# Domestic Homicide Review Executive Summary

Commissioned by the Safer Solihull Partnership

Under s9 of the Domestic Violence Crime and Victims Act 2004

## In respect of the death of ‘Rosie’ who died in July 2020

Review produced by Independent Chair Jan Pickles OBE

Date report completed: 17.12.22

# Contents

## Acronyms used and a glossary of terms

**SIAS-**Solihull Integrated Addiction Service (SIAS) is a substance misuse partnership between five organisations jointly responsible for the delivery of the drug, alcohol, and gambling services, in the Borough of Solihull. SIAS comprises of BSMHFT, Welcome, Changes UK & Aquarius and includes a Young Persons service.

**Psychiatric Liaison** offers an integrated service in Acute (General) Hospitals in Birmingham & Solihull. It provides a 24-hour single point of access to mental health services for all inpatients and people who attend emergency departments in acute hospitals who are aged 16 and over. It provides comprehensive multidisciplinary assessments of people with mental health problems in the general hospital setting.

**The Criminal Justice Liaison and Diversion service** are a specialised team provided by BSMHFT to work within police custody suites, Birmingham Magistrates Court, and the community. The team assesses vulnerable individuals with complex needs who are being brought into the Criminal Justice System having been accused of criminal activity. These needs include, but is not limited to, support with mental health, a learning disability, substance misuse, homelessness, financial needs, or social difficulties.

**Birmingham Healthy Minds** is an NHS primary care psychological therapies service for people with depression and anxiety symptoms. They offer a variety of treatments depending on an individual's needs, for example cognitive behavioural therapy, mindfulness, and interpersonal therapy.

**Community Mental Health Team- Community Mental Health Teams (CMHT)** support people living in the community who have complex or serious mental health problems. The CMHT is staffed by a multi-disciplinary team which includes psychiatrists, community psychiatric nurses, clinical psychologists, and social workers. The CMHT provides assessment, specialist support, treatment and care planning for service users aged 18 years and upwards.

**Birmingham and Solihull Mental Health Foundation Trust** (BSMHFT)

**Solihull Metropolitan Borough Council Children's Services** (CS)

**West Midlands Police** (WMP)

**MARAC** The Multi-Agency Risk Assessment Conference is an information sharing and planning meeting for high-risk victims of domestic abuse.

**University Hospital Birmingham Accident and Emergency Unit** (UHB A&E Unit)

**West Midlands Ambulance Service** (WMAS)

**Birmingham and Solihull Women's Aid** (BSWA)

**Crown Prosecution Service** (CPS)

**Domestic Abuse Stalking and 'Honour' based violence risk checklist** (DASH) A checklist completed by agencies to identify victim risk in these issues.

**Spousal Abuse Risk Assessment** (SARA) The Spousal Assault Risk Assessment (SARA) by Kropp, Hart, Webster & Eaves (1995) is used to assess the risk of intimate partner violence. Their tool recognises that intimate partner violence may occur without regard to gender (male on female, female on male, female on female, male on male, and any other combination including trans and non-binary individuals), marital status (married and common law individuals may engage in intimate partner violence) and does not necessarily require physical injury.

**Deprivation of liberty** (DoLS) The Deprivation of Liberty Safeguards (DoLS), which apply only in England and Wales, are an amendment to the Mental Capacity Act 2005. The DoLS under the MCA allows restraint and restrictions that amount to a deprivation of liberty to be used in hospitals and care homes – but only if they are in a person's best interests.

**Domestic Violence Prevention Order** (DVPO) Domestic Violence Protection Orders (DVPOs) were introduced across England and Wales in March 2014 as part of the Call to End Violence Against Women and Girls action plan.

Under the DVPO scheme, police and magistrates have the power to ban a domestic violence perpetrator from returning to their home or having contact with the victim for up to 28 days in the immediate aftermath of a domestic violence incident. An initial temporary notice, the Domestic Violence Protection Notice (DVPN) can be issued when authorised by a senior police officer, and this is then followed by a DVPO which will be imposed at the magistrates' court.

The Crime and Security Act (CSA 2010) Sections 24-33 of the Act relate to Domestic Violence Protection Notices and Orders (DVPNs and DVPOs).

**Solihull Metropolitan Borough Council Adult Social Care** (ASC)

**Probation Service** (PS)

**West Midlands Community Rehabilitation Company** (CRC)

## 1.THE REVIEW PROCESS

This Executive Summary outlines the process undertaken by Safer Solihull Partnership Domestic Homicide Review Panel in reviewing the death of Rosie whose death occurred at her home in July 2020. Rosie's death was caused by strangulation, smothering and 54 multiple knife wounds inflicted in a frenzied attack by her partner of a few weeks, Nick.

The family chose the pseudonyms used in this report, the Panel agreed that the victim would be referred to as Rosie and the perpetrator who she had known for a matter of weeks as Nick. This Review focused on Rosie's previous relationship with her then partner Edward who was known to be abusive to her. The Panel believed this abuse wore her down leaving her more vulnerable in her relationship with Nick and was therefore relevant and significant.

Following a 16-day trial in November 2021, Nick was found guilty of Murder and was sentenced in early December 2021 to Life Imprisonment to serve a minimum of 25 years in prison. His mother was found guilty of Assisting an Offender and Perverting the Course of Justice by her involvement in their attempt to cover up the murder. In passing sentence, Judge Melbourne Inman QC said neither Nick nor his mother, had shown any remorse for the "savage" murder of Rosie. He described their efforts to conceal the crime as "calm and calculated" and said of Nick, "You are an extremely dangerous man. You went to her flat. You left the flat two-and-a-half hours later. During that time, you savagely attacked Rosie. You used serious physical violence on her. You also strangled her. You smothered her with your right hand. You inflicted fifty-four separate injuries with those knives. The violence was on any view extreme. When you used the knives, Rosie was still conscious. This was obviously a sustained attack. Rosie must have been wholly terrified before she suffered the fatal injuries. Having killed her you set about in a calm and collected manner trying to get away with it. You enlisted the help of your mother and within nine minutes you set in to train your false trail. You continued the pretence with her family. You appeared to be extremely distressed. You were confident with your deception. You believed your plan would succeed."

In terms of the Protected Characteristics within the Equality Act 2010 Rosie was 38 years old at the time of her death. In July 2020 she identified as female and White British. She had been diagnosed with Epilepsy and with was experiencing ongoing health issues related to her use of alcohol.

In terms of Nick and the Protected Characteristics within the Equality Act 2010 he identifies as White British and male he was 37 years old at the time of the murder. He stated during the Criminal Justice process that he had no serious health conditions but suffered from depression and anxiety and received Sertraline medication. Nick also disclosed at the trial that he was a diabetic and required ongoing treatment for this.

The DHR process began with an initial meeting of the Safer Solihull Partnership (SSP) in August 2020. They concluded that Rosie's death did meet the Home Office criteria and the decision to hold a Domestic Homicide Review (DHR) was agreed. Fifteen agencies that potentially had contact with Rosie or Nick or her previous partner Edward prior to the point of the murder were contacted and asked to confirm whether they had any involvement with them and if so to secure their files.

