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Foreword by the Chair of the Review
This report outlines the findings and recommendations following the Domestic Homicide Review into the death of Miriam, a young mother who was tragically murdered by her ex-partner in 2015.

The panel wishes to send their sincere condolences to Miriam’s family and friends.

1 Introduction
1. This report of a domestic homicide review examines agency responses and support given to Miriam, a resident of Sandwell, prior to the point of her death in 2015.
2. In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.
3. The review asked IMR (Individual Management Review) authors to consider agencies’ contact/involvement with Miriam and Graham from 2007. However, as the DHR progressed, it became clear that the review needed to consider the start of the relationship between Miriam and Graham from around 2003 and Miriam’s family history from the death of her father.

1.1 Timescales
1. This review began in autumn 2015 and due to a number of issues, including the incorrect person initially being charged with the murder of Miriam, delays in the court case, the repeat collation of information held by partner agencies to establish the contact with the newly alleged perpetrator and the perpetrator’s late involvement with the review, this has resulted in the review being delayed but concluded in 2018.

1.2 Confidentiality
1. The findings of each IMR are confidential. Information is available only to participating officers and their line managers.
2. The family members and any other adults identified in this DHR have been given pseudonyms to protect their identity. The panel selected the names in the absence of the family’s involvement with the DHR.

- Miriam (the victim) was 26 at the time of the homicide.
- Graham (the perpetrator) was 62
- Ethan born 2008
- Rebecca born 2009
- Isaac born 2010
- Karl (Miriam’s brother)
- Flynn (Miriam’s brother)
- Julia (Miriam’s sister-in-law)
- Faith (Julia’s daughter)
- Stanley (Miriam’s boyfriend following separation from Graham)

1.3 Methodology

1. In September 2015, the West Midlands Police Public Protection Unit sent a formal notification to the Chair of the Safer Sandwell Partnership, advising that the circumstances of this case may fit the definition of a Domestic Homicide Review as defined in the Domestic Violence, Crimes and Victims Act 2004.

2. Following notification of this incident, the SMBC Domestic Abuse Team collated a range of information from partner agencies to establish the contact they had had with the victim and her family. From this it was identified that the victim was known to local agencies.

3. The information from partner agencies was shared with the DHR Standing Panel and Chair of the Safer Sandwell Partnership who decided that the criteria for holding a Domestic Homicide Review under Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004) was clearly met and directed that such a review be carried out into the circumstances surrounding this case. The Safer Sandwell Partnership Board confirmed this on 24th September 2015.
1.4 Involvement of family, friends, work colleagues, neighbours and wider community

1. The chair wrote to Miriam’s family at the start of the DHR, explaining the purpose of the review and inviting them to contribute. Details of specialist advocacy services which could assist with their involvement in the review were provided. Only one response was received, just before publication of the report, indicating that a family member wished to engage in the DHR. However, despite several attempts to make contact to arrange a meeting, no further contact was received from the family.

2. Graham was also contacted and offered the opportunity to contribute, however he did not initially choose to engage with the Review. He did however make contact on the 21st December 2017 and asked to discuss the final Overview Report with the Chair. It was the Chair’s view that it would be difficult to effectively discuss a completed Overview Report if Graham had not first been given the opportunity to consider its contents. In view of Graham’s literacy levels, he was assisted to consider the final Overview Report by his Probation Officer, who fed back his responses to the Chair.

3. Apparently, Graham continues to maintain he is not guilty of Miriam’s murder. In his view, he was a good parent and he believes that this was a view endorsed by Children’s Social Care. (This contention is considered at length in the Overview Report.) Graham’s Probation Officer confirmed that Graham was no longer seeking a meeting with the Chair. It was the Chair’s view that it was unlikely that learning would emerge from a face-to-face meeting, if Graham did not accept the jury’s verdict.

4. Following the conviction of Graham in 2017, the Chair repeated the same offer to Miriam’s brother, Karl. He informed the Safer Sandwell Partnership that for personal reasons he felt unable to contribute.

5. A friend of Miriam, who was also a potential witness at the criminal proceedings, indicated a desire to contribute. However, following the trial, attempts to re-contact her were unsuccessful. It has since been established that she has left the country and no forwarding address is known.
6. Julia and Faith (the children’s aunt and cousin respectively) assisted Graham with the care of the children. The Chair wrote to them both at the start of the DHR and again following Graham’s conviction. The Safer Sandwell Partnership received no response.

7. No other family or friends were identified and neither Graham nor Miriam were in employment during the period under review, so no work colleagues have been identified.

8. Stanley, a partner of Miriam after she left Graham, who was initially charged with the murder of Miriam, but later exonerated, agreed to speak with the Chair. His perceptions of key events are included where appropriate.

1.5 Contributors to the Review

1. Individual Management Reviews (IMRs) were required from:

- West Midlands Police
- Sandwell & West Birmingham Clinical Commissioning Group - GPs
- Sandwell and West Birmingham Hospitals Trust
- Sandwell MBC Children’s Services
- Children’s Centre
- Sandwell MBC Education – Primary School
- Sandwell MBC Housing Choice
- Sandwell MBC Adult Social Care
- A voluntary sector family support organisation
- Black Country Partnership NHS Foundation Trust

2. Helpful reports were required from:

- Day Care Nursery – Helpful report
- UK Visas and Immigration – Helpful report
- Sandwell School Nursing Service – Birmingham Community Health Care (BCHC)
### 1.6 The Review Panel Members

<table>
<thead>
<tr>
<th>Agency</th>
<th>Role/Job title</th>
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<tbody>
<tr>
<td>Simon Hill</td>
<td>Independent Chair and Overview Author</td>
</tr>
<tr>
<td>Sandwell MBC</td>
<td>Domestic Abuse Team Manager</td>
</tr>
<tr>
<td>Black Country Women’s Aid</td>
<td>Executive Director</td>
</tr>
<tr>
<td>West Midlands Police</td>
<td>Public Protection Unit, Detective Chief Inspector</td>
</tr>
<tr>
<td>Sandwell MBC</td>
<td>Group Head to Safeguarding/Quality &amp; Development (Children’s Services)</td>
</tr>
<tr>
<td>Sandwell MBC</td>
<td>Safeguarding Operations Manager (Adult Services)</td>
</tr>
<tr>
<td>Sandwell &amp; West Birmingham CCG</td>
<td>Designated Nurse for Safeguarding Children</td>
</tr>
<tr>
<td>Black Country Partnership NHS Foundation Trust</td>
<td>Head of Adult Safeguarding</td>
</tr>
<tr>
<td>Sandwell MBC</td>
<td>Group Head to Safeguarding/Quality Assurance &amp; Development (Children’s Services)</td>
</tr>
<tr>
<td>Sandwell &amp; West Birmingham CCG</td>
<td>Assistant designated Named Nurse &amp; Strategic Lead for Domestic Abuse</td>
</tr>
<tr>
<td>Black Country Partnership NHS Foundation Trust</td>
<td>Head of Adult Safeguarding</td>
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<tr>
<td>Sandwell MBC</td>
<td>DA Incidents Review Coordinator</td>
</tr>
<tr>
<td>Sandwell MBC</td>
<td>Domestic Abuse Administrator</td>
</tr>
<tr>
<td>Birmingham Cross City CCG</td>
<td>Associate Chief Nurse and Quality Officer was identified as a panel member but was unable to attend any panels and was not replaced by her agency. She was included in all circulations of IMRs and the Overview Report.</td>
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All of the panel members were entirely independent of the events described in the DHR and none had management responsibility or oversight for any professionals during the period under review.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Commentary</th>
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<tbody>
<tr>
<td>19/10/2015</td>
<td>Panel meeting</td>
<td>This panel meeting was carried out on the premise that Stanley was the perpetrator</td>
</tr>
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10/11/2015  IMR author’s briefing
22/11/2015  Terms of reference amended  Chair informs IMR authors that Stanley is no longer considered the perpetrator, who is now identified as Graham
22/01/2016  Panel meeting  Home Office informed of the change in the terms of reference and informed that Graham is the alleged perpetrator (29/01/16) Extension requested
29/01/2016  Home Office response  Extension agreed
22/02/2016  Panel meeting
18/03/2016  Panel meeting  DHR suspended because of the DHR’s intention to speak to key professional who may also be witnesses
01/09/2016  Letter to Home Office  Safer Sandwell Partnership inform H.O. of a delay in the trial until 2017
10/03/2017  Learning Event  Key professionals attend a learning event with DHR panel and IMR authors
03/04/2017  Panel Meeting
08/05/2017  Panel Meeting
19/06/2017  Learning event/Panel Meeting  Key managers convened to discuss learning from the DHR
31/07/2017  Panel Meeting

1.7 Author of the Overview Report

1. The Chair and Overview report writer, Simon Hill is a retired Police Public Protection supervisor with West Midlands Police with twelve years’ experience managing a team conducting child and adult safeguarding and major investigations including domestic abuse. He retired from the service in November 2013. He had no involvement with any of the subjects of this review, nor with any of the police interventions in this case.

2. Prior to leaving the service, he managed the Public Protection Review Team for four years, writing or overseeing all IMRs submitted in over thirty DHRs, and SCRs. He has chaired numerous DHRs and adult SCRs in the West Midlands. He is completely independent of the Safer Sandwell Partnership.
1.8 Parallel reviews

There were no other parallel reviews regarding this case. The DHR panel advised HM Coroner in September 2015 that a DHR was being undertaken. The review was commenced in advance of criminal proceedings having been concluded and therefore proceeded with awareness of the issues of disclosure that may arise. The DHR was concluded after the court case ended.

1.9 Equality and diversity

1. The review considered the nine protected characteristics under the Equality Act 2010 and recognised that Graham believed that some professional’s attitudes to his parenting capacity were based upon racial prejudice and a failure to understand his culture. This area is considered further within the DHR.

2. The DHR concluded that none of the other protected characteristics were relevant and there is no evidence that barriers existed that prevented the family accessing services.

3. The failure of Graham to take up literacy and numeracy support during the period of Children’s Services involvement seemed more to be related to Graham’s own view about the need for him to work on these skills.

1.10 Dissemination

This report will be published on the website of Sandwell Metropolitan Borough Council.

2 Terms of reference

1. The Terms of Reference for this DHR are divided into two categories i.e.:

- The generic questions that must be clearly addressed in all reports; and
- Specific questions which need only be answered by the agency to which they are directed.
2. The generic questions are as follows:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?
- Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
- Did the agency have policies and procedures in place for dealing with concerns about domestic violence?
- Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
- Did the agency comply with domestic violence protocols agreed with other agencies, including any information sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case?
- Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and the decisions made?
- Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim’s wishes and feelings ascertained and considered?
• Is it reasonable to assume that the wishes of the victim should have been known?
• Was the victim informed of options/choices to make informed decisions?
• Were they signposted to other agencies?
• Was anything known about the perpetrator? For example, were they being managed under MAPPA?
• Had the victim disclosed to anyone and, if so, was the response appropriate?
• Was this information recorded and shared, where appropriate?
• Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
• Was consideration for vulnerability and disability necessary?
• Were Senior Managers or agencies and professionals involved at the appropriate points?
• Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
• Are there ways of working effectively that could be passed on to other organisations or individuals?
• Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
• How accessible were the services for the victim and the perpetrator?
• To what degree could the homicide have been accurately predicted and prevented?
3. In addition to the above, agencies are asked to respond specifically to the following questions:
   • In relation to the victim, what level of assessment was undertaken by your agency at the first point of contact?
   • In relation to the victim, what (if any) vulnerabilities were your agency aware of, how did you reach those conclusions and how did they influence your practice?
   • Where your records show references to the mental health and/or learning disability of the victim, what was the evidence basis for that?

4. In addition, for Black Country Partnership Foundation Trust and the CCG:
   • Was there a formal diagnosis of the victim’s mental health or learning disability?
   • What medication was prescribed to the victim and for what reasons?
   • Please detail any liaison between mental health services (community based or secondary) and GP services, in relation to the care of the victim.

3 Background information (the facts)

1. Miriam grew up in Birmingham. She had two older siblings, Flynn and Karl. Her father died in 2000, when she was ten years old. She and her mother left the family home and went to live with maternal grandmother and grandfather with whom she was very close.

2. Miriam apparently largely withdrew from school during years 9 and 10, to care for her grieving mother, who herself died in 2003. Miriam was then fourteen.

3. Miriam first met Graham during this period, when she was 14 and he was 50. (He had emigrated from Jamaica in 2001. He had three adult children in Jamaica.) He lived with his partner, in a neighbouring flat to her grandparents. They apparently first encountered each other when they entered into conversations as he stood outside his home, smoking.
4. Evidence provided by Miriam during child protection enquiries (but now impossible to verify) suggested that although a friendship developed, they did not enter into a sexual relationship until she was 16. However, the developing relationship between Graham and Miriam did come to light and was considered significant enough to cause the breakdown of his relationship with his partner. Graham moved to his sister Julia’s home. Miriam stated that their first sexual encounter was between Christmas and New Year 2005. Medical records show that she had a termination at 9 weeks gestation in February 2006. Although by this time she was absent from school, she had not reached school leaving age. Family support professionals recall Graham being emphatic that there was no sexual element to their friendship until Miriam was over 16. There is no evidence that her brothers or grandparents reported concerns about the appropriateness of the developing relationship between Graham and Miriam. It therefore is possible that initially, they were unaware.

5. She suffered further bereavement with the death of her grandfather in 2007. The loss of three of her most significant adults in childhood or adolescence was to have a profound impact upon her emotional wellbeing. From this point on she had no significant family member looking out for her interests or gently challenging her decisions.

6. Miriam moved to Location 1 in 2007, which coincided with the death of her grandfather. She became pregnant with Ethan, who was born in 2008. At this time, Graham was living mostly with his sister, Julia, but was visiting Miriam and Ethan and occasionally staying. Rebecca was born only 11 months later in 2009. Miriam had moved to Location 2 around a month after she was born. Their third child, Isaac, was born in 2010, Miriam was now 21 and Graham was 57. It was around this time that Graham started spending more time with his family. The family moved to Location 3 in March 2011. They lived together at this address until they separated in February 2013, from which point Miriam only had supervised access to the children. She lived for some of the time with her brother Karl, but also had a new flat, Location 4. Graham and the children remained at Location 3 until the homicide.
7. Since the trial of Graham, it has become apparent that in summer 2015, Graham seriously assaulted Stanley who had been in a relationship with Miriam. Around this time Miriam spent around a month living with Graham, before deciding that she would return to Location 4. It appears that Graham watched these premises and saw Stanley visit Miriam. When Stanley left in the morning of the murder, Graham gained access to the flat and strangled Miriam. The recent presence of Stanley at the address, coupled with suspicions being raised by Graham, led to Stanley’s arrest and charge with murder. It was not until late 2015 that the DHR were informed that Graham and not Stanley would face trial for Miriam’s murder.

8. There were significant delays in the trial process, but Graham was convicted in early 2017 of Miriam’s murder with the recommendation he serve a minimum of 21 years.

4 Chronology of key events

1. This DHR concerns a family with complex needs, and a mother, Miriam, who should have been recognised from the outset of professional engagements as very vulnerable in her own right. Both parents were ill equipped to cope with the challenges of rearing three children born only 27 months apart. However, Miriam’s vulnerability manifested itself in part through aggressive and unpredictable behaviour, which led to her being considered by professionals to pose a risk to her children and their father.

2. Miriam’s relationship with Graham (who was 36 years her senior) had started when she was herself a child. She gave birth to her first child at 18 and had had three children by the time she was 21. The third child, Isaac, was born in 2010 and Miriam subsequently made the claim during rows with Graham that he was not the father. (Graham’s paternity has never been established, but the Family Court was satisfied that Graham was indeed the father.)
3. Miriam was from a white British background. Graham is Jamaican and had grown up there, immigrating to Britain in 2001. There appeared to be differing cultural values that manifested over the years in tensions and poor communication. Sometimes this led them both to make casually racist remarks in the presence of social workers. (Chair’s note: When Graham considered the Overview Report, he denied making any racist remarks.)

4. Neither Miriam’s family, nor the relatives of Graham living in the UK, were initially supportive of the relationship.

5. Miriam came to the relationship with very evident vulnerability. She had suffered significant adverse childhood experiences. Bereavements, a termination and her consequent depression, undiagnosed mental health issues, combined with an apparent learning disability, made her ill equipped to cope with parenting three young children. She had little practical family support. Although her brother and sister-in-law visited often, her brother apparently got on well with Graham and according to a support worker ‘sided with him’. It seems unlikely he would have been sympathetic to any complaints about Graham made by Miriam. Miriam’s relationship with Graham’s relatives rapidly deteriorated. (On the birth of her first child, the family lived briefly with the paternal aunt Julia, but Miriam and Julia appeared to clash, and Miriam moved out.)

