of the perpetrator's two youngest children contacted the police offender manager to the effect that the perpetrator had not been sighted at the Court.

8.26 At the end of **May 2013,** information was exchanged between Children's Social Care and the police offender manager to the effect that the perpetrator had arrived at the meeting but he had refused to disclose the name of his current partner. He did, however disclose that she had two children and said he would pass on the contact number for Children's Services social care to his partner. The police offender manager contacted the sister of the Woman when it was disclosed that the perpetrator was in a relationship with the Woman. A search of a social networking site also indicated that the perpetrator and the Woman were in a relationship. It does not appear that this information was shared with any other agency at this time.

It was established during the IPCC investigation that the Woman's sister

telephoned the Woman at the end of May 2013 and left an answer phone message that the police had rung her asking about the perpetrator.

8.27 The next day**,** the Child was taken for an unplanned appointment to the 'well baby' clinic by the Woman. The Child was found to be in good health by health visitors.

8.28 Two days later**,** the police offender manager spoke to the perpetrator by telephone when the perpetrator was urged to get his partner to make contact with Children's Social Care as this would help him in his wish of being allowed contact to his own children. The perpetrator said he would speak with her over the weekend. The police offender manager went off duty later that day without having recorded any information on VISOR since the beginning of April 2013, although it has been established that information was recorded in a book which only was accessible to other members of the Offender Management team. There is no indication that the identity of the Woman and her children was shared with any other agency.

8.29 At 23:03 hours**,** the day after the police offender manager had spoken to the perpetrator, the perpetrator sent a text message to the police offender management team's duty mobile phone to the effect that he had killed the Woman who he named and he gave her address and asked what he should do. The message was not picked up until the following day at **1010 hours.** Police officers attended the Woman's address and found the bodies of the Woman and the Child. The Child was in a cot and the Woman was in bed, both of them had marks around their necks. The eldest child of the Woman was not in the house but was staying with Partner 1. The perpetrator was later arrested at another address and was sectioned under the Mental Health Act. However, after mental health assessment he was found fit to be interviewed.

9 Criminal Proceedings and Parallel Investigations

9.1 The perpetrator was convicted of the murder of the Child and the Woman after

pleading ‘guilty’ in December 2013. He was sentenced to life imprisonment with a minimum of 29 years to be served. The Judge described the perpetrator as ‘evil and dangerous beyond measure’. During his interview by the Police the perpetrator answered ‘no comment’ to questions or just declined to answer other than to say that he had asked the Woman to marry him. It was thought that the Woman had declined his proposal and this is what led to the murders.

9.2 During the criminal investigation it transpired that after the deaths of the Child and the Woman, the perpetrator had posted messages on a social networking site as follows – ‘**Sometimes we just have to do things we shouldn’t but that’s life I guess Oh well’ and ‘I’m sorry it had to come to this’.**

9.3 It also became known during the criminal investigation that the Child had sustained an injury whilst in the care of the Perpetrator. In early May 2013 the Woman had told the long term foster carer that the Child had rolled off a bed onto some toys and as a result had two black eyes, a split lip and weakness of the upper body. Despite being urged to seek medical attention for the Child the Woman failed to do so. The black eyes and split lip injuries were seen by Partner 1 who was given the same explanation for the injuries but was told that the Child had been in the care of the long term foster carer and not the perpetrator.

9.4 An Inquest was opened and adjourned in relation to the deaths of the Child and the Woman and it is understood that the verdict of the criminal court will be accepted by the Coroner.

9.5 An investigation by the Independent Police Complaints Commission (IPCC) has been conducted into the offender management of the perpetrator by police officers. As a consequence the police IMR author was unable to interview the police practitioners and a learning event to try and establish not only what but why actions were or were not undertaken could not be held as this may have compromised that investigation.

9.6 As a result of the findings of the IPCC investigation misconduct proceedings are pending in relation to some police officers who were involved in the offender management of the perpetrator. In addition 16 recommendations were made in respect of organisational learning gleaned during the investigation.

10 Family Engagement

10.1 Following the completion of the criminal proceedings, the long term foster carer, partners 1 and 2, the eldest sibling of the Woman and the perpetrator agreed to contribute to this review and all were seen by the independent chair and author. The Woman's sister was contacted but declined to contribute to this review.