The initial scoping of 15 agencies identified twelve agencies had relevant information. Of these nine were asked to provide Independent Management Reviews (IMRs) which were commissioned from professionals who were independent from any involvement with the victim, her family, or the alleged perpetrators. Three other agencies were asked to provide relevant information specific to Rosie's children.

The DHR was in turn delayed by the impact of the Covid -19 pandemic on the Criminal Justice process, The Family Liaison Officer and the Victim Support Homicide Team Advocate arranged for the Chair to meet with Rosie's parents in January 2022 and again in July 2022 to review a near final draft of the DHR. An offer was made to them to speak with the Panel.

Following his sentence, the Chair wrote to Nick offering to visit him in custody to discuss the Review. This letter was delivered by the Probation Service so that the process could be explained to him, he chose not to co-operate.

## 2.CONTRIBUTORS TO THE REVIEW

The following agencies were required to produce an IMR on behalf of their organisation.

1. Birmingham and Solihull Women's Aid (BSWA)
2. University Hospital Birmingham (UHB)
3. West Midlands Police (WMP)
4. Birmingham & Solihull Clinical Commissioning Group (BSCCG)
5. Birmingham and Solihull Mental Health Foundation Trust (BSMHFT)
6. West Midlands Community Rehabilitation Company (CRC)
7. SMBC Adult Social Care (ASC)
8. MARAC (Multi- Agency Risk Assessment Conference)
9. West Midlands Ambulance Service (WMAS)

Information Reports were provided by Solihull Children's Services and Solihull Education Safeguarding who liaised with schools in Warwickshire and Staffordshire.

Further scoping information was received from Staffordshire Children's Services and South Warwickshire Foundation Trust who commission School Nursing in the area.

The CCG IMR author reviewed the GP notes for Rosie and Nick on two occasions and spoke with the Clinical Reporting Coordinator. The IMR Author would have liked to have had copies of both sets of notes but had to compromise with reviewing the notes at the GP surgery following concerns from the GP practice about providing copies to the review.

## 3.THE REVIEW PANEL MEMBERS

The following agencies were invited to be part of the DHR Panel. All members were representatives of their respective organisations and had had no direct or line management responsibility for services provided to Rosie, Nick, or Edward.

| | Agency Representative | Role | Name |
|---|---|---|---|
| **1** | Independent Chair | Chair and Author | Jan Pickles |
| **2** | SMBC Community Safety Lead | Executive lead officer for review - Safer Solihull Partnership/Panel Member | Gillian Crabbe |
| **3** | SMBC Adult Social Care | Agency Expert lead Officer and Panel Member | Bethany Hutchinson |
| **4** | Birmingham and Solihull Mental Health Foundation Trust | Agency Expert lead Officer and Panel Member | Yvonne Hartwell |
| **5** | Birmingham and Solihull Clinical Commissioning Group | Agency Expert lead Officer and Panel Member | Andrew Colson |
| **6** | Solihull MBC Domestic Abuse Co-ordinator | Agency Expert lead Officer and Panel Member | Caroline Murray |
| **7** | Birmingham and Solihull Women's Aid | Agency Expert lead Officer and Panel Member | Ferhut Jabeen |
| **8** | West Midlands Police | Detective Inspector and Panel Member | Andrew Bridgewater |
| **9** | University Hospital Birmingham | Agency Expert lead Officer and Panel Member | Pam Rees |
| **10** | Community Rehabilitation Company until June 2021 when re-integrated into the National Probation Service | Agency Expert lead Officer and Panel Member | Marj Rodgers |

## 4.AUTHOR OF THE OVERVIEW REPORT

Jan Pickles was appointed as Independent Chair of the DHR and author of this report in August 2020. She is a qualified and registered social worker with over forty years' experience of working with perpetrators and victims of domestic abuse, coercive control, and sexual violence, both operationally and in a strategic capacity. In 2004, she received an OBE for services to victims of domestic abuse for the development of both the MARAC model and for the development of the role of Independent Domestic Violence Advisers (IDVAs). In 2010, she received the First Minister of Wales's Recognition Award for the establishment of services for victims of sexual violence. She has held roles as a Probation Officer, Social Worker, Social Work Manager, Assistant Police and Crime Commissioner and as a Ministerial Adviser. She is currently an Independent Board member on an NHS Trust and a member of the National Independent Safeguarding Board for Wales. She has completed the Home Office training for chairs and authors of Domestic Homicide Reviews.

Jan Pickles is not currently employed by any of the statutory agencies involved in the Review (as identified in section 9 of the Act) and have had no previous involvement or contact with the family or any of the other parties involved in the events under Review.

## 5.THE TERMS OF REFERENCE FOR THE REVIEW

1. Background - This review is being conducted by Safer Solihull Partnership in response to the requirements of Section 9 of the Domestic Violence, Crime and Victims Act (2004). This creates an expectation for local areas to undertake a multi-agency review following a domestic violence homicide. This provision came into force on 13 April 2011. Domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

- A person to whom they were related or with whom they were or had been in an intimate personal relationship.
- A member of the same household as themselves.

They are held to examine the case in question by involving practitioners, agencies, friends, and family in order to identify any learning, which may be implemented to contribute to prevention of such crimes in the future.

The case in question relates to the death of Rosie. The circumstances of their death have been assessed by the Chair of the Safer Solihull Partnership and our Partners against the Home Office definition, detailed below, at a meeting in August 2020.

2. Criteria for Domestic Homicide Review - The definition states that domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: Psychological, Physical, Sexual,

Financial and Emotional. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage.

3. When to undertake a Domestic Homicide Review. - A Domestic Homicide Review should be undertaken when the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by—

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

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

It should be noted that an 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

A member of the same household is defined in section 5 (4) of the Domestic Violence, Crime and Victims Act [2004] as: (a) a person is to be regarded as a "member" of a particular household, even if he/she does not live in that household, if he/she visits it so often and for such periods of time that it is reasonable to regard him/her as a member of it; (b) where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

4. Circumstances of the incident

In July 2020, Rosie died as a result of multiple knife wounds. Nick, partner of Rosie, has been charged with murder. Edward is a previous partner of Rosie who had been abusive in that relationship.

5. Deliberations of the Safer Solihull Community Safety Partnership

The Safer Solihull Partnership Chair sat in August 2020 to consider the circumstances of the incident and to determine whether or not it is 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. The Chair took advice from officers who offered expert advice.

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 because:

- An adult had died and

- The alleged perpetrator was reported to have had an intimate relationship with the victim.

The Chair of Safer Solihull Partnership considered, based on replies received to date, which agencies had been involved with the family and the relevance of this involvement with the incident.

They used this information to determine which agencies should be involved within the review and be requested to conduct Individual Management Reviews (IMRs). It is acknowledged that as the review progresses along with the criminal justice process other services and parties may be identified who can inform the review process.