6. Graham and Miriam’s relationship was evidently very volatile, with neither parent demonstrating for any consistent period of time the emotional stability and the parenting capacity required to raise three young children independent of family or professional support. From birth and throughout the children’s early years, their parents argued and created a harmful home environment. Miriam appeared to professionals to be self-centred and emotionally unavailable to her children. Professionals recognised Miriam was highly dependent upon Graham, prioritising her relationship with him over the needs of her children.

7. From 2008 until 2015, Early Help support and child protection enquiries identified the weaknesses of both parents and their need for close support and supervision in order to provide ‘good enough’ parenting.
8. Successive child protection enquiries appeared to have led to the conclusion by late 2013 that a care order and the removal of the children from both parents was the preferred option. However, by early 2014, Children’s Services (CS) had endorsed Graham as sole carer, supported by his family. Miriam was considered to have such complex needs that CS had concluded that no package of support could affect the necessary changes in Miriam’s behaviour in an acceptable timescale to allow her to have care of her children.

9. The family were financially insecure, living primarily on benefits. Although Graham had a ‘morning job’ for some time, and was an occasional DJ, he also spent a large part of the time under review out of work and certificated as ‘unfit’. Miriam had the primary care of three young children and had no paid employment during the period under review. Graham was neither literate nor numerate, and it appeared that for this reason, Miriam controlled the family finances. Professionals sometimes characterised this as unhelpful, controlling behaviour by Miriam. Their poor financial situation led them to become in rent arrears, subject to a fine for non-payment of a TV licence, and ultimately in several thousand pounds of debt. These were issues support workers devoted much of their time to.

10. In addition, due to their poverty, the family experienced poor living conditions. It is a feature of the DHR that both Graham and Miriam had considerable contact with housing professionals over the period under review. In contrast with their apparent inability to cope with adversity in their home life, they seemed reasonably adept at finding their way through the complex homelessness procedures.

11. In the early years Graham was not apparently living with Miriam on a permanent basis, staying with his sister’s family. For several years, the council Housing Services were unaware that Graham and Miriam were connected. Miriam first came to notice as a single parent with one child, Ethan, when she applied for housing in 2008. However, she made no ‘bids’ on properties. She was living then at Location 1.

12. She re-registered with Housing in December 2010, from a different address, Location 2, where she had been a tenant since 2009. She applied as a single
parent with three children. Graham also registered in December 2010 but as a single man. He was then apparently living at Julia’s address.

13. It was not until June 2011 that Graham added the children to his housing application, saying that although they lived at Location 3 with their mother, he was applying for custody. He still however was being offered accommodation for a single person, refusing a property in August 2011 on the grounds of ill health.

14. In March 2011 Miriam had taken up a private tenancy at Location 3. The combined chronology would indicate that Graham was living with Miriam at this time. The accommodation was unsuitable and in a poor state of repair. Their tenancy was precarious, because the landlord was in default on a mortgage on the property and the property was subject to action for repossession. From August 2011 to January 2012 the SMBC Private Sector Housing Team were supporting Miriam to require the landlord to carry out repairs. It would appear that Graham was present during several of the visits in this period. Notwithstanding this, when in January 2012 Miriam claimed that she was about to become homeless due to repossession, she applied as a single parent with three children and Graham was not included on the application.

15. In addition to their financial insecurity and poor housing, domestic abuse and neglect of the children were key concerns identified by family support workers and Children’s Services for all of the period under review.

16. Over much of the period from 2009 until March 2015, the family had intensive family support from two separate services; a Children’s Centre supporting the children and family with nursery provision and allocated support workers, but also support workers from a voluntary sector family support organisation supporting Miriam with her learning difficulties.

17. The level of commitment of the key support workers and the duration of their engagement with the family is a key feature of this review. They worked tirelessly and often with little encouragement to support the children and parents. There is strong evidence that support workers frequently shared information and concerns. Although these concerns were raised with
Children’s Services (CS) they often were returned as not meeting the thresholds for statutory intervention.

18. The family were first identified as vulnerable in 2008 at the time of the birth of Ethan, their first child. It was the Children’s Centre and a health visitor who identified concerns, because of Miriam’s believed learning disability and the impact this could have on her parenting. (At the same time Miriam was presenting to her GP with postnatal depression.)

19. For almost a year, the health visitor, Children’s Centre worker and Maternity Support sought to engage with Miriam and Graham with limited success. Miriam was pregnant with her second child, Rebecca, within three months of the birth of Ethan.

20. Children’s Services (CS) received the first referral concerning the family in 2008. Over the subsequent four years, the children were subject of an initial assessment, a core assessment and two assessments under CAFs. CS was also informed of concerns around domestic abuse on five separate occasions. The family were an open case to CS for most of the period under review. The view of CS, summarised in their IMR, suggested that during this period, Miriam was considered to be incapable of providing appropriate parenting. This was combined with apparent frequent displays of anger and aggression directed towards Graham.

21. On the other hand, CS characterised Graham as having consistently expressed ‘concerns about the welfare of the children in the care of their mother.’ However increasing anxiety about both parents’ ability to provide appropriate care, meant the case escalated first to a Child Protection Plan (Dec 2012) and subsequently, a Supervision Order (Feb 2014). There was concerning evidence of the children’s developmental delay and the parents’ apparent inability to provide a stimulating home environment.

22. The combined chronology includes the numerous occasions when Graham reported concerns about Miriam’s parenting to either Police or family support workers. (11/11/2009, 17/12/2009, 11/01/11, 13/06/2011, 01/11/12). In Graham’s view, expressed to professionals over the years, Miriam could not cope and was ‘lazy.’ She allegedly needed to be told what to do, Graham
claimed this extended to ‘when to change a nappy.’ Support workers (who repeatedly noted that Miriam and the children were still in their nightwear when they called in the middle of the day) corroborated this. They recognised that Graham did all the family’s cooking but Miriam claimed Graham would not teach her.

23. The family support workers from the Children’s Centre raised many of these concerns. After the unsuccessful attempts to engage with the family in 2008 and early 2009, they started to work extremely closely with the family in the autumn of 2009 and remained working with the family until April 2013.

24. Over that period, the DHR combined chronology records well over three hundred visits, meetings and phone calls initially mostly with Miriam but then with them both, as well as close contact with the children.

25. Miriam expressed an inability to deal with one of the children whom she felt had very challenging behaviour. There was little evidence that they caused their father the same problems, however support workers and social workers considered that neither parent was consistent in their discipline. Miriam was apparently childlike in her dealings with the children, and unable to set appropriate boundaries. Neither the nursery nor the school experienced the disruptive behaviour the child allegedly exhibited when with their mother. However, the children experienced concerning developmental delay, and it was clear that their parents had little appreciation of how to create a nurturing learning environment.

26. The presence of domestic abuse between the parents was central to the concerns of the Family Support workers and Children’s Services shared these concerns. Many entries in the combined chronology describe how the Children’s Centre Family Support Workers (CCFSW 1 and 2) were witness to the very frequent arguments between Miriam and Graham. These often occurred during visits. Miriam displayed uncontrollable bursts of anger and would apparently hit walls and doors and, on occasions, herself.

27. Professionals knew that the arguments were frequent and abusive. Whilst Miriam was frequently identified as abusing Graham, the reciprocal nature of the abuse was not so evident in professional’s records. Miriam however told
professionals and acquaintances that Graham repeatedly called her names and attacked her ability to care for her children, calling her ‘lazy’ and ‘fat’. The name-calling appeared to have a profound impact upon her self-esteem. Miriam twice called police complaining of domestic abuse by Graham, although she only once claimed to have been hit; an allegation she later withdrew.

28. Graham called police once to allege domestic abuse by Miriam. He claimed to support workers to have been assaulted by Miriam and stated that he was ‘scared’ of Miriam. (A support worker witnessed one incident of assault by Miriam.) He was offered support from domestic abuse services but declined to engage.

29. On three occasions in the period under review, Miriam was noted to have bruising, but was only once asked directly whether her injuries were the result of domestic abuse by Graham. She always denied there was physical violence, and there is no other recorded evidence of domestic violence by Graham against Miriam.

30. Although police attended several incidents recorded as domestic abuse, they were not allegations that resulted in the arrest of either party. They were assessed as ‘standard’ risk, which would lead simply to letters signposting to domestic abuse services. Neither parent was assessed as being at high risk or subject of a Multi-Agency Risk Assessment Conference (MARAC). From a policing perspective, based upon the frequency of calls for help and the severity of the incidents attended, domestic abuse was not a significant issue during the period under review.

31. The more significant police callouts were when professionals were concerned about the behaviour of Miriam and the child protection concerns that arose. (One incident led to Miriam being arrested to prevent a breach of the peace but she was rapidly de-arrested when she was away from the home.)

32. Domestic abuse was nonetheless a major contributory factor when the Local Authority was given a Supervision Order in February 2014. The Supervision Order described Graham as a victim of domestic abuse. Although the schedule of facts presented to court stated; ‘the parents have often allowed the children
to see and hear violent rows when they shout at, hit and abuse each other. This distresses the children and makes them anxious and aggressive’.

33. Graham’s responsibility for the domestic abuse appeared to be minimised by professionals, and contrasted with Miriam’s very frequent volatile behaviour, which also manifested itself in outbursts aimed at professionals. However, one of the directions of the order was that Graham should attend a domestic abuse programme since he failed to acknowledge the impact it had had on his children. He apparently never complied with the direction.

34. The support workers from the Children’s Centre commenced their work with the family shortly after the birth of Ethan and continued during the two subsequent pregnancies and births. Over the four years of their engagement with the family, there was increasing concern that the development of the children was delayed. There were significant concerns that Miriam was unable to provide the nurturing care and stimulation that the children required. Graham was also seen to have little understanding of positive parenting.

35. On several occasions during the involvement with the family, one or other child was found to have injuries that the parents alleged were accidental or inflicted by a sibling. A lack of appropriate supervision of the children by both parents was a recurrent concern and one that remained relevant in relation to Graham as sole carer, even during the Supervision Order.

36. The concerns led to referrals to CS in October 2010, February and December 2011 and November 2012. In December 2012, following concerns that one of the children had been injured due to lack of supervision, the children were made subject of a Care Plan due to emotional abuse.

37. A key episode in February 2013, when the children were already on a Care Plan, involved concerns that Miriam was in a mental health crisis and had repeatedly punched the walls in the presence of the children, who were scared.

38. As a consequence, Miriam separated from Graham from February 2013 until the homicide. They claimed to no longer be in a relationship. There followed a long period of supervised contact with the children, held at the Children’s Centre. This was under a working agreement with Graham and Miriam rather
than a court order. The arrangements, which involved Graham bringing the children to the Children’s Centre for contact, meant there were opportunities for conflict, which did occur on several occasions. Miriam was considered by professionals to be the instigator. Support workers noted that when conflict arose, Graham would try to defuse the situation by leaving.

39. It seems clear that having her children removed from her joint care and placed in the sole care of Graham had a negative impact upon Miriam’s mental stability at a period when her behaviour was subject to close attention. By April 2013, Miriam had reached a point where her aggression and abusive reactions to professionals was a particular concern. These included threats to get the lead social worker killed. However, with a Child Protection Plan in place, and Miriam now living out of area with her brother, it was agreed in April that the Children’s Centre workers should withdraw and close their case. They had been an ever-present support to Miriam, reacting to each and every crisis patiently, despite Miriam’s extraordinarily volatile and changeable moods.

40. As Graham assumed greater responsibility for the children, his own shortcomings as a parent became clearer. In 2013, there were several concerns about lack of supervision, accidental injuries and dangers in the home to which he seemed oblivious. Graham’s associates were considered unsuitable yet were having access to the children. His cannabis use was identified as problematic. Professionals began to be concerned that he did not understand or demonstrate a willingness to engage with the Care Plan except to his terms.

41. The family were still supported by the voluntary sector family support organisation social worker, who had for a period overlapped with the Children’s Centre provision. Under the Child in Need plan in early 2015, Miriam was allowed to pick up each child from school on a rotational basis and have unsupervised contact in her home. The Supervision Order ended in February 2015. Thereafter it is unclear how much time Graham and Miriam spent together.

42. Miriam’s complex needs were identified as being relevant by every professional who came into contact with her either in response to concerning
incidents, or in more routine professional engagements. The relationship between her mental health concerns, bereavement trauma and learning disabilities only emerged slowly.

43. Miriam’s intellectual disabilities were identified early, but not fully assessed during her time at school. Miriam herself disputed the diagnosis. Yet during the course of child protection enquiries some professionals described her ‘learning disabilities’ as ‘profound’ or ‘severe’.

44. Miriam received support from a voluntary sector family support organisation from March until September 2010 and then again from February 2012 until the end of July 2014. Their remit was to provide support for adults with learning disabilities who also had children. The chronology records around 150 meetings, visits, appointments and phone calls with the family over the two periods.

45. Yet the levels of any learning disabilities were not assessed until July 2013 when an Educational Psychologist conducted psychometric tests during the council’s application for a Supervision Order. The report’s conclusions were available to the court and to key social workers and support workers engaging with the family.

46. She was assessed using the Wechsler IV\(^1\) Psychometric tests. These showed that Miriam would experience significant difficulties successfully understanding and expressing language. The data also showed that she had trouble with activities requiring skills in speed of processing, attention, concentration and mental control. The report concluded Miriam would find it difficult to learn and retain new information. Her overall IQ level score of 53 placed her in the bottom 2% of the UK adult population. This would suggest she had a mild/moderate intellectual disability.

47. BILD, the disabilities support charity, describe the impact of these IQ scores on day to day living: ‘People with a moderate learning disability have an IQ of 35 to 50 and are likely to have some language skills that mean they can

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\(^1\) The Wechsler Adult Intelligence Scale (WAIS) is an IQ test designed to measure intelligence and cognitive ability in adults and older adolescents and is the most widely used IQ test in the world.
communicate about their day to day needs and wishes. Some people may need more support caring for themselves, but many will be able to carry out day-to-day tasks.’

48. ‘People with a mild learning disability have an IQ of 50 to 70 and are usually able to hold a conversation and communicate most of their needs and wishes. They may need some support to understand abstract or complex ideas. People are often independent in caring for themselves and doing many everyday tasks. They usually have some basic reading and writing skills. People with a mild learning disability quite often go undiagnosed.’

49. The trauma she suffered in her adolescence following successive bereavements was addressed on several occasions. Following the death of her mother in 2003, she had received support from CRUSE. The DHR was unable to obtain details of the outcome of this support.

50. Miriam was subject to a CORE assessment by the Primary Care Liaison team in March 2008 again in relation to depression as a consequence of bereavement trauma. She was advised to undergo counselling but attended only two of the six sessions offered.

51. Miriam’s GP became aware in late December 2011 and January 2012 of Miriam’s minor self-harm episodes, anxiety and panic attacks, sleep deprivation and mood swings and the impact her unhappy relationship was having upon her mental health. Her low self-esteem was noted. The GP felt Miriam might be suffering bipolar disorder that needed to be explored. Although this assessment was requested, no definitive mental health assessment was available to professionals at this stage. The GP was able to arrange very swiftly eight one-to-one counselling sessions between January and May 2012. Miriam was referred back for counselling in November 2012 but did not attend and after several appointments were missed was referred back to her GP.

52. The counselling sessions identified the significant impact of bereavement but also noted her poor relationship and that Miriam felt unsupported by Graham who did not ‘understand’ mental health concerns. (This was an observation
echoed by voluntary sector family support organisation support workers once they started working with the family.)

53. For much of the period under review Miriam was taking the anti-depressant medications, Citalopram or Sertraline.

54. In March 2013, as a consequence of the care order applications before the Court, a consultant psychiatrist assessed Miriam as suffering a personality disorder. This was disputed by Miriam but re-affirmed by the psychiatrist in a conversation with Children’s Services in August 2013. The consultant psychiatrist described her personality disorder as ‘untreatable’ and explained ‘there are no resources available.’

55. There did not appear to be recommendations for mental health support for Miriam accompanying the psychiatric report. This coupled with the questionable view that a personality disorder was ‘untreatable’ probably accounted for the pessimistic long-term prognosis for Miriam’s mental health that was manifested by Children’s Services during care proceedings.

56. Miriam did however attend an anger management course from May to July 2013, to try and address her poor self-control, which she had acknowledged was at the heart of her problems. After attending the full course, she told social workers that she now understood the strategies she was supposed to employ. The DHR noted that after Miriam had attended these sessions (which ended in July 2013), the combined chronology contained no significant examples of the kind of violent confrontations and arguments with Graham that had been witnessed by professionals. There was some evidence of improvement in Miriam’s behaviour. During a home visit by the voluntary sector family support organisation involving contact between Graham and Miriam in June 2013, a support worker recorded her observation that Miriam was calmer and more rational than Graham, who expressed frustration at the continued interventions in his life by CS.

57. CS’s supervision of the family started in December 2012 where a CP plan was commenced due to emotional abuse. 2013 saw the worst of the clashes between Graham and Miriam as Graham had sole care of the children after the
incident in February 2013 (paragraph 37 above) and supervised contacts provided a frequent ‘flashpoint’.

