Sandwell Partnership
MAKING CHANGE HAPPEN
Safer Sandwell Partnership

EXECUTIVE SUMMARY

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

of a

Domestic Homicide Review
Overview Report
DHR Case No 7

Report into the death of a woman

who died in 2015 aged 43 years

Report produced by Malcolm Ross M.Sc.
Independent Chair and Author

List of Abbreviations

BCPFT	Black Country Partnership Foundation Trust
BCWA	Black Country Women's Aid
CAMHS	Child and Adolescent Mental Health Services
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
DNA	Did not attend (usually for medical appointments)
E.C.G.	Electrocardiogram (medical test)
GP	General Practitioner
IMR	Individual Management Report
MBC	Metropolitan Borough Council
NHS	National Health Service
RAD	Resource Allocator Despatcher (Police post)
SWBCCG	Sandwell and West Birmingham Clinical Commissioning Group
SWBHT	Sandwell and West Birmingham Hospitals Trust

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The members of this review panel offer their sincere condolences to the family of Lena for the sad loss of their mother in such tragic circumstances.

The pseudonyms for Lena, her children and Lena's ex-husband Adam, have been chosen by the Author after advice from the Home Office Quality Assurance Panel. They have not been confirmed by the family members.

The Perpetrator has not given permission for details of his medical records to be disclosed to the review. Neither have either of the children mentioned herein. The report therefore mentions referrals but does not include how those referrals came about and which agency made the referral.

Introduction

Lena was a Polish woman, aged 43 years at the time of her death in 2015. She was divorced from her first husband, Adam, the father of her two children. She was living with a male partner, the Perpetrator. Her children are referred to as Child 1 and Child 2.

There were domestic abuse issues between Adam and Lena. Lena made several calls for assistance to the police but English not being her first language made communication difficult for her. Officers and Police call handlers however, did their best to deal with her domestic abuse complaints according to procedures. Appropriate referrals were made with a view to providing support for Lena.

Lena's partner, who is the Perpetrator, was born in Poland but is an American citizen living in the UK. It appears that Lena had sponsored him to come to the United Kingdom after meeting him on an internet dating website.

In 2015, police were called by the Ambulance Service to Lena's home to a report that a woman was believed to have suffered a cardiac arrest and had cut herself. On arrival officers found the dead body of Lena. She had suffered a number of significant injuries. Her partner was arrested on suspicion of the murder of Lena.

The Perpetrator appeared before Birmingham Crown Court in 2016 and pleaded guilty to her murder. He was sentenced to life imprisonment with a recommendation that he serves 20 years.

The purpose of a Domestic Homicide Review is determined by the Home Office under the Domestic Violence Crimes and Victims Act 2004, as being:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and

- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working,

- Contribute to a better understanding of the nature of domestic violence and abuse: and