10.2 The foster carer described the Woman who she fostered from the age of 10 years as being 'a good little girl who always wanted to please'. The foster care placement lasted until the Woman went to university but they remained close. The Woman was well liked, hardworking, liked to be 'in charge and be the boss'. She said that when the Woman was 15 years old she started her relationship with Partner 1, and would sometimes see him without telling her foster carer who was concerned about the age gap (of 11 years) but the Woman was determined and eventually the Woman and Partner 1 were together for about eight years. The Woman lived near to the foster carer with Partner 1 and after having her first child she went to work full time. The foster carer felt that maybe the Woman may have begun to live her 'teenage' years which she had missed out on by becoming tied at an early age and hence began the relationship with Partner 2. After the birth of the Child when the Woman returned to work, the foster carer would help in caring for the Woman's children but found she could not manage to lift the Child. The Child was described by the long term foster carer as happy, trying to sit up but not yet stable. The foster carer described the relationship between the Woman and Partner 2 as 'stormy', breaking up before the birth of the Child but getting back together after the birth. The foster carer believed that the Woman and the perpetrator got together soon after he was released from prison, although

at first he was in a relationship with the Woman's sister. In any event the relationship with Partner 2 ceased soon after the perpetrator 'came on the scene'. She knows that Partner 2 did not see much of the Child afterwards. She felt that the Woman minimised the past behaviour of the perpetrator and perhaps thought she could cope as she worked with people who had behaviour problems. The foster carer believes that there should have been more checking up on the perpetrator when he was released from prison as he always seemed to be at the Woman's house. She felt that he was 'sneaky' and she believed that the Woman was taking risks with him. She described the Woman as being smiling and happy in front of the perpetrator but more negative about him when he wasn't there and was doubtful that the Woman would have agreed to marry him. The foster carer felt that she had to accept the perpetrator otherwise she would 'lose' the Woman. This is why she did not take action when the Woman failed to seek medical attention for the Child after sustaining bruising to the eyes, a split lip and weakness to the upper body when in the care of the perpetrator.

10.3 Partner 1 described the Woman as loving and caring but could be 'fiery' and manipulative when not getting her own way. They went through a lot to be together as Children's Social Care disapproved due to their age gap. However they were together for eight years and he helped to support her when she was studying for her degree. She was very protective of her children and he believed that she would have been fearful of losing her children if her relationship with the perpetrator was known by the authorities. Partner 1 had some prior knowledge of the perpetrator because of his involvement with the Woman's family and with mutual family friends. He had some knowledge of the assault which led to the perpetrator's imprisonment and believed that this should have been enough to cause the Woman to steer clear of him. Partner 1 was particularly concerned about the lack of action by Police and Children's Social Care when he reported receiving text messages from the perpetrator alleging that his child was at risk of being in contact with a 'paedophile' (PPRC). His expectation was that there would be a home visit to check on the safety of the children. When he received the text messages he was reluctant to return his child to the Woman who pleaded with him and said that her

relationship with the perpetrator had ended.

10.4 Partner 2 described the Woman as headstrong and that she 'wore the trousers'. He stressed how much he loved her, that he had left his marriage and two children for her and that the Child was planned. It was agreed that as she earned more than him, that he would stay home and care for the Child. However, he was jealous and did not trust the Woman due to messages he had found on her phone. He admitted being aggressive but not to her but to her belongings, such as phones and computers. He described the Woman as a 'wonderful mom' who would always put her children first. He said the Woman threw him out after the perpetrator was released from prison. At first the perpetrator was with the Woman's sister, but partner 2 became aware of texts between the perpetrator and the Woman and that the Woman would transport the perpetrator so that he could meet his Licence conditions. The perpetrator talked openly about his conviction and it seemed that the Woman's family used to 'defend' him as he was believed to have been 'protecting his sister'. After their relationship ended Partner 2 was homeless and had limited contact with the Child. Partner 2 thought that his Child was being cared for by the long term foster carer and was unaware that the perpetrator was being allowed to. He was also unaware of any injury to the Child. Partner 2 felt that there should have been more monitoring of the perpetrator when he was released from prison but stated that the Woman would have kept quiet about the relationship as she would have been worried about the authorities getting to know.

10.5 The Woman's eldest sibling described the Woman as sensible and someone who doted on her children. She was never involved in drugs and wanted to become a foster carer herself. He described how difficult their childhood was due to parental alcohol abuse and domestic abuse. All of the children went into care but it was only a few years ago that he and the Woman actually got in touch and they were afterwards in regular contact. The Woman was a little cagey about her relationships but the eldest sibling felt that during each of them there were problems and she was mistreated in some way. The eldest sibling knew of the perpetrator and had met him in passing when he was with

his other sister. He knew the perpetrator had been in prison but not why. He thought the Woman knew some of this but not the whole story and that when she found out he should not be around children she ended it. At that time he had received texts from the perpetrator but was not aware that they had got back together. The eldest sibling knew that just before the deaths of the Woman and the Child, the Police had been told by his other sister that the Woman was in a relationship with the perpetrator and he wanted to know what had been done about it.