58. Yet Graham’s sole care of the children came to be seen by all professionals as very problematic. In April 2013, after a first home visit had found Graham outside, with the children inside, unsupervised, a further unannounced visit by CS found the children again at risk. They were playing within reach of both an unprotected, plugged in, hot iron and a full Calpol bottle. One of the children was noted to have a bruised eye. Graham did not respond well to the safeguarding advice he was given, claiming that children ‘were born with their behaviour and parenting doesn’t make a difference’.

59. In May 2013, a home visit again found Graham outside the front door smoking what was believed by social workers to be cannabis, whilst the children were inside unsupervised. One of the children was seen to hand his father a packet of cigarettes though the letterbox.

60. An anonymous allegation investigated by CS suggested that Graham had left the children in the care of a male friend who was drunk and who had recognised alcohol issues.

61. In July 2013, the children’s school raised concerns that one of the children had an injury.

62. In August 2013, according to a statement presented to court, two announced home visits by the Children’s Guardian found the property in ‘complete chaos’. The guardian noted that the children were unkempt with dirty hair and clothes. Two of the children had on unmatched shoes. The sitting room was so cluttered there was no space to sit. The children were downstairs when the guardian arrived and had to call to their father who took some time to come down, which suggested that they had again been unsupervised. Graham when challenged was ‘not acknowledging the Local Authority’s concerns and did not require their assistance’.

63. The local authority’s position became clear and was supported by the Children’s Guardian; Graham was not capable of providing the necessary safe environment for the children, and Miriam remained a risk. They therefore sought an interim care order (ICO) however the parents contested this.
64. The Children’s Guardian prepared a report to court in September 2013, acknowledging that Graham was now receiving significant support from his sister Julia and his niece Faith. However, the guardian maintained that Graham still needed to be able to demonstrate the ability to learn and change;

65. ‘I consider that a thorough intensive and time limited assessment is required of how Graham manages the children’s day-to-day care, their stimulation, health needs and their emotional wellbeing. In addition, how the paternal family assist in the children’s care and to what degree that support is appropriate or whether it has become a substitute care arrangement due to levels of Graham’s attentiveness to the children.’

66. During the following four months, Graham received support from Julia and Faith and apparently managed to improve the standard of care of the children and managed to maintain order in the home. By January 2014, the Local Authority had undergone a change of direction and felt that a 12-month supervision order was an appropriate level of intervention.

67. The Children’s Guardian seemed reassured that change had occurred but attached caveats to the positive assessment of Graham. In particular, it was suggested that the Order may need to be extended. The high level of family support was a positive feature but led the Guardian to consider that, without continued family support, Graham may not be able to maintain the improvement once professionals were no longer involved. The PAMS 2 assessment carried out indicated that Graham struggled to provide evidence of how he had changed, tending to one-word answers to questions.

68. Both Julia and Faith acknowledged that Graham needed frequent prompting to ensure his care of the children was appropriate but felt he could achieve change with their help.

69. The Supervision Order granted in February 2014 made certain stipulations of Graham to address the deficiencies in his parenting capacity. He was to

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2 PAMS is a methodical and functional method of looking at parenting which incorporates evidence-based and multidimensional assessment tools – including the exploration of the parent’s knowledge of parenting, observations of the parent and child together, feedback from the parent, and feedback from other professionals.
complete work around domestic abuse and the impact on children. He was required to engage with basic literacy skills and complete parenting courses. Graham and Miriam were informed that if they resumed their relationship, the matter would be taken back before the court.

70. The DHR found little evidence that Graham and Miriam actively engaged with the Supervision Order’s Child in Need Plan during most of 2014, and this was the view of the Care Management SW (who took on the supervision of the family in October 2014).

71. It appeared that Graham was not prepared to engage with any of the stipulations of the order aimed at improving his parenting skills and reducing his reliance upon his family. He refused to engage with a domestic abuse programme. He engaged briefly with literacy skills but then withdrew. When challenged, he stated he did not need the work because he had Julia and Faith’s help. The DHR found no evidence that he engaged with the Family Intervention Programme (FIP) parenting classes as stipulated in the plan, or the Changes programme, which in contrast, Miriam did attend.

72. Supervision orders are managed under a Child in Need (CIN) Plan and consequently the Child Protection Plan was closed in February 2014.

73. The Children’s Services report at the Review Conference gave an indication that long-term planning was based upon the continuing success of the combined care provided by Graham, Julia and Faith.

74. Children’s Services summarised their view of the prospects for being able to address Miriam’s mental health and behavioural issues explaining; ‘that the degree of intervention and psychotherapeutic work required to address Miriam’s dysfunction is so great that it would not be completed in timescales suitable for the children and in fact may never be completed. To this end there is a poor prognosis for change and a strong likelihood that the safety of the children would be impacted upon’.

75. If Graham was therefore to become a long-term single parent and principal carer for the children, he needed to demonstrate an ability to maintain an acceptable standard when no longer intensively supervised by Julia and Faith. Yet it is far from clear how much routine care of the children was done by
Graham, during the Supervision Order. Although the home was cleaner, it seems the very frequent interventions of Faith and Julia may have been the reason.

76. Graham was still exhibiting some of the behaviours that had caused concern in 2013. In November 2014, the SW could detect a smell of cannabis in the house. During a visit in February 2015, the SW was concerned that a saw, hammer and knife had been left out within the children’s reach. In addition, Graham was associating with friends who were suspected of being involved in cannabis cultivation.

77. Although Miria’s relationship with Graham was believed to be at an end, her contact with the children would remain an issue, requiring careful management, since it had been the catalyst for domestic rows and disputes in the past. The use of a Contact Centre continued during the supervision order. Miriam was allowed increasing access, until she had each child staying with her overnight on a rotational basis.

78. By January 2015, Children’s Services were aware that Graham had formed a new relationship with a female acquaintance. Graham refused to allow police checks to be carried out on her and would not co-operate with CS to allow any assessment of her. Miriam knew of her frequent presence in the home and was unhappy about it. However, there is no evidence it led to arguments between Graham and Miriam.

79. By March 2015, the view of Children’s Services was that their involvement could end. Although Graham was offered Early Help support, he was clear that he could manage on his own and did not want further involvement of professionals in his life. Graham and Miriam were apparently apart and intended to remain so, which Children’s Services felt was in the best interests of the children.

80. At the Review meeting of the 13/03/15 the Care Management Social worker made it clear that she did not yet want Miriam collecting or being responsible for all three children at once; this would be something that may be possible in the future. However, given that the intention expressed at the meeting and
endorsed by those present, was to close the case, this was being left to Graham and Miriam to manage.

81. On the 18/03/15 the Care Management Social Worker went back to Graham’s home for a farewell visit. The records show that the SW found Graham to be heavily under the influence of cannabis and was staggering and ‘toppling over things’. The children were unsupervised and the house was in ‘disarray’. The concerns were recorded but not subject to any management oversight on the day. Children’s social services did not instigate any emergency procedures.

82. On the 24/03/15 the team manager was not on duty and the covering manager endorsed the case closure based upon the rationale already recorded by the absent team manager, but before the recent visit. There is no evidence that the manager was aware of the new concerns or that they had been raised in such a way that closure of the case would have been impossible, without an appropriate risk assessment.

83. This was the last involvement of Children’s Services until after the homicide of Miriam.

84. It is unclear when Graham and Miriam started spending more time together, however there is some evidence from sources other than Children’s Services that this was the case and that it may have started during the Supervision Order.

85. In June 2014, Miriam sought contraception from her GP in Birmingham, because she stated ‘she was in a relationship with her ex-partner’. In October 2014, Miriam told a social worker she was still in a relationship with Graham, but this was not confirmed by Graham and did not tally with the view of professionals.

86. At some time in early 2015, Miriam started a relationship with a Jamaican male of 52, Stanley, who was married and living with his wife. In a conversation with the chair he disclosed that he had met Miriam by chance in a local shop and they fell into conversation. He began to visit her at her flat, Location 4. The relationship became a sexual one. Stanley claimed that he knew Graham who he had also encountered by chance in the main street, near his home. He did not immediately make any connections between Graham and Miriam.
However apparently because he tended to routinely use a distinctive looking cycle, Graham and Miriam realised they both knew Stanley.

87. Shortly after, Graham apparently called out to Stanley in the street and revealed that Miriam had said Stanley was helping her out and ‘was very kind.’ Stanley stated he felt uncomfortable meeting Graham, who Miriam had told him he had treated her badly, abusing her verbally, and on at least one occasion physically.

88. He felt anxious but was not threatened by Graham, who was not apparently outwardly challenging him about the relationship. It appears that on several occasions they discussed the developing friendship between Miriam and Stanley.

89. At some time in summer 2015, according to Stanley, Miriam told Graham that she was in a sexual relationship with Stanley and compared the two men in a way that was unfavourable to Graham.

90. Also, in summer 2015, Stanley had been at home and was watching TV. He decided to go out and buy some cans of drink, and near the off licence encountered Graham. He told him his plan, and Graham suggested he would pay for the drinks if Stanley would buy them, explaining he was barred from the premises after a dispute with the licensee. He then suggested that they returned to Location 3 which was nearby. Stanley agreed and went to Graham’s home. The children were apparently visiting the maternal uncle.

91. Stanley states that there was no confrontation or any indication of Graham’s intentions, if these had been formed in advance. At one point, Graham was pacing around behind him and then struck Stanley forcefully to the head. (He later found out from Miriam the weapon was a hammer.) Stanley and Graham then began to fight, as Stanley tried to escape through the front door. Graham prevented this, locking the door and removing the key. Graham then armed himself with a small kitchen knife as Stanley tried to escape through the back door. He stabbed Stanley through the windpipe, but in the struggle, Stanley managed to remove the knife, sustaining a severe cut to the palm of his hand. Using the knife to hold Graham off, he managed to get to the rear of the premises and to his cycle.
92. He then rode home, having made improvised bandages to cover his wound in a local takeaway restaurant. At home, he secured more permanent bandages to his wounds, removed bloodied clothes, and hid the knife in a cupboard. He then cycled to the nearest A & E hospital, where he collapsed, and because of the extent of his injuries, was placed in an induced coma.

93. When police spoke to Stanley, he did not identify Graham as his attacker. Instead, to prevent his wife discovering the relationship with Miriam, he reported being attacked in the street by three unknown men.

94. When he was discharged from hospital some days later he realised Miriam had made repeated calls and text messages to him. She had apparently become aware from Graham that he had been in a fight with a man and had stabbed him, but apparently, she claimed she was unaware that it was Stanley.

95. Stanley stated that he received no further threats from Graham, but that Miriam pleaded with him not to report Graham, because she felt if he did, Children’s Services would remove the children from her. (If this was indeed her view, it is possible that she meant that with Graham removed from care of the children, they would be placed in LA care). Stanley stated he remained silent because he felt sorry for Miriam.

96. Stanley said that local opinion was that Miriam had encouraged Graham to attack Stanley on her behalf. When challenged he offered no reason why this would be the case and said that Miriam was insistent that this was not so.

97. It appears that Miriam was again living with Graham from around the time of the attack upon Stanley. It is not clear whether she felt safer being with Graham, but Stanley stated that she was not apparently scared of him, but said she was ‘watching Stanley’s back’ which suggests she may have been fearful for Stanley?

98. A few weeks later, Miriam called police saying that she was receiving threats from a man by text, who had threatened to ‘shut her up for good.’ The police log stated that around a month before, the same man had ‘threatened her children’s father with a knife.’ On attendance to Location 3, police established the man was Stanley. The officers were told in Graham’s presence that Miriam had had a brief sexual relationship with Stanley. They viewed the texts on
Miriam’s phone, none of which were menacing, and included one from Stanley saying; ‘shut up and leave me alone.’

99. It became clear to officers that Miriam’s motive was to get into contact with Stanley and she asked the officers to tell Stanley to contact her, which they declined to do. The allegation of a threat with a knife, which had been made by Miriam in her call to police, was not discussed at the instigation of the officers, nor was it mentioned again by Miriam, or Graham if indeed he knew it had been made. The closure of the police log made no reference to this part of the allegation.

100. At some time in the period after the assault by Graham, Stanley and Miriam resumed their relationship. They were not apparently fearful of Graham. Miriam moved out of Location 3 and back to her flat at Location 4, where the night before the homicide, Stanley became the last person to see Miriam alive. On the day of the murder, Graham gained access to Miriam’s flat, having apparently seen Stanley leave. He strangled Miriam and went to lengths to remove any forensic evidence. Her brother Karl discovered Miriam’s body.

5 Analysis

1. In analysing the prolonged engagement that Early Help professionals and Children’s Services had with the family, the DHR has attempted to identify the decisions that had an impact upon the safeguarding of not only the children, but also their parents. Particularly relevant were the opportunities that professionals had to understand the needs of the whole family and identify their strengths but also issues that needed to be addressed and prioritise them appropriately.

2. With hindsight, the tragic outcome of this case would suggest that Graham was jealous, controlling and possessive, even though he frequently told professionals he did not want a relationship with Miriam. His attempt to murder Miriam’s short-term partner, Stanley, and the later homicide of Miriam, is the most compelling evidence of Graham’s need to control that
relationship. Miriam had appeared dependent upon Graham and although Graham gave an outward impression to professionals of finding this wearisome, it seems he went to lengths to cultivate it. Ultimately it seems it was Miriam giving her affection to a new partner, that led to her death.

3. What is clear is that this very violent outcome was entirely unpredictable. Graham had no history of violence, and the relationship, although plagued by domestic abuse, showed few signs of physical abuse, albeit the DHR has indicated worrying potential signs in relation to physical abuse of Miriam.

4. What apparently was never fully understood was the basis of the friendship and then relationship, between Graham and Miriam. Should Graham have been identified early on as exploiting a vulnerable child?

5.1.1 Miriam’s early vulnerabilities: Absence from school, learning disabilities, poor sexual health and child sexual exploitation (CSE)

1. Miriam’s failure to regularly attend school, and the emotional pressure associated with caring for her mother during the terminal stage of cancer, led to a period of Children’s Services involvement from March 2003 until May 2004.

2. The scant records that remain suggest that concerns were around Miriam’s absences from school as she nursed her mother. The notes allude to her mother’s apparent ‘blasé’ attitude to Miriam’s attendance. There was one recorded meeting at Miriam’s school in November 2003, involving a social work team manager, an Education Welfare officer, and Miriam’s head of year to plan a home visit, and a revised shortened timetable to encourage attendance.

3. Miriam’s learning disability was known, but she did not have a Statement of Special Educational Need (SEN). She was recorded at Stage 2 (of a four-step process) and her withdrawal from school meant she never received the level of support that would have accompanied a SEN, or any formal assessment of her learning disability whilst in compulsory education.

4. Miriam’s role as a young carer does not seem to have been fully acknowledged and whilst Miriam’s mother’s attitude to her education was considered poor,
it is perhaps understandable that she wanted to spend as much time with her
daughter as possible. Social Care closed the case in 2004 (some months after
Miriam’s mother died) and there is no indication that Miriam was recognised
as vulnerable or requiring support beyond a referral to CRUSE.

5. The DHR has not been able to establish whether professionals also identified
during this crucial period that Graham was involved with Miriam, although he
seemingly was. (Birmingham Children’s Social Care destroyed paper files in
2008 in line with their retention policy.) It is quite possible Graham’s grooming
of Miriam was not known to Children’s Services, her mother, grandparents or
brothers. It is also unclear when Graham broke up with his partner and left the
address, and whether the reason (his relationship with Miriam) became known
to Miriam’s family.

6. As a consequence, if there was no professional assessment of Miriam’s
developing relationship with a man 36 years her senior, this was a missed
opportunity to investigate in its earliest stages what was to become an
exploitive sexual relationship involving a child or young person and an adult.

7. Had the relationship been identified, child protection procedures that existed
at the time could have identified Graham as a potentially risky adult, although
the understanding of the dynamics of child sexual exploitation (CSE) and
procedures were significantly less developed than they are today. Civil
remedies that form part of current CSE responses, such as child abduction
warning notices (Section 2 Child Abduction Act 1984), were already being used
to prevent the removal of a child from a parent or carer in cases where
grooming was suspected. They served as a formalised warning to a potential
perpetrator to stop associating with a named child.

