SAFER WOLVERHAMPTON PARTNERSHIP

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

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1. Introduction

1.1 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 chid in the family as C1.

1.2 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.

1.3 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.

1.4 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.

1.5 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.

1.6 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 —

(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.

1.7 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.

1.8 On 24th January 2012 members of the Safer Wolverhampton Partnership met to consider the circumstances of this case and the Chair of the Partnership decided that the circumstances did meet the criteria for a Domestic Homicide Review (DHR), and as such a review should be conducted under Home Officer Guidance as well as guidance from Safer Wolverhampton Partnership[3].

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 ***www.homeoffice.gov.uk/publications/crime/DHR-guidance***
[2] Home Office Guidance Page 8
[3] Safer Wolverhampton Partnership – Process for undertaking a Domestic Homicide Review Protocol – Wolverhampton City Council – Nov 2011

1.9 The Review was Chaired Mr Pete Morgan and this Report Authored on behalf of the Domestic Homicide Review Panel (the Panel) by Mr Malcolm Ross, both Independent Consultants.

1.10 The administration and management of the Review process has been carried out by Mrs Karen Samuels of Wolverhampton City Council, Safer Wolverhampton Partnership.

1.11 In accordance with Home Office Guidance[4], Safer Wolverhampton Partnership informed the Home Office in writing of the confirmed intention to conduct a DHR on 30th January 2012.

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

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

Governance and Accountability:

2.2 The Review will be conducted in accordance with the SWP Domestic Homicide Review Procedure

2.3 As the Accountable Body responsible for its commissioning, the Safer Wolverhampton Partnership (SWP) will receive updates on progress of the Review at scheduled SWP Board meetings.

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

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

[4] Page 8 MAS Guidance

3. Purpose of the Review

3.1 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

3.2 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:

identify a definitive timeline of events leading to the homicide for the victim and the alleged perpetrator

1) establish whether failings occurred in the assessment, care or treatment of all family members

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

4. Review Time Period

4.1 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.

5. Panel Membership

5.1 The Panel will comprise individuals across a broad spectrum of both statutory and voluntary sector agencies. Representation should be at a sufficient level of seniority within their respective organizations to commit to the delivery of resulting recommendations. The Panel shall consist of core representation from the following agencies:

- West Midlands Police
- Staffordshire and West Midlands Probation Trust
- Wolverhampton Domestic Violence Forum
- West Midlands Strategic Health Authority
- Primary Care Trust NHS Wolverhampton
- Royal Wolverhampton Hospital Trust
- Black Country Partnership Foundation Trust (BCPFT)
- Wolverhampton City Council - Community Safety
- Wolverhampton City Council – Adult Services
- Wolverhampton City Council – Children and Young People's Service

- BME United

5.2 Further agencies may be asked to join the Panel in the light of the progress of the Review.

6. Independent Management Reviews (IMRs)

6.1 IMRs were requested from the following agencies:

- 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
- School 1
- School 2
- School 3
- Spurgeons
- Base 25
- The Haven
- Refugee Migrant Centre

6.2 Further agencies may be asked to submit IMRs in the light of the progress of the Review.

6.3 Relevant services in Birmingham who were or might have been contacted prior to the family's arrival in Wolverhampton may also be asked to submit IMRs.

6.4 Procedural or policy information may be requested to aid the understanding of the Panel.

6.5 To aid the Review process, the following representation may also be sought from independent persons qualified to offer expert opinion/advice to the Panel.

- Independent expert on mental health;
- Agency with awareness of cultural issues of Kurdish Muslim women; and
- Homeless services expert.

6.6 The Panel will offer the families and relevant others of both the victim and the alleged perpetrator the opportunity to comment upon the quality and nature of the services they and the victim and alleged perpetrator received.

7. Family Liaison

7.1 Contact with H1 will be directed through his solicitor. Contact with C1 will be directed through Wolverhampton City Council's Children and Young People Service. Contact with other family members of both V1 and H1 shall be directed through the appointed Family Liaison Officer from West Midlands Police.

8. Media Strategy

8.1 Media contact concerning the review shall be the responsibility of the Chair of the Safer Wolverhampton Partnership in consultation with the Review Panel Chair and the Head of Community Safety. Overall management will be directed through Wolverhampton City Council (WCC) Communications Team.

9. Legal Advice

9.1 Legal advice will be sought, as appropriate from WCC Legal Department to ensure the review process and final Overview Report maintains a commitment to safeguard the anonymity of C1.

10. Liaison with the Police

10.1 The Chair of the Review Panel will be responsible for ensuring appropriate liaison with the Crown Prosecution Service and the Police through the Disclosure Officer identified by the West Midlands Police.

10.2 In the light of information brought to the Chair's attention, these Terms of Reference will be subject to review and revision at the discretion of the Panel Chair in consultation with the Review Panel and with the agreement of the Chair of the Safer Wolverhampton Partnership

11. Home Office Guidance

11.1 Guidance[5] determines that the aim of an IMR is to:

- 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.

11.2 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.

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

11.4 The IMR Reports were of a mixed standard, reflecting the experience and expertise of their authors and their agencies of origin. There had been insufficient time to provide briefing sessions for the IMR authors but individual mentoring sessions were provided where necessary. A full and comprehensive review of the agencies' involvement and the

[5] Home Office Guidance Page 17

lessons to be learnt was thereby achieved.

12. Domestic Homicide Review Panel

12.1 A Domestic Homicide Review Panel (the Panel) of those professionals nominated by their agency formed to discuss and review draft IMRs and consider the issues that arose from them. Mr Pete Morgan chaired the Panel. Mr Malcolm Ross was the Independent Author for the Overview Report on behalf of the Panel. Other members of the Panel and their professional responsibilities were:

Karen Samuels - Head of Community Safety SWP
Kathy Cole-Evans - Wolverhampton Domestic Violence Forum Strategy Coordinator
Paul Drover - Detective Chief Inspector West Midlands Police
Penny Darlington - Wolverhampton City Council Head of Adult Safeguarding
Neil Appleby - Staffordshire and West Midlands Probation Trust Head of Probation Wolverhampton LDU
Debbie Edwards - Royal Wolverhampton Hospital Trust Matron and Safeguarding Adult Lead
Elaine Thompson - West Midlands Strategic Health Authority Clinical Quality and Patient Safety Manager
Sally Roberts - Primary Care Trust NHS Wolverhampton Assistant Director of Nursing Quality and Safety – BCC Lead for Quality and Effectiveness.
Gillian Mobbs - Black Country Partnership NHS Foundation Trust Divisional Manager for Older Adults
Liz Norris - Wolverhampton City Council Children and Young People's Services Deputy Head of safeguarding Service (Children's)
Administrative Support
Parpinder Singh - Wolverhampton City Community Safety/SWP Community Safety Coordinator

Raj Khera - Wolverhampton City Council Community Safety/SWP Community Safety Administrator

12.2 A representative of a local Black and Ethnic Minority (BME) organisation was invited to join the Panel but was unable to attend any meetings, As a result, expert advice and guidance regarding issues arising from the family's cultural background was obtained from the Iranian Kurdish Women's Rights Organisation.

13. Independent Overview Report

13.1 Home Office Guidance[6] requires that;

"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and

"The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

13.2 The Safer Wolverhampton Partnership decided to appoint both an Independent Author and an Independent Chair for the Domestic Homicide Review. Having sought expressions of interest in both posts, they appointed Mr Pete Morgan as the Independent Chair and Mr Malcolm Ross as the Independent Author.

13.3 Mr Pete Morgan is currently the Independent Chair of the Worcestershire Safeguarding Adults Board, having retired as the Head of Service – Safeguarding Adults with Birmingham City Council. In the above roles, he has commissioned Serious Case Reviews as well as participated in them and their ratification by the relevant Safeguarding Adults Board. He has had no involvement directly or indirectly with any

[6] Home Office Guidance page 11

member of the family concerned in this Review or the commissioning, delivery or management of any of the services that they either received or were eligible for. He drafted the Domestic Homicide Review Procedure followed by this Review and chaired the meetings of the Review Panel, agreed its membership and drafted its Terms of Reference. The Panel reviewed and, where necessary, sought revisions to the IMRs written as part of the Review, contributing to the preparation of the Report. He also attended the Safer Wolverhampton Partnership to keep them informed of the progress of the Review.

13.4 Mr Malcolm Ross was appointed at an early stage, as Author. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing Serious Case Reviews and Chairing that process and more recently, performing both functions in relation to Domestic Homicide Reviews. He has had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

14. Individual Needs

14.1 Home Office Guidance[7] 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?"

14.2 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

[7] Home Office Guidance page 25

interpreter were often missed. On many occasions C1 was used as an interpreter for his mother and father, or sometimes a family friend. Thus the vulnerability of both V1 and C1 was often not considered or recognised.

15. Family Involvement

15.1 Home Office Guidance[8] 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."

15.2 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

[8] Home Office Guidance page 15

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 meet with the family and explain the DHR process.

16. Sequence of events
September 2008 – December 2009

16.1 On 24th September 2008 V1, H1 and C1 arrived in the UK at Gatwick Airport and claimed asylum at Immigration Control. H1's grounds for claiming asylum were that, whilst working as a central heating engineer in Iran he had attended the offices of the Supreme Leader and whilst there had a conversation with an employee of the 'Supreme Leader' who confided in H1 that staff were going to be dismissed because of lack of funding and he was of the opinion that money should not be sent to political groups. H1 had repeated this conversation to another and the 'Supreme Leader' had found out. H1 believed that he was on a list to be arrested for disclosing this information. He also claimed that he had witnessed his friend being murdered by supporters of the Government's agents.

16.2 The family were referred to the Midlands Asylum Team and an arrangement for their first reporting event was made for 29th September 2008.

16.3 The following day 25th September the family were given temporary accommodation in a hostel in Birmingham by the United Property Management (UPM).

16.4 UPM Ltd., have a contract with the United Kingdom Border Agency (UKBA), to provide full board accommodation for destitute asylum seekers and to offer support and eventually provide 'move on 'accommodation anywhere in the West Midlands area.

16.5 Once the family arrived at the hostel, they received a normal induction and were seen by the Refugee Council within 48 hours, who assisted them to apply for support. They also had a health screening, which is normal practice.

16.6 On 6th October 2008 H1 failed to attend at an appointment with his solicitor.

16.7 On 16th October 2008 H1 presented at a local hospital casualty department complaining of a back injury sustained whilst at work in Iran. He was given pain relief.

16.8 On 22nd October 2008 the family were allocated local authority accommodation in Wolverhampton to be taken up on 23rd October 2008.

16.9 Again on 22nd October 2008 H1 attended the casualty department feeling dizzy. He complained of being depressed and anxious due to the forthcoming house move. He was diagnosed with depression and anxiety and with the assistance of a translator assured that his GP would review him the following day. Indeed his GP attended at his home twice that same day (on 22nd October) but on both occasions they were unable to gain access.

16.10 On the same day H1's solicitor contacted the UKBA requesting a reschedule of the interview he was to have on 24th October as H1 had mental health problems and was on medication. The solicitor was

asked to provide medical evidence which was not forthcoming and the following day H1 attended for his interview with UKBA officials.

16.11 At the interview H1 presented as confused and in an anxious state. The UKBA official considered that he was too ill for the interview. She contacted his GP who agreed that H1 was showing signs of depression following witnessing his friend being murdered in Iran and the GP believed that his condition was genuine. The interview was re-arranged for 6 weeks hence.

16.12 On 9th December 2008 C1 attended to his GP's surgery with an interpreter. (Details of who the interpreter was are not recorded) He complained of feeling overweight. He was 9 years old at the time. There is nothing to indicate that there was any exploration as to why he should feel in this way. He was advised about exercise.

16.13 On the same day H1 attended at the GP's surgery requesting medication. He explained that some 4 months previously, he had witnessed his friend being killed by Government's agents in his home country. He had been taking Mirtazapine which helped his anxiety but did make him dizzy. There are no details of an interpreter being present. The GP noted that he would seek a special centre for H1 to attend for treatment for his diagnosis of Post-Traumatic Stress Disorder with an interpreter but nothing appears to have been concluded in this respect.

16.14 H1 attended at UKBA for interview on 15th December 2008 but was vague about times and dates relating to their questioning, which he blamed on his medication.

16.15 On 13th January 2009 a note on the GP's file indicates that H1 went to see the health team for asylum seekers in Birmingham and told them

he felt suicidal as his tablets had stopped. He did not request more tablets but the team referred the event to his GP. The GP also received a letter from the Birmingham asylum team to the effect that H1 was threatening to kill himself, his wife and child and set their surgery alight. Again there are no details of an interpreter being present during this visit. On the same day the Black Country Partnership Mental Health Trust (BCPFT) Mental Health Crisis Team received a referral from H1's GP to the effect that he had threatened to kill himself and his wife and child, and the assumption was that the threat was real. He was diagnosed by his GP with Post Traumatic Stress Disorder[9].

16.16 "Post-traumatic stress disorder (or PTSD for short) is the name given to the psychological and physical problems that can sometimes follow particular threatening or distressing events. These events might include:

- a major disaster
- war
- rape or sexual, physical or emotional abuse
- witnessing a violent death
- a serious accident
- traumatic childbirth
- other situations in which a person was very afraid, horrified, helpless, or felt that his or her life was in danger.

The trauma can be a single event or a series of events taking place over many months or even years".

[9] NICE Post-traumatic stress disorder (PTSD): the treatment of PTSD in adults and children. Understanding NICE guidance – information for people with PTSD, their advocates and carers, and the public. Source: NICE (March 2005) http://www.nice.org.uk/nicemedia/live/10966/29782/29782.pdf

16.17 H1 was duly assessed and accepted for service provision by the Crisis and Home Treatment Team. Inpatient care was not deemed necessary and instead Home Treatment was considered an appropriate way of managing his mental ill-health.

16.18 On 15th January 2009 he told his GP that he was feeling very low, angry and had suicidal thoughts and feelings of wanting to strangle himself, his wife and child. Doctor's records indicate that he was with an interpreter but who that was is not recorded. This was the second time in 2 days he had made these comments, the first being on 13th January. He had a sense of hopelessness but stated that he wanted help because he might act on the impulses. The GP made a referral to Single Point of Access (SPA) who would arrange for a Home Treatment Team and a psychiatrist to review his case at Steps to Health that afternoon. It is not clear what the outcome of that referral was.

16.19 On 24th January 2009 H1 was assessed as being at risk in areas of self-harm and hallucinations.

16.20 On 24th January 2009, the UKBA wrote to H1 informing him that his application for asylum had been refused. It had not been accepted by UKBA that H1 had a well-founded fear of return to Iran because there were aspects of his claim that were not believed due to discrepancies within his claim. He was informed that a deadline for an appeal was 11th February 2009.

16.21 On 11th February 2009 the UKBA were contacted by a Mental Health Worker stating that H1 was too ill to report. He was suffering from depression, paranoia and flashbacks from his experience in Iran

16.22 On 13th February a decision was made by UKBA that H1's reporting would be suspended indefinitely and V1 would have to report monthly,

making her the principal in the relationship as far as the UKBA was concerned.

16.23 Also on 13th February 2009 H1 again went to see his GP with his wife and an interpreter. Again no details of the interpreter are recorded. V1 told the GP that the Home Treatment Team wanted to take H1's blood pressure and raised questions about whether he should be admitted to hospital due to his mental state. He was refusing to eat, talk or take medication and he was not sleeping. The Home Treatment Team were contacted and stated that they had not told him to go to his GP and that they were going to see him that afternoon. It is not clear whether the team did visit him that afternoon. V1 was worried that there were discrepancies between her statement and those of the Home Treatment Team.

16.24 On 25th February 2009 there were signs that V1 was being affected by her husband's periods of mental ill-health. She contacted UKBA stating that she was unable to report as her husband had deteriorated. Irrespective of the reason given UKBA noted that she had not reported and her excuse was not accepted. H1 was admitted to a psychiatric hospital for an assessment as his condition had worsened following his application for asylum being refused. It is not clear under what Section of the Mental Health Act he was admitted. The following day H1 was discharged home and the Home Treatment Service continued to provide support. It is recorded that he was still concerned about his asylum application.

16.25 On 19th March H1 was prescribed antibiotics by his GP and a note on file states that he had no suicidal thoughts. There is nothing to indicate that an interpreter was present.

16.26 In April 2009 V1 reported to a Care Programme Approach (CPA) meeting that H1 was not eating and was screaming at night time.

16.27 On 14th May 2009 H1 again attended at his GP's surgery with his wife. She complained that the situation was now very difficult with H1. He was refusing to keep appointments, and was constantly scared during the night, being withdrawn and hiding during the night time. She feared that he may harm himself. The GP's decision was to wait until his Steps to Health appointment and Steps to Health may increase his medication, but if the situation was to get worse V1 had the contact details of the Home Treatment Team.