10.6 The perpetrator stated that he had known the Woman since she was about 12 years old and they had met because they had been in care. He said that he had been seeing the Woman's sister and that after his release from prison they would meet at the Woman's house. He said that he had told his offender manager about his relationship with the Woman's sister but not about his relationship with the Woman. He said that the Woman had known about his Licence conditions and he had shown her the letter with the conditions laid out. He said that the Woman did not want him to tell of their relationship because she did not want the authorities involved. He said he too did not want that because he had been recalled to prison before so they both wanted to keep their relationship secret. He wished now that he had told his offender manager. He thought that social workers removed children too easily rather than sit and discuss possible solutions. However when later asked about his own childhood he felt that he should have been removed from home earlier and placed in foster care. He was a teenager when he went into care and he was in children's homes with others whose behaviour was like his. He said that he regrets not having told anyone about his relationship with the Woman but he did know that she would have finished with him if she had been forced to choose between him and her children. He said that an end to their relationship would have 'destroyed' him but would have prevented what occurred from happening and 'they would be here now'. He regretted this and said that he wanted the family to know this. The perpetrator said that he had been under a lot of stress about trying to get contact with his two youngest children. He could not understand why he could send them cards and write to them when in prison but that this was stopped when he was released. He said

that the social workers were only interested in who he was currently in a relationship with.

10.7 Asked about his accommodation he said that the staff were nice but it was completely unsuitable because other residents had mental health issues or learning disabilities. He would not have moved in with the Woman so quickly had he been in more suitable accommodation.

10.8 When asked about the injuries to the Child he said that he thought the Woman had sought medical help but that may have been when the Child had a rash. He did say that the Child had fallen from a bed but seemed 'unaware' of the injuries.

10.9 The perpetrator was asked whether in his view anything could have prevented what occurred. He said that he would have benefitted from more appropriate anger management when in prison and that his release could have been gradual. The whole thing in his opinion was rushed. He said he had done some short courses in prison which were group courses and it had been suggested that he use exercise to defuse stress but that did not work for him. He felt he needed one to one counselling and when he had received that it had been beneficial but had not continued. He said he had asked for an open prison but that was not agreed and he had wanted to return to Birmingham upon his first release but that too had been refused. He spoke positively about the police offender manager and both probation offender managers and in particular said the one in Wales was firm but listened to him and that was a good thing. He thought his Licence period should have been longer and he should have stayed longer in the Approved premises where the staff were good. He would have welcomed help with anger management, money management and shopping advice as he found these things difficult. He thought that a peer mentor prior to release from prison would have been helpful.

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11. ANALYSIS OF AGENCIES INVOLVEMENT

11.1 The Woman and the perpetrator were both taken into care as children due to parental violence and substance/alcohol abuse. The Woman was only 6 years of age and apart from a short period in a children's home was to benefit from being in foster care which included a long term placement with a foster carer to whom she remained close as an adult. Throughout her time in care there were no behavioural problems and the only concern raised was over her relationship with Partner 1 due to the age difference. She achieved good academic achievement, was hard working and was thought a stable, focused, ambitious individual by the time she had progressed to independent living. Apart from contact with health professionals for general health matters in relation to herself and her children she had little contact with any other agencies after leaving care. Each of her relationships encountered difficulties and it is evident that domestic abuse occurred.

11.2 On the other hand the perpetrator was a teenager when taken into care and he was placed in children's homes. He was disruptive, violent and displayed challenging behaviour throughout his time in care. By the age of 17 years he had a total of 33 criminal convictions several of which involved violence. He had a number of relationships with women, often involving domestic abuse and there were concerns about non accidental injuries to two of his children. He was therefore known to a range of agencies and he usually appeared compliant whilst withholding information. There is no doubt that due to his time in children's homes, youth offender institutions and prison that he was 'institutionalised' and had difficulty coping in society. The Woman and the perpetrator shared the same social circles as both kept in contact with family members and peers who had been in the care system at the same time. It is apparent that within this social circle there was a degree of acceptance and minimisation of abusive behaviour.

11.3 There was effective management of the perpetrator, particularly when he was first released under Licence. Relationships he had formed were identified and prompt safeguarding actions in relation to the women and their children were

undertaken. However as the end of his sentence date approached and Licence restrictions were due to cease whilst still appearing compliant, it is apparent he became more manipulative and less willing to disclose information and there was a lack of supervision or management oversight at that time.

11.4 There was a great deal of information sharing between agencies although there was some delay in record keeping, submission of MAPPA referrals and authorisation of the transfer of the case from Wales probation to West Midlands probation.