The Chair and panel also considered the involvement of family members and others in the process.

The following persons were identified as potential contributors to the review and will be contacted under guidance from the criminal investigation team.

6. Family composition Privileged information – **Redacted**

For the purpose of responses from agencies the following are considered to be significant persons, only in respect of their known interactions and relationship with either the victim or alleged perpetrator **Redacted**

7. Notifications to Home Office

The Home Office were notified of the Chair's decision to conduct a Domestic Homicide Review on 31/08/2020.

8. Parallel investigations

The following processes and investigations are also taking place:

a) The case is subject to criminal proceedings

b) Coroner's Inquest (awaiting confirmation)

9. Family involvement - The Chair of the panel will ensure that members of the family will be sensitively invited to contribute to the review. In the first instance the subjects (to be determined by the DHR Chair and Panel members in consultation with the Police) will be notified of the review and contacted by the Independent Chair of the Panel or their nominee to advise them of the review process taking place and inform them at what point they will be able to contribute to the review. The Timing of any dialogue will be agreed with the Police and the Crown Prosecution Service to ensure that evidence for any future criminal proceedings is not compromised.

10. Commissioning of the Independent Chair and Author of the panel - The Chair of the Safer Solihull Partnership commissioned an independent person with appropriate experience to chair the review panel and produce an overview report that will be published in full in line with DHR procedure. Janet Pickles OBE has been appointed as the Independent Chair of the DHR Review Panel and Overview Author in this case with effect from 01/10/2020.

11. Domestic Homicide Review Panel Membership - The following agencies will form the DHR panel:

1. Independent Chair and report Author – Janet Pickles OBE
2. SMBC Community Safety Lead
3. SMBC Adult Social Care
4. Birmingham and Solihull Mental Health Foundation Trust
5. Birmingham and Solihull Clinical Commissioning Group
6. Solihull MBC Domestic Abuse Co-ordinator
7. West Midlands Police
8. University Hospital Board
9. Community Rehabilitation Company
10. Birmingham and Solihull Women's Aid

The DHR Chair and panel members will, as required, identify any additional expertise required to support a robust and comprehensive learning process.

12. Scope and Time period of review - Upon on receipt of the notification of the homicide from West Midlands Police agencies were asked to review all relevant records relating to the subjects Rosie, Nick and Edward and identify any other relevant individuals that could assist the review process. Based on those initial scanning replies to the period for the review has been identified as July 2016 to the date of the death of the victim. July 2016 has been selected as the victim's final relationship was short in duration and this covers the period in which the victim was involved in a number of reported abusive relationships. However, if agencies discover information that is relevant to the review before this date it should be included in the IMR. July 2020 has been determined as the end of the review period as this the date of the death of Rosie.

13. Organisations within the scope of the Domestic Homicide Review - The following agencies were asked to review all relevant records relating to the victim, Rosie and alleged perpetrator Nick and her previous partner Edward to determine if they were known to their agency/service and the scope of that knowledge/involvement. Agencies declaring previous involvement were: Where the victim and alleged perpetrator were known, each agency is required to provide their agency Individual Management Reviews (IMRs). Agency's authors of the IMRs should be selected using the criteria at Section 7 Point 66 of the Safer Solihull Practice Guidance for Domestic Homicide Reviews V5 June 2017. Where an Agency is also required to be a member of the Domestic Homicide Review Panel, a different agency representative should be identified for each role.

14. Practitioner Involvement - All IMR Authors are expected to obtain the views of the practitioners involved in working with the subject and family to inform single agency learning. The Independent DHR Panel Chairperson will ensure the views of the Safer Solihull Domestic Priority Group are sought and used to identify 'system' learning during the progress of the review and to support the quality of the learning identified in the Overview Report. Each agency will provide the names of staff to be interviewed as part of their IMR to Gillian Crabbe, Community Safety Lead and this information will be shared with West Midlands Police and the Chair of the DHR prior to any interviews taking place, to ensure that there is no conflict of interest.

15. Individual Management Reviews - In completing the IMR it is important that the authors recognise that there is one victim and one perpetrator and to treat each separately, if both are known to their agency and to note any differences in levels of risk or vulnerability. If either Rosie or Nick or Edward were not known to your agency this should be clearly stated, at the relevant section in the IMR template, for clarification purposes. All authors of Individual Management Review reports must submit evidence of written authorisation and ownership of their agency Individual Management Review by the Senior Officer in the organisation who has commissioned the report, challenged and quality assured its contents, accepted its findings, and will ensure that its recommendations are delivered. The Senior Officer must have the authority for ensuring that the learning and recommendations of both the individual management review and where appropriate the overview report are acted on in a timely way.

16. Timescales for submission of Individual Management Reviews. - IMR Authors are requested to securely submit their completed reports to, Community Safety Lead by no later than February 2021 to a secure email account. (*There was some delay in receiving all IMRs to mid-March 2021 due to the second period of lockdown and pressures on frontline agencies due to the pandemic which led to staff being redeployed and facing other imminent demands.)* In addition to the codes provided, namely Rosie, the victim and Nick, the perpetrator a common system of referencing professionals involved should be set by each agency, along with their initials. Where a professional appears in more than one IMR, these will used in all relevant documentation e.g., Health Visitor 1 XXX, GP 1 XXX, Social worker 1 XXX. (Note: this will become evident at IMRs are received and reviewed by the panel). This system of referencing will be used in the overview report so as to preserve the anonymity of professionals involved in working with the victim and family. The use of pseudonyms for the victim, perpetrator and other family members will be agreed in consultation with the family.

17. Information Sharing - 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.

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. All information and correspondence in respect of the DHR should be transmitted securely and the preferred method is secure email. If an agency does not have arrangements to communicate via secure email, please contact SSP to identify and agree an alternative safe method of delivery. The following principles should be complied with at all times:

- We only share the minimum information needed to inform the completion of the review.
- If personal or sensitive information is shared by email it is sent by encrypted email.
- Information should not be stored on laptop computers or other similar devices unless the equipment is encrypted.

- Printing and the storing of documents should be in a controlled environment and secure to prevent disclosure of confidential material.
- If paper copies are used and stored, then they must be secured and out of sight, preferably under lock and key
- Paper copies MUST be disposed of by shredding or incineration

18. Key Lines of Enquiry- The review should address both the 'generic issues' set out in the Statutory Guidance, and the following specific issues identified in this particular case:

- What decisions could have been made and action taken by agencies to prevent the homicide of Rosie or prevent Adult 2 from being a perpetrator of homicide
- How effective were agencies in identifying and responding to both need and risk?
- The relationship between Rosie and 2 was brief and this review wishes to widen its focus to establish if there is any learning from Rosie previous relationship with Edward. The review anticipates there may be learning on that relates to victims who experience serial abusive relationships.
- How effective were agencies in working together to prevent harm through domestic abuse in Solihull?
- What lessons can be learnt to prevent harm in the future

Individual Management Review Authors will therefore be asked to respond to the following questions in respect of their involvement with Rosie and Adult 2.