16.28 The UKBA received a letter from H1's psychiatrist on 21st May 2009 that stated:

"If H1's treatment was stopped his condition would worsen immediately, putting his own welfare and even safety at risk, not only to himself but also to his wife and child. I do not believe that he would survive long, both his serious disorders carry considerable suicide risks, and with it a severe risk of such seriously impaired judgement that it would place his family in jeopardy." Comments were made that he had been offered hospital treatment but had refused. An assessment was being carried out to see if an admission could be made under the Mental Health Act 1983. He was admitted later the same day under Section 3 Mental Health Act 1983. He was discharged 6 days later

However on 8st June 2009 H1 was admitted again under Section 2 Mental Health Act 1983 to Penn Hospital with psychotic symptoms and having taken an overdose. He was discharged on 24th July.

16.29 On 10th June UKBA dismissed H1's appeal on all grounds including his mental health grounds. A Judge found that H1 would not be at any risk should he return to Iran. He was admitted to Wolverhampton Hospital overnight after he had taken an overdose of prescribed tablets. He was

transferred to Penn Mental Hospital and was detained for a further 7 weeks.

16.30 The following week V1 took over the application for leave to remain to the UKBA in her own right with C1 and H1 being her dependents. On 7th July 2009 V1 and C1 were allowed to remain in their accommodation, H1 remaining in hospital until the 24th July, when his mental health had improved and he was discharged. V1 was reported as being keen to have him home.

16.31 On 4th August 2009 UKBA confirmed that H1 had been released from hospital and was now added to the application of his wife V1. During the period from August to September 2009 H1's mental health condition varied between an 'improvement and not being very well.'

16.32 On 22nd August 2009 H1 reported that he was having trouble sleeping without tablets.

16.33 On 4th September 2009 H1 again presented at his GP with his wife. V1 explained that he spends a lot of his time in his room. He was showing the occasional episode of anger. She denied any domestic violence in the relationship when asked by her GP. His sleeping was still poor. The GP's decided to defer any action until 11th September (a week later) when H1 was to see his mental health care coordinator who, a note indicates was away until 7th September. There is nothing to indicate that this person was contacted by the GP, although the surgery left a message with Steps to Health for the Care Coordinator to contact the surgery.

16.34 On 30th October 2009 the Carer Support Team from the City Council received a Mental Health Joint Carer's Assessment Form from the Community Psychiatric Nurse (CPN) for H1. This form had been

completed on 12th May 2009. Carer Support Team is part of Wolverhampton's Adult Social Care Services and provides a service to adult carers over the age of 18 years. Its remit is:

- To identify informal Carers who care for an individual living in Wolverhampton
- To undertake an Assessment of Need for informal Carers where this has not been undertaken as part of a Community Care Assessment.
- The provision of carer specific services where appropriate
- The provision of emotional support, advice and assistance
- Support and Signposting to other relevant sources of support
- Provision of carer specific welfare rights advice and support

16.35 The assessment was accepted as a referral in that it identified the need for support and possibly carer specific services. The main issue was the opportunity for V1 to learn English and provide respite from her carer's role. However, there was a problem with funding as the family were failed asylum seekers and the V1 had no recourse to public funds. The Head of Welfare Rights and Financial Assessments from Wolverhampton Council intervened and sought legal advice from the Council's solicitors which declared it would be a breach of V1's human rights not to support her in these circumstances. Based on this assessment a European Human Rights Court Assessment form was completed but not until 27th July 2010 and the services were provided but not until 13th September 2010, some 1 year 4 months after the initial competition of the Joint Carers Assessment form.

16.36 On the same day 30th October 2009, H1 became very distressed, trying to jump out of a window and banging his head. Police were called. He was taken to Penn Hospital by a friend. He was distressed about the

forthcoming interview with the Immigration Service. He was admitted informally and discharged on 23rd November 2009.

16.37 During the remainder of that year H1 remained stable, but in December V1 expressed to the Community Mental Health Team details of the strain of being a full time carer to him and the impact this was having on her and C1. The matter was referred to the Carers Team but a note states; 'but needs permission from Home Office'.

January 2010 – October 2010

16.38 On 11th January 2010 a medical review of H1's mental health found him to be anxious with depression and being a moderate suicide risk.

16.39 On 21st January H1 was taken to Wolverhampton Hospital by ambulance suffering from an overdose of prescribed drugs. Whilst the Police were informed of this incident, Police would not normally attend 'unless there was a risk to staff or the public or a vulnerable person had been identified.' There was no contact between the Police and V1 at this time. He was discharged from hospital on 29th January 2010. On the same day members of the Mental Health Crisis Team went to visit him. H1 refused to come down from an upstairs room to see them until persuaded by V1, but then he didn't speak.

16.40 On 1st February Police were again called to the offices of Steps to Health where H1 was self-harming, banging his head on the wall. A Mental Health Crisis Team member offered him admission to hospital but he refused. He was then arrested under Section 136 of the Mental Health Act 1983[10] and taken to the nearest Police Station. He needed

[10] Section 136 Mental Health Act 1983 as amended by Mental Health Act 2007, states: If a constable find in a public place a person who appears to be suffering from mental disorder and to be in immediate need of care or control, the constable may if he thinks it necessary to do so in the interests of that person, or for the protection of others remove that person to a place of safety.

restraining as he was banging his head on the wall. He was assessed on 2nd February and returned to Penn Hospital under Sec 2 Mental Health Act 1983. On this occasion a Farsi speaking interpreter was used to assist in the process.

1641 During his admission to Penn Hospital on 9th February 2010 he became agitated and assaulted 2 members of staff. He was transferred to Walsall Manor Hospital suffering from pneumonia. During his stay in Walsall Manor Hospital he went absent without permission and was found at home by the Police. He refused to return to the hospital and was discharged against medical advice. The detention pursuant to Section 2 lapsed while he was in the Walsall Manor Hospital. V1 was contacted by the hospital and stated that H1 was not at home but she was coping with him.

16.42 On 17th February 2010 H1 was discharged from hospital and remained out of hospital.

16.43 On 8th March 2010 Police were notified that he had gone missing from hospital. He was found at home by the Police and returned to hospital. The Police missing persons (MISPER) report classed H1 as a medium risk but nothing was mentioned on the report of his previous suicidal attempts and the threats to his family he had previously made. H1 refused to return to the ward and he was discharged against medical advice.

16.44 On 14th March 2010 he was again admitted informally to hospital as he did not want to go home and V1 was unable to cope with him. However on 15th March 2010, after being given leave from the hospital he refused to return to the ward, he was again discharged against medical advice.

16.45 On 9th April H1 was re-admitted to hospital informally. He reported he could hear voices. He also admitted threatening to jump off a balcony when V1 had hidden his tablets to prevent him overdosing. On 21st April BCP records indicate that he was involved in 'a violent incident on the ward and had to be restrained'. He was discharged on 26th April.

16.46 On 13th May 2010 H1 attended at his GP's surgery with an interpreter. (Again no details recorded) He was unsure of why he was there but had a query about his medication. There is a note to suggest that the Home Treatment Team was no longer engaged with H1.

16.47 Two weeks later H1 was back at the surgery. He wanted a repeat prescription but was getting agitated at his GP's reception. V1 had taken him and left the surgery when H1 started to become difficult. He was issued with a prescription for 2 further weeks. He didn't collect another prescription until 25th June 4 weeks following the previous visit, so it is not known if he was taking medication during that time period.

16.48 In June V1 it was reported by the Community Mental Health Team that V1 was tearful and stressed and by 24th June 2010 there were enquiries being made by the GP about obtaining the services of a Farsi speaking counsellor. A note in the Black Country Partnership NHS Foundation Trust IMR for this date indicates that:

> "24.6.10 V1 seen separately at outpatient clinic. Reported that when H1 shouted at night at voices, and when she tried to reassure him, he became angry to the extent that on one occasion she has to leave the house for her own protection at 3am. However she also stated that he had never hurt her or C1."

16.49 On 20th July 2010, he presented at his GP's surgery, quiet, paranoid and withdrawn. He had an interpreter with him, but no details are given as to their identity. His family were frightened and concerned and a letter of help promised on 24th June by his GP had not materialised. (There is nothing in the chronology from Primary care Trust (PCT) to indicate what that letter of help was about). H1 was also attempting to give up smoking.

16.50 On 12th August H1 was described by the Community Mental Health Team as being distressed.

16.51 On 14th August 2010, C1 reported to the Police that H1 was trying to kill himself at the home address. The Police attended and forced entry into the house and arrested H1 under the provisions of Section 136 Mental Health Act 1983.

16.52 A Mental Health Act Assessment was undertaken at Walsall Police Station that evening. C1 is listed as being present during this incident and 'great concerns' are expressed by V1 and C1 about the mental state of H1. C1 told officers that H1 had tried to kill himself with a knife and tablets on previous occasions. Police made a referral to Adult Social Care's Access and Initial Assessment Team.

16.53 The outcome of the assessment was H1 was not detained under the Mental Health Act, both assessing doctors acknowledged that he was displaying agitation, anxiety and possible depressive symptoms. It was felt that he could be supported by the Wolverhampton Home Treatment Team. There is a note on the Police IMR to the effect that although concerns were expressed about the well-being of H1, the vulnerability of V1 and C1 was not considered separately.

16.54 Over the next few days it appears that H1's condition deteriorated and notes in the Mental Health Crisis Team record that V1 was very concerned about her own safety and that of C1. She asked that H1 be admitted to hospital but he was assessed as not being detainable. V1 was advised to contact the Police if she was concerned.

16.55 On 17th August 2010, H1's GP made a home visit as the Mental Health Crisis Team had requested a mental health assessment. H1 had made more suicidal threats and V1 was frightened for her own safety but there had been no evidence of violence towards her. It was clear that she was struggling to cope with her very distressed husband. The GP could not section H1, but could have requested a second medical assessment by a Section 12 Doctor and an assessment by an Approved Mental Health practitioner (AMHP) if he/she thought H1 needed to be admitted to hospital. Instead the GP relied on the Home Treatment Team to 'go in and make adjustments'.

16.56 On 19th August 2010, H1 was distressed and still hearing voices. His medication was adjusted and Home Treatment was to continue.

16.57 On 27th August 2010, a referral for C1 was made by the Police to Children and Young People's Services saying that H1 was trying to kill himself. This was the first time C1 had been referred to Children and Young People's Services. A home visit was made but not until the 6th September 2010, some 10 days later due to the case being allocated to a part time worker, a weekend and a Bank Holiday. During August H1 attempted to quit his smoking habit of 20 – 30 cigarettes per day, by using patches.

16.58 On 28th August 2010 C1 called the Police to say that H1 was having mental health problems and his doctors had forgotten to give him his medication. He also believed that H1 was attempting to commit suicide.

Both V1 and C1 had fled the house in fear of their safety. A referral was made to the Police Child Protection Team and although a DASH risk assessment form was not completed, a copy of the papers were referred to the Police Child Protection Unit, which was the first recognition of child protection risks to C1. A DASH risk assessment was not carried out as the officers did not feel that there was any immediate risk to the family. A Mental Health Crisis Team Worker from BCPFT attended at the family home but V1 and C1 had left the house for their own safety.

16.59 On 3rd September 2010 V1 refused consent for H1 to have home leave from hospital, but the Mental Health Section was rescinded by the hospital. He had been placed on a Section 5(2) order on the previous day but his wife was not happy and wanted him home permanently. Although his condition had improved he took his own discharge against medical advice.

16.60 On 6th September 2010 a home visit took place with a Social Worker from Children and Young People's Services and a Farsi interpreter present. V1's concern about the impact of H1's behaviour was acknowledged and responded to in that C1 was referred to Base 25 for counselling and to Spurgeons so that he could join a Young Carers Group. His school was made aware for the first time that there were problems with H1's mental health. At this point the Social Worker recommended that the case be closed without a Child in Need Plan or a Common Assessment Framework plan, on the basis that C1 had been referred to counselling and support services. This decision was supported by a duty manager.

16.61 On 7th September 2010 H1 was asked if he would stay on the ward and he refused. He was offered discharge with Mental Health Crisis Team support to which he agreed; however the Mental Health Crisis Team

was unable to offer such support on this occasion and V1 refused to agree, so H1 was discharged against medical advice.

16.62 At school 1, (hereinafter referred to as "School 1" to protect C1's identity), C1 agreed to attend for counselling sessions and to attend a Young Carers Group run by Spurgeons, but he declined to engage with Spurgeons. Members of Staff at the School 1 were asked to help monitor C1. He had joined School 1 in September 2010 and Children and Young People's Services had alerted School 1 to issues regarding his home life. There were regular Child in Need meetings that only commenced in 2011, to which representatives from School 1 attended. School 1 instigated interventions immediately as C1 commenced at the school, which included counselling, Young Carers Group, relaxation classes and one to one sessions with identified staff in school on an "as necessary" basis. School 1 was also aware of the issues with H1 and the School 1 had a photograph of H1 and had strategies in place should he be seen near or on the school premises. Throughout his time at the school C1 interacted well with staff and his peers and did not disclose information to suggest he was experiencing or witnessing domestic violence or that he was being bullied. There was a concern raised at Child in Need meetings by the school attendance officer about C1's attendance at school. This was discussed and monitored. The reason for his non-attendance and truanting was that C1 was bullied at school because his father was Iranian and had a history of periods of mental ill-health. Other pupils called C1 "a terrorist."

16.63 On 20th September 2010, School 1 made a referral to Base 25, an advice and information centre for young people between the ages of 11 and 25 years. C1 attended for 10 counselling sessions the last one being in May 2011, when he chose to end the counselling sessions of his own accord on the basis that he was moving to another school. During his time with Base 25 he was able to resolve conflicts with other

pupils and improve relationships with teachers. He did not, however, disclose any information about domestic violence within his family. As Base 25 had no information about domestic violence issues the matter was not raised with him. The focus of the counselling he received was around school issues. All Base 25 staff are trained in Domestic Violence issues and if these had been raised or suspected during the session, it is understood that a referral would have been made to Children's Social Care.

16.64 C1 was also referred to the Family Life and Emotional Health Project in September 2010 by his school. This project works with young people who are living in an environment where a parent or carer has a recognised mental health condition that is impacting on the young person. He was keen to join this group and attend its work programme. However his stay with that group was short lived and on 1st November 2010 he was discharged from that project as C1 was the only child that attended and the group collapsed. A note records that the Children and Young People's Services Social Worker was not informed.

16.65 During C1's time with Base 25, H1 was in hospital. Base 25 staff met V1 on one occasion but as she could not speak English, communication with her was described as 'very quiet'. There is nothing to suggest that an interpreter was considered and it appears that all communication was directly between C1 and Base 25 staff.

16.66 C1 disclosed that he was anxious about the bullying and that he was missing his extended family in Iran. Once C1 had made the decision to end the sessions with Base 25 he was offered an open ended invitation to return at any time he felt the need.

16.67 During the rest of September 2010, H1 continued to receive treatment in the community for his mental health problems. V1 described his

behaviour as being unpredictable but he didn't want to go back to hospital.

16.68 During October the Mental Health Mental Health Crisis Team had an almost daily contact with H1. His mood varied but V1 reported that he was not being violent towards her or C1.

November 2010 - December 2011

16.69 In November 2010 V1 attended at the UKBA offices in Croydon claiming asylum in her own right with C1 and H1 as her dependants. (H1 was very unwell at this time and had requested an inability to travel note from his GP) As she was on her own C1 was advised to return with H1 and C1 in the future to arrange for screening and fingerprints to be taken. In early December 2010 UKBA wrote to V1 informing her that asylum support was to stop on 19th December 2010 due to failure to report for the previous year despite UKBA's efforts. Five days later V1 attended UKBA Offices in Croydon to claim asylum. She confirmed that C1 was to be her dependant and she took a letter with her from the 'Mental Health Unit' in Wolverhampton confirming that H1 was in hospital and could not travel to UKBA offices for the asylum process. She was informed that the family would not get support unless she began reporting. She reported to UKBA on 21st December and support recommenced.

16.70 On 10th December 2010 C1 presented to his GP complaining about 'limb problems'. He was referred to hospital for X-rays which detected a minor finger fracture. He was treated and discharged.

16.71 On 17th January 2011 V1 made a second claim for asylum on the ground of being of Christian faith. She attended a 'substantive' interview, where she stated that the whole family had converted to Christianity in September 2009 and they had been baptised in June

2010. She said that she had to stay with H1 all of the time and if she left him alone he hurt himself. She said 'He hurts himself, he hurts us. He is not normal. This is difficult for me and my son'. This was the first time that UKBA had been made aware of the issue of Domestic Violence and their guidance and procedures require them to act more positively than they did.

16.72 On 20th January 2011 V1 was granted asylum for herself and her family for a period of 5 years. On 31st January V1 was informed by UKBA that she had been overpaid support allowance. However, within 4 days UKBA considered it uneconomical to claim back the overpayment from V1 and withdrew the issue.

16.73 V1, H1 and C1 were granted indefinite stay status by UKBA on 9th February 2011 and accordingly had to leave their address by 18th February 2011. They were advised to contact the local housing authority to request alternative accommodation.