11.5 There were clear indications that the perpetrator was in a relationship and whilst there was a great deal of activity, there were missed opportunities when information was passed on which could have led to identifying the Woman at an early stage. When eventually her identity was established there was a failure to take prompt action which could have served to safeguard the Child and the Woman which seems to indicate a lack of understanding of the risk that the perpetrator posed.

KEY ISSUES

- **Acceptance/Minimisation of Abusive Behaviour**

11.6 Both the Woman and the perpetrator were Looked After Children but had very different experiences during their care The Woman matured into a stable, focused individual who was successful academically and in her working life. The perpetrator failed to achieve, was constantly violent and abusive to others and became institutionalised having spent time in children's homes, youth offender institutions and ultimately prison. However they both came from a background of parental violence and alcohol/substance abuse. They both maintained contact with siblings and other Looked After children who had also experienced similar early childhoods. It is apparent from this review and from information gleaned during the criminal investigation that physical, sexual and emotional abuse was part of many of the relationships which some of these

young people formed. Indeed in respect of the perpetrator there are indications that he was abusive towards all of the women with whom he had relationships. It seems that there was a culture of acceptance and minimisation of this type of behaviour. When the perpetrator attacked and caused very serious injury to the ex-partner of his sister it was seemingly viewed as almost acceptable as he was acting 'on behalf' of his sister and the effects upon the children who witnessed the attack were not fully appreciated. In addition the person who was identified as posing a risk to children was able to form relationships with women in this 'social' circle and was referred to as a 'family friend' despite his behaviour being widely known about.

11.7 It appears that Looked After Children in the care of Birmingham Children's Social Care would only benefit from awareness raising work in respect of positive 'healthy' relationships if included in individual care plans should this be identified as an issue by key workers. However it is known that Birmingham & Solihull Women's Aid have delivered awareness raising work in education and youth settings for over ten years. This work aims to take a preventative and early intervention approach by:

- creating a greater awareness of identifying abusive and controlling behaviour;
- enabling young people to develop safety and help seeking strategies;
- increasing self-esteem and well-being;
- aiding early identification of risk.

It is, of course possible that some young 'Looked After' people in Birmingham may have benefitted from such inputs in school or other youth settings and also to professionals working with young people. It is evident that young 'Looked After' people in Birmingham and their key workers would benefit from education inputs of this type in respect of positive 'healthy' relationships.

Recommendation 1

Raise the awareness of all Children in Care and those who care for them about what constitutes a safe and a risky relationship, with a view to supporting an outcome that all children in care enter into positive and healthy relationships.

Aim:

to increase awareness in Looked After Young People of what constitutes a safe or risky relationship. Looked After Young People may be especially vulnerable in relationships and may accept or minimise abuse.

- **Information Sharing and Record Keeping**

11.8 There is evidence of good information sharing across agencies in relation to the risk posed by the perpetrator to women and children and prompt referrals were made to Children's Social Care in the relevant areas. However there were missed opportunities when the risk to the Woman and Child could have been identified.

11.9 The first instances occurred at the end of March 2013 when the perpetrator sent text messages to Partner 1 and to the workplace of the Woman. Contained within both messages was information which revealed that there was a relationship between the perpetrator and the Woman. In respect of the messages sent to Partner 1 there was additional reference to possible contact between the Woman's eldest child and a PPRC. Whilst initially thinking the text messages were malicious, Partner 1 was concerned enough to report the matter to the Police and to Children's Social Care and named both the perpetrator and the PPRC. However neither agency took any further action assuming that the texts were malicious without making any checks or in the case of the Police passing on the information to the relevant Police area. It is evident that clear safeguarding risks to the children were missed.

Recommendation 2

All Police Officers and staff recognise the importance of considering the safeguarding of children and young persons identified within any reported incident.

Aim:

to ensure that messages are not just categorised as malicious or anti-social without their content being analysed.

11.10 The text messages received at the Woman's place of work, a Care Home, were also viewed as malicious but had the Police been informed then it was possible that the relationship between the perpetrator and the Woman could have been identified.

11.11 The police offender manager discovered the identity of the Woman in late May 2013 but this information was not shared with Children's Social Care. The police offender manager did speak with the perpetrator and encouraged him to persuade the Woman to contact Children's Social Care. This demonstrates a lack of understanding of the high risk posed by the perpetrator and as soon as the Woman was identified, information should have been shared and safeguarding measures taken.

11.12 The police offender manager recorded information and actions with regard to the perpetrator into a book which was only accessible to members of that particular offender management team rather than straight onto VISOR which is searchable across the West Midlands to police and probation personnel. The reason seems to be that there was limited access to VISOR. However this meant that those entries on VISOR were considerably delayed and fell well below the required standard of three days. Indeed some entries were made after the deaths of the Woman and the Child. The use of a book in these circumstances was not common practice in the West Midlands and has now been ceased. The issue of prompt recording information/actions on VISOR is addressed by a single agency recommendation.

