Overview Report:

Domestic Homicide Review in respect of the death of 'Rosie' in July 2020

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COMMISSIONED BY THE SAFER SOLIHULL PARTNERSHIP

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Foreword by the Chair of the Review

As the Chair of this Domestic Homicide Review Panel, I would wish to add my deepest sympathies, along with those of the Panel to those that loved Rosie. Rosie was described by her family as a "beautiful, bubbly lady who had a heart of gold", adding it was "unbearable to think that she will not get to see her children grow up". The Court heard from Rosie's children, they stated "Mother's Day this year was the first time we did not send or make a card. It was a very difficult day for us to get through." They added: "You left us beautiful memories. Your love is still our guide. Although we can't see you, we know you will always be by our side."

The Panel would like to thank Rosie's family for their help in creating this review at a time of terrible grief and having just gone through a gruelling trial.

We hope that this review has honoured Rosie's life.

– Jan Pickles OBE Chair and Author

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)

Queen Elizabeth Hospital Birmingham (QEHB)

1 The circumstances that led to this review

This report of a domestic homicide review examines agency responses and support given to Rosie, a resident of Solihull prior to the point of her death at her home in July 2020. Rosie's death was due to strangulation, smothering and 54 multiple knife wounds inflicted by her new partner, Nick in a frenzied attack. 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 addition to agency involvement the review will also examine past events to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

The review will consider agencies' contact and involvement with Rosie and Nick and look back to understand the events that led to her death. The key purpose for undertaking DHR's is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and as thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.1 Timescales

This review began in December 2020 and was concluded in July 2022. This Review was delayed by the COVID-19 pandemic which in turn delayed the Criminal Trial until November 2021. Advice from the Senior Investigating Officer was that family, employer and friends could not be spoken with until after that date. Rosie was also referred by her employer through Occupational Health for private health care which the Panel could not follow up prior to the trial with her employer due to them potentially being a witness. Following the trial, contact was made with her last employer, a large insurance company. The period under review is the four years preceding Rosie's death from July 2016 until July 2020. The review panel following the scoping of agencies involved with Rosie decided on this period as although her relationship with the perpetrator was short in duration, three weeks we believe; we were aware that Rosie's previous relationship involved domestic abuse and contributed indirectly to her death. The review panel wished to identify whether there was learning in terms of what could have prevented this tragedy.

1.2 Methodology (see also Appendix 1)

The purpose of this Domestic Homicide Review overview report is to ensure that the review is:

- Conducted according to good practice, with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse including their dependent children.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

Solihull Metropolitan Borough Council (SMBC) agreed that the criteria for a DHR was met in August 2020 and commissioned Jan Pickles to undertake the review. The initial scoping of 12 agencies identified all twelve agencies had relevant information. Of these ten 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 information specific to Rosie's children. (In the case of the University Hospitals Birmingham NHS Trust the IMR authors had not been directly involved in the clinical care of those involved in this review. However, one author did review and process a mental capacity assessment and accompanying application for a Deprivation of Liberty Safeguards (DoLS) during an admission to Queen Elizabeth Hospital in January 2020. The other author also gave safeguarding advice to the ward during Rosie's admission at QEHB.) The Independent Management Reviews author has indicated whether there is confidence in the findings and made recommendations to the Panel.

The Independent Management Reviews have been authorised by a responsible officer in each organisation. The agencies' Independent Management Reviews were integrated into an overarching chronology of events from July 2016 until July 2020.

1.3 Terms of Reference (see Appendix 2)

In addition to the standard areas a review is expected to cover, the review panel asked that the following areas were addressed in the Individual Management Reviews and the Overview Report:

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 in March 2020 may have had on their service response and delivery 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 2005?

iv) Could agencies adopt a trauma informed lens when reviewing Rosie's engagement with their agency?

1.4 Confidentiality

The findings of this review are confidential, the confidentiality statement was reviewed at each panel meeting. Information is available only to participating officers/professionals and their line managers. In order to protect the identity of the victim the family were asked to choose pseudonyms.

1.5 Equality

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 White British, female and heterosexual. She had a diagnosis of Epilepsy and was experiencing ongoing physical and mental health issues such as anxiety and depression specifically related to stress and her use of alcohol. These factors, the family believe increased her risk of domestic abuse.

In terms of Nick and the protected characteristics within the Equality Act 2010 he identifies as White British, heterosexual and male; he was 37 years old at the time he committed Rosie's 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[1]. When interviewed post sentence he informed the Chair that he had been diagnosed as suffering with two types of Personality Disorder during his period of remand in custody prior to the trial. Nick also disclosed to the Chair that he was a diabetic and required ongoing treatment for this.

1.6 Involvement of Rosie's family

Immediately following their appointment, the Chair contacted Victim's Support Homicide Team who were already supporting Rosie's family and had provided information and leaflets on the DHR process. Through the Homicide Team the Chair was able to pass on their condolences but were advised as they were witnesses that contact could not be made until after the trial. Due to this reason, the Chair was also unable to meet with Rosie's employer or friends at that time. The DHR process was impeded by COVID-19 which impacted agencies resources to complete the IMRs and then by the ongoing delays to the trial during the second lockdown period. In January 2022, the Chair met with Rosie's parents who described being well supported by the Family Liaison Officer of WMP and the Victim's Support Homicide Advocate. In July 2022 the Chair again met with Rosie's parents for them to review the near final draft of the DHR.

The next of kin for the family was identified as her mother, she gave permission for the panel to view Rosie's' medical records as part of the review.

In the process of drafting this report the Chair has provided the family with a draft report and met with the family to seek their views to ensure the review is as accurate as it can be. Rosie's parents describe their treasured daughter as "warm, loving, and generous who tried hard to put her children first." They spoke of her determination and ability which led to her having a successful career whilst still being able to care for her family deeply. They were a close family who spoke every day and whose loss is immense,

The DHR panel agreed a communications strategy that sought to keep the family informed throughout the review and worked with both the Family Liaison Officer and Victims Support Homicide Team to do so. From the initial contact, the family were provided with information

[1] Sertraline prescribed to treat depression, and anxiety disorders (such as panic disorder, social anxiety disorder, post-traumatic stress disorder), and obsessive-compulsive disorder (OCD).

regarding access to advocacy and support services. The Chair / author have tried to be sensitive to their wishes, their need for privacy and support and to maintain any existing arrangements that were in place to achieve this. Prior to the submission the review was shared with the family.

1.7 Involvement of Rosie's ex-employer

The Chair met with Rosie's employer- a large insurance company who outlined Rosie's employment history from 2006 and their attempts to support her with what had been identified as a problem she had with alcohol. At no point did Rosie disclose domestic abuse to her employer, nor did they suspect it was an issue. Their approach to her was to offer time off and occupational health support, they have sought guidance and drafted a Domestic Abuse Policy, the content of which appears in line with best practice for an employer. However, Rosie's parents believe the stress of her high-profile role caused her to seek solace in alcohol.

1.8 Involvement of the Perpetrator

Following the sentencing of Nick, the Chair wrote to him in prison and requested his involvement in the review. The letter to him was hand delivered by the Probation staff in the prison so that any questions he had about the review process could be fully addressed. In March 2022, the Chair was informed that the perpetrator had been advised by his lawyer not to co-operate with the review as he was appealing against the conviction and sentence. Following the conclusion of his unsuccessful appeal against his sentence Nick met with the author. At this meeting he informed the author that he had been diagnosed pre-trial as suffering with two types of Personality Disorder. He was during this interview apologetic, stating that he struggled with the thought that he had taken the life of the mother of two young children.

2. The Review Process

2.1 Panel membership

All Panel members had no direct contact or line management of staff involved with Rosie's care or services received by Nick. Therefore, though employed by the agency listed below their role as Panel members was to provide professional scrutiny of the IMRs with their specialist knowledge skills and experience.

	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 and expert in substance abuse	Yvonne Hartwell
5	Birmingham and Solihull Clinical Commissioning Group	Agency Expert lead Officer and Panel Member	Andrew Colson
6	Public Health Solihull MBC	Senior commissioning Manager for Domestic abuse, Sexual abuse & sexual health, 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 Probation Service	Agency Expert lead Officer and Panel Member	Marj Rogers

2.2 Agencies that provided an Individual Management Review

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. Staffordshire and 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)
10. Education Safeguarding, Solihull MBC who liaised with schools in Warwickshire and Staffordshire.

An Information Report was provided by Solihull Children's Services.

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 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 just reviewing the notes at the GP surgery as there were concerns from the practice about providing copies to the review.

2.3 Review Panel Meetings

The panel met on eight occasions in December 2020 to request the IMRs and in March, April, May, June, August, and December 2021, May, and June 2022 to review the IMRs and then to comment on successive four drafts of the review. All Panel meetings were held virtually, initially due to the Covid-19 travel restrictions.

2.4 Author of the Review

Jan Pickles was appointed as Chair of the DHR and author of this report in October 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 Multi Agency Risk Assessment Conference (MARAC) model and for development of the role of Independent Domestic Violence Advisers (IDVAs). In 2010, she was awarded 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 at the NSPCC, Assistant Police and Crime Commissioner

and as a Ministerial Adviser. She currently is an Independent Board member on a Welsh 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.

2.5 Parallel Reviews

The Safer Solihull Partnership informed the Coroner in December 2020 that this DHR was to take place and the Inquest remained adjourned at the time of finalising this report. The Panel was not aware of any other related agency internal or independent review.

2.6 Dissemination

The findings will be published in accordance with the Home Office Guidance to enable the lessons learned to be shared in the wider arena. The full DHR was shared with Rosie's parents in final draft and their comments were welcomed and incorporated into the final document prior to being presented to the commissioning authority. Once agreed by them the final draft will be sent to the Home Office for quality assurance and then published in such a way that will respect the family's privacy.

A copy of the executive summary will be sent to the Perpetrator in prison, and we have asked that the Probation and Prison staff provide support at that time.

3. Background Information

3.1 Rosie had lived in the West Midlands near her family all of her life, she was killed in her flat in Solihull, where she lived alone. Rosie had been in a long-term relationship with a partner with whom they shared two children. Following the breakdown of this relationship she began a relationship with Edward for approximately eighteen months. Soon after that ended Rosie met and dated Nick who within weeks was responsible for her death. At the trial it was noted that Nick was a 'jealous and possessive person' and had accused Rosie of being unfaithful the day before her death. Following a night out on the Saturday before Rosie's murder, Nick had been staying at Rosie's flat and at some point, in the early hours of Sunday morning in mid July 2020 murdered her. Her body was found later that day when Nick contacted the Police to report that he had 'visited Rosie to find the door unlocked and her injured inside.' Nick was arrested at the scene. On forensic examination Rosie was found to have fifty-four sharp force injuries concentrated to the neck area made by two knives and she had been strangled and smothered. The cause of death was recorded as 'sharp force injury to the neck.' The Criminal Justice process had to be adjourned for a specialist Pathologists report to be prepared. Nick was charged with Rosie's murder and remanded in custody. In between killing her and calling the police, Nick used the time to destroy all incriminating evidence of the murder. He was aided in this by his mother who drove him to a nearby canal to dispose of the evidence These facts only came to light because they were caught on the accused mother's car dashboard camera. His mother received a 3-year term of imprisonment for 'Assisting an offender and perverting the course of justice'.

3.2 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 passing sentence, Judge Melbourne Inman QC said neither Nick nor his mother, had shown any remorse for the "savage" murder and added: "It was mere good fortune that your car had CCTV which revealed what you had done." He described their efforts to conceal the crime as "calm and calculated" and said: "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."

3.3 Very little is known about Nick and his relationship history. During the short time he and Rosie were together. Domestic abuse was neither reported nor known by agencies to have been present in their relationship. There are no police records to indicate that the relationship had commenced, and Nick has no previous convictions or cautions for domestic abuse related offending. In fact, he has no real history of violence at all, and his last contact with police was in September 2010. However, the Panel were aware of Rosie's previous relationship with Edward which was known to be domestically abusive.

4. Chronology

4.1 Rosie was born and spent most of her life in Solihull in the West Midlands, she and her sister were raised by her parents in a stable and loving family. Rosie was described by her family as 'bright and ambitious', she worked for most of her life in the insurance industry. She gradually assumed roles with greater responsibility and eventually was responsible for managing accounts involving a series of high-profile claims for the company. The Adult Safeguarding IMR[2] 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 twenty-year relationship with her long-term partner, and they had two children who at her death were still young, aged eight and twelve years. The children both attended local schools and there are no records to indicate there were any concerns about their home life until the couple separated sometime in 2017. Both parents worked and there is some indication of stress within the household, records indicate that Rosie felt that they had little time for each other, both working different shift patterns.

4.2 However, from 2016, life changed markedly for Rosie. The reasons for this are not known. There is however, beginning at this time, evidence from a number of sources that indicate Rosie's mental health was deteriorating along with an increase in her alcohol misuse, resulting in a great deal of friction and stress within the family. Child 1's school record from March 2019 shows that child 1 was 'very anxious and this sometimes impacts on child 1's concentration in lessons because for the past three years Mum has been an alcoholic'[3]. The information from the GP Practice records state that four to five years before her murder, Rosie was in general a healthy young woman who had very little need to visit her GP or seek health advice. This changed sometime around 2016 with Rosie feeling increasingly stressed at work, as a result of which Rosie's use of alcohol increased to problematic levels, which was dealt with by referrals to SIAS and in secondary care as her addiction became more embedded. The GP also made two referrals to Adult Social Care (ASC) over concerns that Rosie was experiencing domestic abuse at the hands of her then partner. The panel understand there were admissions into the Priory Private Clinic funded via her ex-employer insurance, but the Panel were unable to access this information despite repeated requests. Birmingham Heartlands Hospital records show that Rosie's attendances at A&E was mostly connected to her alcohol misuse and linked effects- injuries and withdrawal symptoms that had begun in July 2016. Birmingham & Solihull Mental Health Trust (B&SMHT) in their IMR observed that Rosie stated that her use of alcohol started to become problematic during her relationship with the children's father. She also later disclosed to a worker at Solihull Integrated Addiction Service (SIAS) a Health Service funded substance abuse team that her "alcohol intake increased prior to this as she was controlled by ex-partner (*sic*), including

[2] Adult Social Care and Support SMBC P2 1.1
[3] Solihull Metropolitan Borough Council: Individual Management Review Education P8

informing her what she could wear and would only let her go out for work. She also stated she has a new partner who is very supportive." [4].