16.74 Wolverhampton City Council received a referral stating the family were homeless due to their permission to stay being confirmed as indefinite. They were placed in temporary accommodation. The Council made a referral to Wolverhampton Homes, an Arm's-Length Management Organisation that manages properties on behalf of Wolverhampton City Council. V1 had been referred to Wolverhampton Homes due to the family being homeless and in priority need. The referral form received by Wolverhampton Homes indicated that H1 was to be included in the application initially but his name had been crossed out with a note saying 'can't apply at the moment'. The reason for this was not recorded. However, information provided in the referral included the fact that he had been sectioned under the Mental Health Act 1983 and that he was attending out patients' services.

16.75 During February 2011 H1's mental state was still a cause for concern. However, a risk assessment of H1 and the family conducted by Housing Options indicated a low risk of H1 causing harm to the family thereby enabling the family to take up residence in new temporary accommodation which had been made available for the family (hereinafter referred to as "House 1".

16.76 On 1st March 2011 V1 had complained to the Community Mental Health Team that H1 had threatened to kill her and C1 with a knife and V1 and C1 had fled the house in fear for their own safety. There was a multi-agency response to this incident, involving Housing, Children and Young People's Services, the Police and also mental health workers.

16.77 The Police were approached to gain entry into House 1 with a warrant under Section 136 of the Mental Health Act 1983. Initially the involvement of the Police was questioned by the Duty Inspector, but when procedures had been clarified the Police forced entry into House 1, but H1 was not present. V1 and C1 had by this time been rehoused overnight at a local hotel for their safety. The Police remained at the address to secure the door and whilst at House 1, H1 returned. Adult Social Care was requested to return to House 1 and they did so with a letter signed by a psychiatrist and a community psychiatric nurse. The letter indicated that due to H1's periods of mental ill-health and PTSD he was likely to be at risk of harming himself and also further suicide attempts.

16.78 The letter supported the warrant. H1 was taken to the local psychiatric hospital by ambulance under the terms of the warrant. A referral was made to the Children and Young People's Service's Team for an Initial Assessment which concluded that a strategy discussion could be initiated under Section 47 Children Act 1989. The result of that decision was that although the case had been referred for consideration of a

section 47 investigation and concerns were recorded as being substantiated, the case was transferred to another locality social work team for a further assessment in the Child in Need arena and for Child in Need planning rather than child protection. This was on the basis that it was believed that C1 was safe in the care of V1 whilst H1 was in hospital.

16.79 V1 contacted the housing authorities and informed them that she no longer wished for H1 to move House 2 with her.

16.80 On 1st March 2011 a CPN requested an urgent Mental Health Act Assessment of H1 under the Mental Health Act 1983 given H1's threats to kill V1 and C1 while holding a knife. Children and Young People's Services had re-housed V1 and C1, and H1 was prevented from having any contact with them. H1 was denying the allegation and he was admitted to hospital under Section 3 Mental Health Act 1983[11]. There was no referral to either adult safeguarding or child protection made by any agency to social services, albeit on 3rd March H1's risk was described as 'suicide and high risk to others'

16.81 On 3rd March 2011 H1's assessment completed while H1 was in hospital, identified that the risk of harm to himself and suicide was high. A week later H1 requested that he be allowed home to House 2. V1 was in support of this application but H1's application was refused as it would not be possible due to the risk that H1 posed to C1. When V1 stated that she wanted H1 home, it was considered that she did not appreciate the seriousness of the situation with H1's mental health problems and she was advised, that if he was discharged to supported accommodation (a hostel) then he should only have supervised contact with C1.

[11] Section 3 Mental Health Act 1983 allows a person to be admitted to hospital for treatment. Detention can be up to 6 months.

16.82 25th March 2011 saw the first comprehensively attended Child in Need Planning meeting, attended by representatives from Children and Young People's Services, School 1, housing services, V1, C1, a school nurse and a community psychiatric nurse. Information was exchanged well at this meeting with domestic violence being the key consideration. A list of useful actions was the result, which included the following decisions

- H1 should not be allowed to return home to House 2.
- His contact with C1 should be supervised and he should only have telephone contact with V1.
- A Social Worker should visit the family every six weeks and advise the Police accordingly regarding the assessed risk of domestic violence.
- C1 should attend counselling at school and engage with the Young Carers Group,
- V1 was to telephone the Police if H1 attempts to have direct contact with the family and the Homeless Service were to continue to support V1 and C1.
- If H1 were to be discharged it would only be when he was well enough and it would not be to the House 2 or to wherever V1 and C1 were living at any relevant time.

16.83 It was agreed at the meeting that if progress was not made the case should be 'stepped up' to one of child protection.

16.84 V1 made a request for C1 to move to a school closer to where the family were living, but as this was temporary accommodation it was decided that he should stay at his present school until they had a settled permanent address. It was also noted that some of his absences were due to him attending appointments with V1 in order to translate for her.

16.85 In preparation for his discharge from hospital, H1 was informed that he could not have contact with children so he could not live with his wife or his friend who also had children. His friend was to make enquiries within the Iranian community to see if anyone else could house him. The Police created a log on the command and control computer system indicating that any calls to the address of V1 were to be treated as urgent. This request had come from a Social Worker in the North East Locality Team, Children and Young People's Services.

16.86 H1 remained in hospital for another week as a voluntary patient while the issue of his accommodation was resolved. Plans were made for him to stay at a hostel on the grounds that he could see his wife but not his son. All of this time, reports suggest his mental state was improving and on 14th April 2011 he was described as being the 'best he had been' during a Multi-Disciplinary Team Meeting. On that same day, V1 reported that H1 had been following her in the local town. On this day Housing Options were contacted by C1's Social Worker who informed them that H1 was to be discharged and V1 now wished for him to return to live with her and C1.

16.87 During April 2011 V1 had contact with the Refugee and Migrant Centre (R&MC) and received support and advice mainly around benefits. A more detailed summary of the R&MC involvement is not possible as the worker she saw has since died and there are no records of her involvement.

16.88 On 21st April H1 was informed that he could only go to his extended family in Leicester if Children and Young People's Services there were content with the arrangements. On this date C1 reported that H1 was following him. On 28th April H1 was discharged from hospital but went

to Birmingham rather than Leicester, but there are no details as to with whom he went or where he went.

16.89 At the beginning of May 2011, representatives from School 1 attended another Child in Need (CIN) meeting. It was learned that H1 had been to the school recently. The School 2 were unaware of this until V1 told them. School 2 was issued with a photograph of H1 in order to raise the alarm should he attend the school again. C1 stated that he did not want to see H1 at school and the arrangements included the Police being informed if H1 did go to the school. The Head Teacher and H1's CPN held discussions about the safety of staff and students within the school, based on the information shared at the last CIN meeting.

16.90 On 11th May C1 had attended his tenth counselling meeting and he expressed a wish that he no longer wanted to go to any more such meetings.

16.91 On 12th May 2011 H1 was described by hospital staff as causing no concerns by his behaviour and on the following day he was discharged to a hostel/hotel in Wolverhampton.

16.92 On 14th May the Police received a call from the Ambulance Control to the effect that ambulance staff were trying to restrain a man who was a psychiatric patient. He had been banging his head and threatening to jump from a tall building. H1 was transported to Penn Psychiatric Hospital after being restrained and handcuffed. He was voluntarily admitted.

16.93 On 26th May 2011 another CIN meeting was held and well attended by professionals. It was stated that H1's mental health was improving extremely well due to changes in his medication. It was agreed that there was a risk regarding H1's potential behaviour problems when H1

was discharged from hospital again. The Children and Young People's Services Manager insisted that H1 should not be discharged from hospital to the family home. When he is discharged the meeting agreed that it should be a discharge to another address different from that of the family home. H1 was discharged to a friend's house.

16.94 However, by the beginning of June, V1 had changed her mind about H1 remaining in hospital. She wanted him to live with her and C1. On 2nd June 2011 there was a Multi-Disciplinary Team Meeting attended by BCPFT staff, V1 and an interpreter, which concluded that H1 was very much settled showing no evidence of PTSD or psychotic symptoms. V1 said that he had been home and she had seen him with C1 over the previous few days and that he seemed fine. H1 was advised not to go to House 2 without the permission of Children's Social Care.

16.95 The plan therefore, was to wait until Children's Social Care had decided about his contact with V1 and C1 and to make arrangements for H1's discharge the following week. The following day, 3rd June, the Care Coordinator e- mailed Children and Young People's Services outlining the plan and requesting agreement that H1 should return home. Children's Social Care agreed to attend the meeting the following week on 9th June, although there is evidence of differing understandings of the status of that meeting.

16.96 On 2nd June 2011 C1's Social Worker contacted Housing Options informing Housing Options that H1 was to be discharged from hospital as V1 now wished for him to live with her and C1. She also wanted H1 to be part of the application for housing. On 6th June the Housing Options Coordinator at Wolverhampton City Council informed H1's CPN that due to a previous incident where threats had been made to V1 he was unable to agree that H1 be housed as part of the family unit as the risk was perceived to be too great. H1 was therefore offered alternative

accommodation in bed and breakfast premises. H1 declined to stay there and moved back in with V1, a move that was completely unbeknownst to Housing Options until they were informed by the CPN on 9th June. The Housing Options Coordinator was quite clear that he disagreed with H1 being allowed to live in the family home, but he was assured by both the CPN and the Social Worker that V1 and C1 were not at risk at present and they would be closely monitored on a weekly basis. Housing Options were opposed to H1 staying at the home and withdrew support visits due to the risk posed to their staff. The family were, however, offered support from the office rather than having home visits.

16.97 On 9th June 2011 a Care Programme Approach meeting took place, attended by H1's CPN, a Registered Mental Health Nurse from Penn Hospital, a Social Worker from Penn Hospital and Social Worker from Children and Young People's Services and a Consultant Psychiatrist. At this meeting, according to the Children and Young People's Services IMR, the Social Worker and Manager expressed their disagreement with H1 being discharged as they felt it was too soon for him to go home. They even considered invoking child protection procedures. The Mental Health IMR however indicates that there was a consensus of agreement that H1 was fit to be discharged home. The Children and Young People's Services IMR state that H1's Consultant Psychiatrist stated at the meeting that H1 was 'no more likely to carry out threats to kill than other men in the population'. This is discussed fully in the analysis section of this Report.

16.98 The Children and Young People's Services IMR records this meeting and comments:

"The tension of this disagreement is not reflected in the letter sent by PH (H1's CPN) to the allocated Social Worker dated 15th June 2011.

The letter points out that the revised care plan of [H1] is attached and in the needs box on accommodation, the plan records:

Attempts to support [H1] and his family to gain long term accommodation will be made with the support of housing options and Wolverhampton Homes.

By the time this letter was received and despite the reservations of social care and housing [H1] had moved back in to the family home unbeknownst to the allocated Social Worker."

The Black Country Partnership NHS Mental Health IMR records a slightly different version of events about this disagreement. To quote from the IMR, it says:

> "There is a document in the Community Mental Health Team ("CMHT") notes which sets out the opposing positions of the BCPFT (as written by the care coordinator) and Housing Options. When this is read it is clear that Housing Options felt that they were the only people who thought the issue should be dealt with as an adult/child protection issue. Housing Options record several conversations with the Care Coordinator, one with the Consultant Psychiatrist and one with the Children's Social Worker. They report that in all of those conversations only the Children's Social Worker expressed any misgivings (but see next paragraph); the Consultant Psychiatrist challenged the basis of Housing Options' risk assessment. Housing Options regarded the decision as to whether this family could be reunited as "theirs".
>
> The Housing Options department says it was not invited to the discharge meeting. The Care Coordinator says that it was. There is no corroboration in the files to support either position.
>
> The reported misgivings of the Children and Young People's Services Social Worker are interesting in that she was part of the ward review and she supported the move home. Even if she had had second thoughts later there are child protection procedures she could have initiated to at least safeguard the child. This was

not done. Indeed in a letter to Housing Options dated 18th August 2011 (after [H1] had gone home) she states;

"The risks referred to are related to [H1's] presentation when he was unwell.....these risks are no longer present"

16.99 This letter was in support of a refusal of a particular house however that appeal was not upheld.

16.100 The house that the family moved into was described by the Care Coordinator as lacking basic amenities. There are records of attempts to obtain money to purchase such amenities. This work was only partially completed when the Care Coordinator fell ill and became absent from work. However, the welfare benefits officer continued to work on the case.

16.101 Over the next few days C1 was cause for concern at school. His attendance was only 78% and a pattern was emerging of his being absent on Thursdays and Fridays. Indeed, on 9th June he called the school to say that he would not be in school that day as V1 had to go to a meeting, presumably the Care Approach Programme meeting mentioned above

16.102 On 15th June 2011 a Children and Young People's Services Social Worker contacted a Safeguarding Review Manager for confirmation that the case was correctly designated as a Child in Need case. This was agreed but with the caveat that if the situation worsened the case would be re-designated as a Child Protection case. When interviewed by the IMR author, practitioners stated that they felt it was best to accept their discomfort about this decision and proceed by supporting the arrangements as all indicators suggested it was going well for the family.

16.103 On 17th June 2011, a planned home visit by a Children and Young People's Services Social Worker found V1 and C1 at home. H1 was

also there in bed. V1 explained that now H1 was taking different medication she was able to cope and felt very happy that he is home. C1 also stated that he liked his father being at home. It was noted, however, that the Social Worker did not see H1 during the visit. A similar situation occurred on 23rd June when H1 was not seen by the Social Worker, and again on 30th June 2011. On this latest occasion both V1 and C1 expressed a wish to move house nearer to their friends as they felt isolated where they were living and V1 said she wanted assistance to learn to speak English.

16.104 On 7th July C1's absence from School 2 was again a cause for concern. He had been absent for the last 3 days and C1 phoned the school himself to say that he had a doctor's appointment and he was choosing to stay away from counselling and relaxation classes. The following week V1 telephoned the school to say that H1 had a medical appointment and she was taking C1 with her. School 2 expressed the view that this could not be condoned. A few days later V1 called the school again to say that she had a doctor's appointment and would be unable to take C1 to school. An unannounced home visit by a Children and Young People's Services Social Worker and a senior colleague found H1 answering the door. This was the only time a Social Worker had met H1, but it is noted that he did not speak throughout the visit.

16.105 Two further multi-agency planning meetings convened by Children and Young People's Services took place on 18th August and 27th September. At both meetings, it is recorded, 'key partners attended and good progress against the plans and objectives was recorded'.

16.106 During September 2011 the family were informed that they were going to be evicted from the house as they could not pay the utility bills and were unable to claim benefits. V1 was offered and accepted an alternative property in Wolverhampton (House 3)

16.107 Later in September 2011 C1's behaviour in school was deteriorating. Another CIN meeting took place but V1 failed to attend. C1 was described as being easily led by peers and acting in 'a silly way'. However the following day it is recorded that C1's attendance had been 100% during that particular term.

16.108 V1 expressed her dissatisfaction about her new house, House 3, saying that it was substandard and also stated that she had not seen her Social Worker. Wolverhampton Homes attempted to try to resolve the problem by not moving them until suitable accommodation had been found. On 2nd November 2011 V1 signed for new accommodation, (House 4), the tenancy being in her sole name.

16.109 H1's mental health seemed to be stable during this period with no concerns from professionals or from V1. The family were offered financial support by Children and Young People's Services, and also successfully claimed Child Benefit with the assistance of the Refugee and Migrant Centre.

16.110 On 28th September 2011 H1 was seen for a review at his GP's surgery. He was with V1 and an interpreter, but no details as to who the interpreter was have been recorded. H1 was described as struggling, and apparently the family had been in contact with Community Psychiatric Nurse but they had not yet been seen. The GP noted that she would 'chase the CPN up', which she did the following day.

16.111 Another CIN meeting was held on 21st November 2011 and H1 attended with V1 and a friend who acted as an interpreter. A Social Worker managed to ensure a crisis loan was arranged for the family for the following week. Another new house (House 5) had been allocated and because of that V1 made an application for C1 to move schools.

16.112 On 6th December 2011 both V1 and H1 attended with C1 at a pre-admission meeting at the new school (School 2). It is recorded that all of the conversations were between C1 and H1 and there was nothing

from V1. School 1 had not flagged any safeguarding issues to the new school so the School 2 was unaware of the previous mental health issues with H1 and the problems C1 had been having at School 1, or Children and Young People's Services involvement with the family.

16.113 On 21st December 2011 the records of a Children and Young People's Services supervision session between a supervisor and an allocated social worker, records indicate that V1 was coping well, H1's mental health was stable and Adult Mental Health Services continue to monitor his medication. There was a discussion about the possibility of closing the case in so far as Children and Young People's Services were concerned after a meeting with all other professionals.

16.114 On 22nd December the Community Mental Health Team contacted V1 by telephone. She stated that H1 did not live at that address any longer and as she could not communicate in English, she put the phone down. It appears nothing more was done about this incident.

16.115 That was to be the last contact any agency had with V1. On 29th December an ambulance was called to the family home after C1 had run to a neighbour, covered in blood saying that H1 had killed V1 Police attended and found V1 with major stab wounds and also H1 with knife wounds to his stomach.

