SAFER WOLVERHAMPTON PARTNERSHIP

Executive Summary of Overview Report

Domestic Homicide Review of the Circumstances Concerning the death of

'V1'

An Iranian Kurdish Woman (born 11.9.75 Iran)

Died 29th December 2011 aged 36 years

Independent Author
Malcolm Ross M.Sc.

Independent Chair
Pete Morgan BA MA CQSW

Introduction

For the purposes of this review report and in order to protect the identity of those involved the victim will be known as V1, the husband as H1, and the child in the family as C1.

V1 was born in Iran and was 36 years old at the time of her death. She was married to H1 who was born in 1972 and was 39 years of age when V1 died. Their son, C1 was born in 1999 and was 12 years of age at the time of his mother's death.

The family arrived in the UK in 2008 from Iran. V1 had no family in the UK and H1 had relatives in Leicester and London. They were temporarily housed in Birmingham before settling in Wolverhampton. Their Wolverhampton home had been identified for them by United Property Management. V1 was unable to speak English, her native language being Farsi.

H1 was identified as having periods of mental ill-health on his arrival in the UK. He has been in receipt of Mental Health Services, including in-patient services throughout the period from the family's arrival in the UK.

On 29th December 2011, Police were called to the family home in Wolverhampton where C1 had raised the alarm regarding H1 attacking V1 with a knife. C1 had witnessed the incident. C1 stated he had pulled H1 away from V1 and H1 stabbed himself after stabbing V1. V1 was pronounced dead at the scene. H1 was taken to hospital and treated for his stab wounds. He was later arrested and charged. He is awaiting trial at the Crown Court. C1 was taken to a place of safety by Children and Young People's Services and is presently in foster care.

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

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

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

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

In compliance with Home Office Guidance[2], West Midlands Police notified the circumstances of the death in writing to the statutory Community Safety Partnership for Wolverhampton.

The Domestic Homicide Review Panel

The Review was carried out by a Domestic Homicide Review Panel made up of representatives of the agencies who were involved delivering services to the family of V1. It included Senior Officers of agencies that were involved. The professional designations of the Panel members were:

- Detective Chief Inspector from West Midlands Police
- Head of Community Safety, Safer Wolverhampton Partnership
- Head of Wolverhampton LDU Probation, Staffordshire and West Midlands Probation Trust
- Strategy Coordinator Wolverhampton Domestic Violence Forum
- Head of Adult Safeguarding Wolverhampton City Council
- Matron and Safeguarding Adult Lead, Royal Wolverhampton Hospital Trust
- Clinical Quality and Patient safety Manager, West Midlands Strategic Health Authority
- Assistant Director of Nursing Quality and Safety – BCC Lead for Quality and Effectiveness Primary care Trust NHS Wolverhampton
- Black Country Partnership Foundation Trust (BCPFT)
- Wolverhampton City Council – Children and Young People's Service

The Panel Chair was Mr Pete Morgan who is currently the Independent Chair of the Worcestershire Safeguarding Adults Board, having retired as the Head of Service – Safeguarding Adults with Birmingham City Council. The Overview Report Author was Mr Malcolm Ross, a retired Senior Detective from West Midlands Police. He has

[2] Home Office Guidance Page 8

considerable experience in conducting case reviews for Local Authorities in the United Kingdom. Both of these people are independent of any agency involved in this case.

Terms of Reference (anonymised from the original to protect the identity of individuals)

In accordance with the above, a Domestic Homicide Review (the Review) will be commissioned with regard to the homicide of V1

Governance and Accountability:

The Review will be conducted in accordance with the Safer Wolverhampton Partnership (SWP) Domestic Homicide Review Procedure

As the Accountable Body responsible for its commissioning, the SWP will receive updates on progress of the Review at scheduled SWP Board meetings.

The Chair of SWP will receive regular briefings from the Review Panel Chair on progress

Administrative support will be provided by the Head of Community Safety, SWP

Purpose of the Review

The purpose of having a Domestic Homicide Review is not to reinvestigate or to apportion blame, it is to:

- Establish what lessons are to be learned from the domestic 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 policies and procedures as appropriate;

- Prevent domestic violence homicides and improve service responses for all domestic violence victims and their children through improved intra and inter agency working.
- Ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions, responsive to the needs of the victim, with an aim to avoid future incidents of domestic homicide and violence.
- Assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff

Additionally, this Review will also consider the services and support provided to both the family and its individual members as they pertain to the homicide to:

1) identify a definitive timeline of events leading to the homicide for the victim and the alleged perpetrator
2) establish whether failings occurred in the assessment, care or treatment of all family members
3) identify whether there were any mental health or capacity issues at the time of the homicide for the victim of the alleged perpetrator
4) identify whether safeguarding arrangements had been considered or were effectively in place for all family members
5) establish how recurrence – if appropriate – may be reduced or eliminated
6) formulate recommendations and an Action Plan
7) provide a report as a record of the investigation process
8) provide a means of sharing learning from the incident
9) provide a report to enable the SWP to meet its responsibilities under its Domestic Homicide Review Procedures

Review Time Period

The Review will consider the events of the family's life from the point of entry into the UK – 24th September 2008 to 31st December 2011.