8. Clearly if Miriam was determined to form a relationship with Graham, it is
possible that she could have waited until adolescence, however there is strong
evidence from the events that unfolded that Graham and Miriam intended to
have a sexual relationship. She reported that her first sexual encounter
occurred between Christmas and New Year 2005, when she would have been
16 years old. She then had a termination in February 2006 that, in her view,
led to her depression. She had not yet left her grandparents’ home (she left
around the time her grandfather died in December 2007). At the time, she said
the sexual activity and pregnancy was with a male of around her own age,
however she would not identify him. With hindsight, this was probably an
attempt to prevent her relationship with Graham being investigated.
9. It is not possible to tell what level of counselling, screening and assessment
was carried out when she sought a termination. Professionals coming into
contact with Miriam usually quickly identified some learning disability, so it
does not seem unreasonable to suggest some level of safeguarding concern
should have been present during any counselling/consultation.
10. Miriam’s GP notes describe how because of a very early resumption of sexual
activity following the termination, she suffered pain and infections. There is
no evidence of any referrals or support being offered at this point.
11. Miriam was pregnant again by 2007 and she did not attend (DNAed) several
early appointments. In 2007 she lost her grandfather, who had been the last
significant adult in her life (apart from Graham). She now had no one left
‘looking out for her’ and advising her on her life decisions. Ethan was born in
2008.
12. The teenage pregnancy midwife and maternity support workers recognised
concerns for Miriam based around what they described as ‘profound learning
difficulties’ and depression due to bereavements and a referral was made to
Social Services and Miriam was introduced to the Children’s Centre. Significant
work was done by these services to engage with Miriam and yet she was soon
pregnant for a third time, three months after giving birth.
13. Despite the good work by the teenage pregnancy midwife to support Miriam,
because of concerns that she would not have the parenting skills needed,
Graham’s role was apparently not explored, and the support offered by Julia
(Graham’s sister) was characterised as positive. However, the relationship
between Julia and Miriam rapidly broke down, and by late 2008 she had moved
out. Apparently, Julia would not, or could not, tell concerned professionals
where Miriam had moved.
14. Community health services continued to try and engage with Miriam up to and
after the birth of Rebecca in 2009. Yet only a month later, Miriam was
reporting unprotected sexual intercourse with Graham and was undergoing pregnancy tests. In late 2009, she attended the Family Planning Clinic to have a contraceptive implant, and Miriam stated she did not need it because she had split up from Graham the day before. A week later, asked about what contraception she would adopt, she explained they would use condoms, although Graham ‘did not like using them.’

15. Although health professionals apparently worked hard to try to empower Miriam to take control of her sexual health, the absence of an independent family member advising her and questioning her choices seems to have been a significant reason for Miriam’s vulnerability. Graham’s involvement in the care of his two children was very limited, as was his support for Miriam. His demands in relation to sexual activity appeared selfish and reckless and showed no regard for Miriam’s health. It does not appear that professionals challenged this harmful dynamic or robustly challenged Graham.

16. By 21, Miriam was a very vulnerable mother of three children. There is no evidence that professionals identified as potential abuse Miriam’s four pregnancies and three births, so close together. Reproductive coercion is increasingly recognised as a form of abuse but was less so then.

17. It is possible that Miriam chose to become pregnant to reinforce her connection to Graham. (However, his failure to move in with her after the first two births would suggest this was unlikely). Just as strong an argument could be made that having three children increased Miriam’s dependency upon Graham and he exerted his control through her children.

18. Had what appeared to be an inappropriate relationship been investigated at the time, it is possible that it would have confirmed that Graham had been grooming Miriam from an early age, even if could not be established that sexual activity had occurred before Miriam reached her sixteenth birthday. The domestic abuse concerns that first were reported in 2009, only a few weeks after the birth of Rebecca, would have consequently been viewed through the prism of this potentially exploitative relationship. It was an evident characteristic of Miriam’s relationship with Graham that she was highly dependent. In a later court statement SW1 explained; ‘Miriam and Graham
have prioritised their attachment and relationship with each other over their attachment and relationship with their children.’

19. Even if professionals knew little of how the relationship started, these issues, which related to the dynamics of that relationship and motives of Graham and Miriam, should have been explored in detail in 2008/2009. (This seems particularly relevant since any ‘corporate memory’ of the Children’s Services work had been lost because of file destruction policies.)

20. It did not appear that the Children’s Centre or Children’s Services started their engagement with the family with a careful assessment of the genesis of the relationship. It is also apparent that professionals shied away from asking ‘difficult questions’ about this apparently exploitative relationship. None of the IMRs were able to provide a comprehensive account of Miriam’s early years which would suggest that practice was not informed by this crucial understanding. It was only in the social worker’s initial statement to the court during the proceedings for the Care Order (August 2013) that any detailed history emerged.

21. If the child protection and safeguarding work was not carried out with a clear understanding of the parent’s complex needs and the true nature of their lives together, then there was a real risk that subsequent assessments would be potentially flawed and unreliable.

22. The lack of an early assessment, in the view of the Children’s Centre IMR, explained a lack of direction in the lengthy engagement of the support worker team, who became very task-driven.

23. Even when safeguarding concerns were raised about Miriam’s ability to look after Ethan, it did not seem that any attempt was made to understand the impact of her childhood experiences and her reliance upon Graham. Similarly, the birth of Rebecca, only eleven months after the birth of Ethan, did not prompt such enquiries.

24. Work carried out to support Miriam as a young mother was well meaning and diligent but did not grasp the central issue. Miriam was a child with significant vulnerabilities when Graham started a relationship with her, and this
relationship carried on from childhood, throughout the transition into adulthood.

25. The DHR considered whether professionals in Sandwell now have a better understanding of child sexual exploitation and vulnerability and would recognise how the same vulnerabilities impact upon a young adult as they transition from child to adult during the critical years from 16-18. These issues are addressed in section 11.1

5.1.2 Domestic abuse and the mechanics of coercive or controlling behaviour

1. If, as seems the case, Early Help and child protection assessments were not informed by a genuine understanding of the family’s background, and the impact of bereavement on Miriam’s susceptibility to being groomed, then it became all the more important that professionals recognised the true nature of the domestic abuse occurring within the family context.

2. The risk that interventions will be ineffective is far greater when domestic abuse is recognised, but not properly understood. It appeared to the DHR that professionals failed to address the central presenting issue in understanding the family; why was Miriam so hostile to Graham and yet so apparently dependent upon him?

3. The DHR acknowledged that Miriam gave many of the outward signs of being the principal perpetrator of domestic abuse. There is little doubt that Miriam frequently drew attention to herself. Her outwardly volatile and frequently aggressive behaviour and absence of consistent parenting capacity justifiably caused safeguarding professionals to fear for the safety and wellbeing of children in her care.

4. Yet although professionals often described Miriam’s challenging behaviours, their assessments were not based upon a proper understanding of her historical relationship with Graham and the critical impact of her childhood experiences upon those behaviours. It appears that Miriam was seldom given the opportunity to explore the influences upon her behaviours and this probably caused her the intense frustration she often demonstrated to professionals. Miriam’s increasing anger, her aggressive reactions, challenged
professionals. Their analysis increasingly focused on her behaviour, leading her to withdraw and become less co-operative and apparently more irrational. This narrative became so firmly embedded that her later small but significant steps towards appropriate parenting were not celebrated or given proper weight.

5. Notwithstanding this, the child protection measures that were eventually taken were justifiable; indeed, it could be argued that thresholds had been met before December 2012, when the children were taken to Child Protection Conference and placed on a plan. Family Support were involved with the family for three years and probably prevented them spiralling into crisis on numerous occasions. However, in the absence of any genuine progression, they may also have delayed the inevitable: statutory child protection interventions.

6. Domestic abuse was a concerning feature of the relationship from very early on. Professionals were witness to episodes where Miriam was volatile and angry with Graham, shouting and abusing him in front of them on multiple occasions. Her lack of self-control, her unpredictable behaviour, was ascribed to her learning disability, her mental health and her apparent personality disorder.

7. There has been no satisfactory evidence offered to the DHR that demonstrated professionals considered the motives behind Graham entering in a relationship with a vulnerable, recently-bereaved child. It does not appear he was ever genuinely respectful and supportive, understanding her complex needs and helping her to cope with them. Instead, he seemed frequently negative and quick to inform professionals of her inadequacies and the impact they were having on him. Only her growing dependency upon Graham was evident.

8. Miriam’s vulnerabilities were well known, but the potential link to domestic abuse was not always made. The counsellor who worked with Miriam over eight sessions in January to June 2012 told the learning event that Miriam never disclosed the presence of domestic abuse, and the referrals made did not explain that Miriam was considered to be both a victim and perpetrator of domestic abuse. It appeared to the DHR that this was a significant missed opportunity to help Miriam to understand her underlying issues. This seemed
to be because the GP who saw Miriam was deflected from asking questions about domestic abuse by Miriam but also by the family support worker.

9. By late 2011, there was increasing evidence that Miriam was suffering depression accompanied by suicidal thoughts. She apparently received no support from Graham, who by his own admission did not ‘understand depression’. In December 2011, she attended her GP with CCFSW1, and when asked about the causes of her depression, said she had ‘no problems’ at home. The CC records showed CCFSW1 agreed. The GP therefore noted that Miriam had a support worker and a ‘supportive partner’.

10. This was a significant missed opportunity to explore with Miriam the risk of domestic abuse in the household. Given that only seven days before Children’s Services had started a CAF, it seems extraordinary that with a professional present, who had repeatedly witnessed abusive behaviour, Miriam was apparently not encouraged to disclose it. Instead, the GP gained no understanding of the dysfunctional relationship between Graham and Miriam. This would have influenced the issues raised in the counselling referral made and would explain why the counsellor did not take the opportunity to explore the impact of domestic abuse.

11. Yet in January 2012 when counselling had already started, Miriam told the same GP that her depression was caused by her troubled relationship with her partner. This did not apparently prompt the GP to ask questions about domestic abuse and the conversation seemed restricted to discussing services like ‘Relate’.

12. In May 2012 when the counselling sessions were completed, and the same GP reviewed Miriam, the records showed ‘she felt that she had progressed but still suffered with significant anxiety. She stated that her partner was finding it hard to understand but told the GP that he was kind to her.’

13. At the very least, there appeared to be contradictions in Miriam’s feelings towards Graham that should have been explored through the context of domestic abuse. It is likely, however, that the GP would have expected such information to have come from the support worker and be acted upon by that worker if domestic abuse existed.
14. The support workers and Children’s Services had shared concerns about domestic abuse and it is frustrating that the counsellor was apparently unaware of how significant those concerns were.

15. It seemed to the DHR that running through the engagements of most professionals was an apparent lack of awareness of how coercive or controlling behaviour in a relationship can be disguised behind compliance. Professionals appeared to be disproportionately influenced by Miriam’s erratic behaviours and did not adequately explore the part Graham potentially played in reinforcing these behaviours, rather than providing Miriam support. Graham’s ability to offer professionals apparent rationality and calm contrasted with Miriam’s outward displays of volatility, and created a narrative so firmly imbedded that it became impossible to dislodge even when, later on, Graham’s own inadequate parenting became evident.

16. Miriam was in a relationship with a man on whom she clearly depended, but upon whom she could not depend. As later experience would show, when Graham was given sole care of the children, he also had very little understanding of appropriate parenting (in spite of having already had three children in Jamaica.) He failed to supervise the children, who suffered injuries, and was only able to manage the household with the direct and near constant interventions of two relatives, Julia and Faith. When less closely supervised towards the end of the supervision order, it is clear the cleanliness and order deteriorated.

17. In the early years of agency involvement with the family, at least until February 2013, when he had sole care of the children, he was able to convince professionals that Miriam was largely to blame for the deficient parenting, without his part in the neglect being highlighted. He also managed to persuade professionals that he was a victim of Miriam’s domestic abuse that was unprovoked and irrational.

18. In his study of coercive controlling men ‘Why Does He Do That?’ 3, Lundy Bancroft, who spent seventeen years leading the first programme for abusive

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3 Why Does He Do That? Inside the Minds of Angry and Controlling Men. Lundy Bancroft
men in the US, ‘Emerge’, describes how; ‘In one important way, an abusive man works like a magician. His tricks largely rely on getting you to look off in the wrong direction, distracting your attention so that you won’t notice where the real action is.’

19. There is considerable evidence that Graham repeatedly undermined Miriam’s self-esteem, attacking her parenting ability in front of professionals from very early on. He appeared quick to judge and point out poor parenting by Miriam, even though she had looked after Ethan and Rebecca largely on her own.

20. In the first six months of the family support engagement from August 2009, Graham was apparently rarely present. In late 2009, by which time Miriam was pregnant with her third child, Graham demonstrated his willingness to criticise Miriam without accepting his responsibilities. CCFSW1 recorded; ‘Graham stated that Miriam needed support and that he could only look in on the children from time to time as he had other business to sort.’ Graham had no full-time work, being signed off as unfit, so it is hard to identify what responsibilities he had that took precedence over sharing in the care of his children.

21. When a voluntary sector family support organisation began their first period of work with Miriam in March 2010, Graham was noted as the father, but he was living at his sister’s home.

22. At some point in 2010, probably around the birth of his son Isaac, Graham finally began to spend longer in the family home. However, he clearly did not see this as a positive experience, saying to CCFSW1 that; ‘he felt that they were spending too much time together and that she needed to access a course or attend the children’s centre.’

23. When Miriam reacted with hostility to being accused by Graham of what any parent would consider to be a most serious failing; neglect, it was her frustration and anger that was documented, without apparently questioning the lack of support from Graham, even though support workers noted on several occasions that Graham would not engage with them either.

24. Although domestic abuse was understood to involve them both, it was Miriam’s behaviour which was seen as the key concern, not the behaviour of
Graham, even though abusive, derogatory and insulting words directed at a partner with a learning disability, depression and high-level trauma could only serve to undermine her parenting.

25. Graham’s allegations often lacked substance or were in response to Miriam challenging Graham because of his lack of support. Graham made a serious allegation when he told police that Miriam was neglecting their children (11/11/09), but then was unable to offer any evidence to substantiate the allegation. A health visitor witnessed a ‘heated argument’ (17/12/2009) when Graham alleged Miriam had shaken one of the children.

26. On the 08/03/2011 Graham again raised concerns directly with police. He called saying he was having problems with ‘an aggressive, nagging’ girlfriend. They established that he apparently lived elsewhere and suggested that he leave to defuse the situation. Miriam became tearful and said she was lonely and could not bring up three children on her own. If Miriam was heavily reliant upon Graham and vulnerable, this incident illustrates his willingness to exploit it to serve his purpose around an incident that did not appear to require police interventions. It also helped to formalise his victim status.

27. On the 14/03/2011, Graham complained to Children’s Services that one of the children could have been injured when Miriam left them unsupervised by a window. It seemed that Graham’s repeated complaints to professionals began to substantially undermine Miriam. Graham however did not apparently become the protective father the children allegedly needed, preferring to portray himself as powerless in the face of Miriam’s aggression.

28. CCFSW1, who got to know the family better than any other professional over years of engagements, had observed several behaviours in Graham but had not identified at the time, how they might serve Graham’s purpose. She recognised in January 2010 that Graham ‘antagonised’ Miriam and recorded this in her notes. Miriam constantly expressed to professionals her ‘frustration’ that her views were not understood.

29. CCFSW1 described at the Learning Event held with key professionals a response used by Graham on numerous occasions (including with the officers on the 08/03/2011) which she had thought at the time was a positive. She
acknowledged that with hindsight and a better understanding of coercive control, she might have been misled.

30. When an argument occurred, Graham would suddenly calm and offer to leave, which would cause Miriam to cry and say that she could not cope without him. Viewed in the context of a recent domestic argument, this apparently rational behaviour by Graham contrasted with Miriam’s apparently irrational behaviour.

31. Professor Evan Stark, the leading authority on Coercive Control describes how abusive men think of themselves as rational and reasonable and contrast their behaviour with the irrational and hysterical behaviour of the woman. “Men who enjoy these habits of mind think they are entitled to continually assess what their partners think and feel, how they behave, and how they use their personal time and resources. By contrasting their own propensity for reasoned and rational argument to their partners’ “crazy” views and behaviours controllers build an elaborate pseudo-logic out of sarcasm, disdain and insult that they bring to bear on judgements about women’s everyday behaviour.”

32. This interpretation of behaviours seems to describe accurately Graham’s attitudes and a cycle of behaviours that were repeated on several occasions and formed part of the growing body of evidence that cast Miriam as the principal cause for concern.

33. The DHR was concerned that this narrative seemed so entrenched, despite the evidence that Miriam was claiming to be a victim.

34. In January 2012, Miriam explained that she had not brought one of the children back to nursery after the Christmas break because she had a bruised eye, caused by a child throwing a TV remote. Miriam said she had not wanted to be ‘judged’. When she was seen on the 11/01/12, it does not appear that any questions were asked to establish if this could in fact be domestic abuse by Graham. This was a further missed opportunity to discover the true nature of domestic abuse in the relationship. It is a concern that there was no
exploration of this possibility, given the extended work the Children’s Centre were carrying out, and the recognised domestic abuse.

35. A month later, in February, Miriam called police to ask for advice on how to leave an abusive relationship, saying her partner was verbally abusive and picked on her. On the 20/02/12, CCFSW1 saw another example of the hostile dynamic that existed. Graham said that when Miriam was nagging, he got a headache. He asked whether she (Miriam) wanted to ‘see him sent down for murder?’. For her part Miriam repeated her recurrent complaint saying Graham ‘put her down.’