11.13 The probation offender manager 1 did not fully record the significant amount of safeguarding activity which served to have an effect on the OASys assessment of medium risk of serious harm to children which would correctly have been assessed as high.

- **Offender Management/MAPPA**

11.14 Considerable activity took place across agencies to manage the risk posed by the perpetrator. He was discussed at twelve MAPPA meetings, ten of which were in Wales and the remainder in Birmingham. There was also a professionals' meeting in Birmingham which was held during the transfer stage of the case. Appropriate disclosures were made and safeguarding measures taken.

11.15 Whilst the perpetrator was in prison there was good liaison with Children's Social Care, the Police and probation victim liaison unit, over threats made to the mother of his two youngest children and to the victim of the offence for which he had been imprisoned. Prior to his first release on Licence a referral to MAPPA as a category 2, level 2 offender was appropriately made, although this should have been actioned two months earlier. The timing did not adversely affect the management of the case and stringent Licence conditions were formulated which were necessary to safeguard victims and children. Effective monitoring and risk management by staff from the Approved Premises where he was resident resulted in the discovery of two relationships with women which the perpetrator had failed to disclose. There was a great deal of activity to ensure that children of the women involved were safeguarded. Likewise when the perpetrator was released a second time which was two months prior to his end sentence date, there were appropriate and stringent Licence conditions and an early discovery of another relationship which the perpetrator did not readily disclose but which was successfully disrupted and safeguarding measures taken in relation to that woman's child. During the criminal investigation and this review it was found that whilst in prison the perpetrator had received several visits from women who he had

formed relationships with. Some of this information was known whilst he was in custody but not taken into account when sentence planning. Indeed the relationship with the Woman's sister was only acted upon when staff at the Approved Premises found valentine cards addressed to the perpetrator but it was known that she had been visiting the perpetrator prior to his release. Earlier identification and discussion at sentence planning meetings of those emerging relationships could have provided opportunity to forward plan safeguarding measures in relation to those women and their children.

Recommendation 3

Probation Offender Managers should ensure that information about visitors to Domestic Violence perpetrators supplied by the prison service is considered at MAPP meetings and six weeks prior to release from prison so that any necessary enquiries regarding potential new partners can be undertaken.

Aim: to ensure forward planning can take account of known relationships

11.16 There was however a delay in the transfer of the case from Wales to Birmingham as Senior Managers must authorise transfer and the request was late in being actioned which resulted in the actual transfer not being confirmed until 13 days after the perpetrator's release on Licence. Whilst the case was still under the supervision of Wales Probation the matter was overcome by the identification of a probation offender manager in Birmingham who supervised the case in liaison with the offender manager in Wales. In any event the professionals' meeting held in Birmingham ensured that appropriate actions and Licence conditions pertinent to Birmingham were formulated whilst the case was still subject of MAPPA in Wales. It was also at that meeting that recognition of the heightened risk to children was made in view of all of the child safeguarding measures that had taken place due to the relationships that the perpetrator had managed to form. This delay in transfer did not prevent robust management of the case but potentially could have prevented effective management measures being implemented. It should be noted that this issue

is subject of a single agency recommendation.

11.17 Application for a Violent Offender Order (V00) was discussed and considered at the professional's meeting held in Birmingham in December 2012 and at a MAPPA panel meeting in Wales in January 2013. However at the MAPPA meeting held in Birmingham in February 2013 it was reported by a police officer from Wales that a VOO was not appropriate as the case did not meet the criteria but the rationale for this was not fully recorded. Bearing in mind that the conditions imposed on the perpetrator would cease at the end of his Licence, there should have been greater consideration made in respect of the use of a VOO to manage the known high risk that he posed to known adults and children, after all his youngest children, their carers, his ex -partner and his eldest child were all locally resident. In addition there was the risk to the victim of his index offence and it soon became known that he was in another relationship, which he was unwilling to disclose, with a Woman who had children.

11.18 Legislation which created Violent Offender Orders came into force on 3 August 2009. It allows the police service to apply to a magistrate's court for an order which prevents a violent offender having access to named individuals, certain places, premises or events if certain qualifying criteria are met. These criteria have been set at a high level which in most cases will be met where the perpetrator has committed a serious violent offence, been sentenced to 12 months or more in prison and is assessed to continue to pose a risk of serious violent harm to the public. It was sought to ensure that the threshold for the criteria which would qualify a perpetrator for the application of a VOO was high but nevertheless proportionate to the potential criminal act that it was seeking to prevent.