Individual Management Reviews.

The Panel requested the following agencies to carry out Individual Management Reviews (IMRs) of their agencies' involvement and produce Reports. The aim of IMRs was to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, how those changes will be brought about.

The following agencies were requested to prepare chronologies of their involvement with V1 and her family and produce IMR reports.

- West Midlands Police
- West Midlands Probation Service
- UK Border Agency
- Royal Wolverhampton Hospital Trust
- Black Country Partnership NHS Foundation Trust
- GPs
- West Midlands Ambulance Trust
- Wolverhampton City Council – Adult Social Care
- Wolverhampton City Council - Housing Support
- Wolverhampton Homes
- United Property Management
- Wolverhampton City Council – Children and Young People Service
- Primary School
- High School
- Catholic High School
- Spurgeons
- Base 25
- The Haven
- Refugee Migrant Centre

Guidance[3] determines that the aim of an IMR is to:

[3] **Home Office Guidance Page 17**

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

Agencies were encouraged to make recommendations within their IMRs, and these were accepted and adopted by the agencies that commissioned the Reports. The recommendations are supported by the Panel Chair and the Overview Author.

The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

To aid the Review process, the following representation was also sought from independent persons qualified to offer expert opinion/advice to the Panel regarding awareness of cultural issues of Kurdish Muslim women.

Individual Needs

Home Office Guidance[4] requires consideration of individual needs and specifically:

> "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?"

There is evidence throughout this review that consideration of the family's linguistic needs were not taken into account when accessing services as they should have been. Opportunities to seek a Farsi interpreter were often missed. On many occasions C1 was used as an interpreter for his mother and father, or sometimes a family friend. The vulnerability of both V1 and C1 was often not considered or recognised.

[4] Home Office Guidance page 25

Family Involvement

Home Office Guidance[5] requires that:

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

and:

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

In this case the Overview Report Author made contact with the Senior Investigating Officer (SIO) from West Midlands Police at an early stage. The families of both V1 and H1 as well as H1 himself have been written to offering them the opportunity to contribute to the Review and to receive its findings and recommendations. Contact with the family of V1 was aggravated in that her parents live in Iran and did not speak English. It was understood that her parents left their family home en route to the UK but had been prevented from leaving Istanbul due to visa and documentation problems. They eventually arrived in the UK and liaised with the Police Investigation. They have since returned to Iran with the body of V1 to arrange the funeral. It is anticipated that the family will return to Britain to be present during the forthcoming criminal trial and arrangements will be in hand for the Chair of the Panel and Author of the Report to offer to meet with the family and explain the DHR process and its findings.

Independent Overview Report

Government guidance requires that an Overview Report of the Domestic Homicide Review should be written by a person involved from an early stage with appropriate qualifications, knowledge and experience. The Overview Report brings together and

[5] **Home Office Guidance page 15**

analyses the findings of the various reports from agencies and others, and makes recommendations for future action.

This document is a Summary of the Overview Report of the Domestic Homicide Review prepared by Mr Ross on behalf of the panel and accepted by the Safer Wolverhampton Partnership
Board.

The Overview Report comments that the business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

The individual agency reports contain recommendations that concern those agencies that are supported in the Overview Report.

A list of the Recommendations made in the Overview Report is set out at the end of this summary.

Summary of background

In September 2008 H1, V1 and C1 arrived in the UK and H1 claimed asylum, stating that he had witnessed his friend being killed in Iran and he believed he would be arrested if he returned to Iran. He was referred to the Midlands Asylum Team who quickly found accommodation for the family. The following month the family were re-housed in Wolverhampton.

Just before the move to Wolverhampton H1 presented at the local hospital feeling depressed and anxious about the forthcoming house move. He was diagnosed with depression and anxiety and he was prescribed medication. A request to postpone an appointment with the United Kingdom Border Agency (UKBA) was made due to his mental illness, but as medical evidence could not be obtained in time the

appointment went ahead. Despite his attending the appointment UKBA staff considered that H1 was too ill to continue with the interview which was re-arranged.

In December 2008 C1 went to his GP with an interpreter. He complained about that he was overweight. He was 9 years old at the time and there is nothing to indicate that anything was done about his complaint. On the same day H1 went to his GP requesting medication for his anxiety. The GP noted that H1 needed to attend a special centre for treatment for Post Traumatic Stress Disorder (PTSD) but nothing appears to have been done about taking that any further.

By January 2009 H1 was threatening to commit suicide and harm V1 and C1. He also threatened to set fire to the GP's surgery. He was referred to the Black Country Partnership Mental Health Trust (BCPMHT) for treatment, where his PTSD diagnosis was confirmed.

H1 was assessed under the Mental Health Act 1983 as not needing admission to hospital and he was referred to the Home Treatment Team. Later that month he reported to his GP that he again had suicidal thoughts and wanted to strangle himself, V1 and C1. He stated that he might act impulsively and he wanted help. A risk assessment carried out on 24th January 2009 indicated that he was at risk of self-harm and hallucinations. There was nothing mentioned of the threats and thereby the risks to V1 or C1 and there was nothing to indicate that any significance was placed on Child Protection issues in relation to C1.