- Highlight good practice

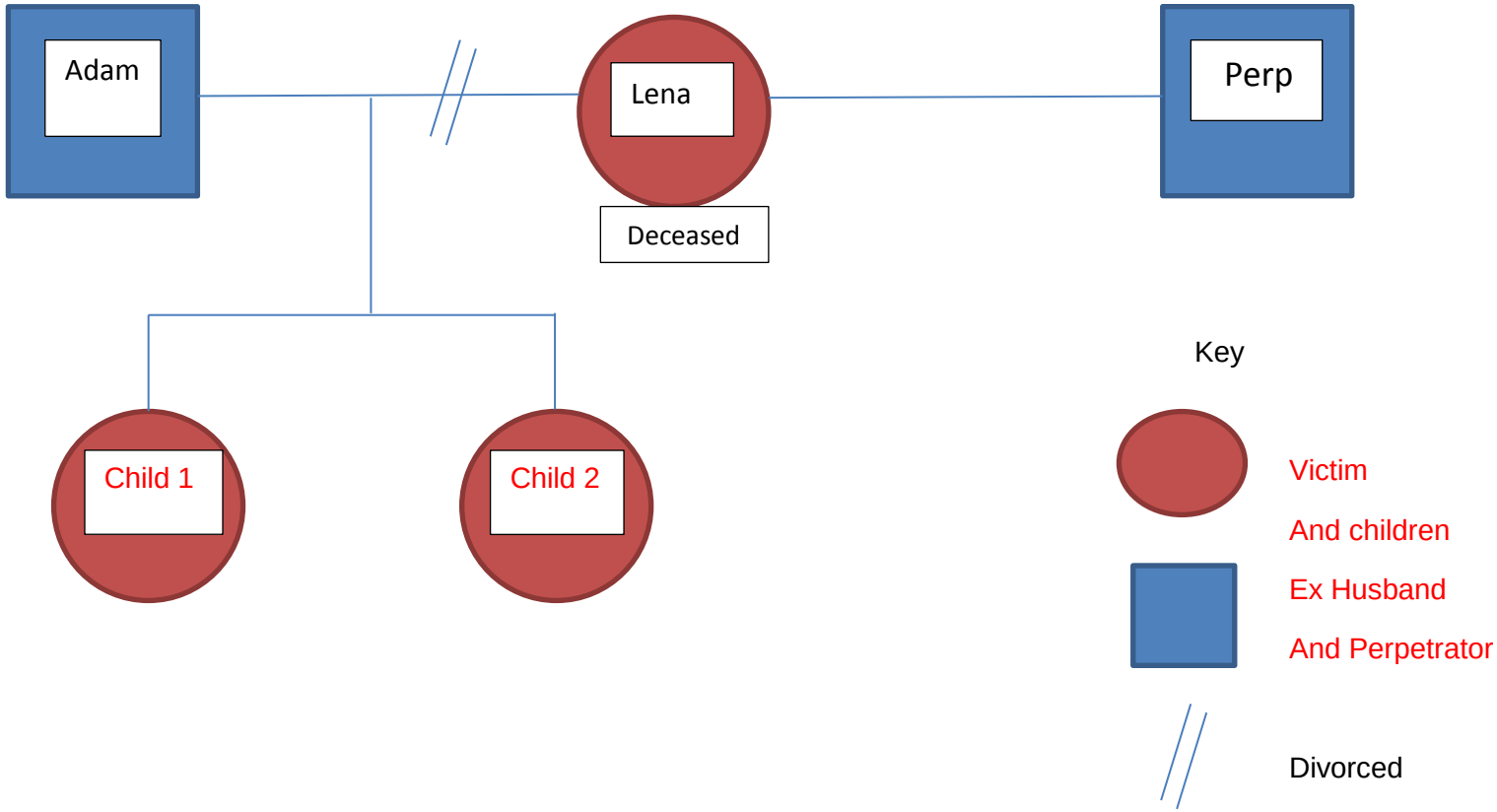
The details of the Domestic Homicide Review Panel members, Terms of Reference, Family involvement and administration of the panel can be found in the Overview Report for this review.

Persons concerned in this review

The various people concerned in this review are referred to by a pseudonym or code in order to protect the identity of the children in the family:

Referred to as:	**Relationship to Victim**
Lena	Female – mother of Child 1 & Child 2 – divorced wife of Adam and Partner of Perpetrator
Adam	Male – Divorced husband of Lena. Father of Child 1 & Child 2
Perpetrator	Male – Partner of Victim and sometime referred to as Step Father to siblings
Child 1	Oldest child of Lena and Adam
Child 2	Youngest child of Lena and Adam

GENOGRAM


Adam
Lena
Perp
Deceased
Child 1
Child 2
Key
Victim
And children
Ex Husband
And Perpetrator
Divorced

Summary of events

In March 2009, Lena went to a local police station on two occasions and reported that she was having a difficult time with her husband Adam, exacerbated by his drinking. She was advised to speak to the Citizen's Advice Bureau and she was given details of how to contact them. She was also referred to SOADA (Sandwell Organisations Against Domestic Abuse).

Around 2011, Lena and Adam divorced and Lena became acquainted with the Perpetrator via the internet and he moved to the UK to live with Lena.

It was well known that the Perpetrator had an alcohol misuse problem and it was clear that the Perpetrator was misleading agencies about his alcohol intake when he was still drinking above the safe limit. There is nothing to suggest that there was any consideration of the risks that this may have on his family life. He was however referred to and assessed by the Community Alcohol Team and then referred to a Tier 2 Alcohol Service, Swanswell. A risk assessment conducted revealed no risk of domestic violence towards Lena. He failed to attend the Swanswell appointments.

In December 2013, Swanswell closed the case on the Perpetrator due to his failure to attend appointments.

There were missed opportunities to identify possible risks in this family. The Perpetrator still had an alcohol misuse problem and Lena had reported stress-related symptoms. There is no record of Lena being involved in any surgery visits with the children.