11.19 In this case the perpetrator would have been eligible due to the offence he committed. There is a need to show that the offender had subsequently acted in such a way to warrant the issuing of a VOO. In this case the identity of the Woman and the Child was not known but since the perpetrator's conviction he had threatened harm to the victim, his ex-partner and to her child and he had

also withheld information about relationships. Whilst it is acknowledged that the Woman and her Child could not be named and their location identified at that time, there was the potential of continued risk to others who had been identified in his Licence conditions. Therefore legal advice could have been sought when his case transferred to Birmingham.

Recommendation 4

MAPP panels to consider the use of a Violent Offender Order where formal supervision is ending.

Aim: to ensure robust use of a VOO in appropriate circumstances to enable forward planning.

11.20 Effective management of the perpetrator continued whist on Licence but it became apparent that he was in another relationship and, as previously discussed there were missed opportunities to identify the Woman. The perpetrator nearing the end date of his sentence became less compliant. Ten days prior to the end of Licence he moved into accommodation which he has described as being unsuitable as the other residents had mental health problems and claimed that he would not have moved in with the Woman so quickly had this not been the case.

11.21 The Panel sought assurance that detailed information was supplied to the facilitator and providers of the accommodation in respect of the risks posed by the perpetrator. It was established that full information was exchanged and that neither the perpetrator or the provider raised any concerns at the time. Information was exchanged by staff at the accommodation with the Police. It is apparent that the procedure and referral processes in respect of offender accommodation are robust and hence there is no necessity for a recommendation is respect of this issue.

11.22 He was appropriately reclassified as a category 3 offender but remained at high risk and at a MAPP meeting held in April 2013 various actions were set in

an effort to trace the Woman including a search of social networking sites. Whilst it is evident that there was activity carried out it took some time before the identity of the Woman was discovered despite the fact that it is now known that there would have been indications on social networking sites of the relationship between the Woman and the perpetrator. Unfortunately when the identity of the Woman was discovered, this did not result in immediate action to safeguard the children of the Woman. The approach taken was to speak with the perpetrator who was asked to persuade the Woman to contact Children's Social Care. This showed a lack of understanding of domestic abuse bearing in mind the perpetrator's history and of the risk that he posed to children and to the Woman. There was also little evidence of any supervision or management oversight at this critical time.

11.23 During the criminal proceedings it was found that the perpetrator murdered the Woman and the Child after his proposal of marriage was declined and also it was probable that their relationship would end if she felt that she had to choose between him and her children. Research and crime surveys have consistently shown that victims are at most risk when a relationship ends and this factor does not appear to have been understood by the police offender manager.

Recommendation 5

West Midlands Police and Birmingham Children's Social Care Services to review domestic violence training to ensure learning from this case in relation to control, coercion and risk by perpetrators is fully incorporated.

Aim: to ensure that information sharing requests do not increase risk to potential victims.

- **Domestic Abuse**

11.24 Prior to entering the care system domestic abuse impacted on the childhoods

of both the Woman and the perpetrator. Indeed the level of abuse and violence witnessed by the perpetrator was high and it is recorded that he and his siblings tried to intervene on occasions when their mother was being attacked. The perpetrator went on to display violent behaviour himself and he was convicted of offences of assault, some of which were against girlfriends. During the criminal investigation it transpired that he was a controlling and manipulative individual and incidents of abuse were recalled by various girlfriends. In the Woman's relationships there were also indications of domestic abuse. During court proceedings over the residence of her eldest child counter-allegations of domestic abuse were made between her and Partner 1 and early in their relationship her sister reported to Children's Social Care that the Woman had been abused. Furthermore during her time with Partner 2 there was one incident of domestic abuse reported to the Police and it is apparent that they encountered difficulties in their relationship, indeed Partner 2 has acknowledged that as a result of jealousy he would be physically violent towards property owned by the Woman.

11.25 Whilst there were no reports of domestic abuse between the perpetrator and the Woman it has been established that there was controlling and manipulative behaviour by the perpetrator. This was displayed during his reaction when it seems she tried to end their relationship at the end of March 2013. He sent text messages to Partner 1 and to her place of work with allegations about the safety of her eldest child, her suitability to work in a care home and about her termination of a pregnancy by a previous partner. It is also known through information gleaned during criminal proceedings, that he sent similar text messages to her family members and to mutual friends as well as posting messages via social networking sites. It cannot be established the extent of any abuse and the reasons why the relationship continued but it is surprising how quickly the relationship between perpetrator and the Woman progressed. It seems there were together for only a little over three months. It is thought that the Woman did not want the authorities to know about her relationship with the perpetrator which was illustrated by her failure to seek medical attention for injuries sustained by the Child whilst in the care of the perpetrator.