On the same day H1 learned from the UKBA that his asylum application had been refused. On the date for the appeal against this decision, the Mental Health Worker contacted the UKBA stating that H1 was too ill to appear and suffering from depression paranoia and flashbacks from his experiences in Iran. Two days later the UKBA decided to suspend H1's reporting indefinitely and caused V1 to report monthly, thus making her the principle in the relationship as far as the UKBA were concerned.

During February 2009 H1's mental health deteriorated and was affecting V1. She contacted the UKBA stating that she was unable to report because of H1's illness but this was not accepted by the UKBA. H1 was admitted to a psychiatric hospital for an assessment as his condition had worsened. However the following day he was discharged home and the Home Treatment Service continued to support him.

By May 2009 H1 was screaming at night time, was not eating and was withdrawn. V1 believed that he would harm himself. His GP increased his medication and told V1 to contact the Home Treatment Team if his condition worsened. H1's psychiatrist wrote to the UKBA stating that his condition was severe and that he was at risk of suicide and placing his family in jeopardy by his seriously impaired judgement. His wife and child were at risk. Again there was no consideration of either adult or child safeguarding in respect of V1 and C1.

In June a Judge dismissed his appeal for asylum stating that there was no risk to H1 if he was to return to Iran. H1 took an overdose that day and was admitted to psychiatric hospital where he was detained for 7 weeks.

V1 took over the application to stay in the UK. In August 2009 H1 was discharged from hospital but was soon visiting his GP complaining of poor sleeping and periods of extreme anger. V1 denied any episodes of domestic violence during this period.

In October 2009 the Carer Support Team from the City Council received a Mental Health Joint Carers Assessment form from the Mental Health Community Psychiatric Nurse for H1. This form made an assessment of the needs of the carers for mentally ill people such as V1 as she cared for H1. One of her main needs was to learn English. However funding problems and the fact that they were failed asylum seekers meant that V1 had no recourse to public funds and the assessment application was refused. This was deemed to be in breach of V1's human rights under European Law and the decision was reversed but not until 1 years and 4 months later.

October 2009 saw an episode where H1 tried to jump out of an open window and was very distressed. The police attended and a friend took him to a psychiatric hospital. He was disturbed due to a forthcoming interview with the Immigration Service. He was detained in hospital for nearly a month.

In January 2010 there was no improvement in the mental health of H1. He was admitted to a mental hospital in February where he assaulted two members of staff. He was suffering from pneumonia and was transferred to a general hospital from where he went absent and was found at home. He was not returned to hospital as V1 stated that she was coping with him.

During March 2010 H1 was admitted and discharged from hospital on several occasions and on each discharge V1 expressed her wish to have H1 home, sometimes through an interpreter and sometimes not.

In May 2010 H1 made several visits to his GP. He was depressed and showed signs of agitation at the reception of the GP's surgery. There is evidence that he was erratic in taking his medication.

It was during June 2010 that V1 expressed her concerns at an out patient's clinic that she has to leave the family home for fear of her own safety when H1 becomes aggressive and ill.

On 14th August C1 called the police stating that H1 had threatening to kill himself with a knife. The police attended and arrested H1 under Section 136 Mental Health Act 1983 which gives the police power to detain anyone who is at risk of harming themselves or another and remove that person to a place of safety, in this case a police station. There H1 was assessed by two doctors who concluded that H1 would be better treated by the Home treatment Team and he was not so ill as to warrant admitting him into hospital. The police report (IMR) acknowledges the fact that neither the well-being of V1 nor C1 was considered. This incident was dealt with purely as an incident involving a mentally ill man.

Throughout the remainder of August, H1's condition deteriorated and there were opportunities to admit him into a psychiatric hospital but his GP preferred to leave his treatment to the Home Treatment Team.

At the end of August C1 again called the police as H1 was attempting to commit suicide. Both V1 and C1 had fled from the family home in fear for their lives. The police made a referral to the Child Protection Team but failed to complete a DASH Risk Assessment form, (a form that is required when police attend domestically related incidents). Apparently officers did not feel that there was an immediate risk to V1 or C1. The referral was allocated to a part time social worker over a Bank Holiday weekend. Consequently a home visit was not carried out until September.

During September 2010 C1 was referred for counselling due to the effect H1's mental illness was having on him and his schooling. Children and Young Peoples Services, who had been involved with C1 and his family closed the case without a Child In Need Plan or a Common Assessment Framework Plan being put in place, either of which would have ensured continued supervision of C1. C1 later declined to accept the support of counselling.

CI attended three schools during the time period of this review. The second school were aware that he was known to Children and Young People's Service, indeed staff from the school attended the meetings. The school had been given a photograph of H1, who, on advice from V1 was not to collect C1 from school and if he was seen and recognised from the photograph the authorities were to be informed. At this school C1 was bullied because he was Iranian and referred to as a terrorist. Mention was made by fellow pupils of his father being mentally ill. The family moved house primarily to be nearer to friends and other people from the Kurdish Iranian community. This necessitated C1 moving school, which he did just before Christmas 2010. C1 attended his new school for only a couple of days before the Christmas end of term holiday, but it wasn't until after the children returned to school after the Christmas break that his new school became aware of the history of his family problems and his previous dealings with Children and Young People's Services. His school file from his second school had not followed him to his third school.

