# Domestic Homicide Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

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# In respect of the deaths of Adult 1 & Adult 2[1]

In August 2018

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

[1] Names redacted

**A statement from the aunt and sister of the deceased**

**Adult 1**

Adult 1, my darling niece, was born on a beautiful day in spring in the heart of Damascus in Syria. The sun shone, and the birds sang as if the universe was celebrating her arrival. I knew she was exceptional from the moment she came into this world. She was the most beautiful baby I had ever seen; her soft pink cheeks and sparkling blue eyes. Her personality shone through as she grew older, and it was impossible not to fall in love with her.

Adult 1 was my niece, and she was another blessing in our lives. I had the privilege of raising her for the first two years of her life, and she quickly became like a daughter and closest friend. Our bond was unbreakable; she became a significant part of my life. I watched her grow into a beautiful young woman, and I am proud to have been a part of her life.

She was happy and energetic, with a twinkle in her eye that hinted at the mischievous streak she would later develop. As Adult 2's third daughter, she was showered with love and attention, and she blossomed into a confident and sociable child.

Adult 1's smile was infectious, and she had a way of making everyone feel welcome and included. Whether at school or a family gathering, she had a knack for drawing people in and making them feel at ease. Her warmth and kindness were evident in everything she did, and it was no surprise that she was loved by everyone who met her.

As she grew older, Adult 1 became a strong and independent young woman, always eager to take on new challenges and pursue her dreams. She had a keen sense of purpose and a determination that was awe-inspiring. Her caring nature, loyalty, and wisdom belied her youth, and she had a quirky sense of humour that made her a joy to be around. Her voice was like music to our ears; she had a beautiful voice she used to sing to us when all the family got together.

It is impossible to put into words how much Adult 1 meant to us. She was the light of our lives, bringing us together and making us whole. Losing her has left a void that can never be filled, especially for her child who does not understand why she left so early and their wish is always to have their mum.

It breaks my heart to think that her life was cut short and that she will never have the chance to grow up and reach her full potential. The memories of her sweet face and infectious laugh are all we have left of her, but they will forever be cherished and treasured in our hearts.

## Adult 2

Adult 2 was my oldest sister; she meant the world to me as a big sister with 11 years different in our ages; I saw her as a mother figure besides being my sister and my best friend who supported me all my life, the book of my secrets as I always called her. She was the paradise of my happiness, which I no longer have.
Before I begin to tell you, who Adult 2 was, I would like first to address who she is to me and why I live by her legacy. As I write this reflection, I imagine her sitting next to me; Adult 2, you are the world to me; even if you are not here, you taught me that love has no boundaries and nothing will get between us, even if it is death. Her absence in my life has left a void that can never be filled. My heart aches for her daily, and I cannot help but reminisce about our beautiful memories.
Adult 2 was born to a big family of 10; she came after four boys and mothered everyone, especially the young siblings. Adult 2 also played a big part in her mother's life; she was always supportive and loving to her and sharing all the difficulties my family faced; for sure, my mum missed her, and she has left an immense gap in her life. Also, Adult 2 continued to be family support and a heart even when the war started in Syria. She supported everyone, including her children, who lived in Syria then.
How do I describe our immense love for Adult 2? She was the epitome of love and kindness, an angel in human form. Her selfless nature and unwavering support were the pillars that held our family together; she had a heart of gold. Adult 2 had an extremely pure soul, always happy and thankful. Her personality was very generous in all aspects. Her presence brought joy and happiness to everyone she touched, even her sense of humour beyond imagination; you could not help if you met her to love her character immediately.
She was the heartbeat of the family; therefore, we consider ourselves survivors; our hearts are only beating because of her memories, trying to survive the pain we left with, but the love we hold for her, and the memories keep us going before some of us crumble. Adult 2 is family, especially her small children, whom she left behind very young to understand her absence. The world lost a beautiful soul, but her spirit lives on in our hearts forever.

## Adult 1 and Adult 2's lives

I am reminded that their legacy lives on through us. Their love and beautiful memories are the fuel that keeps us going, even amid pain and suffering. We are committed to carrying their legacy and using their story to make a difference. We will fight for justice and ensure that others live without fear and harm.
My mum, our family, and everyone who knew them will forever miss them. The world lost beautiful souls, but their spirit lives on in our hearts forever.

## إفادة خالة المتوفية وأختها

### البالغ 1

البالغ 1، ولدت ابنة أختي الغالية، في يوم جميل من أيام الربيع في قلب مدينة دمشق في سوريا. وكانت الشمس مشرقة والطيور تغني وكأن الكون يحتفل بقدومها. وعرفت أنها كانت طفلة استثنائية منذ لحظة مجيئها إلى هذا العالم. لقد كانت أجمل طفلة رأيتها في حياتي بخدودها الوردية الناعمة وعيونها الزرقاء المتلألئة. وتألقت شخصيتها مع تقدمها في السن، وكان من المستحيل عدم الافتنان بها.

لقد كانت البالغ1 ابنة أختي وكانت بمثابة نعمة أخرى رزقنا بها في حياتنا. وكان لي شرف تربيتها في أول عامين من حياتها، وسرعان ما أصبحت مثل الابنة والصديقة الحميمة. وكانت الاواصر بيننا غير قابلة للزعزعة. فقد أصبحت جزءًا مهمًا من حياتي. وشاهدتها وهي تنمو لتصبح شابة جميلة، وأنا فخورة بأنني كنت جزءًا من حياتها.

كانت سعيدة وتتقد حيوية، مع وميض في عينيها يشير إلى مسحة من الذكاء والذي سوف يطبع حياتها لاحقًا. وباعتبارها الابنة الثالثة للبالغ 2، فقد تم غمرها بالحب والرعاية، وترعرعت لتصبح طفلة واثقة من نفسها ومؤنسة.

كانت ابتسامة البالغ 1 لا تقاوم، وكانت لديها طريقة في جعل الجميع يشعرون بالترحيب والاندماج. وسواء في المدرسة أو في تجمع عائلي، فقد كانت لديها موهبة في جذب الناس وجعلهم يشعرون بالراحة. وكان دفئها ولطفها يتجلى في كل ما تفعله، ولم يكن من المستغرب أنها كانت محبوبة من كل من التقى بها.

ومع تقدمها في السن، أصبحت البالغ 1 امرأة شابة قوية ومستقلة، حريصة كل الحرص على مواجهة التحديات الجديدة وتحقيق أحلامها. وكان لديها إحساس قوي بالهدف والتصميم بطريقة مذهلة. إن طبيعتها الحنونة، وولائها، وحكمتها لا تتفق وصغر سنها، وكانت تتحلى بروح دعابة في غاية من الطرافة تجعل كل من حواليها سعيدا. وكنا نتلذذ بسماع صوتها العذب، فقد كانت تتمتع بصوت رخيم وكانت تغني لنا عندما يجتمع جميع أفراد العائلة.

فمن المستحيل أن تعبّر الكلمات عما كان البالغ 1 يعني بالنسبة لنا. لقد كانت نور حياتنا، تقربنا إلى بعضنا البعض وتجعلنا وحدة متكاملة. لقد ترك غيابها فراغًا لا يمكن ملؤه أبدًا، خاصة بالنسبة لطفلها الذي لم يدرك سبب رحيلها المبكر وتتمثل رغبته دائمًا في تواجد والدته بجانبه.

إن قلبي ينفطر حزنا عندما أرى أن حياتها قد قصفت وأنها لن تتاح لها الفرصة أبدًا للنمو وتحقيق إمكاناتها الكاملة. إن ذكريات وجهها الجميل وضحكتها التي لا تقاوم هو كل ما تبقى لنا منها، لكنها ستظل محبوبة وعزيزة في قلوبنا إلى الأبد.

## البالغ 2

كان البالغ 2 هي أختي الكبرى؛ لقد كانت شخصية في بالغ الأهمية في حياتي كأخت كبيرة تكبرني 11 عامًا؛ عرفتها كأم مثالية إلى جانب كونها أختي وصديقتي المفضلة التي دعمتني طوال حياتي، لقد كانت كنز اسراري كما كنت أسميها دائمًا. كانت جنة سعادتي التي لم أعد أملكها.

قبل أن أبدأ بإخباركم من هي البالغ 2، أود أولاً أن أتحدث عما كانت تعنيه بالنسبة لي ولماذا أعيش وفقًا لإرثها. وأنا أكتب هذه التأملات، أتخيلها جالسة بجانبي؛ البالغ 2، أنت اهم شخص بالنسبة لي؛ حتى لو لم تكن هنا فقد علمتني أن ليس الحب حدود ولن يحول بيننا شيء حتى لو كان الموت. لقد ترك غيابها في حياتي فراغا لا يمكن ملؤه. وقلبي يعتصر ألما لها يوميًا، ولا يسعني إلا أن أتذكر ذكرياتنا الجميلة. ولدت البالغ 2 في عائلة كبيرة مكونة من 10 أفراد؛ لقد ولدت بعد أربعة ذكور وكانت أمًا للجميع، وخاصة الأشقاء الصغار. ولعبت البالغ 2 أيضًا دورًا هاماً في حياة والدتها؛ وكانت دائما داعمة ومحبة لها وتقاسمني كل الصعوبات التي تواجهها عائلتي؛ ومن المؤكد أن أمي افتقدتها وتركت فجوة كبيرة في حياتها. واستمرت البالغ 2 كذلك في تقديم الدعم للأسرة وكانت القلب النابض لها حتى عندما بدأت الحرب في سوريا. لقد قدمت الدعم للجميع، بما في ذلك أطفالها، الذين كانوا يعيشون في سوريا في ذلك الوقت.

كيف أصف حبنا الجم للبالغ 2؟ لقد كانت مثالاً صادقا للحب والعطف، لقد كانت ملاكاً على هيئة إنسان. كانت طبيعتها المتفانية ودعمها الذي لا يتزعزع هي الركائز التي جمعت عائلتنا بعضها ببعض؛ وكانت على درجة كبيرة من الطيبة ودماثة الاخلاق. وكان لدى البالغ 2 روحاً نقية للغاية وكانت سعيدة وممنونة دائما. وكانت شخصيتها كريمة جدا في جميع الجوانب. وكان حضورها يبعث البهجة والسعادة في كل من تقترب منه، حتى روح الدعابة التي تتمتع بها والتي تفوق الخيال؛ فأنت إذا التقيتها لا يمكنك الإفلات من الافتنان بشخصيتها المرحة في الحال.

لقد كانت القلب النابض للعائلة؛ ولذلك نعتبر أنفسنا الناجين؛ وقلوبنا لا تنبض إلا بفضل ذكرياتها، ونسعى الى مكابدة الألم الذي اصابنا، لكن الحب الذي نكنه لها والذكريات تجعلنا نستمر قبل أن ينهار البعض منا. البالغ 2 هي العائلة، وخاصة أطفالها الصغار، الذين فارقتهم في سن بحيث لا يدركون سبب غيابها. لقد فقد العالم روحًا جميلة، لكن روحها ستعيش في قلوبنا مدى الدهر.

## حياة البالغ 1 وحياة والبالغ 2

أذكر أن إرثهم لا يزال حيا بفضلنا. إن حبهم وذكرياتهم الجميلة هي الزاد الذي يبقينا على قيد الحياة، حتى في خضم الألم والمعاناة. ونحن ملتزمون بحمل إرثهم واستخدام قصتهم لإحداث الفرق. وسنكافح من أجل العدالة لنضمن أن يعيش الآخرون دون خوف أو أذى.

أمي وعائلتي وكل من يعرفهم سوف يفتقدونهم إلى الأبد. لقد فقد العالم أرواحًا جميلة، لكن روحهم ستعيش في قلوبنا إلى الأبد.

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## PREFACE

Members of the review panel offer their deepest sympathy to all who have been affected by the deaths of Adult 1 and Adult 2.

# 1. INTRODUCTION

## 1.1 Summary of the circumstances leading to the review

1. This domestic homicide review concerns the circumstances leading to the murders of 22-year-old Adult 1 and her 49-year-old mother, Adult 2, who had intervened to protect her daughter from the perpetrator's violent attack.
2. Both victims were residents of Solihull. Adult 1 had separated from her husband and taken a non-molestation order out against him as he had repeatedly abused her. The perpetrator stalked both mother and daughter 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.
3. Adult 1 was a young mother and had been in contact with numerous agencies regarding the domestic abuse that she was experiencing. She had left war-torn Syria at the age of eighteen to be with her mother and her family who had settled in the UK many years before.

## 1.2 Aim and purpose of a domestic homicide review

4. Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be 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 she was related or with whom she was or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the death.
5. The purpose of a DHR 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; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

6. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened before each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.
7. The review examined agency responses and support provided in the period prior to the deaths. In addition to agency involvement, the review also examined the past to identify any relevant background or trail of abuse before the homicides; whether support was accessed in the community and whether there were any known barriers to accessing support. By taking a holistic approach, the review sought to identify appropriate solutions to make the future safer.

## 1.3 Timescales

8. Solihull's Community Safety Partnership, hereinafter referred to as the Safer Solihull Partnership, was notified of the death in August 2018. The decision to undertake a review was made, after consultation with partners, by the Chair of the Partnership and the Home Office was notified in September 2018.
9. An independent chair was commissioned, and the initial panel was held in November 2018 where a decision was made to postpone the review until criminal proceedings had concluded. The Home Office were promptly notified of the delay. Thereafter the perpetrator pleaded guilty, and the review was able to resume in the January of 2019. However, further delays emerged as the review had to wait for the results of an investigation by the Independent Office of Police Conduct (IOPC) before concluding the analysis of the police response. The IOPC report was finalised in July 2020, shared with West Midlands Police for comment and then shared with the review panel in February 2021.
10. The panel's approval of the draft Overview Report in August 2021 was followed by a period of engagement and consultation with the family before the report was presented to Safer Solihull Partnership in September 2021. The Partnership themselves sought clarification of some detail before endorsing the report in March 2022. The report was submitted to the Home Office in May 2022. The Home Office responded requiring certain details in December 2022 before endorsing the report [insert date before publication].

## 1.4 Confidentiality

11. During the course of this review, the details have remained confidential, available only to participating professionals and their direct line management. This report has sought to extract sufficient detail from the victims' narratives for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

## 2. TERMS OF REFERENCE

### 2.1 Methodology and Engagement with Family

12. All local agencies were notified of the death and were promptly asked to examine their records to establish if they had been approached by, or provided any services to, the family and to secure records if there had been any involvement.
13. Arrangements were made to appoint the Independent Domestic Homicide Review Chair and Author and agree the make-up of the multi-agency review panel. The victim's family were notified of the domestic homicide review and Adult 2's sister, who was Adult 1's aunt, was nominated to represent the family and engaged actively throughout the review. She has been supported by Advocacy After Fatal Domestic Abuse, the Victim Support Homicide Service, the Centre for Women's Justice and an Independent Advocate.
14. The Independent Chair and panel drafted the terms of reference and key lines of enquiry for the review. The Chair met with Adult 2's sister who provided further questions which were incorporated directly into the review.
15. The panel met on seven occasions. Agencies that were involved were asked to provide Individual Management Reviews (IMRs) and chronologies of their contacts with the victims and the perpetrator. Panel members were able to discuss the progress of the IMRs and request further clarification and additional material, where needed.
16. The Chair went on to meet and update the family at various points during the review. At the end of the review, the family and their advocates had the opportunity to read and digest the draft Overview Report and their comments were incorporated into the final report. The Chair met again with Adult 2's sister and her advocates to discuss the response from the Home Office and their comments were added before the report was finalised. Family members will be notified before publication of the report and engagement and support will be offered by the Partnership again at this time.
17. The Chair wrote directly to the perpetrator seeking his engagement with the review, after confirming his literacy, but he did not respond and was therefore deemed to have declined to be involved. He also declined to be involved in the inquest which followed.

### 2.2 Independent Chair and Overview Author

18. The Independent Chair and Overview Author is Paula Harding, who has compiled the Overview Report, the Executive Summary and coordinated the integrated action

plan. Paula Harding has over twenty-five years' experience of working in domestic abuse and related services with senior local authority and specialist third sector experience. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013 as well as the online training provided by the Home Office: *Conducting a Homicide Review*[2].

19. Paula Harding worked for a neighbouring local authority as the strategic lead for violence against women for more than a decade. Since leaving the statutory sector in 2016, she has worked as an independent consultant, mainly engaged in chairing and authoring domestic homicide and safeguarding adult reviews. Beyond this review, she was not employed by any agency of Safer Solihull Partnership and was independent of the case and the local area.

**2.3 Members of the Review Panel**

20. Multi-agency membership of this review panel was determined by the Independent Chair and consisted of senior managers and/or designated professionals from the key statutory agencies. Panel members had not had any direct contact or management involvement with the victim, and they were not the authors of agency reports provided to the review.

21. Birmingham and Solihull Women's Aid, who deliver domestic abuse services in the area, 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.

22. The review panel members were:

| Name | Designation | Organisation |
|---|---|---|
| Paula Harding | Independent Chair | - |

[2] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

| | | |
|---|---|---|
| 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[3] | 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[4] | Deputy Designated Nurse for Safeguarding | Birmingham and Solihull Clinical Commissioning Group |
| Kirsty Baker[5] | 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 |

23. As the review had been significantly delayed, there were understandably changes in personnel and representation on the panel over the course of the review. However, the Chair ensured that this did not impact upon the continuity of the review, briefing new members independently as required.

[3] Jenny Evans replaced Gemma Wragg who originally represented Birmingham and Solihull Women's Aid on the panel
[4] Andrew Colson replaced Karen Cope on the panel from July 2021
[5] Kirsty Baker replaced Tony Kuffa on the panel from March 2021

## 2.4 Scope and Key Lines of Enquiry

24. 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.

25. 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?

26. Agencies were asked to provide chronologies, information reports or Individual Management Reviews, dependent upon their degree of involvement. Individual Management Reviews were provided by the following agencies and written by report authors who were independent of the case:

- 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

27. Information reports and chronologies were provided by the following agencies:
- 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

28. 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 Metropolitan Borough Council 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?

### 2.5 Time Period

29. The panel agreed that the review should focus on the period between February 2016 and the date of the homicide in order that Adult 1's first contact with agencies whilst she was pregnant could be incorporated into the review. The review also considered relevant information relating to agencies' contact outside that timeframe for contextual purposes. Specifically, information was also requested from Solihull College regarding the period when Adult 1 and the perpetrator first met at college and from the UK Border Agency regarding how the perpetrator's age was verified when he entered the country.

### 2.6 Agencies without contact and other enquiries

30. 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)

31. As well as contacting agencies, the review sought to contact Adult 1's neighbours who reported the domestic abuse to the police in August 2018. Family members believed that neighbours also had to chase the perpetrator away on one occasion. Solihull Community Housing assisted in delivering the Independent Chair's letters to the neighbours, but none sought to engage with the review.

## 2.7 Definitions

32. During the course of this review, the Domestic Abuse Act 2021 was enacted and introduced a legal definition of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

    (a)physical or sexual abuse
    (b)violent or threatening behaviour
    (c)controlling or coercive behaviour
    (d)economic abuse
    (e)psychological, emotional or other abuse (s1: Domestic Abuse Act 2021)[6]

33. The Act further introduced into law that children are to be legally recognised as victims of domestic abuse by virtue of their seeing, hearing, or experiencing the effects of the abuse (s1.1: Domestic Abuse Act 2021)[7]. We will see that this extension to the definition would have been highly pertinent to this family. Indeed, the Home Office has emphasized that of the key functions of the Domestic Abuse Commissioner will be to encourage good practice in the identification of children affected by domestic abuse and the provision of protection and support for these children (Home Office, 2021).

34. Economic abuse was also a feature of this case and is defined as any behaviour that has a substantial adverse effect on a person's ability to acquire, use, or maintain money or other property or obtain goods or services (s.3: Domestic Abuse Act 2021).[8]

## 2.8 Parallel Reviews

35. As well as being subject to criminal proceedings, the perpetrator was under the supervision of Staffordshire and West Midlands Community Rehabilitation Company at the time of the homicide. A Serious Further Incident Investigation was therefore undertaken concerning the response of probation services.

36. An investigation was also undertaken by the Independent Office for Police Conduct, and the findings were incorporated into the review.

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[6] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted
[7] ibid
[8] ibid

37. The inquest took place after the domestic homicide review had concluded and whilst the report was being considered by the Home Office quality assurance process. However, a draft of the report was shared with the coroner and the jury, after the permission of the Home Office had been obtained by the coroner.

38. The inquest concluded in November 2022 with a verdict of unlawful killing for both women and narrative verdicts setting out multiple ways in which police failures into escalating domestic abuse materially contributed to the deaths of both women.

39. In their concluding narrative, the jury found that there were failures in training and understanding of West Midlands police domestic abuse policy and failures to understand the nature of domestic abuse and a victim's response to it. They concluded that the numerous failures to respond to incidents between April and August 2018 materially contributed to the deaths of both women. They also concluded that failures to respond to repeat 999 calls on the night of the homicides, materially contributed to the murders.

40. The coroner issued a statutory Regulation 28 Notice to Prevent Future Deaths to West Midlands Police requiring them to take action within 56 days to address the failures in policing domestic abuse that were identified by the inquest. West Midlands Police is due to respond by the 19 January 2023 and the Chief Coroner may publish a complete, redacted or summary of their response, thereafter.

### 2.9 Equality and Diversity

41. The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010[9] and considered that issues of sex, age, maternity, religion, race and ethnicity were relevant to this review. Wider vulnerabilities were also considered.

42. In respect of sex and gendered violence, being female is the single greatest risk factor for domestic abuse and domestic homicide. In the largest study of domestic homicide reviews in England and Wales to date (n=141), 81% of victims of domestic homicide were female and 86% of perpetrators were male (Chantler et al., 2020). The significance of sex and violence against women should, therefore, always be considered within a domestic homicide review.

[9] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

43. Both victims were of Syrian origin and known to be strong in their Islamic faith. Whereas Adult 2 had lived in the UK for many years, her daughter had arrived in the UK only four years prior to the homicide, when aged only 18 years. The panel therefore considered whether Adult 1 as a young, more newly arrived woman, and young mother, may have faced particular barriers in identifying and accessing support.

44. The perpetrator is a Muslim of Afghan origin and Pashtun heritage. He arrived in the UK with his parents in 2012, ostensibly as a juvenile. There have since been concerns regarding the accuracy of his age at that time and whether he was actually older than his documents suggested. He was known by probation services to have problems with gambling, but it was not known whether the extent of his gambling was at the level of an addiction or vulnerability.

45. The difference in culture between the victims and the perpetrator as well as the intersectional impact of race, ethnicity, religion, age, sex and gender roles will be considered in depth within this report. Moreover, the victim's family were concerned that Adult 1 may have been treated less favourably as a result of her social class and reduced economic circumstances and this was also considered in relation to each agency's responses.

### 2.10 Dissemination

46. The following recipients will receive a copy of the completed report:
    - The victim's family and their advocates in Victim Support Homicide Service, Advocacy After Fatal Domestic Abuse and the Centre for Women's Justice
    - Agencies participating in the review
    - Agencies of Safer Solihull Partnership
    - Office of the West Midlands Police and Crime Commissioner
    - Office of the Domestic Abuse Commissioner

47. The report will be published on the Safer Solihull Partnership's website.

## 3. BACKGROUND INFORMATION

### 3.1. Persons featured in this review

48. In order to protect the identity of the victim and the family, the following anonymised terms have been used throughout this report:

| Pseudonym | Individual | Age at time of homicide |
| --- | --- | --- |
| Adult 1 | Victim and daughter of Adult 2 | 22 |

| Adult 2 | Victim and mother of Adult 1 | 49 |
|---|---|---|
| The perpetrator | Perpetrator and estranged husband of Adult 1 | 21 |
| The child | Adult 1’s child | 2 |
| Ex-husband | Adult 1’s former husband and father of the child | Not relevant |

49. Adult 1 was born in Syria and was raised by her father. He died during the civil war in Syria when Adult 1 was 14 but she stayed with her siblings for the rest of her teenage years whilst the war was raging around them. In 2014, at the age of 18, Adult 1 left Syria to join her mother and her family in Solihull. Her entry to the UK was sponsored by her stepfather on the basis of her taking up studies at Solihull College. Her mother, Adult 2, had joined her sister and settled in the UK many years previously. Having re-married, Adult 2 had a further three children and was active in the local community, supporting homeless and vulnerable people.
50. The perpetrator had entered the UK with his mother and siblings in 2012 to join his father who was already resident. As his age was later to come into question, the Home Office confirmed that the perpetrator had entered the country whilst a child and that his age of 15 was established through his Afghan passport which was submitted at the time of his application for a dependent’s visa. No age assessment was therefore conducted as it was not deemed to be required.
51. The perpetrator was already married in Afghanistan with a young family when he came to the UK and, if his age was as declared, this marriage would have to be considered to have been a forced marriage.
52. In 2014, he received a conviction relating to driving offences and obstructing a police officer. In January 2016, he was working in his family’s shop when he assaulted a customer for which he was arrested and received a caution (warning), having admitted common assault by battery.
53. Having entered the UK, the perpetrator was granted leave to remain until July 2019. He was permitted to work, but Adult 1 was of the opinion that he could not claim benefits.

### 3.2. The homicides

54. On the evening of the homicides, the perpetrator followed Adult 1 and Adult 2 to a shisha lounge in Birmingham city centre and confronted Adult 1 and the male acquaintance that she was meeting. It was later described that the perpetrator appeared enraged that Adult 1 was out for the evening without his consent. He took Adult 1’s phone, threatened to kill her and slapped Adult 2 across the face. On leaving, the perpetrator drove past the shisha lounge gesturing a cutting motion across his neck to Adult 1[10]. The police were called but unable to attend immediately due to a firearms incident that was happening nearby. They provided advice to Adult 1 to wait inside the restaurant, in a public place, for the police to arrive. However, as time passed, Adult 2 and Adult 1 decided to make their way to Adult 1’s home.
55. The perpetrator drove to his family’s supermarket where he collected a steak knife with a twelve-inch blade from under the food preparation counter, concealed the knife around his waist and, unbeknown to mother and daughter, followed them to their family home.
56. Adult 1 called the police several times from outside her own flat, advising them that the perpetrator was drunk and might get a knife and she was told to go to her mother’s home and call 999 if the perpetrator turned up. Before they were able to enter the family home, the perpetrator stabbed Adult 1 several times and then stabbed Adult 2 as she was trying to protect her daughter. The attacks took place in clear sight of the family home and was witnessed by one of Adult 2’s children who had heard the sound of screaming.
57. The perpetrator fled the scene, and a national manhunt was undertaken. He was apprehended three days later whilst resisting arrest.
58. The perpetrator pleaded guilty to murder but on sentencing, the judge rejected specific claims of mitigation in which he denied any previous mistreatment or domestic abuse of Adult 1 or threats made towards her mother. The judge identified several serious aggravating factors within the sentencing remarks, namely: the sustained and determined nature of the attacks taking place in public and witnessed by a child; the pre-meditation of the attacks and flouting of the non-molestation order that was in place at the time. The culmination of a pattern of domestic abuse was also recognised and drawing upon the Sentencing Council’s Guidelines on domestic abuse, this was considered to “make the offending more serious because it represents a violation of the trust and security that normally exists between people in an intimate relationship.” (Judge’s Sentencing Remarks on 17.12.2018)
59. He was sentenced to a minimum term of imprisonment of 32 years and 137 days before the Parole board may consider his possible release.