4.3 In June 2017 Rosie was referred to the company's Occupational Health Department by her employer due to her issues with alcohol and her performance at work had been affected for some time, according to her employment records. In August or September 2017 Rosie and the children's father separated, largely it seems due to the pressure generated by Rosie's behaviour. Rosie said her relationship and family had suffered as they never had time to talk alone or spend time together as they were working different shifts. Solihull Children's Services (CS) became involved following a referral by the children's paternal grandfather raising concerns about their mother's addiction to alcohol and the impact that it was having on his grandchildren, at the end of August 2017 CS recorded that the grandfather "stated that he had removed the children from the home environment to ensure that they did not continue to be impacted by their mother's actions. Father and children were residing with paternal Grandfather."[5] There is no record of CS informing the children's schools of this change. The family did not reconcile.

4.4 The children's father had initially made a referral to SIAS on Rosie's behalf in August 2016 in response to Rosie's increasingly erratic behaviour, followed up by a further referral from her GP a year later. Rosie attended some of the appointments offered, however attendance was sporadic, and she informed SIAS that she would access help through her employers and not them. However, this was also the pattern of her attendance at the Employee Occupational Health sessions with Rosie failing to attend planned meetings. Rosie's contact with SIAS was to continue intermittently from this period until her death, with periods of engagement, lapse, and return. SIAS were persistent in their attempts to maintain contact with her, despite her difficulties in sustaining engagement 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 herself as separated from her family, that she drank a bottle of vodka and cider per day due to relationship difficulties, and that she worked for an insurance company and had been referred by occupational health in that company to a private doctor.[6]

4.5 In October 2017, Rosie called the West Midlands Police (WMP) alleging she was being harassed by her ex-partner and his family. WMP later attended the home and found the children's father collecting their possessions from what had been the family home, still occupied by Rosie. Rosie alleged that he had stolen money from her account on two occasions using her cards and taken her car keys. The IMR from WMP states that "police records do not evidence a history of domestic abuse or family conflict specific to the children's father reported during the twenty-year relationship." The police were called to the family home on two occasions towards the end of

[4] Birmingham and Solihull Mental Health NHS Foundation Trust P12

[5] Family Support and Child Protection Service

[6] UHB IMR chronology 27/8/2017 P9

2017, indicating worsening relations between family members following the separation. Firstly, in mid-September 2017 Rosie was arrested on suspicion of assaulting her sister, following an argument related to Rosie's drinking. No formal prosecution was made. Then, in late October 2017 SIAS record that Rosie had been told to move out of the family home by the children's father, who, along with the two children were living with his own parents.

4.6 Rosie's first attendance at hospital relating to symptoms of alcohol misuse or overdose began in August 2017. It was reported that she had hit her head after falling due to her drinking. She had attended the Hospital with her new partner'- Edward. The explanation for her injury was accepted. There would be a number of such attendances in which bruising was noticed- from fresh or old injures, for which Rosie usually provided explanations related to falls due to clumsiness. These were generally accepted. In November 2017 Rosie's first overdose was recorded, (the hospital notes 'information' relating to a previous overdose in August 2017, but that there was nothing in UHB/HEFT files about this). Hospital records state this to have been caused "by low mood for past 3 months since relationship they were not married) ended resulting in limited contact since with her children (documented aged 6 and 9 years old) and ongoing related court case." Rosie also described her ex-partner as "controlling in everything"[78]. Rosie was assessed by the Liaison 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. In December 2017 Rosie presented as incoherent to her manager at a return-to-work meeting, the employer felt that Rosie had been choosing previously to contact her manager when she was sober. Then in January 2018 Rosie reported to SIAS an overall improvement in her situation, that she was in control of her drinking and seeing her children more often, in new stable accommodation and with a new partner- the Panel believe this was likely to have been Edward and that this was to become an abusive relationship. She was discharged from the service.

4.7 Around this time her employer tried two return to work processes, but Rosie was considered alcohol dependent and unfit to return to work and was offered ongoing support from Occupational Health. The employer stated in February 2018 that Rosie fell asleep in a management meeting, and they removed her car keys as she appeared drunk and sent her home in a taxi. Her manager at the time took the unusual step for this company of ringing her parents to establish that she had got home safely but also to share her concern for Rosie. Rosie at the time did not feel supported by her employer and at an assessment with a specialist Doctor organised by her employer's occupational health unit, she revealed she was drinking a bottle of vodka a day and for the first time mentioned that she was under stress due to work pressures. At no point did she disclose or was directly asked about domestic abuse. In June 2018, her employer received a sick note from her GP which outlined Rosie's alcohol dependence, depression, and anxiety. The company was going through a restructuring process and Rosie chose to take a redundancy package that paid a smaller lump sum and monthly payments which because of her ill health would have continued

[7] West Midlands Police (WMP) Individual Management Review 1.17

[8] Birmingham and Solihull Mental Health NHS Foundation Trust IMR P12

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.

4.8 The first recorded indication of Rosie sustaining a physical injury that may have been caused by her partner Edward was in January 2018 was when she attended University Hospital Birmingham (UHB), and bruising was noted on the back and front of her body by hospital staff. She stated the bruises were due to her 'falling out of a taxi,' and staff accepted this explanation. There was another similar attendance at UHB A&E at the beginning of September 2018, when Rosie attended with injuries sustained again 'after falling'. A nurse noted and enquired about bruising on both of her arms which Rosie stated was due to her fall. This was accepted. It seems likely that this was a difficult period for Rosie. She had lost her family, was unable to cope with work due to depression and was drinking heavily. In September 2018 Rosie attended the Medical Assessment Unit (MAU) with her sister. Rosie's sister told staff that Rosie was 'alcohol dependent' and that she had recently been made redundant. The WMP IMR confirms this, stating that around mid-September 2018 Rosie was made redundant following a period of about twelve months absence from her workplace due to illness. They state. "In the lead-up to redundancy, Rosie experienced two failed attempts to resume work following a period of depression related absence…. It seems Rosie was treated by her GP at this time. It seems therefore, Rosie attempted to address the depression and associated anxiety she was experiencing"[9] . In addition, the children's father had in December 2018 secured a Court Order requiring that Rosie only have supervised contact with her children. This was understandable as it is clear that the children had been affected emotionally by Rosie's behaviour, however it must have been, along with the loss of her employment, relationship, and home another setback for her. It is of note that Rosie observed this condition and did only see her children when supervised.

4.9 The IMR from 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…. Ultimately, these events led to an ascribed high risk of domestic abuse status and MARAC procedures were initiated. Such was the concern for Rosie (that) WMP, and crown prosecutors sought evidenced-based-prosecutions on two occasions."[10] In mid-November 2018 Rosie attended UHB A&E Unit with a head injury, from a fall due to drinking. Rosie gave two different explanations for her fall, which could have been seen as suspicious. Rosie also stated that she had 'recently' been made redundant and that she 'drinks most days.' On examination it was noted there were, extensive bruising on face and body-varying ages of bruises"[11] noted. Although Rosie did disclose that her partner had been violent to her in the past, and she had provided two different explanations for the

[9] WMP IMR1.11 &1.12 P3
[10] WMP IMR 1.24 P.4
[11] UHB chronology P10

bruising, it seems that Rosie's explanation of 'being clumsy' was accepted and that there was "nothing documented in regard to any further enquiry of abuse or signposting"[12]. The Panel also note that Rosie's partner had called A&E to enquire about her well-being and staff notes recorded that he seemed "genuinely concerned." The Panel believe that this suggests a possible attempt by Edward to influence or even 'groom' hospital staff and may have been a factor in them not being more curious as to the origin of the bruising. Following another callout in late September 2018 to Rosie's flat concerning a 'verbal argument,' WMP Officers noted and questioned Rosie about "visible bruising to Rosie's neck, arms, shoulder and lower leg to which she became emotional and disclosed a number of assaults spanning three months."[13] Rosie later withdrew her complaint, and the prosecution was dropped. The WMP IMR states that the officer involved "made real effort to converse with Rosie and understand the dynamics of abuse Rosie may have been facing."[14]

4.10 Rosie was first attended to by the West Midlands Ambulance Service (WMAS) in February 2019, at which they "found extensive bruising to Rosie, who disclosed that her partner is abusing her indicating a bruise to forehead where he has headbutted her, bruises to face and neck from attempted strangulation and bruises to torso and down left leg."[15] A friend accompanying Rosie to hospital told staff that her partner was on bail for assaulting Rosie. Hospital staff responded and alerted WMP which led to Edward's arrest on the ward. An examination on the ward showed that Rosie had "bruising all over, swollen jaw. Has been punched many times."[16] Rosie made a disclosure regarding domestic abuse which was recorded in her notes as "Has been punched over a long period of time. Abuse started 5 months ago (states he has been her partner for 2 years). Abuse has escalated recently, has been smothered with pillows. Partner currently in custody."[17] . They also note that Rosie had lost three stone in weight in three months. A Psychiatric assessment found that she was heavily intoxicated and lacked capacity. SIAS were notified and assessed her. Rosie agreed to contact them on discharge. Rosie was reported by the SIAS worker to be "tearful as he (Edward) would not have anywhere to live and never has money, despite working."[18] Her partner had access to the flat, later reports by Rosie of her having to live with friends due to him staying at her flat seem to confirm that Edward had access to her flat. This disclosure suggests Rosie was facing financial, physical abuse and 'cuckooing' as well at this time[19]. Rosie was advised to contact Women's Aid. WMP were not informed. 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 apparent breach of bail conditions.[20] Rosie ended

[12] UHB chronology P10
[13] WMP IMR 1.31 P4
[14] WMP IMR 1.35 P4
[15] West Midlands Ambulance Service (WMAS) IMR P.8
[16] UHB IMR P12
[17] University Hospital Birmingham (UHB) IMR Chronology P12
[18] B&SMHT IMR P14
[19] https://www.manchestersafeguardingpartnership.co.uk/resource/cuckooing-advice-for-all/
[20] B&SMHT P16 1.5.2019

contact with them at the beginning of May 2019 after another hospital admission. At that time Rosie disclosed “that she is back with her partner Edward in separate housing” The SIAS worker 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” SIAS state that “It is recorded as a protective factor that (Rosie) has a supportive partner”[21], which is a concern to the Panel. The SIAS IMR states there were times she felt able to be open with staff about assaults but also times where despite evident bruising she would deny the abuse and claim Edward was loving and supportive. There is no record of SIAS checking with the Police that Rosie had reported the assault to them. The WMP chronology shows that Rosie had reported an assault by Edward on her in April 2019, which resulted in a further referral to MARAC.

4.11 WMP received a call from Rosie’s sister in late of February 2019 expressing ‘concerns’ for Rosie and reporting Edward to be breaching his bail conditions. WMP later contacted Rosie who disclosed that she was being abused by Edward. This was recorded as a ‘high risk domestic abuse’ incident. In late April 2019 Rosie contacted WMP and reported that she had been assaulted by Edward. A WMP officer attended the flat, Edward was still there and denied the assault. Although Rosie was not able to give evidence due to being intoxicated, the police continued with the prosecution following consultation with Crown Prosecution Service (CPS). It was agreed that Rosie was “of such vulnerability she was not able to make fully informed decisions.”[22] This was one of two ‘evidence led’ prosecutions of Edward in this case. Records do not indicate whether a DASH was completed. A DASH is a Domestic Abuse Stalking and ‘Honour’ based violence risk checklist completed by agencies to identify victim risk in these issues. The MARAC referral also went ahead. Edward’s prosecution was later heard and dismissed at Birmingham Magistrates Court in late December 2019, although a Restraining Order was imposed in respect of 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” [23]. 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.

4.12 Adult Safeguarding received a referral from Rosie’s GP in mid-March 2019 due to injuries suspected to have been related to domestic abuse noted when she attended the surgery. There were four telephone contacts with Rosie during which she did acknowledge her injuries were related to abuse and admitted her fear of Edward after initially denying this. Help was offered including advise to contact the police and Women’s Aid. Rosie stated she was too afraid to contact the police. Rosie opted to end contact with Solihull Metropolitan Borough Council ASC seven days

[21] ibid
[22] WMP IMR P16 5/4/2019
[23] Brighton &Solihull Mental Health Team (BSMH) IMR P36

later in March 2019. The author of the ASC IMR summarised ASC contact with Rosie as a "similar theme to other agencies in that Rosie would adopt a pattern where she would initially deny any domestic abuse (often despite physical evidence), would be reluctant to engage with professionals and would decline any offer of further intervention or support"[24] . Again, the Social Worker did not check with police to establish that they knew of this latest assault nor question Rosie's Safety Plan, which was unrealistic, nor suggest more evidence-based actions such as a Restraining Order. The IMR author summarised that whilst pertinent onward referrals were made, a more proactive and personal approach in introducing Rosie to Women's Aid may have been beneficial. ASC were again contacted by Rosie's GP in early April 2019 again suspecting domestic abuse related injuries. In response, the Social Worker contacted Rosie by phone and Rosie reassured the worker that she was safe, and living at a friend's house, that she was too afraid of her partner to live at her home as he was there. The Social Worker responded by offering to refer her to services (Women's Aid) and again Rosie declined. Rosie stated the police had been informed. The Social worker did not check this was the case nor offer more evidence-based advice such as obtaining an Injunction Order, etc. Another opportunity for ASC to intervene was lost when Rosie was admitted to A&E ten days later in April 2019 and bruising suspected to be domestic abuse related was noted and a referral to Adult Safeguarding was made by nursing staff. Unfortunately, due to poor communication between ASC and ward staff Rosie had already been discharged before a Social Worker was able to see her. Attempts made to visit Rosie at home by Social Workers were unsuccessful.

4.13 It is from this point on that the violence and abuse within the relationship began to result in police and medical involvement on a much more frequent scale than before. 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 discussed at Solihull MARAC in mid-March, mid-May, early in July and mid-November 2019. Through this time, Rosie and Edward remained together, any separations were temporary, caused by bail conditions or arguments etc which when removed or resolved, the relationship would be resumed. Rosie did not engage with MARAC at any point. An indication of the danger Rosie was in but unaware of was her disclosure in mid-March 2019 when completing a DASH form with a Police Officer; when asked about her injuries the officer reported that Rosie "states this was from prolonged attacks over a three-month period, and these had been caused by her partner. Rosie has also confirmed the offender has attempted to suffocate her, preventing her from breathing" and after the DASH was completed Rosie added "When he loses it, he petrifies me...he puts the pillow over my face…he puts his hand around my throat...makes me gasp."[25] This would suggest that Rosie had become so worn down by the abuse that she was beyond considering alternatives or routes of escape.

4.14 As standard procedure, Birmingham & Solihull Women's Aid (BSWA) were requested by MARAC to contact Rosie to engage and support her after each MARAC referral. They followed the

[24] ASC IMR 1.1 P2
[25] WM MARAC IMR P3

agreed procedure but were unable to engage Rosie. BSWA state in their IMR that “we couldn’t establish contact with her and apart from one face to face meeting at the end of July 2019 and three significant phone conversations didn’t have a lot of actual contact with her at all.”[26] As BSWA would contact Rosie following each MARAC referral, some contact of sorts was maintained from February 2019 to March 2020, records show a high number of calls from BSWA of which few were taken by Rosie. Rosie was offered support on several occasions, some of which she accepted but would then cancel or nor respond to follow-up calls. In May 2019 she was informed of the full range of Housing options which she decided she did not want to follow up, stating she did not want any support from BSWA. A DASH was completed by BSWA in June 2019. Rosie stated on several occasions that she had a friend with whom she stayed and felt safe with in Walsall. She was planning to move there but never made it. This seemed to be her safety plan when she was particularly fearful. The impression gained though not stated, was that she did not feel safe where she was at this time due to her fear of Edward.

4.15 The pattern of injuries sustained by Rosie and callouts responded to by WMP and West Midlands Ambulance Services WMAS) and Hospital admissions continued through 2019 and into 2020. The pattern changed in that the injuries Rosie sustained became more serious and numerous, and Rosie began to develop chronic signs of physical and mental ill-health. For example, early in April 2019, WMAS crew attended and observed Rosie with large amount of bruising over her whole body with extreme tenderness on her right side of ribs and pain to right side of jaw, and that she was hallucinating. Later that month the Ambulance Service attended after Rosie was reported to have had four seizures that day. She was taken to hospital and remained there for three days. She was assessed initially as lacking capacity, and a ‘Deprivation of liberty’(DoLS) urgent authorisation was made at the beginning of May 2019. The DoLS lapsed after the initial 7-day urgent authorisation and a further application was not sought as Rosie’s symptoms improved and she regained her mental capacity. It is of note in regard to responding to potential abuse that UHB ward notes recorded in April 2019 state that it was “Unclear if patient’s partner was allowed to stay on the ward throughout the day’. Staff noted aggression from partner over the phone when asked to call back later.”[27] This could be seen as potentially controlling and coercive behaviour with the perpetrator operating in ‘plain sight.’ Similar behaviour by Rosie’s partner had been noted by ward staff in mid-September 2018 and at the beginning of February 2019. There are no indications to suggest his behaviour was responded to, although it was noted in ward records.

4.16 Rosie’s partner and perpetrator 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’ The Order was deemed to have been completed satisfactorily at its termination, in April 2020, although WMP chronology shows that Edward continued to assault Rosie and WMP attended on a number of occasions in relation to those alleged assaults throughout the period of

[26] Birmingham & Solihull Women’s Aid BSWA IMR 1.2 P2
[27] UHB IMR chronology P12 30/4/2019

supervision. There is no indication to suggest that the supervising officer was aware of or responded in any way to this information. In addition, overall attendance by Edward was poor, and his compliance poorly managed, in part, due to Edward's stated employment and health problems, but also poor oversight of the case caused by the Responsible Officer holding the case sited in Birmingham, when Edward was resident in Solihull and being supervised on a temporary basis by an officer in Solihull. Transfer of the Order to the correct area was never initiated, although it should have been a priority as this could have hampered the success of any enforcement action taken. Edward made it clear at interview with the Supervising Officer that he was returning to live at the victim's address. There was no home visit to assess and approve or refuse this arrangement in terms of risk to the victim despite practice instructions that state one should have been undertaken, and the address assessed as suitable or not before the offender be allowed to move, in line with the Her Majesty's Prison and Probation Service Case Management Framework and Domestic Abuse Policy 2018. The IMR from the CRC also identified "a lack of inquisitive questioning or clarification of key information surrounding the extent of abuse and the implications for Rosie of him returning to live with her."[28] There is no explanation for this. Edward did complete the domestic abuse perpetrator programme 'Safer Choices' which in large part was the most offence, risk and change focussed intervention within the sentence, but he did not start that until January 2020, nine months into a 12-month Order. Edward completed the Order 'satisfactorily' in April 2020. Edward is described as having poor physical and emotional health and that several of his absences when he was not seen at all through June and July 2019 were due to ill health. There is no evidence this ill health was corroborated by his officer as it should have been. MARAC requested further information concerning Edward from his Officer in July 2019, but as this case had not been transferred, the request went to the supervising officer who still officially held the case and that officer did not pass that request on, nor was the request entered onto the case recording system. The officer in Solihull who was supervising Edward was therefore unaware of the request and importantly of the further incident of domestic abuse the request stemmed from. It is noteworthy that there is no reference within the IMR from the CRC of either the Offender Assessment System (OASys) risk assessment (this is the risk and need assessment used by the Prison and Probation Service), or the use of an accredited specialist domestic abuse assessment tool such as the Spousal Assault Risk Assessment (SARA) to assess the risk of intimate partner violence which should have been used.

4.17 Rosie next attended UHB in mid-August 2019. Admission notes state she was covered in bruising. Rosie was assessed with her partner present who was allowed on the ward despite her previous disclosures of his abuse of her. Rosie remained in hospital for four days and ward notes record that she disclosed to a nurse on the ward that he (her partner) "sometimes lashes out at her when she answers him back, but she hits him back and is not scared of him."[29] There was a ward note regarding the source of the bruising with a question mark on file. Four days after this

[28] Staffordshire and West Midlands Community Rehabilitation Company IMR P12
[29] UHB IMR P13 chronology 18.8.2019

admission in August 2019 ward notes stated that Rosie's "partner was with her eating takeaway at the beginning of the shift, 2nd nurse noted concerns about this due to safeguarding issue."[30] Safeguarding referrals were made, it is not clear from records if this occurrence involving the perpetrator was seen as a 'near miss' and addressed in terms of managing future risk of abuse in the hospital.

4.18 From August to November 2019 Rosie presented five times to A&E at the UHB. Injuries noted at presentation included a fractured finger, a bruise on her forehead, and a suspected seizure. Following those, In mid-November Rosie again attended with a suspected overdose, and in late November 2019 she attended the fracture clinic in relation to a three-week injury from an assault. Just prior to this in late October 2019 Rosie reported to police that Edward had contacted her by phone, breaching bail conditions that had been imposed due to an earlier allegation of assault. A Police Officer attended the ward and Rosie disclosed that her partner had committed several assaults against her since June 2019. A warrant was issued for Edward's arrest. He was located by WMP in mid-November and remanded in custody for a month until early December 2019. The contact made by Edward was identified on the DASH/DARA (Domestic Abuse Risk Assessment) as a high risk' incident and due to the number of previous MARAC's held the response was escalated to a 'Complex Case Discussion.' The Complex Case Discussion was held as planned 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, though no minutes of this meeting were taken. It is noteworthy that throughout all of the IMR's apart from that of WMP and BSWA there is no reference to the use of the DASH nor any other accredited domestic abuse assessment tool, by the other agencies in regular contact with Rosie-such as UHB A&E, the psychiatry service, SIAS (although they are licenced users), and ASC. This seems an omission and an obstacle to developing a common language and understanding of the nature and levels of risks to the victims all agencies in the area are working with.

4.19 It is self-evident that Rosie's two children would have been affected by the separation of their parents in 2017, and the aftermath of that which is obviously still with them. The children only feature to any significant degree in the IMR from Solihull Metropolitan Borough Council (Education). This IMR is in relation to the school the children transferred to as a result of the move (school 2) from their previous home (school 1). There is little information about the children from the school they attended prior to the move. (School 1) This is the school the children would have attended during the period up to and including their parents' separation. Records indicate this to have been a fraught time when there was known to be significant discord between the parents and worry over Rosie's drinking and linked behaviour. Unfortunately, school 1 has very little to say about their observations on the behaviour of the children at this time. The school state this was because the "school had very few concerns about the children because the children's father was

[30] UHB IMR Chronology P14 22.8.2019

keeping them safe. Their attendance was 100% and some pastoral support was provided" [31]. The Panel are puzzled by this and wonder whether this might indicate that the school were either not seeing signs of behaviour change linked to this, or not recognising such signs for what they were. School 1 did not provide a written handover to school 2, instead handover was conducted by a phone call. The Panel are aware that school 1 was informed by the children's father that their mother was having problems with her drinking, and that it was not safe for the children to be around her at this time. In handover the school 1 stated that the children had 'witnessed a lot of things,' that the father and children have had counselling and support with coping with mum's drink problem, that the children's father 'was great' and warned the new school to be aware of the younger child's moods, 'particularly in relation to other children' and that child 2 can be unsettled after contact with mother. School 2 felt the handover to be unsatisfactory given the low level of information it gave them[32]. This was addressed by the Solihull IMR author and the Chair of the Panel has contacted the CSP's in the areas the children are now receiving education to alert them to the safeguarding process issues raised by the Panel.

4.20 From the documentation provided by school 2 and school 3 the Panel are aware that both children caused concern to staff at the schools as a result of the impact of the events within the family on them. They expressed high levels of anxiety and unhappiness in their behaviour and attitudes both in relation to learning but also to their ability to cope with everyday school life. The Panel would record that they admire the sensitivity and determination of staff at the schools to do all they could to help in this, despite the low level of information provided by school 1 to them. Both children expressed discomfort early on in the school year. In September 2019, child 2 disclosed worry about mother and arguments within the home. The school took a proactive approach and planned to contact the children's father to discuss the impact this was having on child 2, they also noted that child 2 had been upset after speaking with another child in the school. In October Child 2 began to self-harm, possibly because of anger due to all the disruption they were living through.

4.21 Records suggest that child 1 was affected mostly by worry about their mother, and why she was behaving in the way she was which was unsettling to them. There were arguments and evidence of tension between the father and child 1, and later in 2020 of child 1 arguing and fighting with other children in the family. Weekends were often particularly difficult when the children would have contact with their mother, or she would ring them either drunk or distressed. The fallout of the distress caused by that would often colour the weekend and their return to school. There was an incident described at the end of January 2020 in which child 1 showed a staff member bruising and possible finger marks in child 1's body and arm. This was referred to the DSL, but there is no evidence on file of a child safeguarding referral being made. There were also some potential indications of domestic abuse provided by the children. Two in particular

[31] Solihull Metropolitan Borough Council: Education (SMBC Education) 2.6 P5

[32] SMBC (Education) chronology 18.9.2019 P.10

appear relevant, at the end of February 2020 in which child 2 refers to their mother having had a fall and 'bumped' her head, and that she was in hospital with that[33]. This was not picked up. Later on, the same day DSL 2 in speaking to the new partner of the children's father about an injury to child 1's head, caused by another child, she replied that she herself 'sometimes felt like punching child1'.[34] Considering the pressure the family were under this should have been explored further and possibly a referral made to Children's Services. There was later a concern expressed by a staff member about child 1 walking home unsupervised and possibly being left alone in the house, again, there is no record of these concerns being discussed with the DSL or referred to safeguarding.[35] The school were aware and responded proactively both in terms of the pastoral needs of the children but also in trying to limit the damage their home life was having on their time in school. School 2 states that "Referrals were made for emotional support and an emotion coach worked with child 2 from September 2019 to March 2020. The children's father and his new partner engaged well with this. As child 2 was deemed vulnerable, there was regular weekly contact by phone with the family during the various Covid-19 lockdowns. Child 2 was offered a place in school but chose to work at home. Engagement with remote learning was variable."[36] Child 1 was referred for work with the School Nursing Service to better understand and manage the child's feelings, events, and experiences since separation. Although not evaluated, the school believe this work to have had positive outcomes. It appears from school records that child 1 was better able to communicate concerns and feelings with school staff after this.

4.22 It is of concern that notes made at Rosie's attendance at UHB A&E in early October 2019, with a fracture to her finger, did not state whether she was asked any domestic abuse screening questions, despite the injury being one often associated with partner abuse and her record as a previous victim of such abuse. WMAS received four callouts to Rosie's address between October and November 2019, two concerning her feeling suicidal, one having a seizure and one in which she had woken up having been 'spiked' and discovered she had been robbed and her window broken.

4.23 In early December 2019, the WMP victim led prosecution relating to charges in April 2019 was heard and dismissed at Birmingham Magistrates Court, although a Restraining Order was granted with prohibitive measures relating to contact and proximity involving both Rosie and Edward until December 2021. Rosie believed she was made subject by the Court to a similar Restraining Order to protect Edward. As stated above the approach she believed was taken in Court with her was deeply resented by Rosie who stated, "she had lost all faith in police and courts

[33] SMBC (Education) Chronology 27.2.20 P13
[34] SMBC Chronology 27.2,20 P13
[35] SMBC (Education) Chronology 16.9.20 P16
[36] SMBC (Education) P17

over recent appearance and felt belittled when she could not remember stuff such as which hand had held her down with the pillow" [37].

4.24 Rosie attended UHB A&E at the end of January 2020 with a head injury sustained the previous day, stating she had been bleeding from her ear. She denied the injury was a result of domestic abuse but acknowledged her partner "regularly physically abuses her-suffocation, pinches legs, pulls hair, punches face, shouts, hits and smashes things, very angry and jealous."[38] She did sometime after admission acknowledge her injuries were caused by her partner. There was an exchange of information with Occupational Health, and Children's Services. The day after admission Rosie insisted that she wanted to return home, absconded and was brought back onto the ward, stating she would continue to try leaving the ward. Rosie was formally assessed under the Mental Capacity Act as temporarily unable to make an informed decision about her care and treatment. An urgent request to detain her on the ward to receive care and treatment under the Deprivation of Liberty Safeguards (DoLS) was authorised for 7 days. Rosie's mental capacity was subsequently reassessed by the Ward Consultant on 31 January 2020 in which she was deemed to have mental capacity, therefore negating the need for a further DoLS authorisation. On the same day Adult Social Care Services determined that "Safeguarding is closed as SU has capacity and does not want the case moving forward"[39] . It was arranged that Adult Safeguarding would signpost for domestic abuse support and contact her GP for follow up and updated the Police. It was recorded that she had suffered a 'mild to moderate injury to the brain' and would need follow up.

