The Solihull Partnership

Safer Solihull

Local Police and Crime Board

Involving local people in keeping Solihull safe

Executive Summary

Domestic Homicide Review of the circumstances concerning

The death of a woman who

Died: August 2013

Independent Chair and Author

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May 2015

1: Introduction

1.1 Domestic Homicide Reviews (DHR) are one way to improve responses to domestic abuse. They aim to prevent what happened in any given case being repeated. The primary purpose of a Domestic Homicide Reviews (DHR) is to 'establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims'.[1]

1.2 The requirement to undertake Reviews is part of the Domestic Violence, Crime and Victims Act 2004 and became law from 13th April 2011. These reviews are undertaken in accordance with guidance published by the Home Office and are chaired by an independent person. Reviews will not seek to lay blame but to consider what happened and what, if anything, could have been done differently. If appropriate, they will also recommend actions to improve responses to domestic violence situations in the future.

1.3 A Panel of professionals from various public bodies undertook this review, considering information provided by a number of organisations in the form of individual management reports (IMR). Reports were provided by: West Midlands Police; NHS England (GPs' involvement), Heart of England NHS Foundation Trust; and Bromford Housing Association. Each author confirmed that they had not had any previous direct involvement and each report was authorised by a senior officer of the organisation in question. In addition; Information reports were requested from West Midlands Ambulance Trust; and from Child 1's former school which was provided by Education Services.

1.4 The review panel agreed that the time frame for the review should be the period: 1st January 2000 to 8th August 2013. The start date was the first date that agencies identified relevant records relating to a previous relationship of Adult 2 with Adult 3. The 8th August 2013 was the date of Adult 1's death.

1.5 In order to retain the anonymity of those involved, the family members will be referred to within this report as follows:

Adult 1	Subject of this review
Adult 2	Perpetrator and partner of Adult 1
Child 1	Child of Adult 1 and of Adult 2
Adult 3	Former partner of Adult 2
Adult 4	Brother of Adult 1
Adult 5	Mother of Adult 1 and current carer of child 1
Adult 6	Step Father of Adult 1
Adult 7	Friend of Adult 1

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – April 2011: Section 3.3

2: Summary of facts

2.1 Adult 1 was killed in the early hours of 8th August 2013 at her home address which was within a block of flats. Also living at this address were her partner, Adult 2, and their daughter, Child 1, although the daughter was at that time staying with friends. (This was during the school summer holidays).

2.2 According to both the Police and the WM Ambulance Service reports; both the neighbours and Adult 2 contacted the emergency services. Adult 2 in his 999 call is recorded as being in a distressed state and saying that he had stabbed his partner and cut her throat and was going to kill himself. He was still on the phone when the police officers arrived.

2.3 Adult 2 was arrested and charged on suspicion of murder and remanded in custody.

2.4 On 3rd September 2014, Adult 2 was convicted of murder and sentenced to life imprisonment with a requirement to serve at least 15 years.

2.5 As part of the subsequent criminal proceedings, mental health assessments were undertaken. At his trial Adult 2 claimed that his judgement was impaired due to Alcohol Dependency Syndrome but the jury rejected this.

2.6 The inquest in respect of Adult 1's death was closed on 5th November 2014 with no separate, independent verdict as the case had been heard in full in the Crown Court. There were no other, parallel, enquiries following this death.

2.7 Since Adult 1's death, Child 1 has been cared for by her maternal Grandmother (Adult 5) and family members.

3: Conclusions and recommendations

3.1 From the evidence available to the Review from the individual management reports, there is nothing to suggest that this event could have been predicted or prevented. There is no suggestion of a motive and no prior warning. The family chose not to be involved in the review and, therefore, it is not known whether the same view is held by them, or possible to consider any conclusions or recommendations from them.

3.2 The Terms of Reference agreed by the Board refer to the effectiveness of agencies in identifying, analysing and responding to risk and vulnerability; the provision of services in response to this; the quality of inter-agency working practice and policies and any action necessary to improve this. It appears, however, that at no time during this relationship did Adult 1 seek support from any identified agency for any form of domestic abuse; few agencies were involved with any members of the family; and no disclosures were made by any other concerned individual. It has not been possible, therefore, to address those aspects of the terms of reference relating to agency responses to victim and perpetrator other than in hypothetical terms.

3.3 Each individual management review report (with the exception of Education Services who had no contact with Adult 2) refers to issues relating to alcohol abuse. Whilst it is acknowledged that alcohol misuse does not cause domestic abuse or child abuse: when it is present alongside these, there is an increased risk of harm. None of the practitioners involved appear to have made this link or considered the impact on any children within the household.

3.4 A number of individual management reports and also panel members from various organisations have identified developments that have taken place within the timeframe of the review in respect of attitudes and responses to domestic abuse. Whilst it is not claimed that any of these would have altered the outcome in this particular case, they are outlined within the Overview Report as matters which may influence future incidents.

3.5 Four key areas were identified by the Review which has led to recommendations to the Safer Solihull Partnership:

- Increased knowledge of the inter-linkage between different forms of abuse;
- the need to fully implement and embed any new developments into mainstream structures; processes and practice (including funding);
- the knowledge and understanding of employers of the issue of domestic abuse, and of their responsibilities in respect of staff who may be subject to this;
- the maintenance and improvement of services currently available to prevent, identify and respond to domestic abuse within the Borough.

In each case, the accompanying action plan outlines a number of steps to achieving the recommendation:

3.6 In respect of the first area of concern, the review makes the following recommendation:

> The Safer Solihull Partnership should ensure that all those working in the area of domestic abuse; have knowledge of the inter-linking between this and other forms of abuse: child protection, adult protection, alcohol abuse and safeguarding generally; to ensure that these risks are appropriately addressed.

3.7 The review was pleased to be able to include references to other recent developments made in respect of a number of agencies' responses to domestic abuse and commends the individual organisations for this. The review panel is aware, however, that such developments are not ends in themselves and, therefore makes the following recommendation:

> The Safer Solihull Partnership should ensure that the recent developments described by a number of organisations in relation to domestic abuse have been fully implemented and are embedded within their structures; processes; and practice. (These developments can be found in section 5 of the Overview Report)

3.8 A specific issue was raised in this review regarding the role of employers in supporting those caught up in domestic abuse. Companies, therefore, need to have policies and procedures in place and publicity within the workplace to promote these. Whilst acknowledging the limitations on placing requirements on private organisations, the review makes the following recommendation:

> That the Safer Solihull Partnership should identify any opportunity that it, or its constituent members, have to increase the knowledge and understanding of employers of the issue of domestic abuse, and of their responsibilities in respect of staff who may be subject to this, to ensure that staff are better supported.

3.9 The panel is aware that commissioning bodies are currently in a difficult position: attempting to manage service delivery within ever tightening resources. These difficulties are exacerbated by the fact that tackling domestic abuse is not underpinned by statutory duties and that this, therefore, has to compete with other pressing issues. The panel is convinced, however, that the impact of domestic abuse is so wide, not only in terms of the victim and perpetrator but also their families and wider community; and so long lasting, particularly when children are caught up in the conflict[2], that it remains important, despite acknowledging the current difficulties, to make the following recommendation:

> The Safer Solihull Partnership should to do all in its power to maintain and improve the services currently available to prevent, identify and respond to domestic abuse within the Borough.

Anne M Cole 28th May 2015

[2] Included in definition of harm: Adoption & Children Act 2002