[10] The police were not advised about the perpetrator’s gestures at this time

## 4. CHRONOLOGY

60. This section has been based on information provided from agencies' reports; summaries of criminal proceedings; the IOPC report; sentencing remarks made by the judge and the statement that Adult 1 made in order to obtain a non-molestation order. They represent the author and panel's view of significant information and events, and which will be analysed in later sections. The chronology starts when Adult 1 entered the UK.

### *Meeting at college*

61. Adult 1 met the perpetrator at Solihull College where they both attended during the academic year 2014/15. They were in the same class for about a month and began a relationship in which the perpetrator asked Adult 1 to marry him very shortly afterwards. However, she discovered that he had a family in Afghanistan and thought that his age was older than officials thought. Indeed, family members were aware that he boasted about being older to his peers whilst at college, although there is no indication that the College was aware of this.
62. In January 2015, Adult 1 advised the college that the perpetrator's behaviour had become obsessive and menacing, wherein the College advised her and her mother to report these concerns to the Police. The perpetrator was in Afghanistan at this time but when he returned the next month, he was withdrawn from college as a result of his long, unauthorised absence and his access to enter the college was removed. Security personnel at the college had also been provided with a picture of the perpetrator to ensure that he would not gain any unauthorised access to the campus.

### *The victim's first marriage*

63. In July 2015, Adult 1 hastily married another person, in part, her family thought, to avoid the perpetrator who was already stalking and harassing her and using Facebook to track her through her friends and family. However, the perpetrator continued to harass her even after she was married.
64. Once married Adult 1 moved into her husband's family home in Birmingham but their relationship ended within the year, whilst she was pregnant, and she returned to live with her mother. During her pregnancy, she was routinely asked about domestic abuse by midwives, but did not disclose any concerns.

### *Incident in the maternity hospital*

65. In April 2016, Adult 1 gave birth to her child. Her ex-husband, the father of the child, arrived at the hospital unexpectedly with his brother and was abusive and threatening to Adult 1. She told an Arabic speaking doctor that their relationship had broken down as her husband did not want her to keep the baby and that she was scared of her husband and his family.

66. The hospital contacted the police who asked Adult 1's ex-husband to leave and he complied with their request. The Police gave Adult 1 safety advice and advised on legal remedies. The incident was assessed by the police as standard risk and recorded as a 'domestic abuse non-crime incident' in accordance with recording standards.

67. As well as contacting the police, the hospital also made a safeguarding child referral, notified the health visitor, and provided Adult 1 with details of agencies that could support her. Ward staff enabled Adult 2 to be accommodated overnight to stay with her daughter as she was upset and scared.

68. The matter was listed for multi-agency joint screening regarding concerns for the child. The hospital midwife referred the child to the Multi-Agency Safeguarding Hub (MASH) as she needed to ascertain the level of risk to the new-born baby as part of a safe hospital discharge plan. Children's services considered that Adult 1 had "acted appropriately by moving back in with her mother and by calling the police". The child's father was also thought by this time to have gone abroad. Children's Services closed the referral with no further action as it was not considered to have reached safeguarding thresholds, but information was nevertheless shared with health visitors who visited Adult 1 at her mother's address and advised Adult 1 on the process for rehousing. The community midwife also visited her at this time and found no concerns.

### *Homeless application*

69. In May 2016, Adult 1 approached Solihull Community Housing. She had gone to stay temporarily with her mother following the breakdown of her relationship, but the family home was overcrowded, and she could no longer stay there. She was provided with temporary accommodation, a food parcel and was advised that the local authority had a duty to house her as a homeless person, and later, in September 2016, offered a flat which she accepted.

70. Although the presenting feature of Adult 1's homelessness was overcrowding at her family home, it was noted in her application records that she had experienced domestic abuse from her ex-husband in respect of his visit to her at the hospital shortly after the child was born.

71. The start of Adult 1's tenancy was followed up by a tenancy support officer who visited Adult 1 in November 2016 to carry out an initial tenancy review. This was the first of the three tenancy visits that should take place within the first nine months of a tenancy according to local procedures. Housing Services also received complaints of noise nuisance which were discussed, and which Adult 1 denied, saying that she lived alone. No further complaints about noise were received after this visit.

***Threats to kill from the victim's ex-husband***

72. In February 2017, Adult 1 and the perpetrator reported to the police that Adult 1's ex-husband's family had made threats to him that they, "will come and get them both" and alleged that he was a drug dealer and gangster and had access to firearms, although firearms had not been seen. Adult 1 was visited at home and advised that she had not been party to the threats. The perpetrator declined to provide a statement of complaint and officers took advice from the Duty Inspector and 'sig markers' were placed upon the shop and the home addresses of Adult 1 and her mother. The review was unable to establish whether Adult 2 was aware of the 'sig marker', although it was known that safety planning was not undertaken with her. Although there had been one previous report of domestic abuse from Adult 1's ex-husband, the police did not consider the threats as, so-called, 'honour-based violence.'

***Marriage to perpetrator***

73. Adult 1 and the perpetrator were married in an Islamic ceremony in April 2017. Much later Adult 1 went on to tell her family that the perpetrator had forced her into this marriage by threatening to harm her family if she did not comply and threatened to kill her and her family if she ever tried to get a divorce.

***Safeguarding referral***

74. In mid-June 2017, Adult 1 attended the Emergency Department with shortness of breath and a burning sensation in her chest. She did not wait to be seen but attended a nearby hospital the next day where observations were taken, and she was discharged without follow-up.

75. Later that month, a neighbourhood officer from Solihull Community Housing made the second routine visit to Adult 1 but, during the visit, the officer became concerned regarding bruising across the child's head which Adult 1 explained had arisen from a fire door closing on the child. However, the officer also noticed that Adult 1 had a possible bruise on her face and observed controlling behaviour from the perpetrator

who represented himself as Adult 1's cousin. The child also appeared very distressed as the neighbourhood officer was leaving. As a result, the neighbourhood officer contacted the Solihull MASH and was asked to make a referral which was made the same day.

76. Further enquiries were conducted by Children's Services, who, despite concerns of a possible non-accidental injury and a report of coercive and controlling behaviour, did not initiate a Section 47 investigation[11] or undertake a strategy discussion[12] as would have been expected in these circumstances.

77. Nonetheless, the Emergency Duty Team attempted to contact the family through a home visit that evening, as well as the next morning, eventually contacting Adult 1 by phone and Adult 1 agreed to take her child to hospital to be checked out. Checks were undertaken with the police and the hospital who confirmed that the child's injury was consistent with Adult 1's explanation. A visit was booked with the Emergency Duty Team but appears not to have taken place and the case was closed with no further action taken to consider the possible concerns regarding coercive and controlling behaviour and possible injuries to the child's mother.

***First report to the police***

78. After midnight on an evening in late July 2017, Adult 1's downstairs neighbours made a report to the police that they could hear the sounds of adults arguing and a child screaming from Adult 1's flat. They were not able to provide the resident's name. The call handler recorded the previous threat from Adult 1's ex-partner and that Adult 1 was a repeat victim of domestic abuse. The police were delayed in arrival, due to police resources being deployed on another urgent matter, but when they arrived and made enquiries of Adult 1, they were satisfied from her explanation that the child had been unsettled from arriving home late. There is no evidence that the officers made enquiries with the original caller and the records did not clarify if both occupants were spoken to separately. However, the brief nature of the notes recorded by the officers indicate that there was nothing presented to the officers of concern. Nonetheless, it was considered that the investigation had been closed whilst there were reasonable lines of enquiry left to pursue.

***Incidents leading to the end of the relationship***

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[11] A Section 47 enquiry under the Children Act 2014, refers to the duty of Children's Social Care to carry out an investigation when they have 'reasonable cause to suspect that a child in their area is suffering, or is likely to suffer, significant harm'

[12] A strategy discussion, also referred to as a strategy meeting, takes place under the aforementioned Section 47 enquiry to determine whether a full enquiry and core assessment is needed under Section 46 of the Act

79. In October 2017, Adult 1 attended Solihull Hospital with an injury to her right hand, explaining that she had fallen two days previously. She was discharged without the need for follow-up and the clinician later advised that no concerns were identified during the presentation that would have prompted selective enquiry regarding domestic abuse.[13]

80. In December 2017, the perpetrator took £2000 from Adult 1, which were her savings that she had hidden in her bedroom[14]. He appeared to have used the money to facilitate a trip to Afghanistan. Adult 1 discovered that, contrary to his assurances otherwise, the perpetrator was already married in Afghanistan and Adult 1 found out that he was expecting his fourth child from this marriage.

81. Adult 1 decided to end the relationship when the perpetrator returned from this visit in January 2018, and she went to stay with her mother. However, the perpetrator became very threatening, controlling, jealous and volatile with her and she felt compelled to return to her flat, leaving her child temporarily with her mother. Over the next three months, the perpetrator went on to attempt to rape her on several occasions, but she was too embarrassed and ashamed to tell anyone[15].

82. During this period, in February 2018, Adult 1 attended Solihull Hospital a number of times and had a brief period as an in-patient as a result of rheumatoid pain she was experiencing. She insisted on being discharged, explaining that she wanted to attend college, but returned later in the month explaining that the pain was affecting her daily activities to the point where she was finding it difficult to pick up her child and go to college. Her medication was reviewed, and she was advised that she needed specialist follow-up to investigate her condition.

83. Whilst Adult 1 was an inpatient, the perpetrator attended the Emergency Department with a cut to his hand which he explained had been caused by his self-harm with a Stanley knife. He was reviewed by the mental health liaison service, Rapid, Assessment, Interface, Discharge (RAID) where he reported being low because of his wife leaving him. The ward staff had refused him entry to the ward on Adult 1's request. He stated that he regretted self-harm, denied any suicidal thoughts or plans and mental health workers found no signs of mental illness. However, no safeguarding child referral was made and the perpetrator's relation to the child was not clear.

***Criminal conviction and probation involvement***

[13] Routine enquiry in relation to domestic abuse is not used in this Emergency Department although they do use selective questioning where indicated.

[14] This information was provided by Adult 1 in her application for a non-molestation order on 15.08.18

[15] ibid

84. In March 2018, the perpetrator was convicted of an offence regarding the unlawful sale of cigarettes and sentenced to a 12-month community order with the requirement of 100 hours of unpaid work and 20 days Rehabilitation Activity Requirement.[16] He was assessed as posing a low risk of harm and low risk of offending. However, the assessment identified that the offence was linked to his gambling: he admitted to playing daily on roulette machines and therefore the National Probation Service recommended that he work with rehabilitation services to address this through a gambling awareness workbook. However, this workbook was not available to Staffordshire and West Midlands Community Rehabilitation Company and the recommendation, which was not a requirement, was not taken up. He attended his first appointment with the Community Rehabilitation Company in March 2018 and the probation practitioner promptly contacted Solihull MASH who advised that the family were not current to Children's Services. The perpetrator commenced his unpaid work requirement in March.

***Second report to the police***

85. Over the Easter period in April 2018, Adult 1 contacted the police stating that her ex-boyfriend was at her door; had made previous threats to kill her; always made her stay at home and had taken her bank cards and paperwork. The call received an immediate response, and the police found the perpetrator present outside the address. Adult 1 had put the perpetrator's belongings into black bin bags and left them outside for him to collect and he had refused to leave the address, instead sitting outside in his car.

86. A Domestic Abuse, Stalking, Harassment and 'Honour' Based Violence (DASH) risk assessment was completed with Adult 1, who responded to four specific questions within the assessment: that she had 'tried to separate in the last year'; 'had experienced financial issues'; that the perpetrator 'had threatened or attempted suicide', where his cutting himself was noted; that she 'had been made 'to do or say things of a sexual nature that makes you feel bad or that physically hurts you' where verbal abuse was noted. There was little recorded in the relevant free text areas in the DASH in order to elaborate or contextualise Adult 1's responses. Her comments from her initial call, in respect to being made to stay at home, did not feature in the DASH and the police report of the incident although it was recorded that Adult 1 denied that threats to kill had been made and did not disclose any fear or that any physical violence had been used against her. She did however say that she thought

[16] A Rehabilitation Activity Requirement is a court-ordered requirement that a defendant participates in activity to reduce the prospect of their reoffending, forming part of a community or suspended sentence order.

that the perpetrator would not leave her alone after this incident and she was therefore advised to consider pursuing a non-molestation order through the National Centre for Domestic Violence (NCDV) and she consented to her details being shared with support agencies.

87. The IOPC were satisfied that the assessment of standard risk was correct at this time as it was the first known report of domestic abuse between the couple[17] and the level of controlling behaviour displayed by the perpetrator did not appear to meet the threshold for his arrest for this offence.

88. The perpetrator's vehicle was seized as it had no valid policy of insurance and Adult 1's bank, electricity and bank cards, which were in the car were returned to her. The perpetrator explained that they had been left in the vehicle the day before rather than deliberately or intentionally withheld. Thereafter, he was instructed to leave the location in order to prevent a breach of the peace and there was no record of the officers questioning the perpetrator over theft of Adult 1's sources of movement identification and money, either in the context of theft or as coercive control and economic abuse.[18]

89. Unbeknown to the police, the perpetrator made a threatening phone call to Adult 1 later that day and she went to stay with her mother, allowing the perpetrator to stay in her home as he was homeless. However, a few days later she changed her mind about the perpetrator staying in her home and changed the locks. This resulted in him sleeping in his car outside her mother's house for 12 days whilst begging her to take him back. He also sent Adult 1 and her family, a picture of himself with a cut left wrist, Adult 1's name written in blood and was threatening to kill himself.

90. The police referred the reported incident to the multi-agency Domestic Abuse Triage. Using the Domestic Abuse Risk Identification Matrix (DVRIM) tool, agencies assessed that the child faced minimum risk (Level 1), despite the fact that the child was reported to have been present at the time of the domestic abuse incident and that sexual violence had been featured within the DASH that had been completed by the child's mother. However, Children's Services noted that this level of detail did not appear to have been shared at the multi-agency meeting. [19] It was noted in the records that no further action was required as the mother had "acted appropriately". Because of the minimum risk level, no agency was tasked by Domestic Abuse Triage to undertake any follow-up with the family and no referrals or signposting to

[17] Their names had not been recorded in the third-party report on 29.07.17 which was not recorded as a domestic abuse incident

[18] Note that the IOPC report did not appear to question why the perpetrator's account of the incident was not discussed with him.

[19] The review has been unable to establish with certainty whether the level of information was shared on this occasion, whilst recognising that it would have been normal practice to do so.

domestic abuse services were undertaken. Neither was there any indication that the mother and child's safety at Adult 1's mother's home was questioned.

***Probation appointments***

91. The perpetrator attended a planned appointment with probation services and disclosed that he had been asked to leave the address by his partner and that the police had been called. He advised that this argument had started when his father had told his partner that he was married and had a wife and children in Afghanistan. The probation practitioner did not make further enquiries or address the domestic abuse that was becoming apparent as indicated by the police call-out. The perpetrator's gambling was also discussed at their meeting, and it was recommended that he consider Gamblers Anonymous, but this was not subsequently followed up with him either.
92. Later in April 2018, the perpetrator told his probation practitioner that he had lost his job because of his criminal record and having to attend frequent hospital appointments with his partner. He said that he no longer wanted to live with his partner and therefore housing options were discussed. However, the underlying reasons were not explored or linked with previous disclosure of the police calling out to the home.

***Emergency Department report***

93. Two days later, Adult 1 called for an ambulance at 04:00 complaining of chest pains. Paramedics noted that she had fresh bruising on her arms and appeared highly stressed. On her way to hospital, and alone in the ambulance, she told the ambulance crew that her partner was violent towards her and that she had attempted to leave him in the past, but the perpetrator had sent her messages and pictures of himself self-harming. She also said that she was isolated from her family. Ambulance staff made a referral to MASH as they were concerned regarding the domestic abuse and that the child had been left with the perpetrator.
94. After Adult 1 arrived at the Emergency Department, she told the nurse that the perpetrator had assaulted the child. The nurse made a referral to the MASH, as well as raised an adult safeguarding concern with the local authority and contacted the police reporting domestic abuse and safeguarding concerns for the child. Adult Social Care assessed that Adult 1 did not meet the criteria for their support as they considered that she had no care and support needs but referred the case to Children's Social Care and notified the hospital which had made the referral. In the meantime, the nurse relayed the information about her bruising which Adult 1 had said had occurred that day; advised that Adult 1 had "previous beatings from this male" and raised concerns about the child being in the perpetrator's care. Adult 1

told hospital staff that she wanted the perpetrator to have a mental health review because of his self-harming but it is unclear from records whether this was explored.

95. The nurse spoke with Adult 1 in some depth. She said that she did not want to be separated from her husband at this time and declined Women's Aid support. She said that her child had not been physically abused but that she would provide a statement to the police.

96. A police officer spoke with Adult 1 alone in a hospital cubicle where Adult 1 described a "fight" the previous night and described herself as "just as bad". She advised officers that it was likely that both she and the perpetrator would have injuries. Adult 1 went on to decline to make a complaint against the perpetrator or for her bruising to be photographed and did not consent for her details to be shared with support agencies. Adult 1 also told officers that the perpetrator "loves the child" and the police officer noted that there was no intimation from anyone other than the nurse that the child was at risk and that it had not been recorded that Adult 1 had shared any concerns with the paramedics about leaving the child with the perpetrator. Officers nonetheless completed a DASH, and, identifying the previous recorded incident of domestic abuse earlier that month, assessed the risk that she faced as medium. They updated the warning marker on Adult 1's address in order to inform future incidents and kept the log open for possible enquiries including contact with the paramedics, hospital staff and the perpetrator.

97. Other officers visited Adult 1's home a number of times that morning in order to speak with the perpetrator in relation to the allegations concerning the care of the child and in relation to his own welfare as Adult 1 indicated that he may be injured. A third visit found Adult 1 at home with the child having been discharged from hospital and she continued to decline her support for further criminal action. At this time, the perpetrator was out at work and he was not seen. The description of his condition and the events were therefore not corroborated. Officers arranged with housing services for the locks to the property to be changed. Although Adult 1 did not appear to officers to be supportive of further action against her abuser, they did not appear to have considered wider Sanctuary measures or the potential for a Domestic Violence Protection Order or Notice. Changing of locks on these grounds did not appear to have generated a referral for Sanctuary or rehousing from Housing Services either. Sanctuary would have enabled a risk assessment of the dwelling and referral to Women's Aid or consideration of the need to be rehoused.

98. The Sergeant who routinely reviewed the officer's response acknowledged the professional judgement displayed by the officers in determining the assessment of 'medium' risk. However, the Public Protection Unit also reviewed the case and downgraded the risk level to 'standard' as they did not feel that a clear rationale for this assessment had been provided and filed the matter for no further action beyond

the automatic referral to the Domestic Abuse Triage Process where it was discussed four days later.

### *Child safeguarding*

99. The Domestic Abuse Triage multi-agency meeting determined that there were sufficient child safeguarding concerns to refer to MASH. The Domestic Abuse Triage document identified that Adult 1 had been subject to previous domestic abuse.

100. This was the third referral to Children's Services and a social work assessment was undertaken over the next month. The social worker called Adult 1 at home but rightly ended the call when a man answered and instead contacted the Designated Safeguarding Lead at the Solihull College to arrange to meet Adult 1 there. During their meeting, Adult 1 minimised the domestic abuse that she was experiencing, repeating her previous claims that they were "both as bad as each other", referring to mutual violence and disclosing chest pains as a result of stress. She went on to indicate that the ambulance crew had misunderstood her desire to be left alone, claiming that she was referring to wanting to be left alone by the perpetrator's family, who were causing arguments, rather than by the perpetrator himself.

### *Allegations of familial abuse*

101. In mid-May 2018, the perpetrator's father contacted the police saying, "My son is hitting me". Police officers responded promptly and spoke with the father in a mixture of Urdu and English. He advised that his son had requested money from him, and his refusal led to an argument. Thereafter, the father declined to provide any further details, to complete the DASH or be referred for support. Whilst initially the father did not want his son to visit the family home, after speaking with his wife, he agreed to only exclude him from the shop. The perpetrator appeared to have left the family home before officers arrived and it was noted that he only visited every few months or so. From the information that was known, officers recorded an assessment of standard risk. The reasons why the perpetrator wanted money were not provided to the police although the perpetrator's prior offending had been linked to needing money for gambling.

102. The social worker (SW2) visited Adult 1's home where Adult 1 and the perpetrator advised that the recent arguments had been a result of the perpetrator's family not approving of their relationship. The child was observed to be well, relaxed and holding the perpetrator's hand and the social worker was clear that there were no safeguarding concerns, save for routine checks which were later completed with the nursery and the health visitor with no concerns outstanding.

***Further reports to the police***

103. Ten days later, Adult 1 contacted 999 saying that she had been punched in the abdomen and face by her partner, who had since left the location. The 'SIG' marker relating to previous incidents of domestic abuse was noted on the log by the call-handler, but the previous two recent incidents were not attached to the log. As police officers were about to arrive at the address, Adult 1 telephoned to say that she wanted to cancel the officers attending. Officers nevertheless spoke with Adult 1 who told them that she had been punched in the face and stomach when she confronted the perpetrator about his wife and family in Afghanistan. The Ambulance Service were also in attendance and examined Adult 1.

104. Adult 1 declined to make a complaint against the perpetrator as well as declined to support a prosecution, to engage with the DASH or to allow photographic evidence being taken, although no facial injuries were visible. Officers ensured that the child was unharmed, checked the child's living conditions, for safeguarding purposes, which were described as good and noted that the perpetrator had no keys to Adult 1's home. In the absence of checking the previous history of domestic abuse, officers assessed the risk that Adult 1 faced as a result of this incident as 'standard'. The sergeant reviewed the case and determined that the threshold to arrest the perpetrator had not been met and further determined that there appeared no purpose in undertaking a voluntary interview in these circumstances.

105. The police notified Children's Services. The Duty Manager asked a social worker (SW3) to visit as the allocated social worker was on leave. Although non-one was home when the visit was made Adult 1 telephoned the social worker (SW3) and explained that she was staying with her parents and didn't intend to return home. However, the next day Adult 1 contacted the police again, explaining that her husband was outside her home throwing stones at the window and would not leave.

106. The call was graded for an immediate response and officers were diverted from another incident to attend. Before they arrived, Adult 1 had phoned the police again to advise that the perpetrator was at her door and trying to get into her home. She said that earlier in the day, he had taken her car and her passport but did not advise them that the perpetrator had earlier used ladders to climb up to a kitchen window and let himself into her home and that she had had to change the locks.

107. Officers arrived promptly but did not appear to have been aware of the previous history. After talking with Adult 1, they returned her car keys, located her passport and child's birth certificate and provided safeguarding advice. The police removed the perpetrator from outside the address in order to prevent a breach of the peace and advised him that if he returned, he could face arrest. The threshold for criminal action in respect of theft of car keys and identity documents had not been met.

108. Officers checked the safety and wellbeing of the child and noted the last incident of domestic abuse but not the two incidents prior to this, all of which happened within a two-month timeframe. Adult 1 declined to contribute to the DASH and did not consent to information being shared with support agencies. Her risk was assessed as standard. This assessment was supported by the Sergeant reviewing the case, despite the escalating nature of four incidents in two months; the previous medium risk assessment and officer's inability to engage the victim or enable referral to support agencies.

109. On the following day, the concierge from Adult 1's block of flats contacted the police to report the perpetrator trying to gain access to the flat and continuing to throw stones as Adult 1's windows in order to gain her attention. The concierge was aware that the police had attended the day before and it appeared that the perpetrator had not heeded the police officer's warning of the day before. The police arrived promptly to find that Adult 1 was not at home and after speaking with the concierge conducted a search of the area before closing the case without engaging with the perpetrator or alerting Adult 1 to the perpetrator's continuing harassment

110. In response to the report to the police, the social worker (SW3) called Adult 1 who explained that she had returned to the property because she had become worried about the perpetrator removing her things, such as the passport and car keys. The social worker provided Adult 1 with contact details for Women's Aid. This was the first reference to Children's Services providing Adult 1 with these details and Adult 1 proceeded to contact the Birmingham and Solihull Women's Aid Helpline the same day.

111. The helpline worker discussed risk and safety planning, housing options and civil orders with Adult 1. As she did not want to move, she was given the details for the National Centre for Domestic Violence who specialise in obtaining civil orders.

112. Adult 1 spoke about the pressure that she was feeling from other agencies. In particular, she advised that social services were questioning why the police were being called so much and said that the police had told her that if she didn't sort this out then social services would take her child. Adult 1 told the helpline worker that the police were being called because of repeated harassment from her ex-partner and the helpline worker reassured her that contacting the police was the right course of action and suggested that she may want to consider moving temporarily to a refuge if the civil order did not prevent the harassment.

113. Adult 1 also spoke about her sense of isolation and so the helpline worker discussed how she could access their case work support. The worker did not identify that Adult 1 lived in Solihull and so she was given their Birmingham number for floating support and advised about drop-in sites across Birmingham. Although access to support in Solihull is through a different contact number, there was no record that she

contacted the local Women's Aid again, nor contacted the National Centre for Domestic Violence.

114. Although this helpline covers the two local authority areas of Birmingham and Solihull, Women's Aid have a more localised service which is funded as part of the local domestic abuse pathway. Neither Women's Aid nor the social worker referred her to this local service which would have had slightly more capacity to see her in person unlike in the Birmingham area where their resources were more stretched at the time.

115. Early in June 2018, Adult 1's allocated social worker returned from leave and was tasked with visiting Adult 1 and undertaking checks with the nursery which were done. Adult 1 advised that she had separated from the perpetrator and the social worker checked the flat, finding no signs of him living there. The social worker was also tasked to engage with the perpetrator during the next two supervision sessions but failing to gain a phone number for him as he had changed his number, did not do so. During the month, Adult 1 was advised that the perpetrator should have no contact the child and the nursery was advised to let Children's Services know if the perpetrator attempted to collect the child from nursery. It was noted that Adult 1 had since declined support from Women's Aid and 'Child-In-Need' support from the local authority.

116. Health visitors undertook a home visit around the same time and recorded a positive health assessment for Adult 1's child who was reported to be sociable and attending nursery locally whilst Adult 1 attended college. Health visitors had received notifications from the hospital the month before that Adult 1's child had bumped his face on a stone whilst running in the garden and had checked that the family were known to children's services. Adult 1

117. In mid-June 2018, the perpetrator made a further disclosure to his probation practitioner that the police had been called to deal with disputes between him and his partner and that he was homeless. Whilst he was referred to a partnership agency for housing support, the probation practitioner did not follow up on this disclosure until early July and then using an incorrect communication method, against protocol, which only enabled the police to send log numbers rather than detail.

118. Later in June 2018, Housing Services responded to the request for a repair to Adult 1's front door which had been damaged by the perpetrator. This did not appear to give rise to any further actions or enquiry regarding domestic abuse.

119. In early July 2018, the social work assessment was closed on the basis that the relationship had ended. Neither the social worker (SW2) or the team managers had seen the multi-agency information contained within the Domestic Abuse Triage document, although two reports had been made to the police whilst the case was being assessed.

120. Approximately three weeks before the homicides, Adult 1 made further and definitive attempts to end the relationship and the perpetrator returned to live with his parents although it later transpired that the perpetrator continued to stalk her and monitor her whereabouts.

***Taken to Hospital***

121. In early August 2018, Adult 1 attended Heartlands Hospital by ambulance suffering from chest pain and feeling anxious over the duration of her illness and lack of GP support and lack of specialist referral. She was assessed and discharged to see her GP only to return again four days later with the same symptoms alongside having difficulty swallowing. She declined blood tests, as she had had them four days previously, and was discharged to her GP. Adult 1's history of previous attendances and a summary of the safeguarding referral made in April were clear on the patient record but were not used to discuss any underlying issues on this occasion.

***Neighbours report to the Police***

122. Six days later West Midlands Police received a call from Adult 1's neighbour advising that there had just been a 'domestic' happening that had woken their family and that a male had just driven off in a van. Officers were dispatched and, in the meantime, the call handler attempted to call Adult 1 on her mobile phone but not gaining a response, contacted the neighbour again. By this time, the neighbour had heard Adult 1 screaming and being slapped and had gone to the address to confront the perpetrator who was coming out of the flat with blood on his arm[20]. The caller went on to say that they always see the woman with black eyes and bruising.

123. The police graded the incident for an immediate response but as a result of limited resources, officers from Coventry had to be allocated and took 34 minutes to arrive. Although police records were described as being particularly sparse and sub-standard on this occasion, it appears that Adult 1 engaged with the completion of the DASH, referring to their separation, the perpetrator's jealousy, having nowhere to live and how he had tried to cut himself previously. Adult 1 accepted a referral to the National Centre for Domestic Violence and her details were referred[21]. Neither the perpetrator nor the neighbour appeared to have been spoken with in connection with this incident. The officers recorded that this was a verbal argument and Adult 1

[20] Note that the IOPC were unable to confirm that the issue of having blood on his arm had been disclosed during the call.

[21] Note that the NCDV provided a nil response to the scoping for the DHR. IOPC advised received on 13.08.18.

was assessed again as facing standard risk. This assessment that was not subject to review by a supervisor as would have been expected. It is not known from police records whether the full history of incidents was referred to in reaching this decision, but a full summary of the domestic abuse history was available to officers and would have warranted a medium risk assessment and consideration for Domestic Violence Protection Orders and Notices as well as Sanctuary scheme for home security.

***Instructing a Solicitor***

124. Two days later, Adult 1 met with a solicitor and instructed that they apply for a non-molestation order against the perpetrator. In her statement she referred to this most recent incident, describing how he had smashed her mobile phone against the wall, punched her to the face and then kicked her whilst on the floor. She stated that the neighbours had called the police and were shouting at the perpetrator as he left but when she told the police officer that she had been beaten up, she was advised to see a solicitor. The statement went on to describe a catalogue of verbal, physical, mental and emotional abuse and its impact upon Adult 1.

125. The next day, the Domestic Violence Triage were automatically notified by the police about the five incidents in five months and made a child safeguarding referral to the MASH.

126. Two days later, Adult 1 was granted a non-molestation order at Birmingham Family Court and the order was personally served on the perpetrator the next day by AA Process Servers. The order prohibited the perpetrator from threatening or using violence against her; intimidating or pestering her; coming within 100 metres of her home; sending threatening or abusive letters, texts, emails, or derogatory social network posts or communicating with her in any way other than through her solicitor.

127. Included in the papers that were served upon the perpetrator, was a copy of the detailed statement that Adult 1 had made to obtain the order, as is common practice. However, West Midlands Police were not automatically informed that the *ex-parte* order[22] had been granted and served on the perpetrator, as the Process Server delayed five days before notifying the solicitor that the order had been served.

128. Two social workers spoke with Adult 1 over the phone, including the social worker who had previously been allocated to her (SW2). Adult 1 advised them that neighbours had seen her ex-partner forcing his way into her home. She went on to explain how on the occasion that she let him in, he became abusive, smashed her

[22] An *ex-parte* decision is one decided by a judge without requiring all of the parties to the dispute to be present, usually in an emergency. In this case the perpetrator was not present.

phone and accused her of cheating and so she had been to the police, gained a non-molestation order, had gone to stay with her mother whilst she got a transfer and did not want the perpetrator anywhere near her child.

129. Neither the perpetrator nor Adult 1's mother had been spoken with. However, a decision was made by the Duty Team Manager, who had been contacted by email, to refer Adult 1 and her child to the early help service, known locally as Engage, after she agreed to receive support from Women's Aid. Consideration as to why this was not escalated to a full social work assessment under Section 47, Children Act 1989 is considered later in this report.

130. Adult 1 went on to contact Solihull Community Housing through their contact centre, Solihull Connect, requesting a move due to the domestic abuse that she was experiencing from the perpetrator. She advised them that he was jumping in through windows, parking his car outside the flat and that she had obtained a non-molestation order against him. She was advised that the Housing Options Team would contact her.

***Family Intervention***

131. Adult 1's stepfather met the perpetrator four days later, returning his personal belongings from Adult 1's flat and asking the perpetrator to stay away. However, the perpetrator responded saying that Adult 1 was his wife.

132. On the next day, the Housing Options Team called Adult 1 and conducted a triage assessment over the phone. Adult 1 confirmed that she was able to stay safely with her mother for the time being and an appointment was made for a Friday later in the month. On the Friday, she phoned to say that she was unable to make the 11:30 appointment and asked if an appointment could be made for the next working day. She was informed that she could attend that afternoon for a 'sit and wait' service. However, this service was for those who had nowhere to stay that night and so, after waiting, the Home Options Team advised that as she could remain safely at her mother's house, then a further appointment was booked for the end of August.

133. In the same week, Adult 1 attended the Rheumatology Department of the Hospital where her medications were reviewed and her attendance at the Emergency Department noted, and no disclosure or enquiry was generated concerning domestic abuse.

***Serving the Non-Molestation Order***

134. On the Friday before the bank holiday, two days after receiving notification that the order had been served on the perpetrator, a copy of the *ex-parte* non-molestation order was sent by post to the West Midlands Police Public Protection Unit by Adult 1's solicitor. At this point, the perpetrator would have known about the order for

seven days, yet the police who were responsible for policing the order were still not aware. The letter containing the document was opened on the Tuesday after the bank holiday, two days after the homicide.

***The evening of the homicide***

135. On the evening of the homicide Adult 2 accompanied her daughter to a shisha lounge in Birmingham where Adult 1 had arranged to meet a male acquaintance. However, shortly after arriving, at 22:34, Adult 1 had to call the police as the perpetrator appeared to have followed them there. Adult 1 advised the call handler that she was having trouble with her ex-partner, who had slapped her and slapped and kicked her mother and that she had a non-molestation order to prevent him coming near her. Having established their current location, Adult 1's home address, Adult 2's name and the nature of injury, the operator asked them to remain inside the premises and wait for officers to arrive, which Adult 1 agreed to do. The call lasted 6 minutes until 22:40.
136. The incident log was classified as domestic abuse requiring an immediate response, meaning 'as soon as possible or within fifteen minutes.'
137. At 22:41, checks were made against the Police National Computer and previous incidents to Adult 1's home address and noted that there had been 16 'logs' to the caller's address. The Police had not been made aware of the threat to kill that the perpetrator had signalled to Adult 1 as he left the shisha lounge.
138. At 22:49 the incident log was updated to reflect that officers would be dispatched to the restaurant once it was safe to do so. The police were actively engaged in a live firearms incident nearby and for reasons of public safety, the firearms incident had to be resolved before unarmed police officers could be dispatched to a nearby area. Individuals were detained in relation to the firearms incident at 22:57 and police officers were dispatched to attend the restaurant at 23:06 arriving at 23:17 hours.
139. In the meantime, and not having been made aware of the delays, Adult 1 made a further call to the police at 23:08 to say that she had left the restaurant and was on her way home. She asked that officers visit her at her home address in Solihull as she was worried that he might come to the house and harm her again. She repeated that she had a non-molestation order and that the perpetrator had already slapped and kicked her mum many times that evening.
140. The change of address required the incident log to be transferred from one control room to another. This overlapped with the officers who had been deployed to the shisha lounge attending the premises to find the log updated to say that Adult 1 had returned home. The officers made contact with the force control room and checked that the log would be redirected, which happened at 23.30.
141. In the meantime, Birmingham CCTV control room had been notified of events at 23:10, in order to monitor and record events.

142. At 23:42, Adult 1 contacted the police for the third time that evening from outside her flat in Solihull. She was inside her car with her mother, waiting for police officers to arrive and reiterated her concerns this time saying that he was drunk and might get a knife or something with which to hurt her. Despite the need for an immediate response, all police units were already committed and unable to be deployed. At 00:18, the police operator rang Adult 1 but the call was not answered.

143. At 00:26, Adult 1 rang the police again to advise that this was her fourth call and that she had been waiting for two hours. She reiterated that she had obtained a non-molestation order and that the perpetrator had assaulted her and her mother that evening in front of witnesses and that they should arrest him straight away without needing to see her. However, as she did not have keys to her flat on her and, appearing understandably frustrated by the lack of police attendance, she told the call handler that officers could attend the following day and that she and her mother were leaving her address to go to her mother's address. It was evident that Adult 1 still expected the police to arrest him that evening and to take action against the breach of the non-molestation order. However, the IOPC investigation found that Adult 1 had been told by police that they could not arrest the perpetrator without seeing the non-molestation order.

144. The call handler advised her to lock the door at her mother's home and to phone 999 if he showed up. The perpetrator was not known to be at their location and the risk assessment was updated to reflect that she would be at a likely place of safety where others resided, and the log was changed to reflect the change in the response that was required from an immediate response to a scheduled investigation.

145. At 12:32am. the Police Resource Allocation Dispatcher contacted Adult 1 to make an appointment to see her the following day between 08:00 and 10:00. As the police had advised her that they could not arrest the perpetrator without seeing the non-molestation order, Adult 1 phoned her sister, and she sent a photograph of the order through WhatsApp to her phone.

146. At 12:34 am whilst on the telephone with Adult 1, the call handler returned the grading to one which required an immediate response as screaming could be heard. Police officers arrived at the scene at 12:42 to find that both Adult 1 and Adult 2 had been killed.

## 5. OVERVIEW OF AGENCY INVOLVEMENT

147. This section considers the Individual Management Review and Information Reports completed by individual agencies and the outcomes of discussions with the review panel concerning improvements to services in the future.

### 5.1 West Midlands Police

148. The responses of West Midlands Police were subject both to an Individual Management Review and a detailed investigation of eleven separate incidents by the Independent Office for Police Conduct. These eleven incidents of the perpetrator's violence or abuse involved an assault on a shop customer for which he received a caution: one report of domestic abuse towards his father and nine reports of his domestic abuse towards Adult 1. Of these nine reports, Adult 1 made the reports to the police directly on five occasions and a third party reported their concerns on four occasions. The police had also responded to two reports concerning domestic abuse from Adult 1's ex-husband or family, and one criminal conviction of the perpetrator for unlawful sale of cigarettes for which he received a twelve-month community sentence.

***History of domestic violence and abuse***

149. Information in relation to previous incidents was either not available or not sought by police officers in the majority of cases and this was seen to lead to an incomplete risk assessment and minimising of the risks that Adult 1 faced. It also meant that there was little specialist oversight of Adult 1's circumstances by the Public Protection Unit.
150. At the time of the first reports of potential domestic abuse in summer 2017, all response officers in West Midlands Police should have carried mobility devices which contained access to intelligence systems. These should have enabled officers to conduct address and person checks whilst on route to an incident giving them a greater understanding of the history within a relationship and a more in-depth understanding of what they may face upon arrival at an incident. They also had access to the initial log created by the call taker and should have been able to read the entirety of the log, ensuring a full understanding of the circumstances as provided by the call taker.
151. Whilst information should have been available to officers, on five occasions, it was not accessed and opportunities for an effective response to risk were missed. For

example, in Adult 1's second report in late May 2018, these missed opportunities began with the call handler who put the domestic abuse warning marker on the log to inform the officers responding to the incident but did not also link the two episodes of the previous month to the log. Thereafter, neither the responding officers, nor the sergeant who reviewed the case, undertook checks on these previous incidents.

152. On another occasion, the initial log would have alerted officers to the fact of previous domestic abuse reports but again did not attach the details of previous reports. On three other occasions, officers did not access the information that was available and therefore each incident and assessment was handled on an individual basis. The IOPC investigation questioned whether officers were choosing not to access this previous history or that their mobile devices did not permit them to review this information (IOPC,2020:127). However, the causes remain unclear on each occasion. Although the Public Protection Unit reviews incidents involving those assessed as facing medium to high risk, three front-line officers erroneously believed that the Public Protection Unit would automatically review the incidents assessed as standard risk and in doing so check for previous knowledge of domestic abuse. This mistaken reliance on the Public Protection Unit may account for the failure to check for the history of domestic abuse during some of these incidents and features within the recommendations. Nonetheless, the fact that this happened on four occasions, and included supervisors as well as front line officers, a recommendation has been made for West Midlands Police to provide assurance that previous history of domestic abuse is both available and being routinely accessed by attending officers.

***Engagement with DASH***

153. There were a number of occasions when Adult 1 was considered to be un-cooperative with police enquires and, in particular, declined responding to the DASH. Indeed, the IOPC report considered that "she does not appear to have ever fully engaged with this process…[or]… provided officers with detailed answer to the questions" (IOPC, 2020:126). It is not uncommon for agencies to view victims of domestic abuse as uncooperative and cite their lack of engagement as contributing to poor outcomes. However, wherever possible, reviews of this nature should seek to reframe this assessment by considering how agencies had themselves been unable to engage meaningfully with the victim. Turning responsibility around in this way is an important ingredient when considering agencies' own responsibility to work differently to support, protect and engage with those at risk.

154. How the DASH was completed in Adult 1's case deserves attention in this regard. For example, in the victim's first report, there was little information recorded on the DASH report. She had provided information in her initial call that she had separated

from the perpetrator who had made threats to kill her, made her stay at home and that he self-harmed. In response to the DASH questions, she asserted that she had tried to separate in the last year; that she was subject to sexual coercion or abuse; that there were financial issues and that the perpetrator had threatened or attempted suicide. From records and statements provided to the IOPC report, it is hard to see how the officers sought to engage further with Adult 1 to determine the level of risk from these factors or from her own initial report.

155. Moreover, the victim did not repeat the allegations that she had made in her initial call, that the perpetrator had threatened to kill her when it came to responding to the DASH and these initial disclosures were not examined with her thereafter. A recommendation has therefore been made that West Midlands Police provides assurance that all disclosures made in a domestic abuse victim's initial call to the police, are followed up in the subsequent investigation and risk assessment.

156. On the occasion of this first report, Adult 1 consented to her information being shared with other services but there was no indication that this was done. Adult 1's engagement did not appear to be in question in this instance. Thereafter, she declined to provide statements or comply fully with the DASH in the future, and it begs the question what happened in the interim to alter her approach. There was no indication that officers were looking holistically at the circumstances disclosed in each report or probing whether other factors may be influencing her reluctance to disclose or be affecting her confidence in the police.

157. In relation to the third reported incident later in April 2018, it was considered that the Public Protection Unit should not have reduced the risk grading from 'medium' to 'standard' and should not have closed the case before completing the further enquiries that were planned with health staff and the perpetrator himself. The IOPC report (2020) considered that assumptions had been made that the perpetrator would not incriminate himself under voluntary interview and that the input from health staff would be hearsay evidence. However, health staff had seen the bruising and could provide statements to that effect. This was therefore a missed opportunity to take positive action against the perpetrator and maintain concerns about the risk that Adult 1 faced at an appropriate level to safeguard her then and in the future.

158. West Midlands Police were one of the first pilot areas for the replacement of the DASH with the Domestic Abuse Risk Assessment (DARA) under the evaluation of the College of Policing. After consultation with the College of Policing who are evaluating the impact of the new assessment, it is not yet conclusively known how this may impact upon the effectiveness of identification of risk assessment within the force. However, the *Domestic Abuse Matters* programme has been delivered to all response officers and Domestic Abuse Champions in the Force and plans are in place to deliver the programme across the Force.

159. The *Domestic Abuse Matters* course was developed by the College of Policing and SafeLives, a domestic abuse charity, as a bespoke cultural change programme for police officers and staff in England and Wales. It was developed in response to Her Majesty's Inspectorate of Constabulary report**,** '*Everyone's business: Improving the police response to domestic abuse'* (2014) which highlighted the need for improvements in how police forces and officers understood and responded to coercive control. The programme has sought to transform the response to domestic abuse, ensuring that controlling and coercive behaviour is better understood, challenging victim blaming, and prompting officers to recognise the high levels of manipulation used by those perpetrating it, including in interactions with law enforcement (SafeLives, undated). In the light of these developments, the Force has committed to provide assurance to the Community Safety Partnership about the effectiveness of their identification and response to coercive control.

***Exercising the powers that were available***

160. The IOPC report considered that there were times when it appeared that all possible lines of enquiry and positive action were not undertaken as would have been expected by the force's domestic policy (2020:119). There were also times when the range of criminal offences were not considered.

161. The review examined the thirteen occasions when reports were made to the police in respect of the perpetrator. It transpired that he was arrested in connection with two incidents: cigarette smuggling and an assault of another within a shop. On the remaining eleven occasions involving allegations of domestic abuse against Adult 1 and his father, he was not arrested or requested to attend a voluntary interview despite being named as the suspect in relation to two assaults of Adult 1. On these two occasions in May 2018, there appeared to be insufficient evidence to arrest him for the alleged assaults. However, there were four occasions when the perpetrator could have been invited for voluntary interview.[23] Whilst the IOPC recognised that a voluntary interview "may or may not have provided the police with evidence of an offence, it would have at least shown that officers took reasonable and proportionate steps to investigate or make further enquiries of a domestic violence offence." (IOPC, 2020: 115)

162. On each occasion when a third party reported to the police, further evidential enquiries were not made. Hospital staff and paramedics had witnessed bruising; the housing concierge had witnessed potential harassment and neighbours had disclosed witnessing repeated injuries.

[23] *On 02.04.18; 27.04.18; 27.05.18; 10.08,18.*

163. Looking beyond the allegations for actual assault, other allegations appeared to indicate other offences. For example, the police were made aware in reports over three days at the end of May 2018, that the perpetrator may be harassing Adult 1 and may be committing an offence of harassment in doing so. Notwithstanding Adult 1's hesitancy to disclose her experiences when questioned or support action against the perpetrator, the absence of a holistic view of the repeated reports meant that consideration was not being given to the potential for coercive control.

164. By treating the reports individually and episodically, the pattern and content of allegations made, particularly between April and August 2018; the rapidity of reports; the perpetrator's repeated attempts to enter the property; the distress being caused to Adult 1 by his repeated attempts at contact; his control of her movements (passport and child's birth certificate) and access to cash (bank cards), could have been seen within the context of coercive control and economic abuse. It was noted that the repeated low grading of risk meant that specialist officers in the Public Protection Unit would not have had the opportunity to review the case when harassment or coercive control were becoming indicated.

165. On several occasions, it was evident that officers gave Adult 1 safeguarding advice, encouragement to obtain a non-molestation order, signposting to the National Centre for Domestic Violence and advice to change the locks on her flat. However, it did not appear that consideration had been given to the use of Domestic Violence Protection Order (DVPO) or the Sanctuary Scheme for home security beyond advice on changing the locks. This latter would have been particularly relevant as, unbeknown to the police, the perpetrator had climbed into Adult 1's first floor flat through a window and may have been an indicator of the need for rehousing.

166. The lack of consideration given to the use of a Domestic Violence Protection Order (DVPO) at a critical time, fifteen days before the homicide, was noted. It was also recognised that the under-use of DVPOs has been criticised nationally, despite their introduction into the armoury of police forces in 2014 (CWJ,2019). [24] Indeed, the Centre for Women's Justice demonstrated that, in the year ending March 2018, DVPOs were only applied for in 1 per cent of the total domestic abuse crimes (CWJ,2019). These orders provide a short-term breathing space, requiring the perpetrator not to contact the victim or attend her home address for up to 28 days. Unlike other civil orders used for domestic abuse, they do not rely upon a victim to pro-actively take out an order themselves and can be pursued without the victim's active support to protect from violence or the threat of violence. The responsibility

[24] Allegations of the failure of police forces nationally to consider Domestic Abuse Prevention Orders and Notices has formed part of a super-complaint by the Centre for Women's Justice (2019) "*Police Failure To Use Protective Measures In Cases Involving Violence Against Women And Girls*"

for action therefore rests upon the police and in doing so, does not place the burden for taking action against the perpetrator, upon the victim.

167. It was noted that the new Domestic Abuse Act 2021 has introduced Domestic Abuse Protection Notice which are intended to "…bring together the strongest elements of the existing protective order regime into a single comprehensive, flexible order to afford longer-term protection for victims of domestic abuse and their children" (Home Office, 2021:4) Statutory guidance for the police in meeting their duty to provide this protection will be forthcoming.

168. The review heard that since these murders, West Midlands Police has created a Civil Interventions Team with increased capacity and responsibility for supporting the completion of a broader range of civil order applications across both adult and child investigation. The team service the orders upon the respondent and support the victim and the Force is therefore prepared and in a stronger position to develop the approach to civil interventions required of the new legislation.

169. In respect of missing the potential stalking offences, since this time, West Midlands Police have also introduced training on stalking for first responders and secondary investigators to delivered over 2021. Moreover, in January 2020, Stalking Protection Orders were introduced, and West Midlands Police have been able to increase the number of these orders through this Civil Interventions Team. The panel therefore determined that the outcome of these very positive actions should form part of the overall assurance to the Community Safety Partnership that stalking is being effectively identified and responded to.

170. In respect of the potential for missed crimes, West Midlands Police have introduced a dedicated team that checks for missed crimes before police logs are closed and prioritises any missed crimes concerning domestic abuse, criminal assault, stalking and harassment from the records made. Whilst this a very positive step, it nonetheless relies upon effective recording by first responders and their supervisors and recommendation followed to provide assurance to the Community Safety Partnership that crimes concerning domestic abuse, coercive control, stalking and harassment are not missed.

171. In two incidents, the perpetrator was warned that he would be arrested for breach of the peace if he returned to Adult 1's home, although when he did return, he faced no consequence as, whilst officers tried to locate him, the actions were discontinued following a change of shift. West Midlands Police did not consider that this was a matter of continuity between shifts and were confident that the systems were in place to ensure that the new shift would have had all the information required to make a decision about future actions needed. It appears therefore that there was insufficient priority given to acting upon the actions and warnings given. This point contributes to the recommendation about the assurance needed by the Community

Safety Partnership of the effectiveness of the response to domestic abuse and coercive control.

172. In these ways there were several missed opportunities for the police to have taken more positive action commensurate with the reports that were being made and as a result, West Midlands Police have made recommendations for themselves to strengthen their responses. Nonetheless, beyond a lack of awareness, it was not evident to the review, why the expected responses were consistently not taken.

***Police Resources & Capacity***

173. The majority of reports to the police required an immediate or a priority response. However, there were four occasions when a lack of police resources on the day meant that the response to immediate calls for assistance were not able to be responded to within the prescribed time period.[25] Following the first neighbour report of hearing loud arguments and a child crying, the police were unable to respond to the incident, telephoning Adult 1 after approximately 90 minutes and arranging to attend the next morning. Likewise, following the victim's report in May 2018, the police had to make an appointment the next day.

174. Delays in the response to a third-party report earlier in August 2018 arose out of the availability of only single crewed cars when double crewed cars should attend domestic abuse. Finally, on the night of the homicide, the review heard how police delays arose out of a combination of variables including:
- the timing and location of a firearms incident when the initial call was made from the shisha lounge
- the changes of location for the victims
- insufficient resources to respond to Adult 1's third call

175. The police reflected that as police officers were not available to attend, an option may have been for the victims to travel to an open police station. However, at that time of night, the only police station that was open 24 hours in the vicinity was Birmingham Central Police Station, approximately 11 miles away, where there is no public car park. In order to attend the police station in person, Adult 1 and her mother would have had to walk alone to the police station from the nearest car park. In any event, this option was not offered at the time.

176. There is no doubt that West Midlands Police faced acute resourcing issues on the night of the homicide and in view of this, arranging an appointment early the next morning when they had reason to believe that she was at a place of safety, with a number of family members and where the perpetrator was not known to have followed her, would not have been an unreasonable decision in itself at that point if

[25] On 29.09.17; 29.05.18; 11.08.18; 26.08.18

resources would not allow otherwise. However, Adult 1's frustration of waiting for the police to attend was amplified by her repeated concerns that the perpetrator could come and attack her at any time. The sense of her frustration and agreeing to arrange an appointment for the next day may have been influenced by the delays that she had experienced on previous occasions that we have seen where the police were unable to attend due to resourcing issues.

177. Moreover, the review heard how the recurrent issue of police resources may also be having an impact on decisions made, as well as delays in their responses. The IMR author suggested that

> *"Increasingly with restricted resources and raising demand the police need to consider which cases are likely to achieve a positive outcome based on the evidence available, and to consider the role of other organisations in determining what other positive action can be taken." (West Midlands Police IMR)*

178. This position provides a number of challenges to the approach of policing domestic abuse. It is known that a significant proportion of victims, for a range of understandable reasons, will not wish to support the prosecution of their abuser and so this approach is of great significance to the fair and proportionate treatment of victims.

179. In order to ensure that the police have undertaken their duty to those victims that they have not been able to engage, amongst other things, they would rely upon looking holistically at the pattern, nature and history of known domestic abuse; effective evidence gathering; taking positive action; utilising all powers that are available; effective risk assessment and effective engagement with specialist domestic abuse services. Beyond one direct referral to the National Centre for Domestic Violence in the last weeks of Adult 1's life, there was no evidence of engagement with domestic abuse services despite Adult 1 agreeing that her details could be shared following her first report, when it was shared with Children's Services for the purposes of multi-agency screening of risk to the child. There were evident shortcomings in each of these areas in this case.

180. Resources were clearly not the only factor influencing the shortcomings in this case. However, it would appear that frank conversations need to be held with partner agencies and with the public about how the police will respond to domestic abuse as this resource-led approach, whilst understandable, has profound implications for the individual and multi-agency response to domestic abuse and will be considered further in the thematic section which follows.

181. West Midlands Police have therefore agreed to provide assurance to the Community Safety Partnership on the following shortcomings identified in this response:

- 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 necessary information about the nature and history of reported abuse to a child and parent is shared with partner agencies in order to enable an informed multi-agency assessment of risk of abused parent and child.[26]
- 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.

**5.2 Solihull Children's Services**

182. Solihull Children's Services responded to three referrals in respect of the domestic abuse that Adult 1 was experiencing from the perpetrator and recognised that that there had been shortcomings in each of their responses
183. The first referral regarding this perpetrator[27] was made in June 2017, when Adult 1's child was 15 months old. We have seen that it was made by a housing officer who was concerned about bruising to both Adult 1 and her child as well as suspicions about the perpetrator's control in the household. This referral of a potential non-accidental injury and coercive control did not lead to a multi-agency strategy

[26] It was noted that the very nature of information sharing in the context of child safeguarding is a dynamic process, often undertaken in emergency conditions, and it is not always possible to record every point, more than a summary of what has been shared between agencies, for example in a strategy meeting.
[27] This was the second referral made to Children's Services. The previous referral concerned Adult 1's ex-husband and her brother-in-law.

meeting or formal child protection assessment. As the referral was made on a Friday afternoon, MASH did not undertake a threshold visit. Instead, the Emergency Duty Team made attempts to visit but did not meet with the young family. They were able to contact Adult 1 by phone where she agreed to take her child to hospital to be checked. Children's Services then relied upon the hospital assessment of accidental harm and closed the case. In this way, they did not address the other concerns that had been made in the referral regarding possible concerns of coercive and controlling behaviour and injury to the child's mother.

184. The second set of referrals was received in April 2018 from the Ambulance, the Hospital's Emergency Department and the Police, in respect of the same incident that day.

185. The MASH team agreed that as the child may be at risk of suffering significant harm, that a Section 47 (Children Act 1989) enquiry should be initiated. Indeed,

> *"Local authorities, with the help of other organisations as appropriate, have a duty to make enquiries under section 47 of the Children Act 1989 if they have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, to enable them to decide whether they should take any action to safeguard and promote the child's welfare."* (Working Together to Safeguard Children, 2015[28])

186. The social work assessment was then progressed through the Children's Assessment Team. This team progresses referrals made to MASH and completes assessments to determine any risks to children. The same social worker as before (SW2) was tasked with undertaking the assessment and showed initiative in contacting Adult 1 more safely through the college.

187. The MASH team had received the police report which at that time outlined the risks of separation; the perpetrator's self-harm when she had tried to end the relationship previously; sexual violence/coercion and financial issues. However, the MASH team advised that they had not considered the referral from the Hospital, which had initially been sent to Birmingham and diverted to Solihull, even though by that time it was available to them. It was not known why this information was not considered.

188. In contrast to what Adult 1 had said to the nurse and the ambulance crew, with whom a rapport had clearly been built, Adult 1 advised the social worker (SW2) that the perpetrator was not a dangerous man; that he has never got angry with her or the child and was an amazing father.

189. During the assessment, the social worker (SW2) undertook safety planning with Adult 1 but the degree to which Adult 1's family was supportive of the young mother was not explored in any detail and the social worker had not been directed in supervision to speak with Adult 1's mother. Neither did it appear that the social

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[28] This version of Working Together was been superseded by a later version in 2018, but responsibilities around section 47 have not changed in this regard.

worker had been directed through supervision to make use of tools such as DASH, DVRIM or the Faith and Culture Safeguarding Checklist which would help update and contextualise Adult 1's experiences and the impact upon her child and inform a better understanding of coercive control. It was later observed that the *Signs of Safety*[29] child protection case management tool was used. *Signs of Safety* is a strengths-based approach to child protection casework that seeks to integrate professional knowledge with local family and cultural knowledge. This model is used locally for all cases as standard practice, but the issues of coercive control did not emerge from this assessment. The social worker (SW2) advised that they had used the domestic abuse 'power and control wheel'[30] that was specifically for BME families when meeting with Adult 1. The 'power and control' wheel is a common diagrammatic method of working with a domestic abuse victim to identify the different ways in which they are abused and enable this to be seen in the context of their abuser's overall power and control over them. The BME version of this tool specifically captures the additional dimensions of abuse that black, minority ethnic and refugee women may face. However, this was not referenced in the social work assessment.

190. The assessment did not include a financial assessment as Adult 1 gave no indication to the social worker that she was struggling financially, and the social worker was not aware that Adult 1 had approached Housing Services for a food parcel previously or advised by any other organisation that this was an issue. Whilst the DASH taken in April 2018 had identified financial issues, it was evident that not all information had been accessed.

191. Before the assessment was completed, Children's Services were notified by the Police that Adult 1 had been punched in the lip by the perpetrator. As the allocated social worker was on leave, social worker (SW3) visited Adult 1 who said that she had taken her child to stay with her mother and had no intention of returning. However, Children's Services were notified within days of another incident. Although the social worker (SW3) phoned Adult 1 and provided her with Women's Aid details for support, there was no record kept about the nature of management advice on the earlier occasion and no record that management advice was sought concerning this incident. It is not known whether this was a matter of poor recording or a lack of managerial oversight. The Women's Aid number given appeared to be the wider helpline number rather than the local number for Women's Aid in the Solihull domestic abuse pathway.

[29] Further information on the Signs of Safety model can be found at https://www.signsofsafety.net/

[30] Further information can be found on the 'power and control wheel' at https://www.theduluthmodel.org

192. When the allocated social worker (SW2) returned from leave a week later, there was no record that the practitioner had been updated by a manager on their return, although the service was confident that such a discussion would have taken place. Irrespective, the social worker attempted to call Adult 1. In supervision some days later, SW2 was set tasks to gain the views of the perpetrator and rigorous attempts were made to contact and locate the perpetrator. These were unsuccessful as there was no way of getting in touch with him.

193. The Team Manager closed the social work assessment, and it was not evident in supervision that a full chronology of events had been considered, particularly as the latest two social work responses to police reports had lacked management oversight. Moreover, there were also apparent shortcomings in supervision that the social worker (SW2) received: not requiring wider support networks to be checked for a young and vulnerable mother; not identifying the perpetrator's use of self-harm as a form of coercive control and not using the DASH or the DVRIM to focus the analysis on coercive control. In these ways it was difficult to see how a broader understanding of domestic abuse and the context of the young mother's experiences and the impact upon the child could be achieved.

194. The allocated social worker (SW2) in this case was within their first post qualifying year and subject to the Assessed and Supported Year of Employment (ASYE) programme. This programme gives newly qualified social workers extra support during their first year of employment in order to help them develop their skills, knowledge and professional confidence. Whilst the social worker had received the requisite number of supervision sessions at this time, there did not appear to have been any checks on whether actions and tasks required had been undertaken or whether this newly qualified social worker was struggling with any aspect of the tasks assigned. In fact, the same tasks had been duplicated in bi-weekly supervision. Neither did it appear that there was any consideration of the need to undertake closer scrutiny of available records before closing the case of a newly qualified social worker. However, the social worker's supervisor was on leave when the case was closed by the team manager. A recommendation has therefore been made for Children's Services to ensure that sufficient supervision is provided to newly qualifying social workers and that there is close scrutiny of their cases before case closure.

195. Perhaps most significantly, the Team Manager's rationale for closing the case reflected a misunderstanding of the nature of domestic abuse and potential risk of separation:

> *"While it is worrying that …Adult 1… has been in 2 relationships where there has been domestic abuse and from her views it appears that she has sought to minimise the incidents. I acknowledge that she is reporting that the relationship is over and that this is also as a result of … [the perpetrator]'s*

*family interference that is upsetting Adult 1, however the concern is that they may resume the relationship and the altercations will continue. Adult 1 would benefit from work and support around understanding domestic abuse and the impact on children however at this stage she is declining and as they are suggesting the relationship is over this reduced the risks therefore I am in agreement to no further action. However further concerns may then need to be considered and further action required as Child 1 will be at risk of harm if he continues to be exposed to his mom and [the perpetrator]'s arguing and fighting."*

196. This rationale raises a number of issues, including:
- It implied that risks reduce on separation. There remains significant evidence that, on the contrary, risks increase on separation
- It implied that there was mutual violence (them arguing and fighting), which was a minimisation of the perpetrator's domestic abuse that was known to be happening at that time and a collusion with Adult 1's self-blame.
- It implied that Adult 1 was wilfully minimising the domestic abuse from her two relationships without appearing to give consideration to the complex reasons why a young, isolated mother who was relatively newly arrived to the country and experiencing domestic abuse, may minimise her experiences to others, as well as possibly to herself.

197. We have seen that the third referral resulted in the two social workers who had been involved previously (SW2) (SW3), speaking with Adult 1 and providing some continuity to the response. Both social workers identified that Adult 1 was taking steps to protect herself and her child through gaining a non-molestation order, by staying temporarily with her mother and by seeking a move. However, the social workers had not seen the Domestic Abuse Triage documents which contained the history of escalating abuse and multi-agency information, and which had supported the multi-agency determination that there were child protection concerns for the child. These documents had been uploaded onto the child's electronic record and were available. The review was unable to establish why these records were not accessed.

198. The two Duty Team Managers, who were responsible for the decision making in this instance, made a decision that there was no need for a formal intervention from children's social work services. In this way, a referral was made to the Early Help Service for Adult 1 to gain support from Women's Aid. Had a decision been made for a full social work assessment of child protection, then the features of the relationship and threat from the perpetrator could have been examined more thoroughly. It would also have required communicating directly with the

perpetrator, which had not been done on the previous assessment, and assessing the ongoing risk that he was presenting to Adult 1 and the child.

199. The IMR author refers to the understanding that neither of the Duty Team Managers looked at the Domestic Abuse Triage documents before making the decision that no formal intervention was required, implying that, had the history been known, then a different decision would have been made. Whilst a number of relevant documents including the Triage document, the homeless application and the adult safeguarding referral, were not referenced in the social work assessment, the child's record by this time would have included each of the police reports and both social workers were familiar with the case.

200. Importantly, the decision making appears to have been based upon the view that Adult 1 was taking the action necessary to prevent significant harm to her child. This reliance upon a mother to protect her child, which is not an uncommon response, will be discussed further in the later sections. However, there were clear shortcomings in this particular instance in: not identifying the significance of an escalation of threat; not interviewing the perpetrator who was referred to incorrectly as the child's father; not contacting Adult 1's mother and in not considering the safety of the young mother and child staying temporarily in Adult 2's family home. Had Adult 2 been approached she may have alerted social workers to the fact that the perpetrator had stalked Adult 1 on previous times when she had stayed there and that he had broken into her home as well.

201. Although assessments were each completed within the required timescales, a lack of awareness was evident at times in most of the Service's responses to domestic abuse, and key risks in respect of the implications of the perpetrator's self-harm and the increased risk on separation were not identified. Whilst it was found that each of the managers had received training on domestic abuse, their responses did not evidence this and indicated that awareness of domestic abuse and coercive control had not been embedded in the organisation

202. As a result of their reflections, Children's Services have identified the following learning for their organisation:

- Acknowledging the potential for coercive and controlling behaviour needs to be routine within the process of assessing domestic abuse
- Domestic abuse specific assessment tools such as DASH and DVRIM need to be used in order to facilitate a broader understanding of domestic abuse and the context of harm for mother and child
- Clarity over relationships and clarity over the sequence of events needs to be established using a genogram and chronology. In this case it was evident that the whole chronology had not been taken into account and some staff were unclear about the relationship of the perpetrator to both Adult 1 and the child
- All relevant information on a child's file must be explored

- When positive change is seen, the ability to sustain that change needs to be considered (whether a non-molestation order will have the required effect)
- Perpetrators should be involved in the assessment in a safe way and not invisible to the child protection process
- Wherever possible, extended family networks should be involved and promoted as part of the process of building safety plans and the ability of the family network to sustain support is considered.
- Supervisors have a role in ensuring each of the above is present in assessment and safety planning.
- Recognising the increased risk of separation
- The need to strengthen record keeping as a number of important points were not recorded including home visits
- The need for management oversight of interventions, particularly when there is an escalation
- Managers need to ensure that all required tasks and an holistic approach to domestic abuse have been undertaken before closing a file
- The need to strengthen relationships with specialist domestic abuse services and knowledge of the Solihull domestic abuse pathway

203. More recently, significant changes have been made to the 'front door' to Children's Services in Solihull which include the multi-agency Domestic Abuse Triage process that was in place at the time. These changes are considered further in the thematic section on risk below. However, the panel recognised that their challenges of the approach to domestic abuse within the child safeguarding responses was not only a local matter but was a common deficit in national responses to children living with domestic abuse as illustrated by research, reviews and joint targeted area inspections (JTAI,2017; Sidebottom et al. 2016; Brandon et al, 2014, 2020; Katz, 2021). This issue will be considered further in the thematic section which follows

## 5.3 Solihull Community Housing

204. Since 2016, Solihull Community Housing responded to two periods of homelessness for Adult 1 and her child. Thereafter they responded to one report of noise nuisance, one domestic abuse related repair and made two reports to other agencies regarding concerns over domestic abuse.

205. On the first occasion of homelessness, following the breakdown of her marriage to the child's father, Adult 1 was provided with temporary accommodation then housed permanently in a flat where she was routinely visited twice by housing officers. On the second occasion, the neighbourhood officer acted swiftly upon concerns regarding Adult 1's visible bruising and the perpetrator's concerning, potentially controlling demeanour by separating the individuals during the

inspection of the property, obtaining the perpetrator's contact details and referring to MASH, which was seen to be good practice.

206. On the second occasion of homelessness, there emerged some confusion and delay over the process of completing a personalised housing plan. When Adult 1 was unable to attend the appointment that had been made for her, seven days after her initial call, there was confusion over how she should best reschedule which provided further delays. Although matters of risk were discussed at each point of contact, and Adult 1 confirmed that she could stay safely at her mother's home temporarily, the panel considered that there should be some method of expediting the homeless assessment for victims of domestic abuse.

207. Solihull's Housing Options Service had been remodelled four months earlier, in order to be compliant with new homelessness duties introduced by the Homelessness Reduction Act 2017. The Act introduced new 'prevent' and 'relief' duties designed to engage with persons threatened with homelessness and agree a detailed, personalised housing plan. The changes required revised customer pathways and did have significant resource implications, although it was not considered by the IMR author to have impacted directly upon the service response in this case. Nevertheless, additional staffing resources have since been made available to the homeless pathway and the requirement for staff to ask all victims about the safety of their current accommodation has been reinforced.

208. Beyond homelessness, Adult 1 came to the social landlord's attention in respect of noise nuisance where the relationship between anti-social behaviour and domestic abuse was not specifically written into policies and procedures. Likewise, the need for a repair to Adult 1's front door arising from the perpetrator's damage should have been an alert to Housing Services and, at minimum, generated further enquiry with their resident.

209. Although staff followed the prescribed pathways and procedures that existed at the time in each regard, Solihull Community Housing committed to undertake an organisation-wide review of their responses to domestic abuse and to pledge to 'Make a Stand'. The Make a Stand pledge has been developed by the Chartered Institute of Housing in partnership with Women's Aid and the Domestic Abuse Housing Alliance. It was created to encourage housing organisations to make a commitment to support people experiencing domestic abuse through policies, information for residents and support for staff.

210. In this way, Solihull Community Housing has committed to strengthening their policies and pathways for domestic abuse across the organisation including the issues that were relevant for Adult 1: the need for timely responses to homelessness through domestic abuse; the relationship between anti-social behaviour and domestic abuse; the pathways for identifying domestic abuse victims from patterns of disrepair and the need to look holistically at Sanctuary responses for home safety

as well as the need for rehousing when lock changes are required. Significantly, Solihull Community Housing has also committed to explore accreditation through the Domestic Abuse Housing Alliance in order to provide a 'whole organisation' approach to domestic abuse. The service will provide assurance to the Community Safety Partnership concerning the outcomes of these commitments. The matter of the awareness of the benefits of a Sanctuary Scheme and the relationship of anti-social behaviour to domestic abuse are considered in the thematic section to follow.

## 5.4 Birmingham and Solihull Clinical Commissioning Group

211. Birmingham and Solihull Clinical Commissioning Group considered the three GP Practices that had provided primary care to the two victims and the perpetrator.

212. Both Adult 2 and Adult 1 were registered with the first GP Practice although Adult 1 moved practices after the birth of her child. Adult 2 had a good relationship with the Practice but made no disclosures regarding the domestic abuse of her daughter. However, the health visitors located in the Practice received a notification of the domestic abuse incident on the day of the child's birth and this was recorded on the child's record only. Had it been recorded on Adult 1's records, it could have been discussed at her post- natal assessment. In this way, it was reflected that there was poor information sharing across agencies within this primary care setting and recommendations have been made to review their systems of receiving and progressing information which give rise to safeguarding concerns and to improve knowledge and skills in domestic abuse. The practice has since become an *Identification and Referral to Improve Safety* (IRIS) practice. [31]

213. Adult 1 was registered with the second GP Practice between November 2016 and August 2018. During this time, she called an ambulance on ten occasions and was often taken to hospital or presented to the GP with vague symptoms. It was reflected that as vague symptoms may be indicative of domestic abuse there were missed opportunities to pro-actively enquire about domestic abuse (Department of Health and Social Care, 2017). The health visiting service and the Emergency Department did share information, which highlighted the history and escalating risk of domestic abuse, but no assessments were undertaken by the Practice regarding the impact upon, or safety of Adult 1 or her child. This GP practice has also made recommendations to become an IRIS practice, whereby they would be trained and supported to routinely enquire about domestic abuse in specific situations, and to review their systems for receiving and progressing information where there are safeguarding concerns.

[31] Identification and Referral to Improve Safety - a general practice-based domestic violence and abuse training support and referral programme

214. The perpetrator was registered with a third GP Practice who were aware that he had self-harmed in February 2018 and had had a psychiatric assessment which referred him back to his GP. The Practice was already an IRIS Practice but at the time of writing, IRIS did not include responding to perpetrators of domestic abuse. It was noted that there was a national pilot, RE-PROVIDE, being trialled which was exploring how primary care may respond to male perpetrators of domestic abuse but the evidence to support practice was not yet available. This Practice has recommended that it undertakes refresher IRIS training, nonetheless.

215. The review noted the good practice in Birmingham and Solihull Clinical Commissioning Group's success in recruiting 80 per cent of GP practices in their region to the IRIS scheme and is in the process of completing the delivery of training to each of these practices. In so doing, it has significantly extended the awareness of domestic abuse and improved the effectiveness of the response to domestic abuse at a primary care level.

## 5.5 University Hospitals Birmingham NHS Foundation Trust

216. Adult 1 attended both Heartlands and Solihull Hospitals within the Trust on numerous occasions and her child also was attended the Emergency Department on five occasions.

217. Routine enquiry on domestic abuse was undertaken in midwifery services during Adult 1's antenatal period. During the post-natal period, domestic abuse and child safeguarding concerns were responded to robustly through information sharing with the police, health visitors, domestic abuse midwife and a referral to children's services. Moreover, Adult 1 was not discharged from hospital until midwives had confirmation from children's services that it was safe for her to be discharged to her mother's address. However, the Trust reflected that this could have been strengthened had they held a discharge planning meeting for Adult 1 and her new-born's discharge from hospital after the birth

218. It was noted that the Trust employs a specialist midwife for domestic abuse who supports staff in caring for women and their families affected by domestic abuse, as well as providing training and attending MARACs. All maternity staff receive mandatory safeguarding training on routine enquiry with a compliance rate of 93 per cent.

219. When domestic abuse was disclosed to staff in the Emergency Department in April 2018, a referral was made to Children's Services, advising them that domestic abuse was happening whilst the child was around, and a referral was made to Adult Services for Adult 1 although this referral was slightly delayed as it was sent in error to a neighbouring authority before being relayed to Solihull Adult Services. The

police were already on the scene and hospital staff advised Adult 1 about Women's Aid services, but she declined their help. However, when it was known that Adult 1 was to return to the perpetrator who was also self-harming, the Trust reflected that they should have held a discussion with the social work team as this was recognised to be an indicator of high-risk of domestic abuse and referral to MARAC could have been considered.

220. Likewise, when the perpetrator attended the Emergency Department with a self-harm injury, disclosing his recent separation and two-year-old stepchild, a safeguarding children referral should have been shared with Children's Services to ensure that they could assess whether this resulted in increased risk or need for the child. It has not been possible to find out why this was not done, as the relevant staff have since left the Trust.

221. For the child, three of the five attendances were in regard to childhood illnesses and two in relation to head injuries and safeguarding alerts had been suitably attached to the child's records in relation to the known domestic abuse. As we have seen, the injury to the forehead, in July 2017 was assessed as consistent with an accident and whilst not considered suspicious, it generated information sharing with children's services as it was known that there had been domestic abuse in the household. However, it was noted that the documentation on this assessment was not in line with best practice and the issue has been addressed with the clinician concerned.

222. There were a number of later attendances for Adult 1 when it was not clear that the previous history of domestic abuse was addressed when completing assessments. During the last attendance, for example, the summary of the safeguarding referral that the Trust had made four months earlier had been summarised and made clearly visible but did not appear to have been utilised in order to further understand Adult 1's presentation. Clinicians advised that this was a particularly busy shift in the Emergency Department with reduced staffing levels. They explained that the focus and primary concern of staff would therefore have had to be on the presenting issue. It was noted that the Trust is now in the process of promoting selective questioning within the Emergency Department, applying the NICE Guidance on Domestic Abuse (NICE, 2014;2016;2017), and seeking funding to locate an IDVA within the department. However, the Trust noted that driving these improved responses is constrained by the environment of the Emergency Department which offers little confidentiality.

223. In the absence of following up on Adult 1's history, it was reflected that opportunities to enquire and respond to domestic abuse as well as to promote the support that specialist domestic abuse agencies could provide, were not always taken. Moreover, there were occasions in both midwifery services and the Emergency Department when names and relationships of family members were not always recorded.

224. As a result of these reflections, the Trust has made the following recommendations for itself:

- 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 routine domestic abuse enquiry following the NICE recommended domestic abuse questions into Emergency Departments and assessment areas
- To continue to deliver the current domestic abuse training programme and strategy
- To issue standards to the Emergency Department 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 domestic abuse services to the staff that work within the Emergency Department
- To continue to seek funding for a co-located Independent Domestic Violence Advisor service within the Emergency Department

225. It was noteworthy that the victim appeared to feel able to disclose more fully when ward staff in the hospital arranged for her to see an Arabic speaking doctor, despite her good command of English. In terms of cultural sensitivity, this was seen as good practice.

### 5.6 Birmingham and Solihull Women's Aid

226. Women's Aid explained how helpline calls are led by the caller's needs, but that risk assessment and safety planning always form an essential part of their response, as it did in this case. The role of the specialist sector was recognised by the panel as intrinsic to the co-ordinated community response to domestic abuse, not least because their positioning as independent and expert services, means that they are more likely to be able to gain a fuller picture of risk than statutory agencies. Likewise, the helpline worker provided a discussion of options and services available, routes into refuge and practical information. It was clear that Adult 1 felt that she was experiencing pressure from other agencies and the helpline worker reassured her that she should continue to call the police when she needed to but that she might also want to consider refuge if the harassment continued.

227. However, the helpline worker did not consider that Adult 1 may be from Solihull where there is a specific pathway into Women's Aid services and Adult 1 may indeed

have benefited from knowing about these more locally accessible services. All helpline staff and volunteers have since been reminded about the importance of checking where callers live before referring or providing information about how to access services thereafter.

### 5.7 Probation Services

228. The perpetrator was under the supervision of Staffordshire and West Midlands Community Rehabilitation Company (SWMCRC) for an unrelated offence at the time that the homicide occurred. He had disclosed risk factors about relationship disputes since the earliest assessment with SWMCRC and it was considered that these should have triggered a request for further information from the police. This may have informed the probation practitioner's decision about whether to complete a fuller assessment of risk, known as OASys layer 3, and a Spousal Assault Risk Assessment (SARA). This would have screened for domestic abuse risk related factors that the perpetrator posed towards Adult 1.
229. The need to undertake a fuller assessment was confirmed soon afterwards. Despite a disclosure about the police having been called and his having a wife and children elsewhere, the probation practitioner did not consider potential risks arising from domestic abuse or seek to explore the dynamic of his relationship with his wife in Afghanistan. A second disclosure of police attendance gave rise to a delay of three weeks before making an enquiry with the police and then making the enquiry, against protocol, through an insecure email channel which did not enable the police to respond with any detail beyond log numbers. This was not followed up, which was seen as particularly disappointing as the probation practitioner was based within the police station at that time. It was considered that the co-location may have been counter-productive if there was an over-reliance upon locally established information sharing practices rather than adherence to regionally agreed protocols with the Police.
230. It was also considered that there had been a lack of professional curiosity across the period of supervision. For example, in April 2018, the perpetrator advised that he no longer wanted to reside with his partner, but this was taken at face value without exploring any underlying reasons as to why the relationship was ending. There were missed opportunities to explore domestic abuse and to engage with partner agencies to obtain further information which would have supported the management and assessment of risk. Whilst Children's Services were contacted at the outset, this case highlights the requirement for regular checks to be made throughout a person's sentence.

231. Issues of gambling and the support that could be offered by Gamblers Anonymous were discussed but not followed up by the probation practitioner. The Gambling Workbook, referred to by the National Probation Service, had been decommissioned locally as part of the Transforming Rehabilitation process that opened up the market to new rehabilitation providers, including the community rehabilitation companies in 2014 (Ministry of Justice, 2013). The review was advised that the Community Rehabilitation Company did not offer a Gambling Pathway Intervention itself, but in this case, it had not been a requirement of his sentence.

232. Between March and August 2018, the perpetrator completed his 100 hours unpaid work hours but missed several appointments. Whilst enforcement of missed appointments was commenced, there was a failure to follow through on action for breach of his sentence requirements. However, the perpetrator was reported to have presented well in appointments, was articulate and polite and had a positive attitude towards completing his unpaid hours. He did not present any derogatory attitudes towards Adult 1 that in themselves would have required challenge, but there was not sufficient focus on exploring his understanding of the dynamics of the relationship.

233. This combination of deficits where practice fell below expected standards, occurred within the context of a high caseload in a particularly pressurised team with high absenteeism within both the team and management. There existed a sense of firefighting and that was coupled with a perception that the perpetrator was low risk based upon the offence for which he was convicted. However, these factors did not fully explain why opportunities were not taken to uncover and challenge domestic abuse behaviours that needed prioritising above completion of unpaid work or the ability to find employment. Responses reflected a lack of awareness of domestic abuse and the management oversight was not effective in challenging and influencing the direction of risk management focus with the perpetrator.

234. Since this time, the particular staffing pressures on that particular team have been resolved and full case management oversight resumed. However, SWMCRC have identified recommendations to ensure that the following key lessons are implemented:

- Ongoing safeguarding checks need to be completed by probation practitioners and ongoing risk management activities when risks have been disclosed and new information is obtained
- Practice needs to improve in the identification, recognition and understanding of domestic abuse and links to risk management
- A more proactive and investigative approach needs to be undertaken when concerns around domestic abuse/disputes are disclosed
- Manager oversights need to be effective in identifying and supporting probation practitioners to identify the nature of changing risk

- Requests for information need to be timely and completed in-line with the agreed multi agency processes
- Ensure that SWM CRC has communicated clearly to the National Probation Service about the suite of interventions that are available for delivery to service users in order to inform effective sentencing requirements.
- Improved practice is needed in relation to timely enforcement
- Organisational restructure has been needed for the Solihull team in order to build resource capacity and resilience.

235. In view of the unification of the National Probation Service and Community Rehabilitation Companies and their return to public control under the new Probation Service in June 2021, the review has recommended that learning from this review, together with outstanding recommendations and actions for probation services, be adopted by the new organisational model in the region.

## 6. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS

### 6.1 Experiences of domestic abuse

236. A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Section 7, Multi-Agency Statutory Guidance, 2016). It may therefore be helpful to summarise the wide-ranging domestic abuse that Adult 1 experienced from the perpetrator, only some of which was known by agencies at the time. A wider picture of the domestic abuse has been established through Adult 1's later statement for a non-molestation order and from information provided to the review by her family.

***Grooming***

237. Reports of domestic abuse occurred quickly in Adult 1's marriage to the perpetrator, but the perpetrator's abuse had also been evident in their earliest contact whilst they were both studying at Solihull College. Although they had only been in the same class for about a month, the perpetrator quickly asked Adult 1 to marry him. Indeed, rapidly intensifying courtship is a common feature in the repertoire of violent men (Wiener, 2018:507). Intense romance is often a predatory tactic used to build a swift and deep emotional connection and it is to Adult 1's credit that she resisted at that time.

***Surveillance, stalking and harassment***

238. As soon as Adult 1 found out that the perpetrator was already married with children, she sought to end contact with him. He then progressed to stalk her using social media and harass her whilst at college. This stalking behaviour was to continue in the years which followed and enabled the perpetrator to eventually locate and kill Adult 1 and her mother

239. Later, when Adult 1 was seeking to end the marriage, the perpetrator continued to harass her by parking for long periods outside her flat or outside her mother's home when she had gone to stay there. Adult 1 was made aware by neighbours that the perpetrator had entered her flat, whilst she was out, by jumping through the window. He had also broken into her mother's home.

**Learning Point: Stalking and Harassment.** Evidence has revealed that stalking behaviour should always be taken seriously as it usually involves the perpetrator's fixation and obsession. In research on domestic homicides, stalking behaviours were present in ninety-four percent of the homicides (Monckton-Smith et al.,2017:12).

240. Since these homicides took place, Stalking Protection Orders have been introduced by the Stalking Protection Act 2019 and allow for earlier police intervention in stalking cases, even before the threshold for criminal proceedings has been met[32].

241. In the days leading up to the murder, the perpetrator was found to have been monitoring Adult 1's movements. This use of technology for the purposes of surveillance is further indicated by the speed with which the perpetrator arrived at the shisha lounge after Adult 1 and Adult 2 arrived on the evening of the homicide. The use of technology to perpetrate domestic abuse, referred to as 'tech abuse', has become increasingly common. The domestic abuse charity, Refuge, reported that in 2019, 72% of women accessing its services said that they had been subjected to technology-facilitated abuse. They recognised that "modern technology gives perpetrators ever-growing ways to stalk, isolate and control women using the tools of everyday life" (Refuge, 2021).

242. Whilst a range of national policies and legal frameworks deal with the different dimensions of 'tech abuse', including domestic abuse law, government online harms policy and cyber security policy for internet-connected devices, victims themselves will often be unaware of how a perpetrator is tracking their movements and contact

[32] Further information on Stalking Protection Order can be found in the statutory guidance available online at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951354/SPOs_statutory_guidance_English_with_changes__002_.pdf

with others (Christie and Wright, 2020). As a result, organisations have increasingly started to produce guidance on ''tech abuse for victims and professionals working with victims (Refuge, 2020; UCL, 2019; SafeLives, undated).

243. However, despite this growing availability of resources to help educate victims and practitioners on 'tech abuse', some experts have highlighted that support services currently lack the awareness and technical capacity to adequately respond to 'tech abuse', and that is it not often explicitly considered in risk assessments and safety plans for victims and survivors.

| **Recommendation: Stalking and 'Tech Abuse'** |
| --- |
| Solihull Community Safety 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. |
| Solihull Community Safety 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 |

***Fear and threats to kill***

244. Adult 1 first told the police that the perpetrator had made threats to kill her in April 2018, although this was not repeated during the discussions with officers when the domestic abuse risk assessment was being completed shortly afterwards. Her family were not made aware of the abuse for some time. However, Adult 1 later told close members of her family that she knew the perpetrator was going to kill her one day. Her fear was not only for herself: the perpetrator had threatened to harm her family if she did not marry him and threatened to kill her family if she left him and went into hiding.

245. Moreover, the perpetrator had threatened to kill her and her family if she told the police, yet Adult 1 was brave enough to tell the police about these threats when she contacted them for help.

***Isolation and imprisonment***

246. Despite Adult 1 being a resourceful, resilient, and independent young woman, she was relatively new to the UK and would likely have lacked knowledge of both the culture and support systems that were available. Although her family had established strong roots in the UK and will have had robust knowledge themselves, Adult 1 told the local Women's Aid helpline that she had become more isolated from her family. In this way, she will have also been isolated from their emotional support

and we have seen that she did not feel able to tell her family about the abuse for some time. She also later disclosed that the perpetrator did not let her have friends.

247. It is well researched that those seeking to control their partners will often isolate them from family and from services in order to, "… prevent disclosure, instil dependency, monopolise their resources and express exclusive ownership" (Stark, 2007:262). Indeed, only days before he killed Adult 1, the perpetrator told a member of the victim's family that he owned his wife. Moreover, four months prior to this, Adult 1 had also told the police that the perpetrator was preventing her from going out which should have been explored further after it was disclosed.

***Health indicators of domestic abuse***

248. From June 2017 onwards, Adult 1 presented to health agencies with a wide range of health issues, including amongst them breathing issues and chronic pain which was later diagnosed as rheumatoid arthritis. Recent research has demonstrated that women experiencing domestic abuse are at double the risk of developing long-term illnesses that cause widespread bodily pain (Chandan et al.,2019). Moreover, repeated health consultations without a clear diagnosis and chronic pain are both considered to be indicators of abuse which should give rise to enquiry about domestic abuse within health settings (NICE Quality Standard 116, 2016).

| **Learning Point: Health Indicators**<br>Practitioners and clinicians need to be alert to the range of indicators of domestic abuse within the NICE Quality Standard on Domestic Abuse including repeated health consultations with vague symptoms as well as chronic pain. |
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249. It was noted that both the hospital and GP practices were making great strides to strengthen domestic abuse pathways and access to specialist domestic abuse services. We have seen that For the Clinical Commissioning Group, this has led to 70 per cent coverage of the IRIS programme. The review heard how the extension of the primary care programme and commensurate pathways in hospital Emergency Departments Extension in health settings each relied upon funding being made available.

| **Recommendation: Strengthening domestic abuse pathways in health** |
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| 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. |
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### *Physical and sexual violence*

250. The perpetrator's physical violence, both to Adult 1 and others, had been reported to several agencies. For Adult 1, this will likely have been an ever-present threat to her and her child. However, in response to DASH questions asked by the police, Adult 1 disclosed that she had also been subject to sexual abuse. The specific question asked whether the abuser made her, "Do or say things of a sexual nature that makes you feel bad or that physically hurts you or another?". Although there was no indication that Adult 1 elaborated on this in police records, Adult 1 disclosed in her later application for a non-molestation order that the perpetrator had attempted to rape her on successive occasions prior to her making that report in April 2018. It was recognised that the openness of her affirmation of sexual abuse, although not elaborated on, appeared to be a brave attempt by Adult 1 to engage and test the protective nature of the police's response.

| **Learning Point: Sexual violence and coercion** |
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| Practitioners should always take disclosures of sexual violence and coercion very seriously. Victims will often be testing how well they are responded to before disclosing further information about the nature of the abuse. |

### *Threats of suicide and self-harm*

251. In April 2018, various agencies became aware that the perpetrator had self-harmed, having cut his arm with a knife. It appears that he later tried to carve her name into his arm. Adult 1 told ambulance crew that when she had tried to leave him in the past, he had sent her pictures of his self-harm and she worried about his mental health. She went on to ask the hospital for his mental health to be assessed. She also told the police that he had threatened suicide.
252. Threats to kill or harm themselves are tactics used regularly as a means to coercively control a victim of domestic abuse. In one study of violent men, Stark found that more than half of the men threatened to kill or harm themselves if their victim left them and more went on to use this threat in order to get their victim to obey their wishes (2007: 253).

### *Economic abuse and gambling*

253. Adult 1 was a young lone parent, raising her child on welfare benefits. She had had to use a food bank and was still managing to save, even with her low income. It is therefore very disturbing to find that the perpetrator stole her savings of £2000, in order, it appeared, to facilitate a trip to his other family in Afghanistan. Some months later he also went on to steal her car.

254. In another incident, the perpetrator assaulted and pressurised his father to give him money which resulted in his father having to call the police. It is not known whether the perpetrator had demanded money from Adult 1 with such menaces. Significantly, the perpetrator had a problem with gambling, and this was seen by probation services to have led to the criminal offence for which he was under their supervision. In these circumstances, both the police and probation services could have questioned the impact of his gambling upon his home life or questioned whether his demanding money menacingly from others may have meant that he was also doing the same to his wife.

255. Sharp-Jeffs and Learmouth recognised that economic abuse has received little attention in research and is often not treated as important in practice despite featuring in just over a third of intimate partner homicides in England and Wales (2017:4) At the same time, the relationship between gambling and domestic abuse is still little understood. Although Dowling et al. (2016) have pointed to a number of small scale-studies which have shown a higher co-occurrence of perpetrating domestic violence for problem gamblers, there is too little research from which to draw any conclusions relevant to this set of circumstances, particularly as the extent of the perpetrator’s gambling was not known.

### *Culture and domestic abuse*

256. The perpetrator demonstrated and expressed a clear sense of ownership of Adult 1, as his wife, which will likely have enabled his self-justification of his abuse. However, the extent to which this abuse was generated from his own sense of entitlement or exacerbated by his upbringing in the rigid patriarchal systems of the Afghan culture, with which he had continued contact, is not known. Nonetheless, his appearing to have two wives was an indicator of his deep-seated inequitable attitudes towards women. Indeed, the victims’ family commented upon a wide difference in attitudes between the perpetrator and their own, based upon their cultural heritage and education.

257. It has been widely evidenced that women have traditionally faced a highly subordinated position in Afghan society and as a result there remains a high prevalence in the country of domestic abuse, rape, forced marriage, child marriage, as well as retaliation for women who breach cultural norms and traditions. (CEDAW, 2013). A recent report by the United Nations (2018) recognised that women in Afghanistan had limited recourse to the law to protect them from domestic abuse and so-called 'honour' killings were rarely investigated by the police.

258. Violence against women is a universal phenomenon and it should be noted that the UK, Syria and Afghanistan each experience high levels of violence against women, differentiated only by degree. Nonetheless, it is important for service providers and policy makers to consider cultural values, norms and beliefs in order, at least, to ensure that services can be effective in meeting needs and breaking down barriers that may exist (Kouta et al., 2018). It was not evident that these were taken into account in relation to the risk that the perpetrator posed in this case.

259. Neither was it evident in Adult 1's contact with child protection or criminal justice agencies that her particular vulnerabilities were being taken into account when the risks that she faced, or the services that she was to be offered, were being considered.

***So-called 'honour-based' violence***

260. So-called 'honour' based violence is most commonly committed against young women by male relatives who view the violence as necessary in order to preserve or restore the values, norms and traditions of the family and community by removing the perceived 'shame' associated with the young woman's behaviour (Gill et al, 2012). It was noted that the couple's report of threats of violence from Adult 1's ex-husband in February 2017 was not considered in the light of so-called 'honour' based violence and as such, no domestic abuse risk assessment was undertaken when police officers visited. In the absence of direct reference to 'honour', the officers appeared to take at face value the allegations that the threats came from a gangster and drug dealer. However, this threat to "murder both of them" came from her ex-husband who had recently been reported for domestic abuse against Adult 1. The review therefore considered that police officers should have been open to the possibility of so-called 'honour-based' violence and conducted enquiries on that basis. A recommendation has therefore been made that the Police provide assurance that officers are effectively identifying and responding to so-called 'honour-based' violence.

261. Moreover, it was questioned whether the issue of so-called 'honour'-based violence was considered by agencies as a potential factor in the perpetrator's abuse of Adult 1 and threat to Adult 2. We have seen above that the perpetrator appeared to hold

highly discriminatory attitudes to women and considered that he 'owned' his wife. Whilst the degree to which his actions were influenced by the concept of honour is not known, so-called 'honour killings' are commonly justified by their perpetrators as a response to perceived female adultery (Anitha & Gill, 2011). For Adult 1 she was killed when the perpetrator believed she was being adulterous. Adult 2 was killed defending her daughter, but her killing could be seen within the context of her defence of her daughter's independence. Indeed so-called ' 'honour' based violence often acts "to reinforce patriarchal relations through the policing of women's activities and sexual behaviour" (Gill et al, 2012: 84).

262. It is therefore incumbent upon all agencies to consider the possibility that so-called 'honour' may be a driving factor or contributor to violence against women and consider this in the light of increased threat. In this case, the threat could have been to both Adult 1 and her mother and it could be argued that had there been an opportunity to more robustly assess risk with the range of factors being made known, then the risk that both women faced may have been increased from a level of medium to high-risk and a referral to MARAC undertaken. Indeed, it was noted that risk assessments were not undertaken when Adult 1 went to live with her mother, but it also appears that there was a lack of consideration given to any risks that Adult 2 may have faced by taking her daughter into her home. Had consideration been given to 'honour' based violence, then the risks to Adult 2 may also have been taken into account.

**Learning Point:**
Professionals always need to consider the potential for so-called ''honour' based violence and the heightened threat that this brings, particularly to women, and use 'honour' based markers and indicators in their assessment of risk

***Forced marriage***

263. Although no agency was specifically aware, both Adult 1 and the perpetrator appeared to have been subject to forced marriage at different times. The accuracy of the perpetrator's age was questioned during the review as he appeared older than records would suggest. However, if records were indeed accurate, then his marriage in Afghanistan should be seen as a forced marriage as he would have been a child at the time and have had children whilst still very young himself. Although the perpetrator's father explained that his son's prolonged absence from college was because he had a family bereavement in Afghanistan, Solihull College were not made aware that he may have been married until several months after he had been withdrawn from his course.

264. Whilst he may have been brutalised by these experiences, he nevertheless went on to force Adult 1 into marriage by threatening to harm her family if she did not comply. It was evident that she did not feel able to tell agencies about this. She later went on to tell family members that on the day of her marriage, the perpetrator told her,

> "*today you are mine. In my culture there is no divorce. The day you leave, is the day you'll go to your grave. I'll kill you and your family*."

***An Intersectional Equalities Lens***

265. Adult 1's circumstances included a range of factors which intersected to increase her vulnerability and risk to the domestic abuse that she was experiencing from the perpetrator. These included: her young age; being a young mother; her recent history of escaping from a war-torn country; her recent history of domestic abuse from her first husband; the risk of so-called 'honour' based violence; forced marriage; her lack of familiarity with the society to which she had moved; being reliant on welfare benefits and social housing; the potential conflict between hers and the perpetrator's different cultures.

266. Intersectionality has become increasingly used as a means to better understand the lived experience of victims of domestic abuse and the risk factors and barriers which they face. It also enables greater awareness of the ways in which structural inequalities influence institutional responses that further marginalise, exacerbate and reinforce the inequality that women experiencing violence and abuse experience. There was no indication that agencies were able to appreciate Adult 1's experiences by taking into account her individual and interlocking social identities of, for example, her race, age, class and sex. Nor did there appear to be any appreciation of structural inequalities which may provide further barriers and marginalisation from sources of support and protection for her.

267. It was considered that if a specialist domestic abuse service had been able to be engaged beyond the telephone assessment, then this intersectional, equality lens could have been applied to Adult 1's experience and a more accurate understanding of risk and needs developed. In turn, this could have led to advocacy services for her to help overcome her marginalisation and the barriers which she faced. It was noted that whilst Birmingham and Solihull Women's Aid is not a dedicated services for addressing violence against Black and Minoritised women and girls, the majority of both their staff and those using their service are Black or Minoritised women. In this way Birmingham and Solihull Women's Aid have been able to demonstrate their ability to address issue of intersectionality alongside their specialist expertise in

addressing violence against women and so were well placed to be providing that specialist level of advocacy that Adult 1 would have benefited from.

**Learning Point:** In order to accurately understand the range of risks and needs experienced by Black or Minoritised women experiencing domestic abuse, practitioners need to appreciate how the woman's chronology and various identities interface with the structural barriers and inequalities that she will encounter. Wherever possible, practitioners should be working hand-in-hand with the specialist domestic abuse sector and enabling their advocacy to help overcome those barriers and marginalisation.

***Coercive Control***

268. By identifying each aspect of abuse in this way, it is possible to identify the extent of the perpetrator's coercive control over Adult 1. Living with coercive control has been described as living in a "state of siege" (Dutton 1992:1208). Coercive control impacts upon a victim's autonomy and sense of self; regulates her behaviour; isolates her from support; distorts her perspective; leaves her in a state of fear and hyper-vigilance and deprives her of the means to resist or escape (ibid).
269. In the face of this, Adult 1 showed remarkable resilience, particularly given the vulnerability of her circumstances. She was a very young woman who, as well as having had to flee a war, had experienced abuse and the breakdown of her first relationship whilst pregnant; was a young lone parent in a new country with a new culture and new language; had been homeless with a new baby and had to establish a new life for herself.
270. The introduction of coercive control into legislation in 2015 has been a watershed moment for understanding how agencies need to respond to domestic abuse. Professionals are now required to be aware that below the surface of the individual episodes that they respond to, a victim will be subjected to an array of tactics that combine to subordinate and degrade her. This knowledge should have reframed every aspect of agencies' involvement with the victim and led to a shift from an incident-led to a model of engagement that appreciates the likelihood of coercive control. Although it would be fair to say that no agency was aware of the full picture, it will be seen in the sections that follow, that the required shift in approach was not evident in professional responses to Adult 1 or her child and there was no evidence that responding to coercive control was embedded into professional practice.
271. The absence of a clear understanding of the importance of coercive control when making judgements about victims and perpetrators has serious implications for the effectiveness of current approaches to domestic abuse. Purposeful and systematic

efforts are required in order to support practitioners to recognise and respond effectively to coercive control.

272. We have seen that had the incidents of abuse that had been disclosed by Adult 1 been viewed cumulatively, then the wider history and pattern of coercive and controlling behaviour that underpinned each incident could have been better understood. Likewise had risk assessments been undertaken in a more holistic way paying particular attention to the signs of so-called 'honour' based violence then it is likely that Adult 1 would have been seen as facing high-risk, leading to a referral to MARAC. This in turn could have led to a potentially more effective multi-agency response; greater scrutiny of the perpetrator by probation and police services and the offer of a dedicated Independent Domestic Violence Advisor for Adult 1. Overall, it was considered that there was a lack of professional curiosity from several agencies who could have escalated the case to MARAC.

**Learning Point:**
Professionals need to be aware that in-between the individual episodes of violence and crisis that they respond to, a domestic abuse victim will normally be being subjected to coercive control. There may be no aspect of a victim's daily life that has not been subjected to surveillance, threats, jealousy, degradation, secrecy and fear and when a victim seeks help or tries to end the relationship, she and her children may face serious risk.

**Recommendation: Transforming the Culture**
Solihull Community Safety 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

### *Separation*

273. Recent separation is a key factor for agencies to consider when they are assessing the risk of serious harm from domestic abuse. Adult 1 was known to have been trying to end the relationship with the perpetrator since at least April 2018 and this featured in the DASH undertaken by the police at that time.
274. The perpetrator deliberately tried to prevent Adult 1 from ending the relationship by telling her that he would kill her family is she ever disappeared. This meant that she would have likely been too afraid to consider going to a refuge.
275. Stark (2007) recognised how separation represents the greatest threat to a perpetrator's control and will often be the motivation for their significant harm. Indeed, a significant proportion of women who are killed by their partners are killed when they are trying to separate (Home Office, 2016; Humphreys and Thiara, 2002). The Femicide Census found that at least 43% of the women killed by partners or former partners over the last ten years, were known to have separated or taken steps to separate from the perpetrator (Femicide Census, 2020:30).
276. Agencies treated the victim's separation as a protective factor for her child without recognising the need to safety plan and consider the need to increase support and protective services for the young mother and child rather than withdraw the very services that the young family needed.

| **Learning Point: Separation** |
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| Separation should not be treated as a protective factor for a domestic abuse victim or her children unless accompanied by rigorous safety planning and safety measures being put in place by those statutory agencies charged with their protection. |

## 6.2 Child safeguarding and domestic abuse

277. Domestic abuse is the most commonly cited factor bringing children to the attention of children's social care services to determine whether they need support or protection (JTAI, 2017; Sidebottom, 2016). Domestic abuse is also the most common factor known when children are at risk (JTAI, 2017). Despite this, in recent years, national attention has been drawn to deficits in the mainstream approach to safeguarding children living with domestic abuse. Various research and inspections have examined national child protection practice and found that it has commonly relied upon abused mothers to protect their children rather than the perpetrator to

stop being abusive; assumed that separation or removal of the perpetrator will automatically remove risk; overemphasized singular incidents of physical violence rather than recognition of a wider pattern of abuse and control; undertaken only superficial assessment of abusers who remain largely invisible to the process and lacked an understanding about the impact of coercive control on children and their mothers (JTAI,2017; Sidebottom et al. 2016; Brandon et al, 2014, 2020;Stanley et al, 2018; Katz, 2020). Alarmingly, research has shown that making demands on already vulnerable women, will often increase theirs, and their children's, vulnerability to harm and reduce the flow of information between families and professionals that is needed for adequate assessment of risk (Stanley et al.,2018:15). It is within this national context of child protection practice that Solihull's response in this case is assessed.

***Structure***

278. In view of the high volume of domestic abuse reports to agencies, particularly within the context of child safeguarding, sophisticated systems and well-coordinated processes are needed. Structurally, until 2019, Solihull's multi-agency Domestic Abuse Triage was positioned outside of the Multi-Agency Safeguarding Hub (MASH) and managed by non-qualified social workers. Where risks to children were identified, the case was referred into the MASH. This process was considered to be cumbersome, involved delays and risked information being missed in the transfer of cases. In this particular case, social workers did not attend each of the three triage meetings that took place. Domestic Abuse Triage has since been amalgamated into the local MASH. The change is currently subject to an internal audit to be reported to Solihull Safeguarding Children Partnership.

***Information Sharing***

279. The review found that there was evidence at times of good multi-agency information sharing, particularly from hospital staff to the police. However, in respect of information sharing around the child, four months before the murders, it was not certain whether the police shared key information about the child being present when an assault took place or that Adult 1 had disclosed sexual assault, although it was considered that this information would normally have been shared. We have seen that this, or the failure to take the information into account, contributed to risk being minimised and the absence of any perceived need to undertake any follow-up with the family or referrals or signposting to domestic abuse services undertaken. Children's Services were also not aware that the perpetrator was being supervised by probation services.

280. In each of these incidents, it did not appear that there was any lack of clarity over what information could legitimately be shared, but more that there needs to be checks within the system that all relevant information has been shared. The significant improvements that have occurred in Solihull's multi-agency approach to child safeguarding and co-location of services indicate that these deficits would be unlikely to happen in the future. However, questions remain about how criminal justice agencies become aware of civil orders and this is considered in a later section.

281. The review panel reflected that information sharing within the context of domestic abuse carries significant risks in its own right and that there should be an open discussion with a victim about what information is going to be shared and who with, subject to any risks inherent for children in doing so. This is considered further below.

***Relying on mothers to protect their children***

282. As this review progressed, it became clear that a lot of good work had been done in Solihull to improve the multi-agency understanding and approach to domestic abuse. Nonetheless, organisations charged with protecting the child and meeting the child's needs, continued to demonstrate some fundamental misunderstandings about how best to apply their knowledge of domestic abuse most effectively.

283. For example, in responses to the third referral to Children's Services, they concluded that there was no need for a formal social work intervention as Adult 1 was considered to be 'acting appropriately' in protecting her child. She was seen to be doing this by separating from the perpetrator, gaining a non-molestation order, staying temporarily with her mother and by seeking a move.

284. We have seen above how relying upon a non-abusing parent to protect her child by separating from a perpetrator of domestic abuse is a flawed response without safety-planning support and protective interventions from the organisations charged with their protection. However, the over-reliance upon this young mother to protect her child and herself was flawed in other regards. This was not because of what she did not do, as she did everything that could have reasonably been expected of her, but because her actions alone would not have been enough for her to protect herself and her child from the intent of the perpetrator.

285. Rather than serving to protect the victim and child, gaining a non-molestation order appeared to put them at greater risk because it appeared both to provoke the perpetrator and afford Adult 1 a greater confidence in the justice system to be able to protect her than was warranted.

286. Likewise going to stay with Adult 1's mother was seen as a protective factor, but no independent enquiries were made to find out whether there may be risks involved in this course of action. The perpetrator had broken into Adult 2's home previously

without consequence and continued to stalk and harass Adult 1 whilst she was at her mother's home.

287. The Team Manager closed the social work assessment, and it was apparent that there were shortcomings in the supervision that the social worker (SW2) had received. Indeed, the latest two social work responses to police reports had lacked this management oversight. Relying on the young mother's actions and closing the assessment at this time had the effect that a full chronology of events was not undertaken; the range and escalation of the perpetrator behaviour and his use of self-harm had not been considered; wider support networks had not been checked for safety, particularly as the perpetrator had broken into her mother's home; dedicated domestic abuse risk assessments (DASH and DVRIM) were not employed to focus the analysis on coercive control and effective partnership working had not been undertaken. In these ways it was difficult to see how a broader understanding of domestic abuse and the context of the young mother's experiences and the impact upon the child could be achieved. That is not to anticipate that a full child protection assessment would, or should, have resulted in the removal of the child into local authority care. Removal of children is the last resort of any child protection regime. Rather, had a full assessment been undertaken then the social worker would have been able to identify that the perpetrator was under probation supervision at the time and been able to furnish the probation officer with the full information about the perpetrator's abusive behaviour. This in turn could have led to action being taken by probation, who were charged with the management of the perpetrator in the community, but who themselves had not undertaken a full assessment. The absence of a co-ordinated response to the threat that the perpetrator posed to the young family was therefore evident to the review.

***Fear of children being removed***

288. It was also noted that the involvement of children's services itself appeared to create a barrier to help seeking for Adult 1 who feared her child being taken into the care of the local authority. She told her family that a police officer had told her that if the violence continued then social services would take her child[33]. The perpetrator also appeared to hold this threat over her, and this will undoubtedly have had an impact upon her trust of Children's Services; her help-seeking from them and the flow of information between the family and professionals thereafter which will have informed any subsequent risk assessments.

289. How practitioners describe the role of agencies in protecting victims of domestic abuse and their children is very important. Earlier research into West Midland's

[33] The review was unable to establish whether a police officer expressly said this to the victim.

domestic homicide reviews highlighted that women's fear of losing children to the care system was a significant barrier to them seeking help (Neville and Sanders-McDonagh's, 2014). The threat of children being removed to care is often held over victims by their abusers.

**Learning Point: Victims of domestic abuse will often be fearful of their children being removed from their care as a result of social work involvement.** Practitioners from all agencies need to take great care in explaining the reason for referrals and the role of children's services in supporting and protecting the non-abusing parent and child. Only by building the trust of abused mothers can effective risk assessment and engagement take place.

***Victim Blaming***

290. Linked to this, was the paucity of the interpretation of Adult 1's actions in the sense of victim blaming. For example, the social work manager's commentary on case closure referred to Adult 1 wilfully minimising the domestic abuse from her two relationships. They did not appear to give consideration to the complex reasons why she may be minimising those experiences to others, as well as possibly to herself.

**Learning Point: Blaming the Victim for Minimising their Abuse**
There will be a range of reasons why a victim of domestic abuse will minimise the abuse they experience including danger and fear; lack of trust in authorities to keep them safe or understand the experience of coercive control; shame, embarrassment, or denial, to name a few. Practitioners need to consider the complex reasons why a victim may minimise their experiences and in response they should seek to establish a trusting relationship, with themselves or specialist workers, for these reasons to be explored.

***Invisible Abusers***

291. We have seen that there were times during child protection enquiries when the level of risk that Adult 1 and her child faced was minimised by practitioners. This included assumptions being made of there being mutual violence based upon Adult 1's self-blame and upon her descriptions of arguing and fighting. This was in part reinforced by a failure of practitioners to put the whole picture of information together. It was also reinforced by the absence of any real focus on the perpetrator. Not only was he not being held accountable for his abusive behaviours through the criminal justice process, but he was also not being scrutinised by child protection system because

the focus was so resolutely on Adult 1's actions to keep the child safe. Without this focus on the perpetrator's mind-set and behaviour, there would necessarily be a high risk of recurrence once the immediate crisis has passed.

292. Stanley et al (2018) recognised these and similar dangers inherent for families where child protection professionals assign non-abusing mothers the sole responsibility for their children's safety rather than a requirement for the perpetrator to stop the abuse. In response, there has been a growing body of interventions that aim to challenge the exclusion of men from social work interventions with families experiencing domestic abuse (Stanley and Humphreys, 2017; Safe and Sound Insitute,2017) Evidence is building internationally that, alongside a cultural shift in the approach, that firstly mapping the pattern of coercive control and then engaging with perpetrators and holding them accountable in a variety of ways, including through court processes, reduces the risks to children. (Safe and Sound Institute, 2017:3)

**Learning Point: Reliance on mothers and invisibility of domestic abusers**
It is now widely evidenced that an over-reliance on non-abusing parents (usually the mother) and lack of attention to the abusive partner does not keep children or mothers safe. Practitioners need to think how they can assess the risk from the abuser, safety plan with the victim and act, individually and collectively, to protect the family more effectively.

293. These homicides therefore add weight to the national body of concerns that greater intervention is needed to work collaboratively with other agencies and with mothers experiencing domestic abuse and to take action against abusers in order to effectively safeguard children.

**Recommendation: 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 safeguarding 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 safeguarding assessments and that they are held accountable for their abuse and threat to the family
- a mother's attempts to separate from an abuser are not necessarily seen as a protective factor. Robust safety planning is needed, often alongside multi-agency protective interventions, in recognition of the additional risk that separation often entails

## 6.3 Managing Offenders

***Risk Assessment***

294. Research into domestic homicides found that perpetrators' histories revealed a range of potential risk indicators which may have enhanced their risk of perpetrating domestic homicide. The single largest category was previous violent behaviour (70%) (Chantler et al.,2020)

295. We have seen that none of the core statutory services who are charged with public protection, took a holistic view of the family or their journey through services. This incident led approach and failure to integrate the history of previous behaviour into the risk assessment, has been a consistent feature of serious case reviews (Sidebottom et al, 2014: 243). In respect of the management of risk, the perpetrator's known history did not appear to influence the assessment of risk and there was a lack of professional curiosity demonstrated by each of these core services.

***Civil Action***

296. Following advice, Adult 1 sought a non-molestation order to protect her and her child from the perpetrator. However, in the same way as separation increases risk, the risk of serious harm also increases when a domestic abuse victim is known to have sought help from agencies (Stark, 2007). At these times, perpetrators will often act to maintain their control over their victim (ibid). Indeed, in a neighbouring authority, two recent domestic homicide reviews have featured the deaths of women who had gained non-molestation orders shortly before they were killed.

**Learning point:** Practitioners should consider the risks involved for victims in taking out orders against their abusers without undertaking rigorous safety planning and implementing further protective mechanisms

***Domestic Violence and Abuse Protection Orders***

297. At the time of these homicides, there was no single order that was accessible across the criminal, family and civil courts to protect Adult 1 and her child. In respect of the orders that were available, we have seen that there was a lack of consideration given, particularly 15 days before the homicides to the use of Domestic Violence Protection Orders. Moreover, there was also a delay and confusion in the delivery and recording of the Non-Molestation Order that the victim had gained and the confidence that the victim had in the order was not realised in the response of the solicitor and, in turn, the police. The introduction of Domestic Abuse Protection Orders (DAPOs) through the recent Domestic Abuse Act 2021 should serve to strengthen this confusing process of gaining protection for victims of domestic violence and their families

298. DAPOs are being introduced "to bring together the strongest elements of existing protective orders into a single comprehensive, flexible order which will provide more effective and longer-term protection to victims of domestic abuse and their children" (Home Office, 2020). The orders will be flexible in duration and allow courts to impose both prohibitions and positive requirements on perpetrators. These could include prohibiting any form of contact with the victim as well as requiring the perpetrator to attend programmes such as to address their domestic abuse or gambling addiction (ibid). Had they existed at the time Adult 1 was seeking help from the police, and had the officers identified their applicability to Adult 1, then the overall police response would undoubtedly have been strengthened. It would also have overcome the challenge that this case presented of how information from the Family Court is transferred to the police, which we have seen was delayed and clumsy in this case and in the future will undoubtedly be regulated by statutory guidance.

299. Whilst the final guidance for DAPOs has not yet been released, third parties will be able to apply for a DAPO directly to the Family Court. This means that social workers may be able to apply on behalf of individuals who they are working with and who are experiencing domestic abuse. Had DAPOs been in place when Children's Services were assessing the risks to the child, the pursuit of a DAPO by a social worker could have strengthened the focus on the abuser. Moreover, the Domestic Abuse Act 2021 introduces within legislation for the first time, that a child who sees or hears, or experiences the effects of, domestic abuse and is related to the person being abused, is also to be regarded as a victim of domestic abuse in their own right (Jacobs, 2021)[34]. This will help to ensure that services consider and address the needs

[34] Before the introduction of the Domestic Abuse Act 2021, section 120 of the Adoption and Children Act 2002 clarified the definition of harm in the Children Act 1989 to make clear that the significant harm a

of children affected by domestic abuse and have greater powers in their armoury to challenge the behaviour of perpetrators of domestic abuse.

**Recommendation: 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

300. As well as the police not being aware that a non-molestation order had been granted in a timely way, the probation service were not aware either. It is essential that all agencies tasked with managing domestic abuse perpetrators and offenders have timely information concerning the perpetrator's behaviour. As the perpetrator was under supervision of probation services at the time the non-molestation order was taken out, probation services had powers to take enforcement action themselves. The review noted that the implementation of the Domestic Abuse Act 2021 will mean that the variety of orders will each be channelled through the police, which should have the effect of streamlining notifications to relevant parties (Home Office, 2021a).

child may be at risk of suffering includes any impairment of the child's health or development as a result of witnessing the ill-treatment of another person, such as domestic violence.

*Sanctuary Scheme*

301. Whilst both the police and housing services were pro-active in arranging a change of locks for Adult 1 when she shared concerns over his access to the property, we have seen that the Sanctuary Scheme offers greater protection and options than merely a lock change. Sanctuary Schemes have been designed to provide a more holistic response to victims of domestic abuse who fear that their abusers will force entry to their homes.

302. Sanctuaries are created, as part of a multi-agency response to domestic abuse, by enhancing security in the property through 'target hardening' of the property and the provision of safety equipment. In order to be effective, they need to be individual packages informed by a full risk assessment of the type and condition of the property and the needs and circumstances of the individual household (DCLG[35],2010). Where the risk is determined to be too great, it should also provide a pathway to refuge and moving accommodation. In Solihull, Sanctuary is a partnership between Solihull Community Housing, West Midlands Police, West Midlands Fire Service and Birmingham and Solihull Women's Aid.

303. The review heard that the Sanctuary Scheme in Solihull was at times, as in this case, under-utilised. Moreover, as these schemes are commissioned at the local authority level, agencies such as police, probation, fire and regional social landlords have to become familiar with diverse schemes offered across the region's authorities.

| **Recommendation: Sanctuary Scheme**<br>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.<br><br>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 |
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[35] The Department of Communities and Local Government (DCLG) has since become the Ministry of Communities and Local Government

*Anti-Social Behaviour*

304. Although only Solihull Community Housing were called upon to respond to a report of noise nuisance in this case, addressing anti-social behaviour is a multi-agency activity and one which is often a useful indicator of underlying domestic abuse. In an earlier study of the characteristics of households (n=67) which had been subject to complaints of anti-social behaviour, it was found that the majority of complaints related to women-headed households (77%) and the majority of those in respect of adults, related to domestic abuse (66%) (Hunter et al, 2001). In this way, women are more likely to be at risk of action against anti-social behaviour, including the risk of losing their home (ibid).

305. For Adult 1 the report of noise nuisance was addressed without risk of further action. However, the circumstances illustrate how reports by neighbours provide an important source of early intervention in the absence of domestic abuse reports being made. It is therefore important that responding agencies are alert to the potential for underlying domestic abuse and responding with effective risk assessment and interventions.

**Learning Point: Anti-Social Behaviour and Domestic Abuse**
Noise and anti-social behaviour will often mask the existence of underlying domestic abuse. Routine enquiry on domestic abuse followed, where indicated and necessary, by risk assessment and interventions should therefore be an intrinsic element of the response to reports of anti-social behaviour by neighbours.

**Recommendation: 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.[36]

## 6.4 Accountability

306. Adult 2's sister was very much engaged with this review and has already began campaigning for improvement in public services' response to domestic abuse. It was therefore seen as particularly important that the Community Safety Partnership reported back with evidence on how the recommendations from this review had

[36] The review recognised that domestic abuse related anti-social behaviour can take place in non-residential settings. However, it was recognised that, given the scale of unrelated anti-social behaviour in other settings, it would not be tenable for the police to monitor in such a way that would enable this recommendation to be Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) as required by Statutory Guidance

been enacted and were providing greater safety and support for future victims of domestic abuse.

| **Recommendation 8: Accountability** |
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| 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. |

## 7. CONCLUDING REMARKS

307. This review has considered the alarming nature of the domestic abuse that was perpetrated against Adult 1 and her child, as well as the nature of agencies' responses over the 30 months before her husband brutally killed her and her mother. Adult 1 was subjected to physical and sexual violence, coercive control, bigamy, forced marriage, threats to kill and attempts to isolate and restrict her movements through economic abuse. The perpetrator went to great lengths to monitor her movements, stalk and harass her; attempted to manipulate her through threats of suicide should she leave him.

308. Although the perpetrator had threatened Adult 1 that he would kill her and her family if she reported the abuse to the police, she bravely and repeatedly sought support and protection. Whilst no agency was aware of the full picture of domestic abuse, the review considered that there was a lack of consideration about the likely nature of coercive control that would underpin the reported incidents of which they were aware.

309. Child protection practice fell into the well evidenced traps of placing an over-reliance upon abused mothers to keep themselves and their children safe from the abuser; of relying upon separation without assessing the increased risk this brings; of blaming the victim; of lacking a focus on the abuser as the source of threat to the child and of 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, it will be incumbent upon these arrangements to provide assurance that an understanding of coercive control is embedded into the response.

310. Adult 1 had a range of factors which intersected to increase her vulnerability, but it was not evident that these were holistically being taken into account by any of the core statutory services charged with public protection. Neither was the perpetrator sufficiently held to account when accusations were made against him. Much attention has been drawn to the delays in the police response on the evening of the

homicides. However, there was more that could have been done to protect the young family in the preceding months and, whilst clearly West Midlands Police are taking great efforts to improve their force's understanding of coercive control, they are nonetheless being called to provide evidence of their improved response to domestic abuse.

311. This tragic case demonstrates clearly the need for all our front-line practitioners to develop a greater understanding of coercive control, and in doing so, be curious about what may be under the surface of the abuse that they see. 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. This review most significantly calls upon practitioners to listen fully to abused women when they seek our help, and respond more effectively, in order that more lives are not lost and families shattered by the brutal loss of those so dear to them.

# 8. RECOMMENDATIONS

## 8.1 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 seeking evidence on how agencies are:

- 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 in order that 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 to enable a 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.

## 8.2 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 and 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.

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## ABBREVIATIONS

**AAFDA:** Advocacy After Fatal Domestic Abuse
**ASYE:** Assessed and Supported Year of Employment for newly qualified social workers
**CAT:** Children's Assessment Team
**CSP:** Community Safety Partnership
**CCG**: Clinical Commissioning Group
**CPS:** Crown Prosecution Service
**DAPO:** Domestic Abuse Protection Order
**DARA:** Domestic Abuse Risk Assessment
**DASH**: Domestic Abuse, Stalking and Harassment and 'Honour-based' violence risk identification, assessment and management model
**DoH:** Department of Health
**DCLG:** Department for Communities and Local Government (since replaced by the Ministry for the same)
**DHR:** Domestic Homicide Review
**DVRIM:** Domestic Abuse Risk Identification Matrix
**GP**: General Practitioner
**HMCPSI:** Her Majesty's Crown Prosecution Service Inspectorate
**HMICFRS:** Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
**IDVA:** Independent Domestic Violence Advisor
**IMR:** Individual Management Review – reports submitted to review by agencies
**IOPC:** Independent Office for Police Conduct
**IRIS:** Identification and Referral to Improve Safety - a general practice-based domestic violence and abuse training support and referral programme
**JTAI:** Joint Targeted Area Inspection
**MASH:** Multi-Agency Safeguarding Hub
**NCDV:** National Centre for Domestic Violence
**RAID**: Rapid, Assessment, Interface, Discharge Team was part of Birmingham and Solihull Mental Health Foundation Trust
**SMART:** Specific, Measurable, Achievable, Relevant, and Time-bound

## GLOSSARY

**Assessed and Supported Year of Employment** (ASYE) is a programme that gives newly qualified social workers extra support during their first year of employment.
The programme aims to help them develop their skills, knowledge and professional confidence.

**Common assault by battery** (beating) involves the actual use of force but only results in a very minor or no perceivable injury to the victim.

**Domestic Abuse Triage –** former multi-agency arrangements in the West Midlands to screen and identify risk to a victim following a report to the police

**Domestic Abuse Risk Identification Matrix:** a tool, developed by Barnardos, which enables practitioners to assess the level of risks to children from domestic abuse. It contains a list of risk factors, vulnerabilities and protective factors which helps practitioners recognise whether a child is at minimum (level 1), moderate, serious or severe risk (level 5).

**DASH Risk Assessment Model** identifies three levels of risk that officers can make and determine on submission.

- Standard – Current evidence does not indicate likelihood of causing serious harm.
- Medium – There are identifiable indicators of risk of serious harm. The perpetrator has the potential to cause serious harm but is unlikely to do so unless there is a change in the circumstances.
- High – There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

**Evidence-led prosecution**: where a victim of domestic abuse decides not to support a prosecution, and police and prosecutors should therefore consider whether it is possible to bring a prosecution without that support.

**Hearsay:** is testimony or documents quoting people who are not present in court, and hearsay evidence is inadmissible for lack of a first-hand witness. When the person being quoted is not present, establishing credibility becomes impossible, as does cross-examination

**Identification and Referral to Improve Safety** - a general practice-based domestic violence and abuse training support and referral programme

**Multi-Agency Safeguarding Hub – In** Solihull, the Multi-Agency Safeguarding Hub (MASH) is a partnership between Solihull Metropolitan Borough Council, Children's Social Work Services, Education, Solihull Community Housing, West Midlands Police and Health agencies. These professionals work together and share information to safeguard children and young people in response to a referral about a child who may have been harmed or put at risk.

**Rehabilitation Activity Requirement -** one of the requirements that can be included within a community order or suspended sentence order under the Offender Rehabilitation Act 2014. The main purpose is to secure someone's rehabilitation, restoring service users to a purposeful life in which they do not reoffend.

**Section 47 -** A Section 47 Enquiry is initiated under the Children Act 1989 to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

**Strategy discussion -** The purpose of a strategy discussion is to decide whether the threshold has been met for a single or joint agency) child protection investigation, and to plan that investigation. They happen when it is believed a child has suffered, or is likely to suffer, serious harm.

# ACTION PLAN

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**This action plan is a live document and subject to change as outcomes are delivered.**

## OVERVIEW RECOMMENDATIONS

<table>
<tr><td colspan="7">Recommendation 1(i): 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.</td></tr>
<tr><th>REF</th><th>Action (SMART)</th><th>Lead Officer</th><th>Target date for completion</th><th>Desired outcome of the action</th><th>Monitoring arrangements</th><th>How will Success be Measured and Outcome</th></tr>
<tr><td>1.1</td><td>Information on stalking & harassment to be incorporated on the borough domestic abuse website and annual 16 days VAWG communications campaign.</td><td>DA Lead</td><td>November 2022</td><td rowspan="2">More victims are protected from stalking and harassment.</td><td rowspan="2">• 16 days VAWG campaign delivered.<br>• Public Information accessible, evidenced by website data dashboard quarterly report.<br>• 60 professionals trained across multi agency including Health, Police, Probation, housing, Children and Adult Services.<br>Baseline data collected for:<br>• Domestic abuse helpline data (BSWA)<br>• Crime recording (WMP)</td><td rowspan="2">• Increased number of Stalking Protection Orders gained<br>• Breaches of Stalking Protection Orders enforced<br>• 25% increase in reporting of stalking & harassment</td></tr>
<tr><td>1.2</td><td>Multi-agency training and awareness raising with professionals</td><td>DA Lead</td><td>December 2021</td></tr>
</table>

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | • Orders Granted (CPS, Courts) | |
| | Update: Complete<br><br>16 days VAWG campion ran from the 25th November 2022 to 10th December 2022. Tuesday 6th December was dedicated to raising awareness of stalking & harassment, which included information on what stalking & harassment is, links to the West Midlands stalking & harassment Service and local domestic abuse services. You tube clip on the behaviour and a workplace poster.<br><br>The 2022- 2024 Domestic Abuse Partnership Board communication plan includes the tactics to continue to raise awareness of stalking & harassment<br><br>SMBC domestic abuse webpage has been updated to provide a range of information on different forms of abusive behaviour, and includes information on stalking & harassment<br><br>The Solihull Safeguarding Adults Board (SSAB) has commissioned a domestic abuse training session, which includes a focus on stalking and harassment. The Board are monitoring training needs and will provide a dedicated session on stalking & harassment if need is identified | | | | | |

**Recommendation 1 (ii):** 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

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 1ii.1 | Information on 'tech abuse to be incorporated on the borough's domestic abuse | DA Lead | November 2022 | More victims are protected from 'tech' abuse | • Public Information accessible, evidenced by website data dashboard quarterly report. | • 50% increase in professionals identifying and communicating risk |

| | | | | | | |
|---|---|---|---|---|---|---|
| | website and annual 16 days VAWG communications campaign. | | | Professionals identify risks from 'tech' abuse and communicate risks to victims and, where necessary, other professionals | • Public Information of what tech abuse is and tips to protect privacy is accessible. | to victims and where necessary to other professionals. |
| 1ii.2 | Multi-agency training and awareness raising with professionals on risk from 'tech' abuse | DA Lead | December 2021 | | | |
| | Update:<br>SMBC domestic abuse webpage has been updated to provide a range of information on different forms of abusive behaviour, and includes information on tech abuse and tips to help stay safe<br>16 days VAWG campion ran from the 25 November 2022 to 10th December 2022. Tuesday 6th December was dedicated to raising awareness of stalking & harassment, which included information on tech abuse. SSAB commissioned Birmingham and Solihull Women's Aid to deliver a webinar in Nov 2022 as part of National Safeguarding Week, this was attended by a multi-agency audience of 85 people. A brief guide to tech abuse is currently in development and will be published on the SSAB website. | | | | | |

| 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. | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 2.1 | Report shared with Solihull Health and Well Being Board for consideration in enabling the extension of the domestic abuse programmes in primary care and Emergency Departments | Director of Nursing – Quality & Safeguarding | December 2022 | Robust evidence-based pathways exist for domestic abuse across all primary care and Emergency Departments with IDVA roles embedded in both settings | Report shared.<br><br>Commissioning arrangements detail IRIS, IDVAs and pathways in place. | • All Solihull GP practices fully trained.<br>• 50% increase in GP practices identifying and communicating risk to victims and where necessary to other professionals. |
| | Update: Complete.<br>IRIS is embedded as part of Primary Care. The number of GP practises trained in IRIS in Solihull have increased from 14 in 2018-2019 to 28 in 2023-2024. The average monthly referrals from Primary care to specialist support through the IRIS programme have increased from 7.75 in 2018-2019 to 9 in 2023- 2024<br>IDVA's were situated in a local hospital setting, but due to funding issues were subsequently ceased, but pathways between specialist support and secondary care are in place. | | | | | |

**Recommendation 3:** 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 seeking evidence on how agencies are:

- 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 '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

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 3.1 | Multi-agency training and awareness raising with professionals on coercive control | LSCP | May 2022 | Multi-agency practitioners have greater awareness of coercive control | To undertake a section 11 self-assessment audit<br><br>60 professionals trained across multi agency including Health, Police, Probation, housing, Children and Adult Services. | 50% increase in professionals identifying and communicating risk to victims and where necessary to other professionals. |
| 3.2 | A robust and improved understanding of | LSCP | May 2022 | Domestic Abuse Strategic Group agrees multi-agency framework for | To undertake a section 11 self-assessment audit | Increase in organisations understanding coercive |

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| | coercive control has become embedded into each organisation | | | assessing improvements by agency in responding to domestic abuse and coercive control | Post training evaluation completed after 3 months demonstrating how professionals have used their training in their practice. | control and collecting the appropriate data. |
| 3.3 | Monitoring the evidence of change in how the understanding of coercive control has become embedded into each organisation | Domestic Abuse Strategic Group | December 2022 | Improved responses by agencies to domestic abuse and coercive control, evidenced on a regular basis and embedded into agency performance targets | Outcome of section 11 audit and agency action plans | Evidence of change captured in agency performance indicators |
| | Progress update: - Complete<br><br>Coercive control is a part of domestic abuse training delivered by both our Adult and Children Safeguarding<br><br>West Midlands Office of Police and Crime Commissioners (OPCC) commissioned and delivered several open access training sessions on coercive control to improve understanding, identification and response.<br><br>The Solihull Safeguarding Adults Board (SSAB), Solihull Safeguarding Childrens Board (SSCB) and Domestic Abuse Partnership Board DAPB)completed a Domestic Abuse Assurance audit across partners in March 23. This included a focus on capturing agencies understanding and responses to coercive control. The findings of the exercise informed multi agency training priorities for 23/24.<br><br>A tiered domestic abuse training model was commissioned and delivered to registered social housing landlords across the borough, which included a focus on coercive control. | | | | | |

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| | In 2023 Children Social Care introduced a schedule of comprehensive mandatory domestic abuse training for all their practitioners, which included coercive control.<br><br>DAPB members are recommended to focus on coercive control as part of single agency domestic abuse training.<br><br>A West Midlands DA competency framework has been developed and cascaded across partner. The OPCC are leading a review of the framework in 2023. Competency In an understanding and ability to identify and respond to coercive and controlling behaviour is included. |

**Recommendation 4: Domestic Abuse and Child Safeguarding**

Safer Solihull Partnership to share this report with Local Childrens Safeguarding Partnership in order that a domestic abuse focussed review of multi-agency responses to child protection be undertaken 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

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
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| 4.1 | Report shared with Local Childrens Safeguarding Partnership. | Chair of CSP | Informally November 2021. Formally once approved by Home Office | Learning from the review shared and prompts action | Report shared and actions arising.<br><br>Aligned with section 11 audit on domestic abuse | Report shared<br><br>Childrens Services understand the report and undertake the appropriate actions. |
| 4.2 | Multi-agency review of child safeguarding practice in context of coercive control determines actions needed to improve practice responses | LSCP | May 2022<br><br>December 2022 | Clarity amongst children's workforce of effective responses to safeguarding children and their non-abusing parent in the context of domestic abuse. Safe and unsafe practices highlighted. | Review undertaken<br><br>Aligned with section 11 audit on domestic abuse<br><br>Actions arising from the review undertaken | Multi agencies to understand the report and undertake the appropriate actions to improve practice responses. |
| | Progress update: - Complete<br><br>Children social Care has undertaken a review of their approach to domestic abuse. As a result of this there have been several changes made for the purpose of improving understanding, identification and management of families where domestic abuse is a factor. This includes:<br><br>• Mandatory domestic abuse training to all staff on domestic abuse<br>• Specialist domestic abuse advocate positioned within the multi-agency safeguarding hub<br>• Implementation of the guided intervention model via Richmond Fellowship, to improve identification and response to those who are at risk of or are causing harm through domestic abuse and including upskilling our workforce via 10 different workshops delivered around domestic abuse related issues to the workforce.<br>• We are working with Police colleagues and others across the West Midlands to review and strengthen Operation Encompass, a process for sharing proportionate information with schools | | | | | |

**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.

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 5.1 | Public information includes information on DVPNs and DVPOs | WMP DA Supt Lead | May 2022 | Victims, are aware of the protection that domestic violence protection order affords and empowered to ask for them | • Establish monitoring baseline<br>• Recording (WMP)<br>• Orders granted (CPS,Courts)<br>• Breaches of orders (WMP, CPS and Courts) | Increase in number of DVPOs & DVPNs applied for<br><br>Increase in number of referrals from other agencies for DVPOs and DVPNs |
| 5.2 | Availability of DVPNs and DVPOs included in multi-agency training and awareness | Agency leads for Domestic Abuse Partnership Board | May 2022 | Civil orders team established.<br><br>(children) roll out of awareness training across | Referrals for DVPNs and DVPOs from agencies | Increase in number of DVPOs & DVPNs granted |

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| | raising with professionals | | | agencies enabling awareness of the protection that domestic violence protection notices and orders affords, include within safety planning and make referrals to the police | | Breaches of DVPOs and DVPNs are investigated, and action taken in a timely manner |

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| 5.3 | Availability of DAPNs and DAPOs included in multi-agency training and awareness raising with professionals | Agency leads for Domestic Abuse Partnership Board | 2023 (date to be confirmed by HM Government) | Practitioners across agencies are aware of the protection that DAPOs and DAPNs affords, include within safety planning, and make applications for third party orders | Third party applications for DAPNs and DAPOs from agencies | Number of third party DAPNs and DAPOs achieved |
| 5.4 | Preparation is undertaken for implementing the Domestic Abuse Act 2021 in respect of child safeguarding | LSCP | December 2022 | Procedures and practice strengthened in safeguarding child victims of domestic abuse and the application of DAPNs and DAPOs by safeguarding practitioners. | Policies and procedures | Number of third party DAPNs and DAPOs achieved |
| | Progress Update - Complete<br><br>West Midlands have a dedicated team who manage DVPN/DVPO applications and raise awareness of the process and benefits of these orders internally and externally. Since the team has been in place, there has been an increase in numbers of applications for DVPN/O’s, and this | | | | | |

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| | continues to be monitored by West Midlands Police through their performance structures. Looking ahead, further growth of this team is being considered as well as wider training across the Force in DVPO/N application.<br><br>WMP applied but were not selected for the DAPN/O pilot, the forces that have been selected will have the pilot for a period of at least two years (currently due to start Spring 2024) following spring 2026 DAPN/O's will then be rolled out nationwide at which time WMP will also have access to them to replace DVPN/O's. The team also ran some training specifically for Solihull partners on DVPN's and DVPO's and how information can be shared both ways and how they can be better managed by partnership working, which saw good attendance and positive feedback as to the content.<br><br>Additionally, work is ongoing through the WMP DA desk and Information Advisory Group around information sharing and onward referrals for victims and offenders following DVPN/O's being issued/granted and how partners can support once the orders are in place in a timely manner within the 28 days order duration.<br><br>Series of webinars ran across the borough in the lead up and early months of the launch of the DA Act. Dedicated session provided to children social care staff.<br><br>SMBC DA web page includes a section on DA CYP – to provide information, advice and links to help for CYP living with DA and experiencing it in their own relationship. |

**Recommendation 6(i): 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.

<table>
<tr><th>REF</th><th>Action (SMART)</th><th>Lead Officer</th><th>Target date for completion</th><th>Desired outcome of the action</th><th>Monitoring arrangements</th><th>How will Success be Measured and Outcome</th></tr>
<tr><td>6i.1</td><td>Solihull Community Housing provides assurance that the Sanctuary Scheme is embedded into homelessness pathways and well utilised</td><td>Executive Director of Housing and Communities, Solihull Community Housing</td><td>May 2022</td><td>Sanctuary Scheme is well utilised and embedded into local responses</td><td rowspan="2">Requests for Sanctuary scheme<br><br>Referrals for Sanctuary Scheme made by professionals<br><br>Number of Sanctuary schemes undertaken<br><br>Commissioning arrangements detail for sanctuary and pathways in place.</td><td rowspan="2">Funding secured for Sanctuary Scheme from Solihull Council (confirmed 20.10.21)<br><br>50% increase in professionals identifying and communicating risk to victims and where necessary to other professionals.</td></tr>
<tr><td>6i.2.</td><td>Solihull Community Housing promotes the Sanctuary Scheme amongst partner agencies</td><td>Executive Director of Housing and Communities, Solihull Community Housing</td><td>December 2021</td><td>Multi-agency professionals made aware of the range of protective measures available through the Sanctuary Scheme; provide options to victims and include in safety planning</td></tr>
<tr><td></td><td colspan="6">Progress Update: Complete. The Sanctuary Scheme was relaunched through a new commissioned provider in June 2021. The Sanctuary Scheme is now embedded as one housing option within a suite of Housing Options for individuals who have approached due to domestic abuse, for those individuals who wish to remain in their home.</td></tr>
</table>

| | From June 2021 (launch date) to March 2022 there were 18 Sanctuary installations. From April 2022 to July 2022 there have been an additional 10 Sanctuary installations. This is a marked increase on the preceding 12 months (4 completed installations). There has been an 85% successful installation rate, with reasons for non-installation centring around victims reconsidering their housing options.<br><br>The Sanctuary Scheme has been promoted through the Multi-Agency Homelessness Forum through:<br>• A monthly review of the Homelessness and Rough Sleeping Action Plan containing a key action to launch and embed the Sanctuary Scheme<br>• SMBC Domestic Abuse Strategy launch including information about the Sanctuary Scheme<br>• Review of Housing Pathways for Vulnerable Groups including domestic abuse and use of the Sanctuary Scheme<br>The Sanctuary Scheme has also been promoted through MARAC and Neighbourhood Services meetings. |
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**Recommendation 6(ii):** The Regional Domestic Abuse Board of the Office of West Midlands Police and Crime Commissioner to enable consistency of approach and pathways to Sanctuary Schemes across the region in order to strengthen the effectiveness of referrals to the scheme.

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 6ii.1 | Mapp out availability of sanctuary schemes across the region.<br><br>Share learning of this review with | SMBC DA Lead attending Regional DA Board | July 2022 | More victims have access to choose to remain in their own home, were safe, with enhanced security. | Confirmation of the regions offer of the Sanctuary scheme<br><br>Pathway referrals reviewed.<br><br>The role and purpose of Sanctuary Schemes an | Increase in numbers of victims referred into sanctuary scheme. |

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| | DA leads across the region with a recommendation to review referral pathways.<br>Raise the role and purpose of Sanctuary Schemes at the West Midlands Domestic Abuse Strategic Board | | | | agenda item at the West Midlands Domestic Abuse Strategic Board | |
| | Update: mapping exercise of sanctuary schemes across the west midlands was completed spring 2021. Not all areas offer Sanctuary and there is a wide variation in the service models for those that area. The role of Sanctuary provision has been shared. Locally, our Sanctuary scheme was promoted, and is monitored quarterly to ensure it is effective. | | | | | |

**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.

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 7.1 | SCH to introduce systems sub code to their ASB reporting procedures to identify domestic abuse cases | Head of Neighbourhood Services SCH | September 2022 | Masked domestic abuse is identified and responded to effectively | Case audits<br>Case Reviews utilising DAHA recommended checklist<br>Reflective supervision<br>Use of Domestic Abuse Sub Codes reports | SCH collect appropriate data and implement the correct reporting procedures.<br><br>SCH staff are trained to identify and respond to |

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| | masked by complaints of ASB | | | | | levels of masked domestic abuse within ASB. |
| 7.2 | Best Practice in responding to domestic abuse related anti-social behaviour promoted with registered social landlords in Solihull at designated meeting | Housing & Communities | July 2023 | Registered Social Landlord providers awareness of best practice | Registered Provider attendance at the specified event.<br><br>Briefing materials to be forwarded to any RP that was not in attendance. | Best practice shared<br><br>Increase in registered landlords understanding how domestic abuse relates to anti-social behaviour. |
| | Update - Monitoring and training measures in place and metrics have been added for opened and closed cases, where DA is the root cause of the Anti-Social Behaviour complaint into ASB quarterly reporting process.<br>Solihull Community Housing (SCH) can give assurance around activity<br><br>• The Anti-Social Behaviour (ASB) Partnership Problem Solving Panel (PPSP) now provides a wider invitation for Registered Provider's (RP's) to request attendance for complex case management<br>• The Domestic Abuse (DA) and ASB strategies were both delivered at the newly formed RP forum which provide opportunity for the Council to feedback on their priorities<br>• Solihull Community Housing (SCH) delivered a joint session with the police on Domestic Abuse Protection Order (DAPO) and Domestic Abuse Protection Notice (DAPN) and good practice involving housing, with all stakeholders invited.<br>• Domestic Abuse presentation delivered to Registered Provider Forum which included awareness raising and best practice.<br>• SCH are currently developing their approach to domestic abuse, as part of a programme of work for Domestic Abuse Housing Alliance (DAHA) accreditation | | | | | |

| Recommendation 8: Accountability<br>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 and the family have an opportunity to contribute to change | | | | | | |
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| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 8.1 | Action Plans shared and meeting arranged | Chair of Domestic Abuse Strategic Group | 12 months after publication. | The CSP can demonstrate with evidence the improvements that have been made | Action Plans and evidence | The bereaved family are satisfied that there are clear and demonstrable outcomes from each of the recommendations |
| | Update: Draft copies of review were shared with the family, which included proposed recommendations. learning from this review has been shared with the Domestic Abuse Partnership Board. The DA Delivery plan incorporates relevant recommendations. The Domestic Abuse Partnership Board will provide an update to the family. | | | | | |

# INDIVIDUAL AGENCY RECOMMENDATIONS

## Individual Agency Recommendations for GP Practice*s* 1 *& 2*

**Recommendation 1:** The Practice to improve knowledge and skills with regard to identification of domestic abuse by becoming an IRIS accredited practice

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 1.1 | Practitioners recognise and respond to the needs of victims of domestic abuse | Practice Safeguarding Lead/Clinical Lead IRIS | September 2019 | The Practice will have improved knowledge and skills with regard to the identification of domestic abuse and will have a specialist referral pathway in house. Victims of domestic abuse are identified and offered specialist domestic abuse support services | Monitoring of referral through IRISi BSOL Steering Group. Practice evaluation and monitoring and reporting into BSOL CCG safeguarding assurance group | The Practice will have become an IRIS Practice. Ongoing identification and referral for support will be made to the IRIS Project |
| **Update** | Practice 1 has been fully IRIS trained for some time now. Practice 2 is willing to become an IRIS trained Practice but due to Covid-19 pandemic dates have been cancelled several times, but the Advocate is confident that they will have dates arranged very shortly. | | | | | |
| 1.2 | The progress of referral activity by this Practice in the IRIS Project is monitored to | Designated Nurse for Safeguarding (IRIS Lead). Birmingham and Solihull CCG. | January 2020 | | Quarterly monitoring of referral through IRISi BSOL Steering Group and monitoring and reporting | Ongoing identification and monitoring of referrals made to the IRIS Project |

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| | evidence that practitioners continue to identify victims of domestic abuse by their presenting needs and using proactive questioning | | | | into BSOL CCG safeguarding assurance group | |
| **Update** | Practice 1 since having the training have been one of the highest referrers quarter on quarter. | | | | | |

| **Recommendation 2:** 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. | | | | | | |
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| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 2.1 | Practices to review systems of receiving information | Practice manager and Practice safeguarding lead | July 2019 | Information received, safeguarding issues considered, and appropriate action taken, including raising alerts on the system | Practice running an audit after 3 months | Audit outcome will show activity and alerts increase |
| **Update** | There high referral rate also demonstrates that they have been able to review information that is coming into them. This will be continued to be monitored. | | | | | |
| 2.2 | Policies, procedures and local practice to | Practice manager and Practice safeguarding lead | April 2021 | A review of policies and procedures will have been undertaken and reviewed | Policy changed will be supported by the Deputy | Policies and procedures in place. |

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| | be reviewed and amended as appropriate to reflect these changes | and Deputy Designated Safeguarding Nurse (CCG) | | and amended to reflect these changes | Designated Safeguarding Nurse (CCG) | Practice Manager/Safeguarding Lead to order the policy implementation 3 and 6 months after the revisions have been made to test sustained improvement. Action plans and audits submitted to the Deputy Designated Safeguarding Nurse (CCG) for reporting into the CCG Safeguarding Assurance Group. |
| **Update** | Policies have been updated and improved and submitted. | | | | | |

**Individual Agency Recommendations for GP Practice 3**

**Recommendation 1:** The practice to improve knowledge and skills with regard to identification of domestic abuse by IRIS refresher training

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 1.1 | The Practice will receive IRIS training, supporting them to recognised and respond to the needs of victims of domestic abuse | Practice Safeguarding Lead and IRIS Project lead | July 2019 | Practices will have refreshed their knowledge and skills with regard to the identification of domestic abuse will have a specialist referral pathway in house. | Quarterly monitoring of referral through IRISi BSOL Steering Group and monitoring and reporting into BSOL CCG safeguarding assurance group | The practice will have undertaken an IRISi update |
| **Update** | This Practice had IRIS update sessions in September 2019. This Practice continue to make regular referrals show in each quarterly report and in Q2 2021-22 were one of the highest referrers. | | | | | |

**Individual Agency Recommendations for Solihull Children's Services**

**Recommendation 1:** Learning from the IMR process to be fed back to managers formally.

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 1.1 | Managers' meeting to be attended to present learning from the IMR. | Joel Desous (Acting Head of Service for CIN) Simon Stubbs (Head of Service for Safeguards) Anna Stephens (Acting Head of Service for Looked After Children) | No later than June 2019 | For the learning from this IMR to be understood within the service. | Within 1:1s | It will be seen through themed case file audits in line with Recommendations 3 & 4 if this learning is evidenced by responses of CSWS to cases where there are concerns about Domestic Abuse or coercive and controlling behaviour. |

| **Recommendation 2:** Raise the profile and understanding about Domestic Abuse and 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 | | | | | | |
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| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 2.1 | This process could include delivery and learning through a variety of means which are most effective, i.e. workshops. Work Force Development will be consulted. | Joel Desous<br><br>Simon Stubbs<br><br>Deborah Adams (IRO) | No later than August 2019<br><br>Update: completed and should be on-going | To ensure the managers and workers understand and are supported to respond effectively when there are concerns about Domestic Abuse, coercion and control, and coercive behaviours. | Within Managers' Meetings | When the work is completed |
| **Update** | This action is completed and shall be ongoing. | | | | | |

| **Recommendation 3:** Solihull Children's Social Work Service to be reassured 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. | | | | | | |
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| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 3.1 | A dip sample of previous cases from | Joel Desous | 31/04/2019 | Audits of the relevant cases to be clear about | Within 1:1s | When outcome has been written and shared to |

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| | December 2018 to February 2019 to be audited | | Update: As audits were not undertaken this recommendation should carry forward to be completed within 4 months. | how Risk Assessment tools and documents on the current record of the children are informing decision making. | | inform the learning for CSWS in Recommendation 2. |
| **Update** | As audits were not undertaken this recommendation should carry forward to be completed within 4 months | | | | | |
| 3.2 | A dip sample of cases from April 2019 to May 2019 to be audited. | Joel Desous | 31/06/2018<br><br>Update: As audits were not undertaken this recommendation should carry forward to be completed within 4 months. | Audits of the relevant cases to be clear about how Risk Assessment tools and documents on the current record of the children are informing decision making. | Within 1:1s | When outcomes have been written and shared to inform the learning for CSW in Recommendation 2. |
| **Update** | As audits were not undertaken this recommendation should carry forward to be completed within 4 months | | | | | |

**Recommendation 4:** For Solihull Children's Social Work Service 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.

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
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| 4.1 | A dip sample of previous cases from December 2018 to February 2019 to be audited that have gone into a Social Work Assessment or are already allocated within CSWS. | Joel Desous<br><br>Anna Stephens | 31/05/2019<br><br>Update: As audits were not undertaken this recommendation should carry forward to be completed within 4 months. | Audits to be clear about how risk assessment tools and tools like Genograms and chronologies are being used to inform the SOS process of seeing safety over time and informing the quality of safety planning. | Within 1:1s | When outcome has been written and shared to inform the learning for CSWS in Recommendation 2. |
| **Update** | As audits were not undertaken this recommendation should carry forward to be completed within 4 months | | | | | |
| 4.2 | A dip sample of cases from April 2019 to May 2019 to be audited | Joel Desous | 31/06/2019 | Audits to be clear about how risk assessment tools and tools like Genograms and | Within 1:1s | When outcome has been written and shared to inform the learning for |

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| | that have gone into a Social Work Assessment or are already allocated within CSWS. | Anna Stephens | Update: As audits were not undertaken this recommend ation should carry forward to be completed within 4 months. | chronologies are being used to inform the SOS process of seeing safety over time and informing the quality of safety planning. | | CSWS in Recommendation 2. |

**Recommendation** 5: Strengthen the relationships of Children's Services with specialist domestic abuse services and improve practitioner knowledge of the Solihull domestic abuse pathway

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 5.1 | We are working closely with our domestic abuse Commissioning colleagues to have an IDVA located within our MASH and support the wider domestic | Tony McGregor | October 2023 | Children and their families receive timely intervention in line with their needs and our workers have an increased understanding and knowledge around domestic | We will work closely with and alongside our commissioning colleagues, workforce colleagues to ensure the domestic abuse pathway is developed, and understood by workers | Families receive timely intervention and are signposted and supported in lien with their needs and local services are responsive to their needs and |

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| | abuse work including increased awareness raising of service provision and support for parents and children and young people | | | abuse and pathways to support | | practitioners demonstrate increased awareness of service provision |

Appendix A

**Individual Agency Recommendations for University Hospitals Birmingham NHS Foundation Trust**

<table>
<tr><td colspan="7">Recommendation 1: 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</td></tr>
<tr><th>REF</th><th>Action (SMART)</th><th>Lead Officer</th><th>Target date for completion</th><th>Desired outcome of the action</th><th>Monitoring arrangements</th><th>How will Success be Measured and Outcome</th></tr>
<tr><td>1.1</td><td>Review the Midwifery DA training</td><td>Specialist DA Midwife</td><td>July 2019</td><td>Midwives are all aware of the expectations for them in relation to the DA pathway.</td><td>Reporting of training compliance rates and evaluations.</td><td>Quarterly Audit report on domestic abuse pathway to go to Audit sub group meeting.</td></tr>
<tr><td colspan="2">Update</td><td colspan="5">The DA Training for midwives has been reviewed and updated</td></tr>
<tr><td>1.2</td><td>Key learning points from the review should be delivered to all community midwives as part of reflective discussion sessions.</td><td>Specialist DA Midwife</td><td>July 2019</td><td>Community Midwives are aware of the case and have opportunity to reflect on the implications for their practice.</td><td>Reporting of training compliance rates.</td><td>Quarterly Audit report on domestic abuse pathway</td></tr>
<tr><td colspan="2">Update</td><td colspan="5">Action completed</td></tr>
<tr><td>1.3</td><td>DA audit completed quarterly to include the use of DASH in Maternity Services and the number of referrals to MARAC.</td><td>Specialist DA Midwife</td><td>July 2018</td><td>The maternity service can demonstrate that they are appropriately utilising the DASH risk assessment</td><td>Quarterly DA audit in place</td><td>Audit will demonstrate that the DASH risk assessment is being utilise din line with maternity guidelines.</td></tr>
</table>

Appendix A

<table>
<tr><td colspan="7">Recommendation 2: To embed the DA NICE questions into UHB HGS Emergency Departments and assessment areas</td></tr>
<tr><th>REF</th><th>Action (SMART)</th><th>Lead Officer</th><th>Target date for completion</th><th>Desired outcome of the action</th><th>Monitoring arrangements</th><th>How will Success be Measured and Outcome</th></tr>
<tr><td>2.1</td><td>Maintain training on the use of the DA questions for all ED staff with quarterly reporting</td><td>Adult Safeguarding Team</td><td>July 2019</td><td>Staff develop skill and competence in safe use of the NICE DA questions.</td><td>Quarterly recording of training compliance rates reported to the Safeguarding Group.</td><td>Increased use of the NICE DA questions. Staff reporting feeling skills and confident.</td></tr>
<tr><td>Update</td><td colspan="6">Pre covid we had begun work with consultants and Senior nursing team to develop and build on the work the safeguarding childrens team had done in Emergency Department . We are currently developing a new electronic patient system and plan to add the DA questions</td></tr>
<tr><td>2.2</td><td>Develop a standardised format to collate the information from NICE DA questions when patients present with injuries, substance misuse or mental health issues.</td><td>Adult Safeguarding Team</td><td>July 2019</td><td>Increased numbers of patients will be asked direct questions about domestic abuse and have the opportunity to disclose safely..</td><td>Review of Incident reports that feature DA</td><td>As above</td></tr>
<tr><td>Update</td><td colspan="6"></td></tr>
</table>

| **Recommendation 3:** Continue with UHB current DA training and strategy | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 3.1 | Review the Training Needs Analysis for DA | Clinical Educator Safeguarding | April 2019 | We will continue to have a robust training plan in place that is reflective of the needs of the service | Training will be monitored via the learning and development group and formal report to the Safeguarding groups | Review of training evaluations |
| **Update** | Completed. Training needs analysis has been reviewed and updated | | | | | |
| 3.2 | Revisit the current DA strategy and work plan to ensure that it is current and fit for purpose | Head of Safeguarding | June 2019 | We will continue to have a robust strategy in place that will help support the safeguarding team and give clear direction/purpose | Strategy will be discussed and shared at the safeguarding Board | Review of training evaluations |
| **Update** | Action completed: Our DA Policy is in the process of being approved. | | | | | |

| **Recommendation 4:** 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. | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |

| 4.1 | Develop ED documentation standards and issue to the ED staff | Head of Safeguarding | July 2019 | Staff have a clear set of standards in relation to the assessments they are required to complete in relation to who accompanies patients and information from their previous attendance including alerts.<br>Assessments include relevant information. | Audit following the issue of standards, | Compliance with standards demonstrated in the audit |
|---|---|---|---|---|---|---|
| **Update** | Currently developing a safeguarding risk assessment into our new electronic patient systems | | | | | |
| 4.2 | Cascade learning to ED, assessment areas and safeguarding champions via supervision and other methods such as case study, newsletter | Adult Safeguarding Team | September 2019 | Staff will have increased awareness on recording social history and robust assessment | Compliance will be discussed at the safeguarding operational group meetings | |
| **Update** | This is completed. A Quarterly Safeguarding Newsletter is used to disseminate information. Supervision used to discuss safeguarding cases and related lessons. | | | | | |

| **Recommendation 5:** To promote the benefit of specialist DA services to the staff that work within ED | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |

| 5.1 | Work in partnership with BSWA to organise awareness sessions for staff in ED | Safeguarding team | November 2019 | Staff will have an increased awareness and understanding of the DA services and how to access them | DA steering group | Staff reporting Referrals to specialist services |
|---|---|---|---|---|---|---|
| **Update** | Action completed | | | | | |
| 5.2 | Use a variety of communication aids such as leaflets, newsletters, case studies to help raise awareness | Safeguarding team | November 2019 | Staff will have an increased awareness and understanding of the DA services and how to access them | DA steering group | Staff reporting Referrals to specialist services |
| **Update** | Quarterly newsletter is produced and disseminated across the Trust. | | | | | |

**Recommendation 6:** To continue to seek funding for a co-located IDVA service/purple clinic for ED

| REF | Action (SMART) | Lead Officer | Target date | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 6.1 | To work with other partners/agencies to see if funding can be secured for a “purple clinic/IDVA service | Head of safeguarding | March 2020 | IDVA service/purple clinic will be available for patients and staff to access | DA steering group & Adult safeguarding strategic group | Patient & staff feedback |
| **Update** | IDVA in Place | | | | | |
| 6.2 | If funding unable to be secured escalate to the safeguarding boards | Head of safeguarding | March 2020 | SAB’s notified & for the independent chairs consider options | As above | IDVA Service in place. |

| **Update** | As above. |
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Appendix A

**Individual Agency Recommendations for Solihull Community Housing**

| **Recommendation 1:** Improve the organisation wide response to Domestic Abuse | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 1.1 | Conclude outstanding recommendations from DHR SOL 5, encompassing further learning from DHR SOL 6 | DG/AT | September 2019 | Improved organisation wide response to Domestic Abuse | Executive Management Team (EMT) | Resulting service improvement action plan (and case audits) |
| **Update** | Action Complete | | | | | |
| 1.2 | To explore DAHA accreditation for a 'whole organisation' approach to domestic abuse. | Executive Director Housing and Communiti es / Head of Policy | September 2019 | To improve SCH's response to domestic abuse through the introduction and adoption of an established set of standards as set out by DAHA. This is being further complemented through an accreditation process to embed the approach across SCH.<br><br>Improved communication and joint approach to | SCH's Safeguarding, Exploitation and Domestic Abuse (SEDA) group.<br><br>Executive oversight through SCH annual Delivery Plan | Having explored accreditation process and benefits, SCH is committed to embarking on DAHA accreditation in 2022/23 |

| | | | | | | |
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| | | | | people presenting / experiencing domestic abuse, particularly through Neighbourhood and Home Options teams. Escalation of complex cases and adoption of 'case conference' approach | | |
| **Update** | Action (to explore) DAHA accreditation completed in 2021 with commitment to embark on accreditation process in 2022/23. Improved communication and joint approach service improvements implemented | | | | | |

**Recommendation 2:** Ensure the customer pathway arrangements are robust, particularly in relation to victims of domestic abuse.