11.26 The woman had been very successful academically and in her career, was always very protective of her children and was described as a good caring mother. The Woman was outwardly a strong character and her work involved caring for people with behaviour difficulties and mental health issues. It may have been difficult for her as a professional in Social Care/health to seek help or report being a victim of domestic abuse as perhaps she thought that she should be able to cope and overcome the situation. She may also have been concerned about judgements of others and possible repercussions in respect of her professional role. The woman may have been influenced by the culmination of domestic abuse experienced during her adult life and it is not known what level of coercion and fear she was potentially subjected to during her relationship with the perpetrator.

11.27 The initial sentence plan in respect of the perpetrator identified actions around accredited programmes which included Controlling Anger & Learning to Manage it (CALM) and he was assessed for the Integrated Domestic Abuse Programme (IDAP) but he did not actually complete either of these programmes. Activity centred on substance misuse interventions which were not a priority as substance misuse was not linked to the perpetrator's risk of harm. There was a lack of focus upon domestic abuse which may have been due to the fact that the offence for which he was imprisoned was against an adult male, the ex-partner of the perpetrator's sister. However his history of domestic abuse, concerns about non-accidental injury to his own children as well as committing the serious assault in the presence of children were not sufficiently focused upon. Hence an opportunity to challenge and attempt to remedy whilst in prison was not pursued.

Recommendation 6

Offender Managers to set accredited Domestic Abuse Programmes as an objective for custodial sentence planning, where appropriate, and encourage transfer to a prison providing that intervention where possible.

Aim: to ensure appropriate interventions are in place during custodial sentences for serial domestic violence perpetrators.

11.28 Since the deaths of the Woman and the Child a Serial Domestic Abuse Perpetrators Project has been developed by Wales Probation and the Integrated Offender Management (IOM) Cymru team. This project was as a result of findings in the management of this case which revealed that there was a real need for serial perpetrators to be classified, screened, flagged and tracked across force boundaries. This project is in early stages but it is clearly an issue which needs addressing nationally. In the West Midlands police area there are currently four domestic abuse offender programmes operating which undertake work to manage serial offenders. Two of these programmes are running within Birmingham. West Midlands Police are currently undergoing a process of Service Transformation which incorporates the recommendations contained in the HMIC publication *'Everyone's business: Improving the police response to domestic abuse'* which was published in March 2014. A multi-agency Domestic Abuse Offender management Reference Group has been established to formulate the management of domestic abuse offenders.

Recommendation 7

Birmingham Community Safety Partnership and Police and Crime Board to review local arrangements for the effective management of domestic violence abusers and offenders.

Aim:

To ensure a robust approach is in place to effectively manage serial offenders of domestic abuse.

12 Good Practice

12.1 The probation Offender manager in Wales showed great tenacity and determination to ensure safeguarding of women and their children and

appropriate disclosure when the perpetrator formed relationships. This was exceptional and a good example of the system working with excellent information sharing and disclosure of relevant information to ensure that children and women were protected.

12.2 The holding of a professional's meeting in Birmingham when there was a delay in the transfer of the case. This ensured that relevant information and actions were taken to manage the risk posed by the perpetrator. The recognition that he posed a high risk to children rather than a medium risk demonstrated a good understanding of the nature of his behaviour and at that stage deflected from a focus upon his risk to the adult male who was the victim of his index offence and an understanding of the effect upon children who were present, plus the more recent developments in the relationships he had formed with women and the risk to them and their children.

13 Single Agency Recommendations

13.1 All agencies that had had significant involvement with the Child, the Woman and the perpetrator were required to compile an individual management review to provide an independent, open and critical analysis on individual and organisational practice, five organisations submitted IMR's making a total of sixteen recommendations focused on improving practice.

13.2 The respective Boards require that organisations provide direct feedback of the key learning to the professionals involved in the case and where individual practice, supervision or management has fallen below the expected standards, appropriate action is taken by the organisation concerned.

Recommendation 8

Those organisations that completed an IMR or information report are required to provide evidence that action has been taken to address individual and management practice which has fallen below expected professional standards.

Aim:

to ensure prompt action is taken to address identified deficits.

14 Lessons Learnt

- Information exchange between agencies in the main was good
- Information/actions were not consistently recorded in a timely manner
- Significant safeguarding activity was undertaken but was not fully recorded which served to indicate a medium rather than high risk of harm to children
- Police and Children's Social Care missed opportunity to identify relationship and hence risk when information passed to them
- Immediate action to safeguard the Child and the Woman after her identity was established was not taken and there was a lack of supervision/management oversight at this time
- The high risk to children posed by the perpetrator was not identified at an early stage and the significance of serial domestic abuse was not recognised
- Identified was a culture amongst a group of young people who had been in the care system of acceptance and minimisation of violence, sexual offending and domestic abuse.