In January 2015, school staff made a visit to Child 2's home. They found the house to be cold and dismal. The family were advised to discuss the matter with the family GP. The Perpetrator visited the school and explained that an appointment had been made for Child 2 with the GP.

In April 2015, Lena attended at A&E with a suspected threatened miscarriage. She was found to be 4 weeks pregnant. She was not pregnant at the time of her death.

In June 2015, Child 2 attended a health appointment and a further appointment was made for July. The parents cancelled the later appointment and Child 2 was unable to keep a further booked appointment. It was believed that Child 2 had gone on holiday to Poland. Another letter was sent stating that unless something was heard from them before September 2015, Child 2's case would be closed.

Later in 2015, police were called to Lena's home address where she was found by Child 1 on her bed deceased, with severe knife wounds.

The Perpetrator was arrested and charged with Lena's murder.

Analysis and Recommendations

The death of Lena in this case was as a result of an unprovoked attack on her by the Perpetrator, her partner. The Perpetrator had come from the USA to be with Lena following internet dating. It transpired that the Perpetrator had an alcohol misuse problem. Added to that is the fact that the Perpetrator was a very jealous person and no doubt a controlling person as well.

The review found that the death of Lena was not preventable or predictable. There were, however missed opportunities for professionals to identify issues or glean information on family dynamics.

There are several issues and learning points that have been identified during the review process that are worthy of comment.

They are:

- The Perpetrator's alcohol misuse and how that was dealt with by professionals.
- Child 2's wellbeing

- Mental Health, and GP referral process
- Consideration of the safeguarding of Lena and Child 2
- Cultural issues of domestic abuse within the Polish community.
- The Perpetrator's controlling nature

The Perpetrator's alcohol misuse and how that was dealt with by professionals.

It is beyond doubt that the Perpetrator was less than honest when discussing his alcohol intake. There is little evidence that he sought help to reduce the amount he was drinking. He missed several appointments. He was referred to an alcohol support organisation, Swanswell, but he failed to attend. However, Swanswell did not inform the Perpetrator's GP of his failure to attend.

Two Learning Points have been identified with regard to this:

> ***Learning point No 1***
>
> *It is good practice for follow up enquiries to be made by agencies after non-attendances for appointments and for the GP and other agencies to be informed and information shared.*
>
> *The outcome of this would be an opportunity to re-examines any risk that may exist as a result of non-attendance for appointments.*
>
> ***Learning Point No 2***
>
> *GP/health/hospital professionals should demonstrate curiosity and consider risk assessments in cases where there is evidence of alcohol misuse and should raise questions about potential risks and impact on well-being of other family members. Such professionals should consider facts that may not be readily visible.*
>
> *The outcome of this could be an opportunity to identify other people, adults and children, who may be at risk as a result of alcohol misuse by someone in the same household and to conduct a holistic risk assessment.*

Swanswell removed him from their case load. Swanswell have since amended their procedures regarding passing on information about failure to attend appointments.

Child 2's wellbeing

In April 2009, concerns about Child 2's attendance were raised by the school. Child 2 had returned to Poland and subsequently returned to the UK in September 2009. In early 2009, the police had been called to the family home due to domestic arguments involving Lena and Adam, as a result of which a significant warning marker had been placed on the address by the police.

In January 2015, Child 2's home was described as being cold and dismal. School staff spoke to Child 2 and the Perpetrator who said that the family were also concerned about Child 2 and that an appointment had been made with the GP.

Following further concerns, Child 2 was then referred to another service. In summer 2015, Child 2 missed several appointments with this service because the family was in Poland. It was presumed that there was no longer a wish to attend and Child 2's case was closed without further reference to the GP or any other agency working with Child 2.

Referral processes

An Early Help Assessment the school completed with regard to Child 2 was entered onto the Early Help computerised system (E-Caf). A referral that was made did not contain any details of Child 2's family background, therefore there were no immediate risk indicators identified.

At the first appointment, no immediate risk indicators were identified and another appointment was made for Child 2 to return for a more detailed meeting where details of the family circumstances etc. would have been probed in more depth.

Child 2 was not taken to the second appointment. The case was closed when nothing further was heard. The family had been in Poland during the school holidays.

In summary, agencies should have access to the Early Help System, E-Caf, and a check may have revealed all of the information about Child 2. This would have enabled agencies to have accessed information held on Child 2 by other organisations which indicated that the case should not have been closed without further consultation with Shield, the school and the School Nursing Service to ascertain what needed to be done.