- Can you provide a brief summary of the role of your organisation in responding to domestic abuse?
- Can your agency provide a brief pen picture of Rosie, Adult 2& Adult 3together with and any knowledge your agency had of their relationship?
- What needs and vulnerabilities did your agency identify in Rosie (the victim) and how did your agency respond?
- What needs and vulnerabilities did your agency identify in adult 2 (the alleged perpetrator) and Adult 3the previous perpetrator and how did your agency respond?
- What threat and risks did your agency identify for either Rosie, Adult 2 or Adult 3and how did your agency respond? Consider identified threat and risk for this relationship as well as the potential for threat to other people.
- If domestic abuse was not disclosed or known about, how might your agency have identified the existence of domestic abuse from other issues presented to your agency?
- How well equipped were staff in responding to the needs, threat or risk identified for both Rosie Adult 2 and Edward. Were staff supported to respond to issues of domestic abuse, safeguarding, public protection, and multiple and complex needs.
- 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 affect your agency's response in the future or were any taking place at the time of your agency contact with Rosie or adult 2?
- 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? If no recommendations are being made, please state, why.

19. Enquiries specific to this review - i) The scoping identified agencies had limited contact with Rosie could agencies consider if more could have been done to engage her? ii) As this homicide occurred during the COVID-19 pandemic, could agencies consider the impact this and the lockdown arrangements may have had on their service to this case. iii) Rosie was for part of her life dependent on alcohol could agencies consider how this impacted on her ability to make decisions and her capacity under the Mental Capacity Act. iv) Could agencies adopt a trauma informed lens when reviewing Rosie engagement with their agency?

20. Process- To identify key agencies and professionals involved with the deceased, the alleged perpetrator and other key family members and commission individual management reviews to be completed by February 2021, detailing the nature and extent of their involvement. Agencies currently identified are:

- Birmingham Solihull Clinical Commissioning Group (BSOL CCG)
- University Hospitals Birmingham (UHB)
- Birmingham Solihull Mental Health Foundation Trust (BSMHFT)
- West Midlands Ambulance Service (WMAS)
- West Midlands Police (WMP)
- Community Rehabilitation Company (CRC)
- Birmingham and Solihull Women's Aid (BSWA)
- Multi Agency Risk Assessment Conference (MARAC)
- Solihull Council – Adult Social Care (SMBC ASC)
- Solihull Council – Education Safeguarding.

The Panel will receive the IMR reports from the above agencies and, based on the information provided, will consider the extent at which this review may need to be extended to involve others. The review Panel will consider the completed IMRs and information reports, seek additional information as required and, based on the information and analysis available will, together with the Review Chair, formulate any recommendations necessary to be presented to the Safer Solihull Partnership. The Panel will undertake all the above actions and present findings to Safer Solihull Partnership Executive board.

21. Overview report - The Overview report will be published in full and should be produced in a manner that focuses on the professional involvement and inter-agency working with the family as opposed to the detailed history and experiences of the life of the victim or others referred to in section 5. The report should identify the key inter-agency 'system' learning, good practice and specifically address:

- The effectiveness of multi-agency identification, analysis and management of risk and information sharing arrangements including any identified barriers to achieving effective management of risk.
- The quality of risk assessments and validity of any tools or processes used to identify protective factors as well as risk factors.
- The quality and impact of multi-agency planning, and review processes used to promote improved outcomes.
- The impact and quality of professional supervision and its contribution to securing good quality practice including exploration of the 'rule of optimism' or any over-reliance on protective factors.
- The application of 'thresholds and the degree of shared understanding and agreement across the partnership of those thresholds.
- Any 'cultural practice norms' that could impact on the professional network's capacity to deliver high quality practice.

The findings from this DHR should be considered alongside learning from DHRs conducted elsewhere, local audit findings, peer review feedback and findings from relevant research and take account of the socio-economic background of the family and their community.

- To assess the quality of learning, identified by each agency submitting an IMR and the response to that learning.
- To establish a multi-agency action plan as a consequence from any 'system' issues arising from the overview report.

22. Media Strategy - In accordance with the Safer Solihull Communication Strategy, any media enquiries in respect of the Domestic Homicide Review will be managed by the Local Authority communications team in conjunction with constituent partner agencies.

23. Review- These Terms of Reference will be reviewed by the Domestic Homicide Review Panel under the leadership of the Independent Chairperson in the light of any new information, which emerges from the IMRs or criminal investigation. This is to ensure a dynamic learning process.

## 6.SUMMARY CHRONOLOGY

6.1 Rosie was born and lived in Solihull in the West Midlands for all of her life. Her family described her as a loving, bright, and ambitious person. She worked for most of her life in the insurance industry and achieved significant promotions with the company she worked for. She was made responsible for managing accounts involving a series of high-profile claims for the company. The Adult Safeguarding IMR[1] describes Rosie as having had "a steady home, a network of support in friends and family and full-time employment." Rosie had been in a long-term relationship and had two school age children with her partner. There are no records to indicate there were any significant problems until the couple separated sometime in 2016.

[1] Adult Social Care and Support SMBC P2 1.1

There are some indicators of potential stress within the relationship and that Rosie felt that they had little time for each other, both working different shift patterns.

6.2 There is evidence that suggests around 2016, Rosie's mental health began to deteriorate along with an increase in her alcohol misuse. This led to friction and stress within the family. The impact on the children of this had been noted at their respective schools, and by the family's GP to whom Rosie had presented. Rosie had also presented at the area's A&E Unit with alcohol related issues. Rosie also later disclosed to a worker at Solihull Integrated Addiction Service (SIAS) that her "alcohol intake increased prior to this as she was controlled by ex-husband (*sic*), including informing her what she could wear and would only let her go out for work." Rosie also experienced problems at work and she was referred to their occupational health service. There was further deterioration, and in June 2017 the couple separated, after a Grandparent had removed the children due to his concerns for their safety and well-being and had informed Children's Services of this.

6.3 Rosie had contact with SIAS, the local alcohol support agency from 2016 until her death. Her attendance was erratic with them as was her response to the help provided by her employer's Occupational Health Service. There was a pattern of attendance following referral followed by missed appointments and then discontinuance. SIAS were persistent in their attempts to maintain contact with her, despite her reluctance throughout this time. The family's concerns continued in terms of Rosie's drinking and behaviour. Rosie attended the A&E Unit of University Hospital Birmingham (UHB) towards the end of August 2017, where she described drinking a bottle of vodka and cider per day, due to relationship difficulties. In October 2017 Rosie left the family home where she had been living on her own, after her partner had left her. Records show that she obtained good quality rented accommodation sometime after this within the area but not precisely when this was. She remained in this property until her death. It is clear given her accounts that she often did not feel safe or settled there.