36. On the 20/03/12, Miriam told housing that her partner was verbally abusive. In their IMR Neighbourhood Team acknowledged that they had failed to respond to this or refer the information. Miriam called police in October 2012 saying; ‘I want this fool out of my house he keeps hitting on me’. When police attended she made no allegation.

37. Miriam was characterised by Graham to be ‘nagging’ and he was frustrated by her anger. This is another strong indicator of a controlling mindset; allowing himself to be angry but denying that right to Miriam when it was a challenge to him. It is a measure of the failure to understand the nature of the domestic abuse, that professionals did not document what Miriam was complaining about, beyond feeling unsupported. It may very likely have been Graham’s apparent reluctance to play a full part in the care of the children. It seems that this aspect of the inadequate parenting did not receive the correct prominence.

38. There was no compelling evidence brought to the DHR that Graham either acknowledged his own equal responsibility for neglect of the children or recognised his unhelpful mindset; that parenting was primarily Miriam’s responsibility. Instead he repeatedly attacked Miriam’s worthiness as a mother.

39. The concerns about Miriam reached the level requiring statutory intervention around the 01/11/12, when Graham alleged to CCFSW1 that whilst he was out, one of the children had suffered an injury to their legs (bruising and swelling) when they had pulled a TV onto themselves. The allegation of lack of
supervision by Miriam was coupled with an allegation made directly to Children’s Services that Miriam had threatened to kill the children. (It is worth noting that neither parent took the child for medical treatment, saying they could not afford a taxi.) These reports were the catalyst for the case to go to Child Protection Conference.

40. It was noted by the DHR that at the very point that the apparent neglect and domestic abuse by Miriam was considered sufficiently serious that family support were actively encouraging Graham to find alternative housing, and take the children, he chose to go on an extended visit home to Jamaica from the 18/11/12 until 08/12/12. This would appear to undermine his apparent concern about Miriam’s ability to care for the children.

41. No action was taken to remove the children during this absence, and with the occasional support of a friend, Miriam coped with the care of the children without incident or fresh concerns. This enforced ‘trial period’ seemed to go by largely unremarked by Children’s Services, even though it offered a ‘sign of safety’ that contradicted the received narrative that Graham kept the family together.

42. The ICPC put new pressures upon Miriam, but it was an incident in February 2013, that finally cemented the view that Miriam was a risk to her children. The incident on the 13/02/13 was highly significant, because it was the tipping point that led to Miriam losing the care of her children. She would never regain unrestricted access to her children. Under a working agreement after the incident, she agreed to supervised access only. It was also the point at which Graham and Miriam separated, although with hindsight it seems that neither party thought of the separation as permanent.

43. After a row with Graham witnessed by a support worker, Miriam screamed at one of the children and punched a hole in the wall causing damage and scaring the children. She was seen to assault Graham (although no injury was caused, and it was not reported as a crime). Police were called, and Miriam was arrested to prevent a breach of the peace then rapidly de-arrested and taken to her aunt in Birmingham. The children temporarily went with Graham to Julia’s home.
44. It is noteworthy that once again, Miriam’s volatile behaviour apparently caused professionals to be distracted from further potential evidence of domestic abuse. Miriam had clear injuries on her arm and leg and claimed they had been caused in a fall. Children’s Services never questioned the cause of the injuries once the situation calmed, dealing instead with Miriam’s behaviour.

45. This was an important missed opportunity. In the context of a family with a longstanding domestic abuse history, there should have been a detailed examination of the cause of the injury. It would appear that as CS arranged the working agreement this was not considered.

46. The incidents served as grounds for removing Miriam from the home under a working agreement, and this decision was probably defensible from a child protection standpoint. However, it is also true that the failure to understand the relationship and the impact it had on Miriam, was as much to blame for her losing her children. It could be argued professionals had formed opinions and sought evidence that confirmed their assessments but did not give contradictory evidence due weight.

47. The DHR was struck by the un-nuanced descriptions of the parents in the Children’s Services IMR (and others), apparently gleaned from interviews with key professionals, and agency records. They allowed little room for doubt as to who was the main safeguarding risk;

48. ‘The concerns have always been about Miriam’s ability to care for the children and provide them good enough parenting. Miriam’s own needs have been central to the children’s lives in respect of her known learning difficulties, depression and her inability to regulate her own behaviour and attitude in front of her children i.e. aggression, violence and non-engagement. Throughout the records, evidence shows the parents having a very difficult relationship, for example, father is very concerned for the welfare of their children and does his utmost to bring this to the department’s attention working towards taking on permanent care of the children. Whereas mother has been concerned to the point of obsessive regarding her relationship with Mr Graham and her need to be his partner. The IMR reported that; ‘Graham was viewed as the victim of
abuse and Miriam the perpetrator of domestic violence and abuse by all those involved with this family.’ Children’s Services were not alone in this judgement.

49. The voluntary sector family support organisation IMR author concluded; ‘I can find no evidence of Graham being the perpetrator of domestic abuse towards Miriam.’

50. The Children’s Guardian in a statement to court offered the analysis; ‘Miriam accepts that she would become aggressive with Graham when he would ridicule her. Miriam accepts that this behaviour caused the children harm. I am not able to state whether she is able to recognise the nature of the harm.’ It is a demonstration of how little understanding there was of Miriam’s lived experience, that she was criticised for responding with aggression faced with Graham’s ridicule. The Guardian considered her aggression as harmful to the children. The fact that Graham undermined and ridiculed the children’s mother may have explained one of the children’s challenging behaviour directed towards her, and not their father. This observation was never apparently made.

51. The IMRs and statements appear to reflect a fundamental misunderstanding of the nature of controlling behaviour in a relationship. Because Miriam was outwardly volatile and was seen on occasions to slap or strike Graham (although it is suggested that these were fortunately very minor assaults), she is described as the principal, even the sole offender. This DHR has advanced an argument that this was a simplistic, indeed naïve interpretation. It would have been far more helpful if Graham had been robustly challenged about his lack of respect for Miriam and his undermining language calculated to reduce her self-esteem.

52. Whilst Graham felt he was allowed to constantly judge and criticise Miriam she apparently had no similar rights. If she challenged Graham, she was ‘nagging’, if she made demands of him, he would leave her to cope on her own. He did not understand depression and did not try and understand.

53. It was a measure of how completely Graham had persuaded professionals that Miriam was the risk that even after his arrest for murder, the Children’s
Services IMR reported; ‘the social worker was shocked to hear that Graham was arrested for the murder of Miriam as she describes him as never aggressive or abusive, never made derogatory statements about Miriam; and demonstrated good enough parenting, was interactive and playful with the children. Graham is described as Miriam’s safeguard and protector and there was no indication he had/or would hurt her.’

54. The DHR acknowledged that understanding the true dynamic between Graham and Miriam was a challenge for professionals, whose primary concern was to prevent the children suffering significant harm. The DHR has advanced a different hypothesis and interpretation of the significance of domestic abuse, and an alternative assessment of who held the power in the relationship. It is influenced by a degree of hindsight, which was not available to practitioners.

55. Professionals often identified emotional abuse as domestic abuse during this period and what Miriam experienced should have been recognised as such. Whether it would have been addressed is unclear. In September 2012, the Government added coercive and controlling behaviour to the definition of domestic abuse because it was felt that the true impact of emotional abuse was poorly understood and too much emphasis was placed upon physical violence.

56. This case demonstrates clearly why it was correct to widen the definition of domestic abuse, because professionals were not aware of the power of controlling behaviour and were too easily influenced by the obvious signs of domestic friction, without analysing why they were occurring.

57. Many of the professionals in this case attended a Learning Event in March 2017 where coercive control was considered as learning from the case. It was clear that in the intervening years their professional practice had taken coercive control increasingly into account. There was a willingness to accept that Graham may have manipulated their practice to divert attention from his own shortcomings and lack of engagement.

58. When Children’s Services ended their engagement with Graham and the children in March 2015, Children’s Services knew that there remained strong evidence that Graham was not maintaining an acceptable standard in the
home, and his cannabis use was evident and problematic when he was found to be so under the influence of the drug that he was tripping up. The Child in Need plan should not have been closed and there should have been consideration of using police protection to remove the children. Neither happened and this was acknowledged by Children’s Services to be a significant concern.

59. Graham declined continuing family support; he had long resented social service intrusion in his life. He had undergone none of the courses and training to improve his literacy and parenting skills that had been recommended under the supervision order.

60. The Children’s Guardian had recommended a Family Group Conference during the Supervision Order. Because the Assessment Framework requires that consideration is given to the support that can be provided by the wider family. The key principle underpinning a family group conference is that the family knows how best to look after the child. Usually, a social worker will attend the conference to explain the concerns that have been identified by the local authority, and the family – assisted by an independent facilitator – will discuss the position and try to devise a plan which meets the child’s needs. At the end of the conference the social worker is invited back and will review the plan in order to ensure that it adequately protects the child and promotes their welfare.

61. This helpful practice was not carried out in this case, so CS had no clear understanding going forward of how much family support Graham would receive. It seems clear that Graham would be reluctant to cope on his own, and if he struggled with care it would be tempting for him to allow Miriam more access. It was naïve of CS to imagine that Graham and Miriam would remain separated, and shows how little understanding of the relationship they had gained over several years of engagements.
5.1.3 The understanding of the impact of learning difficulties and mental health upon Miriam

1. The DHR has concluded that professionals did not question how Graham exerted significant control over Miriam from the start of their relationship, and had also missed signs that it was in fact Graham who triggered the very public displays of domestic friction by antagonising Miriam.

2. The absence of a proper understanding of the controlling and coercive behaviour at the heart of the relationship did not alter the fact that both parents were recognised as being responsible for the abusive behaviour.

3. The widely held view amongst professionals was that Graham’s abuse was a reaction to Miriam’s challenging behaviours. Yet it is clear that Graham subjected Miriam to frequent belittling language attacking her abilities as a mother. This would be corrosive in any relationship. It does not appear that any careful consideration was given to the additional harm this could cause a mother with learning difficulties, depression and possibly a personality disorder. Miriam had no family or friends supporting her or challenging the behaviour.

4. A learning difficulty does not inevitably cause parenting difficulties. Parenting capacity changes and is influenced by the complexity of the parenting task and by factors like parental mental health and the level of support on offer.

5. Miriam’s mental health was poor from early on in the period under assessment and this together with her learning difficulties would have had an impact upon parenting capacity. However, it does not appear that Miriam was offered formal assessments of parenting capacity suitable for a parent with a learning disability from the point the first concern was raised in 2008 until the Local Authority was seeking an Interim Care Order. It seems inappropriate that at the Initial Child Protection Conference a report to Conference could state; ‘Miriam appears to have some learning disabilities however there is no formal diagnosis.’

6. This seems particularly unhelpful given that Miriam was receiving significant support from two different Early Help services. One of those services specialised in providing support for parents with learning disabilities, so the
explanation in their IMR that their operating procedures at that time did not require any formal assessment of clients at the start of provision seems extraordinary. They relied upon the vague impressions and assessments of Miriam’s GP and health visitors. (Author’s note: this service no longer provides family support services.)

7. The psychometric tests undertaken (Section 4: Overview paragraphs 45-48) were in July 2013, seven months after Miriam’s parenting had already been considered at an Initial Child Protection Conference (ICPC) and a formal child protection plan under statutory measures had been put in place. They were too late to be a support to Miriam or inform professional practice and should instead have prompted proper assessments.

8. The ‘Working Together with Parents Network’5 advises professionals that IQ is a ‘poor predictor’ and an ‘unreliable assessment’ of parenting capacity. They advise such tests should not be used as evidence of parenting capacity. They are considered a ‘poor substitute for assessments that consider actual parenting performance and the historical and environmental (physical, financial, social and cultural) influences on care-giving.’ Instead they should ‘provide an indication of how a person takes in, retains and makes use of information and this should inform the type of assessment used and the manner in which it is carried out.’ By the time the psychometric tests were carried out, and this guidance was available to professionals, five years of professional engagements with Miriam had already occurred without the benefit of this knowledge.

9. There is no evidence that Miriam was ever offered further parenting assessments that followed best practice for assessing parents with learning disabilities. The only assessment undertaken seems to have been as part of the Core Assessment. By then, assessment of Miriam could only take place in the unhelpful and entirely artificial context of supervised access.

10. This was probably because by August 2013, Children’s Services were either applying for an Interim Care Order, or later a Supervision Order, but in either

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5 ‘Working Together with Parents Network’ Support professionals working with parents with learning difficulties: Parenting assessment For Parents with Learning difficulties
case Miriam was no longer having unsupervised access to the children, and she was not seen as a viable carer either in the short or long-term (Section 4: Overview, paragraph 74). It is hardly surprising therefore that the assessment documented several occasions when Miriam was unable to respond appropriately to the needs of the children.

11. The Children’s Centre support workers do not document any attempts to provide support tailored to Miriam’s learning needs. Although they provided substantial support it was of the kind offered to parents without Miriam’s specific needs. Even when a voluntary sector family support organisation became involved, there was little evidence of practitioners being orientated towards specific measures needed to aid communication and learning for Miriam.

12. Miriam was expected to participate in course to improve her parenting as part of the Child Protection Plan of December 2012; (Sandwell’s Changes programme and Triple P to address perceived behavioural problems with one of the children). It should be stressed that unlike Graham, Miriam did engage with the parenting courses suggested. However, it is clear that they were not courses that were designed for parents with learning disabilities. Miriam needed encouragement to develop new parenting skills in the home. She needed teaching materials that did not rely heavily upon literacy skills. Properly planned work would have allowed re-assessment of parenting capacity and an acknowledgement of Miriam’s progress.

13. It is hard to avoid the conclusion that for some professionals, Miriam’s learning disability was considered along with her mental health issues, as the reason she showed poor parenting capacity and there seemed little optimism that new parenting skills could be taught.

14. ‘Working Together With Parents Network’ described the risk of such an approach; ‘substantial resources may be invested in the family, but without careful assessment of the individual learning needs of the parent/s the result can be partial or complete failure to assist families.’

15. By the time the children were subject to a care plan (Dec 2012), it is clear that the professional focus was very definitely on Miriam. Even when the same
failings became evident in Graham’s care of the children (February until August 2013), it did not cause any reflection on the assessments and analysis of the family’s needs, except that both parents were considered as unable to provide ‘good enough’ parenting.

16. The tragedy for Miriam was that being removed from her children and Graham, increased her emotional torment. Her subsequent behaviour reinforced previous judgements. Progress she made was ignored. Her attendance on anger management training between May and July 2013 saw a change in how she dealt with conflict. Yet at the application for an ICO, it was only a volatile incident in April 2013 that was offered as evidence of her character. A voluntary sector family support organisation had documented a positive change in Miriam’s behaviour in June and July 2013, but this was not highlighted.

17. The Review considered whether a recommendation concerning agency working with parents with learning disabilities was appropriate. However, it was the Panel’s view that since the only ‘specialist’ service subject to this DHR no longer offer this level of support in Sandwell, the learning from this Review in this section and section 8.5 was sufficient to promote better practice.

5.1.4 Graham’s cultural attitudes to parenting

1. There is considerable attention given in social work to the ‘absent father’ and the failure to understand the views and beliefs of fathers concerning parenting. Graham was a Jamaican man in his late fifties, who may well have had cultural attitudes that influenced his mindset. There was little evidence of Graham’s views being explored to address the apparent contradiction between his willingness to decry Miriam’s parenting, whilst only engaging with the children on his own terms. (His willingness to cook for the family the Jamaican food he was used to, is the only significant contribution recorded, but it is alluded to in several professionals’ reports as a positive).

2. Graham felt that professionals were prejudiced against him on grounds of race. It is very possible that what he was alluding to was a failure to discover his beliefs and attitudes, because when a professional who was of a similar age
and background became involved, he was more receptive. Graham was clearly often absent from the lives of the children in the early years. Later Miriam claimed he ‘did all the child care’ but this may have been out of a sense of loyalty to Graham. In any case when left to his own devices he showed poor parenting capacity. It was only with the help of Julia and Faith that he was able to demonstrate good enough parenting. It is an indication of how low the expectations were of Graham, that when Children’s Services closed their case in March 2015 at the end of the Supervision Order the home was found to be chaotic and Graham was tripping over things due to consumption of cannabis.

5.1.5 Miriam and Graham in the period leading up to the homicide

1. With hindsight, it is now evident that immediately preceding the homicide, Miriam did spend time in the home with Graham. Most troublingly it was immediately after Graham had attempted to murder Stanley. It is impossible to say whether she did this willingly or was coerced, but Stanley stated in conversation with the Overview author that Miriam knew Graham had attacked him. Miriam apparently told Stanley that by being with Graham she was ‘watching his back’. Many victims of domestic abuse feel safer with an offender because they can watch for changes in mood and anticipate risk to themselves, their children and others.

2. The DHR has identified the report to Police in summer 2015 as the final missed opportunity in this case. Once Stanley had been identified as an offender who had allegedly threatened Graham with a knife, the attending officer should have addressed this threat. Miriam had made the same allegation to her GP two days after the attempted murder of Stanley, telling the GP she had just left a relationship because it turned ‘nasty’ after her new friend had threatened her children’s father with a knife).