During November 2010 V1 had dealings with the UKBA, who, at one time threatened to remove support because H1 had not signed and reported. A letter had to be produced confirming that H1 was far too ill to report and eventually support was re-instated. At yet another interview with the UKBA in January 2011 V1 disclosed that H1 hurt her and her son and she thought that H1 was not normal. This was the first time the UKBA had become aware of any domestic violence issue in the family and they failed to implement their own clear guidelines about referrals to other agencies when such information came to their attention.

On 20th January 2011 V1 and her family were granted asylum for a 5 year period, and the following month they were granted indefinite leave to stay. This however, meant that they had to leave their accommodation and find alternative housing. The family were allocated temporary accommodation.

In March 2011 the police were called to the family home to gain entry with a warrant under Sec 136 Mental Health Act 1983 to remove H1 who had threatened to kill V1 and C1 with a knife. On arrival of the police V1 and C1 had again fled for their own safety and H1 was also missing from the house. H1 soon returned home and was taken to a psychiatric hospital for treatment. There was no referral to either adult or child protection made to any agency, albeit 2 days later his risk was determined as' suicide and high risk to others.'

Later in March 2011 a Child in Need Planning meeting took place and decisions were made at that meeting that included not allowing H1 to return home and that H1's contact with C1 should be supervised. His contact with V1 should only be by telephone. Another decision was that if H1 was to be discharged from hospital it should only be when he is well enough to be discharged and he would not be allowed to go to the home address or to where V1 and C1 were living at that time.

Despite these decisions, H1 was allowed out of hospital for periods of time and V1 complained that he was following her around the local town centre. At the same time

C1's social worker stated that as H1 was due for release, V1 now wished for him to return home.

On 21st April 2011 H1 was told that if he was discharged he could only go to friends in Leicestershire if Children and Young People's Service there were content with the arrangements. H1 was discharged on 28th April but went to the family home in Birmingham rather than the agreed location, Leicestershire.

In May 2011, H1 was detained after threatening to jump from a tall building and admitted to psychiatric hospital. It was decided that when he was to be discharged, it should be to the home of a family friend. However in June V1 changed her mind about H1 being in hospital and wanted him home to live with her and C1. There followed a period of misunderstanding and confusion between housing, social services and the hospital authorities regarding the discharge of H1. Housing insisted that he should not be discharged, Social Services stated that he should not be discharged, but H1's CPN and C1's social worker insisted that H1 offered no risk to either C1 or V1. The Mental Health Management report indicated that there was an agreement by all agencies that H1 could be discharged home.

In June 2011 C1's attendance at school was of concern, falling to only 78% and he was regularly absent on Thursdays and Fridays. It appears that he was acting as an interpreter for his mother at various meetings she had to attend.

By September 2011 C1's behaviour and attendance at school was again cause for concern. He was considered a Child in Need and there was a meeting under the Child in Need procedures this month but V1 failed to attend. The family were informed that they were to be evicted from their house due to the non payment of their utility bills. They were moved to new accommodation which V1 was not satisfied with so they were moved again.

H1's mental state during December was described as stable. Adult Mental Health Services were monitoring his medication. On 22nd December the Community Mental Health Team contacted V1 by telephone. She explained that H1 did not live with her anymore and she put the phone down. It appears no action was taken as a result of this information.

On 29th December 2011 an ambulance was called to the home address after C1 had run to a neighbour, saying that H1 had killed V1 by stabbing her with a knife. Police and emergency services attended and found V1 dead and H1 with self-inflicted stab wounds. H1 was treated for his wounds, arrested and he has been charged with the murder of V1. He is awaiting trial at the Crown Court.

Comment and Recommendations.

Government Guidance[6] requires that:

'The Overview Report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports or information commissioned from any other relevant source'.

This review is complex and has called for over 20 Individual Management Reviews from various agencies that had dealings with the family before V1 was killed. The victim, husband and son were all Iranian Kurdish migrants, with very little understanding of the English language. Conversely the Review Panel had very little understanding of Iranian Kurdish culture and took the opportunity early into the review to seek professional guidance from the London based Iranian and Kurdish Women's Rights Organisation (IKWRO), who gave the Panel advice about the culture of the Iranian Kurdish community, which was very helpful in the creation of the Overview Report.

The Overview Report indicates that there were several areas that required comment.

They were:

- Lack of Domestic Violence, Safeguarding Adults and Child Protection referrals from agencies.
- Wolverhampton Domestic Violence Forum
- Risk Assessments
- Multi-Agency Public Protection Arrangements

[6] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 Page 18 **www.**homeoffice**.gov.uk/publications/crime/DHR-guidance**

- Multi-Agency Risk Assessment Conferences
- Child Protection referrals
- H1's Discharge Planning Meeting 9th June 2011
- Care Programme Approach
- Education
- General Practitioners
- BCPFT, Walsall Healthcare NHST and DWPT
- V1's capacity and assessments
- Base 25 and C1's counselling
- The Use of Interpreters
- Police Investigations
- Policy and training
- Poor Information Sharing

A brief resume of each of these points follows.