4.25 Following that attendance Rosie again attended hospital with fresh injuries on five occasions between February and March 2020. Presentations included another head injury, bleeding from the ear, a shoulder injury, a collapse or seizure and blood from left ear and left eye, following 'a collapse.'[40] There is no reference through these entries of any enquiries or referrals to either safeguarding or the police. Rosie's mother, when told of discharge being planned for her daughter on the mid to late February 2020 told staff 'She would die' if she was discharged. This was not explored further with her by staff and Rosie's explanation for bruising on her body as being due to 'a fall' was noted and accepted by staff on the ward. Rosie herself stated that she 'wanted support' and 'could not cope on her own.'[41] UHB's chronology states that the nurse 'noted that she was 'mobile and self-caring'[42] and made a referral to the psychiatry team. This suggests minimal exploration of the meaning of Rosie's statement and that it was made in relation to physical and not emotional needs. Rosie attended again at the beginning of April 2020 with a bruise to the head, caused she said by her partner. Rosie was heavily intoxicated having been found on the

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[37] BSMHT IMR SIAS8 P22 13.12.2019
[38] UHB IMR P15 27.1.20
[39] UHB IMR P16 28.1.20-31.1.20
[40] UHB IMR P16 3.2.20-26.3.20
[41] UHB IMR P17 20.2.20
[42] UHB IMR P17

road saying, “she wanted to kill herself”[43] She stated she did not want to involve the police. On being seen by the Psychiatric Team she was discharged and notes state referral to safeguarding was made. It is noted in the chronology that the “discharge plan is unclear and does not clarify what support was in place or what had been done in regard to Safeguarding.” There is no record of the receipt of the referral in the Adult Safeguarding chronology for that date. In mid-May Rosie was again admitted with a number of injuries which she stated were due to abuse from her partner and her father. It was also noted that she had a recent rib fracture and a 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 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.

4.26 In early June 2020 WMAS attended Rosie’s property following an emergency call by her father. On entering the property, ambulance crew found Rosie unconscious with ligature marks around her neck and cuts on her neck. Bruising was noted all over her body. She was known to be a victim of domestic abuse. A DoLS assessment was recommended by a doctor attending given her known confusion, but this was not referred to SMBC Adult Social Care (ASC). The chronology also points out that although safeguarding concerns were noted there was no record of any referrals or enquiries received by adult or child safeguarding teams. Rosie was reluctant to stay in hospital soon after she was admitted and started to recover physically. It was stated in the chronology that Rosie wanted to leave the hospital as ‘staff were making fun of her…but was prevented from doing so as she lacked capacity.’ This is odd as there had not been a DoLS application made or received. Rosie was discharged in mid-June 2020 and 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 BSMHFT's Safeguarding Team that if Rosie presented again at UHB that she be referred to the Hospital Psychiatry team to enable her to discuss in safety 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. It was noted that if Rosie presented again at UHB and should a referral be made, then Liaison Psychiatry staff to explore domestic abuse. 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.” [44]

4.27 Sometime after this discharge, Rosie had a long telephone call with a SIAS worker, with whom she disclosed how she had ‘hit rock bottom’ but was now starting to recover and planned to have contact with her children again. She spoke positively about her new partner (presumably then Nick) and that she was looking forward to the future. The panel were unable to ascertain

[43] UHB IMR P16 1.4.20
[44] BSMHT IMR P 42

when or how she met Nick, but it appears this was in mid-June 2020 some weeks before her murder.

4.28 In mid-July 2020 WMAS received a 999 call and attended Rosie's flat. Rosie was observed to be "unconscious and not breathing. Rosie was found on her left side in foetal position, her head was covered in dried blood, and she was on grey shag pile rug which was soaked in blood"[45] . There were no signs of life. The crew observed "catastrophic injuries to her neck around her carotid area and back of neck behind her left ear and across the top of her spine." An attending Police officer noted time of death.

4.29 The perpetrator

It is believed although cannot be confirmed that at some point after Rosie's discharge from hospital in mid-June 2020, Rosie began a relationship with Nick, who was not currently known to any services in the area. WMP state, "There are no police records to indicate the relationship had commenced and Nick has no previous convictions or cautions for domestic abuse related offending. In fact, he has no real history of violence and his last contact with police is September 2010." [46]

4.30 However, Nick was referred to SIAS in August 2019 and was assessed by them in September 2019 due to concerns about his alcohol and substance misuse and linked problems with anger and violence. He disclosed "that he was experiencing 'dark thoughts' and wanted to hurt himself or someone else. He had also stated that he had had thoughts to stab himself in the neck. This appeared to be viewed as an acute crisis to which advice was given on where to access help."[47] This was an omission on the part of SIAS staff as it took no account of the risk of harm to others that such thoughts and feelings may have posed. As a minimum this information should have been passed to WMP. At a follow up appointment less than three weeks later he described his abstinence from cocaine and that he felt his alcohol use was controlled and that he did not need further assistance. He was discharged from the service.

4.31 WMP records state that the murder occurred on the evening in mid-July 2020, and that Rosie and Nick had been out drinking in local public houses, during which time they met another couple who invited them to their house. The couples continued drinking and after some time Nick and the other male left the house to get more drink. On their return Nick became enraged as he believed that Rosie had "cheated on him" with the female. They then left the house together and returned to Rosie's flat. At some point in the early hours of the following morning Nick murdered Rosie. Nick then contacted WMP to report that he had attended Rosie's address to find the door unlocked and her injured inside. Nick was arrested at the scene. A forensic examination of Rosie found fifty-four "sharp force injuries concentrated to the neck area. The cause of death was recorded as sharp

[45] WMAS P15, 12.7.20
[46] WMP IMR P30 1.92
[47] BSMHT IMR P42

force injury to the neck."[48] Nick was charged with Rosie's murder. Nick's mother was also then charged with perverting the course of justice by making a false witness statement to police.

[48] WMP IMR P30 1.96

5. Overview

5.1 It should be said at the outset that very few agencies had any information relating to the perpetrator Nick, nor could they have been expected to have had. He was unknown to the agencies and was not a known associate of Rosie's until after the murder. He did not attend with her nor was at her home in any of the contacts she had with emergency or medical staff. He had no significant involvement with the Criminal Justice system. We can however describe what was known by agencies in their work with Rosie and managing the consequences of the abuse she was enduring at the hands of Edward in the years before her murder. This is significant as the Panel believe it was these experiences which reduced Rosie so physically and mentally that she was so vulnerable with such fatal consequences when she met Nick.

5.2 The Panel had no contact with the children or their father who did not want to be involved in the DHR process, we cannot speculate on the impact of any injuries seen but note the impact on the children of having a mother with alcohol issues and the support provided by the schools for that.

5.3 School 1 in Solihull state that both children had attended their school until July 2019 and that they had identified that the children's mother was 'vulnerable' after being informed by the children's father of her alcohol misuse and linked problems that had led to child 1 and 2 moving with their father to live with his parents. This would mean the children moving to another school in the area where his parents lived. Records suggest that School 1 had already become aware of problems at home due to remarks the children had made, but not the full extent The chronology suggest no information regarding these issues of separation and substance misuse was sent by School 1 to school 2, before September 2019 and the start of the new school year. Information exchange was prompted by School 2 who became aware due to disclosures and the behaviour of the children of significant issues concerning their welfare, which led them to contact school 1 on in September 2019, twelve days after the start of term. There was an informal information exchange and the chronology notes that School 2 received no written information concerning the family and the welfare of the children. This seems odd given the emotional and behavioural impact of the parents' separation noted quickly by School 2 on the children and the need very early on in the term to respond to the vulnerabilities and emotional and behavioural problems demonstrated by child 1 and 2. This level of seriousness of the impact of the separation on the children does not seem to have been identified by School 1.

5.4 School 2 made a referral in November 2019 to the School Nurse who completed a programme with child 1 about the impact on children of adult alcohol and drug issues. They also articulated a number of times in their report their awareness of the impact on the children and wider family of Rosie's problems and the separation. There was also information recorded by school 2 in terms of their mother's vulnerability because of her drinking and arguments between the children's mother and father, and its impact on them, but only oblique references to injury caused to Rosie which could have alerted the DSL to possible domestic abuse. There was one other possible disclosure of domestic abuse in July 2020 in which School 2 recorded that child 2 had reported that their

mother “had fallen over and bumped her head.”[49] Which could have been explored and was not. Possibly a missed opportunity. It is noticeable that neither of the schools enquired about the possibility of domestic abuse with either the children or the adults with whom they had contact. There were clearer references however to potential safeguarding issues involving the children, which were not picked up, in particular child 1 walking home on their own and possibly being left on their own at home and suggestions of possible intra -family violence within the home. These were recorded but not followed up by safeguarding leads within the school. Child 1 was recorded to have had suspicious bruising on their arm in January 2020, but no action other than recording the resemblance to finger marks was taken. The emergency services, in particular the WMP and WMAS had the most contact with Rosie at critical times, attending at her home in response to incidents and crisis. WMP had since September 2018 attended numerous callouts to Rosie’s home in response to domestic abuse related incidents. She was assessed as at ‘High Risk’ and four MARACs, and a High-Risk Case Conference were called to attempt to manage the risk. These events led to Rosie being seen as at high risk of domestic abuse throughout the course of her relationship with Edward and four MARAC procedures and two evidence led prosecutions were initiated by WMP. A Restraining Order was issued at Birmingham Magistrates Court in December 2019 as a result of a police-led prosecution. Edward was the perpetrator in all cases. It is not known when Rosie’s relationship with Nick began, but WMP believe that her relationship ended with Edward sometime after July 2020, the Police believe this may have been a product of the pattern of continual arrest and remand as a result of police action or the Restraining Order imposed in December 2019. WMP believe that it was sometime in June 2020 that she began her relationship with Nick. Nick was not known to WMP and had no records for violence and no convictions at all since 2010.

5.5 WMAS were called to attend Rosie on 28 separate occasions. Each attendance was for a medical emergency in either her home address or a public place, in response to seizures, falls, assaults, self-harm, overdose, suicidal ideation, and alcohol related incidents. WMAS in all attended twenty times to Rosie’s flat in the period of this review. There is evidence in the IMR of ambulance crews being aware of Rosie’s vulnerability and of them working with her to encourage her to accept treatment when she was reluctant to. 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 at the time that many of the injuries they witnessed were due to domestic abuse. In many of the call outs, WMP were either at the scene or had called WMAS to attend. The WMAS IMR states that Rosie “disclosed she was a victim of domestic abuse on five separate occasions. There is evidence that on two of the five attendances, police and other relevant agencies were informed. For the further three attendances there is no evidence of police involvement or signposting of domestic abuse services.”[50] In January 2020 the Panel noted that although WMP were not informed, an adult a safeguarding referral was made. For the two other

[49]SMBC (Education) 5.3 P21
[50]WMAS IMR P13

attendances in which Rosie disclosed domestic abuse there is no evidence of WMAS involving the police or signposting of domestic abuse services.

5.6 ASC were aware that Rosie was a victim of domestic abuse, and that the perpetrator was Edward. Between mid-March 2019 and mid-May 2020, ASC received five safeguarding notifications regarding Rosie. Rosie's GP had referred her to ASC twice due to suspicion of injuries being caused by domestic abuse. The safeguarding concerns were all referred by partner agencies. ASC state that although not all referrals were directly related to domestic abuse, this formed part of discussions during each contact.[51] ASC were at this time aware that Rosie was estranged from her family, misused alcohol, was emotionally vulnerable and that her relationship with Edward was abusive. In March 2019 Rosie disclosed to ASC that her injuries were related to abuse, but said she was 'too scared' to go to the police as she felt they could not protect her. Information from other agencies and her own presentation indicated to ASC that she had 'capacity', and no action was taken other than signposting. Records indicate that ASC felt Rosie had social and personal support in that she was described as having a good home, employment, and a supportive family. This view may have influenced their assessment of her capacity and her ability to manage the risks within her relationship. Later in August 2019 Rosie was again hospitalised and injuries felt to have been caused by domestic abuse were noted and a referral made to ASC by hospital staff. Due to poor communication between ASC and the Hospital, Rosie was discharged before ASC were able to assess her. Attempts made to contact and visit Rosie following discharge by ASC were unsuccessful. The last contact with ASC was in January 2020, following admission to hospital with 'significant' injuries thought to be related to domestic abuse. Rosie was assessed by ASC, and she denied the injuries to be related to domestic abuse. Although on admission she was deemed to lack capacity, Rosie was subsequently assessed by the Ward Consultant to have regained capacity by the time ASC interviewed her. Despite the serious injuries and evidence of abuse, Rosie's denial of abuse and her assessment as having capacity, prevented them from taking any action other than the ASC worker contacting both the GP to ask them to raise the issue with her and notifying WMP.

5.7 Staffordshire and West Midlands CRC had responsibility for supervising Rosie's perpetrator, Edward. Edward was supervised by a probation officer who knew that Rosie was Edward's victim and that for most of the time Edward was subject to the Probation Order he was living with Rosie. Edward was not visited at this address by his Probation Officer to assess whether this address was suitable as he should have been. The supervising probation Officer had no information relating to the further assaults by Edward on Rosie, other than requests for information from MARAC about Edward. These requests for information from the MARAC do not appear to have generated any response from the Supervising Officer, which puzzles the Panel. The Panel understand from the CRC IMR that requests for information from MARAC did not provide information relating to the reason for the MARAC request for information, which seems to be a gap. In addition, the Panel are aware that on one occasion, requests for information from MARAC

[51] ASC IMR P13

were not passed on to the supervising officer by the CRC. Overall, there seems to have been a lack of engagement with the MARAC process by the supervising officer and the CRC, which perplexes the Panel as the officer is described as experienced and well regarded. From the lack of activity and oversight of this case the Panel can only assume that either the officer was unaware of the risk posed by Edward to Rosie or was aware but believed those risks were being managed. There were no disclosures from Edward relating to these assaults to his supervising officer and it seems contact overall between Edward and his officer with irregular with many absences recorded as due to illness and employment. As there was no home visit made, as required within the supervision standards the Panel assume that Edward's presence at the address was not risk assessed. The supervising officer was not aware of a further court appearance related to another domestic abuse incident listed for mid-September 2019, until informed by Edward, and requests by MARAC for information which should have alerted the officer to further domestic violence were not received by that officer due to information not being passed on by the agency. Edward's case does not appear to have received close supervision, although case notes do not state this, this may have been due to lack of knowledge of the frequency and seriousness with which Edward was assaulting Rosie and the level of risk he posed to her, due in itself to the low level of oversight of him and information not being passed on within the organisation to the supervising officer. There is no reference to the supervising officer receiving notifications by the police of alleged crimes committed by Edward- the officer did not know for instance that Edward had been remanded in custody following an alleged assault of Rosie, until informed by Edward's father in November 2019. The Domestic Abuse Perpetrator Programme, (attendance was a condition of the order) was only commenced in January 2020, nine months into the 12-month Order. This seems an oversight, and along with the other issues in the order such as no home visit, infrequent contact, lack of knowledge of Edward's further court appearances indicate to the panel poor management of this case in all of its elements.

5.8 Rosie attended the Emergency Departments (ED) at Birmingham Heartlands Hospital and Solihull Hospital 26 times during the review period of July 2016-July 2020. Most attendances were in relation to alcohol withdrawal and associated collapses and seizures, sometimes resulting in head and body injuries. On some occasions Rosie required hospital admission for further treatment for alcohol withdrawal or injury. During this time, she made several disclosures of domestic abuse from her partner, bruising, which should have been considered suspicious was noted at her attendance in January 2018 at UHB A&E department. Her explanation for the bruising was not questioned by staff. In November 2018, she again attended with significant bruising and did disclose that she was the victim of domestic abuse. There is no record of any action being taken in response to this. In 2019 Rosie attended four times to A&E, and with each visit injuries including bruising were noted and disclosures of being choked and 'smothered' were given. There is no record of action being taken. Rosie's partner, Edward attended with her in August 2019 and even provided her medical history to ward staff. He was also allowed to remain on the ward with her. In February 2020 Rosie attended again with bruises to her body and face, which should have been considered suspicious. Her explanations were again not questioned. Although SIAS notes indicate that at this time hospital staff had been notified of her MARAC status, and both Rosie and her mother stated to nurses on the ward that she was unable to cope at home, she was discharged. Rosie again presented in May 2020 with multiple contusions and disclosed that her injuries were due to abuse from her then ex-partner and father. A safeguarding referral was made

but later withdrawn as Rosie retracted her statement. The IMR from UHB identify the implication of this lack of inquiry by staff at the hospital when they state that 'from a child safeguarding point of view in the 26 A&E attendances, Rosie was asked thirteen times if she had children. This meant correspondingly that there were thirteen occasions in which she had attended with injuries indicative of domestic abuse in which she was not asked if she had children. Of the thirteen occasions when she was asked if she had children, 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 a large number of A&E contacts with Rosie any transferable risk to children was not considered.'[52] This is contrary to NICE guidelines.

5.9 SIAS were the only agency involved directly with Nick, from August 2019 for about 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."[53] It does not seem that these disclosures generated any concerns or enquiries concerning risks to the other residents of this property, nor seeing it as a potential case of 'Intimate Family Violence' and Coercive and Controlling Behaviour.

5.10 After the conclusion of a lengthy appeal process Nick's sentence was confirmed and he then agreed to contribute to the Review process. In November 2022 the author interviewed Nick in custody. In interview he disclosed he had been abusive and aggressive at his parent's home, destroying property and putting himself and others at risk. He recognised his behaviour would have been threatening and frightening to his family. Although out of the scope of this Review he described as a child his parents had sought help with his destructive and aggressive behaviour. Therefore, this was an established pattern of behaviour that went onto cause the end of his adult relationships. Following an extreme outburst of destructive behaviour his parents had to return prematurely from a holiday and his mother accompanied him to the GP and was referred to SIAS in 2019. As noted earlier he was assessed as needing help with his cocaine and alcohol addiction. and discharged following him reporting use of substances to have reduced. In interview he now understands that his addiction to have been a symptom of his Personality Disorder which was diagnosed at his pre-trial assessment. On discharge by SIAS he was advised to see his GP about his violence.

5.11 Rosie had originally been referred to SIAS by her ex-partner, the father of her children in August 2017 due to her alcohol misuse. She did not engage effectively. She was, following this referred again on a number of occasions to SIAS following hospital admission due to her alcohol misuse. Although SIAS workers made contact a number of times with her and were persistent in their attempts to work with her, Rosie did not engage. Rosie disclosed to them that her partner had

[52] UHB IMR P30
[53] SIAS IMR P29 chronology 3.4.2019

been abusive to her in August 2017. SIAS were told by Rosie in February 2019, during her hospital admission that she was experiencing domestic abuse. She stated that ward staff had reported this to the Police. WMP IMR confirms this and that the matter was referred to the CPS. There is however no evidence that the SIAS staff themselves checked this information with a third party. Rosie was seen or spoken to several times by SIAS through 2019, either in hospital or by phone. Rosie variously denied or acknowledged she was experiencing abuse over this period. She was generally provided with signposting and advice and offered help with her substance misuse. Rosie never took this up. There is no evidence of SIAS contacting WMP, apart from in November 2019 when Rosie spoke to an SIAS worker about her fears of being stalked by Edward, this was then reported to Police safeguarding. SIAS were probably the last agency to have contact with Rosie- in a phone conversation in early July 2020. In June 2020 a friend of Rosie's had disclosed to them that Rosie was a victim of sexual abuse and probably sexual and financial exploitation, that she was with a new partner and was involved in drug use. All factors suggesting a deterioration in her wellbeing. The worker was advised to inform WMP of this by their supervisor, there is no evidence this was done. A few days later, in early July 2020 another SIAS worker contacted Rosie who described her situation as being very different from that outlined earlier. The worker described Rosie as being positive about the way her life was going and changes that had been made in terms of her alcohol use and relationships with her parents and children. Her new partner was discussed, although no name was confirmed, and she spoke positively about the relationship, sharing no concerns. It is stated in the IMR that the worker 'believed that based on her tone, at that time, there was no evidence to question or contradict this.' At the very least such a positive outlook should have been 'respectfully questioned' as the IMR author from SIAS accepts, when they state "On reflection however, this may be evidence of a sense of professional over optimism. When considering Rosie's history of being a victim of domestic abuse, her overarching vulnerability, it was felt that there was a need for respectful uncertainty around Rosie's new partner who should have been considered as a potential threat. The complexity of this case, due to Rosie's frequency of accessing hospital treatment, her tendency to disengage from services, repeated domestic abuse and unclear relationships with other men, may have been viewed solely in relation to the role of alcohol in her life, impacting directly upon her decisions, rather than viewing Rosie in the context of trauma she had experienced and understanding the wider needs and risks."[54] This was a missed opportunity to have used professional curiosity informed by knowledge of the Rule of Optimism[55] and could have triggered a response.

5.12 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. On each occasion the source of risk was identified as Edward. Given the frequency of MARAC being convened, the case was then referred to the Regional Complex Case Discussion panel in late

[54] B&SMHT 5.3 P40

[55] Revisiting the Rule of Optimism Martin Kettle, Sharon Jackson
The British Journal of Social Work, Volume 47, Issue 6, September 2017, Pages 1624–1640, https://academic.oup.com/bjsw/article-abstract/47/6/1624/4554327?redirectedFrom=fulltext

November 2019 which was not minuted. An aim was established to secure evidence to implement a Domestic Violence Prevention Order.

5.12 Birmingham and Solihull Women's Aid (BSWA) provided the IDVA function within the area at this time. They attempted to contact Rosie after each occurrence and referral from WMP. There were several of these, between February 2019 and her murder, they managed to engage her at one point, creating a safety plan and sharing information on her with the Local Authority Housing Department. Most attempts by them to contact Rosie were not responded to at all. Contact was made in May 2019 following an assault, she was offered but declined a referral to support services. The only exception to the pattern of referral and no contact or contact and Rosie's decline of services offered 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. There were following those three successful contacts with Rosie in which Rosie disclosed a further assault by her partner. A safety plan was completed. This was significant. Rosie then dropped out of contact again. It is of note that Rosie contacted BSWA at the beginning of August 2019 "asking for confirmation of the worker" before the meeting. She then kept contact for two sessions, a significant change of pattern. Rosie appeared to have engaged with this specific member of staff but due to the service model in place at BSWA, this apparent advantage was not used to maintain contact. BSWA acknowledge that their service delivery model does not enable a specific member of staff. to work individually with a particular service user.

6. Analysis

6.1 It is not clear what caused Rosie's tragic descent into such catastrophically poor emotional health, alcohol misuse and vulnerability to abuse. The ending of Rosie's relationship with her long-term partner and the father of their children seems to be the precipitating factor, but those difficulties within that relationship in their turn seem to have been triggered by Rosie's alcohol misuse and low moods leading to significant conflict within the home likely causing the relationship to end. The Panel can only speculate as to the cause of those behaviours and the only trigger known is that Rosie was said to be extremely stressed at work, to the point that she was on sick leave for about two years from 2016, had been referred to Occupational Health, and eventually was made redundant, with a smaller lump sum but a monthly payment of 2/3rds of her salary. Rosie was also in the last couple of years of her relationship with her partner expressing discontent, that she and her partner spent little time together due to their working patterns and she described him as 'controlling' what she wore and when she went out. The Panel know from her parents that Rosie's children were important to her, and it is evident that their removal from the family home and the limited contact that Rosie was allowed with them thereafter must also have been extremely difficult for her. After some months of separation, Rosie was only allowed to have arranged and supervised contact with them, conditions she adhered to until her death.

6.2 Rosie's life course and her tragic death after the separation from the children's father and her children is one of decline in every sense, emotionally, physically, her relationships, alcohol misuse and her sense of self-worth. This decline was played out in full view of her family, children, and local services such as primary and secondary health services, social care services, WMAS and WMP. Rosie's parents believe that Edward was to some extent a positive factor in their daughter's life as he would ensure she ate, they acknowledged that he '" manhandled her" but the true extent of the violence she endured from him was hidden from her parents by Rosie. The Panel regard Edward, unambiguously as the main agent of her destruction. It was the abusive and violent relationship that she was in from 2018 onwards in which Edward systematically reduced her physical and emotional health and resilience to the point at which she Rosie was found in April 2020 lying prone in the road by WMAS expressing that she wanted 'to kill herself'. Although Edward had no part in her death, her relationship with him undoubtably reduced her will, health, and resilience to the point that she was so vulnerable to Nick whom she met soon after their relationship ended and who did soon after killing her.

6.3 As stated above Rosie was a frequent user of primary and secondary health services in the area. There had been several emergency admissions to hospital and referrals by her GP in which it was identified that she was a victim of domestic abuse. Rosie's GP made in 2019 two referrals to ASC as they were concerned, she was a victim of domestic abuse. She often presented with bruises all over her body and generally would initially deny and then admit the origin to be due to physical abuse. She was referred to domestic abuse services, but generally could or would not respond to these, similarly when offered help via SIAS in terms of her alcohol misuse she could not maintain any engagement over time. As described above health staff would notify the police if they were not already involved in cases where abuse was suspected. These two issues were intertwined- ASC described Rosie as "known to experience the toxic triangle of domestic abuse, substance dependency and depression." However, she was also seen to "have a steady home, a

network of support in friends and family and full-time employment."[56] This level of social and personal capital which Rosie had, or at least was considered to have, meant that state agencies felt that they had to respect the decisions Rosie was making, particularly to return to an abusive relationship, as she had the 'capacity' to make such decisions.

6.4 Given that, what is the explanation for the failure of all that knew Rosie to intervene and prevent her tragic decline and death? This in the view of the Panel reduces essentially to three elements. .

1. The inability of any agency to engage her and intervene effectively in Rosie's life.

2. The failure to disrupt the course of abuse by Edward.

3 The lack of an individualised approach for Rosie that recognised the impact of trauma.

These factors are all of course intertwined. Rosie could not in any meaningful way work with the help offered separately in terms of her alcohol misuse and her experience of domestic abuse which were for her connected. Given Rosie's capacity, state services could only work with her with her cooperation. So why was she reluctant to give it? One of the reasons the Panel would suggest is that the offer to Rosie, in the case of B&SMHT and SIAS, of working to achieve alcohol reduction was possibly not one she was at a stage where she was either ready, willing, or able to accept. Rosie was already when offered help initially by SIAS and thereafter, a victim of domestic abuse and showing signs of trauma as identified by ASC. An integrated care pathway based on a dual diagnosis approach (DA and Substance Misuse) was not offered. The fact that Rosie may have depended on alcohol emotionally as well as physically to cope with the abuse does not seem to have been considered. In terms of her hierarchy of needs, for her to feel safe and secure, alcohol may have been the most important thing to her and removing it in the short term would likely have threatened that. Secondly, she was a victim of trauma and there is no reference in SIAS or BSWA contacts of an acknowledgement of this and the use of a 'trauma-based approach.' In fact, it is known that her perpetrator was allowed with her on a UHB ward on three occasions even when she was exhibiting injuries that were related to domestic abuse. Similarly, the model of intervention used by both BSWA, and SIAS was one in which involved Rosie speaking to different workers and having to describe what had happened (and potentially retraumatise her) on several occasions, mostly over the phone. This approach is not consistent with a trauma-based approach and may well also explain her reluctance to depend on such services. BSWA acknowledge the limitations that their funding arrangements have on their service delivery model and lack the resources to provide a more personal approach. Linked to this gap was a lack of professional curiosity as to why Rosie attended at hospital so often, with such injuries and why she would not engage with them. Rosie attended Hospital fourteen times with bruises and injuries associated with domestic abuse and made disclosures of abuse on eight occasions. She was as a result referred to adult safeguarding and sometimes the police. However onward referrals were the usual

[56] ASC IMR 1.1 P3

result of these referrals and Rosie did not take these up and nothing happened. It seems that Rosie was mostly offered a specific intervention such as help with alcohol misuse and that the reason for her failure to engage was not considered and the offer repeated the next time she presented. The IMR from UHB recognises there was no professional curiosity in terms of the domestic abuse Rosie was known to experience and that the 'NICE questions' [57] about domestic abuse were never asked. This is also true of BSWA, activated by MARAC and hospital referrals and not taken up by Rosie. Avoiding hindsight bias both agencies knew the stakes were high for Rosie and her frequent hospital admissions and attendances were resource intensive... Rosie regularly presented both at Hospital and at MARAC with similar serious injuries and reports of incidents and yet there was no sense of a coordinated resource being devoted to her from either the perspective of protecting Rosie nor of resource management- the costs incurred by acute services in responding and treating Rosie. SIAS demonstrated a similar lack of both professional curiosity and over optimism when they managed to make contact with Rosie, this was one of her last contacts with anyone in which she told the SIAS worker that 'she was in a new relationship and that she was happy.' The worker seemed to accept this on face value and did not consider the information about a new relationship to suggest heightened risk for Rosie given her background and vulnerability. The worker asked for no further details of the identity of her partner, nor suggested the need to discuss this new development. Most worryingly this disclosure does not seem to have been passed to the line manager for oversight. Perhaps most fundamental in this case overall is the complete absence of either the direct use of or reference to the DASH or equivalent accredited risk assessment process throughout her contact with Health and other linked organisations – SIAS, Mental Health Teams, WMAS, and Adult Safeguarding. This seems emblematic of the lack of a joined-up approach between inpatient, outpatient and community support services which may have enabled the perpetrator to abuse, control and coerce with few if any consequences, at times in plain sight. BSWA acknowledge that the volume of referrals and their limited number of staff due to the local commissioning arrangements mean it is not possible to meet with women victims in the first instance on an initial contact or guarantee the same member of staff for service users. BSWA were also unaware of Rosie's hospital presentations which do not appear to have been shared with them at MARAC.