Child 2 received numerous referrals for support but it was spasmodic. Work with Child 2 by the agencies involved was uncoordinated. There was no plan and no 'core group' to look at the child's holistic situation. There was no evidence of a Team Around the Family ('TAF') approach led by a lead professional.

Whilst there was no evidence that agencies could have predicted or prevented Lena's death, a better co-ordinated response to Child 2's needs may have led to a better understanding of what was going on in the family and whether there was domestic abuse evident.

Recommendation No. 1

Sandwell Safeguarding Children Board provides assurance that the Lead Professional role (as outlined in Working Together 2015) is understood by all local partner organisations and embedded in practice. In addition, there is a Learning Point identified:

Learning Point No 3

There was good evidence of an Early Help Assessment for Child 2 *being completed but there was a need for other agencies working with* Child 2 *to coordinate their work more effectively and share information. Whilst this does not have a direct link to the death of Lena, more effective and joined up partnership work between school; GP; and health services may have uncovered domestic abuse in the household, or more clarity about what was happening in that household.*

The outcome of this may be that the number of occasions when safeguarding opportunities are missed are reduced.

Consideration of the safeguarding of Lena and Child 2

A referral was made to Swanswell for the Perpetrator, but there was no mention of potential domestic violence although there was mention of the Perpetrator having stress at home and having relationship difficulties with Child 1.

The Education IMR states that Child 2 did not report any concerns to the school regarding issues around domestic violence.

There were, however other concerns raised by the DHR Panel in terms of:

- *There were possible missed opportunities to understand what was going on for* Child 2 *and the family*
- *There was minimal professional contact made with Lena as contact was only made with the Perpetrator who brought* Child 2 *to appointments which raises the issue of whether who had Parental Responsibility was ever established.*
- *The Perpetrator was always accompanying* Child 2 *and* Child 2 *may not therefore have wanted to disclose any issues in his presence.*

- Child 2 *was not given the opportunity to be seen alone by a health service after the initial consultations.*
- *The inappropriate onus on the child and giving them their choice if they do or do not wish to engage with agencies.*

There was no record as to the identity of the person that attended with Child 2 and Lena and assumptions were made by the GP that the man was the step-father and partner.

Learning Point No 4

As a point of good practice, agencies should identify adults who attend with children for medical or mental health appointments (including their relationship with the child and confirm if they have parental responsibility) and record the details accordingly.

The outcome of this would be a better information gathering process that would enable checking of recorded data regarding family members, thereby increasing the opportunities to identify safeguarding concerns.

Learning Point No 5

Reference is made in IMRs that Child 2 *failed to attend appointments or recorded as 'DNA' (did not attend). In the case of children and young people a far better description of this omission to keep appointments is 'WNB' (was not brought) working on the basis that children and most young people are not taken to appointments by parents/carers and repeated WNB's should trigger concerns, follow up and even a referral to the relevant agency for investigation. This may need a robust approach to follow up 'WNB' appointments based on the individual risks and presenting concerns.*

The outcome of this would be to change the culture around Did Not Attend and for professionals to appreciate that many children do not choose 'not to attend' medical appointments, they are not taken, which by the very nature of the terminology should highlight the question, 'why has the child not brought and whether this needs a robust approach to follow up 'WNB' appointments based on the individual risks and presenting concern.

The Perpetrator attempted to obtain information from the GP regarding a pregnancy test which may have been indicative of his controlling behaviour. The GP should have recorded this in Lena's records with a view to discussing this with her at her next appointment. She did not visit her GP again before her death.

The dealings by a health service with Child 2 could have resulted in a referral back to the GP with regard to the 'WNB' appointments. If a referral back to the GP had been made the holistic picture of whole family, and anything of concern at home, may have been exposed.

Cultural issues of domestic abuse within the Polish community.

English was not Lena's first language and she often used the Perpetrator or her children or friends to interpret for her. There is nothing to suggest that consideration had been given to using an official interpreter.

A previous DHR in Sandwell was undertaken following the death of a Polish woman and recommendations from this review have been implemented. However, some work is ongoing to encourage reporting domestic violence by Eastern European communities and improve the response of agencies. Eastern European and Polish led organisations are working with the council and Black Country Women's Aid[1] (BCWA) to support victims of domestic abuse and raise awareness in the Polish and Eastern European communities in Sandwell. There is a Polish speaking IDVA (Independent Domestic Violence Advocate in BCWA. Another Eastern European led

[1] Black Country Women's Aid formerly Sandwell Women's Aid

organisation is also working with communities to provide additional surgery based advice around welfare rights, housing etc. to Sandwell families who may be affected by Domestic Violence.