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 2.1 | Review the customer pathway arrangements (in place since April 2018), particularly in relation to victims of domestic abuse | DG/AT | September 2019 (specifically DA cases) | To give assurance on ready access and timely risk assessment | EMT | Implementation of revised procedures |
| **Update** | Action completed. Suite of Housing Options customer pathways launched in March 2020 through the Homelessness Forum (event at SCH) and reviewed in March 2021 (annual review). These are on the website and are shared with partners. | | | | | |

| Recommendation 3: Ensure organisation can respond to indicators of domestic abuse | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 3.1 | Investigate options for collecting and responding to 'intelligence' which may indicate a risk of domestic abuse.<br><br>To introduce into procedures the need for follow-up contact with the householder where indicators or reports of domestic abuse come to their attention (as in concierge response).<br><br>Strengthen the knowledge and skills of all practitioners to respond to domestic abuse and coercive control | DG/AT | September 2019 | Identified actions required to capture and effectively act upon indicators of potential domestic abuse | EMT | Production of report with recommendations |
| **Update** | Partially completed. Revised target date for full completion March 2022. | | | | | |

| **Recommendation 4:** Improve customer awareness of the pathways and procedures for housing options | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 4.1 | Improved information to customers on pathways and procedures (Housing Options service)<br><br>The Home Options team to routinely ask victims about safety of accommodation. | DG/AT | September 2019 | Improved communication and understanding | Service leads | Customer satisfaction surveys |
| **Update** | Partially completed. Revised target date for full completion March 2022. | | | | | |

Appendix A

**Individual Agency Recommendations for Staffordshire and West Midlands Community Rehabilitation Company**
(these actions were completed before the organisation was returned to public control under the newly created Probation Service in June 2021)

| **Recommendation 1:** Training: | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured** |
| 1.1 | To deliver Domestic Abuse refresher training to all Case Management staff. | PDM's | 31st April 2019 | Relate current research and evidence-based practice to your work with perpetrators of domestic abuse<br><br>Use professional curiosity to identify and respond to risk with appropriate actions and referrals<br><br>Follow RRP guidelines to ensure best practice is achieved and maintained<br><br>For all Case Managers to understand the practice expectations including the importance of partnership working | Regional Managers (RMs) to monitor the training delivered by PDM's<br><br>Regional Managers to report back progress of the delivery of training to L&D Business Partners<br><br>iLearn Training Records (electronic training application) | iLearn Training Records<br><br>Success measures will form part of the CRC's Quality Management Framework.<br>These issues are measured by MI (e.g. case management dashboard and Quality audits) and by quality measures with individual performance framework (PMF). |

| 1.2 | To Deliver refresher Safeguarding Training to all Case Management Staff | Regional Manager | 31st April 2019 | Identify individual and organisational responsibilities in safeguarding<br><br>Refresh knowledge of the categories of abuse, indicators and risk factors<br><br>Explore current and emerging risks that children may face in different environments<br><br>Understand practice expectations including the importance of partnership working<br><br>Identify future learning needs and ways to meet these | Regional Managers to monitor the training delivered by PDM's<br><br>Regional Managers to report back progress of the delivery of training to L&D Business Partners<br><br>iLearn Training Records | iLearn Training Records<br><br>Success measures will form part of the CRC's Quality Management Framework.<br>These issues are measured by MI (e.g. case management dashboard and Quality audits) and by quality measures with individual performance framework (PMF). |
|---|---|---|---|---|---|---|

| **Recommendation 2:** Domestic Abuse Practice: | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 2.1 | To support active risk management across RRP by improving nDelius risk register recording and timely reviews. | PDM1 | December 2019 | Review current registers for each SU and ensure they are appropriate and up to date. Load registers that are not currently there but should be.<br><br>Where activity indicates/highlights a change of risk the completion of an OASys/Progress Review as appropriate.<br><br>Where a deactivated register is on nDelius – deregister and load the current equivalent. | RM's to monitor delivery of workshops to teams.<br><br>RRP data team to monitor the risk register data quality in a monthly MI report which is circulated to all RM's and Ops Director to track month on month improvements. | Success measures will form part of the CRC's Quality Management Framework.<br>These issues are measured by MI (e.g. case management dashboard and Quality audits) and by quality measures with individual performance framework (PMF). |
| 2.2 | Through case oversight and accountability ensure enforcement actions are taken when required. | PDM1 | On going | To track performance in relation to levels of enforcement actions outstanding, with related accountability for local team managers and individuals where the performance is at levels below those set (i.e. no | Measured using local performance for enforcement activity and related accountability to RM1 by PDM1. | Success measures will form part of the CRC's Quality Management Framework.<br>These issues are measured by MI (e.g. case management dashboard and Quality |

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| | | | | more than 15 outstanding enforcement actions per practitioner). | | audits) and by quality measures with individual performance framework (PMF). |
| 2.3 | Implementation of a Case Audit regime to drive and monitor the quality of risk Assessment and risk management practice. | PDM1 | | Implementation of CRC Quality framework including guidance about minimum expectations in every case, "Dip Sampling" audit via local and senior managers; Quality measures as part of individual performance assessment. These activities will drive improvements in the quality of risk assessment/management. | 1. Quality indicator results from "Quality Days" audit exercises, held monthly.<br>2. Profile from "PMF" - individual and Regional assessment of Quality performance.<br>3. Feedback from RM1 concerning implementation of "Every Case Essentials". | Success measures will form part of the CRC's Quality Management Framework.<br>These issues are measured by MI (e.g. case management dashboard and Quality audits) and by quality measures with individual performance framework (PMF). |

**Recommendation 3:** Management Oversight

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| 3.1 | RM1 to dip sample the supervision notes of PDM1 to monitor the quality and effectiveness of manager oversights**.** | Regional Manager for Coventry and Solihull | **31/05/2019** | Assurance that manager oversight are effective in identifying and supporting Probation Practitioners to identify the nature of changing risk | RM dip sampling of supervision notes.<br><br>RM/PDM supervision including coaching. | Success measures will form part of the CRC's Quality Management Framework.<br>These issues are measured by MI (e.g. case management |

| | | | | | | |
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| | | | | | Regional Manager to report back Operations Director, including plan for remedial action, if required. | dashboard and Quality audits) and by quality measures with individual performance framework (PMF). |

| Recommendation 4: Partnership Arrangements | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 4.1 | 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. | PDM1 | June 2019 | Assurance that Known Person's Checks and Domestic Abuse checks are being requested as per SWM CRC's established business processes. | iLearn records<br><br>PDMs to report back Regional Manager, including plan for remedial action, if required.<br><br>Zingtree Report (decision tree guide that can be reported on). | Success measures will form part of the CRC's Quality Management Framework.<br>These issues are measured by MI (e.g. case management dashboard and Quality audits) and by quality measures with individual performance framework (PMF). |
| 4.2 | Communicate to NPS via the Service Integration Group the current list of Pathway Interventions that SWM CRC. | SWM CRC Director Of Operations | June 2019 | Ensure that NPS are aware of the current suite of interventions that are offered by SWM CRC when making proposals to the Court. | Director of Operations to confirm this action has been completed<br><br>NPS to confirm to the Director of Operations that information has been cascaded to NPS teams<br><br>SWM CRC Officer in Court to advise NPS of available interventions offered by the CRC | Success measures will form part of the CRC's Quality Management Framework.<br>These issues are measured by MI (e.g. case management dashboard and Quality audits) and by quality measures with individual performance framework (PMF). |

| **Recommendation 5:** Resource | | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| 5.1 | Planned local management team driven restructuring in cluster to improve staff access to support and build operational resilience. | Local Senior Manager | 30th June 2019 | To put in place the designed re-structuring to enhance service delivery support to Solihull and build a resilient team.<br><br>To improve workload and staffing reliance. | Through the local operational management team via a project plan. | RM oversight.<br>Improved delivery of RAR interventions available.<br>Review compliance and effectiveness in 6 months.<br><br>Regional Manager to report Operations Director, including plan for remedial action, if required. |

Appendix A

## Individual Agency Recommendations for West Midlands Police

**Recommendation 1:** 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
- 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
- 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.

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured/What has been the Outcome |
|---|---|---|---|---|---|---|
| OS/1 | Conducting checks into previous history of domestic abuse when responding to an | CS North (FR) | Complete | Assurance that first responders and supervisors are aware of history when | Through monthly joint Force Response & PPU meeting, seek feedback from R&A who review all | Full compliance with intelligence /history checks. |

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| | incident and when considering risk | | | attending incident of domestic abuse | Domestic Abuse crimes to understand if lack of intelligence checks is an issue. | |
| **Update** | Antecedence checks are required for each Domestic abuse report and forms part of WMP DA Policy. Since 2018, WMP have introduced three new IT systems which provide officers intelligence:<br><br>1. Control Works: Provides Call Handlers with immediate intelligence regarding the caller, the address/location and also any other parties named in the call which is used to understand if repeat victim and to inform the risk assessment and response.<br>2. Business Insights Search: System available on frontline officer's mobility devices which offers oversight of any intelligence, past incidents, crimes and custody information.<br>3. Connect: Introduced in April 2020 and designed to 'connect' people, vehicles, locations etc. in order to inform investigations and provide a richer picture regarding the antecedence of parties involved.<br><br>In addition, any DA incident where children are involved are subject to multi-agency screening which involves the full police history being shared with partners for the purpose of this conversation. | | | | | |
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| OS/2 | Considering all possible lines of enquiry following reports of domestic abuse | DSU Foster (PPU) | On-Going through monthly auditing | Assurance that all enquiries are considered and a) completed or b) justification provided as to why specific enquiries are not relevant / proportionate | Through established monthly auditing process paying particular attention to first responder, investigative officer and supervisory action plans and updates to ensure they are proportionate to the risk presented. | Clear rationales where DA investigations have not been progressed to ensure the decision making is proportionate and in line with WMP Policy. |

| **Update** | West Midlands Police operate a proportionate approach to domestic abuse investigation. In 2018, the decision whether an investigation was to progress or be filed was the responsibility of the DA Investigation Sergeant. In 2019 the PPU restructured and introduced the Review & Allocation Department which, where appropriate, a rationale for referrals to be filed immediately. The R&A function '…adopt a decision-making framework, utilising the THRIVE+ risk assessment tool and the National Decision Making Model (NDMM), acting in accordance with the force vision and values, enhancing the use of discretion, reducing risk aversion and supporting the appropriate allocation of limited policing resources. (PPU Restructure Business Process Design Document October 2018). In addition the NPCC Risk Principles state 'risk taking involves judgement and balance. Decision makers are required to consider the value and likelihood of the possible benefits of a particular decision against the seriousness and likelihood of the possible harms' (Principle 3).<br><br>It is recognised by West Midlands Police that it is not possible to provide a complete set of policy rules for offences which are not going to be further investigated, with each decision bespoke to the circumstances presented. When making a decision, the Sergeant will consider the following:<br>- Level of injury (physical or psychological) or damage sustained<br>- Strength of evidence including medical, CCTV, officer body worn video, witness etc.<br>- Suspect's previous offending history<br>- Level of harm and risk to the victim (and children if applicable)<br>- View of the victim i.e. whether they support a prosecution<br>- Level of evidence should the victim not support (evidence led prosecution)<br>- The prospect of a positive outcome, whether an out of court disposal for offences down the lower end of the risk spectrum or charge with criminal offences for those crimes with higher risk.<br><br>The decision whether to progress a domestic abuse crime investigation is also heavily influenced by the Crown Prosecution Service (CPS) Charging Standards. The standards are in following stages:<br>Stage 1 – The Evidential Stage. There must be sufficient evidence to provide a realistic prospect of conviction, considering ay defence raised and the admissibility and credibility of evidence.<br>Stage 2 – The Public Interest Stage where we need to satisfy CPS of the seriousness of the offence, the culpability of the offender, the harm of the offence, the risk to the community and that charging a person is proportionate in the circumstances posed.<br>There are further stages to satisfy the CPS should we wish to charge and then remand the suspect in custody. |
|---|---|

| | When making a decision to not progress an investigation, a Domestic Abuse Investigation Team Sergeant must make a full and comprehensive record of this decision, detailing their considerations and rationale as to why they have determined that no further investigation should take place.<br><br>These are not easy decisions for Sergeants to make and come with a certain level of risk of a suspect reoffending and serious risk of harm to the victim. It is not easy to foresee further incidents of harm and therefore, using all information available to make these decisions, such as antecedents of the offender is necessary to make risk-based judgements.<br><br>Based on current data, the Public Protection Unit file approximately 45% of all domestic abuse crimes at source with no further investigation. | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| OS/3 | Identifying and responding to coercive control | IDENTIFY:<br>CS Beard (FC)<br><br>DEALING:<br>DSU Foster (PPU) | IDENTIFY:<br>Through daily LQT practices and feedback loop to FR.<br><br>DEALING:<br>On-Going through monthly auditing | CCB to be considered when dealing with all DA calls for services and a crime recorded where the offence has been made out. PPU to proportionately investigate CCB and consider evidence-led prosecutions where the victim does not support an investigation. | Identifying CCB: Through established working practices of LQT and feedback mechanism into Force Response.<br><br>Dealing with CCB: Through established monthly auditing process using CCB as a thematic audit before end 2021. | Compliant CCB recording and clear rationales where CCB investigations have not been progressed to ensure the decision making is proportionate and in line with WMP Policy. |

<table>
<tr><td>Update</td><td colspan="6">On 29th December 2015, s.76 of the Serious Crime Act 2015 was enacted, introducing an offence of Controlling or Coercive Behaviour (“CCB”). In preparation for this, WMP produced a mandatory training package for all officers to complete, accompanied by a video produced by the College of Policing. The training covered the following areas:<br>- Explanation of the legislation.<br>- Role of police officers in recognising CCB and responding accordingly.<br>- Focusing not just on adult impact but impact on children.<br>- Signs, characteristics and evidence of CCB.<br>- Examples of CCB to assist with recognition.<br>- Understanding the difficulties victims face in understanding that they are actually being victimised and abused.<br><br>In 2019, WMP commissioned “Safelives”, a UK wide charity dedicated to ending domestic abuse, to deliver ‘DA Matters’ training to all frontline responding officers. This training was designed to transform the response to domestic abuse, ensuring the voice of the victim is placed at the centre, and CCB is better understood. Approximately 1000 frontline officers attended this training with the objective of better understanding, and therefore dealing with, incidents of domestic abuse.<br><br>In July 2019, West Midlands Police became a pilot force for the College of Policing and started to use an alternative risk assessment tool. The Domestic Abuse Risk Assessment (“DARA”) more greatly recognises coercive controlling behaviour.<br><br>In 2020, WMP introduced a Log Quality Team who review every domestic abuse incident to ensure that the attending officers have recognised and correctly recorded any crimes which have been committed which includes the recognition of CCB.<br><br>All new officers and staff joining WMP now receive specific vulnerability training which includes domestic abuse, CCB, harassment and stalking. For Student Officers, part of their initial training involves working alongside Domestic Abuse Specialist Investigators, gathering evidence from victims, interviewing offenders and preparing case files for the Crown Prosecution Service, enabling them to understand the threat, risk and harm that is associated with domestic abuse from the earliest stage of their service.</td></tr>
<tr><td>REF</td><td>Action (SMART)</td><td>Lead Officer</td><td>Target date for completion</td><td>Desired outcome of the action</td><td>Monitoring arrangements</td><td>How will Success be Measured and Outcome</td></tr>
</table>

<table>
<tr><td>OS/4</td><td>Identifying and responding to stalking and harassment</td><td><u>IDENTIFY:</u><br>CS Beard (FC)<br><br><u>DEALING:</u><br>DSU Foster (PPU)</td><td><u>IDENTIFY:</u><br>On-going through daily LQT practices and feedback loop to FR.<br><br><u>DEALING:</u><br>On-Going through monthly auditing</td><td>S&H to be considered when dealing with all DA calls for services and a crime recorded where the offence has been made out. PPU to proportionately investigate S&H and consider evidence-led prosecutions where the victim does not support an investigation.</td><td><u>Identifying S&H:</u> Through established working practices of LQT and feedback mechanism into Force Response.<br><br><u>Dealing with S&H:</u> Through established monthly auditing process. Stalking was a thematic audit in March 2020. Plus Stalking SPOC dip samples reports for compliance and works alongside external Stalking charities to influence and review case progression.</td><td>Compliant S&H recording and clear rationales where S&H investigations have not been progressed to ensure the decision making is proportionate and in line with WMP Policy.</td></tr>
<tr><td>Update</td><td colspan="6">In 2018, the Home Office changed the ‘counting rules’ for harassment resulting in any crimes of harassment within the domestic definition would result in a crime of stalking. This has resulted in a significant increase in the number of stalking crimes recorded within WMP (and other forces). Feedback from forces (including WMP) is that these changes have had an unintended consequence in regards to create an overcrowded stalking space where we rely on the DARA risk assessment to understand and react to the risk.<br><br>The DARA risk assessment has a specific section which explores in detail S&H under Q.6 of the assessment which forms part of the investigative plan.<br><br>All high-risk stalking crimes should result in a referral to specialist victim’s services (Independent Stalking advocacy caseworkers – ISAC). Referral forms embedded with Intranet for Officers to access.<br><br>WMP hosted a Force stalking seminar in August 2021 and the Stalking SPOC has delivered 9 further training events to WMP staff including Detective Academy to increase stalking awareness and improve the overall response required for stalking allegations.</td></tr>
</table>

| | In May 2023 the Home Office Counting Rules (HOCR) were further updated to provide clearer guidance on the recording of Stalking, harassment and Coercive/Controlling Behaviour and these changes have been communicated and are effective within West Midlands Police. |
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| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| OS/5 | Ensuring that crimes relating to domestic abuse, coercive control, stalking and harassment are not missed | RECORD: CS Beard (FC)<br><br>DARA: CS North (FR) | RECORD: On-going through daily LQT practices and feedback loop to FR.<br><br>DARA: Data available daily through | All crimes relating to domestic abuse, coercive control, stalking and harassment are recorded against each incident reported to WMP. | Recording: Through established working practices of LQT and feedback mechanism into Force Response.<br><br>DARA Compliance: Through established monthly performance reporting through Qlik. | Compliant domestic abuse crime recording through Crime Data Integrity auditing results. |

<table>
<tr><td></td><td></td><td></td><td>Qlik & reported on monthly to team & officer level.</td><td></td><td></td><td></td></tr>
<tr><td>Update</td><td colspan="6">In 2020, WMP introduced a Log Quality Team who review every domestic abuse incident to ensure that the attending officers have recognised and correctly recorded any crimes which have been committed which includes the recognition of CCB.<br><br>In addition, responding officers are required to complete a Domestic Abuse Risk Assessment (DARA) with each DA victim. Where the victim declines to participate in DARA, the attending officer still completes the assessment using information gleaned when speaking with the victim.<br><br>Stalking SPOC has provided training to assist staff to recognise ‘course of conduct’ so that responding and investigating staff can identify the wider pattern of offending associated with stalking.</td></tr>
<tr><td>REF</td><td>Action (SMART)</td><td>Lead Officer</td><td>Target date for completion</td><td>Desired outcome of the action</td><td>Monitoring arrangements</td><td>How will Success be Measured and Outcome</td></tr>
<tr><td>OS/6</td><td>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</td><td>CS North (FR)<br><br>Laura Rogers (PPU)</td><td>On-going</td><td>Comprehensive safeguarding measures completed for each domestic abuse incident reported to WMP.</td><td>MONITORING: Through established monthly auditing process using Safeguarding as a thematic audit in Q.3 2021/22.</td><td>Safeguarding measures and discussion with the victim clearly recorded in each domestic abuse crime report.</td></tr>
</table>

| Update | All officers attending incidents of domestic abuse should be assessing the risk posed to the victim from disclosures made, physical digital, witness evidence and intelligence checks therefore informing the safeguarding measures put in place.<br><br>Victims who are assessed as medium or high risk (via DARA) are subject of enhanced safeguarding through a dedicated team within PPU. All high risk victims are subject of MARAC. | | | | | |
|---|---|---|---|---|---|---|
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| OS/7 | Ensuring that Domestic Abuse Protection Orders are considered and undertaken where appropriate | DSU Foster (PPU) | On-going | DVPN/O plus SPOs to be considered against each DA crime investigation. | Through established monthly auditing process plus through monthly DA Performance meeting where DVPN/O and SPO data is reported by the Civil Intervention Teams Manager (Jack Webb). | DVPN/O plus SPOs to be considered against each DA crime investigation and rationale recording against each crime where this is not deemed relevant. |
| **Update** | WMP are increasing the number of staff in the Civil Interventions Team by 1 x staff member to increase capacity for DVPN/DVPO and SPO applications.<br><br>In 2021, the Civil Intervention Team have conducted training across all Adult Investigation Teams in regard to the thresholds for DVPN/O applications to ensure that investigators are considering them where circumstances dictate.<br><br>Stalking SPOC and legal services have provided SPO training inputs to Investigative staff. | | | | | |
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| OS/8 | Referring domestic abuse victims to local | CS North (FR) | TBC | All adult victims of domestic abuse to referred to | Through Force Response thematic dip-sampling. | Referral pathways and consent of the victim |

| REF | Action (SMART) | Lead Officer | Target date for completion | Desired outcome of the action | Monitoring arrangements | How will Success be Measured and Outcome |
|---|---|---|---|---|---|---|
| | specialist services with their consent | | | specialist support services with their consent. | | clearly recorded in each domestic abuse crime report. |
| **Update** | In 2021, WMP invested in a new IT system known as 'Connect' which allows officers to automatically refer victims of domestic abuse to victim support services with their consent.<br><br>In addition, frontline officer's mobility devices have the NCDV app plus access to the 'no excuse for abuse' website which lists pathways for victims of domestic abuse where direction referrals are made in the presence of the victim.<br><br>ISAC referral forms are available on the Intranet for referral to specialist stalking advocacy caseworkers. | | | | | |
| **REF** | **Action (SMART)** | **Lead Officer** | **Target date for completion** | **Desired outcome of the action** | **Monitoring arrangements** | **How will Success be Measured and Outcome** |
| OS/9 | 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 | DSU Phillips (PPU) | Complete | All information where a child has been subject to or at risk abuse is shared with partner agencies together with parent details in a timely fashion to enable a fuller multi-agency assessment of risk.<br><br>Partner agencies receive referrals through MASH in a timely fashion based on risk.<br><br>In addition all DA incidents are screened through a triage | CRU / MASH referrals are audited each month through dip sampling to ensure the VOC and correct decision making has been recorded and shared in a timely fashion.<br><br>Each local authority area has a QA process and forum (CASS/MASH) that allows monitoring of performance and outcomes such as Early Help, Investigation and CP plans etc. | Success is measured in no's of:<br><br>Referrals sampled that meet the HMICFRS threshold under recent VSA inspection which was positively commented upon – all staff have been trained in this assessment process.<br><br>QA feedback from partners is shared each |

<table>
<tr><td></td><td></td><td></td><td></td><td>process to identify children exposed to domestic abuse and those meeting the threshold are also referred into multi-agency teams for assessment.</td><td>Staff are educated on the importance of professional curiosity which has emerged as a common theme in CA SPRs.</td><td>qtr to allow professional discussions. Issue raised are dealt with locally and at the earliest opportunity. (Red /Amber timeliness targets are set and monitored as well as volume of referrals by agencies).</td></tr>
<tr><td>OS/10</td><td>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</td><td>CS North (FR)</td><td>17/9/2020</td><td>All frontline officers responding to domestic abuse understand that standard risk DA non-crimes do not receive additional scrutiny from PPU and are filed at source</td><td>Through monthly joint Force Response & PPU meeting.</td><td>All standard risk non-crimes filed by originating officers Supervisor.</td></tr>
<tr><td>Update</td><td colspan="6">On 17/9/2020, the Domestic Abuse Lead (DSU Jenny Skyrme), whilst communicating changes to domestic abuse secondary investigation to Force Response Officers, has reitteriated that standard risk non-crimes do not receive additional scrutiny by PPU. This does not apply to standard risk crimes which are privvy to review by PPU in order to determine the investigative pathway.<br><br>Due to the constant flow of officers in Force Response it is important that this messaging is reiterated at regular points.</td></tr>
</table>

## HOME OFFICE FEEDBACK LETTER

Interpersonal Abuse Unit
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25th April 2024

Domestic Homicide Team
Public Health
Solihull Metropolitan Borough Council
Manor Square, Solihull,
West Midlands
B91 3QB

Thank you for resubmitting the report (Adult 1 & Adult 2) for Solihull Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in April 2024.

The QA Panel found this to be a rigorous, objective and detailed DHR, with a clear narrative that gave an insight into just how much abuse Adult 1 was subject to, in a myriad of forms, how resilient and courageous she was and how let down she was. The wide range of abuse to which Adult 1 was subject is explored in detail - coercive control, stalking and harassment, grooming, surveillance, isolation and imprisonment, physical and sexual violence, threats to self-harm and kill and forced marriage. These are brought together well using an overarching ‘intersectional equalities lens’ and this sets out clearly just how vulnerable Adult 1 was. There are brief but sensitive condolences to the family noted in the Preface.

The QA Panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices

and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel