2022

Domestic Homicide Review: Claire (November 2020)

SAFER SOLIHULL PARTNERSHIP (COMPLETED 12TH AUGUST 2022)

SIMON HILL INDEPENDENT CHAIR

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Family statement

My mother was kind, warm hearted, loving, compassionate, trustworthy, loyal, and more. All of the qualities you could ask for she had. She was also very strong willed, stubborn, passionate, funny, and the life and soul of the party. She had the most warming smile and made a stranger feel like a friend.
Her heart was almost too big sometimes!
As my sibling said in his speech at her funeral, she was truly an Angel before she gained her wings. She had so much time for people, particularly the vulnerable. She would help anybody in need, and nothing was ever too much for her, she would go out of her way to help people even if it was a cost to her and she eventually paid the ultimate price for her caring nature.
She was a family girl through and through, she lived for her children, parents and grandchildren they were her whole life. She enjoyed spending time with family, and taking holidays at her much-loved caravan, somewhere she called her happy place. After holidaying in Burnham-on Sea for many years, she always wanted to buy a caravan there of her own and so in 2017 she finally did and would go for the weekend every chance she could. She loved taking her grandchildren to the caravan for the weekend and spoiling them.
In her spare time, she loved to read, she was a big book worm, and she would often spend her days off in Costa, with a coffee and a good book. She loved planting beautiful flowers and plants in her garden and enjoyed growing tomatoes, strawberries, and cucumbers with her grandchildren. She also volunteered for many years as a scout leader and would enjoy organising meetings and events for the scouting children.
she was always the hostess and loved to have the family round for Christmas dinners and BBQ's and would go the extra mile to make things perfect for everyone.

She would do anything for anyone, she went without to make sure others didn't her whole life. She made such an impact on so many people's lives and that showed in a news article that came out shortly after her death about the hundreds of tributes that flooded in via social media from people in my mother's local community,

that knew her through various places of work or her time as a scout leader and all had such nice things to say about what a wonderful person she was.

She was the heart of our family and without her we feel so lost.

There is a huge hole in our hearts that will never be filled. She was the most amazing Mother to my sibling and I and we are just so grateful she was ours for the short amount of time we had her.
There are no words that can really explain the complete horror and suffering our family has endured since we lost our mom and will continue to feel for every minute of every day for the rest of our lives.

1 Introduction

1. The Safer Solihull Partnership wishes to express its' sincere condolences to Claire's family, friends and colleagues for their tragic loss. We would wish to put on record our gratitude for Lucy's willingness to engage with the DHR and represent the views of family at this difficult time
2. This report of a domestic homicide review (DHR) examines agency responses and support given to Claire, a resident of Solihull prior to the point of her death in November 2020. In addition to agency involvement, the review will also examine the past to identify any relevant background or relevant history of abuse before the homicide. It will consider whether support was accessed within the community and whether there were any barriers to accessing that support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.
3. In November 2020, Police were called to an address in Erdington, where they found Claire (born March 1969) in the bedroom of her ex - partner's flat. She was found lying upon her back with several stab wounds. Although officers attempted CPR, she was pronounced deceased by paramedics. Her ex-partner, Andrew, (born February 1968) was present at the address and was immediately arrested on suspicion of her murder.
4. The Review considered agencies contact/involvement with Claire and Andrew from January 2017, the point the perpetrator was released from a prison sentence and was on licence, until the date of Claire's homicide, in November 2020. All agencies were encouraged to include detail of any antecedent history outside this period that they considered was relevant to wider understanding of safeguarding risks

5. A DHR is undertaken to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely as possible, professionals need to understand fully what happened in each homicide, and most importantly, what needs to change, to reduce the risk of such tragedies happening in the future.

2 Timescales

6. 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

3 Confidentiality

7. 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

8. All statutory partners of the Safer Solihull Partnership have signed up to an information sharing protocol that permits the sharing of information between agencies for the purpose of sharing information in the prevention and detection of crime. IMR authors are requested to sign a confidentiality agreement.

9. Agencies should be aware that any information / documentation submitted as part of the Domestic Homicide Review may become disclosable in any criminal trial. The Crown Prosecution Service would adhere to the regional protocol that is in place to manage such disclosure requests.

10. The following principles should be complied with at all times:

a) We only share the minimum information needed to inform the completion of the review.
b) If personal or sensitive information is shared by email it is sent by secure encrypted email.
c) Information should not be stored on laptop computers or other similar devices unless the equipment is encrypted.
d) Printing and the storing of documents should be in a controlled environment and secure to prevent disclosure of confidential material.
e) If paper copies are used and stored, then they must be secured and out of sight, preferably under lock and key
f) Paper copies MUST be disposed of by shredding or incineration

4 Terms of Reference

11. 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?

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?

- *Can you provide a summary of the role and expectation of your organisation in identifying and responding to domestic abuse?*
- *Concentrate on any missed opportunities to identify and support either party in relation to domestic abuse*
- *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.*
- *What needs and vulnerabilities did your agency identify in Claire (the victim) and how did your agency respond?*
- *What needs and vulnerabilities did your agency identify in Andrew (the alleged perpetrator) and how did your agency respond?*
- *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.*
- *If domestic abuse was not known, how might your agency have identified the existence of domestic abuse from other issues presented to you?*
- *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*
- *Can you identify areas of good practice in this case?*
- *Are there any service changes planned or happening that might have affected your agency's response?*
- *Are there lessons to be learnt from this case about how practice could be improved?*
- *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? Were 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?

<u>West Midlands Police</u>

- Summarise any known domestic abuse history involving Andrew and Claire (including reports/incidents outside the timescales for the review) and 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 releas

<u>Birmingham and Solihull CCG (Now NHS Birmingham and Solihull Integrated Care Board)</u>

- 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.

<u>Birmingham & Solihull Mental Health Foundation Trust</u>

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

<u>University Hospitals (Birmingham)</u>

- 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 were requested from:

- Claire's employers- to establish what, if anything, she had disclosed about her domestic situation however they declined to engage with the review.
- The Scout association- (Claire was a Scout Leader) in relation to safeguarding training and domestic abuse support and responses.

5 Methodology

12. The Safer Solihull Partnership received formal notification of the homicide from West Midlands Police in November 2020, and partners were informed of the death with instructions to secure files where necessary. The Safer Solihull Partnership Chair sat on 09th 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

6 Involvement of family, friends, work colleagues, neighbours, and wider Community

13. The DHR contacted Claire's daughter, Lucy, Kelvin, the father of Claire's youngest child, Jo, and Claire's father, Leslie, in writing and the invitations to be involved with the DHR were delivered by the West Midlands Police Family Liaison Officer (FLO) in July 2021. They were sent with the Home Office explanation of the DHR process for families and details of advocacy services. Due to working practices relating to COVID, we were unable to offer face to face contact initially. Following panel meetings, further letters were sent to the family in November 2021.

14. In March 2022, Lucy, Claire's daughter agreed to meet with the DHR Chair. She explained that when first notified of the DHR, she and the family had not felt able to engage, but after a period of counselling, she personally was now finding it easier to talk about her mother's life. She stated other members of the family were not likely to feel able to engage with the DHR. Although the DHR had reached the stage where the

Overview report was being considered by the panel, Lucy was consulted about the Terms of Reference of the DHR and was able to comment on them.

15. The DHR liaised with the allocated Victim Support worker, however the family whilst having preliminary telephone conversations with an advocate, had chosen not to engage with the service, because they had received support from counselling.

16. No friends of the family were identified who expressed an interest in involvement with the DHR.

17. It was known that Claire and Kelvin were Scout leaders and therefore the Chair wrote to the Scout Association. They were unaware of any reported domestic abuse or safeguarding issues.

18. Claire's employers were contacted by the Review; however, they chose not to engage with the DHR process and therefore it is not possible to identify the level of awareness they had in relation to her mental ill health and any links to relationship concerns or domestic abuse.

19. The DHR panel felt no useful insight would be gained by engaging with the perpetrator and the victim's family were made aware of the decision.

7 Contributors to the Review

Individual Management Reviews (IMRs) were required from:

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

8 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	NPS- 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
University Hospitals Birmingham	Maria Kilcoyne/Pam Rees	Adult safeguarding Leads
Solihull Metropolitan Borough Council	Alex Cerruti/ Harry Carter – Community Safety Team	DHR coordinators
2 Hills Consultancy Ltd.	Sonya Hill	Research and administrative support

20. The panel members were entirely independent and had no decision-making or management role in any of the events in this case.

21. Birmingham and Solihull Women's Aid as commissioned providers in Solihull are always expected to be represented on DHRs, but because of exceptional demand at this period, they did not have capacity to be represented on this review. The panel felt that the Domestic abuse Lead had specialist knowledge of the subject area and was assessed to be more than qualified to identify issues related to gender-based violence and barriers a victim may face.

9 Author of the Overview Report

22. 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.

23. 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. Over the last eight years he has chaired numerous DHRs and SARs in the West Midlands region.

10 Parallel Reviews

24. Her Majesty's Coroner opened an inquest in November 2020 which was adjourned pending the outcome of the criminal investigation. The inquest concluded Claire's death was an unlawful killing and that she had died as a result of stab wounds.

11 Ethnicity, Equality & Diversity

25. Claire was a white female who was born and grew up in the neighbourhood in which she lived at the time of her homicide. There is no evidence available to the DHR that any of the protected characteristics were relevant in this case. Claire accessed primary and secondary health services appropriately and was an active member of her community, involved in community groups and the Scout movement, helping both vulnerable adults and children access support.

26. Claire was 51 at the time of her death and therefore was in an age group (50+) considered by some studies[1] more likely to be reluctant to seek help in relation to any experience of domestic abuse when accessing health services. However, most recent studies have concentrated upon elder abuse and considered the 60+ age group, making it hard to draw any reliable conclusions on age as a factor in this DHR.

12 Dissemination

27. The DHR will be shared with partner agencies contributing to the Review, the members of the Safer Solihull Partnership and IRISi in relation to the recommendations and findings.

[1] Julie McGarry et al : The impact of domestic abuse for older women: a review of the literature. (Health & Social Care in the Community 2011)

28. The DHR will be shared with the West Midlands Police and Crime Commissioner and Domestic Abuse Commissioner's Office.

13 Background information (the facts)

29. 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. Andrew had a previous conviction for manslaughter, having been released from custody in relation to that offence in October 2017.

30. Claire lived in Chelmsley Wood and had grown up in the area. She had three older siblings. 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.

31. Claire's daughter, Lucy (born 1990), went to the same school as Andrew and Elaine's son, Steve. Lucy and Steve became friends at school and spent a lot of time in each other's homes. Lucy explained because of her visits, she had realised in her teens that Andrew had a *'drink problem'*. She recognised that Steve seemed to relish spending time with her family, and it was only with hindsight that she recognised it represented an escape from a home life where domestic abuse and drunkenness were commonplace. Although Lucy and Steve developed different friendship groups as they grew up, Steve remained a family friend; he was always welcome at Claire's and would visit to help her out with IT issues. The willingness to support young people was at the heart of Claire's character. She would always go to lengths to make people feel safe and supported.

32. Claire separated from Lucy's father when her daughter was young. She had a subsequent relationship with Kelvin, who was father to their child, Jo (born in 2004). Their relationship started when Lucy was young and they remained sharing the same home, until Claire's murder. Claire worked as a dental receptionist.

33. Kelvin and Claire were involved in the Scouting movement; Claire was a scout leader from 2015 until her death. She enjoyed relaxing and unwinding at a caravan she and Kelvin had permanently pitched on a site by the sea, a couple of hours from home.

34. According to Kelvin, their relationship ended in October 2017; however, they chose to remain cohabiting to bring up Jo, who had been diagnosed with autism. Claire organised the family's finances and Kelvin contributed to the family's expenses. Their relationship remained 'close' in Kelvin's opinion. Kelvin was a

builder, and his work took him away, so that in the years under review, he was only at home a few days a week, usually at weekends.

35. Lucy described her mother as passionately committed to helping anyone she sensed needed support because of their individual vulnerabilities. Over the years, several young people who were struggling were supported by Claire and became friends. Claire would never give up on anyone who asked for her help. Lucy described her mother as '*too nice for her own good*.'

36. It is of note that when Claire started to see Andrew, her relationship was not hidden from Kelvin or the family. It was Andrew's mother and father who persuaded Claire to go and visit him in prison. It is evident that Claire was very close to Andrew's parents, and that they recognised Claire could be a positive influence on their son, having been a friend of the family for so long. They went as far as describing Claire and Andrew as '*soulmates*.'

37. Kelvin first met Andrew when he came to a family gathering at Christmas 2017. Lucy recollected that the whole family, including one of her friends, had played card games and it had been a jovial evening, where everyone but Andrew drank. He refused alcohol; Lucy remembered he commented on pink gin, saying he was '*not nice around drink'.*

38. It is not clear when a relationship started between Andrew and Claire, but by January 2018, he was frequently at the family home. In his statement to Police, Kelvin described him as a 'lodger' from this point, which suggests a significant degree of permanence. Lucy and her husband, in conversation with the Chair described Kelvin as '*laid back'*, accepting an arrangement that many others may have found unacceptable. He was sharing a home with Jo, who was 13 years old, and occasionally, Jo's father. Andrew was on licence and should have been residing at his authorised address. (His licence excluded him from Chelmsley Wood, however Claire's home address was just outside the exclusion area.)

39. Lucy, Claire's daughter, was married and had two children, whom Claire was close to, however the relationship between mother and daughter was strained by the arrival of Andrew, who it seems the entire family grew to distrust and dislike, given his drinking, his aggressive manner and history. Lucy questioned why her mother would get into a relationship with Andrew, because of his past, but initially, she wanted to '*give things a chance, for mum's sake*', because at least early in the relationship, her mother seemed to her to be genuinely happy in Andrew's presence. Once it became evident to them all that Andrew was drinking again, (from mid-June 2018) and Lucy became aware of the significant emotional impact on Claire, she tried to persuade her mother to break away from him.

40. Claire's father and Kelvin described in their police statements domestic incidents involving Andrew. It is hard to be clear when they occurred, but it seems likely they were in 2018. None were reported to Police, nor did they become known to Police offender managers or the National Probation Service, or agencies working to support Andrew, such as the counselling service or SIAS alcohol services. What is known about these episodes, will be considered in detail in the chronology and the analysis will try to possibly identify why these incidents were never reported.

41. Andrew had a history of offending; in the 80s, as a youth, he had been convicted of assault with intent to rob, and theft dwelling.

42. Andrew started a relationship with Elaine in the 80s and was with her for 9 years, before marrying. They went on to have two children together, and Elaine had a daughter from a previous relationship. In 1999, his stepdaughter made serious allegations against Andrew, which were recorded as a crime but did not lead to a criminal charge. Police records of the investigation are sparse and do not provide further background details. The allegations appear to have caused a rift and the continuing presence of Andrew in the home led to the daughter being estranged from her mother, only reconnecting with her and her half siblings after the relationship between her mother and stepfather broke down, in around 2010.

43. In 2006, Andrew's son Steve, who was 17, twice called for police assistance as his father was drunk and arguing with his mother, who was asking for a divorce. Andrew was described by his wife as a '*heavy drinker'* and had been for most of their time together. When intoxicated, which was a frequent occurrence, he would be verbally and sometimes physically aggressive. The police record described Andrew as an alcoholic.

44. Later that year, Andrew's son alleged an actual bodily harm, (ABH) when he was assaulted by his father, who had kicked him to the lower legs. Andrew had been drunk at the time of the assault and had started an argument with his son. He was convicted of this offence. The National Probation Service (NPS) Individual Management Report (IMR) reported that at the time, Children's Services considered Andrew a person who poses a risk to children (PPRC).

45. It is also evident from information obtained by police during this period, that Andrew had not worked since the mid-nineties, and he continued to be largely workless until the homicide. It was not until 2010, that Elaine reported domestic abuse on her own account, but it is evident that drunken, abusive behaviour continued between 2006 and 2010.

46. In 2010, Andrew was the perpetrator in several domestic abuse incidents reported to the police. Andrew was usually intoxicated during these episodes. These involved physical abuse of both Elaine and her daughter. Andrew became suspicious of a friendship between Elaine and a male acquaintance and used his daughter to pass on his threats to kill Elaine and her friend.

47. Once the couple separated, Andrew continued to harass and threaten Elaine, and turned up uninvited at the former family home on several occasions, leading to Elaine seeking, and being granted, a non-molestation order. Thereafter, Elaine reported to the Police two separate breaches of the non-molestation order, involving threats and threatening texts and the incidents lead to arrests.

48. The West Midlands Police IMR noted Andrew was arrested for reported offences on a number of occasions, but not charged or cautioned. Given the time that has elapsed, the available police records make it hard to judge if there were missed opportunities over this period to secure such convictions or cautions. The DHR panel recognised that Police appeared to have responded appropriately, viewed in the context of domestic abuse practice and procedures during that period.

49. Andrew's alcohol misuse continued to be a catalyst for offending. In June 2011, he was convicted of theft and burglary from Chelmsley Wood police station and his sentence included a requirement to undertake a six-month alcohol treatment programme.

50. In November 2011, Andrew was convicted of the manslaughter of a 17-year-old male who had first been reported missing from an address in Chelmsley Wood, in August 1987. In December 1987, the body of the victim was finally discovered, concealed below a manhole in the house's sewage drainage system, wrapped in bed clothes and weighed down with tyres. Andrew was interviewed and stated he had seen the deceased in August 1987 but could not think of any reason why anyone would harm him.

51. The homicide remained undetected until West Midlands Police started a 'cold case' review of the death in 2009. Police re-visited witnesses (not Andrew), but the renewed Police investigation appeared to trigger a response in Andrew, who in 2010 told a friend, whilst drunk, he had killed the victim. Although the friend subsequently passed away, he had repeated the disclosure to others and word of it reached the victim's brother, who notified Police in February 2011. Andrew was approached by police and forcefully denied his alleged confession. However, in July, he called Police and asked to confess because '*he could not live with himself any longer*'.

52. Andrew explained he had been with the victim at his house when an argument started. It transpired that the young victim was the sole occupier of his home, following the recent death of his father. Andrew had been a friend of the deceased's father and had a high regard for him, a feeling not shared by his son. Whilst drunk, the two youths began to argue when Andrew felt his friend was disrespecting his father's memory. Andrew said he punched the victim on the chin. They parted and Andrew went downstairs to 'sleep off' the alcohol. His friend appeared sometime after, and the argument resumed. In Andrew's account, a fight ensued, where the victim picked up a spade and in self-defence, Andrew picked up a length of handle from a trolley jack and delivered a single fatal blow to the head. Some hours later he concealed the body, which was not found for some months. In November 2011, Andrew was sentenced to eleven and a half years imprisonment for manslaughter.

14 Chronology

53. Claire was in contact with Andrew, visiting him as he served his prison sentence for manslaughter. 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 February 2020 whilst his sentence expired on the 4th January 2023.

54. The supervision of Andrew's licence will be considered in the analysis, however upon release 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.

55. Level 1 offenders are managed by a single agency and in Andrew's case, this was to be the National Probation Service (NPS). The terms of his release were appropriately shared between NPS and Police Offender Managers of West Midlands Police so that there was a shared understanding of licence terms and Andrew's approved addresses.

56. Released to an 'approved premises' in Birmingham, he was subject to close supervision until December 2017, when he moved to a NACRO provided accommodation. 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.*'

57. The licence included the provision '*to comply to give a sample of oral fluid/ urine in order to test whether you have any specific class A, Class B drugs or alcohol in your body for the purpose of ensuring that you are complying with condition of your Licence to be of good behaviour.* '

58. The licence conditions were re-iterated to Andrew by hostel staff, and he was subject to alcohol and drugs testing every two to three days. During this period each test was negative. He was seen by his offender manager (OM) in late October, where he was interviewed and assessed under the OASys[2] process as medium risk. The initial areas identified as 'linked to risk of harm to other…. (included) alcohol, emotional wellbeing, lifestyle and associates, relationships, accommodation, thinking and behaviour.'

59. In December 2017, Andrew registered with a GP. In what was considered good practice in the CCG IMR, the GP held what was called a 'bonding consultation' with all new registrations. Andrew declared he did not consume any alcohol. Although the GP knew Andrew had been in prison, he was unaware of Andrew's history of alcoholism and did not know alcohol relapse prevention work had been undertaken with Andrew in custody. Had the GP known, Andrew could have been referred to a relapse prevention programme.

60. Once he moved into NACRO accommodation (a group of five self-contained flats in a house in Edgbaston) he spoke openly to his OM about having '*almost*' bought alcohol from an off- licence. His self-management was seen as a positive sign, but it was felt a referral to a Counselling Service could be helpful and Andrew agreed because he described loneliness, separation from his family and financial concerns. Andrew was informed any overnight stays with his parents needed to be authorised.

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[2] The Offender Assessment System (OASys) is the recording of the assessment of the risks posed by, and needs of, an offender. Its purpose is to act as a tool to support the Offender Manager in managing the sentence, in custody and into the community, and specifically in order to assess the likelihood of re-offending; identifying offender related needs, identifies risk of serious harm to the public, individuals and other risks.

Within OASys, the Offender Group Reconviction Scale (OGRS) estimates the percentage probability of proven reoffending for any recordable offence, within 1 year and 2 years based on static factors, such as age and gender and number of previous sanctions. Offender General Predictor (OGP) and Offender Violence Predictor (OVP) will have been calculated and these incorporate dynamic factors. Offenders with higher OGRS scores are more likely to commit further violent offences, OVP is an improved violence risk estimate. These percentages are categorised into bandings of low, medium, high and very high likelihood of reoffending for any type of offence (OGRS) or violent offence (OVP).

The OASys assessment is completed on all offender's subject to National Probation supervision at commencement and reviewed where significant changes occur in an offender's behaviour.

Regardless of a Domestic violence offence, an offender's relationships will be reviewed within OASys and an assessment as to whether relationships are linked to a serious risk of harm and re-offending. Where a risk of harm and/or re-offending is identified, further investigation in relation to Police intelligence re call out, enquiries through MASH / Social service will be undertaken and appropriate action taken to address domestic violence / relationships through the sentence plan.

61. In late December 2017, he was referred to Counselling. OM had carried a further OASys assessment. The assessment did not identify relationships as a risk when linked to alcohol misuse. It seems therefore that the Counselling referral related entirely to alcohol, emotional resilience, and wellbeing. In January 2018, Andrew attended his first session, and it was to be the start of a lengthy engagement with the service, with 54 sessions from January 2018 to February 2020. Andrew was also seeking employment by undertaking a forklift driving course.

62. 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 discussed '*strategies*' to deal with the situation.

63. Lucy was clear that early on, Claire was offering moral and financial support to Andrew; buying him an ipad so he could '*look for work'*. She would pay Andrew to carry out repairs and work around the house. It appears that Claire was generous financially and supportive of Andrew and he took full advantage.

64. Whilst it was good practice by the OM, in response to this information about a new relationship, to inform the Police of Claire's address, in order that an appropriate marker could be added in case of call outs, there is no evidence that the information sharing led to that marker being placed by the Police and the WMP IMR writer could find no record of it.

65. The NPS IMR noted; *there is no evidence on the case notes re discussion by OM with Andrew regarding the management of this new relationship and contingency planning / risks if the relationship didn't work out and alcohol consumption.'* The licence did not explicitly link 'good behaviour' to total sobriety; whilst the testing regime in the approved accommodation required this, it does not seem the requirement was an expectation, once Andrew moved into supported accommodation. NPS guidance on alcohol licence conditions explains; 'the *condition to be of good behaviour contains sufficient power to request recall in those cases where risk is unacceptable after alcohol consumption or where an offender is ejected from an Approved Premises for consuming alcohol.'*

66. From January and for the next few months, counselling occurred on an almost weekly basis. Kelvin described Andrew as a '*lodger*' by then, so it seems a fair assumption that he spent many nights at Claire's. The OM, in supervision, appeared to demonstrate a lack of professional curiosity in relation to Claire and Andrew. Having had been told theirs was an intimate relationship and despite a requirement of the licence

being Andrew should reside at an approved address, there was no attempt to check how often Andrew was staying overnight at his address, as opposed to Claire's. This may have served to lead Andrew to believe it was not an issue for the OM.

67. In late February 2018, Andrew moved to a shared home which was close to his parents, (but also closer to Claire's address). He had a key worker at this address, but the NPS IMR could find little evidence of liaison between the key worker who had a duty to monitor Andrew's licence compliance, and OM.

68. In late April 2018, Andrew shared with his counsellor that a housemate had unexpectedly died. He had spent the day with his family, but because they were drinking, he found this hard and became annoyed. He saw his OM that day, but as the NPS IMR noted, on the electronic system, nDelius, used by NPS (to which the Counsellor would have had access during the period of engagement with Andrew), there was no record of; *'the OM's interaction with Andrew regarding the sudden death of housemate, re analysis of the situation and impact on him and potential risk escalation relapse into alcohol use.'*

69. In early May 2018, Andrew arrived at a counselling session drunk, disclosed that he had been drinking for '*a while'* but wanted to stop and was sent away by the counsellor with the instruction to return the next day, sober. The counsellor identified this as a risk to Andrew and correctly shared this with OM. The following day, Andrew and the OM discussed his drinking. He described the frequency and quantity of his drinking, and OM raised options; abstinence/social drinking? Andrew was clear that he became argumentative when drunk and that Claire had stated she would end the relationship if he continued to drink.

70. OM referred Andrew to Solihull Integrated Addiction services (SIAS) (the Community alcohol support service for the area.) This was a voluntary referral, but as later events indicated, it does not appear that OM discussed with the SIAS keyworker allocated Andrew's case, the licence terms, in relation to alcohol testing or emphasise the voluntary nature of Andrew's attendance. There was no recorded discussion of Andrew's known risk of violence associated with alcohol and the potential impact of alcohol upon relationships, nor how any change in the risk assessment of Andrew should be managed, given his apparent relapse. The SIAS engagement was not intensive and with hindsight it appears they had little or no knowledge of Claire's place in Andrew's life.

71. The following week, at a review with the OM, post counselling, Andrew presented a more optimistic picture, stating he had an appointment with SIAS and was committed to abstinence, and assured the OM

he had not drunk since the week before. There seemed to be a consistent lack of respectful challenge in relation to such claims by Andrew.

72. In early June 2018, OM conducted a further OASys review and Andrew was considered to remain medium risk. There were no further OASys reviews during the licence period. Having engaged with his SIAS key worker on 'Life Change' to develop a care plan, Andrew arrived drunk at a group education class at the end of June 2018, and in the break went and bought a can of lager.

73. The SIAS keyworker informed OM and they discussed the terms of the licence. Birmingham & Solihull Mental Health Foundation Trust (BSMHFT) commission SIAS, and their IMR recorded that the SIAS worker was then told by OM there were no conditions relating to alcohol. This was not strictly accurate; testing was allowed under the licence. However, it could be argued this was not materially relevant; Andrew was known to be drinking and testing would only have been helpful if he claimed to be sober, but there was significant doubt, or it was felt to be helpful to prove sobriety. The discussion was not focussed upon the actual change in risk; alcohol misuse was always present in Andrew's offending and violence, and in a two-month period he had twice been drunk at scheduled sessions. Professional curiosity should have prompted a consideration of Andrew's likelihood of being drunk more frequently than he was admitting.

74. When the OM supervised Andrew a few days later in early July, OM appeared to clearly identify to Andrew the risk alcohol misuse posed; that if alcohol got out of control it could lead to re-offending and risk to his liberty. There is no record that the OM considered these elements with SIAS, and the NPS IMR is clear,' *OM did not establish the treatment plan with SIAS or maintain contact with SIAS key worker.*' Andrew explained that '*if he was told he cannot drink, he wanted to drink more, and therefore he planned to wait until Claire returned from work to have a social drink with her.'* This appeared to indicate clearly that he was spending time at Claire's address, even when she was not present, but did not prompt further exploration of the part Claire played in supporting Andrew.

75. The next day, in a session between the SIAS keyworker and Andrew, he was offered recovery medication but stated he intended to follow the path he described with his OM the previous day. Between July and September 2018, Andrew did not engage with any SIAS services. The SIAS keyworker had not understood that Andrew's engagement with SIAS was voluntary and not a specific term of the licence and made repeated attempts to speak to OM, with no success. At the end of August, another offender manager told the key worker that there were no alcohol testing requirements as part of the licence, only drug testing.

This was factually inaccurate but missed the key issue in relation to risk. Andrew was clearly not engaging and was by his own admission drinking and on the evidence of his attendance at SIAS, probably to excess.

76. From his police statement, Kelvin described an incident of unreported domestic abuse involving Andrew that appeared to be from around June/July 2018. Andrew had been drinking and Claire was on the phone to a friend involved in Scouting (who has since passed away). Andrew was allegedly shouting abuse about the friend, to which Kelvin objected. Kelvin asked him to keep his '*gob shut*.' Andrew then walked toward Kelvin calling him '*old man'* saying; '*what are you going to do about it*?' and then '*wrapped his arm around his neck*.' Lucy felt that Kelvin, who always hoped to '*get back together'* with her mother, would have respected Claire's instruction or request not to report the incident or disclose it to the police or even to Lucy. For her part, Lucy said had she known of any domestic abuse occurring, she would have reported it, because she knew Andrew to be on licence and any reported incident may have led to a recall.

77. When in September 2018, OM accepted Andrew assertions that he has been provided sufficient strategies by SIAS to limit his alcohol consumption and that he was now only socially drinking, thanks to Claire's support, this should have been checked in a conversation with SIAS keyworker. Given the frequent attempt made by SIAS keyworker to speak to OM in July and August to share concerns about a lack of engagement, this failure seems unprofessional.

78. It is a feature of this period that although OM and in particular the counsellor, but also to a more limited extent, the SIAS keyworker, were all actively engaged with Andrew, they did not, because of their different roles and confidentiality requirements, meet to make any dynamic risk assessment around Andrew's alcohol consumption.

79. For their part, the counselling service's information pack provided to OMs on commissioning, made it clear the only circumstances in which they would breach confidentiality and that would require an identifiable risk to the service user or others. A failure to maintain sobriety would be seen as a development requiring further support, not in the context of the limited and incomplete information provided by OM, as an immediate risk.

80. It could be argued that it was naïve to believe that a service user with a long history of alcohol misuse, could limit his drinking to social occasions without alcohol service support. Andrew was able to tell each professional what he felt they needed to hear, without professional curiosity or respectful challenge. He was discharged from SIAS in September, with OM's agreement.

81. The same month, OM was made aware that a member of IXION (a non-profit training provider where Andrew was attempting to obtain a traffic management qualification) had reported Andrew being extremely rude to her. There was no exploration of the apparent causes of this outburst.

82. In early October 2018, Andrew was de-registered from Integrated Offender Management (IOM) and remained subject to his earlier MAPPA category and level of supervision.

83. The next day, Andrew attended OM's office to collect his work card, accompanied by Claire. There is no recorded evidence of any engagement between OM and Claire. Whilst it is not possible to know whether Claire would have been open about Andrew, or whether Andrew would have resisted such contacts, this appears to be a missed opportunity. There is no evidence this opportunity to engage with Andrew's partner ever occurred again, or was actively considered by OM.

84. This became an even more significant missed opportunity, in the context of admissions made by Andrew in a supervision session with OM, only a week later. He believed his relationship with Claire was over. He disclosed that he had been staying at Claire's house, but that her ex-partner lived there and that this '*caused some issues*'. Claire had asked him to stay at his own flat until these issues were '*sorted out*'.

85. Lucy explained to the Chair that in October 2018, her mother called her in tears, stating; *'I can't do this anymore'*. Andrew had been drinking and it is Lucy's belief that some form of domestic abuse, very possibly physical abuse, had occurred, although Claire did not disclose this. Up until this point, Claire had been supporting Andrew financially, allowing him to drive her car, because he had limited means. Lucy stated that Claire '*threw Andrew out*'. From this point on, Andrew did not stay in the home, but he was still in contact with Claire who Lucy said; '*did not admit defeat easily'.* In-spite of her daughter's increasingly bewilderment that her mother would still stay in touch with Andrew in view of his drinking, Claire appeared to always try and help him and give him a further chance. With hindsight, Lucy recognised it was more because Andrew was controlling and coercive and in Lucy's view '*stalked'* her mother once they split up.

86. Andrew's previous behaviour during his marriage and relationship breakdown, worsened by alcohol, should have served at least as a predictor of potential risk, but as will be established in the analysis, this crucial part of Andrew's antecedent history was never given sufficient weight by NPS or Police, in assessing risk. This disclosure of a relationship ending, should have prompted discussion about the risk of offending, and it could be argued that professional curiosity should have prompted consideration of checks with the police or indeed with Kelvin and Claire.

87. Andrew reassured OM that he had discussed the situation with the counsellor and had agreed strategies to manage this change in circumstance, without alcohol. It is of note that in their report to the DHR, the Counselling service reported that the therapist, who conducted over fifty, one-hour sessions with Andrew declared; '*I am not aware of the details of the relationship Andrew had with the deceased*'. In conversation with the Chair the counsellor indicated that the therapy provided supported Andrew to address his emotions and feelings about his relationships to the extent and level he chose.

88. The changed circumstances were not discussed between OM and the counsellor presumably because OM did not see this a change in risk. The counsellor would not have expected or encouraged such a discussion, which could have breached client confidentiality. The management of this development was the responsibility of OM.

89. Two weeks later, IXION reported Andrew had turned up for an appointment concerning work opportunities, whilst under the influence of alcohol. Andrew denied drinking that day but stated he '*may*' have been drinking the night before. OM did not challenge this, but expressed disappointment, whilst accepting Andrew's contention that he could address this issue with his counsellor. The counsellor would have assisted Andrew with techniques to manage relapses, which formed part of the counselling process.

90. There is no evidence that OM spoke to the counsellor to discuss whether this was even an appropriate path and therefore it is not possible to say whether the counsellor was aware of this most recent relapse. The potential impact upon Andrew's relationship was similarly, not considered.

91. Through late October and November 2018, Andrew saw his counsellor frequently. By this time, he had had 30 face-to- face sessions. NPS recorded the subject areas covered over these sessions which relate to mindset, feelings, and goals. NPS hold no record of any direct consideration of risk between OM and the counsellor, other than when Andrew arrived drunk.

92. At the beginning of December 2018, Andrew told his OM that he '*was much better*' and had reduced alcohol levels to safe amounts. There was no apparent discussion of what '*safe*' amounted to over the upcoming festive period.

93. In mid-January 2019, Andrew told OM that he had once more ended his relationship with Claire, because in part, her father '*did not like him*'. Although they had spent Christmas together, they had agreed it '*would not work*.' Andrew stated he was now back at his shared house and was working towards independent living.

94. With hindsight, it is evident that Andrew had, over the months, disclosed to OM tensions with Kelvin and Claire's father, and the subsequent relationship problems and breakdown. There is no evidence that the information led to an exploration of risk with Andrew. Kelvin described that tension in his Police statement. Claire's father Leslie, came to visit and when greeted by Andrew, he told him; '*not to talk to him because he did not want to know him.*' Leslie called Andrew a '*user'* of people. After he left the home, Andrew declared, '*he would stab him (Leslie) if he ever spoke to him like that again.'*

95. OM's supervision of Andrew in 2019 was not as regular as in the preceding year and appears to have missed potential risk indicators that particularly resonate, given the recognised likely triggers for offending behaviours.

96. On 24th January 2019 Andrew left a message for OM asking to be re-referred to SIAS, but NPS have no record of this being subject to a direct supervision of Andrew and it must be assumed none occurred. Given alcohol misuse, linked to relationship breakdown should have caused concern, it is a measure of how little Andrew's domestic abuse history was taken into consideration. The next day, Andrew failed to attend a counselling session which was recorded as a 'breach action', but not enforced because continuing attendance at counselling was a choice, rather than a licence requirement.

97. On the 28thJanuary 2019, OM re-referred Andrew to SIAS but it is not possible to say what information was shared at that point. (Andrew was not actually contacted by SIAS to arrange re-engagement with the service until late March 2019.)

98. Andrew failed to attend an OM supervision session two days later, 30th January 2019, though he attended the probation office later that morning to see the counsellor, and the NPS IMR noted an official warning should have been sent. (This could have been rescinded if an appropriate explanation for the non-attendance was forthcoming). January 2019 appears with hindsight to be a month where Andrew's behaviours should have caused concern to OM. Andrew had described relationship breakdown, wanted to have alcohol support, missed a crucial supervision session and yet he was not actually supervised by OM again until April. This was acknowledged by the NPS IMR to be poor practice.

99. Throughout April 2019, SIAS attempted to find a mutually convenient time for Andrew to attend a preliminary assessment, but he cancelled appointments because they clashed with training sessions, and he was prioritising obtaining employment.

100. Andrew had had no actual engagement with SIAS, despite being referred by OM in January. When OM supervised Andrew for the first time in two months, in early April, OM accepted his word that he was managing alcohol intake and had reduced alcohol '*by massive proportions*' and that the counselling had been '*invaluable'.* There is no evidence that OM discovered that Andrew had not yet seen SIAS or that there was any discussion of the part SIAS could or should play in his recovery. Similarly, there seems to have been no co-ordination of the approach to be taken to Andrew's alcohol addiction between OM, the counsellor and SIAS.

101. Directly after the supervision, Andrew went into a counselling session that would have encouraged the self-management of his addiction; *'addiction and treating oneself*'. (The NPS IMR was able to provide a list of the subject areas for each counselling session.) In the context of a service user awaiting an initial assessment by SIAS, this seems somewhat contradictory and potentially counterproductive.

102. Ten days later, Andrew had an initial assessment with SIAS, where he identified that living in supported accommodation would have an impact on his recovery. There was no indication given at this point that he either was abstinent or did not need SIAS support.

103. There was no evidence offered to the DHR that the three professionals ever discussed Andrew together. Whilst it may be true that confidentiality and working practices do not allow for this kind of direct discussion, this was an offender still under licence, where the index offence was linked to alcohol. It does not seem unreasonable to suggest as an offender manager, OM should have at the very least co-ordinated and shared information, and it seems a clear example of the lack of supervision of this category/ level of offender which will be discussed in the analysis.

104. There is no evidence in the IMRs submitted to the DHR to indicate the exact level of contact between Andrew and Claire in 2019. Lucy explained she knew they remained in contact but were far less overt about any continuing relationship. For her part, she did not see Andrew, through choice from Autumn 2018 to early 2020. Lucy said although she tried everything she could to persuade her mother to remain separated from Andrew, he was relentless in his manipulation of her mother, with constant text messages and stalking.

105. Claire had a routine she particularly enjoyed, visiting a local garden centre and spending time at the café, having a coffee, and reading her Kindle. Andrew knew this and turned up uninvited. He also knew Claire would not '*make a scene'* in a public place. Lucy was clear that over the period from 2018 until the

homicide, Claire lost contact with friends and became distant with her family when Andrew had influence over her; during the periods where Claire '*escaped*' Andrew the family saw more of her.

106. There is no evidence in the NPS IMR that OM ever re-visited ongoing relationships with Andrew. There was no active consideration of what the loss of Claire's crucial support could mean to Andrew. The absence of professional curiosity seems striking.

107. On 1st May 2019 in a review with OM, Andrew suggested that recent disappointments and an inability to find suitable work may have led him to drink, but this was not the case now and he was commended by OM. A week later, he failed to attend a SIAS appointment, and this was followed up by the service, at which point Andrew claimed to be abstinent and that he no longer required SIAS support. On the 23rd May 2019, SIAS attempted to discuss Andrew's refusal of support with OM, and they finally discussed the situation on the 6thJune 2019. The analysis will consider whether professionals were demonstrating professional over-optimism in relation to Andrew's ability to deal with his addiction without specialist support.

108. The supervision of Andrew was reviewed in June 2019 by a Senior Probation Officer and the intention was that Andrew would be re-allocated to a Probation Service Officer (PSO) still an Offender Manager but without a Probation Officer qualification. In preparation, a Risk of Harm assessment was conducted which the NPS IMR described as '*not in line with Quality Assurance Guidelines*'. The shortcomings around this supervision will be considered in the analysis.

109. In late July, Andrew told OM that he was working as a welder and consequently his alcohol consumption had '*reduced*'. Given his refusal of SIAS support a few weeks before had been based on his declared abstinence, the lack of respectful challenge by OM yet again, seems unfortunate and naïve.

110. In August 2019, the Counselling service was planning to disengage from Andrew. He had had 48 sessions since being referred. The extent to which OM had relied on the counsellor to 'supervise' the client and OM's apparent lack of understanding of the Counsellor's role, will be discussed in the analysis in both section 15.2 and section 15.3.

111. In early September 2019, an incident occurred that demonstrated that Andrew was likely to resort to alcohol as a response to stress and that any perceived progress could be illusory. Andrew attended work drunk and had to leave in the afternoon. (It is perhaps worth noting that the employments being proposed

for Andrew, in the light of his alcohol addiction; forklift driver and welder, do not suggest much evidence of safety risk assessment.)

112. Andrew reported the incident to a duty officer at probation. Andrew explained things were '*too much and that he was sad*.' His daughter had health issues and he was in arrears to his housing provider and was facing possible eviction. Andrew stated he needed support from his counsellor. It is of note, the duty officer also recorded; '*split from partner which he is not bothered about*.' NPS were unable to identify why OM was not involved in assessing this situation but there is no evidence OM revisited the declarations made by Andrew. OM had recorded that Claire and Andrew separated in January, so it seems unlikely that Andrew was referring to that split. It seems a reasonable assumption that this was a new fracturing of the relationship.

113. Two days after the discussion with the duty officer, Andrew attended his counsellor's office unannounced and, in his conversation, stated he was drinking again and described several social stressors. The counsellor held sessions in October and November 2019.

114. Lucy and her husband reported to the Chair an incident that occurred in October 2019. Andrew had texted Lucy's husband, asking to meet to '*iron things out*'. When Lucy found out, she asked her mother why Andrew was contacting her husband? This led Andrew to send a string of abusive texts to Lucy's husband.

115. In early November, Andrew called the duty officer of NPS in tears and the officer recorded that they *'managed to cheer him up a little'*. The officer assured Andrew he could '*call anytime or tomorrow when OM would be available*' which seems commendably empathetic. There was no evidence provided by NPS that there was any supervision of Andrew by OM until his supervision was passed from OM to a Probation Service Officer (PSO), OM2, seven days later.

116. At the handover, Andrew was considered to remain a medium risk of harm to the public; the level at which he had been assessed on release, and he was level 1 Category 1 for MAPPA. His risk was summarised in the following terms: '*Has sporadic alcohol binges – this is linked with offending but no indication that any offending is likely or current.'* The counsellor reported that Andrew had '*engaged really well and made changes.'* They were working towards the end of the licence.

117. In his supervision by OM2 on the 27th November 2019, Andrew reported that he was moving to his parent's home. Whilst the end of his licence was only a few months away, he was required to live at an

address agreed by NPS, so this unauthorised move could have been challenged. It could also have been appropriate to discuss the impact of his parent's drinking and the pressure the upcoming festive period could have upon his apparent sobriety. This seems particularly relevant given that in the next supervision in December, he claimed he moved from supported accommodation because of the presence of a heavy drinker. Andrew claimed to be far happier and '*his partner, son and daughter were just up the road.'*

118. Throughout their supervision of Andrew, NPS had placed little or no importance upon the significant relationships in Andrew's life. The 'on/off' relationship with Claire (for there is no reason to imagine the 'partner' was anyone other than her) prompted no discernible reaction on this occasion or the preceding ones.

119. In the first week in January 2020, immediately after the Festive period, a supervision between NPS and Andrew occurred. Andrew arrived drunk. He admitted to drinking four cans of lager that morning before the supervision. This appears to be a measure of how little consequence Andrew felt NPS would ascribe to his alcoholism. Andrew admitted to drinking thirty units a day. (Given the safe daily amount for men is 3-4 units a day, this admission should have been a significant concern, particularly since alcoholics tend to underestimate their consumption when asked.) He described himself as a '*functioning alcoholic'* who had started drinking again six months ago because he was not coping. He was offered a referral to SIAS, but he said; '*he had been six times and he knew what they would say*.' He claimed to be attending AA meetings instead.

120. In relation to Claire, he again claimed to have split from his partner; when asked, he explained '*they do not fit into each other's lives'.* Lucy is clear that her mother had disclosed to her at around this time that Andrew had been abusive to her whilst drunk and had strangled her.

121. In January 2020, Andrew attended his GP for blood tests relating to his liver function. His tests showed that his liver had suffered the kind of damage associated with prolonged alcohol misuse. The CCG IMR noted that apart from being advised to reduce alcohol there was no exploration of why a patient who claimed to be teetotal in October 2017 was now so unwell, two years later. No formalised assessment or screening of his alcohol use was undertaken which was a missed opportunity.

122. Lucy recollected that in January 2020, an incident occurred that led to Claire breaking off again from Andrew. Lucy's friend (who knew Andrew from the Christmas drinks in Christmas 2017) worked in a local SPAR and told Lucy that Andrew had bought a pack of Special Brew. Lucy informed her mother, but not before Andrew had approached Lucy's friend and in a threatening manner told her not '*tell Lucy things*'.

When Claire became aware of this, she removed all of Andrew's possessions from her house and put them in the front garden. (Although she retained a large amount of Andrew's furniture and household goods stored in her garage).

123. NPS recognised that the termination of licence assessment was not completed with Andrew and on his last attendance at NPS, neither OM2 nor OM were present; Andrew was seen by a duty officer on the 12th February 2020. Andrew described the progress he considered he had made. The duty officer recorded that it seemed Andrew had been drinking '*but he could not be sure'*. The same day Andrew had his 52 and final counselling session. On the 17th February 2020, Andrew announced to OM2 that he was now sober, and the past few weeks had been a mistake. The NPS supervision of Andrew came to an end.

124. 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, she arrived at Lucy's, spotted with Andrew's blood, and extremely upset.

125. The West Midlands Police IMR also described incidents involving Andrew and Claire's family that were not reported at the time. Kelvin described an incident that to the best of his recollection occurred in March 2020. It is unlikely that this was an isolated incident. It occurred during a Sunday lunch, where Andrew was '*drunk'* and *wobbly'* but cheerful. However, Claire had tired of his drunkenness and after the meal asked him to leave and go home. He responded by picking up a swing hammer that had been left on the dining table. Claire grabbed his arm and Kelvin disarmed him. Jo heard the commotion and came downstairs and pushed Andrew, sending him '*flying'* against the table. Andrew then picked up a metal box and tried to hit Jo with it, whereupon Kelvin intervened, punching him several times, and causing a cut to his face. He then threw Andrew out.

126. From February 2020, Lucy believes that her mother was no longer in a relationship with Andrew, but that he was still reliant upon her and placing her under constant pressure to give him a chance. Lucy explained that her mother said that she '*pretended*' to be in an intimate relationship, because it served to keep Andrew happy.

127. In May 2020, SIAS received a further referral for Andrew from managers at a hotel, where Andrew was staying. (Andrew had been living with his parents in a one-bedroom bungalow but had moved out because he was using alcohol and substances and whilst his mother continued to support him, his father did not. He had therefore moved out in March.) This third SIAS referral did not lead to any meaningful engagement with SIAS.

128. Evidence emerged from Police investigations after the homicide, indicating that Claire was still in contact with Andrew, when he was living at the hotel. A police log was recorded on the 15th May 2020, that appears with hindsight, to have been a domestic incident between Claire and Andrew, involving a third-party witness, a thirty-year-old man, Terry, who called Police from a mobile. Terry was also a resident of the hotel and following the homicide when his mobile number was traced by the Incident Room, he later told investigators he had known Andrew since March, when they both were living at the hotel. Although the incident occurred on the street and allegedly involved Claire and Andrew becoming involved in a physical confrontation, by the time the Police arrived all the parties had left the scene, and none could be traced.

129. Lucy explained that in her view, Claire by this point '*did not want anything to do with Andrew*' but knew of a male who was getting him involved in drugs and that she was attempting to break him away from drug use.

130. The account Terry gave of a relationship with Andrew is uncorroborated, but if it is to be believed, by May, and in the months leading to the homicide, Andrew's alcohol dependency was more intense than ever, but he was also now abusing drugs; smoking crack cocaine when he had money or any other drugs he could obtain. Terry claimed that they were both alcoholics and spent time drinking together as friends before their relationship became a sexual one. Andrew told Terry he had no previous homosexual relationships.

131. Terry claimed they argued a lot when drunk and this led to aggression on both their parts, he suffered a black eye at the hands of Andrew, and on another occasion, he grabbed Andrew by the throat.

132. Terry stated that he and Andrew remained in a relationship up to the homicide. It is not hard to imagine the impact that this incident and this new relationship may have had on Claire, who had persevered with Andrew in the face of her family's opposition and distrust. The relationship with Andrew appears to have continued in some form, although in the Autumn of 2020, she told a GP that she was experiencing relationship breakdown.

133. In August 2020, Lucy's children were due to spend a few days with their grandmother at the caravan she owned. Lucy became aware that Claire had invited Andrew who was '*not drinking and was coming to help with jobs*.' Consequently, the children did not go, and Lucy was very hurt by her mother's decision to prioritise Andrew.

134. The family context for Claire's GP consultations, was that this period saw Lucy '*ignore'* her mother having spoken candidly to her of her '*failure as a grandmother*'. When she did eventually see her mother, it was the day after Claire had found Andrew passed out drunk on her kitchen floor. Lucy had been sent photo '*evidence'* of this by her mother. Claire had reached such a low ebb, that when she visited Lucy, she sat sobbing in her garden.

135. From mid- September 2020 until the 6th November 2020, Claire was in contact with her GPs in relation to low mood and self-harm. Due to COVID restrictions, she had five telephone consultations with four different GPs and a single face to face health check with a Health Care Assistant. During the period of COVID restrictions, both Claire as a patient, but also the GPs, were at a disadvantage in terms of being unable to read body language or non-verbal communication. It also made it appreciably more challenging for GPs to make safe enquiry concerning potential domestic abuse. These opportunities did arise, but the CCG IMR is clear, they were missed.

136. Her initial consultation revealed low mood and fleeting suicidal thoughts that were not currently active. Claire explained that she was sleeping less. No questions were asked to establish what had led to this deterioration. Already prescribed fluoxetine, her dose was increased, and she was referred to Improved Access to Psychological Therapies (IAPT) and a review in two weeks was planned.

137. By the first week in October 2020, Claire had been assessed by IAPT. The CCG was not able to establish whether this was a face to face or phone consultation, however their intervention appeared timely. The assessments undertaken used commonly applied questionnaires; PHQ9 and GAD-7. These indicated Claire was suffering severe depression and anxiety. Claire ascribed these feelings to panic she had experienced 2-3 times a week for around seven weeks. She expressed suicidal ideation but not intent. She stated she '*wanted to be there for her child*.' She admitted to cutting her upper arms with a craft knife to '*ease the tension'*. There is no evidence offered that domestic abuse was considered, or any screening questions were asked. (Professionals providing Mental Health Services are expected to ask routine screening questions). Lucy remembered her distress at this period, seeing her mother's bandaged arms. She

described asking her repeatedly' *why do you let him do this to you*?' but Claire sobbed saying '*I can't talk to you*."

138. Her second phone review occurred in the first week of October, before IAPT's letter was received. The review was with a new GP. Based on her levels of anxiety, she was signed off work for two weeks. Although her suicidal ideation was explored, her child, Jo was described as a 'protective factor' against her taking her own life.

139. The third review, in mid-October, was with the GP who had made the IAPT referral, and their letter had now been received by the practice. For a third time, a health professional recorded Jo as protective factor, preventing suicidal ideation from developing into suicidal intent. This will be considered in the analysis, but a belief that a patient's loved ones are a protective factor is widely considered to be an incorrect analysis and often an unsafe one.

140. Claire was signed off work until the start of November 2020 and reviewed again by a second new GP who did not know Claire, on the 19th October 2020. Having re-visited the depression and anxiety and self-harm, the GP explored causes and Claire referenced a '*bereavement in March, a relationship breakdown and an unsupportive daughter.'* This provided an opportunity to ask about domestic relationships and identify a risk of harm, but the GP did not go beyond these superficial disclosures to explore them in any depth.

141. Four days later, Claire was seen at the surgery for a face-to-face health review. Claire was described as '*too upset*' and only a blood test was carried out. Although the health practitioner was used to asking screening questions for domestic abuse, the CCG IMR writer noted she did not ask them on this occasion and could not recollect why she had not done so. It would have been possible to seek direct advice from a GP, given this was the first occasion Claire had been in the surgery. It is unfortunate this opportunity was missed.

142. On the 6th November 2020, the GP who had last reviewed Claire, held a final consultation with her. It was to prove to be the last contact the surgery had with Claire before her homicide, six days later. Claire said she currently felt emotional and tearful. She had returned to work and was being managed appropriately. Claire disclosed occasional self-harm by cutting, but no suicidal thoughts. The GP was awaiting a referral to psychotherapy but in the meantime ensured Claire knew how to seek help in a crisis.

15 Analysis

15.1 Introduction to the analysis

143. Claire had known Andrew for many years, and it is apparent, given her visits to him in Prison, that she understood the nature of his offending and that on release, he was on licence. The circumstances surrounding the manslaughter conviction, in a close community like Chelmsley Wood, would have been common knowledge. Claire, according to her daughter, believed vehemently that Andrew had changed, was remorseful and that his alcoholism had been caused by the guilt he felt, as over the years he kept the homicide secret. Her personality, as someone always prepared to think the best of people and always prepared to offer a hand in support, meant she believed Andrew would not now need to drink, having served his time in prison.

144. Claire knew Elaine, Andrew's ex-wife, but Lucy, her daughter was very certain Claire knew nothing of the domestic abuse history between Elaine and Andrew. She remembered that when Andrew came out of prison, Claire had tried to persuade Elaine to give Andrew another chance, but Elaine had declined. It was Lucy's view that '*not in a million years*' would her mother have tried to effect this reconciliation, had she known of a history of domestic abuse.

145. It is also therefore unlikely that Claire knew that Andrew had been convicted of assaulting his son Steve in 2006, and that earlier, his stepdaughter had alleged to have been abused by him. Given her friendship with Steve, he would have had an opportunity to disclose this, but Lucy explained that the first she had known about Andrew's domestic abuse was after the murder trial, when Steve disclosed the physical violence he and his mother had suffered at the hands of Andrew. It seems likely, therefore, that Claire was similarly unaware of this history.

146. Whilst Police have the ability under Clare's Law[3], to consider making a disclosure to a person at risk of domestic abuse, based on an offender's previous relevant convictions and offending, the Clare's Law request is usually initiated by an offender's new partner, who suspects such offending in the past. It does not seem Claire would have had grounds to suspect a domestic abuse history. The historic domestic abuse in this case, in the absence of domestic abuse convictions, would have been unlikely to provide sufficient grounds for such a disclosure by police. The manslaughter conviction may have been influential, but in this case, no disclosure would have been necessary, because it was already known to Claire.

[3] The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law" enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending

147. Andrew came out of prison in October 2017 and was on licence and subject to a sentence for manslaughter. He was an offender who had, in the twenty months preceding his incarceration for manslaughter, demonstrated domestic abuse behaviours whilst under the influence of drink, leading to arrests and a non-molestation order. This history was very relevant in assessing the risk he could pose to new partners, should he start misusing alcohol.

148. Alcohol was an ever-present trigger for this abuse, as it had been for his criminal convictions. The chronology indicates that Andrew had been an alcoholic for decades and it appears that despite the period of enforced sobriety in prison, he quickly resumed drinking and was unable to maintain any significant period of sobriety. When Offender Managers attempted to support Andrew by referring to support agencies, SIAS and Counselling, there appeared to be a general lack of understanding by OM of the nature of alcohol misuse and a seemingly naïve acceptance of what Andrew reported in relation to his sobriety and dependency levels. (This will be considered at section 15.3)

149. He was managed under the Multi Agency Public Protection Arrangements (MAPPA) by Probation Offender managers for 26 months, and during this period, Andrew disclosed a new relationship with Claire. They were subsequently made aware that there were difficulties between Andrew and Claire's family, and more than once were told that the relationship had ended, although later disclosures suggested this was not permanent. Claire had attended the Probation office with Andrew, but there is no evidence offered that NPS offender managers exhibited any professional curiosity about the relationship or considered direct contact with Claire and the members of the family that Andrew was in conflict with. (The supervision of Andrew by NPS and the apparent missed opportunities, will be considered below in section 15.2)

150. On balance, it seems likely that Claire entered a relationship with Andrew aware of his vulnerabilities and the potential for difficulties but believing she could help him to address alcohol and reorientate his life; this was the explanation for the relationship offered by the prosecution at his trial for Claire's murder. Lucy believed that during the last year of Claire's life, the only remaining motivation for her was not love, but her belief that she could still help Andrew. Later, she recognised that once belief faded, she could not escape Andrew's control and coercion.

151. The statements taken by Police after the homicide, suggest that Claire and Kelvin, her ex-partner, her 13-year-old child, and her father, all experienced Andrew's abusive and violent behaviour. At trial it was suggested that Andrew was jealous of Claire and Kelvin's close relationship and a parallel can be drawn with Andrew's possessive and jealous reactions to his ex-wife's friendships. Claire had told a close friend

that she had tried to break away from Andrew in 2019, but that he had '*pursued her relentlessly'*. If, therefore, Andrew intimidated and controlled Claire and her family, it is possible that they felt unable to report domestic abuse to the Police. The absence of reported incidents is clearly not an indication of a lack of risk, rather it could be evidence of the completeness of Andrew's control. It seems, based upon on her daughter's recollections, that Claire, who told friends she '*loved'* Andrew, may have discouraged her family from reporting any incidents.

152. It is therefore inappropriate and overly optimistic to place reliance upon victims and families feeling able to report domestic abuse to professionals, when coercive and controlling behaviours are so commonly a feature of domestic abuse. An abuser's controlling and coercive behaviour has as its' primary purpose the removal of agency from victims.

153. It is for that reason the professionals in this case who encountered Claire and Andrew, needed to be professionally curious, and in some situations, follow well established professional guidance and protocols to identify any domestic abuse behaviours or risk. With hindsight, Claire's relationship with Andrew impacted upon her wellbeing and her physical and mental health throughout its' duration. It is possible that she may have taken advantage of an opportunity to share her anxieties, had she been given space, and encouragement to do so. Regrettably, the opportunities that presented themselves were not taken by the health professionals. The analysis will question why a failure by Health professionals to 'ask the question' remains such a common finding of DHRs. (Section 15.4)

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

154. In October 2021, the Ministry of Justice and HM Prison & Probation Service published a new framework for the management of Level 1 MAPPA cases[4]. It stated, *Level 1 management does not mean that the offender is low or medium risk. High risk cases can be managed at Level 1, providing the lead agency can sufficiently manage the risk. Multi- agency input is still required at Level 1, but there is no need for formal MAPPA meetings. The lead agency will have sufficient powers to manage the offender effectively, but information sharing with other agencies is still required, and professional's meetings should still take place. The Risk Management Plan (RMP) will be sufficiently robust to manage identified risks.'* The report stressed that a recent Operational and System Assurance Group report, (unpublished) highlighted that the process

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

for managing people at Level 1 varied across the country. Weakness in current NPS practice were highlighted:

- No national guidance relating to the management of Level 1 cases
- Arrangements for the management and review of Level 1 cases by PS are disparate and not consistently effective
- Risk management plans (RMP's) for MAPPA Level 1 cases are not always up to date
- Practitioners did not routinely respond to changes in circumstances by reviewing risk assessments and RMP's
- Many Level 1 reviews did not consider information from other agencies, in particular from the police.

155. The RMP for Andrew, as a MAPPA 1 nominal, appeared to show many of these systemic weaknesses highlighted in the National report. 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. (Considered separately at section 15.3).

156. This appears to have been magnified by a lack of adequate management supervision of OM. Andrew had been on licence supervised by OM for 23 months, before the RMP was subject to management oversight. This meant that for most of Andrew's supervision by NPS, OM was relying upon what appeared later, to the team manager, to be a fundamentally flawed RMP.

157. From the date of his release from custody until February 2020, MM was managed within the Solihull team of the Coventry, Solihull and Warwickshire 'cluster' of National Probation Service Midlands Division, with Solihull by some distance the smallest of the three 'local delivery units'. This was within the period from June 2014 to June 2021 when the Probation Service was divided into two, with National Probation Service providing advice to courts and managing higher risk offenders while Community Rehabilitation Companies managed lower risk offenders and provided a range of interventions to the entire probation caseload. The Midlands Division was inspected by Her Majesty's Inspectorate of Probation in the second half of 2018 with the report, published in December 2018, adjudging the region 'good' and awarding the highest marks of the entire national inspection programme at the time.

158. A challenge for the Solihull NPS team was that it was small, meaning that its resilience could be vulnerable. During the period of the review, however, it remained relatively stable with workloads a little lower than

elsewhere in the division, meaning that the team was occasionally called upon to support other parts of the division who were experiencing greater need. Solihull's small size, as a local authority area, also fostered generally positive partnership arrangements with other agencies, particularly police, largely because it enabled development of effective personal relationships. Policy development and practice guidance, throughout the period of the review, were nationally driven and expectations and standards centrally determined. There was a strong and well-resourced national infrastructure, although this relied, for local translation, upon middle managers.

159. The NPS IMR recognised some gaps in management oversight of casework through to the middle of 2019 which were manifested when additional scrutiny was put in place. This may have persisted because of the smallness and relative discreteness of the Solihull NPS operation. It is a significant concern that this lack of supervision appears not to have been an isolated occurrence. The NPS IMR was open in its' admission that there were concerns at a local level about '*practice issues*' concerning the SPO who had responsibility for the supervision of OM until July 2019. (In the retirement transition of the previous SPO, some concerns about management oversight had emerged and a new SPO had been appointed to review, coach, mentor and quality assure delivery of service.)

160. When a Senior Probation Officer (SPO) did finally review the supervision of Andrew in July 2019, a catalogue of problems was identified; '*The risk of harm analysis was 'not of sufficient standard'. The Risk Management Plan was not in line with Quality Assurance standards. Child safeguarding issues were not addressed. The sentence plan did not prioritise harm objectives. Progress was not monitored for all licence conditions. Plan has not been reviewed promptly, to take into account changes in circumstances. There is no evidence that victim awareness work has been undertaken.'* The SPO noted that OM should have been supervising Andrew monthly which in the latter stages of the supervision, was not the case.

161. 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. 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. 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.

162. 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[5] assessment that indicated he was low risk of violence to partners and others.

163. The NPS IMR analysed the assessment of risk; '*It would have been an expectation that the Offender Manager clarify the behaviour around the restraining Order, regardless of lack of Domestic Violence conviction, and the involvement of Social Services with the family. Lack of professional curiosity by the Offender Mangers and Subsequent Managers can be classed as a missed opportunity to inform the risk management and sentence plan*.'

164. A consequence of this lack of enquiry, was that NPS missed the opportunity to include a sentence plan objective in relation to 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.

165. The RMP for Andrew should also have considered that he had a history which included a conviction for wilful assault of his son, which meant he had been a PPRC. Whilst he had no domestic abuse convictions, his domestic abuse behaviours (described in section 13 paragraphs 14-25) were highly likely to be predictive of risk. Relationship breakdown and controlling and coercive behaviours accompanied by drunkenness were a consistent feature.

[5] 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.

166. The DHR would argue that if OM did not believe this history to be relevant, it perhaps explains why there was no apparent exploration of a relationship with Claire that Andrew did not try to conceal, and what appeared to be an almost complete lack of professional curiosity by OM.

167. This was borne out in the OASys risk assessment by OM. The NPS IMR noted; '*At the 'start of Licence OASys' in October 2017, it was assessed that relationships were linked to serious harm and re-offending along with alcohol misuse. In a review of the OASys assessment in November 2017, OM assessed that alcohol misuse was related to a risk of harm and offending but relationships were not*.' The IMR author explored this decision with OM in interview and it was evident that the absence of convictions or cautions led OM to minimise the significance of a history of domestic abuse and even the assault upon his son.

168. OM's judgement was that relationships were not significant to the risk of re-offending. The NPS IMR did not agree with this assessment.

169. The WMP IMR and responses in follow up questions from the panel identified that Police from Offender Management contributed to the original parole risk assessment, with a summary of '*known history*'. This focused entirely upon convictions and cautions and whilst it included the assault upon his son, it did not disclose the detail of his domestic abuse of the family; stating '*he also had a number of investigations, but no charges including assaults*…' It could be argued that if Police did not consider the domestic abuse history was relevant, due to a lack of convictions and cautions, they were failing to see those incidents in the context of Andrew's alcohol misuse. This seems questionable, given the police assessment, whilst agreeing that level 1 supervision was appropriate, suggested '*If there are future issues around drug/alcohol misuse or housing issues that require intervention from other agencies then I request that he be brought back to panel for further discussion around a change of MAPPA level'.*

170. MAPPA now audit every risk assessment for '*clarity and brevity'*, but the DHR would stress the importance that a nominal's history of domestic abuse be considered as an indicator of possible risk, regardless of whether there are cautions and convictions, and where appropriate, is clearly outlined in assessments shared with NPS.

171. The current Ministry of Justice and HM Prison & Probation Service Domestic Abuse Policy Framework (March 2020) seeks to ensure professionals engaged in the supervision and assessment of offenders are professionally curious and seek relevant information from partner agencies.

172. They provide valuable guidance on how offender managers should approach domestic abuse; '*the identification of domestic abuse is not a one-off activity that occurs at the start of the sentence. Throughout sentence all staff need to use an investigative approach, being vigilant and inquisitive in seeking out information from a wide range of sources to inform an ongoing assessment of whether domestic abuse features in current or previous relationships and approaching the issue with professional curiosity.'*

173. The new MAPPA Framework describes at section 6.2.1. what is required to demonstrate professional curiosity in the context of offender management; '*Professional curiosity when managing a Level 1 case is the process of adopting a healthy scepticism and taking an investigative approach to casework. It involves asking direct questions, active listening, and seeking independent verification of the information that is obtained where possible, not making assumptions, further exploration, and reflective practice. Professional curiosity is a vital aspect of Level 1 management, and such an approach will enhance the Practitioner's ability to effectively monitor progress but also assist with making informed professional judgements on risk and individual need.* '

174. The previously cited Domestic Abuse Policy Framework at section 7.1, describes how professional curiosity is applied to domestic abuse and seems particularly apposite to this case:

175. '*In particular, staff must reassess a case when it is allocated to them and not rely on previous assessments, especially when they have been completed with access to limited information - for instance at court. SFO review and DHRs have identified the importance of:*

- *investigating all available sources of information on people convicted or accused of domestic abuse before interviewing them*
- *adopting a professionally curious approach when interviewing*
- *taking into account prior known incidents of domestic abuse (e.g., police call-out information) in assessments.*
- *identifying changes to dynamic risk factors, updating assessments; and,*
- *acting upon changes to risk. '*

176. When OM supervised Andrew, a West Midlands Police offender manager was responsible for liaison with OM, and it would have been entirely possible to ask the officer to find out sufficient detail of the history for OM to have had the same level of understanding as has been achieved in the DHR of Andrew's abuse of his family in the year before his imprisonment.

177. The multiple examples of OM's failure to explore the nature of Andrew's relationship have been detailed in the chronology. Andrew told OM he was in an intimate relationship with Claire. The NPS IMR identified the sharing of information between OM and the WMP offender manager concerning Claire's address, so that a warning flag could be entered, as good practice, albeit WMP see no evidence of this happening. (Section 14 paragraph 12) However if early on, a potential for police call outs was identified, why was there no subsequent reaction when OM was told that there were relationship difficulties with Claire's ex-partner?

178. This meant OM failed to identify that Andrew and Kelvin were sometimes present in the same house with all the potential for domestic incidents, or that also present was Claire's child, a teenager diagnosed as autistic and therefore particularly vulnerable. When Andrew described relationship breakdown, OM's risk assessment should have considered the potential for risk. Direct enquiry at this point could have revealed tensions between Andrew and the family.

179. Meeting Andrew at Claire's home, it seems, was never considered. That consideration would only have occurred if OM was aware that Andrew was spending significant time at Claire's which does not appear to be the case. Even when Claire attended Probation with Andrew, OM did not take the opportunity to show appropriate professional curiosity. Whilst the NPS/Ministry of Justice Domestic Abuse Policy Framework is new, the observations it contains concerning home visits (section 10.2) as part of the supervision of offenders, date back to 2012; '*Research shows us that individuals feel a benefit when supervision is interactive and engaging, and this includes having home visits (Shapland et al 2012). Home visits should be more than just verification of where someone lives. By seeing individuals in their own environment and with their family members, staff can analyse information gathered from agencies or supervision sessions.*

180. *Home visits enable us to explore who individuals are living with, understand their unique challenges, and build rapport. This can aid a comprehensive assessment of safeguarding concerns in relation to children, vulnerable adults, and partners in cases of domestic abuse. They are also an important means of responding to their accessibility.'*

181. Whilst it may be argued that Andrew was assessed as only medium risk, this was without OM undertaking any enquiries around Claire and her family. It is not possible to know what may have been discovered had OM shown professional curiosity, but it is possible disclosures concerning the nature of the relationship may have been made by one or other member of the family.

182. Andrew was referred for Counselling and had regular, one hour, face to face sessions throughout his licence, delivered at the Probation office. OM's supervision was often directly after these sessions. Whilst OM was aware of an occasion when Andrew arrived to counselling drunk, there is little evidence of discussion of Andrew between OM and the counsellor. This was because the terms of engagement would preclude such discussions.

183. The counsellor would only break confidence, if Andrew posed a risk of harm to himself or others or there was evidence of offending. The counselling service, in their submission to the DHR, made it clear what information they needed upon referral; '*it was not necessary for any Offender Mangers to share with Counselling any offending history or licencing conditions, unless there was a risk issue pertaining to therapy for example a risk to staff… Counselling Ltd entered into all therapeutic interventions with clients based on the information provided on the referral form. This information was based only on emotional wellbeing. '*

184. This was summed up in the therapist's statement to the DHR, '*I was not aware of any prior violence in the historical relationship history. I am not aware of the details of the relationship Andrew had with the deceased.'* Whilst it seems barely conceivable that 52 hours of conversation could result in the counsellor being so unaware of Andrew's wellbeing in relation to current personal relationships, it also contradicts what Andrew told OM; that relationship breakdown with Claire was being addressed with the counsellor.

185. When the counsellor became aware of Andrew's constant alcohol relapses, the approach taken was described by the therapist; '*I had concerns for the risk that Andrew posed to himself, not others, and regularly set out safety plans for harm to self through addiction and relapse prevention. To assist and build on coping strategies, many areas were explored with different interventions. Sessions were opened with addressing the here and now work on the clients' agenda for the sessions the client engaged with.*'

186. OM clearly placed far too much reliance on Counselling (and SIAS) to manage wellbeing as the entire solution to decades of harm from alcohol misuse and as a solution to relapse. As the NPS IMR observed, this caused OM to lose sight of the potential risks. OM's lack of supervision was in part complacency, because NPS were prepared to commission more than fifty sessions with the Counsellor.

187. There were several occasions outlined in the chronology, where Andrew was in technical breach of his licence, but he did not appear to be held to account for this behaviour. This reached such a point at the end of the licence, that he was attending supervision drunk. This seems poor practice and evidence that NPS in this case were not fulfilling their duty as risk managers of MAPPA nominals.

188. National Probation Service point to significant changes in service delivery that would reduce the risk of the type of 'light touch' offender management apparent in this case. The current suite of assessment tools reduces *'professional judgment' with a more prescriptive approach to case management and electronic monitoring of casework. There is now an Effective Practice Framework - part of which identifies suitable licence conditions for all releases. Management oversight is now a regular occurrence ensuring that offenders are managed appropriately, supervised and referral and liaison with external organisations is occurring in the management of risk. There are monthly electronic performance indicators which enable middle and higher managers to ensure that there is a robust approach in the delivery of service.'*

189. The NPS have introduced a domestic abuse pathway that should prompt greater professional curiosity in relation to domestic abuse. The NPS single agency recommendations should mean that they would be able to provide reassurance to the Safer Solihull Partnership of better practice in relation to the supervision of MAPPA level 1 nominals.

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

190. 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. However, the DHR 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.

191. The parole board included in the licence alcohol and drugs testing however this was not an enforceable requirement. Once it became evident Andrew had relapsed into alcohol abuse, OM had to decide how to respond to relapses. The approach taken seemed to allow Andrew to largely dictate terms, often in an unhelpful way. Whilst an alcoholic needs to want to change to achieve sobriety, an offender on licence, it could be argued, should be placed under a degree of compulsion. What consequences would evidence of alcoholic lapses, or a failure to engage with alcohol support, or being drunk in supervision, have for Andrew as an offender on licence? With hindsight, it is clear the answer was, none.

192. The NPS IMR made it clear that the existing licence conditions provided enough scope for OM to make attendance at community-based alcohol programmes a requirement of the licence. This would also have meant Andrew would have been required to engage immediately upon his release with alcohol services providing programmes for recovering alcoholics, and non or poor engagement would have been a breach

of the licence. The lack of clarity and absence of clear objectives led OM to seemingly place an overreliance upon first the counsellor, and then SIAS and then again the counsellor, to manage and report the attendant risk from alcohol relapses. This was an offender manager's primary function and should not have been delegated in this way to other professionals, who were subject to confidentiality agreements that would not encourage sharing of information, except in high-risk contexts. As has been demonstrated in section 15.2, the counsellor was managing sobriety from the perspective of wellbeing, not managing the risk of re-offending, unless Andrew made clear disclosures indicating a risk to others.

193. 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.

194. Professionals working with alcoholics should expect to be lied to and should be ready to show respectful uncertainty. However, honesty on the part of recovering alcoholics is essential to recovery and addicts need to acknowledge that they have lied in the past to avoid shame, detection, or challenge. As Alcoholics Anonymous describe[6]; '*Many recovering persons have been dishonest for a long time, and it will take a while for them to develop an honest way of living. They tend at times to fall back into old patterns of thinking and behaving.'*

195. Evidence would suggest that in the first months after release, Andrew told OM he was determined to remain abstinent and there is evidence that initially he maintained his sobriety. However, by May 2019, he was acknowledging having drunk for a while. When Andrew arrived drunk to a Counselling session (May 2018- section 14 paragraph 15) and therefore was referred to SIAS, his willingness to engage was seen as positive. However, it is apparent from the relatively few and confused conversations between SIAS and OM, that the reason for his referral was not clarified and nor was the issue of sobriety and alcohol testing. SIAS appeared to mistakenly assume that Andrew was attending as a term of his licence. When he subsequently arrived at a SIAS group session (June 2018 section 14 paragraph 18) drunk, it was now evident that Andrew could not maintain his sobriety and there was a clear change in risk. This required decision making by OM, since the response to Andrew would set the marker for future problems.

196. 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 no contact with SIAS in the intervening months, to identify whether any genuine progress was being made. It was left to SIAS to try

[6] addictionsuk.com

to discuss their concerns with OM, and the failure to respond to their messages was unprofessional and discourteous. Andrew must have assumed by the lack of supervision, that OM was not particularly anxious about his failure to stay sober, but also that OM had no concerns around a lack of engagement. This must have sent Andrew all the wrong signals.

197. Andrew gave repeated assurances to OM about the level of his alcohol consumption that were optimistic and positive, and these were recorded without any challenge. This seems naïve practice by OM.

198. It was Andrew who appeared to decide that he would rather deal with alcohol relapses with his counsellor, than with SIAS, an organisation with specific skills in relation to challenging the assertions of addicts in denial. Somewhat ironically, Andrew claimed, on several occasions, to justify disengagement, to have been given sufficient coping strategies by SIAS and there was '*nothing more he needed from their support*.' Given his almost complete non-engagement, this seems at best questionable and yet it was met with no challenge from OM, who had not independently identified Andrew's actual level of engagement with the service.

199. OM did not discuss Andrew's preference with the Counsellor to ensure this was advisable or identify what threshold would apply to identified risk from alcohol. The Counselling service required confidentiality and their Client Therapist agreement stated, '*ethics and note-keeping are all understood and agreed between client and therapist at the outset of any work, along with an understanding of when confidentiality will be broken. As such, if client safety is considered at risk, the safety of another person deemed at risk, or if there is any disclosure re breaching of the law, counsellors always refer directly to the Offender Manager and notes are added to nDelius accordingly.'*

200. As highlighted in section 15.2, OM had made no attempt to discover anything about Andrew's relationship with Claire or considered whether the apparent break-ups would impact upon his psychological state. OM was in no position to inform the counsellor about the possible connection between his relationships and alcohol misuse and as has been noted above, the counsellor knew nothing about Andrew's personal relationship.

201. Similarly, SIAS lacked professional curiosity in relation to their assessment of Andrew. SIAS are commissioned by Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) and they noted in their IMR; '*there were some missed opportunities to, as a minimum gather information on the family, children and any intimate relationships, and ideally, to a greater depth, explore those relationships, particularly given that a previous history of domestic abuse was known*.'

202. 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*.'

203. If emotional wellbeing was being addressed and would lead to reduced drinking or sobriety, OM and OM2 appeared to be naïve in accepting Andrew's word those things were improving. In fact, there is little evidence that Andrew was achieving sobriety.

204. Having disengaged from SIAS with OM's agreement in September 2018, when a third professional, at IXION, reported Andrew was drunk on a training session (October 2019 Section 14 paragraph 32) OM did not reassess risk or inform the counsellor of this development.

205. The pattern of underplaying Andrew's alcohol relapses was maintained by OM in 2019. In January 2019, Andrew asked to be re-referred to SIAS. It is not unreasonable to argue OM should have held a supervision session, to identify why Andrew felt he now needed SIAS, when before he felt his counsellor could manage relapse prevention?

206. A further significant warning sign was a failure by Andrew to attend a supervision session with OM that same week. Far from triggering an urgent reassessment of risk, OM appeared to be prepared to leave the 'supervision' of Andrew to the Counsellor. This appeared to demonstrate a misunderstanding of a counsellor's role and was an inappropriate decision that may be indicative of the poor level of supervision of Level 1 MAPPA offenders highlighted in the report in section 15.2

207. Andrew was not supervised again until April 2019. This also was poor practice, as noted in the NPS IMR; '*Good practice would dictate that that the OM have a clear oversight of the case with regular / monthly supervision sessions and reviews*.'

208. Andrew assured OM that he was managing alcohol intake and there was no attempt by OM to discover his level of engagement with SIAS; in fact, he had not yet had even an initial assessment. At that assessment he claimed to be abstinent and not requiring support. In June, SIAS and OM discussed Andrew and there is little evidence that it pertained to his apparent non-engagement.

209. The review of the case by the Senior Probation Officer in June has been analysed in section 15.2, but it was an opportunity to discuss Andrew's alcohol misuse, that was not taken. OM was beginning to 'detach'

from supervision, knowing it was to be re-allocated to another colleague. It could be argued given the identified failings highlighted by PSO, OM should have re-doubled efforts.

210. A further incident in September 2019, where Andrew arrived at work drunk and spoke to duty officers at NPS in an emotional state, was subject to no supervision by his offender manager, which seems to indicate OM and by extension NPS, were no longer trying to manage alcohol abuse by Andrew. The end of the supervision was in sight, and it appears the only criteria for raised concern was further offending linked to alcohol misuse. In the absence of any reported offending, NPS were now consistently allowing Andrew's words of reassurance to justify an apparent failure to risk assess.

211. NPS supervised Andrew for 26 months. Despite Andrew's assertions to the contrary, his alcohol dependency remained a high-risk factor throughout. There is no reliable evidence that Andrew was truthful with NPS offender managers, rather that they chose to accept his claims without challenge, in the face of repeated examples of dependent behaviour and lack of engagement, that undermined his claims.

212. The failure to consider his domestic abuse history has been identified in section 15.2. The failure to be professionally curious or to consider home visits, when the relationship with Claire became known, meant NPS missed an opportunity to identify possible offending behaviours whilst drunk, including an assault on Kelvin, Claire's ex-partner.

213. In the final supervision session with OM2, in January 2020, Andrew arrived drunk. NPS's response was simple resignation. Andrew was now not even attempting to hide his alcohol dependency from NPS: he probably knew that their ability to control him was almost over. He admitted to drinking thirty units a day. This is by any standards very problematic drinking levels for an offender with his history. (It is not unreasonable to assume this could have been an underestimate.) He was reminded of the risk to himself of being drunk at work. His final review in February 2020 was with a duty officer, who did not know Andrew but felt he had been drinking.

214. It is hard to avoid the conclusion that NPS's management of Andrew's alcohol misuse, a key trigger in re-offending, was a key example of the ineffectual supervision of the licence. The only reassurance NPS could offer at the end of their supervision was there no evidence of offending. With hindsight it seems that was only because no one reported it. Probably only a few weeks after his licence ended, Andrew was involved in drunken assaults on Claire and Kelvin.

215. Andrew's descent into significant alcohol misuse, coupled with drugs misuse, immediately before his murder of Claire, was unfortunately entirely predictable but with better supervision could have been preventable.

216. Andrew was a change resistant drinker; for all his assurance to OM and SIAS, he showed no real intention to reduce or abstain from alcohol and did not engage with or benefit from alcohol treatment. This made the failure of professionals to recognise no real change had occurred even more significant.

217. A Partnership study[7] in 2016 by Alcohol Concern and Against Violence and Abuse (AVA) Stella Project identified the role alcohol played in domestic abuse and DHRs. In its' introduction, the study observes, '*the relationship between alcohol and violence is well researched, although less so in the more complex context of domestic abuse. Whilst there is evidence that alcohol use by perpetrators, and to a lesser extent by victims, increases the frequency of violence and the seriousness of the outcome, this does not mean that alcohol use causes domestic abuse It is neither an excuse nor an explanation.*

218. The study found non-engagement with alcohol services in 80% of the DHRs studied where the perpetrator was a change resistant drinker. This DHR has reflected on the lack of professional curiosity shown in this case, given alcohol was known to be a trigger for Andrew's offending. The failure to even consider the risk to Claire in a relationship with a change resistant drinker was evidence of a broad lack of awareness of the links between alcohol misuse and domestic abuse.

15.4 Identifying risk from domestic abuse: health professionals

219. The National Institute for Health and Care Excellence (NICE) Domestic Violence and Abuse Quality Standard (QS116) has been in place since 2016. It requires that '*people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.'*

220. The NICE Domestic Violence and abuse: multi-agency working Public Health guideline (PH50) described how safe and appropriate questioning should be achieved by agencies as long ago as 2014. It is clear, therefore, that the expectations placed upon commissioners and service providers have been established long enough for there to be demonstrable improvements in service delivery in relation to domestic abuse.

221. 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

[7] **Alcohol Concern and Against Violence and Abuse- Domestic Abuse and change resistant drinkers: preventing and reducing harm. Learning Lessons from Domestic Homicide Reviews Mike Ward et al**

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?

222. 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 (BSWA); IRISi[8] (Identification and Referral to Improve Safety).

223. Birmingham and Solihull CCG and now NHS Birmingham and Solihull Integrated Care Board have shown excellent commitment to IRISi; *'BSolCCG recognises the importance of the evidence-based, social enterprise IRISi in supporting victims of domestic abuse and trying to prevent domestic homicide and so have invested into it since April 2018. The current funding has allowed for 175 out of the 225 Practices that are part of the CCG to be trained and supported by Advocate Educators to 31 March 2021. Practices volunteer to attend two 2-hour sessions of training for up to 90% of all Clinical Staff and one hour for non-clinical Staff, to gain confidence in how to ask patients about domestic abuse, how to respond and then gain consent to refer to IRISi, to allow the patient to get appropriate support according to their individual needs.*'

224. NHS Birmingham and Solihull ICB is awaiting confirmation to secure funding for 2022-2023 to be able to train its remaining 50 Practices and provide ongoing support to the existing IRISi trained Practices.

225. The CCG IMR[9] described expectations concerning post-training practice, and the return they would hope to see from this investment in best practice; '*If a Practice has undergone IRISi training, then there is a high expectation that GPs, Practice Nurses, Health Care Assistants and other Clinical Staff would be asking patients, who present with certain symptoms or conditions highlighted in the training, such as anxiety, depression and panic attacks, about domestic abuse and offer a referral. Reception and Administrative Staff also have separate training in understanding domestic abuse and how to respond.'*

226. The DHR would argue it is essential that Level III Safeguarding Leads in practices ensure that following IRISi training, there is a 'culture shift' across the whole practice team. A practice adult and child safeguarding lead should monitor and audit the frequency with which each member of staff is recording 'asking the question' and identify referrals made to the IRISi practice educator and to support groups.

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[8] IRISi (Identification and referral to improve safety) is an approach adopted nationally which is intended to support clinicians and staff working in Primary Care to recognise and respond to the needs of patients affected by domestic abuse.

[9] This DHR refers to Birmingham and Solihull Clinical Commissioning Group (CCG) but it should be noted that from the 1st July 2022 that body became part of NHS Birmingham and Solihull Integrated Care Board

227. This culture shift would include ensuring that locums (particularly those not IRISi trained) are reminded of the expectations in relation to best practice in this regard. It does not seem unreasonable to propose that even where a GP has not had specific IRISi training, that they should be conscious of the need to 'ask the question'. No GP could reasonably claim to be unaware of the fact that domestic abuse impacts upon the wellbeing of a large cohort of their patients.

228. Some of the staff at the Practice in this case had received IRISi training either at the practice or elsewhere between 2017 and 2019. Two of the GPs, (including the safeguarding lead and the Health Care Associate who saw Claire face-to-face) had received training whilst the remaining two had not. Unfortunately, there is some evidence from the BSol CGG IMR, that training has not yet led to demonstrably better practice. The practice made only four domestic abuse referrals from November 2019 to June 2021. For four months, immediately after their training, COVID had not yet led to restrictions, and it would be hoped to see an immediate uplift in referrals post training.

229. It appears therefore there has not yet been the kind of culture shift necessary at this surgery, and that cannot be accounted for entirely by COVID restrictions being in place. There had been no independently initiated audits to assess the impact of IRISi on their referral rate.

230. The CCG and Birmingham and Solihull Women's Aid (BSWA) who deliver IRISi training, anticipated the impact COVID restrictions would place upon best practice in relation to domestic abuse support, and all practices had received clear guidance from practice educators on how IRISi would support them during COVID. The guidance particularly concentrated on ensuring that telephone consultations with their patients did not increase risk levels.

231. CCG guidance included advice concerning the use of video conferencing, as well as reminders that if a patient was distressed or at risk, or if they feared the patient could not safely disclose, they could book a face-to-face consultation. This was made clear in the CCG IMR offering guidance; *'if they suspect domestic abuse and want to make an enquiry with the certainty that the patient is alone, since April 2020. Due to the COVID restrictions there was a strict "one patient only" rule in consultations. So, if patients were called for face-to-face appointments, it was easy to separate the victim from the perpetrator without alerting suspicion*. '

232. Birmingham and Solihull Women's Aid carried out an Impact study in the first months of April-December 2020 following COVID restrictions. '*Covid-19 impacted referral rates significantly in Q1 of 2020, when we witnessed a 45% decrease in comparison to numbers received in the previous Quarter. Since April, referrals*

rates have been slowly increasing month on month. We often get a dip in referrals over the Christmas period; however, this has not been the case this year, with referral numbers in December 2020 equalling those of November. Whilst referral rates throughout 2020 have been lower in comparison to the same periods in 2019, it is worth noting that this may not be entirely due to the impact of Covid-19. During 2019 the IRIS team was busy delivering high levels of initial training to practices who were new to the IRIS programme. It is likely that this resulted in increased referral rates which may have levelled off over subsequent months anyway, regardless of the pandemic. By December 2020, referral numbers were equal to those of the previous year.'

233. The chronology described in detail the frequent missed opportunities in this case that arose from a combination of factors; COVID restrictions limiting the opportunities for face-to-face consultations, consultations with several locums who had never engaged with Claire, and a more generalised absence of professional curiosity and a failure to follow the guidance provided in their IRISi training. Even where one GP made more extensive enquiry related to social circumstances, Claire described relationship breakdown, no more specific domestic abuse related questions were asked.

234. The Surgery participated in this DHR, and engaged well with the CCG IMR author, (who is the named GP) showing a desire to learn lessons from this tragedy. The DHR Chair is confident that the advice the named GP would have given the surgery would be practical and effective. It would not be unreasonable to expect to see an increase in DA referrals.

235. This leads to a consideration of whether NHS Birmingham and Solihull Integrated Care Board should be satisfied with the referral rates from Solihull and Birmingham's GP practices that now, in large part, have had IRISi training and practice educators embedded for several years?

236. If every GP and practice nurse asked routine questions every time a patient presented with the health indicators of possible domestic abuse, how many referrals could we expect to see? There are 175 GPs practices in the Birmingham and Solihull area that are IRISi trained, and between them they were generating no more than 57 referrals a month, in some months in 2020, less. (BSWAID audit figure for December 2020). Averaged out across a year, that would suggest around 3-4 referrals per practice a year. Given there will be a few practices that exceed that figure, there will be trained practices achieving even fewer referrals. Clearly, not every disclosure will lead to a referral, but that said, this seems to the DHR to be a rather poor return for the effort put into domestic abuse education and support to GPs. More importantly, it suggests that victims of domestic abuse attending surgeries in Solihull with health concerns

that could be indicators of domestic abuse, are not being given the opportunity to disclose their abuse and obtain help.

237. The NHS Birmingham & Solihull Integrated Care Board action plan included an audit of referrals made by their GP practices. This is a positive start. We have been assured that contact has been made with all GP practices to encourage engagement with IRISi and that low referring GPs practices in Solihull are to be approached by advocate educators to encourage better practice.

238. The DHR would encourage NHS Birmingham & Solihull Integrated Care Board to identify with BSWA what an acceptable referral rate, based on the demographic should be, and set SMART targets to reach that level. They should explore all ways of ensuring that on each occasion a patient attends with the health indicators of domestic abuse or has a phone consultation, that they are 'asked the question.'

239. Safeguarding self-audits of GPs practices should include clear figures for DA referrals and this should be a commissioning requirement. The Safer Solihull Partnership would seek assurances from the NHS Birmingham and Solihull Integrated Care Board that they have evaluated whether BSWA is providing an acceptable service and follow up by reviewing commissioning, to set targets for IRISi referrals if necessary.

240. It should also be noted that in relation to her self-harm and suicidal ideation two GPs, as well as IAPT in their report to the surgery noted Jo, Claire's child, as a '*protective factor*'. Whilst a cohesive and supportive family are recognised as a protective factor, reducing the risk of self-harm and suicide, the love and sense of responsibility a suicidal person has for that family member, does not translate into a reliable protective factor. Previous DHRs have identified this as a relatively common error in the practice of professionals.

16 Conclusions

241. 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.

242. 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.

243. 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.

244. 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.)

245. 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.

246. 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.

247. 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 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.

248. 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.

17 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

18 Recommendations

249. 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.

Appendix A

Domestic Homicide Review Action Plan

Contents

Note: The Solihull Domestic Homicide Review group will have oversight of all DHR action plans ensuring that they are monitored and concluded. This forms part of the Solihull monitoring arrangements for all DHRs.

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

Overview Recommendations

RECOMMENDATION 1:

Linked recommendations concerning 'asking the question' in primary and secondary care

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.

Ref	Action (SMART)	Lead Agency	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
1.1	BSOL ICB to improve identification and response to victims	BSOL ICB Safeguarding Team/BSWA	Review is undertaken on the rate of referrals into IRIS, broken down by practice. A summary report of the findings to be presented to the IRIS steering group. Action plan developed which reflects the findings of the review, to include tactics to address practices with below expected referrals. IRISs advocate educators to engage with all practices	Jan 2023	Increase in identification of victims who are engaged with local primary care, and an improved access to specialist support.	Local IRIS steering group responsible for monitoring delivery of IRIS and provide regular updates to the DAPB.

			deemed to be infrequent/low referrers to offer an action plan to improve confidence in 'asking the question'			
1.2	Good practice and learning is shared across BSOL IRIS system. to and share good practice in relation to iRISi and Domestic Abuse across Birmingham and Solihull Primary Care.		BSWA to work in partnership with the ICB Safeguarding to identify good practice in the delivery of IRISi. Process for sharing regular updates to Primary Care and across the system where relevant, is in place.		Local IRIS programme delivery is improved, through adapting to incorporate change and emerging best practice.	Local IRIS steering group responsible
1.3	The Safeguarding Assurance tool used to report to NHS ICB is updated to allow GP safeguarding leads to provide evidence of compliance with NICE Guidance on 'asking the question'.	NHS ICB	BSOL ICB safeguarding team to review primary care polices & procedures for identifying and managing domestic abuse, and to assess effectiveness.		Primary Care are working in line with NICE Guidance and compliant with Recommendation 5 of that guidance; creating an environment that assists disclosure of domestic abuse	Local IRIS steering group
Complete						

RECOMMENDATION 2

The Safer Solihull Partnership to 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.

Ref	Action (SMART)	Lead Agency	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
2.1	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	BSMHFT Safeguarding Team	Our current risk screening tool prompts practitioners to consider domestic abuse when it talks about harm to and from others, there is a free text box for practitioners to add context. BSMHF are currently unable to add in a tick box to confirm that routine enquiry has been completed to gather specific data on this. Following on a domestic abuse audit that was completed in Dec 2022, we sent out a Survey Monkey to teams that receive regular safeguarding supervision. The uptake of the survey was poor.	January 2023	Report to be provided to Safer Solihull Partnership on changes made and the impact upon the number of referrals to domestic abuse support Copies of amended risk assessment tools that include mandatory fields regarding enquiry related to domestic abuse	Feedback to the Safer Solihull Partnership

			The Safeguarding Team are now planning to pilot assurance Visits to 2 identified clinical teams receiving regular safeguarding supervision. This will commence in Sept 2024. One of the key lines of enquiry will be asking about domestic abuse.	End of 2024		
Complete						

RECOMMENDATION 3

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.

Ref	Action (SMART)	Lead Agency	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
3.1	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.	NPS- Head of Probation (North & East Birmingham and Solihull Probation Delivery Unit)	October 2022 – Probation Service reissued MAPPA level 1 framework for universal roll out April 2023 – Embedding of framework is one of the key priorities in Solihull and	January 2023	Implementation of the National Framework within the Solihull NPS area Implementation of the National Framework within the Solihull NPS area	Report to the SSP

			Northeast Birmingham Business Plan April 2024 – Framework fully implemented with compliance monitored in performance meetings supported by monthly data reports			
Progress						

Individual Agency Recommendations

Individual Agency Recommendations for **National Probation Service**

RECCOMMENDATION 1

Middle managers carrying out direct engagement with Offender managers should implement the new quality assurance and supervision framework to enable best practice and senior managers should support the management of quality and performance issues arising from this.

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	Actively address identified poor practice by supporting middle managers (SPO), to implement practice development policies. Hold regular meetings with SPO to discuss improvement practice cases and support SPO in taking policy	NPS- Head of Probation (North & East Birmingham and Solihull Probation Delivery Unit)	January 2022	A robust process of accessing poor performance cases which conclude to an appropriated outcome.	Regular reviews with SPO's and HR of the identified cases.	Increased improvement in overall case management. Reduced cases of poor performance.

	forward where necessary.					

RECCOMMENDATION 2

Middle and Higher Managers ensure that all Offender Managers are supervised according to the new Touchpoints model which embeds a structured approach to accountability and professional curiosity. The Touchpoints model is new and supports Policies already in place regarding staff supervision, reflective practice group sessions and personal/ individual sessions. Countersigning of assessment also enables frequent analysis of practice and areas for improvement.

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	Actively seek Performance information to ensure that Offender Managers are supervised within the 'touch stone' model	NPS- Head of Probation (North & East Birmingham and Solihull Probation Delivery Unit)	January 2022	Required quarterly performance / training data analysis and dissemination of information to SPO's to action information received.	Continued performance / training data. Supervision with SPO's.	Improved performance data. Staff/SPO feedback.

RECCOMMENDATION 3

It is imperative that local providers have good communication links with Offender Mangers and take an active role in risk management plans where relevant. The NPS should work with commissioners and substance misuse service providers to ensure that local commissioning arrangements meet the needs of offenders and that there are specific protocols for offenders on statutory supervision

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	To liaise with local NHS/Public health commissioners in ensuring that commissioned services meet the needs of local offending population needs. Where there are deficits to work with commissioners in addressing deficits / adaptations contracts moving forward.	NPS- Head of Probation (North & East Birmingham and Solihull Probation Delivery Unit)	January 2022	Improved services and engagement with supporting services in the delivery of risk management plans and implementation.	Reviews of service, performance information from commissioned services regarding the number of offenders under statutory supervision engaging in community services.	Reviews of services and performance information.

Appendix A

Individual Agency Recommendations for **NHS Birmingham and Solihull ICB**

RECCOMMENDATION 1

To improve the identification of domestic abuse at both Practices and provide support to female patients who are experiencing or have experienced abusive relationships via the IRIS Advocate Educator.

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	Undertake active enquiry for domestic abuse in consultations involving mental illness, alcohol or substance misuse, chronic pain and other associated health conditions that are known to be associated with domestic abuse	GP Safeguarding Lead	31 March 2022	To improve the identification of domestic abuse at the Practice and provide support via the IRIS Advocate Educator to patients who are experiencing or have experienced abusive relationships. To confirm that the learning is implemented and sustained	Data provided by BSWAID to BSolCCG regarding number of referrals made each quarter for three quarters July- Sep, Oct – Dec 2021, Jan to March 2022	Evidence of referrals being made every quarter by all members of the team Evidence via case studies of patients coded with health conditions related to domestic abuse

Appendix A

Individual Agency Recommendations for **University Hospitals Birmingham**

RECCOMMENDATION 1
Continue to promote a 'think family' approach.

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	Included within our training packages.	Adult Safeguarding Team	6 months – December 2021	Increased awareness about the 'think family' approach.	Safeguarding operational group DA steering group	Safeguarding activity- Referrals for children
1.2	Raise awareness via a number of methods such as a communication campaign, newsletters and briefings for staff.	Adult Safeguarding Team	6 months – December 2021	Increase staff awareness about the 'think family' approach.	Safeguarding operational group DA steering group	Newsletter Briefing notes Referrals for children

RECCOMMENDATION 2

Ensure staff recognise and respond when a patient presents with alcohol misuse and who to sign post to.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured?
2.1	Raise awareness through staff briefings, newsletters and communication campaigns	Adult Safeguarding Team	Ongoing	Patients are referred appropriately to the right support services at the right time.	Safeguarding Operational Group	Newsletter Briefings Audit of Referral figures
2.2	Promote Management of Acute Alcohol Withdrawal policy through briefings, newsletter	Adult Safeguarding Team	6 months – December 2021	For staff to be aware of acute alcohol withdrawal policy	Safeguarding Operational Group	Newsletter Briefings Audit of Referral figures

RECCOMMENDATION 3

Continue to raise awareness of domestic abuse and encourage staff to ask NICE questions when there are indicators of domestic abuse (including substance misuse) and safe to do so.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured?

3.1	Raise awareness of domestic abuse via staff training and communication campaigns.	Adult Safeguarding Team	6 months- December 2021	Staff to be more confident in recognising when domestic abuse is indicated and responding appropriately to it.	DA steering group	Safeguarding activity Audit
3.2	Continue to promote the NICE domestic abuse questions when there is an indicator or disclosure of domestic abuse.	Adult Safeguarding Team	Ongoing	Staff to be more confident in recognising when domestic abuse is indicated and asking NICE questions.	DA steering group	Safeguarding activity Audit

Appendix B

Note from the DHR Chair:

The Home Office QA panel agreed with the learning and analysis in this DHR and gave authority to publish without resubmission. The attached letter from the Home Office Quality & Assurance Panel suggested alterations to the report that the panel felt could assist the reader to understand key themes and learning. Where the Safer Solihull Partnership and Independent Chair endorsed the QA Panel suggestions, these amendments have been made.

Simon Hill

July 2024

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27 November 2023

Thank you for submitting the Domestic Homicide Review (DHR) report (Claire) for Safer Solihull Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 11th October 2023. I apologise for the delay in responding to you.

The QA Panel noted that condolences are given in the review to the victim's family. The Panel also recognises that the use of the family contribution in the report helped give a sense of Claire as an individual. The heartfelt and moving tribute provided by Claire's adult daughter provided an insight into Claire as a person, daughter, mother, grandmother, and carer. The Claire's daughter also contributed to the DHR process, which was positive.

Pseudonyms are used through the review, preserving the anonymity of the victim and the victim's family. A wide range of people were contacted regarding involvement in the DHR, including the family and community. This was reflected throughout the report, with quotes from relevant people. The Panel noted the flexibility regarding Claire's adult daughter input, despite this being later in the process.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- There was no domestic abuse expertise on the panel when conducting the review. The report should address why a specialist domestic abuse service representative was absent.

- There appears to have been delays in completing and agreeing the report in the final year. A comment should be added to explain why this was and focus on any delays that impacted the length of time the review took overall.

- The youngest child's sex is appropriately not given, and the child was given a gender-neutral pseudonym. The family tribute at the start, however, discloses the child's sex.

- Section 6 (methodology) could be strengthened by adding information on the scoping of agency involvement, whether agencies were asked to secure their files, the process undertaken, and other sources of information accessed, interviews held, etc.

- Page 10 mentions that reports were requested from the victim's employer and Scouts Association. The report should clarify what the nature of the reports requested was.

- The report does not disclose whether the perpetrator was approached to contribute to the review.

- The criminal investigation should also be mentioned in the 'Parallel Reviews' section.

- The 'Ethnicity, Equality and Diversity' section states that 'there is no evidence available to the DHR that any of the protected characteristics were relevant in this case'. However, no further information is given. It would help the reader to know what the protected characteristics are, to reference the Equality Act 2010, and to explain why they were considered not relevant.

- It is surprising that 'sex' was not identified as a protected characteristic relevant to this case, given what is known about women disproportionately being the victims of domestic abuse and men the perpetrators.

- The family, PCC and the Domestic Abuse Commissioner's Office should be added to the 'Dissemination' list.

- The majority of the agency involvement represented in the report is in relation to the perpetrator and their offender management. The victim's contact with her GP is represented from September to

November 2020. Given the almost four-year timeframe for the review, it would be surprising if the only agency contact that the victim had was in the last two months before her death. However, if this is the case, it would help to state this for clarity.

- The analysis is rightly critical of the offender supervision and management of the perpetrator. However, this is largely focused on the failings of an individual professional. A comment on the supervisory, cultural, or organisational context they operated within would add depth to the review.

- Whilst there is, quite rightly, a focus on Andrew's alcohol issues, and the lack of curiosity into his drinking and his relationships, it would be useful for there to be a short, evidence-based section exploring the relationship between domestic abuse and alcohol. This would provide context for this case, as well as clarify that alcohol does not cause domestic abuse.

- The review acknowledges that family were aware of the abusive nature of the relationship but did not tell anyone and that this may be because the victim asked them not to, but it would be good to see some consideration of their own information needs and whether these are met locally.

- There are multiple places where the use of 'apparently' seems inappropriate against factual information. See for example page 15, paragraph 14, page 17, paragraph 1, page 19, paragraph 12, page 20, paragraph 14, page 21, paragraph 22. This is recurrent throughout the review.

- 'Irisi' is mentioned several times with no reference or explanation regarding what it is.

- The report needs to be proofread to address the many formatting errors.

- There is nothing to show the monitoring of the actions or to note if or when they are completed in the Action Plan.

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