The review attempted to identify the potential barriers that prevented Lena from disclosing domestic abuse as well as acknowledging the on-going work to encourage the reporting of domestic violence.

Recommendation 2

By June 2017, Safer Sandwell Partnership Board will ensure that work to address domestic abuse, alcohol issues and work with Polish and other Eastern European communities and families is better integrated across the Board's sub groups and in the delivery plans of key partners, so that we better engage them in preventing and reducing domestic abuse, and in alcohol misuse prevention, treatment and support programmes. We will set specific outcomes and actions to achieve effective support for Polish and Eastern European domestic abuse victims and their families.

Recommendation No 3

The Safer Sandwell Partnership to contact key organisations involved with this DHR and the Domestic Abuse Strategic Partnership partners and remind them of the learning from both DHRs regarding the use of interpreters; the importance of the appropriate use of interpreters and asking for assurance (with evidence) that interpreters are being appropriately used.

The Perpetrator's controlling behaviour

The Perpetrator attempted to obtain information from the GP regarding a pregnancy test. This may have been indicative of his controlling behaviour. The GP should have recorded this issue and may have identified it as a warning flag of controlling behaviour for discussion with Lena at her next appointment.

Examples of the Perpetrator's control over Lena have been evident during the review and he was jealous of the relationship between Lena and her children.

It has been stated that Lena did not mention the Perpetrator's drinking habits to any professional.

Conclusion

The Perpetrator was referred for support for his alcohol misuse. However, there were no signs to suggest that this issue had been addressed. There was no indication by any agency of domestic violence between the Perpetrator and Lena. A friend of Lena indicated to the police after the death of Lena that she thought that Lena had intended to terminate the relationship with the Perpetrator which may have been the catalyst for the fatal incident.

Agency involvement with Child 2 during younger years did not indicate that there were any domestic violence issues within the family. It is clear from assessments that Child 2 underwent in 2015, that despite concerns from the school, the result of the assessments was there were no concerns and nothing to indicate domestic violence.

There is clearly a need for agencies to be cognisant about the risks and impact to other family members where alcohol misuse is presented and there is also a need for agencies to use the Lead Professional/Team Around the Family approach to better coordinate work and share information where there are a number of agencies working with children and families.

It is the panel's belief that the death of Lena was not preventable or predictable. There was no disclosed history of previous abuse by the perpetrator. However, the review indicated that there were missed opportunities for professionals to potentially pick up issues or glean information on

family dynamics, either through not following up on appointments that were not attended, not asking questions or not working together effectively.

IMR Recommendations and Learning Points

Overview Recommendations

Recommendation No. 1

Sandwell Safeguarding Children Board provides assurance that the Lead Professional role (as outlined in Working Together 2015) is understood by all local partner organisations and embedded in practice.

Recommendation 2

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In addition to the recommendation and the learning points made in this executive summary, there are several additional recommendations/learning points that individual agencies have made with regard to improvements within their own agency.

These can be summarised as follow:

Sandwell and West Birmingham Hospitals NHS Trust

Increase awareness of domestic abuse in the organisation (knowledge of referral pathways)

Black Country Partnership NHS Foundation Trust

Recommendation No 1

To review a referral form against good practice exemplars from other similar providers and propose amendments

Recommendation No 2

Propose that the Tier 2 provider routinely checks ECAF upon receipt of particular referrals to ensure Early Help contacts and risks are collated

Recommendation No 3

Review of a specific policy DNA /standard operating procedure against good practice exemplars from other similar providers and update as necessary

Clinical Commissioning Group IMR Learning Points

CCG IMR Learning Points:

It is recorded that the nurse smelled alcohol during the consultation. However, this does not appear to have been discussed with the Perpetrator.

Although it is recorded that the Perpetrator lived with a wife and child, there does not appear to have been any discussion as to the impact of his drinking on his parenting capacity and any other safeguarding concerns.

There does not appear to have been any further advice and support sought from the GP practice safeguarding lead/CCG safeguarding team in respect of the above.

Recommendation 1: *Training*

Safeguarding Training to be provided for clinicians in primary care settings on how to approach difficult topics with patients to include the toxic trio, the impact of alcohol misuse on parenting capacity and the signs, symptoms and behaviours children may display when living in a household where there is domestic abuse, and Record Keeping.

Recommendation 2: *Training*

A safeguarding advice and support pathway for primary care to be developed and disseminated to GP practices in Sandwell and West Birmingham.

CCG IMR Learning Point:

As identified in previous Domestic Homicide Reviews and a Serious Case Review in Sandwell there are additional challenges with access to services for local diverse communities whose first language is not English.

The use of appropriate interpreting services can determine the effectiveness of consultations in GP surgeries with patients whose first language is not English.

Recommendation 3: *Practice, Resources*

GP practices in Sandwell and West Birmingham will be advised that best practice indicates the use of interpreting services (face to face or language line) during health consultations with clients whose first language is not English, and that domestic abuse resources in alternative languages will be displayed in all GP practices.

CCG IMR Learning Point:

The new patient registration is a key opportunity to explore wider family and environmental factors, together with significant medical conditions. This issue has been a recurrent theme throughout this and other IMR's that have been undertaken in respect of Primary Care.

Recommendation 4: *Practice, Resources*

A 'new to practice' patient protocol is developed by the GP safeguarding forum for use by practices in Sandwell and West Birmingham.

CCG IMR Learning Points:

As identified by the Royal College of Psychiatrists, children living in households where there is domestic abuse may display a range of signs, symptoms and behaviours.

The importance of record keeping should be included in all training programmes and the need to document who attends for an appointment with a child and their relationship to them.

Within the GP records it was recorded that the perpetrator contacted the GP to discuss a recent visit by Lena attending an A & E department, this conversation was recorded in the perpetrators record and not in Lena's.

Having a DNA (did not attend, which will include was not brought for children) policy for GP practices to follow is recommended and should contain guidance on what to record, this should include guidance to remind practitioners of the importance of recording conversations in the patients record to whom the conversation relates to.

Recommendation 5: *Training*

Every practice should have a DNA to include 'Was Not Brought' (for children) policy that contains guidance on record keeping.

Feedback from the Home Office on the Domestic Homicide Review report

Following submission of the Domestic Homicide Review report to the Home Office and their review of the report, the letter in Appendix 1 was received. The issues raised in the letter have been considered and some amendments were subsequently made to the report prior to publication. Some of the letter is redacted to protect the anonymity of the family.

Appendix 1. Home Office feedback letter

Home Office

Public Protection Unit T: 020 7035 4848
2 Marsham Street London SW1P4DF
www.gov.uk/homeoffice

Maryrose Lappin

Safer Sandwell Partnership

Sandwell Council House Oldbury

West Midlands

B69 3DE

27 September 2017

Dear Ms Lappin,

Thank you for submitting the Domestic Homicide Review report for Sandwell (case 7) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 July 2017. I very much regret the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a thorough, probing and sensitive report in which the lessons have been clearly articulated and well evidenced. The Panel particularly commended the chair for the numerous attempts to engage the family in the review, and recommended the services of an advocate which may be useful in future cases.

There were, however, some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The Panel noted that the report rightly identifies language as a barrier and highlights issues with the perpetrator acting as a translator. The Panel recalled that these are issues which have been identified in a previous DHR from this area and was keen that there should be more links between the two reviews to ensure the learning is coordinated and effective;

- The Panel queried the relevance of xxxxxxxx which is described in detail in the review. If there are links to the circumstances of the homicide, the Panel felt these should be more clearly articulated;

- You may wish to consider including an expression of condolence in the report which would add more humanity to the review;

- An explanation of what Tier 2 and Tier 3 alcohol services described in paragraphs 2.22, 4.5 and 4.6 would assist the lay reader;

- It would be helpful if the report could provide further details to help explain the reference to "poor housing conditions" mentioned in paragraph 4.18;

- Pseudonyms would allow the reader to more easily follow the narrative. The Panel particularly disliked the codes used for the two *children* and the use of the term 'Victim' for the victim;

- Contacting work colleagues may have provided additional insight;

- You may wish to consider removing the actual date of the murder and the gender of the adult child to enhance anonymity;

- Please proof read the report for missing words. For example, paragraphs 3.24 and 5.1.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnguriies@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to your PCC for information.

Yours sincerely

Christian Papaleontiou

Chair of the Home Office DHR Quality Assurance Panel