6.5 Linked to this is Rosie's experience that state services were unable to keep her safe. We have already described that the perpetrator was on several occasions allowed onto the hospital ward with her. Similarly, we know that Rosie was made by him to let him stay with her at her flat when he was homeless, and that sometimes she stayed with friends due to her fear of him. This level of proximity to threat not only re- traumatised Rosie but also displayed the inability of anyone or any organisation to keep her safe. Rosie had on occasions described Edward's readiness to breach bail conditions preventing contact with her and on top of that the dismissal at Birmingham Magistrates Court in December 2019 of the prosecution brought by WMP of Edward further

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

undermined her sense of being able to be kept safe. Rosie said after that Court decision that she had “lost all faith” in the police and the Court.

6.6 Allied to this sense of vulnerability was the apparent ability of Edward to operate openly with few restrictions or consequences to his behaviour. Although he was subject to a twelve month Community Order made in April 2019 requiring regular supervision by a probation officer, he was able to return to the flat of his victim to live without permission being given to do so by his officer, as the IMR from WM CRC explains “ As he had returned to live with Rosie a home visit should have been undertaken within 4 weeks of receiving this information in line with the Case Management Framework and Domestic Abuse Policy 2018. However, as it was expected that the case would be transferred to the Solihull office, the officer expected the receiving officer to undertake the home visit. This did not occur, and despite the offender living with his victim it seems there was very little communication between these officers.”[58] In addition, oversight of Edward by his supervising officer was slight as the IMR from WM CRC acknowledges “Perhaps too much flexibility was granted in this instance as during this period he had 15 absences that were deemed as acceptable”.[59] It is difficult given this light touch to imagine Edward feeling constrained in any way by the Community Order. It is also evident that the supervising officer received very little information from either the WMP or MARAC of Edward’s activity due to poor internal communication within the CRC. Edward was known by the CRC to be a suicide risk in October 2019, and to have walked out of his job and was homeless- all factors known to increase a person’s risk of harm to self and others, but there appears to have been no additional response to these escalating risk factors. These factors would have increased Edward’s risk to Rosie. There was no formal review of the risks he posed to others by his supervising officer as a result of this deterioration, as there should have been. Significantly at no point in this order, even when it was known that Edward had been involved in assaults of Rosie was there an increase in oversight of him, by increasing his contacts with the supervising officer, which should have been a minimum response. The Panel are also aware that the Supervision Order was made in April 2019, but the statutory requirement to attend a Domestic Violence Perpetrator Programme was not activated until January 2020, three months before the expiry of the Order and barely enough time for him to complete the programme and no time to embed the learning from it with him afterwards. It is unlikely that Edward’s risk of reoffending and risk of harm to others was reduced in any way by this intervention and that he remains a risk to other women. The Panel is also puzzled by the lack of use or reference of any domestic abuse specific risk assessment tool in particular the Spousal Assault Risk Assessment (SARA) which should be a requirement in all such cases.

6.7 In summary, the Panel feel the pivotal explanation to be the failure of the services involved to both engage Rosie fruitfully, to protect her and to impose effective restrictions on the abusive activities of Edward. He was not the perpetrator of her murder, but his abuse so reduced Rosie’s resilience that she was rendered vulnerable to what we now know to have been a fatal degree. In

[58] S&WM CRC P11 16.4.2019
[59] S&WMCRC P19 5.1.20

seeking an understanding for the confluence of these factors that led to Rosie's death, the Panel feel that S&WM CRC's lack of case management and managerial oversight of Edward to be a key reason. In addition, none of the organisations that worked with Rosie sought to develop a common strategy when working with her. On the contrary, the Panel feel in each contact she was treated as a new service user. This may have been due to her refusal to cooperate with the services she was offered. The Panel suspect this reluctance may well have been interpreted as a lack of will or motivation on her part. An assumption if it was made, with fatal consequences. The one process seeking to develop a strategy to help keep Rosie safe was the MARAC. Their strategy and action plan were not supported or enabled by the agencies involved and according to BSWA who were represented at all four of the MARAC meetings and the Complex Cases outcomes were not fully communicated to all partners. The Panel believe this omission, along with the factors listed above, to have been critical in understanding why Rosie was killed.

6.8 There were examples of good practice in relation to this case. WMP initiated two 'evidence led' prosecutions of Edward as due to Rosie being drunk when assaulted she would have been unable to give evidence. This demonstrates a proactive approach by WMP. The school that children 1 and 2 transferred to in September 2019 showed remarkable sensitivity in responding to the behaviours of the children and introduced a trauma-based approach within the school, providing for example 'fidget toys' to help one of the children to manage situations of anxiety and stress, and arranging close oversight of the other child. Although Hospital staff did not generally demonstrate victim awareness in terms of Rosie's safety on the ward, ward staff at UHB did demonstrate a victim focus by notifying WMP on one occasion of Edward's intention to come to the ward to see Rosie, thus enabling his arrest.

6.9 In addition to the above factors which identified systemic reduction and loss of resilience in Rosie, another variable was that the services that had come into contact with Nick had not identified the level of risk and imminence of that risk that he posed. This, despite significant disclosures by Nick to them indicating risks to others as well as himself.

6.10 Independently of this case SIAS identified a pattern of behaviour in service users that they work with that suggests a high prevalence of Personality Disorder and have now instituted a Dual Diagnosis approach to assessments.

7. Conclusions

7.1 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 regularly attended by WMP, WMAS, UHB, and her GP. The perpetrator of her reduction, Edward was during all this time being supervised by S&WMCRC 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 and 'cuckooing.'

7.2 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 disruptive interventions 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 she soon was to fall prey to Nick. Rosie felt let down by the Courts in December 2019 when the case against Edward was dismissed, believing erroneously that she also had been made subject to a Restraining Order as had Edward and although an intelligent woman did not understand the Court outcome. There is not a Court IDVA Service at the Magistrates Court as the Specialist Domestic Violence Court (SDVC) is in Birmingham. The Panel is aware that work is currently ongoing to address this gap in services. However, there was a witness service, was this engaged? Her misunderstanding of the Court outcome led Rosie to feel that she could not depend on the legal system to keep her safe and that nothing could stop Edward. One can only imagine the impact of this on her emotionally- following on from the loss of her husband, her children, home, and employment and feeling there was no safe place available to her from Edward.

7.3 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 ultimately was working towards a DVPO to help protect her. Yet there appears a disconnect between this awareness of the level of threat to her and the treatment she received from state services- as an inpatient at hospital, the out- reach services- SIAS, BSWA, WM CRC and the Liaison Psychiatry team at UHB. BSWA note they are a consent led service and did not have Rosie's engagement but contacted her after each MARAC. According to BSWA who attended all of the MARACs and Complex Cases, outcomes from those meetings were not fully communicated to all partners with the latter meeting lacking minutes. Both the 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. The IMR from BSFMHT recognises there was little contact between Psychiatry service in the Trust and "with the police, probation, adults social care and women's aid, for example. This may have resulted in opportunities to alert others for them to be able to continue

and follow up on disclosures or concerns around risk."[60] This may well be a structural issue as described in the IMR due to the acute nature of the setting making it difficult to follow through with referrals once the 'moment is gone' However the IMR identifies that the Psychiatry Unit failed to ask the 'Nice questions', which would have been a brief intervention available that may have alerted staff to this issue.

7.4 The UHB at which Rosie mostly attended both A&E and the general wards allowed her perpetrator onto the wards, did not often enough follow up Rosie's disclosures of abuse, or her and her mother's statement that it was not safe for her at home. There was no awareness demonstrated by ward staff of how the impact that the trauma Rosie had experienced would have affected her and how to respond to her in a helpful way. A graphic example of this was the ward staff allowing the perpetrator onto the ward, and the response to Rosie and her mother both stating she would not be able to cope at home, her mother actually stating 'she will die' if discharged and the nurse in response assessing her physical abilities as sufficient to be discharged and not asking why they both felt that way. Such a limited response may have its origins in burnout or vicarious trauma which is the impact of 'emotional labour'[61] when physical and emotional exhaustion leads to a 'shutting down' emotionally as a means of coping, a known effect in those working in the emergency services in which workload cannot be otherwise controlled. The IMR from UHB identified that "Although staff were identifying and reporting concerns via referral to SIAS and safeguarding referrals, there is little documentation in the records that Rosie had been signposted to appropriate support services for domestic abuse by UHB staff, or that the 3 questions from NICE guidance had been utilised" [62]. Finally, regarding the A&E Department at UHB it is noted that in half of Rosie's attendances she was not asked if she had children, despite usually presenting with and disclosing that her injuries were a result of domestic abuse, and when she was asked and she explained her separation only on three occasions was she then asked if she had any contact with her children. This is a child safeguarding concern at the A&E Unit, and again the issue of vicarious trauma and 'burn-out' may provide an explanation here, in particular the issue of staff frustration in working in a setting designed to be acute, but with demands that at times require more nuanced responses than that.

7.5 The Panel are aware that the ward staff did more often refer to Adult Safeguarding and the addiction team- SIAS who did then sometimes refer to BSWA when abuse was disclosed but neither organisation was able to effectively engage with Rosie, possibly because she did not feel safe, and she had seen no evidence that agencies could make her safe. It is the impression of the Panel that what they were offering her – alcohol reduction and supported accommodation was not what she felt she needed. Furthermore, there is little evidence of these services 'sponsoring' Rosie in the sense of enabling and ensuring she attended services by a more 'hands- on' approach-

[60] B&SMHT 5.3 P39
[61] International Journal of Nursing Studies Volume 70, May 2017, Pages 71-88Nurses' resilience and the emotional labour of nursing work: An integrative review of empirical literature Cynthia Delgadoabc Dominic Uptond Kristen Ransed Trentham Furnessae Kim Fosterae
[62] UHB IMR P37 516

taking Rosie to service offered for example. In most cases she was signposted, and this was repeatedly attempted even though it clearly did not work with her. The impression gained by the Panel is that Rosie's non-attendance indicated to workers that she was not willing rather than being unable to participate. Rosie did show that she could respond to help offered and was most receptive to engage when she had built a connection with a worker, as she had done with a BSWA IRIS[63] worker who met her at the GP surgery. The SIAS model and the BSWA usual model of telephone contact with an unknown worker was not effective for Rosie. BSWA are unable within their resources to routinely offer continuity of worker. It is difficult to establish rapport, trust and motivate people using this method of communication, even more so when service users are traumatised and fearful, and are being asked to relive the trauma when having to describe it again to a different staff member on each contact.

7.6 Finally it must be noted that there is no reference within any of the agencies working to protect and help Rosie, treating her injuries or helping of any type apart from WMP of the use of an accredited domestic abuse specific risk assessment tool. Without this it is difficult to see how different agencies working with Rosie would be able to use a common language and an evidence-based understanding of the level of risks she was facing and appropriate interventions. Without such a tool it seems impossible to work or provide advice and interventions safely to her either within or between organisations. In addition, SIAS have recognised that their assessments should enable a wider assessment of the individual and that many of those referred to them have, in addition to substance misuse problems also have linked mental health issues. They have recently instituted a 'Dual Diagnosis' approach to assessments and treatment with service users seen directly or their worker advised a Mental Health specialist.

[63] IRIS is a specialist domestic violence and abuse (DVA) training, support, and referral programme for General Practices https://irisi.org/about-the-iris-programme/.

8. Lessons to be learnt.

1. The SWM 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 fear of 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 were not able to engage Rosie possibly because of her multiple presenting issues.

6. Lack of the consistent use of the DASH Risk Checklist to assess the level of risk posed to DA survivors within the region. A DASH or other DA Risk Assessment was not undertaken by any of the services provided by Health bodies. 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 a number of safeguarding indicators and did not refer to Children's Services or seek advice from CAMHS.

9. There was a lack of professional curiosity shown by hospital staff (particularly in A&E) and SIAS towards Rosie. 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 individual who repeatedly present and maybe as a result of the impact of 'Emotional Labour' on them.

10. That threats and violence within the home to family member should be identified by agencies as Domestic Abuse and responded to accordingly.

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 that 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 Birmingham North, East and Solihull Probation Service PDU 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 assists in the identification of action needed in cases that have been transferred.
- 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.

9. Recommendations

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 to meet the needs of individuals with dual diagnosis.

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. That Solihull Community Safety Partnership Executive Board's ongoing work following the MARAC Review findings take into account Rosie's case. This case highlights that there is a need for an escalation policy and process in cases which are known to be making frequent demands on services. In cases which involve 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.

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. 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 to 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 scenarios 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 actively to evidence of 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.

Appendix 1: Methodology for the overview report

Data analysis

The Panel discussed the chronology of events and draft recommendations in an inclusive and collaborative way, which involved all members in reflective learning. It was a generative process which encouraged us to ask the aspirational question – 'what a safe system would look like?' The outcomes from this process have formed the basis of the review recommendations. The recommendations were shared with Rosie's family prior to the review being completed to ensure her family were as involved in the outcomes as possible.