15 Conclusion

15.1 Whilst the risk posed by the perpetrator was correctly assessed as high to both known adults and children, it is apparent that when his Licence conditions ended, this was not sufficiently focused upon. This may have been due to the fact that the index offence for which he was imprisoned was a serious assault upon an adult male, but there was overwhelming evidence of the perpetrator's violent behaviour towards females with whom he had formed relationships, and in turn a risk to children, his own and those of others. Indeed whilst in prison he had made threats to the child of an ex-partner.

15.2 It was certainly predictable that the perpetrator could cause harm to others. He was a serial perpetrator of domestic abuse and it is also known from research that a critical time for a victim to be harmed is when a relationship is ended or is about to end. It appears that the Woman refused a marriage proposal from the perpetrator, and that the perpetrator believed that if given an ultimatum she would choose her children over him.

15.3 It is possible that if immediate action had been taken when the identity of the Woman was discovered and a prompt disclosure was made to her about the risk posed to her and to her children, then appropriate safeguarding measures could have been taken, and her death and the death of her Child could potentially have been prevented.

15.4 Prior to publication the Community Safety Partnership will oversee liaison with family members who have contributed to the review process, to share the findings and inform them of the publication arrangements in order to minimise media intrusion for the bereaved family.

APPENDIX A

Bibliography

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APPENDIX B

SINGLE AGENCY RECOMMENDATIONS

There are a total of 21 internal recommendations made by agencies to learn lessons and improve practice were progressed during this the course of the Review. These are as follows:

Birmingham Children's Social Care

- Further audit to be undertaken to determine whether there are examples of children being created on Care First but no referral opened.

- To achieve full CSC involvement at MAPPA level 2 and 3 panels.

Birmingham Cross City CCG

- All practice staff to receive training regarding Domestic Abuse.

Birmingham Women's NHS Foundation Trust

- Remind staff to consistently record the details of others who are present during a consultation i.e. partners, friends and relatives and include conversations that take place involving those individuals.

- Ensure consistency in practice in accordance with Trust guidelines for domestic abuse.

- Share appropriate contextual historical information relating domestic abuse.

Wales Probation Trust and Staffordshire and West Midlands Probation Trust

- OASys practice need to reflect current risk concerns so that appropriate risk management/sentence plans are formulated and implemented, including the use of SARA.

- Case Recording must provide a record of all activity/contacts in a supervised case.

- MAPPA practice. MAPPA panels should reflect the meeting discussion, take an overview of risk concerns and victim safety, be effectively chaired and ensure actions are communicated to those not present at the panel.

- Transfers. Risk Management and Victim Safety is maximised through clear transfer arrangements between Trusts, in particular in early agreement between ACOs/Senior Managers, in High Risk transfer cases.

- Rehabilitative Interventions.

  (i) Interventions identified to address risk should be prioritised and implemented in a custodial/community setting as part of the Sentence Planning / Review / Recall process.

  (ii) Wales Probation Trust should progress offender interventions (eg Accredited Programmes, Specified Activity Requirements) in a timely, pro active manner.

West Midlands Police

- West Midlands Police to ensure that it has a policy covering the management of Category 2 violent MAPPA offenders.

- West Midlands Police should ensure that police information and intelligence on the management of violent MAPPA offenders is recorded on Visor.

- West Midlands Police should ensure that WMP policy covers the use of duty mobile phones by offender management teams (LPU and PPU), including appropriate guidance on out of hours use.

- West Midlands Police to ensure that the training provided to violent MAPPA offender managers is appropriate and tailored to their role.

- West Midlands Police to ensure that Violent MAPPA offenders are considered as a specific cohort in the current review of domestic abuse offender management.

- West Midlands Police to ensure that lessons learned through this IMR are incorporated into policy development and future staff training.

West Mercia Constabulary

- Specific advice should be given to the front counter clerk who took the initial call in regard to the lack of detail obtained and the importance of obtaining such detail.

- Generic advice should be provided to communications staff that full details *must* be obtained from callers in order to best inform the officers dealing with the incident. Once these details have been obtained then the necessary checks *must* be completed and actioned before any consideration can be given to filing the incident.

- Specific advice should be provided to the responding Police Constable detailing the importance of documenting, fully, the message result. (The facility exists for officers to input their own update rather than rely on communications staff to complete it). The officer should be advised that

given the concerns of partner 1 the content of the text should have been included within the message to inform others in the event of a reoccurrence. The officer could also be reminded of the importance of carrying out fundamental checks in order to inform the situation assist those contacting the police. The officer should be advised regarding social service referrals in order to safeguard children.

- Learning and Development should ensure that all officers and staff recognise the importance of considering the safeguarding of children and young persons identified within any reported incident.