SOUTH WORCESTERSHIRE COMMUNITY SAFETY PARTNERSHIP

Executive Summary

Domestic Homicide Review of the Circumstances Concerning

Case 2

A Worcestershire Woman

Died between 17th March and 12th April 2012

aged 48 years

Independent Chair and Author

Malcolm Ross M.Sc.

January 2013

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Domestic Homicide Review of the Circumstances Concerning

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Introduction

For the purposes of this review report and in order to protect the identity of those involved the victim will be known as V1. Her partner and the person convicted of her murder, is referred to as P1. Another partner of V1's is referred to as P2.

V1 had other partners with whom she had some degree of intimate relationship as well as having associations with other men.

V1 had been married twice before, but had divorced both husbands some years ago. She had three sons and two daughters, as well as an adopted daughter, none of whom she saw or had any contact with.

V1's lifestyle was chaotic, fuelled by alcohol. She needed the company of men in her life and by the very nature of the lifestyle she was used to, she attracted various men, many of whom were alcoholics and they had previous convictions. The men took advantage of her and many of them would physically and sexually abuse her. She lived in a Council owned flat which was very often frequented by the men in her life. Disturbances with the neighbours occurred almost daily. Neighbours constantly called for assistance from the Police and Housing but often with little effect. Neighbours with children were often troubled by the noise and offensive behaviour of the men, and V1 from herself on occasions.

Some of the men were subject to Anti-Social Behaviour Orders (ASBOs). They could have been arrested for breaching such an order, but often this did not happen. V1 was also subject of an ASBO, but she not arrested when she causing disturbances.

V1 expressed the intention to marry P1, albeit at that time she was partner of P2. P2 was recalled to prison and whilst in custody P1 and V1 lived together. There were increasing domestic incidents between V1 and P1. Neighbours reported these incidents to the police. On occasions V1 called the police herself to complain, but as is evident throughout this review, V1 was very reluctant to follow up any report or complaint with the police.

The Day Centre where V1 frequented noticed in April 2012, that she had not been seen for some time and the police were notified. Entry was affected into her flat and she was found dead inside.

A Police murder commenced and P1 was arrested shortly afterwards and charged with her murder.

P1 appeared before the Crown Court and on 13th December 2012, after a three- week trial, he was convicted of murder and sentenced to life imprisonment, with a recommendation that he serves 17 years.

The Domestic Violence, Crimes and Victims Act 2004 Section 9(3), which was implemented with due guidance[1] on 13th April 2011, establishes the statutory basis for a Domestic Homicide Review.

Under this section a "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —

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

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

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

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

The Domestic Homicide Review Panel

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

- West Mercia Police
- West Mercia Probation Trust
- Worcestershire NHS Trust
- West Mercia women's Aid
- Stonham (Housing Association)
- Crisis Reduction Initiatives (CRI) Pathways to Recovery
- Worcester Community Housing
- Health

The Chair of the Panel and the Author of the DHR Panel was Mr Malcolm Ross, an Independent Chair and Overview report writer who has over 20 years' experience in writing overview reports and chairing panels in respect of both Domestic Homicide Reviews and also Child Protection Serious Case Reviews.

Terms of reference

Specific areas of concern for the DHR to focus upon

- Organisations' involvement in the case 6 months prior to the first referral to MARAC. (Multi-Agency Risk Assessment Conference)
- Organisations' involvement in the case during times preceding and following subsequent MARAC dates: 25/11/10 and 24/02/11.
- Risk Management Plans considered, implemented and outcomes
- Support Services engagement with deceased in Recovery Programmes

[2] Home Office Guidance Page 8

Purpose of the Review

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

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence homicides and improve service responses for all domestic violence victims and their children through improved intra and inter agency working.
- Ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions, responsive to the needs of the victim, with an aim to avoid future incidents of domestic homicide and violence.
- Assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff

Review Time Period

The Review will consider the events of the V1's life from December 2009 to April 2012.

Family Involvement

Home Office Guidance[3] requires that:

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

> "Members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",
> and:
> "Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers (SIOs) involved in any related Police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

In this case the Overview Report Author made contact with the Senior Investigating Officer (SIO) from West Mercia Police at an early stage. The family members of V1 have been written to via D1 offering the family the opportunity to contribute to the Review and to receive its findings and recommendations.

Individual Agency Management Reviews (IMRs)

IMRs were requested from the following agencies:

- West Mercia Police
- West Mercia Probation Trust
- West Mercia Health and Care NHS Trust
- West Mercia Women's Aid
- Worcester City Council Housing Department.
- Worcester Community Housing
- NHS Worcestershire
- Worcestershire Acute Hospital Trust
- A Day Centre
- CRI Pathways to Recovery

Guidance[4] determines that the aim of an IMR is to:

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

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

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

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

Individual Needs

Home Office Guidance[5] requires consideration of individual needs and specifically:

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

There was a passing suggestion in this case that V1 originated from a travelling community but that was not shared amongst other agencies. Given the fact that this may have been important in trying to understand the reasons why V1 declined assistance from authority, the sharing of this information may have been a vital aspect of V1's life that could have helped the review.

Independent Overview Report

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

[5] Home Office Guidance page 25

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

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

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

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

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

Summary of background

V1 lived in a flat provided by Worcester City Council. During the period between January and April 2010, neighbours near to her flat constantly called the police complaining about her behaviour and also that of the men who associated with her, many of whom were alcoholics. The behaviour was so bad on occasions that neighbour's children were disturbed at all hours of the day and night and they were unable to sleep. Rude, abusive and drunken behaviour was common and threats were made to neighbours who complained to either the police or to housing authorities. Several neighbours left the area because of V1 and her associate's behaviour.

The police attended frequently to V1's flat responding to neighbour's calls and also to calls made by V1 herself. She frequently complained that one of her associates had

physically or sexually assaulted her. Nearly every time the police attended V1 either refused to complain or refused to make a statement in support of her complaint.

The actions of the police in this case have been examined and comments have been made in the overview report. Police action at domestically related incident is governed by guidance issued by the National Police Improvement Agency of 2008 which states that officers must consider that the victim may be reluctant to complain due to intimidation or fear of the assailant, and, if the offender is present assertive action must be taken to remove the offender either by arrest or other agreed action. The victim should be interviewed and given time to think about following the complaint through, which may mean to a court hearing.

In addition to that guidance, during the time parameters of this review, West Mercia Police were piloting a new initiative of Domestic violence Protection Orders (DVPO).

A DVPO is designed to protect the victim of domestic violence/abuse by removing the offender. If there is insufficient evidence to charge with an offence at that point, or, if the victim is reluctant to complain, a Magistrate can issue a DVPO preventing the offender from contacting the victim for a period of 28 days. This gives the victim time to think about their situation and to access any support they may need to help them consider their options for the future.

The result of police action when called to V1's flat did not include consideration for the implementation of a DVPO. Neighbours were told to complain to the Housing Authorities if the nuisance continued, or to call 999 if noise and abuse did not stop.
On one occasion there was a delay of two hours or so before an officer attended. On another occasion messages were left for the Local Policing Team (LPT) to attend when they came on duty, and there is no evidence that the LPT either received the message or indeed attended at all.

On other occasions Police Officers attended and saw signs of disturbance in the flat. V1 and one of her partners were both injured. Neighbours had described the incident as a serious fight. Neither V1 nor her partner wished to complain and the matter was

left at that. There was no consideration of further investigation in order to obtain evidence to sustain an offence of Affray or similar public order offences.
Another consideration regarding the police action was the support for the neighbours and also the view of the neighbours towards the police service. Neighbours were clearly at the end of their tether with V1 and her associates and were desperate for support from somewhere but didn't get that support from the police.

Two recommendations have been made pertinent to the police, one regarding positive action being taken at domestic incidents and the other suggesting that a pilot scheme for anti-social behaviour risk assessment conferences being conducted in Telford and Hereford be implemented across the force area.

There is also a reminder of best practice for the police regarding the power of arrest that can be considered when an Anti-Social Behaviour Order is breached.

The Housing Authority were involved for some years with V1 and officials knew her well. They assisted her in her wishes to be moved to Hereford but this never came to fruition, partly due to V1 changing her mind when she decided to marry her partner P1. Housing, appreciating that evidence sufficient to meet the standards for court action was difficult to obtain due to the reluctance of neighbours to give, statements for fear of reprisals, stated that noise recording systems would be installed to record the level of noise from V1's flat but again this never materialised.

Housing were, however quick to respond to an incident when the water supply to a washing machine in V1's flat had been deliberately disconnected and the leaking water had caused damage to her flat and the flat below. A plumber attended but noticed that there had been a disturbance and V1 was injured. The police were called but no positive action was taken about either the damage caused by the water, or the injury to V1.

V1 was a regular visitor to a Day Centre in Worcester. There she was often provided with meals. The staff at the Centre became very fond of V1 and cared for her welfare. V1 was able to confide in the Centre's staff more so than to anyone else. She would

tell staff about her injuries caused by men using her flat to drink. She would be advised to seek medical assistance for her injuries but she often ignored that advice.

Her partner, P2, had served a period of imprisonment for pouring boiling water over V1's head and injuring her. Whilst in prison however, P2 maintained contact with V1 via telephone calls to the Day Centre and it was by this method that P2 was able to keep abreast of what V1 was doing and who she was associating with. Most of the men who went drinking at her flat were associates of P2 and P2 would soon find out if she was seeking advice from the statutory authorities. She felt under constant pressure and 'surveillance' from P2 albeit he was in prison.

V1 was in a relationship with P1 whilst P2 was in prison, but in 2011 P2 was considered for release on licence. Probation made the decision, in consultation with the MARAC co-ordinator and police and taking into account V1's wishes, that P2 would be released in September 2011, and 'in both of their best interests' he should be released with a condition that he lives with V1. V1 was in agreement with this decision and on release P2 moved back in with V1. Within days there was domestic violence reported to the police by neighbours. In October 2011, V1 made an allegation of a serious sexual assault against P2. She claimed he had beaten her and held a knife against her throat. He was arrested and interviewed but denied any wrong doing. Despite the police trying to persuade V1 to continue with her complaint, she refused and indicated that she wanted to renew the relationship with P2. The Crown Prosecution Service advised that there was little chance of a successful prosecution and instructed the police to take no further action. In any event P2 was recalled to prison by probation for breaching the conditions of his licence.

Over the next few months disorder and nuisance from V1's flat increased with the neighbours making frequent calls to the police. P1 came out of prison and started to frequent V1's flat and inevitably disputes with P1 began to occur. Police were called and found both parties injured after a fight. P1 became aggressive towards the officers and being arrested for a public order offence.

In February 2011, V1 attended the Day Centre complaining that she had been seriously sexually assaulted by a man and was suffering from her injuries. She was

strongly advised to seek urgent medical assistance but declined to do so. A few days later she declared to a Probation Officer that she intended to marry P1, but she was worried about P2's reaction once he found out about her intention.

V1's situation was getting worse. The Housing Authority had decided to impose an eviction notice on her and there was a threat that her electricity was to be cut off. P2 was again being considered for release from prison but it was decided that he would have to complete an anger management course before he could be released.

V1 had good contact with the Independent Domestic Violence Advisor (IDVA) from Worcester Women's Aid, and with the help of the IDVA and through negotiation with the Housing Authority the eviction from her flat was not instigated.

On several occasions during the period of this review, V1 attended at either her GP's surgery or a walk in medical centre, complaining of being seriously sexually assaulted. There is no evidence that she was examined regarding her injuries or given advice or pointed towards rape support centres or agencies. On one occasion she was prescribed antibiotics and steroids for physical injuries she had as a result of sexual abuse.

During the course of this review the author of the Health IMR interviewed the GP and discovered that the surgery had not got a policy for staff regarding an adequate response to domestic violence. New guidance from the Royal College of General Practitioners stipulates that each GP's surgery should have a robust process of actively seeking evidence from patients of domestic abuse, medical as well as non-medical staff should be suitably trained and there should be someone in the practice nominated as the point of contact for advice for patients.

A recommendation has been made regarding the implementation of such a process in GP's surgeries. Another recommendation for GP's is made regarding training in the areas of drug and alcohol awareness and positive action that is necessary in abuse cases where drugs and alcohol are involved.
On occasions V1 attended at the Emergency Department of Hospital, often under the influence of alcohol and often injured, either by assault or accident. There is no

evidence to suggest that a full history of her medical records was conducted and information of previous presentations at the Emergency Department married up to give a holistic view of her lifestyle This resulted in a possible missed opportunity to assess her risk and make due referrals to other agencies.

A recommendation has been made for the Hospital Trust regarding this.

The intention to marry P1 was on and off on a regular basis and depended upon how many times he abused her and how many times the police were called to her flat as a result.

V1 was assaulted by other men that associated with her. On one occasion she alleged that P5 was responsible for an assault whilst she was drunk. She was found in the street and P5 arrested. As was the usual scenario, V1 declined to proceed with any allegation, despite making arrangements with the police to attend at the police station the following day to make a statement, which she failed to do.

There were two occasions when V1 reported to the police that she had had property and money stolen but she was not interested in assisting in the investigation beyond the reporting stage. It is considered that she wanted a crime reference number to make a claim and the reports of thefts were more than likely false.

V1 was subject to risk assessments by the Day Centre, who, in June 2011, decided that she was at high risk from the people she associated with. Other risk assessments were conducted but they mainly concentrated on the risk P2 posed to her. One risk assessment looked at her capacity to make the decision to discharge herself from hospital casualty department. There is no evidence of any assessment being conducted into her capacity to make decisions regarding living with P2 or marrying P1 or indeed deciding to associate with men who constantly abused her. She made decisions not to go through with a move to Hereford and other decisions not to seek medical treatment when injured. No-one considered if she had the mental capacity to make those decisions and assess whether they were made in the best interests of her own safety, or to consider if years of alcohol abuse had, or would have, affected her mental capacity.

V1 made regular visits to either her GP or the walk in medical centre for various ailments, usually after abuse had taken place. She was in need of regular blood checks and assessments for her asthma. Records show that the surgery wrote to her a total of 8 times requesting her to attend for such appointments, all of which she failed to respond to. The fact that she did not attend resulted in yet another letter being produced, probably by a computer. There is no evidence of anyone querying why she had not attended at these appointments or whether she had the wherewithal to actually attend the surgery at any particular given time.

V1 was reluctant to be seen to be seeking advice from ‘authorities’. Mention has been made about P2 getting to know what she was doing even though he was in prison and she feared the consequences if he found out that she was going to agencies for help. Consequently she attended at the Day Centre, mainly for meals but also, on occasions, she met with representatives from West Mercia Women’s Aid (WMWA) at the Centre. WMWA tried to help V1 with her housing and tried to assist her to arrange a move to Hereford. But she demonstrated a stubborn reluctance to finalise arrangements and therefore nothing became of the suggested move.

A recommendation has been made about dealing with reluctant, hard to reach clients and a further recommendation in this area concerns guidance from Herefordshire Safeguarding Children Board respecting working with resistant families. There are some similarities between resistant families in child cases as well as adult cases and the recommendation urges all agencies to include this document in any future training.

There are two multi-agency structures that are relevant to this case.. One MAPPA (Multi-Agency Public Protection Arrangements) meets to discuss the monitoring of offenders and assess the risk they pose to victims and the public. The other MARAC (Multi-Agency Risk Assessment Conference) meets to discuss the welfare of victims and looks at the risk any victim may be subject to.

Both of these meeting took place with regard to P2 (MAPPA) and V1 (MARAC), and as a result the risk that P2 posed to V1 was duly considered. It has already been mentioned that MAPPA decided it was in the best interests of V1 and P2 that he should

reside with V1 upon his release from prison. That decision is considered unwise by the Overview Author.

The main issue with the MAPPA and MARAC meetings in this case was that the risk posed to V1 was totally concentrated on P2 and the other men from whom she was at risk that she associated with, were not considered within the risk element of either meeting. This included P1, who was to subsequently kill her,

Added to this was the aggravating feature that during the time when V1 was at risk, her contact with the Day Centre stopped because the Day Centre lost funding and had to close for a period of time. During that closed period however, records kept at the Day Centre were not passed to any other agency for dissemination.

V1 was not considered to be a vulnerable adult. Despite her lifestyle it was thought that she did not meet the definition of a 'Vulnerable Adult' as set out in the Government document 'No Secrets'.

'No Secrets' sets out the services that can be offered to vulnerable adults in support of their lifestyle or particular problems they have. Because the strict adherence to the definition was made in V1's case, she was not give opportunity to be signposted towards agencies and the help that may have encouraged her away from her risky lifestyle and given her the opportunity to make decisions for herself in order to do so.

The Care and Support Bill, (currently before Parliament), is designed to broaden the criteria for vulnerable adults and should help to include people such as V1 who do not quite fit the definition. At the moment there is a lack of clarity as to whether a person with needs arising from their use of drugs and alcohol is eligible for community care services and therefore whether any referral made would be accepted. It remains the case that V1 was not referred by any agency to adult safeguarding and therefore the potential risk was not known.

Likewise Worcestershire County Council is introducing a policy around this 'gap' called the Protocol for Referral to the Community Intervention Team and there is a recommendation made suggesting that this protocol is implemented with due haste.

The Overview Report mentions training in general, but specifically the Freedom Programme Training to begin in May 2013. This is designed to raise awareness of professionals around domestic abuse and allow them to sign post victims to the Freedom Programme. A similar course will be designed regarding the MARAC referral process. A recommendation is made encouraging agencies to take advantage of these two courses.

Most of the agencies involved in this case have made recommendations pertinent to their own agency and an overarching recommendation has been made in the Overview Report for the Safer Community Partnership to ensure that agency recommendations are implemented within set timescales.

A list of recommendations made in the Overview Report is included at the end of this report.

Conclusions

This is a tragic case of the victim V1, a 48 year old woman, dependent upon alcohol but also dependent upon the need to have associations with men in particular. Those men, by their very nature, were of a similar disposition to V1, alcoholics, men with previous convictions for alcohol related offences, and men who showed no compunction in causing distress and annoyance to neighbours and members of the public whilst under the influence of drink. It is clear that V1 and her associates made the lives of her immediate neighbours unbearable and none of them showed any compassion or consideration to their neighbours and especially their neighbour's children.

There is no doubt that the whole block of flats where V1 lived were terrorised by the behaviour of V1 and her male associates. V1 persisted on having a relationship with the man who seriously injured her by scalding once he had been released from prison, despite extensive efforts by staff from voluntary agencies to persuade her otherwise. She was given on-going support and advice which she was unable to use in a way to keep herself safe. Police were regular attenders at her flat to respond to the nuisance she caused. There were occasions when more assertive and robust action by the

police should have been taken but in reality any such action would have been only a short term remedy because there is no doubt that her and her friends would have been together again, once the police had dealt with them.

By her insisting to associate with these men and from evidence gained from the numerous attendances at the Emergency Department at the local hospital, it was inevitable that when V1 and the men were together, drunkenness and violence would ensue and on occasions serious sexual offenses would be committed. Given these circumstances at least serious injury and possibly her death were predictable.

Throughout this review it is clear agencies were unable to provide appropriate services for V1 that would have assisted her and would have provide support to break the pattern of alcohol abuse, abusive relationships and association with undesirable men, all of which put her at significant risk.

Risk assessments were carried out in relation to P2, whilst P1 is the person convicted of her murder. She intended to marry P1 and albeit he was of the same drinking culture as the other men, it would be reasonable to assume that if P1 and V1 intended to marry that their relationship was perhaps somewhat different to the relationship she had had with other men. It transpires that that was not the case. The degree of violence shown towards V1 by P1 was minimal compared to the violence demonstrated by P2 and other men in her circle of 'friends'. It is considered therefore, that given all of the circumstances her death was not preventable.

Overview Report Recommendations

Recommendation No 1

West Mercia Police should ensure that all front line officers are aware of their responsibilities for positive robust action when attending incidents of domestic abuse irrespective that there may have been repeated calls to the same address or people con concerned, and compliance to NPIA guidance is ensured.

Recommendation No 2

West Mercia Police to assess the impact of the pilot schemes of Anti-Social Behaviour Risk Assessment Conferences in the Telford and Hereford Divisions and consider implementing the concept force wide as soon as possible.

Recommendation No 3

South Worcestershire Community Partnership to request assurance from Clinical Commissioning Groups in Worcestershire that the guidance 'Responding to Domestic Abuse (Royal College General Practitioners June 2012) has been implemented across all general practices.

Recommendation No 4

Worcestershire Acute Hospital Trust to ensure that all Emergency Department staff obtain full details and antecedent information of patients who frequently present with alcohol and/or drug related injuries and share this information with other agencies such as the police and Adult Social Care.

Recommendation No 5

South Worcestershire Community Safety Partnership endorses the draft Protocol for Referral to the Community Intervention Team and seeks its implementation as soon as possible, as is the Adult Social Care Community Intervention Team contained within the Adult Social Care Bill.

Recommendation No 6

The Responsible Authorities within the Community Safety Partnership to explore the possibility of the introduction of a contractual obligation on providers to ensure that client information is passed on to other relevant agencies at the end of the contract.

Recommendation No 7

When dealing with clients who are reluctant to engage at nominated agency premises, consideration should be given by West Mercia Women's Aid to seek alternative premises where the client is comfortable where formal meetings could take place.

Recommendation No 8

When dealing with clients who are reluctant to engage, West Mercia Women's Aid should ensure that there is a positive assumption that the risk is or remains high and the IDVA will refer on to the appropriate source such as the original referrer and MARAC as and when necessary, particularly where the history of abuse appears to be historic.

Recommendation No 9

Worcester Community Housing should review the processes for dealing with situations where tenants are living with frequent disruptions and threats from other residents and their visitors, and make sure that robust systems are in place to ensure effective and timely action in order to safeguard families and children**.**

Recommendation No 10

South Worcestershire Community Safety Partnership to ensure that all agencies attention is drawn to the guidance as issued by:

- Herefordshire Safeguarding Children Board regarding working with resistant, violent and aggressive families;
- Worcestershire Safeguarding Children Board regarding Resistant, Violent and Aggressive Families within Inter-Agency Child Protection Procedures, and
- guidance issues by the Government in December 2012.

Agencies should ensure that this best practice is included in future training and policy documents.

Recommendation No 11

South Worcestershire Community Safety Partnership to encourage all agencies to partake in Freedom Programme Training and MARAC referral training as from May 2013

Recommendation No 12

South Worcestershire Safety Community Partnership to ensure that Individual Management Report recommendations as set out in the in action plans contained within this report, are completed within the timescales indicated and that agencies report to South Worcestershire Safety Community Partnership confirming this within 6 months of the date this report is accepted by the CSP Board.