Lack of Domestic Violence, Safeguarding Adults and Child Protection referrals from agencies.

On 13th January 2009 H1 was referred to Black Country Partnership Foundation Trust (BCPFT) after he had threatening to kill himself, V1 and C1. Despite these threats and the obvious risk to all three people, neither the referring GP or BCPFT made any referrals to either adult safeguarding or to Children and Young People's Services with a view to safeguard V1 and C1.

In May 2009 the UKBA received a letter from H1's psychiatrist to the effect that if his treatment was stopped he would be a risk to himself, V1 and C1 and his judgement would be seriously impaired. Despite the UKBA having specific domestic violence guidance, the guidance was not adhered to and no referrals were made to any other agency.

There are occasions where the police were called to incidents involving H1 as his mental health deteriorated and there was no referral to Children and Young People's Services or Adult Social Services for either C1 or V1.

Wolverhampton Domestic Violence Forum

Wolverhampton Domestic Violence Forum is an established support agency for people who are subject to domestic abuse to seek support and advice from professionals and is available to all agencies to refer victims to.

V1 should have been referred to the Forum from the first contact she and C1 had with agencies. Mental Health Services, Police and GP's should have used the Forum to ensure that V1 received the support available to her, which would have given her options for the future and offered her advice so she could make choices for the benefit of herself and C1. There were no such referrals made to the Forum by any agency and there were missed opportunities to assist her.

Risk Assessments

This case has demonstrated that there was no method of bringing together the numerous risk assessments conducted into H1 and his mental health. Because various agencies used differing risk assessment tools and models there were no opportunities to view the holistic risk he posed to V1 and C1 or indeed to himself.

H1 was admitted to hospital for treatment for his mental instability on several occasions. Each time he received medication and his condition stabilized and he was then discharged back to his family where family life, housing conditions, relationships and his reaction to his experiences in Iran caught up with him again, eventually resulting in his being re-admitted to hospital.

The BCFPT's IMR calls for a nationally agreed risk assessment framework to be used across all mental health agencies, as opposed to the numerous individual assessment tools that are used presently.

The Children and Young People's Services IMR suggests that the Barnardos Domestic Violence Risk Identification Matrix would be more appropriate to use, but any common tool would be a better scenario than the multiple systems that exist at present.

The Panel are of the view that if all of the various risk assessments had been collated H1 would have been identified as posing a High Risk of harm to himself, and to V1 and C1 for the majority of the period of time this review covers.

The Police missed opportunities to complete the usual risk assessment used in domestic abuse cases. The DASH Policy is used widely by police and is enshrined in West Midlands Police policy on such abuse, but the incidents the police attended to were dealt with in terms of H1's mental health rather than being seen as domestic abuse incidents.

Housing Options were aware that H1 had threatened to kill himself and his family, so much so that housing officers were withdrawn from visiting V1's house for fear of their own safety. There is nothing to indicate that Housing Options identified the risk to V1 and C1 and they failed to make any referrals to adult safeguarding, child protection or domestic violence services.

H1's GP was also aware of the threats and his mental health issues. The GP also failed to recognise the risks involved. It appears that the GP considered these issues around H1 mental ill-health and did not consider the wider issues of the risk to his family.

Multi-Agency Public Protection Arrangements

MAPPA guidance sets out the criteria for an offender being considered for supervision. By virtue of H1's lack of previous criminal convictions he did not meet the criteria to be referred to MAPPA and therefore could not be supervised.

Multi-Agency Risk Assessment Conferences

The focus of MARAC is the protection of high risk victims of domestic abuse and meetings are convened to share information to enable an effective risk management plan to be developed. The aim of MARAC is therefore to:

- Share information to increase the safety, health and well-being of victims – adults and their children

- Determine whether the perpetrator poses a significant risk to any particular individual or to the general public
- Construct jointly and implement a Risk Management Plan that provides professional support to all those at risk and that reduces the risk of harm
- Reduce repeat victimisation
- Improve agency accountability; and
- Improve support for staff involved in high risk domestic violence cases

Since September 2006 there has been a MARAC in Wolverhampton meeting every two weeks to discuss high risk cases. In addition Wolverhampton Domestic Violence Forum has been instrumental in developing best practice in Wolverhampton by co-locating services around domestic violence.

This case should have warranted a MARAC meeting but again, no agency sought to refer the family to the MARAC panel, therefore missing the opportunity to share all of the information known about H1, V1 and C1, which in this case would have been extremely useful.

It is the view of the Panel that there is a misconception about the ownership of the MARAC process. It is usual that the Police take the lead and Chair the MARAC meetings but any agency has a duty to inform MARAC of suitable cases. It is not the sole responsibility of the Police to initiate MARAC procedures.

Child Protection referrals

The Police made a referral to Children and Young People's Services in August 2010 after C1 had called to say that H1 was trying to kill himself. Because of a Bank Holiday and weekend leave the case was not picked up by a Social Worker until 10 days after the call. There is an assumption by the Panel that because H1 was detained in hospital agencies assumed that C1 was safe. There was no consideration, however, of what would happen when H1 was discharged from hospital and allowed home. There was no multi-agency input resulting from this incident.

Another referral in March 2011 because of H1's threats to harm himself and his family resulted in an experienced social worker concluding that a strategy meeting

should take place from which a Section 47 investigation should begin. In the end the case was passed to a local team for a further assessment under the Child in Need Procedures rather than the Child Protection Procedures. Again practitioners felt that because H1 was in hospital V1 and C1 were safe and again no consideration for action when he was discharged or what the risks would be when that happened.

Earlier referrals to Children and Young People's Services regarding C1's risk of significant harm may have avoided the missed opportunities to conduct holistic assessments and the brining together of information from all agencies where considered judgements could have been made with regard to supporting the whole family.

H1's Discharge Planning Meeting 9th June 2011

H1 was admitted to hospital in May 2011 after threatening to jump from a building. His condition improved and a meeting took place at the hospital on 9th June. The BCPFT IMR called this meeting a ward round, but the understanding from the Children and Young Peoples Services representative was that the meeting was a Care Programme Approach Meeting (CPA). The meeting was attended by a CPN, BCPFT staff, H1 and V1, an interpreter, a social worker and manager and two teachers from C1's school. Housing Options were invited but did not attend. It was reported that H1 had been allowed out of hospital on occasions, something that Children and Young People's Services were unaware of. The social workers insist that they insisted that H1 should not be discharged to the family home, but there was a contrary view held by the consultant psychiatrist.

The BCPFT note of the meeting suggests that all present were in agreement that the risk that H1 posed to himself and others had decreased and the plan was to discharge him with weekly visits by the Care-Coordinator, visits every three weeks by the Children and Young people's Services, and weekly visits by the Family Advice Support team.

Whatever the decision, the Panel note that H1 had not had the opportunity to have a 'trial period' of staying at home overnight to have a full assessment made of his ability to cope with home circumstances.

Two specific issues arise out of this situation. Firstly, the fact that Housing Options were not included in the meeting was a serious error and secondly that the action plan was implemented without the agreement of all agencies.

Care Programme Approach

The Care Programme Approach (CPA) was introduced by the Department of Health in April 1991 to provide a framework for the delivery of care and treatment in specialist mental health services within the community through effective case management. It stipulates processes that have to be adhered to regarding the discharge of patients and the risk they pose when discharged. Family members must be informed of the risk and consequences of patient discharge. In this case V1 had very little capacity in the English language and possibly could not understand the consequences of H1 being discharged to the family home. V1 was not given a copy of the Care Plan as the guidance requires. Guidance goes on to say that information must be shared appropriately to make sure that people get the services they need. In this case information was not shared amongst all agencies.

Education

Mention has already been made regarding the transfer of records between schools which prevented the sharing of information about C1's involvement with Children and Young People's Services and the fact that C1 was deemed to be a Child in Need.

General Practitioners

There were numerous occasions when H1's GP could have made referrals to both child and adult safeguarding services, but did not. Neither did the GP refer V1 towards any domestic violence support organisations. New guidance issued in June 2012 by the Royal College of General Practitioners stipulates that every GP practice should have a proactive approach towards domestic violence and be able to sign post victims to support agencies. There was no identification of the possible risk of domestic abuse in the family moving from one GP to another, which is a recognized indicator of risk of domestic abuse.

Black Country Partnership Foundation Trust, Walsall Healthcare NHS Trust and Dudley and Walsall Mental Health Partnership

On 14th August 2010, H1 was arrested under Section 136 Mental Health Act and he was assessed by an Approved Mental Health Practitioner and two psychiatrists that he was not ill enough to be detained in hospital in Walsall. There was no communication with V1 or C1 to assist in that decision making process before they decided not to detain him and no consideration of the risk he may pose to them should he be released. In order to arrive at the decision 22 pages of notes were sent to the Walsall Hospital. It was disturbing to note that answers to pertinent questions about H1's mental ill-health were incorrect stating that there were no child protection issues but also adding that his wife and child were affected when he is ill. Comments about the inaccuracy of these notes are made in the Overview Report.

In September 2010 despite having threatened V1 and C1 H1 was discharged from hospital to his home address, without any consideration for their safety.

V1's capacity and assessments

V1 was a vulnerable isolated woman with a limited command of the English language, who had been subjected to domestic violence over an extended period of time and who came from a cultural background where such abuse was accepted. There were occasions when it was clear that she made decisions which were influenced by her cultural roots but which were also to the detriment of her and C1's safety. She was never subjected to any formal assessment to demonstrate her capacity to understand and appreciate the potential risks she faced. The Mental Capacity Act 2005 defines when a person lacks capacity to make rational decisions and in her situation V1 would appear to require a formal assessment of her capacity to make these decisions.

Base 25 and C1's counselling

C1 was referred to Base 25 for counselling, but it appears that the reasons behind the referral namely H1's behaviour and mental ill-health and the domestic violence C1 and V1 were being subjected to and also the effects that was having on C1 were not made clear to Base 25. It appears that agencies assumed that C1 was being

counselled about his family problems when he was not. When he withdrew from the counselling sessions Children and Young People's Services were not informed.

The use of interpreters

During the contact that agencies had with V1 and C1 there was a need for interpreters to assist, but only on rare occasions were interpreters used. In the main, C1 was used to interpret for his mother and father. On one occasion V1 and H1 presented at the GP's surgery with a family friend to interpret.

All agencies had access to 'Language Line', an easy straight forward telephone access system for interpreting services, but failed to use it.

Police Investigations

The Police were made aware on several occasions that H1 had threatened to kill V1 and C1 but the police response was based on the fact that H1 was mentally ill. Although criminal offences of threats to kill may have been committed, no investigations were conducted into the circumstances. If the police had investigated these allegations, a more holistic approach would have been adopted. It would have been disclosed that there was domestic violence within the family, that there were possible child protection issues in the case of C1 and adult protection regarding V1. It is highly unlikely that H1 would have been prosecuted for any offence due to his mental ill-health, but there would have been a more rigorous approach to the family's problems. Agencies would have been brought together and information shared which is what was desperately needed in this case.

Policy and training.

Each agency involved in this review was examined with regard to their respective policies on domestic violence and child protection and adult referral processes. The Overview Report indicates that some of the agencies did not have adequate policies or training and recommendations have been made to address these short comings.

Poor information sharing

The information around H1 threatening to kill V1 and C1 was known to some agencies and not known to others. There was not a formal information sharing policy

between agencies. Agencies appeared to act in silos without the benefit of collation, analysis and dissemination of information and intelligence about this family.

No information was shared with MARAC by way of a referral. Nor was there any exchange of information with adult safeguarding, child protection, Barnardos or specialist Domestic Violence Support Services, thus preventing V1 from receiving support and advice about decisions that would then have been better informed.

Conclusion

This review consisted of over 120 pages of Overview report and some 24 recommendations. Each agency has made recommendations specific to their own agency and the Review Panel endorses all of them.

Throughout this review there is evidence that agencies worked in silos and there was a distinct lack of all issues being brought together to achieve a holistic overview of the whole picture. The three people in this family were seen and dealt with as individuals and this, coupled with the various agencies working in silos, led the Panel to the conclusion that V1's death was preventable, although not in itself predictable.

Recommendations

Recommendation No 1

The Safer Wolverhampton Partnership to seek assurance from the Wolverhampton Safeguarding Children Board that all agencies are meeting the requirements and statutory obligations under Working Together to Safeguard Children.

Recommendation No 2

The Safer Wolverhampton Partnership to seek assurance from the Wolverhampton Safeguarding Adults Board that all agencies are meeting the legal obligations and requirements under 'No Secrets' and working to the Interagency safeguarding Police and Procedures and the associated requirements.

Recommendation No 3

The Safer Wolverhampton Partnership to develop and monitor the implementation of a City wide Domestic Violence Protocol to ensure appropriate referrals are made where children and adults are at risk from Domestic Violence and ensure the

statutory agencies are providing and commissioning services in accordance with the Protocol.

Recommendation No 4

The Safer Wolverhampton Partnership to ensure the relevant NHS Commissioning body has disseminated the guidance 'Responding to Domestic Abuse' from the Royal College General Practitioners dated June 2012 to all GP practices, and required each GP Practice to nominate a member of staff to implement the guidance and provide a list of the nominated persons to the Safer Wolverhampton Partnership as evidence that this has been completed within 12 months from the date this report is accepted by the Safer Wolverhampton Partnership.

Recommendation No 5

The Safer Wolverhampton Partnership to ask the Domestic Violence Forum to develop an inventory of all relevant risk assessment tools and procedures currently used in Wolverhampton by Safeguarding Children and Safeguarding Adults services to promote:

- Consistency of language across them;
- The development of a pathway between them;
  - Clarity and understanding of the different risk assessment tools and procedures used locally across the services; and
  - Triggers to identify situations of Domestic Violence, Safeguarding Children and Adults and implement appropriate action

and further, to require that the Safeguarding Children .Board and the Safeguarding Adults Board demonstrate that relevant Health, Social Care and Housing front line staff are aware of the inventory and are facilitating appropriate holistic risk assessments.

Recommendation No 6

The Safer Wolverhampton Partnership to develop, publicise and implement a clear multi-agency pathway for agencies to refer High Risk cases to MARAC and require the statutory agencies:

- to demonstrate that their staff and those of services they commission are aware of their responsibilities and the processes for referring into a MARAC both in Wolverhampton and elsewhere and
- to demonstrate that the multi-agency pathway is implemented.

Recommendation No 7

The Safer Wolverhampton Partnership to require the Wolverhampton Safeguarding Children Board to:

- ensure that statutory, independent and voluntary agencies who commission or provide services for children and young people review their individual agency's training and awareness of staff regarding the referral process for children considered in need or at risk of significant harm;
- ensure that all agencies review their internal training policies and those of services they commission in respect of Domestic Violence and demonstrate that they are fit for purpose, current and reviewed annually. Training to include awareness training for all staff and volunteers up to its most senior management and supervisors; and
- ensure inter-agency training is commissioned regarding Domestic Violence Management to include the referral process to MARAC, Child Protection and Safeguarding Adults and to raising awareness of MARAC, DASH and the Barnardo's Risk Assessment.

Recommendation No 8

The Safer Wolverhampton Partnership to require health service commissioners to demonstrate that they are commissioning services with appropriate and effective discharge planning procedures in place.

Recommendation No 9

The Safer Wolverhampton Partnership to convene an inter-agency workshop to facilitate a protocol for the development and implementation of Multi-agency Action Plans, to include a dispute resolution process and a review process, and to ensure and monitor its implementation.

.**Recommendation No 10**

The Safer Wolverhampton Partnership to seek assurance from Black Country Partnership Foundation Trust that its guidance for the Care Programme Approach is reviewed and implemented accordingly and evidenced to the Safer Wolverhampton Partnership within 3 months from the date this report is accepted by the Safer Wolverhampton Partnership.

Recommendation No 11

a) The Safer Wolverhampton Partnership to satisfy itself that Policies are in place to ensure the timely transfer of full and accurate school records to support the needs of children and young people**;** and
b) The Safer Wolverhampton Partnership to satisfy itself that policies are in place to demonstrate that Children and Young Person's Services are informed if a known child moves school or there is a change in the child's circumstances.

Recommendation No 12

The Safer Wolverhampton Partnership require that the Black Country Partnership Foundation Trust and recommend that the Walsall Healthcare NHS Trust review their processes of information exchange to ensure that the outcomes of assessments under the Mental Health Act 1983 and Care Programme Approach documents and covering letters that are passed between themselves and other agencies are accurate and up to date, and report the findings of their reviews to the Safer Wolverhampton Partnership within 6 months of the date this report is accepted by the Safer Wolverhampton Partnership.

Recommendation No 13

The Safer Wolverhampton Partnership to require the statutory agencies to demonstrate that services they provide and those they commission, particularly the Black Country Partnership Foundation Trust, and recommend that the Dudley and Walsall Mental Health Partnership NHS Trust, when undertaking Mental Health Assessments under Mental Health Act 1983, exercise their duty of care to ensure the safety of any patient and others including the patient's family before making a decision not to arrange an admission under Mental Health Act 1983

Recommendation No 14

Safer Wolverhampton Partnership to require the Black Country Partnership Foundation Trust to review its discharge communications to ensure appropriate discharge information is sent to the GP within 48 hours of a patient discharge.

Recommendation No 15

The Safer Wolverhampton Partnership to require the Black Country Partnership Foundation Trust to demonstrate that it actively encourages all patients with severe and enduring mental ill-health to register with a local GP.

Recommendation No 16

The Safer Wolverhampton Partnership should require the Black Country Partnership Foundation Trust to demonstrate that, before patients are discharged into the care of a family member, an individual carer's assessment is offered to the family member to ensure they fully understand and appreciate the consequences of the discharge. If this is refused, a comprehensive risk assessment of the home situation should be carried out.

Recommendation No 17

The Safer Wolverhampton Partnership to request assurance from the Wolverhampton Safeguarding Children Board that all agencies are aware of the referral pathway and process to services for children with counselling needs and ensure that, when known, issues of domestic violence or safeguarding are highlighted to ensure that appropriate outcomes are achieved and that there is robust monitoring to ensure that this occurs.

Recommendation No 18 The Safer Wolverhampton Partnership to require statutory agencies to demonstrate that within services they provide internally and commission there is a robust policy for providing interpreting services excluding the use of family members or friends except in extreme emergencies.

Recommendation No 19

The Safer Wolverhampton Partnership to require the West Midlands Police to demonstrate that officers investigate reported incidents even if the suspect is subject to mental health treatment, to ensure that the full circumstances of the offence are known and a proper assessment of the risk to others is ascertained.

Recommendation No 20

The Safer Wolverhampton Partnership seek assurances from the Safeguarding Children and Adult Boards that, as part of their quality assurance processes, the statutory agencies annually monitor their domestic violence training plans and those of services they commission

Recommendation No 21

The Safer Wolverhampton Partnership to ensure that all agencies providing services to children, families and adults have up to date contact details for all Specialist Domestic Violence Services within Wolverhampton to ensure that agencies are able to demonstrate that they signpost and refer victims appropriately to Domestic Violence Services.

Recommendation No 22

The Safer Wolverhampton Partnership to seek assurances from the Safeguarding Children and Adults Boards that work carried out with children and adults at risk:

- Is outcome focused and of a high quality; and
- generates specific referrals for service provision.

And that:

- there is timely and effective information exchange; and
- there is a process of challenge and monitoring when information Sharing is poor and inadequate.

Recommendation No 23

The Safer Wolverhampton Partnership to seek assurance that recommendations contained in individual agency IMRs are being addressed within 6 months from the date this report is accepted by the Safer Wolverhampton Partnership.

Recommendation No 24

The Safer Wolverhampton Partnership should ensure that systems are in place to evidence the progress in relation to the recommendations made in this report.