It must be acknowledged that any review opens anxieties, but it was the panel's intention to create a culture of accountability and learning not of culpability or blame. The review panel were unanimous in wanting to value the actions and approaches that worked well, whilst facing the tough issues of what else could or should have been offered. This was to produce effective recommendations which seek to make others confronted by these complex situations safer.

The chair wished to adopt a 'no surprises' approach, to encourage meaningful discussion and to air differences of opinion. The draft overview report was circulated to the panel and marked Restricted. Until final comments were received the panel members had the right to share the draft report with those participating professionals and their line managers who have a pre-declared interest in the review.

The Home Office guidelines require the final report in full to remain RESTRICTED and must only be disseminated with the agreement of the Chair of the Domestic Homicide Review Panel.

Appendix 2 Terms of Reference

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 her 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 Emotionally 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 person to whom they were related or with whom they were or had been in an intimate personal relationship, or
- a member of the same household as themselves, 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 31st August 2020.

8. Parallel investigations - The following processes and investigations are also taking place:

- The case is subject to criminal proceedings.
- Coroner's Inquest remained adjourned at the time of finalising this report.

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 01st October 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 the review - Upon 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 previously reported abusive relationship. 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 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 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 their 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 as 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 compiled 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 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

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 Nick from being a perpetrator of homicide
- How effective were agencies in identifying and responding to both need and risk?
- The relationship between Rosie and Nick was brief and this review wishes to widen its focus to establish if there is any learning from Rosie’s previous relationship with Edward. The review anticipates there may be learning 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 Nick.

01. Can you provide a brief summary of the role of your organisation in responding to domestic abuse?

02. Can your agency provide a brief pen picture of Rosie, Nick & Edward together with and any knowledge your agency had of their relationship?

03. What needs and vulnerabilities did your agency identify in Rosie (the victim) and how did your agency respond?

04. What needs and vulnerabilities did your agency identify in Nick (the perpetrator) and Edward the previous alleged? perpetrator and how did your agency respond?

05. What threat and risks did your agency identify for either Rosie, Nick or Edward and how did your agency respond? Consider identified threat and risk for this relationship as well as the potential for threat to other people.

06. 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?

07. How well equipped were staff in responding to the needs, threat or risk identified for both Rosie Nick and Edward. Were staff supported to respond to issues of domestic abuse, safeguarding, public protection, and multiple and complex needs.

07.1. Robust policies and procedures in domestic abuse, including policies of direct or routine questioning.

07.2. Strong management and supervision

07.3. Thorough training in the issues and opportunities for personal development

07.4. Having sufficient resources of people and time

08. Can you identify areas of good practice in this case?

09. 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 Nick?

10. Are there lessons to be learnt from this case about how practice could be improved?

11. 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's engagement with their agency?

20. Process - To identify key agencies and professionals involved with the Rosie, Nick, Edward 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.

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Domestic Homicide Review 08 Action Plan

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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

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Overview Recommendations

RECOMMENDATION 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 a strategic model of service delivery through a pooled budget to meet the needs of individuals with dual diagnosis						
Ref	Action (SMART)	Lead Agency	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
1.1	To explore the feasibility of a dedicated local support offer in Solihull that has capability to meet the needs of individual victims that have co-existing vulnerabilities alongside domestic abuse	Public Health DA and Substance Misuse commissioners	Develop an options appraisal briefing paper, reflecting best practice on how to positively engage with individuals with multiple vulnerabilities, including the scope, feasibility and fundings arrangements.	30/06/2023	Improved connectivity of services providing a tailored response which reflects individual need and supports a shared responsibility. We anticipate a 50% increase in Professional	Solihull's Domestic Abuse Partnership board (DAPB) and Combatting Drug & Alcohol Partnership (CDAP) Substance misuse Board will be responsible for monitoring.

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			Briefing paper presented to the DA and Substance Misuse strategic Boards for a decision. If the decision is not to commission a dedicated service, leads from Adult Social Care, Domestic Abuse and substance Misuse to work together on the development of a care pathway to improve co-ordination and working together.		meetings and shared support plans.	
Progress:						

RECOMMENDATION 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:

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(i)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.

(ii) of their effective participation in the MARAC process.

Ref	Action (SMART)	Lead Officer	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
2.1	The Chair of the CSP write to Lead Officers of UHB, ICB, BSMHFT, NHSE, SMBC Adult Social Care, Probation and Domestic Abuse and substance Misuse– Solihull commissioned services to seek assurances to questions i and ii above.	Chair of CSP	Named agencies provide a summary of their approach to management of individuals who present with fluctuating mental capacity,	31/01/2023	Improved understanding and management of individuals with mental fluctuating capacity, evidenced by all relevant agencies' assurances. All contacted agencies and teams give assurances.	DHR Executive Group to review responses and escalate issues to CSP

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	Maintain a regular oversight of Solihull MARAC.	Chair of MARAC/ODOC Governance group	On-going quarterly review of the local MARAC to assess: • levels of Partner engagement in relation to referrals. Information sharing, participation. • Demographics of cases referred to MARAC • Numbers of referrals with forecast activity to ensure there is sufficient capacity to manage referrals.	Commence Oct 2022	Safeguarding of victims managed by Solihull MARAC is improved, with an expected 65% improvement in Partners delivering and updating progress on MARAC actions	Solihull MARAC/ODOC Governance group to monitor and escalate concerns to the DAPB and to share with the Regional MARAC group.
Progress						

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RECOMMENDATION 3: Solihull Community Safety Partnership Executive Board's ongoing work following the MARAC Review findings take into account Rosie's case. This case highlights that there is a need for (i) 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.

Ref	Action (SMART)	Lead Agency	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
3.1	Share learning from this review with Solihull MARAC/ODOC Governance Group and the West Midlands Regional MARAC group to ensure it is reflected and actioned as part of the on-going west midlands regional review work stream.	Solihull MARAC/ODOC Governance group & West Midlands OPCC Regional MARAC Group Solihull MARAC/ODOC group	Scope of the regional review includes a requirement for an escalation process, to include guidance on when cases require escalation to a Professionals meeting, and how this will be managed is developed and communicated to partners. DHR Executive Board agree the revised process	31/5/2023	Improved management and monitoring of repeat and complex MARAC cases, evidenced by a 40% increase in Professional meetings with better safeguarding for individuals. Risk and actions identified by MARAC are reflected and responded to in practice.	Solihull ODOC/MARAC Governance group will be responsible for monitoring the number of high repeat cases listed at MARAC, and reporting to the DAPB.

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			Standing item of the Quarterly Solihull MARAC/ODOC Governance group agenda to review • Number of repeat MARAC cases and action. • Number of Professional meetings that have taken place. • Undertake a dip sample of 12 cases to assess effectiveness. • Create remedial actions to address areas of weakness identified	01/01/2023		
Progress						

RECOMMENDATION 4: 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.

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Ref	Action (SMART)	Lead Officer	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
4.1	Liaise with areas who are delivering the Blue Light project to gather further information on the approach, costs and impact.	SMBC Public Health Substance Misuse Commissioner	Clarity of the project purpose, scope and intended outcomes is accessed. Assessment undertaken on the feasibility of delivering locally, which will be shared with both the DAPB and CDAS Boards for decision making. DAPB boards. The commissioned Substance Misuse Provider capability to identify and respond to co-existing domestic abuse, and	30/4/2023	As a result of this work we expect to have an improved care pathway that enables: University Hospital Birmingham to improve how they identify and intensively support individuals admitted to hospital for alcohol (and/or drug) related incidents. A streamlined link between local commissioned substance misuse services and the hospital will increase access to treatment and support.	A progress report will be submitted to the DHR Executive Board

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			ability to provide a trauma informed response to be reviewed			
Progress						

RECOMMENDATION 5: 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:

(i)That a briefing paper be issued to all relevant staff to explain the purpose of this new practice as soon as is practicable.

(ii)That all front-line staff and managers undertake learning that will enable them to use the DASH effectively.

Ref	Action (SMART)	Lead Officer	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements

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5.1	That a briefing paper be issued to all relevant staff to explain the purpose of this new practice as soon as is practicable	Head of Service Care & Support	Amendments to social care forms to include explicit prompt and link to DASH tool - complete Email to all front-line ACS workers to advise of the changes and reiterate expected practice. Staff to explicitly consider and apply the DASH risk tool in contacts in which domestic abuse is believed to be or has been present. The DASH risk tool is being considered and applied in practice consistently to concerns of domestic abuse.	31/01/2023	Increase in DASH assessments completed by Adult Social Care practitioners.	Via supervisory and reflective case discussion. Via quarterly safeguarding case file audit process.

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5.2	That all front-line staff and managers undertake learning that will enable them to use the DASH effectively.	Head of Service Care & Support	Design training session for front line practitioners to cover the purpose and remit of MARAC and what this means to practice and to revisit the use and expected practice of considering and where appropriate applying the DASH. Training sessions to be delivered to all social work teams throughout February – April 2023.	30/04/2023	Relevant Adult Social Care staff have access to and have completed learning	Via team briefing sessions being delivered from January 2023 onwards. Safeguarding Leaders staffing group to be expert points of contact for ongoing team /individual support. Via supervisory and reflective case discussion. Via quarterly safeguarding case file audit process.
Progress						

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RECOMMENDATION 6: 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.						
Ref	Action (SMART)	Lead Officer	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
6.1	BSMHFT identify patterns and trends around the help seeking behaviour of a patient who potentially is experiencing domestic	Named Nurse for Domestic Abuse	Initial planning session booked for 31.01.23	01/04/2023	Areas of improvement identified and appropriate actions to improve practice implemented.	Undertake a dip sample audit on recent MARAC cases to establish if

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	abuse from their case files, especially when the victim has previously withdrawn their support due to pressure.		Complete a Trust wide Survey Monkey to establish a base line knowledge of Routine Enquiry and practitioners' confidence in asking the questions.			further Routine Enquiry is being considered.
Progress –						

RECOMMENDATION 7: University Hospitals 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.(ii)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.

(iii)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.

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(iv)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.

(v)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.

Ref	Action (SMART)	Lead Officer	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
7.1	Audit programme to include audit of intoxicated adult attendances to EDs and whether they were asked about children	UHB Service lead	Audit programme modified. Audit completed and results reported on.	30/09/2023 and ongoing	Children of adults who attend ED intoxicated will be safeguarded Audit results.	Trust Safeguarding Board ED quality and Safety group Safeguarding Performance and Audit Group
Progress						

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RECOMMENDATION 8: Birmingham and Solihull Women's Aid (BSWAid) 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.						
Ref	Action (SMART)	Lead Officer	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
8.1	All BSWAid frontline staff to be briefed on the purpose and process of Clare's Law.	BSWA area manager	Briefing to be created to support staff's understanding Session delivered to staff as part of on-going training and added to induction training	01/03/2023	A 100% of BSWA frontline practitioners have been briefed on Clare's law, to include: how to assess when it is suitable, how to support clients to activity a request and to safely manage the outcome of a request.	Public Health Domestic Abuse Contract Manager will be responsible for providing assurance to the DHR Executive Board.
Progress update						

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RECOMMENDATION 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).

Ref	Action (SMART)	Lead Officer	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
9.1	Sample audit of IRIS DA cases undertaken, and outcomes reported via quarterly assurance report.	Director of Nursing – Quality & Safeguarding	Sample audits completed Quarterly assurance reporting	Sep 2023	Audits demonstrate practices understand and have a good application of the IRIS programme.	audits and assurance reports monitored through the IRIS Steering Group Reports to Solihull Domestic Abuse Priority Board (DAPB).
Progress Update -						

RECOMMENDATION 10 Birmingham East and Solihull Probation Service:

(i)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.

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(ii) 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.						
Ref	Action (SMART)	Lead Officer	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements
10.1	Probation Service will ensure that case transfers are managed to the standards set in the national Transfer Framework (reissued August 2022) and recorded on the regional transfer spreadsheet	Neil Appleby	9/1/23 New transfers SPO commences Progress to be reviewed at fortnightly pan-Birmingham exec	31/03/2023	Cases to be transferred in accordance with nationally mandated timescales and standards. Target is 20 working days start to finish. Spreadsheet demonstrates timeliness Lack of escalations (clear escalation process is built into policy to counteract slippage) is indicator of success.	Senior Probation Officer with responsibility for transfers for Solihull and Birmingham will monitor process. (new incumbent commences Jan 2023)

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Progress -						
10.2	Review will be distilled into a briefing document to be delivered to probation team identifying key practice imperatives (review, transfer, management oversight, enforcement)	Neil Appleby	9/1/23 New transfers SPO commences Progress to be reviewed at fortnightly pan-Birmingham exec	31/03/2023	Document is produced and teams are briefed More responsive sentence management is evidenced through Probation's regional Quality Management Framework as well as HMIP inspections and HMPPS OSAG (Operational and System Assurance Group) audits	Head of Probation will gain assurance that briefings have occurred. Practice progress to be monitored via existing Quality and Performance systems (transfer database, Touchpoints (MO) dashboard etc).
Progress						

RECOMMENDATION 11: This DHR is shared with the Ministry of Justice and any relevant learning is shared with those responsible for Judicial training on Domestic Abuse.						
Ref	Action (SMART)	Lead Officer	Key Milestones	Target date for completion	Desired Outcome (measure of success)	Monitoring Arrangements

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11.1	a. DHR report shared with MOJ for the attention of those responsible for training. b. The Lord Chief Justice responsible for arrangements for training the courts' judiciary in England and Wales under the Constitutional Reform Act 2005 is provided with the Learning from this case.	Chair of the CSP	Meeting arranged with the Chair of the review and MOJ and SMBC Community Safety Lead	30/04/2023	The MOJ agree to incorporate the learning from this review in their DA training. MOJ staff able to respond to people who present as perpetrators whilst being victims of DA.	Assurance statement from MOJ sought after 12 months' time re impact of changes.
Progress						

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Individual Agency Recommendations

Solihull Metropolitan Borough Council Adult Social Care

Recommendation 1: Increase awareness of psychological trauma and coercion and control.						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	Training needs analysis of current training offer to reflect learning from IMR around coercion and control.	Service Lead	June 2021	To provide professionals with a clear understanding of domestic abuse and barriers to engagement	Added to safeguarding development plan reviewed in supervision and by Safeguarding and Exploitation Board	Report findings to Safeguarding and Exploitation Board
1.2	Develop practice guidance to support non engagement within safeguarding processes.	Service Lead	June 21	Practical guidance to support practice	Added to safeguarding development plan reviewed in supervision and by Safeguarding and Exploitation Board	Report findings to Safeguarding and Exploitation Board

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Recommendation 2: Re-launch the CAADA (now *referred to Safelives Risk Indicator Checklist)*- Dash risk assessment tool and develop practice guidance for use within ACS.						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
2.1	Develop communication plan to re-launch the CAADA-Dash Risk Assessment tool, including adding the form to Liquid Logic	Service Lead	June 21	Support decision making on risk when a person decline safeguarding	Completion of communication plan Number of completed forms on Liquid Logic	Final report to Safeguarding and Exploitation Board

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Recommendation 3: Increase ASC domestic abuse dataset to build on understanding of domestic abuse for adults with care and support needs.						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
3.1	Scope increased data capture with Performance and report this to the Domestic Abuse Board	Service Lead	June 21	Improved understanding of the impact of domestic abuse on people with care and support needs	Added to safeguarding development plan reviewed in supervision and by Safeguarding and Exploitation Board	Data presented to Domestic Abuse Board

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University Hospital Birmingham

Recommendation 1: Practice *Staff in Emergency Departments will, when safe to do so, ask about domestic abuse in patients who present with indicators*						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	To embed selective enquiry within Emergency Departments	Service Lead	30.06.2021	Patients suffering DA are given safe opportunities to disclose	Trust DA steering group Audit of ED notes	Safeguarding referrals for DA Advice calls for DA Referrals to IDVA Audit outcome
1.2	To provide additional training re the role of IDVA in Emergency Departments	Service Lead	30.06.2021	Use of selective enquiry is consistent within the ED and performed by staff who feel confident and competent in its use.	Trust DA steering group	Attendance records
1.3	Work with ED and IT staff to develop adult	Service Lead	30.06.2021	Appropriate adult safeguarding assessment documentation including the	Trust SG Board	Creation of agreed document (date of addition

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	safeguarding assessment documentation			use of the 3 NICE domestic abuse questions will be agreed to ensure safeguarding assessment can be evidenced.		to electronic records cannot as yet be determined)

Recommendation 2: *Staff will be supported to identify and respond appropriately to domestic abuse*						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
2.1	Trust DA procedures for Trust and SH will be updated to include IDVA referral processes	Service Lead	31.4.21	Updated procedure	Trust DA steering group	Publishing of new procedure
2.2	DA Moodle package to be developed	Service Lead	30.06.21	Moodle training package will be available for all staff	Trust DA steering group	Training records

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2.3	Safeguarding supervision within the EDs to be evaluated re perceived stave benefit	Service Lead	31.03.22	Evaluations of supervision will be collated and reported	Trust Learning and Development Group	Report to L&D group

Recommendation 3: *UHB will work alongside other agencies to ensure patients or staff who present with domestic abuse are supported appropriately*						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
3.1	Clear referral pathways for IDVA services will be provided for staff	Service Lead	30.04.21	Domestic abuse procedure will be updated to include referral pathways for IDVAs	Trust DA steering group	Publication of procedure

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Recommendation 4: *Staff will have easy access to a variety of resources to support their care of patients presenting with DA*						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
4.1	4.1 Review of Trust domestic abuse intranet pages	Service Lead	30.06.21	Trust intranet pages will provide accurate and up to date information for staff when dealing with DA	Trust DA steering group	Updated intranet page

Recommendation 5: *Staff will be reminded to record mental capacity assessments in a Trust approved format (PICS or paper form)*						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
5.1	4.1 Review of Trust domestic abuse intranet pages	Service Lead	30.06.21	Trust intranet pages will provide accurate and up to date information for staff when dealing with DA	Trust DA steering group	Updated intranet page

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Recommendation 6: *Staff will be reminded to record mental capacity assessments in a Trust approved format (PICS or paper form)*						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
6.1	Trust frequent attender process to be reviewed	Service Lead	30.09.21	A new frequent attender process will be agreed to cover all sites	Trust Safeguarding Board ED quality and Safety group	Creation of new process on intranet
6.2	Trust frequent attender process to be piloted across all sites	Service Lead	31.12.21	All patients who are deemed to be frequent attenders have appropriate and timely support according to their assessed need	Trust Safeguarding Board ED quality and Safety group	Care plans for frequent attenders available to EDs

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Recommendation 7: *All adults who attend the emergency departments intoxicated across UHB will be asked if they have children*						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
7.1	Audit programme to include audit of intoxicated adult attendances to EDs and whether they were asked about children	Service Lead	30.09.21 and ongoing	Children of adults who attend ED intoxicated will be safeguarded	Trust Safeguarding Board ED quality and Safety group Safeguarding Performance and Audit Group	Audit results

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Birmingham and Solihull Women's Aid

Recommendation 1: *Practice*						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	Review with managers use of case reviews to look at escalation and referral into MARAC/sg where an assault has been reported.	Service Lead	Ongoing	Better assessment of risk for all women reporting incidents	Case reviews	Case reviews

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Recommendation 2: *Practice*						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
3.1	2.1 Flag up to project manager any cases where we receive multiple (more than 2) agency referrals for the same woman where engagement is an issue? Project manager to conduct more detailed reviews of these cases.	Service Lead	Ongoing	Better oversight of repeat referrals and lack of engagement.	Duty to inform manager of repeat referrals where there is a lack of engagement	Manager able to flag up these cases and take appropriate action.

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West Midlands Ambulance Service

Recommendation 1: Work to be undertaken to ensure that documentation reflects the full picture, actions taken, and advice given when attending potential and disclosed domestic abuse cases.						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
3.1	2.1 Flag up to project manager any cases where we receive multiple (more than 2) agency referrals for the same woman where engagement is an issue? Project manager to conduct more detailed reviews of these cases.	Service Lead	Ongoing	Better oversight of repeat referrals and lack of engagement.	Duty to inform manager of repeat referrals where there is a lack of engagement	Manager able to flag up these cases and take appropriate action.

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Birmingham and Solihull Mental Health Foundation Trust

Recommendation 1: Practice/working in partnership/resources						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	The SIAS Partnership Board should review whether all staff working within SIAS should have access to the RiO recording system both within SIAS settings and also within hospital setting to enable better internal communication. This review will also include whether Wi-Fi access for all BSMHFT/SIAS staff working within hospital settings is feasible to	Service Lead	April 2021	Improved record keeping	Review of a dip sample of Patient Report Forms	Repeat audit to be undertaken in 6-12 months

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	allow for accurate and timely recording on service user records.					

Recommendation 2: Practice/working in partnership						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
2.1	The Psychiatric Liaison Service should trial the use of NICE guidance questions for routine/safe enquiry for domestic abuse and evaluate if this approach improves identification and responses to domestic abuse for the patients they assess.					

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Recommendation 3: Training/management/supervision						
ref	**Action (SMART)**	**Lead Officer**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
2.1	The BSMHFT Safeguarding Team and SIAS will review the current local domestic abuse protocol and training offer (SIAS) and ensure that they are fit for purpose and align to BSMHFT safeguarding policy and standards.					

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Solihull Metropolitan Borough Council Education

Recommendation 1: Solihull schools to ensure that comprehensive, written pupil safeguarding and welfare information is sent securely to the receiving school within 15 days of the child's transfer to a new school with the completed child transfer form (CTF).					
ref	**Action (SMART)**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	Reminder to be sent out to school leaders in Headlines.	January 2022	School leaders send CTFs to receiving school within 15 days of the child's transfer. Staff in the receiving school know of any concerns or safeguarding risks.	School leaders and Governing Bodies in individual schools.	Every child transfer meets expectations and required timescales. High quality information enables all children to be appropriately supported and protected by staff in their new school.
1.2	The requirement for appropriate and timely pupil transfer information to be part of safeguarding training for Governors.	April 2022	Safeguarding Governors are fully aware of the need for robust transfer arrangements about pupils' safety and welfare.	School leaders and Governing Bodies in individual schools.	Governors ensure compliance through support and challenge to head teachers.

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Recommendation 2: All Solihull schools and education providers to continue: To work with partners in MARAC (Multi-Agency Risk Assessment Conference) where cases require this so that there is increased safety, health and wellbeing for victims and their children. To work in partnership with the police through Operation Encompass so that children experiencing domestic abuse are appropriately supported All schools in Solihull meet the statutory requirement to teach children and young people about healthy relationships					
ref	**Action (SMART)**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
2.1	MARAC information to be shared with schools via Headlines.	January 2022	School leaders understand the role of education and partner agencies as part of MARAC.	LSCP and Public Health	Conference minutes/notes demonstrate that at least 90% of schools participate in MARAC where cases require this.
2.2	Develop and share anonymised case studies that share good practice relating to Operation Encompass in schools.	April 2022	Schools continue to provide appropriate support for children who experience domestic abuse.	Education Safeguarding sub-group	Children with lived experience of domestic abuse are positive about the support provided by school.
2.3	KCSIE 2020 compliance audit completed by all	January 2022	The school's broad and balanced curriculum teaches pupils about safeguarding,	Leaders and Governors monitor the impact of	Pupils incrementally learn more and remember more about healthy

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	schools and education providers in Solihull		including about healthy relationships.	Relationships, (Sex) and Health Education in schools	relationships. They have the skills to keep themselves safe, including asking for help.

Recommendation 3: Ensure that Solihull schools have a good understanding Solihull's Domestic Abuse Strategy 2021-2025 (currently draft), the underpinning Domestic Abuse Act 2021 and the implications for their practice.					
ref	**Action (SMART)**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
3.1	Draft strategy to be circulated to all schools in Solihull via Headlines.	January 2022	Schools make good use of the robust offer on domestic abuse awareness and healthy relationships that is available to all schools and educational settings (see draft strategy).	School leaders and Governing Bodies in individual schools.	Education staff understand the available domestic abuse provision, using and referring to services effectively.
3.2	Awareness raising with schools in relation to the Domestic Abuse Act 2021.	July 2022	There is a shared understanding of what it means to recognise children as victims in their own right (Domestic Abuse Act 2021).	School leaders and designated safeguarding leads in schools. Education Safeguarding sub-group.	Schools follow local/national guidance related to recognising children as victims in their own right, working in partnership with supporting agencies.

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				LSCP / Solihull's Domestic Abuse Partnership Board.	

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HMPPS Recommendations

Recommendation 1: Working in Partnership					
Ref	**Action (SMART)**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
1.1	Effective inter-agency works to include requesting information from the Police once MARAC involvement is known	September 2021	That in relevant cases it is clearly recorded that police checks have been made following MARAC involvement	RO1's caseload, where MARAC is involved, it is evidenced in the relevant recording systems to reflect good practice	Discussion and sample cases in supervision and case audits where MARAC is a feature of the case.

Recommendation 2: Practice Action					
Ref	**Action (SMART)**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
2.1	To develop practice in managing risk of serious harm and responding to		RO1 to re-visit the Risk of Serious Harm (2020) guidance to refresh understanding of how to	PDM1 to check RO1's understanding of this document.	Measured through findings from case audits.

Appendix 1

	significant change by reviewing risk assessment	September 2021	respond to significant changes. RO1 to provide 5 examples of where there has been an appropriate response to manage a significant change in circumstances and risk of harm	Record reflective discussions in supervision to demonstrate that RO1 is responding to significant changes in regard to risk	Case audit findings and learning assurances to be feedback to Regional Manager

Recommendation 3: Domestic Abuse Practice					
Ref	**Action (SMART)**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will Success be Measured?**
3.1	RO1 to demonstrate greater professional curiosity in her discussions with Service Users	September 2021	PDM1 to ensure that RO1 is familiar with the Practice Guidance- A Framework for Structured Work in Supervision particularly the section in relation to professional curiosity.	PDM1 to check RO1's understanding of this document. Record reflective discussions in supervision to demonstrate that	Measured through findings from Case audits. Findings to be reported to Regional Manager for oversight and signing off as completed.

Appendix 1

			RO1 to provide examples in supervision where she has used professional curiosity to ascertain relevant information linked to risk.	RO1 understands and is using professional curiosity.	

Appendix 2 – Home Office Feedback letter

To be noted by the reader – Following Home Office feedback, amendments were made where appropriate.

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15th February 2024

Caroline Himmons

Administrative Officer

Domestic Homicide Team

Public Health

Solihull Metropolitan Borough Council

Council House Manor Square,

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B91 3QB

Thank you for submitting the Domestic Homicide Review (DHR) report (Rosie) for the Solihull Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21st December 2023. I apologise for the delay in responding to you.

The QA Panel felt that this was a well written report that was easy to read, thorough and informative. It provided an insight into the factors leading up to and contributing to the decline of Rosie's physical and mental health and why this was important. The report also provided a good insight into the importance of a duel diagnosis approach for domestic abuse (DA) and substance misuse. The report highlighted the

Appendix 2 – Home Office Feedback letter

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lack of professional curiosity from agencies and how agencies failed to ask Rosie questions relating to the domestic abuse. 98

There was also good engagement with the family, the report was sensitive to the victim and benefited from the inclusion of a representative of domestic abuse services on the panel.

Nonetheless 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:

- Some spelling and grammar mistakes appear in the report which will need to be corrected.
- The equality and diversity section is combined with the confidentiality section, these two sections need to be separated. The equality and diversity section also needs to be more robustly addressed to reflect the key protective characteristics pertinent to this case – age, sex, mental health, and the intersectionality with domestic abuse.
- The independence of the panel is not stated.
- It would have been helpful to have included an alcohol abuse specialist on the panel.
- There is little reference to any interventions or agencies working with Rosie in regard to her alcohol dependency and minimal information from her GP.
- Information on the relationship between Nick and Rosie would have been helpful; although the relationship was brief, how and where they met feels relevant.
- There was a lack of understanding regarding the impact of DA the children's mother was experiencing although they had been removed from her care, they had supervised contact with her and would have seen her with injuries which may have caused them distress and concern for their mother.
- A fuller picture of Rosie as a person from a family perspective would have been helpful as the perspective that was shared felt negative.

Appendix 2 – Home Office Feedback letter

To be noted by the reader – Following Home Office feedback, amendments were made where appropriate.

- Appendix 4 relating to the DHR Action Plan is blank. An up-to-date action plan needs to be published alongside the DHR.

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