3. When it became evident that Miriam’s additional allegation that Stanley had sent malicious texts was found to lack substance, the officers appeared to lose focus. Viewed in context, this was an allegation against a man with whom Miriam was saying she had had a recent sexual relationship and this disclosure was in the presence of her ex-partner and father of her children. The officers
identified this as a domestic incident. West Midlands Police policy would require officers to check the parties in a domestic for both victim and offender records. It does not appear these wider checks were completed.

4. Had this been done, the recent unsolved serious assault on Stanley would have been identified. Serious assaults that have no apparent motive and do not involve robbery (which was how Stanley described the incident) are unusual. A victim who goes home, tends to his wounds and then cycles his way to hospital with extensive injuries without telling his wife, would seem even stranger.

5. The information that Stanley had allegedly threatened his lover’s partner with a knife, around the time he was seriously assaulted, should have prompted in the officers at the very least curiosity, since good investigation requires an open mind to be maintained. The possibility that a jealous partner arranged an assault upon his rival was not a ‘flight of fancy’, but the kind of motive for crime that Police often encounter. At the very least an intelligence link between the three could have aided the investigation.

6. The DHR chair spoke with Stanley at length and formed the opinion that his anxiety around his wife finding out about his affair was so strong that, even if the investigating detective had spoken discreetly with him to establish his relationship with Miriam and Graham, it is unlikely that he would have changed his account. This is further corroborated by the length of time he was in custody for the murder of Miriam before he revealed Graham as his assailant.

7. It is a matter of opinion whether enquiries by police with Graham about the nature of his relationship with Stanley would have deterred him, particularly since he made the decision to murder Miriam when he found she had renewed her relationship with Stanley.
6 Conclusions

1. In a family with complex needs, where neglect and domestic abuse are identified, Children’s Services and partner agencies should be striving to address the unmet needs of not only the children, but also those of the parents considered to pose a risk. This is central to the ‘Think Family’ or ‘Whole Family’ approach which is now recognised locally and nationally as best practice.

2. Where domestic abuse is recognised as a key concern, all agencies need to be alert to the risk of domestic abuse, post separation. After almost exactly six years of involvement, Children’s Services finally withdrew from the family at the end of a year-long supervision order, in March 2015. However, this decision was founded upon the premise that Graham and Miriam would not cohabit and that Graham and Miriam could agree upon appropriate access to the children. It also relied upon Miriam and Graham now being able to engage with each other in a constructive way, which they had seldom succeeded in doing, even when closely supervised. The DHR found little to suggest that this was a premise based upon sound evidence.

3. If little measurable progress had been achieved in addressing the complex needs and problems of both parents, then any renewal of their relationship as cohabitees put the whole family at risk. Any perceived improvements in the children’s emotional and physical wellbeing and safety could be in serious jeopardy if Miriam and Graham renewed their relationship without addressing the problems and vulnerabilities that had allowed domestic abuse to become common place and had necessitated professional involvement for so long. The final tragic outcome was apparently a shock to all the professionals involved in the case. Miriam’s behaviour was such that they had all identified Graham as being at the greater risk. Graham had no apparent history of violence or propensity towards it. He had concealed from professionals the sense of ownership and entitlement that led him ultimately to murder his children’s mother.

4. It is clear that a history of domestic abuse between a couple does not need to follow a pattern of violence of increasing severity and frequency before a
homicide, although this pattern is not unusual. It is quite possible for a homicide to occur apparently ‘without warning’.

5. It is therefore all the more important to understand the significance of coercive controlling behaviour within domestic abuse and its impact upon parenting and professional practice. The domestic abuse between Graham and Miriam was known and recognised. Whilst it may not have led professionals to predict such a violent outcome, and did not apparently involve significant physical abuse (although the DHR has identified a suspicion that physical abuse occurred), it was a problem that remained an unresolved risk throughout the period with which professionals engaged with the family.

6. It is possible, with hindsight, to advance the hypothesis that controlling behaviour was behind Miriam’s depression, her anger and frustration being exploited by Graham to undermine her standing with professionals.

7. Both parents had real issues with parenting capacity. However, the factors that influenced Miriam’s capacity were not properly considered. She had been in an inappropriate relationship with Graham as a child, and had become totally dependent upon him. She has suffered bereavement, trauma depression and had intellectual disabilities that needed to be properly addressed from the outset. In relation to all of these issues, she was let down. Although it appeared she was apparently extensively supported, it was in ways that did not meet her needs. As a consequence, the child protection measures that removed her children served to increase her desperation, isolation and vulnerability and deepened her mental health problems.

8. Graham on the other hand, was able to avoid any detailed consideration of his parenting or his motives entering in to a relationship with Miriam when she was a vulnerable child. His absence for significant periods of the children’s early years was never robustly challenged, indeed he was seen as the children’s protector, even though there was as much evidence of neglect by him as Miriam. It is hard to avoid the conclusion that there was a lower expectation either because of his gender, age or cultural background.

9. Had Miriam also been able to call upon two relatives to provide constant care and support, it is highly probable that she would have learnt new parenting
skills, because she showed a willingness to learn and master her anger. (It is surely no coincidence that her anger apparently subsided when Graham was no longer routinely belittling her?)

10. When professionals left Graham and Miriam to agree access issues on their own, there was always the risk that the relationship could be resumed. This would have been considered to be a concern from a safeguarding perspective, but in the absence of evidence that the children were at risk of significant harm it was an outcome that Children’s Services would argue they were powerless to prevent.

11. With hindsight, Graham’s vicious assault upon Stanley in 2015, apparently fuelled by jealousy, was an indication of how severe the risk to Miriam was, if she maintained her relationship. Tragically, Stanley obstructed the investigation of the offence to prevent his wife discovering his infidelity. As a consequence, Graham was not identified as the assailant until sometime after the homicide of Miriam. By that stage, Stanley had himself spent some time in custody charged with Miriam’s murder.

12. According to Stanley’s account, Miriam actively discouraged him from reporting the assault for fear that she would lose her children. There is some logic to this viewpoint; if Graham had been arrested for attempted murder, the children would not have been placed with Miriam. In Children’s Services view, she remained unsuitable to have full time care of her children. The only option open would have been Graham’s sister and niece, Julia and Faith, who had previously said they could not care for the children full time (and who were largely hostile to Miriam). It was far more likely that the children would have been fostered. It was therefore entirely in Miriam’s interest that Graham should be at liberty, since he was allowing Miriam increased access to the children.

13. Miriam knew what Graham had done, but in the month before her murder, apparently was living with Graham. It is possible that she felt safer when close to Graham. In that way, she could assess his reaction and whether he posed a risk to her. It is however possible that she did not consider herself to be at risk, or mistakenly believed she could manage that risk. Alternatively, it is possible
that her intellectual disability meant she was ill equipped to weigh up the risks and make a safe decision for her and the children.

14. What was never in doubt was that Miriam loved her children and wanted to be with them. It is also clear that since childhood she had a dependency upon Graham and wanted to be with him also. Whilst Graham had control over Miriam’s access to her children, he had considerable leverage over Miriam, and it may well have been this that led her to put herself at risk, with tragic consequences.

7 Some of the measures already taken in Sandwell to make the future safer

7.1 Sexual health and vulnerability to sexual exploitation.

1. The findings of this review led the DHR to seek reassurance that current sexual health services and community health provision in Sandwell operated within structures and with referral pathways, policies and procedures that would better equip professionals to recognise the vulnerability of a child (under 18) at risk of sexual exploitation.

2. The views of both service commissioners and service providers of sexual health services and community health services in Sandwell were canvassed, seeking written responses to specific questions and engagement with the DHR at a Learning event within a panel session. The Chair was grateful that every agency contributed fully and openly and were responsive to learning from this DHR. (A list of agencies that contributed to the Learning Event is included at Annex A).

3. The current active CSE screening carried out under the Sandwell Multi-Agency CSE strategy (2015-2017), which has been replicated and enhanced in the recently updated strategy, requires CSE screening for any child under 18 referred to the Multi Agency Safeguarding Hub (MASH) for any reason. A referral that suggested that a child or young person and an adult were in an inappropriate relationship would therefore lead to a range of supportive and
preventative measures and a level of scrutiny that did not occur when Miriam was pregnant for the first time.

4. However, the DHR was clear that agencies at the Learning Event would need to demonstrate to the panel that CSE and wider violence and exploitation is properly understood by professionals and that responses today would be supportive not punitive of young people. The DHR sought assurance that their procedures followed local LSCB best practice.

5. Having provided the agencies with a synopsis of the case, the questions asked of the agencies were based on the premise that: ‘The panel distinguished between the likelihood that sexual activity with the perpetrator commenced when the victim was 14-16, and the known fact that it continued through 16-18 and into adulthood. Whilst awareness of Child Sexual Exploitation (CSE) has increased significantly since the events under review, it is not clear to the panel whether service providers would see themselves as responsible for identifying and acting to safeguard young people under 18 vulnerable to CSE.

9. In answering these questions please consider what you feel is the appropriate balance between protecting a child or young person’s right to access sexual health services and make their own choices, and the need for an awareness of that child or young person’s vulnerability to exploitation. When should safeguarding responses occur? Are they age dependent?

7.1.1 Improvements to service responses that would increase the likelihood that appropriate screening would occur and sexual exploitation and safeguarding concerns be identified

1. The meeting and written submissions identified many improvements to service responses that would increase the likelihood that appropriate screening would occur and sexual exploitation would be identified:

• Most agencies now make no distinction between under sixteen and under eighteen in relation to safeguarding screening and CSE screening. (However, see 8.2).
• Contraception and sexual health services carry out screenings of all clients under 18, using Brook’s version of the Bichard checklist ‘Spotting the Signs’. The screening is reviewed after each visit where there are concerns.
• Contraceptive and sexual health services screenings will ask relevant questions about the age of the partner, who the partner is and whether the young person ever feels threatened or is forced to have sex.
• The service will screen over 18s when there are vulnerabilities such as drug or alcohol abuse, or learning difficulties.
• All screenings will be included as part of the client’s electronic records.
• Brook can support low level CSE risk through one-to-one sessions as part of their Education and wellbeing Team remit.
• Brook completes a Core Client Record for every client under 18 that includes a comprehensive social and risk-taking document including CSE screenings. The service has established pathways to Sandwell’s CSE team.
• Marie Stopes International screen all under 18s using a pro forma designed by the British Advisory Service for Sexual Health and HIV (BASHH).
• The Family Nurse Partnership (FNP) has provided support for first-time mothers under 19 since 2009. The service has been remodelled as ‘Best Start’ since July 2017 and will have no age limit in its remit to provide an early intervention service to the ‘most vulnerable and disadvantaged families living within Sandwell.’
• Best Start practitioners have received CSE training and attended CSE Learning and Awareness Events.
• Best Start can access the Sandwell eCAF system and Lead Professional or attend Team Around The Family meetings as part of Early Help.
• School nurses (5-19) are trained in CSE and have access to eCAF.
• Level III Safeguarding Training for GPs and nursing staff includes awareness of CSE (see section 9.4).
7.1.2 Concerns raised about some aspects of current service provision

1. There were concerns raised about some aspects of current service provision:
   • Marie Stopes International (MSI) are the sole service providers for abortions in Sandwell. The current MSI policy only requires CSE screening for under sixteen rather than up to eighteen and CSE training undertaken does not appear to equip staff with an understanding of the CSE screening tool or local CSE structure.
   • MSI currently have very low levels of referrals of safeguarding concerns that raise anxiety about the strength and quality of counselling and screening currently undertaken. (Sandwell MSI Clinic have approximately 23,000 clients a year and in 2016 made 3 safeguarding referrals; 0.01% of their client group). They were unable to say whether these were child or adult safeguarding referrals.
   • MSI currently has no domestic abuse policy for the Sandwell Clinic.
   • MSI professionals trained to Safeguarding Level III or Level IV have not accessed Sandwell Multiagency Threshold Training.
   • Safeguarding leads at MSI have not established robust partnerships with local agencies.
   • MSI currently have no access to Sandwell eCAF, and the process being followed to introduce eCAF is not likely to secure access to the system sufficiently quickly.
   • Contraception services no longer have access to a young person’s nurse who could provide domiciliary visits to under eighteens with concerns, specifically to reduce the risk of pregnancy but also support the young person’s health choices and wellbeing.
   • Several contributors felt feedback following a safeguarding referral is rare and this does not assist agencies working with a young person about whom there are concerns.

2. MSI have responded to the Chair and provided an action plan to address the service shortcomings identified above. It is the view of the DHR that having identified possible areas of concern, these are best addressed as part of the
scrutiny processes required by the commissioners in the Sandwell and West Birmingham CCG. Safeguarding concerns will be shared with the Local Safeguarding Children Board (LSCB).

7.2 Learning disability and learning inclusion

1. The panel reviewed current educational support for learning disability as part of the holistic review (described in section 5 above) of Miriam’s early vulnerabilities. We wanted to seek reassurance that Miriam’s learning difficulties, only fully recognised in adult life, would be recognised sooner today.

2. Since 2014 new legislation requires school to have a Special Educational Needs Co-ordinator as part of the Senior Leadership Team. Schools work in partnership with special Learning Support Teachers and Educational and Child Psychologists to identify children with learning difficulties.

3. Education, Health and Care Plans (EHC) bring agencies together under a statutory basis. If a child or young person (up to the age of 25) has significantly greater difficulty in learning compared to the majority of children of their age they are entitled to an assessment that will lead to an EHC that is reviewed annually.

4. Attendance and Prosecution services in Sandwell are more proactive than in 2003-2006 and this, combined with the more robust identification of learning difficulties, suggests that a child with Miriam’s needs would be supported more effectively in 2017.

7.3 Early Help, ‘Signs of Safety’ and a ‘Whole Family’ approach

1. Sandwell Children’s Services now use the Signs of Safety model, which was adopted in 2015. Professionals are expected to identify and highlight the strengths within the family. To do this they would need to explore the family’s history within an assessment before analysing the information and creating a Signs of Safety plan. Had it been in place at the point that CS planned to disengage from the family, it could have led to a recognition that Miriam had
engaged with all the parenting programmes required of her and was more effective in managing her anger in relation to Graham. It would have brought in to sharp relief the fact that Miriam was isolated and had no support networks.

2. The model also identifies danger signs and the potential risks and describes what needs to happen to reduce risk. Graham's ongoing use of marijuana and the potential for neglect of the children when he was under the influence of drugs were examples of risks that were left unresolved by CS. The risk of renewed domestic abuse between Graham and Miriam, if they resumed their relationship, was another.

3. Using Signs of Safety, a plan that secures the future safety of the children is essential. It requires a specific set of rules and arrangements should the identified dangers occur. By adopting appropriate responses to previously identified risks, it is far more likely that families like the one subject of this review would attain identified safety goals and avoid re-entering the statutory child protection framework. It involves not just the children understanding how to react where they are able, but identifies individuals who will support the family and respond to those dangers seeking support from professionals where necessary.

4. Julia and Faith would have been recognised as a crucial part of that safety plan, and their ongoing willingness to support not only Graham but also Miriam would have been considered.

5. This is the ‘future proofing’ that was so absent in this case, leaving Miriam and her children so vulnerable. This review has questioned the point at which CS disengaged from the family. Although the service recognised that Family Support would have helped Graham, when it was refused, the family was left with no safety plan. It is to be hoped that the application of Signs of Safety at every level of engagement with a family would prevent that situation arising today.

6. The Review panel concluded that some of the interventions of CSC described in this DHR raised serious concerns about their level of understanding of coercive control, but also around decisions to close a case, as well as failure to
plan for the long-term safety of the family. However, we were sufficiently reassured by the approach described in this section, to conclude that a recommendation was not required and that the lessons learnt could help to embed better practice.

7.4 Safeguarding Level III Training for General Practitioners and nursing staff

1. The Sandwell and West Birmingham CCG made a commitment to include learning from local and regional DHRs and SCRs in their Safeguarding Level III training. The Chair was commissioned to deliver 24 three-hour workshops to small groups of practitioners between April 2016 and September 2017. Key themes from this DHR have therefore been included in a case study based in a GP surgery.

2. The session concentrated upon coercive control in domestic abuse and ‘asking the questions’ using the current guidance from Identification and Referral to Improve Safety (IRIS). It also aimed to raise awareness amongst practitioners of Child Sexual Exploitation (CSE) and made use of a nationally recognised training film for GPs made by the Sandwell & West Birmingham CCG; ‘Know the Signs’ (www.youtube.com/watch?v=B37oVxw8CZ4)

3. By September 2017 all Level III practitioners in Sandwell and West Birmingham will have completed the workshop.

7.5 Professionals awareness of the mechanics and techniques of coercive control

1) The Safer Sandwell Partnership commissioned ‘Learning from DHRs’ multi-agency training. Four, three-hour sessions have been delivered to frontline practitioners. (Key workers and managers involved in this case have attended the training.) The case study illustrated how an abuser uses coercive control, both to control their victims and to prevent practitioners safeguarding families. Key learning from this DHR was included in the case study.
8 Lessons to be learnt

8.1 What do we learn about establishing the history of a family with complex needs?

- The history of every family member needs to be fully understood, including the part childhood experiences played in their development and what those mean for their ability to develop and maintain safe and healthy relationships now, and in the future, as well as their ability to parent. The early history of a relationship, especially where there may be child protection concerns, is crucial to understanding the family dynamic and should underpin any assessment.
- The absence of a detailed history from previous agency engagements should not deter professionals from seeking that history at the start of work with a family.
- When working with a family with complex needs, no one agency will be able to provide a complete picture. It is crucial therefore that both universal services, but also professionals offering Early Help, are prepared to share concerns through collective conversations.

8.2 What do we learn about awareness of child sexual exploitation in Sandwell's sexual health services and community health services?

- There is no evidence that during the period under review services recognised that Miriam was subject to grooming and was being sexually exploited as a child.
- During the period under review, child sexual exploitation, when it was recognised, concentrated upon children under sixteen and did not properly consider the exploitation of children under eighteen.
- Although processes and services now have a greater awareness of the need for CSE screening, these can only occur when a vulnerable person accesses
their service. It is still therefore possible that a vulnerable child or young person could be kept from CSE screening or enquiries.

- Out of hours services, whilst providing service users helpful access to 24hr care, also provide a way for a vulnerable person to access contraception without being subject to detailed screening/assessment. The services could therefore potentially unwittingly facilitate the objectives of a person grooming a child or young person.

- Some out of hours services are currently commissioned by GPs and do not fall within the remit of the CCG. (Department of Health guidance does not mandate the level of safeguarding assessment required of out of hours service providers.)

8.3 What do we learn about the significance of coercive control in domestic abuse?

- That an abuser will use tactics to undermine safeguarding by professionals in order to maintain their control.

- Abusers often use counter-allegations, including allegations of child abuse/neglect, to divert attention from their own abusive behaviour.

- A lack of respect and language that impacts on a partner’s self-esteem should always be recognised as a potential sign of controlling behaviour.

- Abusers are skilled in presenting a charming, calm and rational demeanour to professionals, which contrasts with the ‘irrational, emotional responses’ of their victim which the abuser will frequently both cause and highlight to professionals.

- That a victim of coercive control may not recognise their abuse as domestic abuse or be able to name it. For that reason, it is crucial to discover how their everyday life has changed since they met their abuser.

- A controlling abuser is unlikely to respond to criticism or advice and is likely to be antagonistic to agencies challenging their authority or their accumulated rights and entitlements.
• A controlling abuser will never accept blame or admit responsibility for their behaviour.
• Professionals do not all understand the roots of controlling behaviour.

8.4 What do we learn about how Family Support work in this case was co-ordinated, planned and supervised?

• Without focus and a clear plan, support work can be extensive, well-meaning but ineffective.
• Support workers for the family from two different organisations had different remits but did not restrict themselves to those areas. Instead they responded on an incident by incident basis depending upon whoever was available.
• Whilst the needs of the children were paramount and were often met, there was no clear understanding of how to address the parents’ needs, because there was no shared understanding of which issues should be prioritised and no apparent timescale for review and re-assessment.
• The work of the teams delivering support to the family lacked manager oversight and direction.

8.5 What do we learn about the impact of a learning disability upon parenting and how professionals engage with the parent?

• Learning disability can be recognised but not addressed in a family with diverse competing needs.
• Learning disabilities do not inevitably cause parenting difficulties.
• Assessments of parents with learning disabilities should be working towards the ultimate aim of maintaining the children in their family.
• The threat of child removal and stress associated with observation and assessment can impact upon a parent’s performance and the interaction they have with their children.
9 Recommendations

See the accompanying Action Plan for details of actions in support of the recommendations

9.1 Recommendation One

All professionals need to develop an understanding of coercive and controlling behaviour and recognise and identify the dynamics of those behaviours as they manifest themselves, both within a personal relationship and the family. They need an ability to challenge those behaviours as they appear and respond appropriately.

9.2 Recommendation Two

To improve community safety, we should seek to raise awareness of the adverse impact of coercive control in relationships so that not only victims are better able to recognise they are experiencing this form of domestic abuse and seek help and support, but family and friends are better equipped to identify safe and effective pathways to provide that support.

9.3 Recommendation Three

As part of integrated professional practice, the agencies listed in the action plan for this recommendation should be able to demonstrate that consideration of possible coercive controlling behaviour has formed part of assessments, interventions and planning.

9.4 Recommendation Four

The DHR recommends to the Chairs of the 7 West Midlands Safeguarding Children Boards that work to raise awareness of CSE, violence and other exploitation of children under eighteen should be undertaken with all abortion providers across the West Midlands.
9.5 Recommendation Five

Sandwell and West Birmingham CCG should ensure that contracts with Marie Stopes International for the provision of abortion services in Sandwell clearly define their safeguarding arrangements for children under eighteen and vulnerable adults.

In the light of the findings of this DHR, the CCG should provide assurances to the Safer Sandwell Partnership that a specific, measurable and realistic action plan exists to rectify all existing shortcomings in safeguarding at MSI.

10 Annex A

The managers participating at the learning event with Sexual Health & Community Health Commissioners and providers were:

- Director of Midwifery, Sandwell & West Birmingham Hospitals NHS Trust
- Team Leader, Sandwell & West Birmingham Hospitals NHS Trust
- Early Years Programme Manager, Public Health, Sandwell MBC
- Sexual Health Project Manager, Public Health, Sandwell MBC
- Nurse Manager, Brook
- Sandwell Operational Manager/Clinical Lead – School Nursing, Birmingham Community Healthcare NHS Trust
- Team Leader, Birmingham Community Healthcare NHS Trust
- Deputy Chief Nurse, Marie Stopes International – Birmingham
- Regional Business Development Manager, Marie Stopes International
- Operations Manager, Marie Stopes International
- Consultant in Contraception & Sexual Health Dartmouth Clinic, Sandwell Hospital (Written report)
- SMBC Attendance and Prosecution Service Manager (Written report)
- SMBC Learning Disability and Learning Inclusion Services Area Manager (Written report)
**11 DOMESTIC HOMICIDE REVIEW RECOMMENDATIONS - Action Plan**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Scope of Recommendation</th>
<th>Action to take</th>
<th>Lead agency/ Agency lead</th>
<th>Key Milestones achieved in enacting the recommendations</th>
<th>Target date</th>
<th>Completion date and outcomes</th>
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| Recommendation one | The following agencies should implement this recommendation:  
- SMBC Children’s Social Care  
- Sandwell and West Birmingham CCG  
- Black Country Partnership NHS Foundation Trust  
- West Midlands Police | 1/ Provide reassurance to the CSP that your agency has/ or plans to provide Training to frontline staff and managers that seeks to embed the good professional practice described in this recommendation  
2/ Provide details of how policy and procedure has been amended to ensure practice is more likely to recognise the impact of this | SMBC Children’s Social Care (Director of Children & Families);  
SWBCCG (Accountable Officer);  
BCPFT (Chief Executive);  
West Midlands Police (Chief Constable);  
SMBC Children’s | SMBC Domestic Abuse Team to request assurance from named agencies  
Named agencies to provide written assurance to SMBC DA Team  
SMBC DA Team to present assurance received to DHR Standing Panel | Dec 2017  
April 2018  
June 2018 | Agencies’ written assurance to be provided to SMBC DA Team that actions in column 3 have been undertaken and this information to be presented to DHR Standing Panel by June 2018 |
To improve Community Safety, we should seek to raise awareness of the significant adverse impact of coercive control in relationships so that not only victims are better able to recognise they are experiencing this form of domestic abuse and seek help and support, but also their community, family, friends and colleagues are equipped to identify safe and effective.

| Recommendation two | West Midlands Community Safety Partnership/ Office of the West Midlands Police & Crime Commissioner | This Domestic Homicide Review recommends to the Police and Crime Commissioner that a regional campaign is undertaken that raises public and professional’s awareness of the impact of coercive and controlling behaviour and that the proposed creation of a pan West Midlands Community | Office of the Police and Crime Commissioner | SMBC Domestic Abuse Team to write to the WM OPCC advising of this recommendation | WM OPCC to provide written confirmation of the acceptance of the recommendation, and if so, to confirm details of the regional campaign | Dec 2017 | Office of the WM PCC to confirm details of regional campaign by June 2018 |
| **pathways to provide that support** | **Safety Partnership be used as an opportunity to facilitate a West Midlands wide campaign.** | **Recommendation Three**
As part of integrated professional practice, the agencies listed should be able to demonstrate that consideration of possible coercive controlling behaviour has formed part of assessments, interventions and planning. | **The following agencies should implement this recommendation:**
- SMBC Children’s Social Care
- Sandwell and West Birmingham CCG
- Black Country Partnership NHS Foundation Trust
- West Midlands Police  
  | **To demonstrate this, the named agencies should use their existing infrastructure of auditing and quality assurance to identify whether this is the case, by demonstrating that coercive and controlling behaviour is given the same level of scrutiny and monitoring as is currently given to referrals based around incidents of violence in domestic abuse.** | **SMBC Children’s Social Care (Director of Children & Families);**
**SWBCCG (Accountable Officer);**
**BCPFT (Chief Executive);**
**West Midlands Police (Chief Constable);**
**SMBC Children’s Centres** | **SMBC DA Team to write to named agencies to request written assurance and evidence**
**Named agencies to provide assurance and evidence that coercive and controlling behaviour is embedded within their auditing and quality assurance arrangements**
| **SMBC DA Team to present findings to DHR Standing Panel** | **Dec 2017**
| **April 2018**
| **June 2018** | **Assurance and evidence to be provided and presented to DHRSP by June 2018** |
**Recommendation Four**
The DHR recommends to the 7 Children Safeguarding Boards in the West Midlands that work to raise awareness of CSE, violence and other exploitation of children under eighteen should be undertaken with all abortion providers across the West Midlands.

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<th>Recommendation</th>
<th>Sandwell Children’s Centres</th>
<th>Commissioning Officer</th>
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<tbody>
<tr>
<td>7 Local Safeguarding Children Boards (LSCBs) in West Midlands (Birmingham; Coventry; Dudley; Sandwell; Solihull; Walsall; Wolverhampton)</td>
<td>To demonstrate this, the LSCBs should undertake work to ensure that their local provider of abortion services are aware of local children safeguarding procedures; are appropriately connected to local safeguarding arrangements and are making appropriate safeguarding referrals for children and young people under 18 who are experiencing CSE, violence and exploitation</td>
<td>Chairs of 7 West Midlands LSCBs</td>
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<td>SMBC DA Team to write to 7 LSCB Chairs</td>
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<td>Chairs of 7 West Midlands LSCBs to provide written assurance of work undertaken with local abortion providers</td>
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<td>LSCBs’ responses to be presented to DHR Standing Panel</td>
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7 West Midlands LSCB Chairs to provide written assurance of work undertaken with local abortion providers by April 2018. Findings to be presented to DHR Standing Panel by June 2018.
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<tr>
<th><strong>Recommendation</strong></th>
<th><strong>To achieve this the plan should ensure:</strong></th>
<th><strong>Lead Commissioner; Sandwell &amp; West Birmingham Clinical Commissioning Group</strong></th>
<th><strong>SWBCCG to provide written assurance that actions have been undertaken.</strong></th>
<th><strong>April 2018</strong></th>
<th><strong>Written assurance from SWBCCG to be received by April 2018 and presented to DHR Standing Panel by June 2018</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Five Sandwell and West Birmingham CCG should ensure that contracts with Marie Stopes International for the provision of abortion services in Sandwell clearly define their Safeguarding arrangements for children under eighteen and vulnerable adults. In the light of the findings of this DHR, the CCG should provide assurances to the Safer Sandwell Partnership that a specific, measurable and realistic action plan exists to rectify all existing</td>
<td>1/That MSI are screening clients up to eighteen years old for CSE concerns and that their frontline staff at every level engage with local CSE training and have an understanding of the CSE screening tool and local CSE structure</td>
<td>2/That MSI adhere to the Sandwell LSCB threshold document and CSE strategy and make appropriate referrals where necessary.</td>
<td>3/That MSI put in place a domestic abuse policy for the Sandwell Clinic.</td>
<td><strong>June 2018</strong></td>
<td></td>
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<tr>
<td>shortcomings in safeguarding at MSI.</td>
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<tr>
<td>4/That frontline staff at all levels (including those with responsibility for consultation and counselling) engage Sandwell Multiagency Threshold Training.</td>
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<td>5/That Safeguarding leads at MSI have established robust partnerships with local agencies</td>
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<td>6/ That MSI have access to eCAF in Sandwell within an appropriate timescale</td>
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</table>
Individual Management Review (IMRs) action plans

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<tr>
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<tbody>
<tr>
<td>1.1</td>
<td>BCWA to review screening tool to use with male victims of domestic abuse</td>
<td>Chief Executive</td>
<td>January 2016</td>
<td>To ensure we can take an evidenced based approach to understanding male violence and tailor support</td>
<td>To review cases for male victims</td>
<td>Outcomes of assessments/screening tools</td>
</tr>
<tr>
<td>1.2</td>
<td>Review support provided to male victims</td>
<td>Chief Executive</td>
<td>March 2016</td>
<td>To review cases of male victims and assess how many take up support</td>
<td>To carry out an audit of this work and assess impact and</td>
<td>Assess the level of engagement</td>
</tr>
<tr>
<td>1.3</td>
<td>Add working with male victims as a separate part to the case management</td>
<td>Chief Executive</td>
<td>March 2016</td>
<td>To ensure a good level of guidance for staff, especially in</td>
<td>Case management policy in relation to working with male victims to be written/reviewed</td>
<td>Successful engagement with males, clear boundaries, clear</td>
</tr>
<tr>
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</tr>
<tr>
<td>2.1</td>
<td>Ensuring GP, understand the links between mental health and Domestic abuse, through IRIS programme</td>
<td>Chief Executive</td>
<td>March 2016</td>
<td>To ensure mental health is incorporated into understanding domestic abuse</td>
<td>Referral process/support plans</td>
<td>Change in attitudes. Service users engaging in support</td>
</tr>
<tr>
<td>2.2</td>
<td>Ensuring A&amp;E staff understand links between mental health and domestic abuse, through A&amp;E advocates</td>
<td>Chief Executive</td>
<td>August 2016</td>
<td>To ensure training is rolled out within the hospital settings</td>
<td>Reviewing referrals,</td>
<td>Mental health being acknowledged as part of routing screening for domestic abuse</td>
</tr>
</tbody>
</table>
Ensuring mental health and domestic abuse are embedded into domestic abuse level one and level 2 training

Chief Executive

Janu ary 2016

To ensure an understanding of mental health and domestic abuse, understanding complexities and pathways

Reviewing cases and referrals from other agencies

Agencies working together to provide joined up support

**Sandwell MBC - Children’s Social Care**

**Recommendation 1:** Group Head for Safeguarding will feedback to the Principal Social Worker for improvements in practice and the lessons learnt from this IMR – this will include all the headings identified above in relation to the improvements identified.

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<tr>
<td>1.1</td>
<td>The Lessons Learnt will be outlined in writing and a face to face meeting with the PSW and the Workforce Development Officer will take place to demonstrate by using supporting evidence and</td>
<td>Group Head for Safeguarding</td>
<td>12 months</td>
<td>Staff are clear what goes in a record and why Transfer record from worker to worker Early Assessment of Learning needs/disability</td>
<td>Quality Assurance Improvement plans</td>
<td>Carrying out Themed Audit of case files</td>
</tr>
</tbody>
</table>
examples of the areas of practice to improve from the analysis of records made to date from this IMR

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<tbody>
<tr>
<td>1.1</td>
<td>Identified staff in key areas to access training as detailed in Safeguarding</td>
<td>Chief Executive</td>
<td>Dec 2016</td>
<td>Departments meet the training compliance of 90%</td>
<td>Training statistics to be reviewed at Safeguarding Children Operational Group</td>
<td>Departments meet agreed training compliance</td>
</tr>
<tr>
<td></td>
<td>Children Training Strategy &amp; Matrix 2015</td>
<td></td>
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<tr>
<td>1.2</td>
<td>Routine enquiry on domestic abuse in</td>
<td>Chief Executive</td>
<td>April 2016</td>
<td>Key areas adhere to the Domestic Abuse Policy (2014) and have in place</td>
<td>Audit compliance</td>
<td>Audit will demonstrate compliance with</td>
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</table>
1.3 Deliver a programme of CAADA/DASH training in SWBHT

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<tr>
<td>2.1</td>
<td>Policy to include supervision needs in community, acute settings across the organisation</td>
<td>Chief Executive</td>
<td>April 2016</td>
<td>Staff in ED/Sexual Health Services and midwives will have access to formal supervision and oversight</td>
<td>Monthly reporting</td>
<td>Staff have access to supervision, complex cases managed appropriately</td>
</tr>
<tr>
<td>2.2</td>
<td>Safeguarding Children Team contact details available to staff in SWBHT</td>
<td>Chief Executive</td>
<td>December 2015</td>
<td>Staff have access to team details via SWBHT Intranet for advice and support</td>
<td>Audit of advice calls</td>
<td>Staff supported in decision making</td>
</tr>
</tbody>
</table>

Recommendation 2: (Management and Supervision) Develop Child Protection Supervision Policy (in progress)
### Recommendation 3: (Working in partnership) EmbedLead Professional Role in Midwifery Services

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<tbody>
<tr>
<td>3.1</td>
<td>Identify champions in each community and acute midwifery teams</td>
<td>Chief Executive</td>
<td>April 2016</td>
<td>Improved management and co-ordination of complex cases</td>
<td>Case review/audit</td>
<td>Each team will have a LP champion</td>
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</tbody>
</table>

### Daycare Nursery

### Recommendation 1: Practice

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<tr>
<td>1.1</td>
<td>Focusing on breaking down the potential barriers to parents in engage with the nursery</td>
<td>Chief Executive</td>
<td>Ongoing</td>
<td>Supporting the parent in partnership and participation within the nursery environment.</td>
<td>Ongoing</td>
<td>Regular reviews/adaptions to practice if necessary.</td>
</tr>
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### Recommendation 2: Training

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<tr>
<td>2.1</td>
<td>All staff have DV Training/ keep up to date.</td>
<td>Chief Executive</td>
<td>Ongoing</td>
<td>All staff are aware of the potential indicators and how to report.</td>
<td>Ongoing- keep up to date with training dates/ new staff etc.</td>
<td>Depend on if incidents arise, experience of it.</td>
</tr>
<tr>
<td>2.2</td>
<td>Develop DV within policy and procedures.</td>
<td>Chief Executive</td>
<td>February 2016</td>
<td>All staff to comply in line with the policy and procedure.</td>
<td>Review the policy annually or in line with new legislation.</td>
<td>Review and develop the policy where needed.</td>
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</table>

**Sandwell MBC - Children’s Centres**

### Recommendation 1: Practice: That action plans are underpinned by assessments that are regularly reviewed

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</table>
All children’s centre cases are audited to ensure that assessments are on file

SMBC Children’s Centres commissioner

Easter 2016

Assessments on all files

Lead agencies for children’s centres will conduct their own audit

Lead agencies will give the local authority that this process has been successfully completed

Recommendation 2: That all staff have completed domestic abuse training; understand the DASH assessment process; and recognise the importance of professional curiosity (training)

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<tbody>
<tr>
<td>2.1</td>
<td>That all staff have completed domestic abuse training</td>
<td>SMBC Children’s Centres commissioner</td>
<td>31 July 2016</td>
<td>All staff have received training</td>
<td>Audit</td>
<td>100% of staff trained</td>
</tr>
</tbody>
</table>

Recommendation 3: Management:-

- That managers provide reflective supervision for their staff.
- That issues about domestic abuse are considered in supervision sessions.
- That managers think creatively with staff about how resources are used to meet specific needs

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</table>
3.1 | That managers have the skills to give staff reflective supervision | SMBC Children’s Centres commissioner | 31 July 2016 | All Family Support staff receive reflective supervision | Audit | Self-assessment completed by managers and feedback from staff

### A voluntary sector family support organisation

**Recommendation 1:** That the approach to Records Management within this organisation be reviewed. *(Practice)*

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<tbody>
<tr>
<td>1.1</td>
<td>Introduction of a centralised single client record.</td>
<td>Deputy CEO</td>
<td>January 2017</td>
<td>All information held in one location</td>
<td>Quality Sub Committee</td>
<td>In place and effective</td>
</tr>
<tr>
<td>1.2</td>
<td>All referrals, feedback or escalation to other agencies be made in writing and attached to the single file.</td>
<td>CEO</td>
<td>March 2016</td>
<td>A complete record of actions undertaken</td>
<td>Quality Sub Committee</td>
<td>In place and effective</td>
</tr>
<tr>
<td>1.3</td>
<td>That the initial assessment form contains more opportunities to ‘tell the story’ of the people involved.</td>
<td>Deputy CEO</td>
<td>Sept 2016</td>
<td>A more detailed understanding of each client.</td>
<td>Quality Sub Committee</td>
<td>In place and effective</td>
</tr>
<tr>
<td>1.4</td>
<td>That all forms have a lead officer name printed on them as well as a signature.</td>
<td>CEO</td>
<td>March 2016</td>
<td>A clear understanding of who has completed forms</td>
<td>Quality Sub Committee</td>
<td>In place and effective</td>
</tr>
<tr>
<td>1.5</td>
<td>That where employees from other agencies are named, their role and agency are clearly identified.</td>
<td>CEO</td>
<td>March 2016</td>
<td>A clear understanding of who is being referred to, the role they undertake and the organisation they belong to</td>
<td>Quality Sub Committee</td>
<td>In place and effective</td>
</tr>
<tr>
<td>1.6</td>
<td>That a Records Management Policy and Procedures be introduced.</td>
<td>CEO</td>
<td>Sept 2016</td>
<td>Excellent records management and retention schedules</td>
<td>Quality Sub Committee Board of Trustees</td>
<td>In place and effective and legally compliant.</td>
</tr>
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</table>

**Recommendation 2:** That the Data Protection Policy and procedures within this organisation be improved. *(Practice)*

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<tbody>
<tr>
<td>2.1</td>
<td>That appropriate information sharing protocols be implemented.</td>
<td>CEO in consultation with SMBC commissioners</td>
<td>TBC</td>
<td>Legal and effective information sharing</td>
<td>Quality Sub Committee</td>
<td>In place and effective</td>
</tr>
<tr>
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<tr>
<td>3.1</td>
<td>A list of organisations to whom domestic abuse referrals can be made be created.</td>
<td>CEO / SMBC Commissioners SCVO</td>
<td>March 2016</td>
<td>Up to date list which is then given to all support workers and used</td>
<td>Quality Sub Committee</td>
<td>In place and effective</td>
</tr>
<tr>
<td>3.2</td>
<td>A domestic abuse policy and procedures be agreed.</td>
<td>CEO</td>
<td>May 2016</td>
<td>A pathway for supporting clients who are victims of domestic abuse</td>
<td>Quality Sub Committee Board of Trustees</td>
<td>In place and effective</td>
</tr>
<tr>
<td>3.3</td>
<td>A domestic abuse risk assessment toolkit be created and used.</td>
<td>CEO</td>
<td>May 2016</td>
<td>A fit for purpose, externally verified toolkit.</td>
<td>Quality Sub Committee</td>
<td>In place, effective and national best practice</td>
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**Recommendation 4: A review of training take place. (Training)**

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<tbody>
<tr>
<td>4.1</td>
<td>Domestic Abuse training be made mandatory for all</td>
<td>Deputy CEO</td>
<td>July 2016</td>
<td>An organisation well trained in domestic abuse.</td>
<td>Quality Sub Committee</td>
<td>In place and effective</td>
</tr>
</tbody>
</table>
employees and refreshed every two years.

4.2 Safeguarding vulnerable adults training take place on an annual basis by all employees. Deputy CEO July 2016 An organisation that is fully trained on safeguarding vulnerable adults Quality Sub Committee In place and effective

**Recommendation 5:** That commissioners consider the resourcing of domestic abuse support services (*Resources*)

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<tbody>
<tr>
<td>5.1</td>
<td>That culturally sensitive support services for victims of domestic abuse be commissioned</td>
<td>SMBC TBC</td>
<td>TBC</td>
<td>Referral pathways for people of different cultures to access</td>
<td>TBC</td>
<td>In place and effective</td>
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**Recommendation 6:** That measures be put in place to ensure referrals are received and acted on (*Working in partnership*)

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Where a referral takes place from this organisation to another agency follow up emails are sent for updates on the referral and to receive information on the actions taken and the rationale for those actions.

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**Sandwell MBC - Adult Social Care**

**Recommendation 1**
All staff to have updated Safeguarding Training
| 1.1 | Audit of current staff needing updated training. | Floating Support Manager | March 16 | All staff have updated training | Supervision/Team Meetings. | Staff have knowledge and aware of procedures. |

**Recommendation 2:**
Raise staff awareness of Domestic Violence.

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<tbody>
<tr>
<td>2.1</td>
<td>All staff to attend Domestic Violence training</td>
<td>Floating Support Manager</td>
<td>April 2016</td>
<td>All staff has knowledge and awareness of issues in relation to Domestic Violence.</td>
<td>Supervision/Team Meetings</td>
<td>Staff have knowledge and aware of procedures.</td>
</tr>
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</table>

**Recommendation 3:**
Remind staff of the importance of recording and reporting issues that may contribute to future incidents.

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<tr>
<td>3.1</td>
<td>Discuss with staff importance of recording and reporting.</td>
<td>Floating Support Manager</td>
<td>April 16</td>
<td>Staff knowledge and awareness raised.</td>
<td>Supervision/Team Meetings</td>
<td></td>
</tr>
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</table>
Sandwell and West Birmingham Clinical Commissioning Group - GPs

**Recommendation 1: Practice, Resources** - A ‘new to practice’ patient protocol is developed by the GP safeguarding forum for use by practices in Sandwell and West Birmingham.

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<tr>
<td>1.1</td>
<td>To develop a new to practice protocol for Sandwell and West Birmingham GPs.</td>
<td>CCG Strategic Lead for Domestic Abuse</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; March 2017</td>
<td>Protocol is available to GP practices</td>
<td>Sandwell and West Birmingham GP safeguarding forum</td>
<td>GP practices in Sandwell and West Birmingham have access to a new to patient protocol</td>
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</tbody>
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**Recommendation 2: Working in Partnership** - A recommendation is made to NHS England that IMR’s for primary care should provide an overview of all GP practice contacts and be combined into one document.

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<tr>
<td>2.1</td>
<td>To make a recommendation to NHS England that IMR’s for Primary</td>
<td>CCG Strategic Lead for Domestic Abuse</td>
<td>30&lt;sup&gt;th&lt;/sup&gt; April 2016</td>
<td>NHS England receive the recommendation</td>
<td>The formal communication</td>
<td>The recommendations will be made</td>
</tr>
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</table>
Recommendation 3: *(Resources)* A recommendation is made to Sandwell and West Birmingham CCG that the IRIS programme is resourced for all GP practices

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<tr>
<td>3.1</td>
<td>Make a recommendation to Sandwell and Birmingham CCG to fund the IRIS programme for all GP practices</td>
<td>CCG Strategic Lead for Domestic Abuse</td>
<td>30th April 2016</td>
<td>Funding is made available to resource this recommendation</td>
<td>The recommendation is made</td>
<td>The IRIS programme is resourced for all GP practices</td>
</tr>
</tbody>
</table>

Birmingham Cross City Clinical Commissioning Group

Recommendation 1: The practice should remain active within the IRIS programme and should continually support the request for funding from CCG.

<table>
<thead>
<tr>
<th>REF</th>
<th>Action (SMART)</th>
<th>Lead Officer</th>
<th>Target date for</th>
<th>Desired outcome</th>
<th>Monitoring arrangements</th>
<th>How will Success be Measured?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Completion</strong></td>
<td><strong>Lead Nurse for DV to monitor continued participation</strong></td>
<td><strong>Continued participation</strong></td>
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<tr>
<td>1.1</td>
<td>Continue to participate in IRIS programme</td>
<td>Practice Safeguarding &amp; DV lead</td>
<td>June 2016</td>
<td>When new funding continues the programme in 2016 that this practice continue with IRIS</td>
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<td>Lead Nurse for DV to monitor continued participation</td>
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<tr>
<td>1.2</td>
<td>Ensure new staff undergo appropriate training</td>
<td>Practice Safeguarding &amp; DV lead</td>
<td>Within 1 month of appointment</td>
<td>All staff continue to be IRIS trained</td>
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<td>Practice manager to monitor</td>
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<td>Register of trained staff</td>
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<tr>
<td>1.3</td>
<td>Continue to refer victims to DV specialist</td>
<td>Practice Safeguarding &amp; DV lead</td>
<td>On-going</td>
<td>To ensure that victims receive appropriate risk assessment advice and support</td>
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<td>Referrals received by DV specialist</td>
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<td>Numbers of referrals received by DV specialist</td>
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<tr>
<td>1.4</td>
<td>Continue to invite DV specialist to team meetings to go over patient concerns</td>
<td>Practice Safeguarding &amp; DV lead</td>
<td>On-going</td>
<td>To ensure that patients who may be at risk are identified as soon as possible.</td>
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<td>Attendances at meeting</td>
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<td>Numbers of attendance against numbers of meetings.</td>
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</tbody>
</table>

**Sandwell MBC – Neighbourhoods**

**Recommendation 1:** Practice

<table>
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<tr>
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</table>
| 1.1 | Review current handover processes  
• Review how we currently record information in SHAPE and incorporate this into new processes  
• Review how we record and update on the system | Neighbourhood Services Manager | 30/06/2016 | a) There is an appropriate handover of relevant information from Housing Options to the Local Centre when their clients are rehoused into SMBC tenancies  
Information captured on SHAPE is up to date and correct | Action included in Neighbourhoods Safeguarding Action Plan  
Monitored by Neighbourhoods Quality Team | New processes to be sample audited by Neighbourhoods Quality Team |
| 1.2 | Review of the ISO procedures for when dealing with domestic abuse/Homelessness | Business Quality Lead | TBC | Staff have clear processes to follow and are equipped to recognise and deal with domestic abuse disclosures | Action included in Neighbourhoods Safeguarding Action Plan  
Monitored by Neighbourhoods Quality Team | New processes to be sample audited by Neighbourhoods Quality Team |
| 1.3 | Review our homeless prevention processes | Business Manager, Housing | TBC | To ensure that clients who are quite obviously homeless are dealt with as quickly and efficiently as possible and ensure that the outcome is the best one for the family | Action included in Neighbourhoods Safeguarding Action Plan  
Monitored by Neighbourhoods Quality Team | New processes to be sample audited by Neighbourhoods Quality Team |
## Recommendation 2: Training

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Level 3 &amp; 4 officers undertake DASH risk assessment training</td>
<td>Safeguarding Co-ordinator/ L&amp;D Lead</td>
<td>31/12/2016</td>
<td>Staff with Level 3 &amp; 4 safeguarding responsibilities are able to carry out DASH risk assessments and make appropriate referrals</td>
<td>Monitored by Learning &amp; Development</td>
<td>Increased number of referrals to MARAC</td>
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<td>Sample audit by Neighbourhoods Quality Team</td>
<td>All domestic abuse disclosures have DASK risk assessments completed</td>
</tr>
<tr>
<td>2.2</td>
<td>Staff in Sandwell Local Centres undertake appropriate SHAPE training</td>
<td>Neighbourhood Services Manager</td>
<td>31/08/2016</td>
<td>Staff are appropriately trained to interrogate and update the SHAPE system when dealing with homelessness</td>
<td>Monitored by Learning &amp; Development</td>
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<td></td>
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<td>Sample audit by Neighbourhoods Quality Team</td>
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</tr>
<tr>
<td>2.3</td>
<td>Give individual feedback to the staff involved</td>
<td>Neighbourhood Services Manager/ Safeguarding Co-ordinator</td>
<td>30/09/2016</td>
<td>Staff involved in the case improve their practices when dealing with homeless cases</td>
<td>Records from feedback meeting</td>
<td>Improved working practices</td>
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<td>Appraisal mechanisms in place</td>
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<td>Management oversight</td>
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### Recommendation 3: Management and supervision

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<tbody>
<tr>
<td>3.1</td>
<td>Review the supervision arrangements in Housing Options</td>
<td>Business Manager, Housing</td>
<td>TBC</td>
<td>Ensure complex cases of a similar nature to WM has management oversight</td>
<td>Action included in Neighbourhoods Safeguarding Action Plan</td>
<td>New processes to be sample audited by Neighbourhoods Quality Team</td>
</tr>
</tbody>
</table>
4 September 2018

Dear Ms Lappin,

Thank you for submitting the Domestic Homicide Review (DHR) report for Sandwell (Case 6 - “Miriam”) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 27 June. I very much regret the delay in responding.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this is a well written, insightful review of a complex case which provides a clear picture of the vulnerability of the victim and the challenges she faced from a young age. The Panel commended the breadth of expertise on the review panel.

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

- You may wish to consider including a message of condolence in the report to help personalise the review;
- Section 1.8 headed “parallel reviews” is blank;
- In future, you may wish to offer families specialist advocacy support which could assist in their involvement in reviews;
- The Panel suggested a more succinct and less repetitive chronology may help reduce the length of the report;
- Please note the real name of the victim appears on page 39.


date

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

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

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel