2022

Executive Summary: DHR Claire: November 2020

SAFER SOLIHULL PARTNERSHIP

SIMON HILL INDEPENDENT CHAIR & AUTHOR

1 The Review Process

1. This Executive Summary outlines the process undertaken by Safer Solihull Partnership Domestic Homicide Review panel into the homicide of Claire who was resident in their area.

2. The identity of individuals subject to this DHR have been protected through anonymisation to ensure confidentiality is, as far as possible, maintained. Claire's family were given the opportunity to choose the names used but expressed no preferences in this regard:

Role	Anonymisation
Victim	Claire
Perpetrator	Andrew
Victim's former partner	Kelvin
Victim's father	Leslie
Victim's youngest child	Jo
Victim's adult daughter	Lucy
Perpetrator's ex-wife	Elaine
Perpetrator's son	Steve
Perpetrator's daughter	Not named

3. Criminal proceedings were completed in April 2021, Andrew was convicted of the murder of Claire and sentenced to life, with a recommendation that he serve a minimum of twenty years.

4. The Safer Solihull Partnership Chair sat on 9th December 2020, to consider the circumstances of the incident and to determine whether it was appropriate to conduct a Domestic Homicide Review in line with the definition of domestic homicide as defined in the Domestic Violence, Crimes and Victims Act 2004. Councillor Alison Rolf took advice from officers who offered expert advice to the Chair. It was agreed that the circumstances of the death fulfilled the criteria to conduct a domestic homicide review as defined in the Domestic Violence, Crimes and Victims Act 2004.

5. All agencies that potentially could have had contact with Claire and Andrew were contacted through scoping and asked to provide initial details of what involvement they had with the victim and perpetrator.

2 Contributors to the Review

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

   1. National Probation Service
   2. West Midlands Police
   3. Birmingham and Solihull Clinical Commissioning Group (since July 2022 NHS Birmingham & Solihull Integrated Care Board)
   4. Birmingham and Solihull Mental Health Foundation Trust in relation to a commissioned Service providing alcohol support: SIAS
   5. University Hospitals Birmingham
   6. Counselling service: responded to DHR questions and held direct conversation with Chair in May 2022

All IMR authors were independent of the events described in this DHR and were not involved with the parties reviewed or decision making by their agency. This independence was confirmed by the senior managers 'signing off' the IMRs.

3 The Review Panel Members

Agency	Panel Member	Role
None	Simon Hill	Independent Chair
Birmingham & Solihull Mental Health Foundation Trust and SIAS – substance misuse services	Yvonne Hartwell	Adult Safeguarding Lead
National Probation Service	Andy Wade/Neil Appleby	Head of Probation (North & East Birmingham and Solihull Probation Delivery Unit)
West Midlands Police	Scott Shaw	Detective Inspector Public Protection Unit (PPU)
Birmingham & Solihull CCG (Since July 2022 the NHS Birmingham & Solihull Integrated Care Board)	Luisa Blackwell,	Deputy Designated Nurse Safeguarding Children and Adults.

Solihull Metropolitan Borough Council	Caroline Murray	Domestic Abuse Lead: Senior commissioning manager for Domestic abuse, sexual health and sexual abuse
University Hospitals Birmingham	Maria Kilcoyne/Pam Rees	Adult Safeguarding Leads
Solihull Metropolitan Borough Council	Alex Cerruti/ Harry Carter – Community Safety Team	DHR Co-ordinators
2 Hills Consultancy Ltd.	Sonya Hill	Research and administrative support

1. An independent Chair was appointed in January 2021 and the DHR held panels on:

15th April 2021

23rd July 2021

29th July 2021

17th March 2022

2. The DHR was conducted subject to COVID restrictions and altered work practices and therefore all panels were conducted via secure online meetings.

4 Author of the Overview Report

1. Simon Hill is a former West Midlands Police Officer who retired in 2013, having served in the Public Protection Unit covering the Central Birmingham Area and therefore was not involved with anyone subject to this DHR (including earlier events outside the DHR timescales), or any of the policing decisions taken in this case.

2. He was also responsible for the PPU Review team contributing IMRs to DHRs, SCRs and SARs. He received Home Office accredited training in 2013 to fulfil the role of DHR Chair. In the last eight years he has chaired numerous DHRs and SARs in the West Midlands region.

5 Terms of Reference

1. The review should address both the 'generic issues' set out in the Statutory Guidance, and the following specific issues identified in this particular case:

- How effective were agencies in identifying and responding to both need and risk?

- How effective were agencies in working together to prevent harm through domestic abuse in Solihull?
- What (if any) decisions could have been made and action taken by agencies, to prevent the homicide of Claire and Andrew from being a perpetrator of homicide?
- What lessons can be learnt to prevent harm in the future?
- During the period under review have the operating procedures introduced within your agency as a response to COVID-19, impacted upon your professional's abilities to identify domestic abuse and respond accordingly? What steps have been taken to mitigate any impact?

2. Individual Management Review Authors will therefore be asked to respond to the following questions in respect of their involvement with Claire and Andrew during the period from January 2017 until November 2020.

IMR authors should answer each question and indicate whether any question is not applicable and why?

1. *Can you provide a summary of the role and expectation of your organisation to identifying and respond to domestic abuse?*
2. *Concentrate on any missed opportunities to identify and support either party in relation to domestic abuse*
3. *Can your agency provide a brief pen picture of Claire and Andrew, together with and any knowledge your agency had of their relationship? Please also include any previous relationships for either adult, that appear to feature domestic abuse.*
4. *What needs and vulnerabilities did your agency identify in Claire (the victim) and how did your agency respond?*
5. *What needs and vulnerabilities did your agency identify in Andrew (the alleged perpetrator) and how did your agency respond?*
6. *What threat and risks did your agency identify for either Claire or Andrew and how did your agency respond? Consider identified threat and risk for this relationship and prior relationships as well as the potential for threat to other people.*
7. *If domestic abuse was not known, how might your agency have identified the existence of domestic abuse from other issues presented to you?*
8. *How well equipped were staff in responding to the needs, threat or risk identified for both Claire and Andrew? Were staff supported to respond to issues of domestic abuse, safeguarding, public protection and multiple and complex needs through*
    - *Robust policies and procedures in domestic abuse, including policies of direct or routine questioning*
    - *Strong management and supervision*

- *Thorough training in the issues and opportunities for personal development*
- *Having sufficient resources of people and time*

9. *Can you identify areas of good practice in this case?*
10. *Are there any service changes planned or happening that might have affected your agency's response?*
11. *Are there lessons to be learnt from this case about how practice could be improved?*
12. *What recommendations are you making for your organisation and how will the changes be achieved?*

In addition, the following Agency specific questions should be answered (indicate if any question is not applicable and why)

National Probation Service:

- Provide a summary of the index offence requiring supervision by NPS. Identify the length of prison sentence, the period under licence and any supervisory responsibilities for a person no longer on licence, but still serving a sentence post release.
- Identify any information provided by the Prison service that pertained to his time spent in prison that was (or should have been) considered relevant to the assessments on release
- Describe all subsequent risk assessments carried out during the period Andrew was supervised by NPS and explain any significant change in those risk assessments. Were subsequent responses appropriate?
- What level of supervision was Andrew subject to?
- To what extent and in what circumstances, would NPS expect probation officers to identify and manage risk (including domestic abuse) that an offender might pose to their partners (including ex-partners) or family members? Were any such concerns identified at any time?
- Was risk management appropriate in this case based on what was known? (If the IMR author identifies any gaps in awareness of relevant information please explain why this was the case)
- Comment on whether and when, drug/alcohol misuse was a vulnerability that Andrew was known to be experiencing and was action taken by NPS appropriate? (Include any information known to NPS concerning support offered to Andrew in prison in relation to alcohol misuse)
- Indicate any health plan relating to Andrew shared by the Prison Service with NPS, upon release
- Describe the role of your agency and Integrated Offender Management (IOM) in relation to Andrew. Concentrate on any part of IOM's engagement that identified a risk of domestic abuse to any party and describe any response. Were responses (if any) appropriate?

- Identify relevant legislation around sentencing, supervision and licence that were relevant at the time under review. Describe any changes in current legislation, that might improve NPS responses or provide alternative or better ways of managing a similar prisoner upon release on licence

Counselling Service

Enquiries for Counselling Service

Commissioning:

- Please describe the commissioning process between yourselves and the National Probation Service (including the Community Rehabilitation Companies that existed at the time), both in general terms and regarding this client.
- Describe what therapeutic support you were asked to offer Andrew. (The NPS IMR identifies 52 sessions of support for Andrew.)
- Identify any learning concerning the duration and extent of engagement with Andrew.

Management of a Client on Licence:

- Describe what expectations your service would have regarding liaison between an NPS offender manager and a counsellor when a client is under licence? Where those expectations met in this case?
- To what extent did the NPS offender manager share with Counselling Andrew's offending history and licence conditions? Did Counselling have an adequate understanding of all risk factors in this case?
- Given that Andrew had an NPS offender manager, was being supported by SIAS and by your counsellor, identify any record that appropriate professionals from the three agencies discussed or shared a plan to support Andrew's wellbeing and sobriety. Describe where possible, agreed actions in response to changes in Andrew's circumstances.

Adult Safeguarding considerations:

- Andrew was involved in alleged domestic abuse of his ex-wife and children, in the months before he was sentenced to prison for manslaughter. Identify what awareness Counselling had of this history? (Please distinguish between self-disclosure by Andrew and disclosure by professionals. Identify where possible dates any information was obtained.)
- Explain whether there were any risk considerations recorded as this information was identified.
- Identify any disclosures made by Andrew in relation to his relationship with the victim and contact with her family and friends.
- Consider whether the disclosures impacted upon risk and identify how that risk was addressed.

- Describe the boundaries and limits of client confidentiality during therapeutic counselling in general terms and specifically to this case. Is there any evidence of disclosures made by Andrew that indicated potential risk to himself or others, that were or should, with hindsight, have been shared with other agencies?
- Describe any adult safeguarding training provided to counsellors working with Andrew.
- Describe how Counselling counsellors would identify whether a client was a victim of domestic abuse (or a perpetrator of it) and your policy and procedures in relation to domestic abuse.
- What would be appropriate responses?

West Midlands Police

- Summarise any known domestic abuse history involving Andrew and Claire (including reports/incidents outside the timescales for the review) and also any domestic abuse involving either party and other unnamed individuals.
- Summarise any adult or child safeguarding concerns (including those outside the Terms of reference timescales) involving either Claire or Andrew and their immediate families
- Describe the role of your agency and Integrated Offender Management (IOM) in relation to Andrew. Concentrate on any part of IOM's engagement that identified a risk of domestic abuse to any party and describe any response. Were responses (if any) appropriate?
- Describe how NPS and IOM managed Andrew. Did it represent best practice? If not, explain what could have been done differently. Identify any changes to legislation or processes since the period under review that would improve the supervision of similar offenders upon release

Birmingham and Solihull CCG (Now NHS Birmingham and Solihull Integrated Care Board)

- Describe in relation to the GP practice(s) that Claire and Andrew were registered with, whether IRISi training and Adult and Child Safeguarding Level III training had been completed by those required to undertake it, during the period under review.
- Identify in relation to those practices whether they were IRISi trained (provide dates and a description of the process undertaken.)
- Have the Safeguarding Leads at the practice (or the CCG or IRISi) carried out any audits of domestic abuse awareness and referrals before IRIS was in place and since IRISi training?
- Identify whether during the period under review, any CQC inspection of the practices has raised any observations in relation to safeguarding?

- Concentrating on the known engagements with Claire and Andrew during the period under review identify whether they were in person or on the phone or other medium?
- Describe any opportunities to 'ask the question' in line with NICE guidance; concentrate particularly on whether the GPs/practice nurses had had enhanced IRISi training at the time.
- To what extent was the practice's ability to identify the presence of (or risk of) domestic abuse impacted by COVID related restrictions?
- Comment on any safeguarding flagging / alerts on GP records. Were they appropriate and up to date?
- Identify how the practice(s) could improve their response to domestic abuse?
- Identify missed opportunities to identify Andrew as a possible perpetrator of DA.
- Identify how chronic pain experienced by Claire was managed.

Birmingham & Solihull Mental Health Foundation Trust

- In relation to Andrew, what was the nature of the involvement in May 2020 of the Vulnerable Housing Team?

University Hospitals (Birmingham)

- Comment on any engagement with Claire and Andrew in the context of the domestic abuse policy and procedures existing at the time. Did your professionals ask question in relation to possible domestic abuse?
- If opportunities were missed, identify why and any steps that could be taken by UHB to ensure these opportunities are identified
- In relation to either Claire or Andrew attendances at UHB during the timescales stated in the Terms of Reference, were alcohol or drugs identified as a contributory factor?
- What policies or procedures were available to offer support or signposting to drugs/alcohol misuse services? Were responses in this case appropriate?
- In relation to chronic pain experienced by Claire, identify the part UHN played in managing that condition

Ad Hoc reports:

Reports are requested from:

- Claire's employers
- The Scout Association (Claire was a Scout leader)

6 Summary Chronology

1. Claire lived in Chelmsley Wood and had grown up in the area. Her brother had been at school with Andrew, and he had been known to Claire's family from childhood. The parents of both Andrew and Claire had known each other for many years and drank in the same local pub. In addition, Claire knew Elaine, Andrew's wife; they had worked together for a short period. The families were well known to each other.

2. Claire had two children, Mary (who was an adult at the time under review) from a previous relationship and Jo (a child) who was autistic. The child's father, Kelvin, was separated from Claire but still lived in the family home.

3. The relationship between Elaine and Andrew from the 1990s to 2010 was characterised by Andrew's misuse of alcohol which was of longstanding, and by domestic abuse. He was accused by Elaine's daughter, from a previous relationship, of sexual abuse, although no charges ensued. Both Andrew's son and daughter made reports to Police of his violent and threatening behaviour, and he was convicted of an assault on his son when he was 17 years old.

4. Andrew was arrested on several occasions for domestic abuse and assaults but not charged and was subject to a non-molestation order. Most if not all his offending domestic abuse behaviour happened under the influence of alcohol.

5. In 1987, a local man had gone missing and in December of that year, his body was found concealed in a drain on his property. He had been involved in a drunken altercation with his friend Andrew, who had killed him and concealed his body. This homicide remained undetected until 2011, when following the reopening of the case by West Midlands Police, Andrew admitted to the offence.

6. In November 2011, Andrew was convicted of manslaughter and sentenced to eleven and a half years imprisonment. During his incarceration he was occasionally visited by Claire at the request of his parents. He was released on licence in October 2017, having served six years of his 11 and a half years sentence. However, because the original manslaughter offence had been committed before current legislation, (which ensures that prisoners released early are under licence until the end of their sentence,) Andrew's licence supervision effectively ended on the 20th January 2020, whilst his sentence expired on the 4th January 2023.

7. He was allocated under the Multi Agency Public Protection Arrangements (MAPPA) as category 2, (having been convicted of an offence, manslaughter, listed in the Criminal Justice Act 2003, served more than 12 months in prison) and at MAPPA level 1 in terms of supervision. Level 1 offenders are

managed by a single agency and in Andrew's case, this was to be the National Probation Service (NPS). He was supervised by an experienced offender manager (OM) from the Solihull Office of NPS.

8. He was under licence which included numerous conditions; '*to be of good behaviour, not to commit offences, not to enter a defined exclusion zone (Chelmsley Wood) to reside permanently at an address approved by the supervising officer and obtain permission for any stay of one night or more at a different address.*'

9. Whilst the licence could have required engagement with alcohol support services (a failure could have been a breach) or made sobriety a feature of 'good behaviour', these options were not explored, even though alcohol had been a factor in the homicide. Very significantly the domestic abuse history between Andrew and Elaine, which had involved drunken assaults as the relationship deteriorated and she attempted to separate, was not apparently regarded as an indicator of risk because of the absence of convictions or cautions.

10. The NPS IMR was clear in identifying repeated flaws in assessments in this case. Probation risk assessments going as far back as 2011, did not seek to establish the details of Andrew's domestic abuse or the nature of the non- molestation order and this may have compromised an earlier SARA[1] assessment that indicated he was low risk of violence to partners and others.

11. A consequence of this lack of enquiry, was that NPS missed the opportunity to include a sentence plan objective concerning disclosing relationships. This would have required OM to have been far more alert to new relationships and their potential to be both protective factors, but also triggers for alcohol misuse and reoffending.

12. In late December 2017, Andrew was referred to Counselling by OM. (OM had carried a further OASys assessment. This assessment did not identify relationships as a risk when linked to alcohol misuse.) It was therefore a referral to address wellbeing, through counselling. In all, Andrew received 54 sessions of counselling between 2017 and the end of his NPS supervision period in February 2020. It became clear to the NPS IMR author that OM believed that counselling was achieving a level of

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[1] SARA – Spousal Assault risk Assessment Tool - was devised as an evidence based clinical 'checklist' of risk factors, comprised of 20 key items. The tool is seen as a systematic method of collecting, assessing and combining information into risk assessments - which is defined as 'structured professional judgement. 'SARA alone cannot assess the suitability of interventions or management of risk. However, when undertaken correctly it improves the transparency and consistency of decisions made and draws attention to certain risk factors, raising awareness of their importance in relation to supervision and interventions that may be available. SARA is used to inform all assessments of domestic abuse perpetrators. The use of SARA is a validated assessment tool to ensure that service users are assessed consistently and that any negative impact of bias is minimised. SARA, and the OASys assessment, combined with professional judgement contributes to the defensibility of decisions made about the assessment of the risk of serious harm posed by that individual, and assists in the consideration of how best to manage them.

'supervision' of Andrew's wellbeing, the only area considered significant, without considering that patient confidentiality would preclude the counsellor sharing anything with OM other than risk to self or others.

13. In early February 2018, Andrew informed his OM that he was in an '*intimate*' relationship with a woman, (Claire) who he has known '*many years'* who was a friend of his ex-wife, Elaine. He claimed Elaine was '*not happy about this*' and that Claire had tried to talk to her about the situation, but Elaine would not discuss it. It was claimed by Andrew, that the Counsellor had also been informed about the new relationship, because they had apparently discussed '*strategies*' to deal with the situation.
14. It was evident that Andrew was spending considerable time at Claire's, but this did not prompt OM to explore the situation or challenge the failure by Andrew to have this address agreed with OM.
15. From mid-2018 it was known to OM that Andrew was no longer maintaining sobriety, and he was referred to SIAS, the alcohol support service. His engagement was always poor, and OM accepted Andrew's claims about alcohol consumption and renewed sobriety without any respectful uncertainty or consultation with SIAS who for their part, throughout their engagement, remained unclear about the status of Andrew's engagement with their service.
16. Although Andrew went on to disclose relationship problems with Claire, which included problems with her family and more than once claimed to have broken up with her, these changes in potential risk prompted no professional curiosity or robust supervision by OM. In fact, the frequency of supervision was inadequate by NPS standards, and this was compounded by a complete lack of management scrutiny of the case by OM's line manager for the first 23 months of the licence. This fell short of NPS standards but reflected a picture identified by NPS to be unfortunately typical of the supervision of MAPPA level 1 cases.
17. Claire's daughter Lucy confirmed that Claire had supported Andrew financially and had believed that she could help Andrew rehabilitate and stop drinking. She continued to give him the benefit of the doubt even when he relapsed into heavy drinking. Following clashes and disagreements with Kelvin and Leslie, Claire's father, contact between Claire and Andrew was more discreet. Lucy became estranged from her mother because of her seeming inability or unwillingness to break away from Andrew. With hindsight it is clear he was coercive and controlling and used a process of alternate stalking and persuasion to maintain contact with Claire, even though he was increasingly drunk and aggressive.

18. Immediately before, or shortly after the end of NPS supervision in February 2020, a domestic violence episode occurred. Andrew had come to Claire's to collect tools she stored for him in her shed. He knew Claire was alone; Jo was out, and Kelvin was away at work. When Claire tried to stop Andrew entering the garden, he pushed her back causing her to fall heavily against a wrought iron garden table. He then grabbed her by the neck and threatened her by holding a blowtorch to her face. In fear, she punched Andrew in the face in self- defence. She then ran away and escaped through the house. Apparently, she arrived at Lucy's, spotted with Andrew's blood, and extremely upset.
19. At the end of his period of NPS supervision, Andrew was making no attempt to conceal his alcohol misuse, turning up to his final supervision sessions drunk and claiming to be drinking 30 units of alcohol a day.
20. In the last weeks before the homicide, Andrew was living in a hotel and had become involved in an intimate relationship with a younger male which involved alcohol and drug misuse. This relationship was apparently known to Claire.
21. From September to November 2020, in the weeks before her homicide, Claire had online consultations with her GP (speaking to both GPs, nurses and a locum) disclosing depression, low mood and self- harm. Although the practice had received some IRISi training and could call upon a domestic abuse advocate educator, she was never asked directly about domestic abuse. Referred to Improved Access to Psychological Therapies (IAPT) they similarly failed to discuss domestic abuse. These were significant missed opportunities that occurred close to the homicide.
22. In November 2020, at Andrew's flat, Claire was stabbed multiple time by Andrew and died from her injuries.

7 Key issues arising from the Review

7.1 The supervision of Andrew by NPS: October 2017 to February 2020

1. The Risk Management Plan (RMP) for Andrew, as a MAPPA 1 nominal, appeared to show many of the systemic weaknesses highlighted in an NPS National report and addressed in a new framework for managing MAPPA nominals[2]. It did not appear to be informed by a proper understanding of relevant history and there appeared to be a significant lack of professional curiosity in relation to changes in circumstances, that were likely to impact upon risk, forming and break-up of intimate relationships, changes of address without authorisation, persistent alcohol relapses.

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[2] Policy name: Probation Service Management of MAPPA Level 1 Cases Policy Framework

2. OM's professional practice, appeared to lack genuine understanding of the nature of domestic abuse and of risk indicators, that it is essential offender managers consider. OM seemed to show an almost total lack of professional curiosity, a shortcoming recognised nationally by NPS in the supervision of MAPPA level 1 nominals.
3. The risk management of Andrew did not appear to be adequately informed by his history of domestic abuse, that whilst historic, should have been viewed as relevant. Specific circumstances existed in this case, that meant the earlier history was possibly more predictive of risk than may be the case where an offender desists from domestic abuse for a long period. Andrew spent from November 2011 to October 2017 in prison and so was prevented by incarceration from repeating his alcohol related abuse. With hindsight, Andrew resumed drinking soon after release, his relationship with Claire and her family was quickly characterised by coercive and controlling domestic abuse whilst drunk.
4. The NPS have introduced a domestic abuse pathway that should prompt greater professional curiosity in relation to domestic abuse. The NPS single agency recommendations and DHR recommendation should mean that NPS would be able to provide reassurance to the Safer Solihull Partnership of better practice in relation to the supervision of MAPPA level 1 nominals.

7.2 Alcohol dependency and the management of risk: NPS, Counselling and SIAS

1. Alcohol was a trigger for offending and Andrew's history of alcohol misuse had been identified in NPS risk assessments. This was without doubt the single biggest risk factor related to reoffending and it would be reasonable to expect to see evidence of clear thought in the supervision of this known, serious vulnerability. The licence lacked provision for proper supervision of risk caused by predictable alcohol relapses. The DHR chronology identified multiple examples of OM's apparent failure to manage this aspect of Andrew's licence when there were clear indications that Andrew had lapsed and remained an alcoholic.
2. If Andrew had an alcohol addiction, relapses were likely and were not necessarily a sign of failure. The task of the OM was complex; to be supportive and understanding in relation to alcohol misuse, whilst at the same time managing likely risks resulting from relapse.
3. There is no evidence that OM discussed risk management relating to relapses with SIAS nor that Andrew's lack of genuine engagement with SIAS was identified by OM, who made little contact with SIAS to identify whether any genuine progress was being made. It was left to SIAS to try to discuss their concerns with OM, and the failure to respond to their messages was unprofessional and discourteous.

4. The NPS IMR author engaged with OM to identify how the professional had viewed Andrew's recurrent relapses. '*OM's view was that Andrew was binge drinking and his behaviour was cyclical. OM considered that Andrew's alcohol misuse was related to emotional wellbeing and addressing his psychological state would enable him to manage his abstinence*.'

7.3 Identifying risk from domestic abuse: health professionals

1. Some of the permanent staff and the safeguarding lead at the GPs practice at which Claire was registered, had received the specific training delivered to the GPs practice by Birmingham and Solihull Women's Aid; IRISi (Identification and Referral to Improve Safety) making their failure to ask questions about possible domestic abuse, when face with low mood and self-harm, particularly concerning.

2. In recent years, DHRs in Solihull and across the West Midlands, (including several carried out by the Chair), have identified as key learning that GPs, practice nurses and professionals in Mental Health services are still not consistently 'asking the question' of patients who present with mental ill-health, a key indicator of possible domestic abuse. This therefore is not new learning; it has been a recurrent concern. This DHR again raises the question of how can we ensure that this vital protective measure is undertaken?

3. Whilst the CCG (now the NHS Birmingham and Solihull ICB) have shown real commitment to IRISi and secured funding for its rollout, the referral rates achieved from GP surgeries across Solihull, both during the COVID restrictions but also post lockdown, seem worryingly low. This has promoted the DHR to recommend an urgent review of the current situation concerning how Birmingham and Solihull Women's Aid deliver IRISi training to identify any changes or guidance that could secure better practice in identifying domestic abuse and provide victims better support.

8 Conclusions

1. The management and supervision of Andrew between 2017 and 2020 by National Probation Service was flawed and demonstrated many of the systemic weaknesses the service recently identified in relation to the supervision of MAPPA level 1 offenders.

2. The offender manager involved was experienced and should have shown professional curiosity in relation to multiple pieces of information concerning Andrew's changing circumstances; particularly his relapse into alcohol dependency, that left everyone he was in contact with at greater risk. The response to this change in circumstance was muddled and directionless, relying on professional optimism and an overreliance upon other professionals; a counsellor and SIAS key worker whose

terms of engagement did not permit routine sharing of any disclosures made by Andrew, unless they indicated a clear risk to self or others.

3. NPS have demonstrated a change of practice at local level, that should prevent poor management and supervision of Level 1 MAPPA offenders. In addition, their national level changes to MAPPA Level 1 supervision should provide the assurance that Safer Solihull Partnership would seek in response to the learning from this DHR.

4. The Counselling provision to Andrew was extensive, but there is little evidence that any real change in Andrew's wellbeing was achieved. (The service is no longer commissioned by NPS.)

5. It is not possible to say whether if spoken to, Claire would have disclosed her experience of Andrew's increasingly abusive behaviour linked to alcohol. The NPS Offender managers never attempted to find out any details about Andrew's relationship with Claire, nor did they check to see whether there had been breaches of 'good behaviour', a licence requirement, even when Andrew described possible triggers.

6. In the last few months of her life, and despite COVID lockdown restrictions, Claire's GPs were presented with several opportunities to make safe enquiry relating to domestic abuse. None were taken, which is a real concern. It does not appear to the DHR that the practice of Claire's surgery was an example of 'the exception that proves the rule' in relation to safe questioning, when a patient presents with health issues that could indicate a risk of domestic abuse. Rather it seems likely that GPs in Solihull remain reluctant to ask the question and too readily accept non-domestic abuse related explanations for stress, anxiety, and depression, without enquiring to see if domestic abuse could also be a factor.

7. From the perspective of DHRs, the potential part GPs should play in preventing domestic abuse and supporting victims cannot be overstated. No other agency, except for Police, have such opportunities. It is very disheartening to see that it appears these opportunities are often still being missed. This DHR would urge Safer Solihull Partnership and the NHS Birmingham and Solihull Integrated Care Board and BSWA to identify whether the low referral rates relating to IRISi practices is mirrored around the country and whether a new more prescriptive approach is required.

8. Claire's voice was hard to hear in this DHR, which is more reason to deplore apparent missed opportunities and the frequent lack of professional curiosity.

9 Lessons to be Learned

- **The need for all professionals to show greater awareness of when historic domestic abuse behaviours should be seen as a predictor of domestic abuse risk**
- **In assessing risk, professionals did not exhibit an investigative approach, when changes in circumstances should have prompted professional curiosity and appropriate enquiry**
- **Insufficiently close supervision of a Category 2 MAPPA Level 1 offender by National Probation Service**
- **Missed opportunities by Health professionals to make safe enquiry concerning domestic abuse when Claire presented with health indicators that could indicate domestic abuse**
- **Apparent lack of understanding of the nature of alcohol addiction and over optimism in relation to an adult who is alcohol dependent**

10 Recommendations

This DHR identified missed opportunities by GPs and nursing practitioners and IAPT (Improving Access to Psychological Therapies) to identify possible domestic abuse, in line with NICE Guidance concerning 'asking the question', when the victim presented with self-harm, anxiety and depression, which are key indicators of possible domestic abuse. (This weakness in practice has been recognised as key learning in many DHRs across the West Midlands.)

Recommendation One: **The Safer Solihull Partnership would seek assurances from NHS Birmingham & Solihull Integrated Care Board and Birmingham and Solihull Women's Aid (BSWA) who deliver IRISi, that they will review the effectiveness of the IRISi programme to identify why referral rates are low and support all necessary improvements to recognise and respond to victims of domestic abuse more effectively.**

Action one: NHS Birmingham and Solihull Integrated Care Board should receive assurance from Birmingham and Solihull Women's Aid who deliver IRISi (Identification and Referral to Improve Safety) in Birmingham and Solihull, that they have conducted an immediate review of referral rates to IRISi advocate educators by GP practices and engaged with all practices deemed to be infrequent/low referrers to offer an action plan to improve confidence in 'asking the question'

Action two: NHS Birmingham and Solihull Integrated Care Board should request their IT Team identify available functionality within the health record systems used in GP surgeries (Systemone and EMIS) that would assist GPs and nurses to demonstrate they are 'asking the question' when a patient presents with the NICE guidance health indicators that could mean they are experiencing domestic abuse

Action three: The Safeguarding Assurance tool used to report to NHS Birmingham and Solihull ICB should be updated to allow GP safeguarding leads to provide evidence of compliance with NICE Guidance on 'asking the question'. This should include:

- Policies and procedures in place which support the staff with 'asking the question' concerning domestic abuse
- The practice working in line with NICE Guidance and compliant with Recommendation 5 of that guidance; creating an environment that assists disclosure of domestic abuse
- The surgery being able to evidence that practitioners are consistently 'asking the question' when a patient presents with health conditions that could indicate they are experiencing domestic abuse.
- Providing a summary of monitoring processes

Action four: BSWA should work in partnership with the Safeguarding Team at the ICB to identify, highlight and share good practice in relation to iRISi and Domestic Abuse across Birmingham and Solihull Primary Care.

Recommendation two: The Safer Solihull Partnership would seek assurances from Birmingham and Solihull Mental Health Foundation Trust that they engage with Mental Health teams and support any necessary improvements needed to recognise and respond to victims of domestic abuse.

Action: BSMHFT should identify how routine questioning in line with NICE guidance in relation to domestic abuse, could be enhanced and measured by adapting current risk assessment tools to include mandatory fields.

The DHR identified that the management of the perpetrator's licence as a Level 1 MAPPA nominal, exhibited many of the weaknesses identified by NPS in practice nationally.

Recommendation three: The Safer Solihull Partnership recognises that the National Probation Service (NPS) have published a new National framework for the Management of Level 1 MAPPA Cases, that once implemented in the West Midlands, could reduce the risk of the unsafe

management of an offender, that occurred in this case. The Partnership would seek assurance from NPS that this Framework will be adopted in the West Midlands without delay.

Action: NPS to provide SSP with a timescale for the implementation of the Framework for Management of Level 1 MAPPA cases and report to the SSP when that Framework is in place.