The Solihull Partnership

Safer Solihull

Involving local people in keeping Solihull safe

Executive Summary of the Domestic Homicide Review

In respect of the deaths of Adult 1 & Adult 2

In August 2018

Report produced for Solihull Community Safety Partnership by
Paula Harding
Independent Chair and Author
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Contents

A note on confidentiality

The victims are referred to as Adult 1 and Adult 2 in this summary.

1. The homicide

1.1. This domestic homicide review has considered the nature of the domestic abuse that was perpetrated against 22-year-old Adult 1 before she was killed by her estranged husband in August 2018. Despite there being a non-molestation order in place protecting Adult 1, the perpetrator stalked both her and her 49-year-old mother, Adult 2, as they were out one evening and brutally killed them both, in front of their family, whilst Adult 1 was calling the police for assistance.

2. Summary of chronology

2.1. Four years earlier, Adult 1 had left war-torn Syria at the age of eighteen to be with her mother, Adult 2, and her family who had settled in the UK many years before.

2.2. She met the perpetrator at the college in which they were both studying. After a very brief relationship, the perpetrator became obsessive and menacing and Adult 1 hastily married another person, in part, it was thought, to avoid him. The marriage broke down during Adult 1's pregnancy, and the perpetrator, who had persisted with his attention and harassment, appeared to have coerced Adult 1 into marrying him in April 2017.

2.3. Reports of domestic abuse began within three months of the marriage, initially from neighbours. Thereafter the police received a further eight reports of domestic abuse against Adult 1, either from the victim directly, or from third parties, before the final call.

2.4. Adult 1 came into contact with health services as a result of injury and unexplained chronic pain and she called for an ambulance on ten occasions, often with vague symptoms, which were later diagnosed as rheumatoid arthritis. The perceived risk to Adult 1's child also led to the young family being referred to Children's Services on three occasions, but the case was closed two months before the murders, on the basis that Adult 1 had ended the relationship and he had sufficiently protected her child.

2.5. Adult 1 was subjected to significant stalking and harassment, as well as the perpetrator's self-harm and threats, each time she tried to separate from him. Locks were changed on the front door, but he appeared to have gained access through the window to both Adult 1 and her mother's home and at different times had damaged her front door, removed her car keys and passport and stolen her savings. The perpetrator was under the supervision of probation services for unrelated matters at the time.

2.6. Three weeks before her murder, Adult 1 made definitive attempts to end the relationship. On advice, she obtained a non-molestation order from a private solicitor sharing harrowing details of her abuse, and tried to make a homeless application, both of which resulted in delays. Likewise, on the evening of the homicide, the police

experienced delays in reaching her when she called them repeatedly for assistance and they were unable to reach her in time to save her.

3. Key findings

3.1. Experiences of domestic abuse

3.1.1. Whilst no agency was aware of the full picture of domestic abuse at the time, the review found that Adult 1 had been subjected to physical and sexual violence, coercive control, grooming, bigamy, forced marriage, threats to kill, and attempts to isolate and restrict her movements through economic abuse. Her husband had gone to great lengths to monitor her movements, stalk and harass her; attempted to manipulate her through threats of suicide and self-harm should she leave him, and threatened to kill her and her family if she reported the abuse to the police.

3.1.2. Despite her experiences, Adult 1 bravely and repeatedly sought support and protection but, with few exceptions, agencies did not appear to look holistically at her vulnerabilities or engage with her to explore more about the abuse.

3.1.3. Domestic abuse was being seen as episodic and the history of abuse was not being explored sufficiently. Neither were the risks from stalking, harassment and sexual violence taken as seriously as they needed to be. The potential for so-called 'honour-based' violence and abuse was not considered in the context of violence against women, which could have revealed a potential threat to both Adult 1 and her mother. These each contributed to the review panel's understanding that domestic abuse as coercive control was not sufficiently understood by the agencies concerned.

3.1.4. Despite significant advances being made in the local health service response to domestic abuse, indicators of domestic abuse were missed and routine enquiry on domestic abuse therefore not undertaken at those times.

3.2. The risks of separation

3.2.1 Despite the significantly increased risks that separation involves for domestic abuse victims, agencies treated Adult 1's attempts to separate from the perpetrator as a protective factor for her child. Services were withdrawn from the vulnerable young family rather than enhanced safety planning and protective services being put into place.

3.3. Child safeguarding and domestic abuse

3.4. Solihull's response to child safeguarding in this case shared many of the shortcomings identified in national practice response to children at risk through domestic abuse. Child safeguarding practice placed an over-reliance upon the abused young mother to keep herself and her child safe from the abuser. There were incidents of blaming the victim; of lacking a focus on the abuser as the source of threat to the child; not building a trusting relationship with a young, vulnerable mother who feared her child being removed from her care. Whilst much has changed in the intervening time in the

structural response to child safeguarding in Solihull, assurance is needed that child a robust understanding of coercive control is embedded into local responses.

3.4 Managing offenders

3.4.1 Much attention has been drawn to the delays in the police response on the evening of the homicides. However, there was much more that could have been done to protect the young family in the preceding period. The perpetrator was not sufficiently held to account when accusations of domestic abuse were made against him: his history of abuse did not appear to influence assessments of his threat; not all possible lines of enquiry were followed and there were missed opportunities to consider criminal action being taken against him.

3.4.2 Reports of anti-social behaviour were not considered in the context of domestic abuse and protective measures such as the Sanctuary Scheme for home security and Domestic Violence Protection Orders were not applied. Significantly, the perpetrator's own disclosures of domestic abuse to probation services and evidence of domestic abuse from police logs, which were available whilst he was under probation supervision, were neither explored further nor action taken by them

4. Concluding remarks

4.1. This tragic case clearly demonstrates the need for all our front-line practitioners to develop a greater understanding of coercive control, stalking, harassment, tech-abuse, sexual violence, grooming, forced marriage and so-called honour-based violence against women. In so doing, it calls upon practitioners to be curious about what may be under the surface of the abuse that is reported to them and understand the impact of this abuse upon our engagement with both adult and child victims of abuse. The circumstances of the case also highlight the need for practitioners to be looking holistically at an individual's vulnerability and work to overcome the barriers to effective service provision that they may face.

4.2. Adult 2 was a greatly loved pillar of the community and mother of five children who was brutally killed protecting her child. Adult 1 was a resourceful, resilient, independent, loving, young mother who did her best to protect herself, her child and her family. Their deaths need to inspire our services to listen to abused women when they seek our help, and to take every action that is available to us to protect them within our co-ordinated response to domestic abuse.

5. Recommendations

5.1 Overview Recommendations

Recommendation 1: Stalking and 'Tech Abuse'

Safer Solihull Partnership raises the awareness of the public and professionals about stalking as a form of domestic abuse and of the availability of Stalking Protection Orders to protect those individuals affected.

Safer Solihull Partnership raises the awareness of the public and professionals about 'tech' abuse and seeks assurance from agencies that 'tech' abuse features proportionately within their risk assessments and safety planning procedures

Recommendation 2: Strengthening domestic abuse pathways in health

Safer Solihull Partnership shares this report with Solihull Health and Well-Being Board in order to support the extension of the IRIS Programme across all GP practices and to support the provision of domestic abuse pathways incorporating Independent Domestic Violence Advisors across all Emergency Departments in the area.

Recommendation 3: Transforming the Culture

Safer Solihull Partnership to consider what is needed to create a cultural change in how each of the agencies understand and respond to coercive control including:

- providing a focus on demystifying coercive control and including the evidence from this review of grooming, surveillance, stalking and harassment; physical and sexual violence and threat; forced marriage; threats of suicide and self-harm; threats to harm family; isolation, imprisonment and economic abuse
- determining how to evidence whether a robust and improved understanding of coercive control has become embedded into each organisation
- monitoring the evidence of change in how the understanding of coercive control has become embedded into each organisation
- understanding so-called 'honour' based violence in the context of domestic abuse
- understanding how individual identities and structural inequalities create barriers and further marginalisation for Black and Minoritised women

Recommendation 4: Domestic Abuse and Child Safeguarding

Safer Solihull Partnership to share this report with Solihull Child Safeguarding Partnership and seek a domestic abuse focussed review of multi-agency responses to child protection to ensure that:

- the impact of coercive control upon the non-abusing parent is explored and understood
- the reasons why a non-abusing parent may mistrust services and minimise their experiences of abuse, to themselves and others, are understood and meaningful engagement and help-seeking enabled
- there is not an over-reliance upon non-abusing mothers to keep the child safe without effective safety planning and necessary multi-agency interventions
- domestic abuse perpetrators are not invisible to child protection assessments and that they are held accountable for their abuse and threat to the family
- separation from an abuser is not being automatically 'required' of mothers without effective safety planning and necessary multi-agency interventions in recognition of the additional risk that is entailed

Recommendation 5: Domestic Violence Protection Notices and Orders and forthcoming Domestic Abuse Protection Notices and Orders

- Safer Solihull Partnership promotes, with both professionals and the public, the use of Domestic Violence Protection Orders and Notices, and forthcoming Domestic Abuse Protection Notices and Orders, for the protection of both adult and child victims of domestic abuse in order that they are greater utilised.
- That the Partnership monitors the usage of DVPNs and DVPOs, and thereafter DAPNs and DAPOs, to ensure that the promotion has been effective across each domain.
- Safer Solihull Partnership shares this report with Solihull Safeguarding Children Partnership in order that (a) promotion of DVPOs and DVPNs are undertaken with the children's workforce to protect children and their non-abusing parent in plans ranging from early help to child protection and (b) that preparations are made for updating child protection procedures, and best practice promoted in the application of the Domestic Abuse Act 2021, including the recognition of child victims of domestic abuse and the application of DAPOs by safeguarding practitioners.
- That the Partnership shares the report with the Office of West Midlands Police and Crime Commissioner and requests that they monitor the regional use of Domestic Violence Protection Orders and Notices, and the transition to Domestic Abuse Protection Notices and Orders by nominated agencies

Recommendation 6: Sanctuary Scheme

Safer Solihull Partnership seeks assurance from Solihull Community Housing that the Sanctuary Scheme is fully embedded as a response to the prevention of homelessness and that referrals into the scheme are being made by a broad range of agencies including those that have a responsibility to refer under the Homelessness Reduction Act 2017.

The Regional Domestic Abuse Board of the Office of West Midlands Police and Crime Commissioner considers how to enable consistency of approach and pathways to Sanctuary Schemes across the region in order to strengthen the effectiveness of referrals to the scheme.

Recommendation 7: Anti-Social Behaviour and Domestic Abuse

Safer Solihull Partnership should seek assurance from Solihull Community Housing and West Midlands Police that domestic abuse is being identified and appropriately responded to when masked by complaints of anti-social behaviour in a residential setting.

Recommendation 8: Accountability

Safer Solihull Partnership to share an update with the bereaved family in 12 months' time, concerning what has changed as a result of the domestic homicide review and subsequent action plans.

5.2 Individual Recommendations

Birmingham and Solihull Clinical Commissioning Group

GP Practices 1 & 2

- The practice to improve knowledge and skills with regard to identification of domestic abuse by becoming an IRIS accredited practice
- Practices to review systems of receiving information, and the progression of information which gives rise for safeguarding concerns to be discussed, either within the Practice or multi-agency forum.

GP Practice 3

- The practice to improve knowledge and skills with regard to identification of domestic abuse by IRIS refresher training

Birmingham and Solihull Women's Aid

- To remind all staff and volunteers, and new staff through induction training about the importance of checking where callers live before signposting or referring. To amend the content of information resources to ensure that the information for Solihull services is clearly identifiable.

Solihull Children's Social Work Service

- To raise the profile and understanding about Domestic Abuse, Coercion and Control. This will include what coercion and control looks like 'on the ground' when practitioners at Family Support and Social Work level are working with families. Acknowledging the potential for coercive and controlling behaviour needs to be routine within the process of assessing domestic abuse. Recognising the increased risk of separation
- To provide assurance about the responses to cases at Domestic Abuse Triage and MASH have been appropriate in respect of the known information and history where there are concerns about Domestic Abuse and coercion and control. Ensure management oversight of interventions, particularly when there is an escalation. Managers to ensure that all required tasks and that a holistic approach to domestic abuse has been undertaken before closing a file.
- To understand how effectively relevant Risk Assessment tools like the DVRIM, DVRAM, and the DASH, and standard assessment tools are informing social work assessments where domestic abuse and coercive behaviour is a concern. This should include an understanding about the quality of safety planning which is part of the social work assessment process which should include consideration of how the family and network is supporting safety, and conversations with the perpetrator. It should also include consideration of the Signs of Safety model and how safety is being seen over time.
- Strengthen the relationships with specialist domestic abuse services and knowledge of the Solihull domestic abuse pathway

Solihull Community Housing

- Improve the organisation wide response to Domestic Abuse
- Investigate options for collecting and responding to 'intelligence' which may indicate a risk of domestic abuse. To introduce into procedures the need for follow-up contact with the householder where indicators or reports of domestic abuse come to their attention
- Improve information to customers on pathways and procedures (Housing Options service)

Staffordshire and West Midlands Community Rehabilitation Company (now the Probation Service)

- Training
  - To deliver Domestic Abuse refresher training to all Case Management staff.
  - To Deliver refresher Safeguarding Training to all Case Management Staff
- Domestic Abuse Practice:
  - To support active risk management across RRP by improving nDelius risk register recording and timely reviews.
  - Implementation of a Case Audit regime to drive and monitor the quality of risk Assessment and risk management practice.
- Management Oversight
  - To support active risk management across RRP by improving nDelius risk register recording and timely reviews.
  - Through case oversight and accountability ensure enforcement actions are taken when required.
- Partnership Arrangements
  - Process Guidance for completing Domestic Violence and Safeguarding Checks to be re-issued to all Solihull team practitioners and follow up with check of 10 cases within the team (with Domestic Abuse Flags) for such checks.
  - Communicate to NPS via the Service Integration Group the current list of Pathway Interventions that SWM CRC
- Resources
  - Planned local management team driven restructuring in cluster to improve staff access to support and build operational resilience.
- The learning from this review, together with outstanding recommendations and actions for probation services, be adopted by the new organisational model for the Probation Service in the region.

University Hospitals Birmingham NHS Foundation Trust

- Robust and bespoke training around Routine Enquiry to ensure that midwives follow the guideline, and it is recorded appropriately to enable the domestic abuse midwife to audit effectively
- To embed the DA NICE questions into UHB HGS Emergency Departments and assessment areas
- To continue with UHB current DA training and strategy
- To issue standards to the ED in relation to history taking to include who attends with patients (name and relationship), use of information relating to previous attendances and use of safeguarding alerts on children's records.
- To promote the benefit of specialist DA services to the staff that work within ED

West Midlands Police

To provide assurance to Solihull Community Safety Partnership on the effectiveness of responses to domestic abuse in the following regards:

- Checking previous history of domestic abuse when responding to an incident and when considering risk (first responders and supervisors)
- Considering all possible lines of enquiry following reports of domestic abuse, including interviewing third parties and voluntary interviews with perpetrators
- Identifying and responding to coercive control and economic abuse
- Identifying and responding to stalking and harassment
- Identifying and responding to so-called 'honour-based' violence and abuse
- Ensuring that crimes relating to domestic abuse, coercive control stalking and harassment are not missed
- Beyond lock-changes, ensuring that full Sanctuary measures are considered when a domestic abuse victim is under threat as well as the possibility of rehousing
- Ensuring that Domestic Abuse Protection Orders are considered and undertaken when appropriate
- Referring domestic abuse victims to local specialist services with their consent
- Ensuring that full information about the nature of abuse to a child and parent is shared with partner agencies in order to enable a fuller multi-agency assessment of risk of abused parent and child
- Ensuring understanding of the separate responsibilities of officers and public protection units in safeguarding domestic abuse victims considered to be facing a standard level of risk.

Appendix: The Review Process

i. Summary

The decision to undertake a domestic homicide review was made by the Chair of Safer Solihull Partnership, and the Home Office was notified of the decision in September 2018. An independent chair was appointed being someone who was not employed by any agency of Safer Solihull Partnership and was independent of the case and the local area. The review panel were also appointed, and the review was managed in accordance with the relevant statutory guidance.

The review panel members are listed below and included representation from Birmingham and Solihull Women's Aid, who deliver domestic abuse services in the area. They provided particular expertise on gender, domestic abuse and the broader 'victim's perspective' to the panel. Both Syrian and Afghan communities in the area are small and so expert advice was sought separately regarding matters of diversity and equality. Imkaan, a national charity which seeks to provide a collective voice for the Black and Minority Ethnic (BME) ending violence against women and girls sector, joined the panel latterly in order to provide this expertise. The panel members were all independent of the particular case.

The process began with an initial meeting of the review panel in November 2018 but was delayed thereafter, firstly by criminal proceedings and secondly by the delays in sharing the parallel review by the Independent Office for Police Conduct with the panel. Terms of reference were drawn up and incorporated key lines of enquiry as featured below Agencies participating in this review are featured below as well as those who had no contact.

The review panel met on seven occasions and the Independent Chair met with the victims' family a number of times. Family members contributed to the terms of reference and considered the draft Overview Report and their comments have been incorporated.

The Overview Report was endorsed by Safer Solihull Partnership in March 2022 before being submitted to the Home Office for approval.

ii. Review Panel Members

Name	Designation	Organisation
Paula Harding	Independent Chair	-
Rosie Lewis	Head of Policy	Imkaan
Caroline Murray	Senior Commissioning Manager for Domestic Abuse	Solihull Metropolitan Borough Council Public Health Services
Gillian Crabbe	Community Safety Lead	Solihull Metropolitan Borough Council Communities and Partnerships
Jenny Evans[1]	Solihull Outreach Services Manager	Birmingham and Solihull Women's Aid
Joel Desous	Head of Service for Child Protection and Family Support Teams	Solihull Metropolitan Borough Council Children's Services
Andrew Colson[2]	Deputy Designated Nurse for Safeguarding	Birmingham and Solihull Clinical Commissioning Group
Kirsty Baker[3]	Head of Probation. Coventry and Solihull Cluster	Staffordshire and West Midlands Community Rehabilitation Company
Maria Kilcoyne	Deputy Director of Safeguarding	University Hospitals Birmingham NHS Foundation Trust
Pam Rees	Head of Safeguarding	University Hospitals Birmingham NHS Foundation Trust
Sally Simpson	Detective Superintendent	West Midlands Police Public Protection
Surjit Balu	Executive Director of Housing and Communities	Solihull Community Housing

1 Jenny Evans replaced Gemma Wragg who originally represented Birmingham and Solihull Women's Aid on the panel

2 Andrew Colson replaced Karen Cope on the panel from July 2021

3 Kirsty Baker replaced Tony Kuffa on the panel from March 2021

iii. Key Lines of Enquiry

The review sought to address both the 'circumstances of a particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following key lines of enquiry identified in this particular case:

- To establish what contact agencies had with Adult 1, her child and the perpetrator; what services were provided, individually and in partnership; and whether these services were appropriate, timely and effective?
- To establish what contact agencies had with Adult 2 in relation to her daughter's experiences of domestic abuse and whether these services were appropriate, timely and effective?
- To establish whether agencies knew, or could have known, about domestic abuse (applying the government definition of domestic violence and abuse which includes so-called 'honour' based violence) and what actions they took to safeguard and meet the needs of the victims and child and manage the threat from perpetrator.
- To consider whether any other issues of equality or diversity impacted upon the delivery of services and whether needs or risk arising from these factors were addressed.
- To establish how well-equipped staff were in responding to the needs, threat or risk identified for the family through policies and procedures; management and supervision; training; capacity and resources to meet expected standards of practice.
- To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
- To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan
- To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review

The review should also consider:

- Information to be requested from neighbours
- How information produced for a civil court is shared with relevant agencies charged with the safeguarding and protection of affected parties
- How a non-molestation order was obtained, and its details shared with the police for enforcement
- How the perpetrator gained access to a dangerous knife and what lessons can be learnt regarding the regulation, or enforcement of regulations, concerning dangerous weapons?

Agencies were asked to provide chronologies, information reports or Individual Management Reviews, dependent upon their degree of involvement. Individual Management Reviews were provided by:

- Birmingham and Solihull Clinical Commissioning Group
- Solihull Community Housing
- Solihull Metropolitan Borough Council Children's Services
- Staffordshire & West Midlands Community Rehabilitation Company
- University Hospitals Birmingham (Heartlands Hospital)
- West Midlands Police

Information reports and chronologies were provided by:

- Birmingham and Solihull Mental Health Foundation Trust – to include Solihull Integrated Addiction Services
- Birmingham and Solihull Women's Aid
- Birmingham City Council Home Options Service
- Solihull Community Information and Advice Hub
- Solihull Metropolitan Borough Council Customer Services
- Solihull Metropolitan Borough Council Income and Awards
- St Basils (a local charity working with homeless young people)
- West Midlands Ambulance Services

As well as being asked to respond to the key lines of enquiry, certain agencies were also asked to respond to the following specific questions:

Birmingham and Solihull Clinical Commissioning Group

- In relation to Adult 2, whether she ever disclosed her daughter's domestic abuse and if so, how did your service respond?
- In relation to Adult 1, whether any of her presentations could have indicated domestic abuse and if so, whether she was asked about domestic abuse and referred to services thereafter?
- In relation to the perpetrator, whether he made any domestic abuse related disclosures or sought help for gambling and whether the notification received of his self-harm required follow-up?
- Whether the practice has committed to Information and Referral to Improve Safety (IRIS)?

Community Rehabilitation Company

- How did the service respond to the perpetrator regarding:
  - Self-disclosure of abuse
  - Disclosure of being 'kicked out' of home when police were called
  - Safeguarding checks made at beginning

- Gambling addiction?

Solihull Community Housing

- Whether the child safeguarding referral articulated the neighbourhood assistant's concerns about the demeanour of the perpetrator and the visible bruising to Adult 1?
- Outlining the link between anti-social behaviour and domestic abuse, how were reports of noise and nuisance responded to and did they feature in subsequent tenancy checks and considerations of domestic abuse.

Solihull MBC Children's Services

- Were they aware of how frightened Adult 1 was of both social worker and police threats to remove her child? How did social workers consider that threats to remove her child would affect her ability to seek help and protection when she needed it or tell them about the full extent of the abuse that she was receiving?
- What was the plan to keep her and her child safe and how far did they make safeguarding enquiries, such as how safe they would be staying at her mother's home given that the perpetrator had previously broken into her mother's home?

University Hospitals Birmingham

- The extent to which social factors were explored when presented with non-specific pains, gastric and chest pains?
- Whether names of parents were routinely recorded?
- Whether lateral checks were made routinely and followed up?
- Whether staff were alert to child safeguarding concerns arising from the perpetrator's self-harm?

West Midlands Police

- What do the times and transcripts of the calls with the police on the evening of the fatal attacks tell us about the nature of the police response?
- A few weeks before the murder, Adult 1 's neighbours said that they had chased the perpetrator with a stick after they had called the police, but they did not come. Can the police detail how they responded to this report and investigated thereafter?
- Did the police have a copy of the court order and how did this affect future responses to the victims?
- Were the police aware of concerns regarding the perpetrator when he attended Solihull College and how did they respond?
- Did the police consider putting a 'sig marker' on Adult 1's home?

Police, Social Services and Women's Aid

- What options, such as refuge, were offered to Adult 1 and how were they offered?
- Did staff know about the threats that the perpetrator had made to kill her family if she disappeared (into refuge or elsewhere) and if so, how did this affect the options made available to keep Adult 1 and her child safe?

Birmingham and Solihull Mental Health Trust

- Following the perpetrator's self-harm in February 2018, after he advised that he was prevented from having contact with his wife who was also in the hospital, clarify what action, enquiry or information sharing was undertaken in response

Birmingham and Solihull Women's Aid

- The nature of signposting and how accessible these services were.

Solihull College

- Were the college aware of any concerns regarding the friendship between Adult 1 and the perpetrator and if so, how did they respond?
- Did the college have any concerns regarding the authenticity of the perpetrator's age and if so, how did they respond?

West Midlands Ambulance Service

- How much do staff know about previous incidents when attending a call?
- Did staff share information with the police in May 2018, regarding the victim Adult 1, having disclosed domestic abuse to them?
- What follow-up was there to the safeguarding referral made in April 2018?

UK Border Agency

- How effective were UK Border Agency assessments of the age of the perpetrator when he entered the UK?

iv. Agency Involvement in the Review

Individual Management Reviews and chronologies were provided by:

- Birmingham and Solihull Clinical Commissioning Group
- Solihull Community Housing
- Solihull Metropolitan Borough Council Children's Services
- Staffordshire & West Midlands Community Rehabilitation Company
- University Hospitals Birmingham (Heartlands Hospital)
- West Midlands Police

Information reports and chronologies were provided by:

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- Solihull Metropolitan Borough Council Customer Services
- Solihull Metropolitan Borough Council Income and Awards
- St Basils (a local charity working with homeless young people)
- West Midlands Ambulance Services

The following agencies were contacted but confirmed that the individuals had not been known to them or that their contact was not relevant to this review:

- Accord
- Anawim
- Birmingham City Council Adult Social Care
- Birmingham Community Healthcare Trust
- Birmingham Crisis Centre
- Birmingham Women and Children's Hospital
- Black Country Women's Aid
- Change Grow Live
- Gilgal
- MAPPA
- MIND
- Rape and Sexual Violence Project
- Royal Orthopaedic Hospital
- Shelter
- Solihull Community Advice Hubs
- Women Acting in Today's Society (WAITS)