16.116 Police attended and arrested H1. He has been charged with the murder of V1. C1 was made subject of a care order and has been placed in foster care. H1 is awaiting trial at Wolverhampton Crown Court.

17. Analysis and recommendations.

17.1 Government Guidance[12] requires that:

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

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

17.2 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. V1, H1 and C1 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 a London based Iranian and Kurdish Women's Rights Organisation (IKWRO). It may be useful, therefore, to illustrate various issues about the Iranian culture, especially concerning women, which have been learned from IKWRO and other research.

17.3 Iranian Cultural context

Two members of IKWRO travelled to Wolverhampton and gave an in depth briefing about the culture and lifestyle of Kurdish families in Iran, the main aspects of which are reiterated here.

17.4 In relation to Domestic Violence, it is seen as an acceptable part of Iranian/Kurdish culture. It is a male dominated society with women seen as people who live by the rules of the husband. Domestic Violence is seldom reported. The Police in Iran offer very little assistance to women who complain about domestic violence. If the occasion arises where a woman does complain it is seen that she brings shame upon the family. Other women within the community will ostracise any women who complains or reports domestic abuse and very often women will hide the truth from others, including authorities, saying the marriage is fine rather than complain and bring shame to their family.

17.5 In relation to the husband's position in the marriage, it is his duty to provide shelter and food for his family, and it is shameful for him to be materially dependent upon his wife in any way.

17.6 Being mentally ill as an Iranian brings with it a certain stigma. There is a possibility that the person will be considered mentally ill for life and have little interaction with others. The stigma may also be extended towards the person's family and children. If the mentally ill person is the husband in the family, the wife will be held responsible for his illness, being considered a 'bad wife' by not only the husband's family but also her own family and the local community. In these circumstances the wife will receive little support from the husband's family and will be considered incapable. It is expected that the wife would look after her husband within the family home rather than him being admitted into hospital.

17.7 The wife would be seen as the carer of her husband, but she would have difficulty in managing and monitoring his medication and it is therefore difficult for her to meet her responsibilities as a carer. There is no voluntary sector in Iran from which support and guidance could be sought and the authorities such as the Police are viewed with fear and suspicion.

17.8 As far as male friends are concerned, a woman would not have male friends outside of her husband's social circle. She would most definitely not have any male friends of her own.

17.9 IKWRO also stated that any male interpreter would predictably reinforce the views as described from the husband's stance.

17.10 These facts are support by Sanderson[13] who states:

'Family honour (izzat) and shame (sharam) constrain [Asian] women in particular from contacting the Police or Children and Young People's

[13] **Counselling Survivors of Domestic Abuse 2008 JK Publishing page 32**

Services, or separating from their partner. Many Asian women believe they have no safe option or support from family and community when leaving; they stay to prove that they are a dutiful wife. This is compounded by pressure from the extended family to conform to strong traditional roles.'

17.11 Other research shows that the culture of domestic violence in Iran is somewhat supported by the laws of the land. The Iranian Code of Criminal Procedure articles 42,43, and 66, is intend to prohibit violence in the form of kidnapping, gender-based harassment, abuse of pregnant women and crimes against rights and responsibilities within the family structure, but due to cultural and political culture the law does not protect women, prosecute their abusers or provide services to the victim.[14] The Iranian Government is opposed to the development. of refuges for victims of domestic abuse[15]

17.12 There is a significant disparity between treatment of men and women in marriage and divorce;

- Men may marry up to 4 girls and women. They may divorce a woman when they choose.
- Women - It is very difficult for women to divorce men. Often they are forced to stay in abusive marriages. They may lose custody of their children that are older than age 7 to their husband and father-in-law. Since a woman's testimony is only worth half of a man's testimony, it is very difficult to prove domestic abuse.[16]

17.13 Economically, divorce is rarely an option for Iranian women because they are financially dependent upon their husbands. With divorce, the husband has custody of the children and can prevent the woman from

[14] **Moradian, Azad. Domestic Violence against Single and Married Women in Iranian Society. Tolerancy International. September 2009.**
[15] **Esfandiari, Golnaz. World: Violence Against Women -- In Iran, Abuse Is Part Of The Culture. *Payvand Iran News.* 26 Nov. 2003**
[16] Moradian, Azad. Domestic Violence against Single and Married Women in Iranian Society. Tolerancy International. September 2009

seeing her children, a paradigm that prevents most women from talking to their family about abuse, and extremely unlikely to pursue any remedy with the government.[17]

17.14 One also has to consider the culture issues around mental ill-health amongst the Iranian Kurdish population. A study into the stigmatisation of mental ill-health in Iran; Internalized Stigma of Mental illness in Tehran, Iran by Helia Ghanean, Marzieh Nojomi, and Lars Jacobson of the Division of Psychiatry, Umeå University, Umeå, Sweden and Iran University of Medical Sciences (IUMS), Tehran, Iran[18] found that it is possible that discrimination against the mentally ill differs in an Islamic culture where mental ill-health and other ailments are, to some extent, considered to be due to the will of God and therefore untreatable rather than being something that is caused by the person's background or experiences and therefore treatable. They also found that many expressed a concern that a diagnosis of a mental illness would cause problems in and for their family. Many told that they tried to conceal the fact that they were mentally ill from their family and from those close to them in order to avoid problems for themselves, their relatives, and those near to them. Another issue was the feeling that mentally ill people are considered violent and dangerous.

17.15 The family in this review were all very vulnerable in their own rights. H1 had witnessed his friend being killed, suffered from PTSD as a result and was becoming increasingly dependent upon mental health services for stability. His behaviour was unpredictable, and susceptible to sudden episodes of violence or threats of violence.

[17] Esfandiari, Golnaz. World: Violence Against Women -- In Iran, Abuse Is Part Of The Culture. *Payvand Iran News.* 26 Nov. 2003

[18] Internalized Stigma of Mental illness in Tehran, Iran Helia Ghanean, Marzieh Nojomi, Lars Jacobson Division of Psychiatry, Umeå University, Umeå, Sweden and Iran University of Medical Sciences (IUMS), Tehran, Iran Stigma Research and Action, Vol 1, No 1, 11–17 2011. DOI

17.16 V1, a wife and mother, had tried to conform dutifully to the requirements of the Iranian culture, to be a good wife and mother to her son, and had constantly attempted to support her husband even in the face of severe domestic abuse, threats of violence with knives and isolation from any assistance whatsoever. It appears that she continually tried to protect her family from the social stigma and stress due to her husband's mental health problems.

17.17 C1, a young boy who was growing up in a household where there were undoubted threats of violence, sometimes with knives, against V1 and possibly C1, and from which V1 and C1 had had to flee their family home on more than one occasion possibly in fear of their lives. Add to that, C1 not only witnessed H1 threatening and attempting suicide by various methods and on numerous occasions but he had to take full responsibility for both parents by ringing for Police and Ambulance services. He was also bullied at school by fellow pupils calling him a terrorist and teasing him over his father's mental ill-health.

17.18 In addition to these issues, they were all in a foreign country, with little experience of the English way of life systems or services as well as not being familiar with or capable in the English language. They were also all isolated from any extended family members.

17.19 Moghissi[19] states, 'To an uprooted and displaced people, the old, familiar relationships within the family, that is, clearly-defined sex-roles, gender power and authority, represent the lost and the desired past which was dramatically different from the present.' He goes on to say' an inevitable result of life in exile, struggles between men and women and between parents and children emerge and are fought out under the banner of preserving ethnic and racial identity and cultural survival.'

[19] Away from home: Iranian women, displacement cultural resistance and change. Haideh Moghissi. Journal of Comparative Family Studies (Spring 1999): p207

Analysis of Agency Involvement

17.20 The analysis of the agency's involvement raises several issues concerning the domestic homicide but also issues from a child protection view point. It is the view of the Panel that there exists a significant link between the two sets of issues

17.21 There are a number of areas of this review report that the Panel considers require highlighting and commenting upon. Each one will be dealt with individually.

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

17.22 Examining the IMRs submitted in this case there is evidence of a lack of referral to other agencies when disturbing situations arose. This includes referrals of Domestic Abuse, Adult Safeguarding and Child Protection concerns.

17.23 The family first came into the UK in September 2008 and by October 2008 it was recorded that H1's solicitor informed the UKBA that he had mental ill-health problems and asked to reschedule an interview H1 had arranged with them. He attended the following day and was considered too ill for the interview. A UKBA officer contacted H1's GP who was already aware of his mental state and the history behind it. In fact the GP indicated that she had seen H1 on a number of occasions before and considered his illness to be genuine. On 13th January 2009 H1's GP referred him to the BCPFT stating that H1 had threatened V1 and C1, threatened to kill himself and the assumption was that the threats were real. Despite that being the case neither the GP nor the BCPFT made any referral to Children and Young People's Services, Adult Safeguarding or any other agency. There were at least child protection issues to be considered, irrespective of any risk to V1. The outcome of

the referral was that H1 was deemed suitable for a referral to the Home Treatment Team meaning that H1 would return home to where V1 and C1 were living. H1 was later assessed as being at risk of self-harm and experiencing hallucinations, but not a risk to V1 or C1.

17.24 In May 2009 UKBA received a letter from H1's psychiatrist commenting that if his treatment was stopped he would be a risk not only to himself but also to V1 and C1 and that his serious disorders carry considerable suicide risk and with it such seriously impaired judgement that it would place his family in jeopardy. Again neither the UKBA nor Mental Health considered these factors sufficiently warranted a referral to other agencies regarding the safety of V1 or C1. Matters were dealt with in respect to his mental health condition in isolation of anything else although these were not properly progressed.

17.25 On 14th August 2010 C1 reported that H1 was trying to kill himself at home. Police attended and H1 was arrested under Sec 136 Mental Health Act 1983. A later assessment at the Police station deemed him suitable to continue home treatment. There was no referral to other agencies by the Police regarding the safety of V1 or C1. Within the following days V1 requested that H1 be admitted to hospital as she was very concerned about the safety of herself and that of C1. H1's condition had deteriorated. Again a Mental Health Act Assessment was made and he was deemed suitable for the continuance of home treatment. V1 was advised to call the Police if she was further concerned.

17.26 Within two weeks C1 called the Police again. H1 had not taken his medication and C1 believed that H1 was trying to commit suicide. On this occasion there was a referral to the Police Child Protection Unit as well as the Vulnerable Persons Unit. V1 and C1 had left the home address before a crisis worker arrived. This was the first occasion that

proper referrals were made regarding child protection and domestic violence.

17.27 In January 2011 V1 was still pursuing her application for asylum with UKBA. She attended at an interview where she stated that she had to stay with H1 all of the time and if she left him he would hurt himself. She added, 'He hurts himself, he hurts us. He is not normal. This is difficult for me and my son.'

17.28 No referrals were made to either Adult Safeguarding or Child Protection by Children and Young People's Services in respect of the events of 1st March 2011 when H1 threatened his family with knives, because Children and Young People's Services were involved with arranging alternative accommodation for V1 and C1

17.29 UKBA has domestic violence protocols in place but despite this no referral was made about the allegation by V1 or the allegation of child abuse. Children and Young People's Services should have been informed of this serious allegation. The UKBA IMR states: 'The case owner did not respond to this which was not appropriate'.

17.30 While the UKBA is not a direct provider of services to children, it plays a part in identifying and responding to the welfare needs of the children with whom it comes into contact. Section 55 of the Borders, Citizenship and Immigration Act 2009 imposes a duty upon the UKBA to take account of the need to safeguard and promote the welfare of children in discharging its functions. Statutory guidance *Arrangements to Safeguard and Promote Children's Welfare in the UK Border Agency*[20] sets out the agency's responsibilities.

[20] Every Child Matter- Change for Children Statutory guidance to the UK Border Agency on making arrangements to safeguard and promote the welfare of children 2009 UKBA DfCSF

17.31 Guidance indicates clearly that these circumstances should have been an indicator of Domestic Violence ("DV") and UKBA policy clearly states what onward referrals should be made. The case owner at the time is no longer in that role.

17.32 The UKBA acknowledge the short coming of not making referrals when there is clear information about domestic violence and issues around safeguarding of children. It has made recommendations in its IMR regarding refresher training for all officers in respect of domestic violence referrals

Recommendation No 1

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

Wolverhampton Domestic Violence Forum

17.33 Wolverhampton Domestic Violence Forum (WDVF) is a charity that has been in existence since 1997. It is a membership organisation of approximately 50 different agencies across the statutory, voluntary and private sectors in Wolverhampton, and acts as a focus for information and advice on domestic violence. The aims of the charity are to encourage agencies to work together to stop domestic violence, to ensure the safety and empowerment of victims and their children, and to bring perpetrators of domestic violence to justice.

17.34 To meet these objectives, WDVF through its Executive Board develops, agrees, and performance manages a multi-agency city wide strategy and action plan. WDVF raises awareness of domestic violence with the public and with agencies, conducting institutional advocacy encouraging local agencies to adopt international best practice in managing domestic violence. In the last two years, and through the Safer Wolverhampton Partnership and Safeguarding Children's Board, WDVF was instrumental in setting up and hosting a co-located multi-agency domestic violence team. This team continues to conduct twice or three times weekly joint risk assessments and action planning for victims assessed to be at high risk of serious harm or homicide, and for all cases reported to the Police where children or pregnant women are mentioned for a Barnardo's Screening Tool Risk Assessment.

17.35 The co-located team includes the WDVF Strategy Coordinator/Manager, and seconded staff from other agencies on a full and/or part-time basis including an Adult Protection Police Officer, a Senior Housing Officer, an Independent DV Adviser from The Haven Wolverhampton, WDVF's Criminal Justice Independent DV Adviser, WDVF's Independent Sexual Violence Adviser, a Child Protection Police Officer, a Children and Young People's Social Worker, a Safeguarding Children's Specialist Nurse, and a Tenancy Sustainment

Officer from the City Council. The team also uses Language Line translation and interpretation services routinely.

17.36 Based on the criteria for referrals, from its inception in 2010, the DV Co-Located Multi-Agency team should have received this case as both a DV high risk victim referral and on the basis that a child was affected by domestic violence, in addition to a Multi-Agency Risk Assessment Conference referral. Opportunities were missed to refer this case to these risk assessment and safety planning meetings. It is not known whether V1 would have engaged with an Independent DV Adviser, but the Panel considers that this was a further missed opportunity for a specialist to identify the true risks that V1 and C1 were subjected to, to provide V1 with options that were available to her including crisis intervention, access to refuge accommodation and support locally or further afield, and to put in place multi-agency safety plans and specialist support.

17.37 There is no evidence that any agency, especially the GPs involved with V1 and the Mental Health professionals involved with H1 thought to make contact with WDVF. The Panel considers there were lost opportunities to provide support to both V1 and C1.

17.38 There is evidence throughout this review that the intervention of numerous agencies into this family's problems were focused on H1's mental ill-health and therefore dealing with his mental ill-health was assumed to be the remedy for the family's problems. The latter was not the case and the family's problems were far more complex than just H1's mental ill-health.

17.39 There is nothing to indicate that at any time during H1's treatment for his periods of mental ill-health was there any consideration that V1 and C1 were being subjected to domestic violence, irrespective of the fact

that there were allegations of H1 threatening himself and both V1 and C1 with knives, comments V1 made about 'he hurts us' and V1 and C1 having to flee from the household in fear for their lives. It appears neither V1 nor C1 was ever questioned in any depth about the impact H1's behaviour was having on their lives.

17.40 Itzin[21] demonstrates this clearly when she says,

'One of the major challenges to achieving appropriate responses to sexual and domestic violence and abuse within the health sector has been the mistaken perception that these are not health issues, that they are social problems….. All health professionals, as a part of their basic pre-registration training, are introduced to the basic epidemiology of violence and abuse needs to become an integral part of the basic history-taking that is expected wherever any of the signs/symptoms that are associated with violence and abuse occur. Without this, important opportunities for prevention and early intervention will be lost'

Risk assessments

17.41 This case has illustrated that there was a distinct lack of consistency in the assessment of risk across the agencies. There was no active means of drawing together individual agencies' risk assessments in order to obtain a holistic risk assessment of the issues affecting H1 or the risk he posed to others. There was no consistent risk assessment language that pertained to all agencies.

17.42 In this case H1 was considered to be of such a risk to himself that he was treated as an inpatient within the Mental Health Service on numerous occasions. Each time he was treated and given medication. Eventually his mental health improved and he was assessed as being of low risk to himself and he was discharged. Upon returning home with

[21] Domestic and Sexual Violence and Abuse – Tackling the health and mental health effects. Itzi,Taket and Barter-Godfrey Routledge 2010 page 181

his family his mental ill-health would frequently deteriorate and another episode of high risk behaviour would ensue, resulting in another call to the Police and a further admission for assessment and/or treatment.

17.43 In a very helpful addendum to the Mental Health IMR regarding Risk Assessment Procedures, the IMR author points out: 'The Royal College of Psychiatrists suggest in their 2008 report that there should be a nationally agreed risk assessment framework that is validated against the populations in which it is used and is informed by the "evidence base" however it is unsure where the origin for this evidence base is. They found that most Mental Health Trusts were using tools that had been developed locally' The IMR author adds, 'that any tool is merely an aid to professional judgement and possibly their greatest utility is focussing the mind on what the risks actually are.'

17.44 The addendum report is clear that risk assessment for H1 was based on his risk of self –harm or even suicide. To quote the report 'When the risk to non-family members were assessed the evidence was almost non-existent.' However, reference is then made to H1 assaulting a fellow patient and staff whilst in hospital where Police had to be called. Apart from those incidents there is nothing to show that he had ever assaulted or threatened a non-family member.

17.45 With regard to his family the IMR report makes a distinction between H1 threatening his wife and *'indulging in behaviours that could be seen to carry a threat like playing with kitchen knives'* as opposed to threatening them with knives. It goes on to state that there was no evidence of him carrying or threatening with knives whilst he was stable and, '*The history of the contact between the family and mental health services is such that the family had no difficulty (usually via a family friend) in alerting the mental health services of a deterioration in H1's mental health and the chronology shows that the mental health services always responded quickly. The view was that we were protecting his family from harm by assertively and promptly treating H1 and that the*

family's stability was threatened when he was unwell, when he recovered there was always a desire to be reunited.'

17.46 However the report goes on to say, '*Consequently the view of mental health services could be summarised by saying he was a high risk when mentally unwell and a low risk when stable and that he could move from one of these states to the other fairly rapidly.'*

17.47 As far as the Police are concerned, guidance to assessing risk in Domestic Violence cases is set out in the National Police Improvement Agency (NPIA) Guidance on Investigating Domestic Abuse[22]. Among the issues used to establish risk factors for the 'suspect are:

- Previous assaults committed by the 'suspect'
- Escalation and severity of violence including use of weapons
- Child abuse including where the child has been threatened with harm
- Threats or attempts to commit suicide
- Suspects psychological and emotional abuse of the victim including dominance or isolation of the victim (cultural issues)
- Suspect misuse of alcohol or drugs or mental health problems

17.48 Risk factors relating to the victim include:

- Victim's perception that they are at risk
- Social isolation and particular vulnerability of the victim

17.49 In both of these lists above there are factors that match the circumstances of this case irrespective of the mental state of H1, whether he was being admitted to hospital for treatment or being discharged following treatment. For periods of time during the timescales outlined in the terms of reference for this review, V1 and C1 were both at a high risk of harm from H1 and a more proactive

[22] Guidance on Investigating Domestic Abuse NPIA 2009 page 36-39

approach to that risk should have been taken. Additionally H1 was at risk to himself.

17.50 It is the Panel's view that had there been a collation of all of the different risk assessments in a holistic overview H1 would have been identified as posing a high risk of harm to himself and V! and C1 for the majority of time.

17.51 On each occasion that the Police were involved with H1 and his family, a more thorough investigation into the family circumstances should have been made and a DASH risk assessment process instigated.

17.52 West Midlands Police DASH Policy[23] indicates that by using the process as outlined officers would be able to obtain '*information about the circumstances of the victim, information about the perpetrator, the history of any abuse and information about any children/dependants who may be affected by the abuse. Information to help identify risk may also come from Police information systems, witnesses, other agencies and people close to the perpetrator and victim.*'

17.53 The policy goes on to say that, if officers do not complete the DASH risk assessment form the Public Protection Unit (PPU) staff will not be aware of the case and therefore will not be able to risk manage that victim and any children within the household.

17.54 Such was the situation in this case. The Police IMR states,

'[V1] was never considered to be a victim of domestic abuse by Police and was not assessed using the DASH assessment tool. It would appear she was seen primarily as the wife of a vulnerable man and her own safeguarding was overlooked.'

17.55 The Police IMR also states:

[23] West Midlands Police DASH Policy – Domestic Abuse, Stalking and Harassment and Honour based Violence 2011

'V1 told officers that she was capable of 'talking' her husband down when he reached a crisis point. However, the incidents described in the summary clearly show that sometimes she was not. On occasions she had to flee to save herself and C1 from physical harm. Had this been identified as domestic abuse it should have led to further investigation of what had occurred. It is quite possible that criminal offences were part of the events as they unfolded. By not addressing the questions on the DASH forms officers did not discover the full emotional impact of dealing with H1's mental ill-health. Nor were the clear warning signs identified and shared appropriately with other agencies that could have monitored the evolving risk.'

17.56 Housing Options had significant involvement with H1 and his family. H1 was re-housed on a number of occasions and Housing Options was aware of his mental ill-health problems. It was also aware of the comment that H1 had made threats towards V1 and C1 with a knife and that he would 'take them to the grave'. When asked if policies regarding domestic abuse risk assessment and risk management had been in place in this case, the answer was:

> 'No - as V1 was never identified as a victim of domestic violence', and 'all risk assessments were carried out in relation to H1's mental health that pointed towards his risk of self-harm',

and later in the IMR:

> 'the initial assessment made by Housing Options stated that H1 posed very little risk to V1. He however posed more risk of self-harm hence they were accommodated as a family unit.'

17.57 It is interesting to note that on 6th June 2011 the Housing Options Coordinator informed H1's Community Psychiatric Nurse (CPN) that due to a previous incident where threats had been made to V1, H1 could not be considered as part of the family unit due to the risk being too great. It was also stated that Housing Options were withdrawing

support visits due to the risk posed to staff but support would be offered from the Housing Options offices.

17.58 The family were accommodated in several different locations. There was an initial interview and risk assessment conducted on 15th February 2011 followed by temporary accommodation on 18th February. V1 was later interviewed and her application accepted as a priority homeless family and an offer on alternative housing was made into which they moved in October 2011.

17.59 There is no indication that Housing Options identified the risk to V1 or C1 in any formal risk assessment of their own but later recognised this following information from other agencies. However, they did not make referrals to Domestic Violence, Child Protection or Adult Safeguarding Services.

17.60 H1, V1 and C1 had the same GP, who first saw H1 in 2008, when issues around H1's friend being killed were first known. H1 was prescribed medication that continued throughout the time H1 was registered with that GP. In January 2009 H1 disclosed to his GP that he had feelings of wanting to strangle himself, V1 and C1 and was feeling helpless. He wanted assistance as he feared he would act impulsively.

17.61 Throughout the following year H1 reported feeling anxious, low, and depressed and there were many occasions that V1 expressed fear for her own safety and that of C1. She also feared that H1 would commit suicide. Three months before V1's death, the GP saw H1 and noted 'the patient struggling'. There is no record of any risk assessment in relation to V1's or C1's safety. Again, the involvement of the GP was purely regarding the mental health issues of H1 without any consideration of the wider familial issues. There is no record of a referral to Children and Young People's Services regarding any child

protection or domestic violence concerns, and no referral to Adult Safeguarding.

17.62 In June 2012 the RCGP issued guidance[24] for GPs in relation to domestic abuse to the effect that each surgery should have a designated person responsible for coordinating domestic abuse support services and referrals, establishing a domestic abuse care pathway by identifying the signs and symptoms of such abuse and requiring training for both health and non-health staff including GPs.

17.63 On 9th June 2011 a meeting took place on the ward of the psychiatric hospital where H1 was a patient. It was a multi-agency meeting but from the BCPFT IMR it appears that there is some confusion as to whether the meeting was a Care Programme Approach meeting or a 'ward round.'

17.64 Children and Young People's Services Social Worker agreed with the decisions of the meeting. The Panel noted that there are some inconsistencies between the IMRs of C&YPS and BCPFT. This only became apparent during an IMR author's interview with a member of staff within the review process.

17.65 In any event that meeting included a risk assessment of H1's suitability for discharge from hospital. The BCPFT IMR points out that the Trust has its own comprehensive risk assessment tool so DASH is not used.

17.66 The IMR goes on to state,

'It is commonly held within mental health services nationally that there is no universally agreed tool to use for risk assessments. Nor can any

[24] Responding to domestic abuse: Guidance for General Practices. Royal College of General Practitioners, CAADA et al. June 2012

tool substitute for professional judgement but they can and do support such judgements and ensure that the risk assessment has all the relevant details recorded. Wolverhampton's tool allows the recording of the subject both as a potential victim and perpetrator of risky behaviours to themselves or others.'

17.67 The guidance on Care Programme Approach[25] on Risk Assessment and Management indicates:

> **'**Risk assessment is an essential and on-going element of good mental health practice and a critical and integral component of all assessment, planning and review processes.'

and

> 'The philosophy underpinning this framework is one that balances care needs against risk needs, and that emphasises: positive risk management; collaboration with the service user and others involved in care; the importance of recognising and building on the service user's strengths; and the organisation's role in risk management alongside the individual practitioner's. It emphasises the importance of the assessment of dynamic (changing) risk factors, as well as the more well-understood static ones. Where appropriate, criminal justice agencies (particularly the Offender Manager Service (sic) using the OASys system and the Multi-Agency Public Protection Arrangements) can provide essential support to risk assessment in relation to some offenders and should be consulted as part of a holistic assessment'.

17.68 Both of these quotes indicate two necessities for the exchange of information from outside the mental health sphere, by first 'all the relevant information recorded' and second by encouraging collaboration with others involved in care. The fact that the mental health risk

[25] Refocusing the Care Programme Approach – Policy and Positive Practice Guidance D of H March 2008

assessment was carried out with no involvement from other agencies restricted the exchange of '*all relevant information'.* The Care Programme Approach mentions a link with the Multi Agency Public Protection Arrangements (MAPPA) process, which is inextricably linked to MARAC, where the exchange of all relevant information would have been achieved.

17.69 There was no evidence of a multi-agency risk assessment meeting or a meeting under the MARAC procedures. As Base 25 IMR points out,

> 'If there had been any multi-agency risk assessment conferences (i.e. MARACs) we were not aware of them.'

17.70 From Housing Option's position, they were not invited to the meeting on 9th June**.** The formal risk assessment that was conducted by Housing Options was not a DASH risk assessment – it was Housing Option's own generic risk assessment. There is an inconsistency here in that in light of further information about this case, Housing Options acted against their single written generic risk assessment, and actually tried to act appropriately in response to their understanding of the real level of risk. This resulted in disagreement and conflict with the Mental Health Services. Housing Options were acting to protect the family from the known threats of violence despite the fact that they didn't use domestic violence terminology and triggers, whilst Mental Health Services appeared to focus only on their patient and not their familial context and the ensuing protection/ safeguarding issues. Housing Options deserve positive recognition for this.

17.71 The Children and Young People's Services' IMR helpfully points out that risk assessments differ across agencies and makes the suggestion that the Barnardo's Domestic Violence Risk Identification Matrix (DVRIM) would be a more appropriate risk assessment tool to be used

by all agencies. Such a model is successfully used in London Safeguarding Children Boards.

17.72 Indeed a Multi-Agency Screening Tool Protocol [26]was introduced across the West Midlands in August 2009, based on the Barnardo's Multi Agency Domestic Abuse Risk Identification Threshold Scales which assess the risk to children and unborn children resident or normally resident in households where domestic abuse occurs.

17.73 The aims[27] of the Barnardo's Joint Screening Tool are:

- To safeguard children and young people who are resident in domestic abuse situations; and
- To enhance the ability of Police, Children's Social Care and other multi- disciplinary partners to identify the level of risk to children and young people in domestic abuse situations;

  If the concerns are founded then the following procedures (Sec 17 and Sec 47 Children's Act 1989 processes by which children in need and those at risk of significant harm are safeguarded) will be followed in relation to child protection'.

17.74 Had a Joint Steering Meeting been held, as suggested in the Police IMR, it would have had the effect of:

- ensuring timely sharing of information between agencies and promoting the wellbeing and safety of C1 who was being affected by the domestic abuse; and
- jointly assessing the risk/potential risk or safeguarding issues for C1 and responding to his needs being affected by the domestic violence and abuse within the Common Assessment Framework (CAF) and the assessment framework.

[26] Multi-Agency Screening Tool August 2009 All West Midlands LSCB
[27] West Midlands Joint Protocol Child Protection Enquiries and Related Criminal Investigations Sept 2011 All West Midlands LSCB

17.75 The Barnardo's Risk Assessment screening tool was already used at the co-located multi-agency team that WDVF hosts – staffed by the Child Protection Police Officer, a Children and Young People's Service's Social Worker, and Safeguarding Children's Nurse meeting 2-3 times each week to review all Domestic Violence cases referred where children or pregnant women are mentioned. Invariably, cases were referred only be the Police. Case lists are circulated in advance and High Risk Independent DV Advisers (IDVAs) feed in information on these cases. The team members also attend the fortnightly MARACs. In this case the Police declined to refer this case to the multi-agency team – in line with their decision NOT to refer this case to MARAC. Procedurally they should have done both but they did neither.
This was an opportunity missed

Recommendation No 4

Safer Wolverhampton Partnership to ensure the relevant NHS Commissioning body has disseminated the guidance 'Responding to Domestic Abuse' from 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

Multi-Agency Public Protection Arrangements (MAPPA)

17.76 MAPPA Guidance[28] sets out the criteria for an offender being considered for MAPPA supervision and introduces three categories;
Category 1 offenders – Registered Sex Offenders
Category 2 offenders – Violent offenders sentenced to 12 months custody or more
Category 3 offenders – (other than dangerous offenders).This could be offenders who have previously been managed at MAPPA level 2 or 3 under category 1 or 2 and still pose a risk of harm or other persons who, by reason of offences committed by them (wherever committed) are considered by the Responsible Authority to be persons who may cause serious harm to the public.
By virtue of H1's lack of previous criminal convictions, he did not meet the criteria to be referred to MAPPA, so could not be properly referred.

[28] MAPPA Guidance 2012 Version 4 ACPO – Ministry of Justice – National Probation Service- HM Prison Service 2012

Multi Agency Risk Assessment Conference (MARAC)

17.77 A MARAC is a Multi - Agency Risk Assessment Conference that was first introduced in Cardiff in 2003 as part of a concerted approach by South Wales Police and partner agencies to improve their response to domestic abuse. The focus of a MARAC is the protection of the high risk victims of domestic abuse and a meeting is convened to share information to enable an effective risk management plan to be developed. As from 1st July 2012 Co-ordinated Action Against Domestic Abuse (CAADA) have introduced a MARAC development programme across the UK with the introduction of MARAC Development Officers whose role it is to provide one-to-one support to MARAC Chairs, Coordinators and IDVA Service Managers, as well as being a single point of contact for local Domestic Abuse and Violence against Women and Girls Coordinators.

17.78 The aim of the MARAC[29] is 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.

17.79 Each MARAC will have independent Domestic Violence Advisors (IDVA) who undertakes the assessment of the risk posed to the victim.

[29] MAPPA Guidance 2009 Version 3 National MAPPA Team /National Offender Management Service Public Protection Unit ACPO – Ministry of Justice – National Probation Service- HM Prison Service 2009

In order to achieve this, the CAADA-DASH (Co-ordinated Action Against Domestic Abuse – Domestic Abuse, Stalking and Harassment) Risk Assessment Tool is used. If the risk is high the case will be referred to MARAC which consists of representatives from agencies including Health, Police Probation, Children and Young People's Services, Housing, Adult Services, Support Services, Women's Aid and others as appropriate.

17.80 The MAPPA Guidance[30] of 2012 states.

> "The focus of MARAC is the protection of those victims who are at a high risk of serious harm from domestic abuse. A meeting is convened to share information to enable an effective RMP to be developed".

17.81 Links are made with the public protection for safeguarding children and safeguarding vulnerable adults and if necessary, Multi--Agency Public Protection Arrangement (MAPPA)

17.82 Since September 2006 in Wolverhampton there has been a MARAC that has met every two weeks to discuss high risk cases. In addition to MARAC, WDVF has been instrumental in developing international best practice in Wolverhampton by co-locating some services around Domestic Violence. An Adult Protection Police Officer, Senior Housing Officer, the Haven's High Risk IDVA and the Criminal Justice IDVA meet 2 x per week to discuss and manage DASH high risk victims (in line with the Cardiff Women's Safety Unit model) in between MARACs on the basis that for victims at high risk of serious harm or homicide there is an urgent need for a MARAC. Again, this case was not referred by the Police to this meeting.

[30] MAPPA Guidance 2012 Version 4 ACPO – Ministry of Justice – National Probation Service- HM Prison Service 2012

17.83 It is clear that this case warranted a MARAC conference. There was enough concern about the safety of V1 and C1 due to H1's behaviour towards them to justify a high risk MARAC meeting. This would have provided an opportunity for all agencies to exchange information about H1's risk, potential danger to others especially his family and the risk of his own suicide. A multi-agency Risk Management Plan would then have been created designed to offer V1 and C1 support, advice and protection.

17.84 It is noted that V1 was reluctant to let H1 remain in hospital and often refused the conversion between Section 2 and Section 3 Mental Health Act 1983 (the hospital permission to detain H1 for treatment.) It will never be known how much the culture of her native country influenced her decision making, but with proper guidance and advice from a MARAC Risk Management Plan she may have been able to come to alternative conclusions about her own and C1's future. It is difficult to expect a person from V1's cultural background to make significant decisions about their future and that of their children without the proper support and access to information about available support services in a context and country with which they are unfamiliar.

17.85 It is the Panel's view that there is a misconception about the ownership of the MARAC process. Because it is usually chaired by the Police, some professionals appear to believe that referrals for cases being discussed at MARAC have to emanate from the Police. Guidance dictates that any agency can refer to MARAC.

17.86 The lack of any professional considering a referral to MARAC is a serious and serial error that prevented information being exchanged and a holistic view of the issues affecting all three people in this family being considered. It also prevented a multi-agency action plan being implemented that could have supported V1 and C1.

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.**

Child Protection referrals

17.87 In a similar way there were numerous opportunities to consider the safeguarding of C1 in his own right.

17.88 The allegation that H1 was threatening C1 and V1 with knives was, perhaps, the most serious issue that was overlooked. In addition, C1 called the Police on more than one occasion stating that H1 was attempting to commit suicide. He and V1 ran from the house in fear for their lives. V1 reported to the GP and also to the UKBA that 'H1 hurts us'. The Police attended at the request of ambulance personnel to effect the removal of H1 from the family home. They also executed a warrant under Section 136 of the Mental Health Act 1983 to effect his removal from the family home.

17.89 The Police made a referral to Children and Young People's Services on 27th August 2010, after C1 had contacted the Police saying V1 was trying to kill himself. The allocating manager from Children and Young People's Services noted that H1 had been detained in hospital and allocated the case to an experienced Social Worker, who worked part

time. This was immediately prior to a Bank Holiday weekend and the Social Worker did not pick the referral up until Tuesday the following week. She then made arrangements with H1's CPN to do a joint home visit on 6th September, some 10 days after the call from C1 for assistance. The allocating manager has since left the service and has not been interviewed, but the IMR author makes the reasonable assumption that because H1 was detained in hospital, the view was C1 was safe. There was, however, no consideration of what would happen when H1 was discharged from hospital and allowed home again. This decision was not made in a truly multi-agency forum.

17.90 The result of the home visit was a referral for C1 to Base 25 and a suggestion that V1 should seek access to local women's groups for support, V1 declined to do this as she wished to stay at home and look after her husband, another example perhaps, of her being influenced by her cultural background. The Children and Young People's Services IMR points out that this approach to support mother was not sufficient given her vulnerabilities.

17.91 Another referral was made on 1st March 2011 by H1's CPN. H1 had been detained in hospital again and had threatened to kill himself, V1 and C1. V1 said that she could no longer cope and wanted to leave. The referral was allocated to an experienced Social Worker for an initial assessment which concluded that a strategy discussion should be held from which a section 47 Children Act 1989 investigation could begin. Albeit the investigation concluded that the concerns were substantiated, the case was passed to a local team for a further assessment under the 'Child in Need' rather than the Child Protection process. Again practitioners were satisfied that the V1 and C1 were safe as H1 was detained in hospital and that there was therefore no need to proceed to an initial child protection conference.

17.92 The Children and Young People's Services IMR indicates that,' this practice is consistent with Wolverhampton Safeguarding Children Board (WSCB) guidance: 'where concerns are substantiated, but the child is not judged to be at continuing risk of significant harm'. Practitioners felt that this was the case given H1 was in hospital and not having contact with C1, but this ignores the continuing risk caused by H1's mental health problems.

17.93 Again there was no evidence of risk factors being considered should H1 be discharged from hospital and allowed home. This was the second time this situation had arisen in 7 months, and as on the previous occasion, it was only a matter of time before another episode of domestic violence occurred. Children and Young People's Services denied H1 contact with C1 and only allowed telephone contact with V1. The Panel assumes that the consequences of H1 having any other contact with his family were fully explained to all parties, but in the event such contact occurred but no action was taken under the Child Protection procedures, no further risk assessment was conducted and no referral was made to MARAC. The Children's Service's IMR points to an opportunity lost in not referring this case at this stage to MARAC. That together with the Core Assessment would have shared the information which was so important in this case.

17.94 The incident on 14th August 2010 when C1 called for the Police as H1 was trying to commit suicide with a knife and tablet did not result in a referral to Children and Young People's Services about the risk to C1 or indeed V1 to Adult Services. A vulnerable person's referral was made in respect of H1 by the Police. The Police IMR points out occasions on 14.8.2010, 28.8.2010, 1.3.2011, and 29.3.2011, when both V1 and C1 were at risk of significant harm and no referral was made to Children and Young People's Services, but C1 was referred to Children and Young People's Services on 1st March 2011 by H1's CPN.

17.95 The Police IMR quotes West Midlands Police child protection policy:

> '*A steady or sudden deterioration in an adult's mental health can in some cases place a child either at risk or at risk of significant harm. A number of nationally recorded serious case reviews have identified adult mental illness of a parent or carer as a contributory factor in the death or serious injury of a child'*

and makes the point that;

> *'It is felt by the IMR author that had C1 been correctly referred between agencies as a child at risk then the potential vulnerability and dangers may have been highlighted and led to early intervention to safeguard the whole family'* - a comment the Panel agrees with.

17.96 There is ample research showing the effects domestic violence has on children within the family. An author of one such piece of research, McGee, points out fear, sadness, anger, impacts the child's identity and relationships with others, impacts on education and health and their relationship with both of the parents.[31] There is evidence that the vast majority of those issues were experienced by C1 and culminated in him witnessing the death of his mother.

17.97 Earlier referrals to Children and Young People's Services regarding C1's 'risk of significant harm' may have avoided missed opportunities to conduct assessments and would have brought together information from all agencies and considered judgements would have been made regarding support for the whole family, the holistic identification of risk to all three members of the family and coordinated intervention.

[31] Childhood Experiences of Domestic Violence Caroline McGee 2001 FK publishers pages 69 -94

17.98 Working Together to Safeguard Children[32] states:

> 'Where a child is considered to be a possible child in need a referral to Children and Young People's Services should be made in accordance with the agreed LSCB procedure and formats' (5.17) ….. and 'If somebody believes or suspects that a child may be suffering, or is likely to suffer, significant harm then he/she should always refer his or her concerns to the local authority's children's social care services. (5.18)

17.99 Working Together to Safeguard Children also states:

> 'To fulfil their commitment to safeguard and promote the welfare of children….all organisations that provide services for children, parents and families, or work with children, should have in place..
> a clear line of accountability and governance within and across organisations for the commissioning and provision of services designed to safeguard and promote the welfare of children and young people.'(2.11)

17.100 There is no evidence that any child protection enquiries were undertaken by the Police Public Protection Unit or that C1 was identified as being at risk.

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;**

[32] Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children DFCSF March 2010 page 140 and 42

- **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.**

H1's Discharge Planning Meeting 9th June 2011

17.101 On 16th May 2011 H1 was threatening to jump from the top of a building. He was again admitted to hospital for treatment. Over the following two weeks his condition improved and on 2nd June 2011 he was assessed as not posing a risk to his family. His mental health was described as being stable and he had been on home leave the previous day. V1 was expressing a wish that she would rather him be at home, but the BCPFT stated that permission would have to be granted by Children and Young People's Services before he was discharged home. A Social Worker was contacted by e mail with the updated position. It is pointed out in the BCPFT IMR that at this point H1 was a voluntary patient and no restrictions could be placed on his movements but further mental health assessments could take place if deemed necessary. The plan at that stage was to wait until Children and Young People's Services had responded and for him to be discharged the following week.

17.102 On 3rd June 2011 Children and Young People's Services agreed to attend a ward round on 9th June 2011, indicating that they were aware of the intention to discharge H1 home.

17.103 On the 9th June 2011 a meeting took place on the ward where H1 was a patient. The BCPFT IMR called this meeting a ward round, whereas Children and Young People's Services call it a Care Programme Approach Meeting (CPA). The meeting was attended by H1's CPN (Care Coordinator), other BCPFT staff, H1 and V1, an interpreter a Social Worker and Manager from Children and Young People's Services, and two teachers from C1's school. Housing Options were not present.

17.104 Children and Young People's Services recollection of the outcome of the meeting was that it was recorded that H1 was responding extremely well to changes in his medication and his symptoms were entirely controlled. It was reported that H1 had been allowed out when he wanted, something that Children and Young People's Services were unaware of. However, the Social Worker alleges that they insisted that H1 must not be discharged to the family home. It is recorded in Social Worker's files that the consultant psychiatrist explained that H1 was no more likely to carry out threats to kill than other men in the population. H1 was discharged to a friend's house.

17.105 The BCPFT's recollection of the meeting is that all present agreed that H1's risk had reduced as his illness was under control and he could live with V1 and C1. There was an agreed plan developed involving:

- weekly visits by the care coordinator
- visits every three weeks by Children and Young People's Services
- weekly visits by the Family Advice Support Team.

17.106 The Panel make one observation at this point in that H1 was not given the opportunity to stay overnight at home for a trial before being

discharged home. V1 had described H1's behaviour being particularly disturbed at night time and therefore it may have been more appropriate for H1 to stay overnight on occasions before he was discharged. Visiting during the day would be different to staying overnight which may have had different consequences.

17.107 As far as C1's position in the decision to discharge H1 home is concerned, his views were not considered either. As stated elsewhere there was nothing to indicate that the safety of C1 was taken into account. Recently published guidance from the General Medical Council[33] states:

> 'You must consider the safety and welfare of children and young people, whether or not you routinely see them as patients. When you care for an adult patient, that patient must be your first concern, but you must also consider whether your patient poses a risk to children or young people. You must be aware of the risk factors that have been linked to abuse and neglect and look out for signs that the child or young person may be at risk. Risk factors include having parents with mental health or substance misuse issues, living in a home where domestic violence takes place, or living in poverty.'

17.108 On 17th June Children and Young People's Services discovered that H1 was living at home, despite their understanding that he was discharged to a friend's house. On being interviewed during this review process, the Social Worker commented that she thought that she would allow the fact that H1 was living at home to go without comment based on the facts that both V1 and C1 wanted him home, the mental health practitioners strongly recommended that he should return home and that home would provide the most stable environment for him. Advice

[33] Protecting children and young people –The responsibilities of all doctors General Medical Council July 2012 pages 11 and 12

was sought from the Safeguarding Review Manager who concluded that the case should continue in the Child in Need arena as the threshold for significant harm had not been reached. In addition V1 stated that she would contact Mental Health Services should H1's condition deteriorate.

17.109 Housing Support was adamant that they were against H1 being discharged home to live with V1 and C1. They had informed H1's CPN on 6th June that they were unable to accept H1 as part of the family unit due to the risk being too great. Alternative accommodation had been offered to H1 in bed and breakfast accommodation but this had refused. Housing Options were assured by the CPN and, according to the Housing Options IMR, by C1's Social Worker that there was no risk posed at present and the situation would be closely monitored on a weekly basis. Housing Options therefore reluctantly allowed H1 to return home. Housing Options did withdraw support visits to the home but continued to offer support from their offices.

17.110 There are two issues here that are concerning: the first is that a multi-agency action plan was put in place without the agreement and knowledge of all agencies involved. The second is that an action plan that had been agreed on a multi-agency basis was not adhered to but amended without the agreement or knowledge of all agencies involved.

17.111 Agency representatives should be able to express the views of their respective agency and if a decision is made contrary to those views, this should be formally recorded and there should be an accepted challenge process, allowed and understood by all present in order to satisfy all views or to arrive at a compromise.

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.

17.112 A supplementary report dated 26th June 2012 to the BCPFT IMR, concludes that the discharge meeting was held on a multi-agency basis and it was a multi-agency decision to discharge H1 home. Strictly speaking that is correct. However, by not including Housing Support in the decision making process vital information from an agency that had been involved with the family for a considerable period of time was omitted. This again points to the fact that a referral to MARAC would have encouraged all of the other agencies information to be considered regarding all of the decisions made.

17.113 This whole episode illustrates that agencies must be clear about the title, purpose and outcomes of meetings especially when other agencies are involved. Meetings must also be recorded identifying the outcomes of the meeting and any areas of disagreement. These records must be promptly distributed to all attending or sending apologies to the meeting. It also highlights the need for all agencies involved in the case to be present at the meeting to ensure that all information is shared and acted upon.

Care Programme Approach

17.114 Mention has been made about the Care Programme Approach (CPA) and it may be useful for some explanation about CPA and to compare the guidance with the events in this case.

17.115 CPA was introduced by the Department of Health (DoH) 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. Wolverhampton has its own guidance[34] based on the DoH guidance created in April 2009.

17.116 Regarding patient discharge, the Wolverhampton guidance states:

'Prior to discharge from in-patient services the service user and /or care will be given a copy of the discharge summary and the agreed care plan. This plan will be circulated to all other relevant parties within 72 hours of discharge.' (para 20.22)

17.117 There is nothing to suggest that V1 was issued with a copy of any care plan for H1 and if she was the likelihood is that she would not be able to understand it or its consequences.

17.118 In relation to the Care Plan, the Care Coordinator has a responsibility to:

'enable each person to have a personalised care plan based on his/her needs, preferences and choices. To record decisions made about it and ensure that it is reviewed at regular intervals' (para 21.10)

17.119 With regard to risk the guidance states:

'Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and recognition that each service user requires a consistent and individualised approach' (para 22.8) and

'Risk assessment should be reviewed on an on-going basis in line with changing risks of the individual. Reduction in risks would help determine the appropriateness of the CPA level' (para 22.9)

[34] Effective care and Coordination Police Refocused CPA and Care Management. Wolverhampton PCT Wolverhampton CC April 2009

17.120 H1's risk level did change with frequent regularity from high whilst he was at home and in the community, to low once admitted and being treated and back to high again once discharged.

17.121 With regard to carers, the guidance states:

'Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported' (para 23.1)

'Carer assessments must be offered to carers involved and these assessments are independent of the service user's assessments.' (para 23.2)

'The team involved with the service user is responsible for identifying an appropriate staff member to conduct the carer's assessment. It is good practice, however that the service user's care coordinator conducts the care's assessment.' (para 23.3)

17.122 In relation to C1, the guidance confirms:

'A service user's own caring responsibilities should also be explored and appropriate support, contingency and crisis plans put in place for the service user as a carer and for the person they care for' (para 23.6)

17.123 There is nothing to indicate that any of this was considered.

17.124 The importance of information sharing is mentioned within the guidance:

'Information needs to be shared appropriately to make sure that people get the services they need. Information sharing also aids transparency and forms part of our role in the systems that aim to protect people who are at risk. (para 24.2)

'People who are at risk' must in this context include V1 and C1 as well as H1 himself. Information was not shared appropriately.

'CPA standards require that protocols are agreed for the sharing of information with the police, probation services, prisons, court liaison independent/voluntary sector agencies in the care provision.' (para 24.6)

17.125 It is clear that important sections of this guidance were not adhered to in H1's case. The guidance is extremely important to ensure the safeguarding of both adults and children as well as patients with mental ill-health.

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.

Education

17.126 C1's first school, School 1 was aware of the concerns at home having been informed by Children and Young People's Services and the school immediately put interventions into place to assist C1. The school put mechanisms in place when they were aware that H1 had visited the school in case he should do so again. Representatives from the school attended Child in Need meetings and also the Ward Round/CPA meeting at the hospital. School 1's IMR indicates that as students move to another school there is a transfer of information between the old and the new school.

17.127 A pre admission meeting took place at School 2 on 6th December 2011 with H1, V1 and C1 and the acting Head Teacher. The reason given for a change of school was that the family were moving house. It appears

that C1 failed to attend at his new school on the first day, 12th December but started on 13th December. There was no transference of concerns or information from School 2 to School 3. There was information that School 2 had a photograph of H1 in order to raise the alarm should be turn up at school, but this was not forwarded to School 3. C1 was known to Children and Young Person's Services but Education failed to pass on the fact that he had changed schools. There was no school nurse involved with C1, probably because he was receiving counselling from Base 25.

17.128 Consequently it was only after the death of V1 that School 3 discovered that C1 had been subject of a Child in Need plan. There is an expectation that such information would be communicated to the new school before the student actually commences and in this case the new school should have been planning the appropriate care for C1.

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.**
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.**

General Practitioners

17.129 H1's GP noted on 9th December 2008 that H1 should attend a 'specialist centre' with an interpreter for treatment for his PTSD. This, it appears, was never arranged or alternative treatment sought or provided.

17.130 There is no record of the GP making a referral to Children and Young People's Services or indeed Adult Safeguarding on either the 13th January 2009 or 15th January 2009 when H1 expressed suicidal feelings and made threats to kill himself, V1 and C1. The Black Country Custer (BCC) IMR compiled on the GP's behalf states in the comments for the entry of 15th January 2009,

> 'Prompt referral in view of threats of suicide and harm to family'.

The comment referred to a referral to a Single Point of Contact (SPA), but there was no referral to any other agency that would safeguard those at risk.

17.131 H1 was admitted to hospital on 9th April 2010 and admitted threatening to jump off a building because V1 had hidden his tablets in an attempt to prevent him overdosing.

17.132 On 17th August 2010, the BCC IMR states:

> 'Wife frightened for her own safety but there is no evidence of violence or verbal abuse or threats made. She is struggling to cope with her very distressed husband. This is the only record of wife feeling frightened and concerned re her own safety to GP, but at the same time she denies any threats or violence.'

17.133 There is nothing to indicate that any referral was made to domestic violence or support agencies.

17.134 During the creation of the BCPFT IMR, the Panel enquired about the GP's practice domestic violence policy. There did not appear that there was a current Domestic Violence Policy in existence within the practice. A senior member of the reception staff was unable to locate any such policy. Recommendation No 5 is pertinent to this practice in particular.

17.135 V1 died three months or so after the family had been removed from the GP's practice list and there is nothing to indicate that the family sought other GPs services elsewhere.

17.136 It is a recognised practice for victims of domestic violence to move from one GP to another, often without notification. On this occasion medical records were not requested from the old GP practice by another surgery, something that failed to raise any suspicions.

17.137 The BCPFT IMR adds:

> 'This availability of a local service they could seek help from could have been critical in preventing the death of V1'

Black Country Partnership Foundation Trust (BCPFT) Walsall Healthcare NHS Trust (WHNHST) and Dudley and Walsall Mental Health Partnership. (WMHP)

17.138 H1 was detained in hospital under the Mental Health Act 1983 for assessment on 4 occasions. It may be useful to provide a summary of the sections of the Act and the conditions attached to each.

17.139 Between 21st May 2009 and 27th May 2009, he was detained under Section 3. That section states:

' A patient may be admitted to a hospital and detained for a period (6 months) for compulsory treatment if:

a) He is suffering from mental disorder of a nature or degree which makes it appropriate for his to received medical treatment in hospital: and
b) It is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under the section'

17.140 Between 2nd February and 18th February 2010 he was detained under section 2:

'A patient may be admitted to hospital and detained for a period (28 days) on the grounds that:

a) He is suffering from mental disorder of a nature or degree which warrants his detention for assessment (or assessment and treatment) for that period: and
b) He ought to be so detained in the interests of his own health or safety or with a view to the protection of others persons'

17.141 Between 2nd September and 3rd September 2010 he was detained under section 5(2) which covers an in-patient where the clinician has the right to hold a patient for 72 hours to enable a full Mental Health Act Assessment to take place but gives no right for compulsory treatment.

17.142 He was detained again between 2nd March 2011 and 6th April 2011 under section 3.

17.143 Under section 11(4) of the Act a nearest relative has the right to object to a detention under section 3 and if this is the case the detention cannot go ahead.

17.144 On 14th August 2010 H1 was arrested by Police in Wolverhampton and taken to Walsall Manor Hospital under section 136 of the Mental Health Act 1983. He was assessed at the Police station by an Approved Mental Health Practitioner (AMHP) and two psychiatrists who decided that H1 was not detainable under Mental Health Act. There was no communication with either V1 or C1 before the decision was made. It appears there was no consideration as to the risk that may be present when he was released home, irrespective that H1 had threatened to kill V1 and C1. Walsall Hospital contacted Wolverhampton CRHT for information regarding the patient. Wolverhampton Crisis Resolution

Home Treatment (CRHT) faxed 22 pages of notes to the hospital. The date the information was completed is unclear.

17.145 To a question on the form 'Are there any children in need issues?' The answer is 'No'. To 'Are there any child protection issues?' the answer is 'No'. The question, 'Vulnerability of others i.e. depression' the answer is '24.7.09 H1's wife are child are affected when he is ill.'

17.146 The form indicates his spoken language is English when clearly it is not. The form asks for details of any psychiatric history and comments entered read 'No previous psychotic history' and then gives details regarding admissions in March 2009 and June 2009, where records clearly show he was 'admitted with psychotic symptoms very frightened – had taken overdose.' The BCPFT IMR indicates that H1 had been receiving services from the BCPFT or its predecessor since 13th January 2009.

17.147 The form indicates that a risk assessment was completed on 23rd March 2010 but in the next 'box' on the form requesting details of Self-Harm Risk Assessment, no details were entered. So from details on the form, the services in Walsall were unaware of the numerous self-harm threats and attempts H1 had made. Entries on the form continue with the fact that H1 was scared that V1 would leave him and worried that he would harm V1 or C1.

17.148 The Panel is concerned about the accuracy of the information passed between services, some of which would appear to be vitally important to the staff treating a very disturbed person, and for the safety of others.

WHNHST IMR states:

> 'There is no evidence to suggest any consideration in relation to safeguarding. The records state that H1 was known to the Mental Health Crisis Team in Wolverhampton and the assumption is that

this was the team that were notified although the records do not detail this'

17.149 There is nothing to suggest that any enquiries were conducted by WHNHST to satisfy themselves that referrals had been made to either Children and Young People's Services or Adult Safeguarding.

Recommendation No 12

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.

17.150 On 7th September 2010 H1 was asked to remain in hospital on an informal basis. However, he refused to do so and V1 refused to agree to his being treated under Section 3 of the Mental Health Act 1983 so H1 was discharged. V1 expressed the wish to have H1 home. It was known at this stage that he had threatened to harm V1 and C1 as well as himself, but none the less he was allowed home.

17.151 It appears that any mental health assessment ignored H1's self-confessed concerns for the safety of V1 and C1 at his own hands when he was ill. It is difficult to understand how this could be justified.

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

17.152 The following two recommendations have been made by the IMR author of the Black Country PCT Cluster, and relate to BCP NHS Trust discharge policy. They are included in the Overview report as one agency cannot make individual recommendations for another.

Recommendation No 14

The 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.

V1's Capacity and Assessments.

17.153 Much has been said about the vulnerability of V1. She was an isolated woman, with limited command of the English language, who had been subjected to domestic abuse over an extended period of time and who came from a cultural background where such abuse was accepted. There were occasions when she made decisions that may seem to have not been in her best interests, such as objecting to treatment for

V1 whilst he was in hospital, stating that she wanted him home and then contrary to that stating that she wanted a year's break from him.

17.154 Objecting to H1 receiving psychiatric treatment was her right, but there is no evidence that her rights were explained in detail and the consequences of her decisions were outlined to her in a way that enabled her to fully understand them. V1 was never subject to any form of mental capacity assessment with regard to those major decisions for herself, H1 and C1. Was she able to fully understand what was going on with H1? We will never know.

17.155 There is evidence that she complained to her GP and the UKBA about the stress of H1's behaviour, how she found it difficult to cope with his mental ill-health. She is quoted as saying, 'He hurts me and C1'.

17.156 Sanderson states, [35]'As they (victims) soak up the abuser's feelings of inadequacy and self-contempt, their (victims) self-esteem is eroded and any vestige of control is relinquished. The more the survivor absorbs the abuser's distorted perception, the more she loses contact with her own feelings, becoming increasingly depressed and submissive.'

17.157 As time progressed in this case, one can see V1 becoming increasingly depressed and submissive. This must have further affected her capacity to make rational, well thought out decisions.

17.158 The test of Capacity is contained in the Mental Capacity Act of 2005. Section 2 of the Act states:

> '1) A person lacks capacity if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

[35] **Counselling Survivors of Domestic Abuse Christiane Sanderson 2008 JK Publications page 69**

2) It does not matter whether the impairment or disturbance is permanent or temporary.'

17.159 The Act goes on to say that the question of whether a person lacks capacity must be decided on the civil standard of balance of probabilities i.e. more likely than not. This is likely to depend on a number of factors including:

- The gravity of the decision or its consequences
- The person is repeatedly making decisions that put him at risk or resulted in preventable suffering or damage

17.160 Section 3 of the Act states:

1) A person is unable to make a decision for himself if he is unable to –

a) understand the information relevant to the decision

b) retain that information

c) to use or weigh that information as part of the process of making the decision – or

d) communicate that decision.

17.161 Relevant information is defined as the 'reasonable foreseeable consequences of deciding or failing to make decisions'

17.162 Best interests is defined as ' the beliefs and values that would be likely to influence his decision if he had the capacity (including religious beliefs and cultural values) and other factors the individual would be likely to consider if able to do so (this might include a sense of family obligation).

17.163 Brammer[36] argues 'decisions and actions must be in the person's best interests' and states that the Act introduces a 'minimum intervention principle, supporting practices which interfere least with the individual's freedom of action (Article 8 European Convention of Humans Rights – the right to respect for private and family life).

17.164 In V1's situation she may not have understood the consequences of having H1 home from hospital. No one actually assessed her level of understanding to determine if she could comprehend the likely outcomes of her decisions. She was, without doubt a vulnerable woman and there were clear grounds for questioning whether she understood the information relevant to the decisions she was making and being asked to make. Her capacity to make those decisions and her overall situation should therefore have been assessed.

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.

Base 25 and C1's counselling

17.165 On 6th September 2010 Children and Young People's Services made a referral to Base 25 for C1 to receive counselling. The information shared with Base 25 to work with C1 was not sufficient to focus the counselling on the real problems at hand – that of H1's behaviour and its effect on C1. It is difficult to know what outcomes the counselling aimed to achieve. It should not have been C1's responsibility to disclose information about any Domestic Violence he experienced or

[36] **Social Work Law Alison Brammer 207 Peason Longman 2007**

witnessed at home. That should have been the remit of School 2 and Children and Family Support Services who were aware of C1's home situation. C1's circumstances and risk needed to be understood. It would have been very difficult for him to raise the subject of domestic violence and mental ill-health of his father. It appeared that agencies assumed that C1 was being counselled about family problems and decisions were made subsequently on that basis. When C1 subsequently removed himself from all counselling, this should have been reported back to Children and Young People's Services.

17.166 Before agencies refer children for counselling, support and assistance, it is imperative that the needs of the child and purpose of the counselling referral are clearly defined and all relevant information provided to the counselling service to enable the identified outcomes to be achieved.

Recommendation No 17

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.

The use of Interpreters

17.167 The family in this case spoke Farsi. It is acknowledged that to obtain the services of a Farsi interpreter is very difficult, but not impossible.

17.168 Most of the agencies involved in this case had the need to obtain the services of an interpreter in their dealings with H1, V1 or C1, and often V1 and C1 were relied upon to act as interpreters. On occasions H1 and V1 presented at the GP with a friend interpreting for them.

17.169 Home Office Guidance[37] on Domestic Homicide Reviews states:

> 'Extra caution will need to be taken around confidentiality in relation to agency members and interpreters where there are possible links with the family, who may be the perpetrators. Extra caution will also be required when considering the level of participation from family members and should be carefully considered in consultation with a practitioner with expertise in this area',

17.170 The Police IMR points out:

> 'This should not have been the case. In 2008 Language Line was set up. Language Line is a telephone service provided in over 150 languages where a non-English speaking person needs to communicate immediately and the attendance of an interpreter is required. The conversation takes place by use of a telephone or video conferencing facility whereby an immediate conversation takes place usually between the non-English speakers, the Language Line interpreter and the officer. In August 2011 the Ministry of Justice established a five-year language services framework agreement with Applied Language Solutions. The framework agreement provides access to the following services 1) Face-to-face interpretation 2) Telephone interpreting 3) Translation (including Braille and Easy-read) 4) Services for the deaf and deaf/blind (including, but not limited to, British Sign Language, Sign Supported English, Note Taking, Finger Spelling and Lip Speaking) 5) Other non- defined language support services as and when they arise These services are available around the clock, 365 days per year, at any location across England and Wales.'

[37] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 ***page 16***

17.171 Another interesting point raised in the Police IMR:

> 'Language Line should be routinely used at domestic incidents where there are communication issues. It should never be taken for granted that there are no underlying issues without actually communicating with the family. It is basic Police training at domestic situations for the 'parties' to be separated and spoken to. V1 was never spoken to and it is documented more than once that she did not speak English'.
>
> Because of her difficulty in understanding English and because the use of interpreters was spasmodic, V1 was not given the opportunity to be thoroughly questioned about her life and that of C1 within this family setting, and not given the opportunity to be properly supported.

17.172 Housing Options IMR makes comments reading the use of interpreter:

> 'There were a number of needs in relation to language and culture that would have benefitted the whole family. The victim had very poor English language skills and interpreters were often required however friends were often used as interpreters on V1's behalf'

17.173 Wolverhampton Homes IMR states:

> 'Due to the language issues, much of the contact with the family came by speaking to the family friend who acted as SA's interpreter.'

17.174 Without adequate interpreting services how could agencies be assured that V1 understood the potential dangers and risk that she and C1 faced and appreciated her options for support? This is particularly the case given the gender of the friend who interpreted, his primary relationship being with H1 and the cultural expectations of him in a domestic violence situation

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.

Police Investigations

17.175 Comment needs to be made about the Police investigations. Throughout this review comment has been made about the fact that there were missed opportunities to share information that would have enabled an holistic view and understanding of the family's situation to have been obtained.

17.176 V1 constantly complained that H1 threatened to kill her and C1, but dealing with these problems as simply manifestations of H1's mental ill-health, the Police failed to appreciate that there were serious offences being committed. This issue has been identified by the author of the Police IMR who states:

> 'On 1st March 2010, during a meeting with CPN, V1 disclosed that she and C1 had been repeatedly threatened with violence when her husband was suffering with his Post Traumatic Stress Disorder Symptoms. She stated that the last episode had been as recently as two days previously. He had said to her that 'he would take them to the grave'. He was holding a knife at the time he said this. As a result of this information it is understood that V1 and C1 were housed away from the family home where H1 still lived. Police were informed the following day during the execution of the warrant. On receipt of this information from CPN and a Psychiatrist a (WC 392) vulnerable adult log was written up by a

Police Sergeant, who has stated on the document “It is not clear if this has been crime recorded or any action taken by the Police” It went on to say that the incident would be brought to the attention of the Public Protection Unit (PPU) to “see if there has been any Police involvement”.

‘On this occasion the mental health professional was effectively ‘third party’ reporting a criminal offence of Threats to Kill. This was the first report and should have been dealt with as an immediate threat. However, in this circumstance the MHT were detaining H1 with a warrant under the mental health act for mental assessment. It would not have been appropriate to arrest him for this offence at the time. However, he was at no point dealt with for the reported offence. It was not standard practice for the PPU to deal with offences of Threats to Kill, and should have remained with the Local Policing Unit (LPU) for their continued enquiries and subsequent arrest. PPU should have been notified but the follow up offences would have remained with the LPU involved. This was an arrestable offence and positive action should have been taken or at least referred as a High Risk DV matter. ‘

17.177 The Panel agree with this statement. Whilst it is appreciated that H1 was mentally ill at the time of committing these offences and unlikely to have been prosecuted for them, an investigation into the threats to kill should have been conducted and would have been an opportunity to bring agencies together to share information and develop the multi-agency approach the family’s situation merited and required.

17.178 Further, candid and helpful comments in the Police IMR indicate a list of concerns regarding the Police involvement with this family:

- Wider safeguarding issues should have been considered for the family;

- Failure to identify C1 as a vulnerable child .There was an assumption that where there was a need to refer C1, it would be done by another agency;
- The risk of harm to V1 and C1 whether emotional or physical, was not actively considered. Officers did not identify V1 or C1 as potential 'victims';
- There was not sufficient information obtained to fully assess the relevance of completing a DASH assessment during the two incidents of attempted suicide in August 2010;
- There are no records of any referral or information sharing from partner agencies with regard to their involvement with this family;
- Police were not given or did not record a detailed account of H1's medical history to facilitate an informed risk assessment when he was reported as a missing person;
- Irregular spelling of the family names and the fact that the address on one document was totally incorrect hindered any intelligence research by officers;
- A joint agency visit should have been considered in this case to establish the C1's welfare;
- There are pertinent questions within the 'DASH' form that were not asked;
- Failure to record and investigate a third party reported offence of Threats to Kill;
- There is no record of why H1 was 'advised' not to go home when discharged from Psychiatric Hospital and what the potential risks were of H1 moving back in with the family. Police were not informed of the family arrangements and movements; and
- Language Line was not utilised to facilitate appropriate questioning of V1.

Recommendation No 19

The Safer Wolverhampton Partnership to require 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.

Policy and Training

17.179 It is essential that all agencies have current and up to date policies regarding Domestic Abuse and also Child Protection and Adult Safeguarding if agencies are to safeguard adults and children effectively. It is also imperative that all staff are fully and constantly trained in all three policies.

17.180 In the completion of the IMRs all of the agencies involved in this review were asked to describe their agency's policy on domestic abuse and also to detail the training staff receive.

17.181 West Midlands Police have current policies and training in force regarding Domestic Homicide, Risk Assessment, Child and Adult Safeguarding, Missing Persons and DASH training. All officers connected with this case had completed the local DASH training course. DASH training has been carried out across the Force area since 2008.

17.182 Mention has been made of the GP policies above. The BCC IMR indicates that the GP practice had carried out an annual monitoring assessment, but the last two assessments had been self- assessments. The IMR author was surprised when the senior receptionist could not find the adult safeguarding and domestic violence policies and maintained they did not have any. Staff training had been completed in both safeguarding adults and children, but training on domestic abuse last year had been cancelled and not repeated.

17.183 Royal Wolverhampton NHS Trust indicates that staff in A&E departments are trained to Level 1 adult safeguarding and level 3 for child safeguarding. WNHST has active policies regarding domestic violence and adult and child safeguarding

17.184 West Midlands Ambulance Trust likewise has policies in relation to adult and child safeguarding and Domestic Violence and all Trust staff are suitably trained.

17.185 The Refugee and Migrant Centre (RMC) have a policy of referral to other agencies when they become aware of incidents of domestic violence, and staff receives training from Wolverhampton County Council. However, in this particular case, the RMC IMR answers several questions regarding domestic violence training and awareness and the answers were of concern to the panel:

Question: Were any questions asked about domestic violence?

Answer: No. The client did not disclose any information and there were no physical signs for the caseworker to probe

Question: Is it standard practice to raise and ask questions around domestic violence?

Answer: No. Only if the client disclosed this.

17.186 The answers to the questions raise concerns that the quality of training that the RMC states it undertakes is insufficient. Victims of domestic violence often do not complain and staff should develop methods of identifying signs and symptoms of violence within the family/relationship rather than waiting for victims to disclose. It is also of some concern that given the opportunity to make their own recommendations the RMC chose not to do so.

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

17.187 UKBA has a policy of referral regarding incidents such as in this case and Housing, Police and Children and Young People's Services are duly notified if incidents of domestic violence arise. But as the UKBA IMR states there was a:

> 'notable absence of disclosure of violence by H1 to V1 at her own asylum interview. [The] Case owner appears to have entirely ignored this disclosure and did not ask further questions of V1 or express concern to her manager.'

17.188 This issue is addressed in the UKBA's own recommendations. However the UKBA does not have policies or procedures to inform asylum seekers of the services available to them either locally or nationally which are designed to support and advise them accordingly.

17.189 Dudley and Walsall Mental Health Partnership indicate that risk management procedures were in place but not utilised. The Partnership also indicated that it works with the local MARAC procedure.

17.190 Wolverhampton Homes does have a policy regarding referrals for domestic violence incidents and referrals to MARAC. Wolverhampton Homes is also a signatory to the Information Sharing Protocol (Safer Estates) as part of the Crime and Disorder Act 1998. There is a training need here as the last training was completed in 2009, since when there has been significant staff turnover.

17.191 Wolverhampton City Council does not have a policy or procedures for the DASH Risk Assessment process, but do have policies in relation to

working with victims in line with the Homelessness Code of Guidance 2006.

17.192 Wolverhampton Children Services, including Out of Hours Emergency Duty Teams has policies, procedures and training in place for all staff for all staff re Safeguarding Children and Domestic Abuse.

17.193 The WCC (Schools, Skills and Learning) is bound by the provisions of Working Together to Safeguard Children.

17.194 WCC Adult Social Care Services, including Out of Hours Emergency Duty teams has policies, procedures and training in place for all staff re Safeguarding Adults and Domestic Abuse.

17.195 United Property Management indicate in their IMR that nominated staff have Child Safeguarding Training. Domestic Violence training is given to individual staff those who principally lead on domestic violence.

17.196 The IMR also states:

> 'Alternatively, Women's Refuges locally can be contacted but this is usually done via the Police since they have their number and we do not.'

17.197 The Carer Support Team provides services to adult carers. The organisation does not provide training for staff on child protection or domestic violence but staff do receive specific training regarding the safeguarding of vulnerable adults. It is essential that such an organisation that works so closely with vulnerable adults formulates its own domestic violence and child protection policies. This is included in the IMR recommendations.

Recommendation No 21

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.

17.198 There is clearly a need for inter-agency training regarding the management of Domestic Violence situations especially the links between referrals and the MARAC process.

Poor Information sharing

17.199 Mention has been made in this review of the poor information sharing between agencies. The details regarding H1's threats to kill himself, V1 and C1 should have been shared with all social and health care agencies, as well as the Police, Housing, UKBA and Education. Agencies appeared to act in silos without the benefit of collation, analysis and dissemination of information and intelligence about this family and its individual members.

17.200 Wolverhampton Homes became aware of the domestic abuse within the family only after the death of V1. But on reflection there was knowledge of her being a victim on at least one occasion while she was living in temporary accommodation. The IMR indicates that this information was not shared appropriately and the consequences are spelled out in the IMR:

> 'With more information provided in relation to the family's background, Wolverhampton Homes lacked an opportunity to reach informed decisions on:
>
> • Offering V1 specific help by signposting to specialist tenancy support for domestic violence victims
>
> • How to manage contact with V1 as our tenant and someone to whom we owed a duty of care

• How to manage staff contact with H1 (it is not known whether he ever displayed aggressive and/or violent behaviour towards people outside of his own family)
• Whether it was necessary for Wolverhampton Homes to make a safeguarding referral in relation to C1 as a child living in a household with known domestic violence issues
• Whether it was necessary for Wolverhampton Homes to make a referral to MARAC in relation to domestic violence within the family'

17.201 H1's mental ill-health was being dealt with in isolation of any concerns about V1 and C1, when there were ample opportunities and indicators *of the need to move towards adult and child protection structures.* Instead the whole focus of this case was on H1's mental ill-health.

17.202 Education did not ensure the concerns about C1 and his family situation were communicated when he moved school and the transfer of C1's records to his new schools was too slow.

17.203 Recommendations made above regarding MARAC and Child Protection adequately cover these issues.

17.204 This case concerns a family who arrived in the UK and were subject to the asylum process whilst coping with mental illness in their midst. Their capacity in the English language was very limited and thereby their access to assistance difficult. H1 was traumatised by his experiences in Iran and the services the family as a whole received from agencies was very spasmodic and disjointed. The language problem prevented them having access to the appropriate serviced to meet their needs.

Recommendation No 22

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.**

17.205 It is important that the Safer Wolverhampton Partnership ensures that the recommendations contained in this report are progressed, implemented and monitored.

Recommendation No 23

Safer Wolverhampton Partnership to seek assurance that recommendations contained in individual agency IMRs have been implemented within 6 months from the publication of this Overview Report.

Recommendation No 24

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

18. Conclusions

18.1 The death of V1 was preventable and a serious injury or harm to either her or C1 was predictable.

18.2 H1's mental health was unpredictable, both in its nature and in the impact of it on his immediate family. His behaviour could change in the course of a matter of minutes. He was frequently admitted to hospital when he was deemed at risk to himself or others. He was duly treated and his condition appeared to stabilise. Once H1 had stabilised to a degree, he would be discharged home, despite contrary views by some agencies, there was no evidence of stability over a prolonged period of time. Equally that discharge was not supported by a robust package of care which acknowledged his and his family's cultural background. It is appreciated however, that the above occurred between 2008 and 2011 when Mental Health Services were provided by Wolverhampton PCT. From August 2011 Wolverhampton Mental Health Services became part of the BCPFT and since then improvements have been made. Reference is made to a letter from H1's psychiatrist early on in H1's mental ill-health that indicated if his treatment was stopped, he would not survive long, with a severe risk that it would place his family in jeopardy, a prediction that proved only too accurate but which did not lead to any positive action being taken at the time, nor later.

18.3 Once home his mental health and behaviour would deteriorate and he would eventually be admitted to hospital again.

18.4 All three members of this family were very vulnerable people. They were in a foreign country with an alien culture and none of them had a good command of the English language. H1 had mental ill-health problems. V1 was trying to be a good wife and mother, within the expectations of her native culture, was constantly under threat from her ill husband, living with threats of violence and also trying to care for her

son. C1 was a child who, on occasions was living in fear of and for his father. He was bullied at school about his father and about his race. There were several house moves and initially problems with the UKBA and permission to stay in the UK.

18.5 All of them were further isolated by virtue of not having close relatives on hand to assist.

18.6 There were elements of H1's mental care that were good but V1 and C1's needs were peripheral in terms of support. Children and Family Support Services maintained that C1 was a child in need rather than considering him to be at risk of significant harm and invoking an investigation under Section 47 Children Act 1989.

18.7 Evidence of H1's behaviour with knives appears to have been unclearly and inconsistently recorded and interpreted with the use of language such as 'in possession of knives', and 'playing with knives'. Whatever the actual facts of those incidents, C1 reported that H1 had knives and was threatening to kill himself, V1 and C1 himself. That should have been properly investigated and considered putting both of them 'at risk of significant harm'.

18.8 V1 was left to contact Mental Health Services if H1's condition deteriorated. She was often seen without an interpreter or with C1 acting as interpreter, and her degree of understanding of her situation and that of her family was unknown. Her parenting capacity in respect of C1 was never considered by any agency. Reference is made to her wanting H1 home and refusing to allow him to be detained in hospital, but the depth of her understanding of those critical decisions is not known.

18.9 H1's behaviour was becoming more unpredictable. When his mental history is examined, he started being depressed due to his experiences in Iran. He moved to drug overdoses of prescribed drugs, becoming withdrawn at home, hiding, not sleeping, to the more aggressive

behaviour of threats then the use of knives. This escalation began three and a half years before the homicide.

18.10 V1's and C1's reactions to his behaviour were becoming more desperate. They ran away from the house on a number of occasions. C1 contacted the Police for assistance more than once, and even given the cultural restrictions on leaving the marriage, V1 expressed a wish that she could leave H1, albeit that was quickly rescinded.

18.11 A serious incident involving one or more of the family was predictable given the escalation of H1's behaviour whilst he was in the home setting.

18.12 Indeed the Black Country PCT Cluster IMR author feels:

> 'The underlying diagnosis of H1, the failure of his asylum application, the relative social isolation of the family, loss of status of H1,and his previous attempts at self-harm, H1 was certainly a high suicide risk'.

18.13 This further emphasises the fact that the focus of intervention of services was H1's mental health problems as opposed to V1 and C1 and the family as a unit. This is supported by V1 telling Housing Options that H1 no longer lived at the home address, C1 chose to withdraw himself from counselling and V1 appeared to withdraw herself from all agencies, perhaps indicating her loss of trust in any of the services offered.

18.14 The BCPFT IMR author also adds when writing about the family removing themselves from the GPs list 3 months before the death:

> 'This absence of a local service they could seek help from could have been critical in preventing the death of V1'

18.15 Some serious event to either V1 or C1 was predictable. H1's behaviour was so unpredictable and the threats of violence towards V1 and C1

were so frequent that it was only a matter of time before one of them, including H1, was seriously injured.

18.16 It is the view of the Panel, however, that if information had been shared and a referral to MARAC, Adult Safeguarding, Children Safeguarding, Barnardo's or Specialist Domestic Violence Support Services had been made, V1 would have had more opportunities to make informed decisions and would have had more information about the alternative decisions she could have made and the support available to her in this country.

18.17 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 working in silos led to V1's death being preventable.

18.18 The Domestic Homicide Review Panel agree that the death of V1 was preventable, although not, in itself, predictable

Malcolm Ross

September 2012

Recommendations

Recommendation No 1 Page 55

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 Page 55

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 Page 55

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 Page 68

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 Page 68

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 Page 72

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 Page 77

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 Page 81

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 Page 81

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 Page 85

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 Page 86

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 Page 90

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 Page 91

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 Page 92

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 Page 92

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 Page 95

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 Page 96

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 Page 98

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 Page 101

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 Page 103

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 Page 105

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 Page 107

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 Page 108

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 Page 108

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

Abbreviations Key

A&E	Accident and Emergency (Hospital)
AMHP	Approved Mental Health Practitioner
BCC	Black Country Cluster
BCPFT	Black Country Partnership Foundation Trust
BEM	Black Ethnic Minority
C1	Male child of husband and wife
C&YPS	Children and Young People's Services
CAADA	Co-ordinated Action Against Domestic Abuse
CAF	Common Assessment Framework
CIN	Children in Need
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution Home Treatment
CSC	Children's Social Care
DASH	Domestic Abuse, Stalking and Harassment
DHR	Domestic Homicide Review
DVRIM	Domestic Violence Risk Identification Matrix
GP	General Practitioner
H1	Husband (Defendant)
IDVA	Independent Domestic Violence Advisor
IKWRO	Iranian Kurdish Women's Rights Organisation
IMR	Individual Management Reviews
IUMS	Iran University of Medical Science
LPU	Local Policing Units
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference
MHT	Mental Health Team
MISPER	Missing Persons Report (Police)

NHS	National Health Service
NPIA	National Police Improvement Agency
OASys	Offender Analysis System
PCT	Primary Care Trust
PPU	Public Protection Unit (Police)
PTSD	Post Traumatic Stress Disorder
R&MC	Refugee and Migrant Centre
RCGP	Royal College General Practitioners
S1	Primary School
S2	1st Secondary C1 school attended
S3	2nd Secondary C1 school attended
SIO	Senior Investigating Officer (Police)
SPA	Single Point of Access
SWP	Safer Wolverhampton Partnership
UKBA	United Kingdom Border Agency
UPM	United Property Management
V1	Wife (Victim)
WCC	Wolverhampton City Council
WDVF	Wolverhampton Domestic Violence Forum
WHNHST	Walsall Healthcare national Health Service Trust
WMHP	Walsall Mental Health Partnership

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Addendum – DHR'S.A' (Wolverhampton)

19 June 2013

Following submission of the overview report to the Home Office on 23 January 2013, in reference to the Domestic Homicide Review conducted in the case of SA, referred to as 'V1' within the report, it is necessary to provide some updates around the trial of H1 and contact with the family of V1.

Update on the trial of H1

Section 1.5 of the overview report outlined that H1 at that time was awaiting trial at the Crown Court. After some lengthy delays, which were due to the ill health of H1 rendering him unfit to partake in criminal proceedings, *the trial of fact took place on 7 January 2013 where again the defendant was unfit to attend court. The jury found the perpetrator guilty of the act that killed his wife (V1).*

H1 was given a Hospital Order under S.37 Mental Health Act with a Restriction Order under S.41 Mental Health Act that restricts the patient's discharge, transfer or leave of absence from hospital without the consent of the Secretary of State.

Liaison with the family of V1

Section 15.2 of the overview report provided an update on family contact up to the point where V1's family returned to Iran with V1's body.

Throughout criminal justice proceedings and the DHR, agencies have attempted to keep the family involved and informed. The DHR panel agreed within the terms of reference for the review that contact with the family would be channelled through the Police Family Liaison Officer.

The DHR panel chair, on direction by the panel, wrote to the family to offer his condolences on behalf of the panel. The letter, which was also translated into Farsi, explained that as a result of the victim's death, a Domestic Homicide Review will be conducted under the requirements of the Domestic Violence, Crime and Victims Act 2004. The chair invited the family to take part in the review, should they wish to do so, by informing the Police Family Liaison Officer.

Although initially the family engaged with the Police when they first arrived in the country once they returned from Iran, following the funeral, they chose not to engage. Subsequently the Police filtered messages to the family via a family friend.

Liaison with H1

As outlined in section 7.1 of the overview report, the terms of reference for the review stipulated contact with H1 would be channelled through his solicitor. The DHR panel wrote to H1 informing that a DHR was being conducted under the requirements of the Domestic Violence, Crime and Victims Act 2004, this was also translated into Farsi. The opportunity was provided for H1 to feed into the review process; this was not taken up by H1.

Appendix A – Feedback from Home Office Quality Assurance Panel

Home Office

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Parpinder Singh
Community Safety Coordinator
Community Safety Service, Wolverhampton City Council
Red Lion Street
Wolverhampton
WV1 4HL

15 July 2013

Dear Mr Singh,

Thank you for submitting the report from Wolverhampton to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in June, and following further correspondence with you regarding the conclusion of the trial we have now received and considered the additional information.

The QA Panel would like to thank you for conducting this review and for providing them with the final overview report and additional material. In terms of the assessment of reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

The QA Panel would like to commend you on the following that were considered to have been done very well:

- The QA Panel considered the report was thorough, written and structured very well, which made the report flow, and clear to follow
- The report was appropriately victim focussed, and drew a clear picture of who the victim was, as well as what she and her family experienced through their eyes
- The report demonstrates a clear understanding of the compromises faced by victims of domestic abuse, and also the dynamics of both mental health and domestic abuse

- The report shows that the DHR Panel were alert to safeguarding issues and were comprehensive in their description of what agencies practice should have been in comparison to what they did or importantly failed to do.
- The report appears appropriately probing and offers incisive analysis and appropriate challenge for example in statements in the IMRs
- The report brings this information together well to form unambiguous conclusions and recommendations that clearly flow out of the findings.
- There is real sense from reading the report that the panel addressed the DHR process with considerable care and thoughtfulness resulting in a very transparent and open report.

There is one issue that the QA Panel felt would benefit from consideration before you publish the final report:

- Amendment to the Exec summary to include the Black Country Partnership Foundation Trust (BCPFT) and Wolverhampton City Council Children and Young People's Service when listing the panel membership, to match the overview report.

The QA Panel does not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when it is published.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Violent Crime Unit