6.4 Rosie attended A&E in August 2017 with alcohol related symptoms and injuries. She attended with her new partner Edward. This relationship we now know was abusive and would continue to be so until it ended shortly before her death. In August 2017 Rosie attended the local hospital with injuries and symptoms which appeared to be alcohol or drug related. This pattern was to continue until her death. Rosie stated she had hit her head after falling due to her drinking. The explanation for her injury was accepted, as it would be on most other presentations. In November 2017, Rosie's first overdose was recorded, although hospital notes refer to a previous overdose in August that year, this has not been confirmed. Rosie stated she overdosed due to her separation from her partner and children and forthcoming Court case. Rosie was assessed by the Psychiatry Team at UHB, she was felt not to be suicidal and discharged, with a follow up appointment made with SIAS. Rosie did not attend those appointments made with SIAS and following a phone call with them some month later in which she reported things to have improved was discharged.

6.5 By late 2017 Rosie had returned to work, but her return was seen as problematic due to her behaviour at work. In June 2018, her employer received a sick note from her GP which outlined Rosie's alcohol dependence, depression, and anxiety. Rosie was offered and took the offer of redundancy from her employer which paid a smaller lump sum and monthly payments which because of her ill health would have continued until her retirement. The payment was two thirds of her salary in

recognition of her seniority, long service, and ill health. Her employment records indicate a thorough process with Rosie being given the opportunity to remain in work whilst her ill health continued, as an option to redundancy. Her family identified the stress of her work as a contributory factor in her reliance on alcohol.

6.6 Rosie attended University Hospitals Birmingham NHS Foundation Trust (UHB)in January, September, and November 2018. She presented with injuries including bruising which could have drawn suspicion in terms of their cause being by assault rather than accident, however Rosie's explanation of 'falling' and 'clumsiness' was accepted on all occasions. In November 2018 medical examination noted "Extensive bruising on face and body-varying ages of bruises"[2] and she did disclose that she had previously experienced violence. It is of note that Rosie's partner on this occasion had contacted the hospital. This did not seem to have caused any concern to staff on the ward. Her sister in another unrelated meeting attended hospital with her and described her as 'alcohol dependent' and unable to continue in work due to this and her depression. In December 2018 Rosie was told she could only have supervised contact with children, this we know from her family was a devastating for her.

6.7 The IMR from West Midland Police (WMP) indicate that the deterioration in Rosie's emotional wellbeing coincided with an increase in violence and abuse within her new relationship with Edward. WMP state that between September 2018 and December 2019 there were "ten recorded incidents between the couple all termed as domestic abuse and evident of escalating physical abuse". This led to an ascribed high risk of domestic abuse status and MARAC procedures were initiated. The IMR from the West Midland Ambulance Service (WMAS) confirms this pattern, recording that in February 2019 "Abuse started 5 months ago… has escalated recently, has been smothered with pillows… bruising all over. Swollen jaw." Rosie was referred again to SIAS, and she told them that she was afraid of her partner (Edward) and did not feel safe. Rosie was advised to contact Women's Aid. SIAS were only able to maintain spasmodic contact with Rosie by telephone following her discharge and advised her to contact the Police in relation to her partner's abuse.

6.8 In late April 2019 Rosie contacted WMP and reported that she had been assaulted by Edward. WMP attended at Rosie's flat, Edward was still there and denied the assault. Although Rosie was not able to give evidence due to her being intoxicated, the police continued with the prosecution following consultation with the Crown Prosecution Service (CPS). This was one of two victim led prosecutions instigated by WMP of Edward. Records do not indicate whether a DASH was completed. Rosie was referred to MARAC. Edward's prosecution was later to be heard and dismissed at Birmingham Magistrates Court in late December 2019. The Magistrate imposed a Restraining Order on both Rosie and Edward. This judgement by the Court was deeply resented by Rosie and after it she stated she felt 'belittled and had lost all faith in the Police." Following further investigation this appears to have been a misunderstanding by Rosie as the Restraining Order was made against Edward only, to prevent him having contact with Rosie.

[2] UHB chronology P10

6.9 Adult Safeguarding received three referrals concerning Rosie between March and April 2019. There were several telephone contacts with her during which she did acknowledge her injuries were related to abuse and admitted her fear of Edward after initially denying this. However, Rosie turned down their offers of help to contact WMP and Women's Aid disclosing this was due to her fear of her perpetrator. There was no follow-up either with her or WMP. The IMR from Adult Services acknowledges that a more 'proactive and personal' approach may have helped.

6.10 There was another hospital admission in May 2019 and Rosie was again seen by an SIAS worker who noted; "There was evidence of bruises on face arms and legs. (Rosie) States that domestic abuse has happened a couple of times since they have been back together, and she did report it to the police." Rosie was offered support, but this was declined stating that they were "working it out." The SIAS worker recorded as a protective factor that she "had a supportive partner." The SIAS IMR reveals Rosie's ambivalence -sometimes acknowledging her abuse and at others denying it. There is no record of SIAS seeking information from other agencies or MARAC to explore this. The WMP chronology shows that Rosie had reported an assault by Edward of her in April 2019, which resulted in a further referral to MARAC.

6.11 It is from mid-2019 on that the violence and abuse within the relationship with Edward began to result in police and medical involvement on a much more frequent scale than hitherto. An indication of this is the use of the MARAC. Rosie was referred four times in 2019 due to her being assessed at 'High Risk' from Edward's abuse by WMP and was discussed at Solihull MARAC in mid- March, mid-May, early in July and mid-November 2019. Services offered by the MARAC were unable to engage Rosie. An indication of the danger Rosie was in but unaware of was her disclosures in mid-March 2019 to a Police Officer that her injuries had been caused over a three-month period, that he "attempted to suffocate her, preventing her from breathing. She disclosed she was "petrified" of him and that he had attempted to strangle her. This would suggest that Rosie had become so exhausted by the abuse that she was beyond considering alternatives or routes of escape. Following the MARAC review, Birmingham & Solihull Women's Aid (BSWA) were tasked with contacting Rosie as standard procedure, which they did but were unable to engage her, despite a number of calls made to her in this period. BSWA did inform Rosie of all her housing options but noted that she had stated she was too fearful of the perpetrator and could not live in her own flat as he was there.

6.12 The pattern of injuries sustained by Rosie and callouts responded to by Police and Ambulance Services and Hospital admissions continued through 2019 and into 2020. Rosie's injuries and the impact on her became more serious, with her experiencing seizures and hallucinations. In late April 2019 Rosie was again admitted to hospital after she was reported to have had four seizures that day. She was assessed initially as lacking capacity, and a 'Deprivation of liberty'(DoLS) Order was made. Potentially controlling behaviour by Rosie's partner was noted in ward notes. There is no reference to any action being taken regarding these concerns.

6.13 Rosie's partner was sentenced at Birmingham Magistrates Court at the beginning of April 2019 to a 12-month Community Order with a 15-day Rehabilitation Activity Requirement' in relation to his assaults of Rosie. In summary his response to that Order and the Activity Requirement was poor and the Community Order poorly

managed due to administrative mistakes and poor oversight of the case. The issue around his address in unclear. He was living with Rosie, but the suitability of his continuing to reside with the victim does not appear to have been checked and the requirement to complete the domestic abuse group programme was started very late into the order, too late to reinforce any learning with him. Communication between the MARAC and the Officer was poor, and Edward's poor attendance through the life of the order did not result in any sanctions. There is in addition no reference within CRC documents of any domestic abuse risk assessment being used.

6.14 From August to November 2019 Rosie attended A&E five times because of various fractures, seizures, and injuries. On the first occasion she was described as being 'covered in bruising' and remained in hospital for four days and despite previous concerns of controlling behaviour by her partner and her current injuries, her partner was allowed to visit and stay with her on the ward. In November 2019 whilst in hospital Rosie disclosed to a Police Officer that her injuries were due to assaults from her partner, Edward. As a result, he was arrested and remanded in custody and a 'Complex Case Discussion' (a high-level MARAC) was held in late November 2019; the chief action agreed was to request services working with Rosie to officially report any disclosures of domestic abuse made so that a Domestic Violence Prevention Order (DVPO) could be obtained. Records indicate that Rosie was not always asked domestic abuse 'screening questions' when she attended A&E in 2019 despite the suspicious nature of the injuries and explanations given. It is noteworthy that none of the IMR's seen, apart from that of WMP and BSWA make any reference to the use of the DASH, nor any other accredited domestic abuse assessment tool, by the agencies in regular contact with Rosie-such as UHB A&E, the psychiatry service, SIAS (although they are licenced users), ASC or BSWA.

6.15 School records indicate the level of the distress the separation and its continuing fallout had on the two children. Their education was severely affected as was their sense of safety and security both at home and at school. This case has also revealed that information sharing, and handover was poor in relation to child 2 on moving to a new school. This case has highlighted that school 2 took their safeguarding responsibilities seriously, within that though there were clear indicators to the Panel suggesting the possibility of neglect involving the children and of domestic abuse in the home that were not picked up by staff at the time.

6.16 Rosie's presentations to hospital escalated both in frequency and seriousness in 2020 and included head injuries, internal bleeding, a shoulder injury, a collapse or seizure and blood from left ear and left eye, following 'a collapse.'[3] There is no reference through these entries of any enquiries or referrals to either safeguarding or the WMP. Rosie's mother, when told of discharge from hospital being planned for her daughter in late February 2020 told staff 'She would die' if she were discharged and Rosie said that she could not cope. Neither concerns about her coping nor the increasing frequency and seriousness of injuries Rosie was presenting with appeared to have caused concern, and Rosie's explanations for her injuries were again accepted by staff on the ward. The obvious distress of Rosie and her mother of her leaving the ward was not responded to sympathetically.

6.17 In April 2020 Rosie attended A&E with further injuries which she disclosed were due to abuse and it was also noted that she had had a recent rib fracture and a

[3] UHB IMR P16 3.2.20-26.3.20

damaged kidney. She later stated she did not want the police informed. Rosie remained in hospital for eight days. A safeguarding referral had been made in the light of her allegations, the IDVA and community social worker were notified, but the referral was later withdrawn when Rosie stated she did not wish for them to be involved. In early June 2020 Rosie was taken to hospital with 'ligature' marks around her neck and bruising was noted all over her body. She was known to be a victim of domestic abuse and although safeguarding concerns were noted there was no record of any referrals or enquiries received by adult or child safeguarding teams. Rosie was eager to leave hospital soon after she was admitted and started to recover physically and was discharged in mid-June 2020. She did not attend a follow up appointment that had been arranged with her GP, who then informed the hospital there would be no further contact with her. It had been documented by the Trust Safeguarding Team that if Rosie presented again at UHB that she be referred to the Hospital Psychiatry team to enable her to discuss safely the abuse she was experiencing. The referral when made was declined by the Psychiatry Team because the presenting issue was seen as alcohol and not mental health. The Panel support the view of the IMR author that this "is evidence of when domestic abuse, substance misuse and mental health are viewed as separate issues and ignoring the link or context around admission." Soon after this in a phone conversation with an SIAS worker Rosie disclosed that she was in a 'new relationship' (presumably the perpetrator) and that she was 'happy.' A month later in July 2020 she was found dead in her flat.

The perpetrator

6.18 It is believed that Rosie began a relationship with Nick in mid-June 2020 a month before her death. The only record held on Nick by any statutory agency was SIAS. Nick was seen in September 2019 due to concerns about his alcohol and substance misuse and linked problems with anger and violence. He disclosed violent thinking about hurting himself or others. He was given advice on where to access help. There were no steps taken to assess or manage the risk to others that such thoughts and feelings might have posed. This information could have been passed to WMP. At a follow up appointment less than three weeks later Nick discharged himself from the Service.

6.19 It is believed that Nick murdered Rosie in her home in July 2020 after they had met another couple and then gone home. From the trial information it appears Nick believed Rosie had been unfaithful to him and killed her in a jealous frenzy. Nick later contacted the Police after he and his mother had tried to conceal the murder inadvertently recording their actions on his mother's dashcam. The cause of death was recorded as a sharp force injury to the neck.

## 7.KEY ISSUES ARISING FROM THE REVIEW

7.1 None of the agencies involved had any significant contact with Nick prior to the murder of Rosie. This and the lack of any record of previous violent or abusive behaviour meant that it was likely that agencies did not consider Rosie at that time to be at risk.

7.2 Neither of the schools in this case appear to have recognised the added vulnerability and safeguarding risks linked to the difficulties and dislocation being

experienced by the children at home. School 2 responded positively to protecting the children's welfare and learning needs at school but did not follow through with the same level of oversight in terms of the potential safeguarding risks to them from home. There was poor information sharing and possibly record keeping by school 1 relating to child 2 when transferred to school 2 in the summer term In terms of both schools there was little information sharing or use of the Designated Safeguarding Lead (DSL) for information or advice. There were at least three disclosures from the children which should have alerted staff to possible exposure to domestic abuse and neglect at home that were recorded but not acted on in school 2. These issues have been shared with the relevant Community Safety Partnership.

7.3 There is some evidence that the high level of involvement by the Ambulance and WMP attendances at home, arrests and the imposition of a Restraining Order on Edward may have had a deterrent effect and shifted Edward into the decision to end his relationship with Rosie.

7.4 During the period under review WMAS were called to attend Rosie on 28 separate occasions. Each attendance was for a medical emergency at either her home or a public place, in response to seizures, falls, assaults, etc. Records show that Rosie often had visible bruising to her head, shoulders, arms, legs, and torso, and on two occasions strangulation marks around her neck. It was known that many of the injuries WMAS staff witnessed were due to domestic abuse. However, the WMAS IMR states that Rosie "disclosed she was a victim of domestic abuse on five separate occasions and on two of the five attendances, police and other relevant agencies were informed." This suggests i) That only when Rosie named that she was a victim of domestic abuse were agencies informed, ii) of those five occasions WMP were called twice. This suggests how pivotal WMAS could be in initiating protection for victims of abuse, and at the time this resource was not being fully used.

7.5 Adult Safeguarding in Solihull had had contact with Rosie and referrals from other agencies over the course of her relationship with Edward and were aware of her being a victim of domestic abuse. They had collateral information about her vulnerability and circumstances. They state they were prevented from intervening due to her being seen as having 'capacity' and her denial of her being a victim of abuse.

7.6 The poor supervision and management of Edward through the course of his Rehabilitation Order by West Midlands CRC meant that Edward was able to act freely and without consequences in his reduction and destruction of Rosie physically and emotionally. This left her weakened and vulnerable, and the Panel believe more open to the fatal relationship she embarked on with Nick.

7.7 Rosie attended the A & E and Emergency Departments (ED) at UHB, Birmingham Heartlands Hospital and Solihull Hospital 26 times during the review period of July 2016-July 2020. The injuries she attended with should have been considered as suspicious in terms of being caused by domestic abuse and elicited enquiry. WMP were sometimes called in response to her attendances, but in two occasions the perpetrator was given information over the phone and allowed on the

ward with Rosie. There was no evidence of a DASH, or any other accredited risk assessment being completed with her. Rosie was only asked in half of her attendances if she had children, and only on three occasions when she explained that she was separated from them was she asked if she had any contact with them, which she did. This indicates that in many A&E contacts with Rosie any transferable risk to children was not considered.

7.8 SIAS were the only agency involved directly with Nick, from August 2019 for approximately four months. He was referred due to his alcohol and drug use by his GP after an episode he described as a 'meltdown,' when he became aggressive, smashed items in the house he shared with his parents and threatened to burn the house down with him inside. He stated he had "always been an angry person but this has got worse over recent weeks."[4] It does not seem that these disclosures generated any concerns or enquiries concerning risks to the other residents of this property, including his family members.

7.9 Rosie had originally been referred to SIAS by her ex-partner the father of her children in August 2017 and continued to be referred until her death following hospital admissions. She was provided with signposting and advice relating to the domestic abuse and offered help with her substance misuse. Rosie never felt able to engage with these offers. There was infrequent but long-term contact with Rosie, which was never able secure long-term engagement. SIAS did not usually consult with other agencies in contact with her. SIAS were the last agency to speak to Rosie- she contacted them to say that she was in a new relationship (the Panel believe this was Nick) and that it was positive. This information was not shared with any other agency. The SIAS IMR accepts that it should have been more inquisitive in its approach and were too focussed on the issue of her alcohol use to the neglect of other relevant issues.

7.10 Rosie was identified as a High-Risk Victim of domestic Abuse by West Midlands Police and discussed at Solihull MARAC on four occasions in March, May, July, and November 2019. Attempts by MARAC to secure evidence to obtain a Domestic Violence Prevention Order (DVPO) were not successful. This may have been due at least in part by lack of support from some other agencies in this endeavour.

7.11 Birmingham and Solihull Women's Aid (BSWA) provided the IDVA function within the area. They attempted to contact Rosie after each occurrence and referral from WMP. There were several of these, between February 2019 and her murder. Most attempts to engage her were unsuccessful. The only exception to the pattern of referral and decline was following a successful telephone contact with Rosie in July 2019 followed up within a few days by a face-to-face meeting with Rosie at her GP surgery. A Safety Plan was made with Rosie who appeared to have engaged with this specific member of staff, but due to the service model in place (dictated by their funding) at BSWA this apparent advantage was not used to maintain contact. BSWA acknowledge it is currently not feasible for cases to be individually allocated to staff.

## 8.CONCLUSIONS

8.1 Rosie endured two years and several months of abuse at the hands of Edward in plain sight of statutory services, before being murdered by a man she hardly knew after only a matter of weeks of being with him. Rosie was brought to this point whilst being in regular contact with WMP, WMAS, SIAS, UHB, and her GP. The perpetrator of her reduction, Edward was during all this time being supervised by S&WM CRC as part of a supervision order for an assault of her. She was rendered helpless and hopeless by Edward's behaviour, physically and emotionally reduced by her abuser to the point she expressed the wish to die, experiencing regular seizures and fits and living in unsafe accommodation, in which it was suspected she was a victim of sexual and financial exploitation.

8.2 WMP of all the agencies involved were the most proactive and effective. They would pursue and prosecute when involved, and actively sought to disrupt the abuser, in which they were successful, their actions possibly contributing to the relationship ending sometime in the early months of 2020. Unfortunately, this was too late for Rosie as she was by this point so reduced physically and emotionally that it appears she soon was to fall prey to Nick. Rosie felt let down by the actions of Birmingham Magistrates Court in December 2019, as she erroneously believed following the dismissal of the charge of assault against Edward made Rosie subject to a Restraining Order after which she appears to have lost faith in legal processes to protect her.

8.3 There were four MARACs held during the time in question, and finally a Complex Case discussion held just before her death. MARAC had a sense of the threat she faced and was working towards a DVPO to help protect her. Yet there appears a disconnect between this awareness of the threat to her and the treatment she received from statutory services. This may have been due to a problem in information and decision sharing. Both CRC and the in-patient Psychiatry Unit appear disconnected and unaffected by the directions from MARAC, the former seeming unaware of MARAC correspondence, the latter choosing not to follow the agreed MARAC action to speak to Rosie about her abuse and obtain evidence for MARAC. This is recognised to a degree in the IMR from BSFMHT which recognises there was little contact between the Psychiatry Unit in the Trust and other agencies, and that the Psychiatry Unit failed to ask the NICE Domestic Abuse questions[5], which would have been a brief intervention available that may have alerted staff to this issue.

8.4 Rosie mostly attended both A&E and the general wards of UHB allowed her perpetrator onto the wards, did not routinely follow up Rosie's disclosures of abuse

[5] https://www.nice.org.uk/Guidance/PH50

and fear. There was evidence of ward staff not seeing evidence of trauma expressed in front of them, and not following their guidelines relating to domestic abuse. This may have been due to several factors- stress and burnout for instance. Finally, the A&E Department at UHB did not consistently ask routine Child Safeguarding questions at presentation.

8.5 Ward staff did consistently refer to Adult Safeguarding and the addiction team-SIAS who on occasion refer Rosie to BSWA when abuse was disclosed but neither organisation was able to effectively secure her engagement because in the Panel's view Rosie did not feel safe, and she had seen no evidence that agencies could make her safe. There was little evidence of motivational approaches being used to convince her that they could help her. In most cases she was signposted, even though this approach did not work with her. The impression gained by the Panel was that Rosie's non- compliance indicated to workers that she was not willing rather than being unable to participate.

8.6. The SIAS and BSWA usual model of telephone contact from an unknown worker was not effective, it was unable to establish rapport, trust and motivate Rosie.

8.7 Finally it must be noted that there is no reference within any of the agencies involved with Rosie, apart from WMP and BSWA of the use of an accredited domestic abuse specific risk assessment tool. Without this it is difficult to see how different agencies working with her would be able to use a common language and an evidence-based understanding of the level of risks she was facing and appropriate interventions.

## 9.LESSONS TO BE LEARNT

1. The WM CRC had a poor grip of the supervision of Edward's case due to poor case management, internal communication difficulties and not adhering to statutory and good practice guidelines. This may have left the perpetrator to feel able to act without consequences.

2. A low level of awareness of the impact of trauma on Rosie was exhibited by some ward staff and SIAS staff that worked with Rosie.

3. Agreed MARAC actions were not followed by some partner agencies.

4. Best practice guidelines in terms of domestic abuse were not consistently followed throughout Health and Social Care.

5. BSWA & SIAS workers were not able to engage Rosie.

6. Lack of the consistent use of the DASH Risk Checklist to assess the level of risk posed to DA survivors within the region. This hampered communication and understanding both within and between agencies.

7. The Solihull Primary school had no documents/records available relating to the welfare and safety of Rosie's children or concerns about them whilst at the school (left in July 2019) despite Rosie having contact with her children during this period, they were not aware of any domestic abuse concerns.

8. The response by School 2 (from Sept 2019) was trauma informed. However, School 2 missed several safeguarding indicators and did not refer to Children's Services or seek advice from CAHMS.

9. A DASH or other DA Risk Assessment was not undertaken by any of the services provided by local health bodies.

10. There was a lack of professional curiosity shown by hospital staff (particularly in A&E) and SIAS. This may have been due to a lack of a dual diagnosis care pathway (for domestic abuse and alcohol) or a reflection of staff experiencing 'burn out' with individuals who repeatedly present and maybe as a result of the impact of 'Emotional Labour' on them.

Action already taken

- The Solihull CSP have shared with Warwickshire and Staffordshire Education the Panel's concerns regarding a potential missing Safeguarding referral and a potential referral to Child and Family Mental Health Service (CAMHS) in the information shared regarding Rosie's children.

- BSWA provided assurance that they have introduced a 'RAG' rating to identify High Risk/High priority referrals and repeat referrals now have management oversight.

- The IDVA service now attends the Solihull Domestic Abuse Court.

- The Panel were assured following the HMIP Inspection in June 2022 (to be published in August 2022) of medium risk cases managed by the Probation Service Birmingham and Solihull reported that cases of non or erratic attendance are responded to in line with good practice guidelines.

- The Panel were assured that National Probation Transfer Tracker for the transfer of cases has identified escalation points at 20, 30 and 40 days.

- BSMHFT produced a briefing paper for SIAS to take to their local Clinical Governance process highlighting themes specifically between the links between domestic abuse and alcohol and substance misuse.

- Following the regional independent review of MARAC, the Solihull Community Safety Partnership Executive Board are reviewing the MARAC model to address the preliminary findings identified. These are issues with action tracking, capacity of MARAC, escalation processes and the role of professional meetings instead of repeat referrals to MARAC

## 10.RECOMMENDATIONS FROM THE REVIEW

1. The Solihull Community Safety Partnership Executive Board aim to avoid duplication and improve connectivity of services for victims of domestic abuse by exploring the feasibility of a strategic model of service delivery through a pooled budget.

2. The Solihull Community Safety Partnership Executive Board seek assurance from Health, Probation, Adult Social Care and Third Sector agencies who work with victims of domestic abuse

    - That their frontline staff understand the impact of fluctuating capacity on service users with associated chronic problems- in particular, alcohol misuse, mental health, and domestic abuse.
    - Of their effective participation in the MARAC process.

3. Solihull Community Safety Partnership Executive Board's ongoing work following the MARAC Review findings to take into account Rosie's case. This case highlights that there is a need for an escalation policy and process in which cases known to be making frequent demands on services. Multiple presentations or concerns, or in cases involving self-neglect a multi- agency case meeting should be triggered, and other involved agencies invited to discuss best methods of managing the case and (ii) Improved local governance and oversight of Solihull MARAC to ensure it is operating effectively.

4. The SMBC Public Health who are responsible for commissioning Domestic Abuse and substance misuse services review the evaluation of the Sandwell Blue Light project which offers a positive and effective outcome-based model for managing complex cases where a vulnerable person presents to agencies frequently through multi-agency case management.

5. That ASC as a priority prepare and require its front- line staff and their managers to use the DASH in all cases and referrals in which domestic abuse is believed to be or have been present:

- That a briefing paper be issued to all relevant staff to explain the purpose of this new practice as soon as is practicable.
- That all front-line staff and managers undertake learning that will enable them to use the DASH effectively.

6. That BSMHFT identify patterns and trends around the help seeking behaviour of a patient who potentially is experiencing domestic abuse from their case files, especially when the victim has previously withdrawn their support due to pressure.

7. That University Hospital of Birmingham

- Agree a timetable for all clinical staff in the Emergency Department & Assessment areas to be aware of and able to use the NICE DA selective enquiry questions. To enable this a dedicated quiet consulting area to be identified, and appropriate referral forms available and readily accessed on UHB website.

- The gaps in knowledge, understanding and skills this case has highlighted within UHB Staff in managing evidence concerning and/or disclosure of DA will be met by a programme of domestic abuse training, focussed supervision and heightened oversight of identified cases targeted at all patient -facing staff and their managers. This will include situations concerning partners as well as the victims.

- The effectiveness of the IDVA referral pathway within the UHB (funding now ceased) to be reviewed. The UHB to review the DA resources on the UHB website to ensure they are updated and placed in one easy to access section.

- UHB Staff to be reminded to record mental capacity assessments in a Trust approved format (PICS or paper form) via Trust wide communication to all staff.

- UHB undertake a cost- benefit analysis to be carried out to support the case for the retention of the on-site patient/staff IDVA service to be made permanent and full time by establishing the net value the role provides to the UHB and the patients it serves.

8. BSWA ensure all service users are routinely informed of Clare's Law also known as the Domestic Violence Disclosure Scheme (DVDS) giving them the

right to know if their current or ex-partner has any previous history of violence or abuse.

9. Birmingham and Solihull CCG / ICB (from July 2022) will introduce a sample audit of IRIS Domestic Abuse cases as part of their quarterly assurance report, this will be set up and monitored through the IRIS Steering Group with actions according to audit findings. This in turn will then be reported through the Solihull Domestic Abuse Priority Board (DAPB).

10. The Probation Service in Birmingham & Solihull
    - provide reassurance to the Safer Solihull Partnership. that the case transfer process is fit for purpose, and that the learning from this case have been embedded.
    - use this case to illustrate to Probation staff the need to update OASYs, transfer cases, enforce appropriately, or seek managers approval and respond to deterioration in cases.

11. That this DHR is shared with the Ministry of Justice and any relevant learning is shared with those responsible for Judicial training on Domestic Abuse.