The Solihull Partnership
Safer Solihull
Local Police and Crime Board
Involving local people in keeping Solihull safe

Overview Report

Domestic Homicide Review of the circumstances concerning

The death of a woman who

Died: August 2013

Independent Chair and Author

Anne Cole

May 2015

The death of Adult 1 was a tragic occurrence and the Safer Solihull Partnership, who commissioned this Domestic Homicide Review, wishes to extend their condolences to the family.

Domestic Homicide Reviews

1.1.1 Domestic Homicide Reviews (DHR) are one way to improve responses to domestic abuse. They aim to prevent what happened in any given case being repeated.

1.1.2 The requirement to undertake Reviews is part of the Domestic Violence, Crime and Victims Act 2004 and became law from 13th April 2011. These reviews are undertaken in accordance with guidance published by the Home Office and are chaired and reported on by an independent person.

1.1.3 Primarily, the purpose of a DHR is to 'establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims'[1]

1.1.4 Reviews will not seek to lay blame but to consider what happened and what, if anything, could have been done differently. If appropriate, they will also recommend actions to improve responses to domestic abuse situations in the future.

1.2 Local Context

1.2.1 Solihull is a broadly affluent metropolitan borough. It has above average levels of income and home ownership and 50% of residents are classified as belonging to the 'prosperous suburbs' socio-demographic classification. Solihull is, however, challenged by a prosperity gap, with performance indicators in the regeneration area significantly lagging behind that of the rest of the borough: below average incomes; higher population density; and a greater proportion of socially rented housing (62% of borough's total) impact across a range of indicators including educational attainment; employment; crime; and health.

1.2.2 The Black and Asian Minority Ethnic (BAME) population of Solihull has more than doubled since the 2001 census and now represents nearly 11% of the total population, whilst of those aged 15 and under, over 15% are from BAME groups.

1.2.3 Population projections based on 2011 census indicate that the relative aging of the Solihull population will continue and by 2021. It is estimated that the proportion of over 65 years will increase by 19.8% against an overall population increase of 6.9%. This aging population represents a significant and growing challenge in terms of health and social care.[2]

1.2.4 Unemployment within the borough is at 8.5% which is above the national average (7.1%) but slightly below that of the West Midlands (8.8%). Unemployment has increased significantly, by more than double the national

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – April 2011: Section 3.3
[2] People and Place 2014 prepared by Solihull Observatory

rate of increase since mid-2007. There are noticeable variations within the borough itself with 26.6% of those in the regeneration area claiming some form of Out of Work benefit.[3]

1.2.5 Life expectancy for both men and women is higher in Solihull than the national average but again there are inequalities across areas of the borough.[4]

1.2.6 Alcohol specific admissions to hospital are 5.43 per 1,000 compared with a regional average of 6.85 (as at 2010 – 2012). Males account for approximately 2/3 of these admissions.

1.2.7 Alcohol related violent crimes have reduced from over 4.5 per 1,000 in 2008/9 to 2.9 per 1,000 in 2012/13 compared with a national average of 3.8.

1.2.8 The Safer Solihull Local Police and Crime Board is the statutory Community Safety Partnership (CSP) for Solihull and has the duties and responsibilities set out in the Crime and Disorder Act 1998 and subsequently the Police and Justice Act 2006, Policing and Crime Act 2009 and the Health and Social Care Act 2012.

1.2.9 Each year the Safer Solihull Partnership is required to produce a Strategic Assessment report on crime and disorder issues in Solihull. The results of the assessment are used by the Partnership to identify priorities for the coming year. The Partnership produces action plans and project plans which describe how it will deliver on the identified priorities.

1.2.10 The work of the Safer Solihull Partnership includes a focus on responding to domestic abuse which is undertaken on their behalf by the multi-agency Domestic Abuse Priority Group. This group is made up of the following organisations that contribute towards to the delivery of strategy and plans: Local Authority, West Midlands Police, Heart of England Foundation Trust, Birmingham Mental Health Foundation Trust, Staffordshire and West Midlands Community Rehabilitation Company Ltd (Formerly the Probation Service), Victim Support, Birmingham & Solihull Women's Aid, Solihull Community Housing, Solihull Clinical Commissioning Group and Local Safeguarding Board Business Managers.

1.2.11 The Domestic Abuse commissioning plan has 6 key strands, several of which are relevant to this review: to strengthen domestic abuse support for victims, from early help to high risk; to improve the local response to children and young people affected by domestic abuse at all levels including prevention, early intervention and to children in need; to strengthen partner arrangements to deliver the Domestic Abuse strategy; to strengthen arrangements for perpetrator management and conviction; to raise awareness of domestic abuse amongst the public and partner organisations; and to increase the

[3] Taken from JSNA 2013

[4] Although the home address of the subject of this review is not in the regeneration area, the area shares some characteristics. The area is one of the eight out of 13 residential areas identified within the Borough as a higher activity area for the Safer Solihull Partnership

competence and confidence of services to meet needs of victims of domestic abuse. This plan has a series of actions attached and is monitored by the chair of the domestic abuse priority group which is accountable to the Safer Solihull Partnership Executive Board.

1.2.12 In addition to the Safer Solihull Partnership, The Police and Justice Act 2006 introduced a requirement for local authorities to have a "crime and disorder committee" with the power to review or scrutinise decisions made or other action taken by the Community Safety Partnership Responsible Authorities in relation to the discharge of their crime and disorder functions. In Solihull this function is executed by the Stronger Communities and Neighbourhood Services' Crime and Disorder Scrutiny Panel.

1.3 Circumstances leading to this review

1.3.1 The incident occurred on the 8th August 2013. The Police referral indicates that shortly after 02.00 hours neighbours of an address in Solihull were disturbed by the sounds of screaming. On opening their front door they saw the suspect and heard him say the words 'help me', 'I've stabbed her' and 'I've slit her throat'. The neighbours called the police and ambulance services. Officers attended and arrested Adult 2 on suspicion of murder. Paramedics attended the scene but the life of Adult 1 was pronounced extinct shortly afterwards.

1.3.2 Early indications were that Adult 1 was the subject of an attack within the property with a large kitchen knife. The weapon was recovered in the flat. The deceased had a significant cut injury to her throat and defence injuries to upper limbs.

1.3.3 Following notification of the incident by West Midlands Police; the Community Safety Manager requested information from partner agencies. The circumstances and the initial information received were discussed by the Safer Solihull Partnership (SSP) Executive on 5th September 2013 and the Chair of the Partnership confirmed that the criteria for a domestic homicide review (DHR) were met[5]. The review commenced with notification to the Home Office on 6th September 2013.

1.4 Process undertaken for this review

1.4.1 A Panel of professionals from various public bodies, appointed by the Chair the Safer Solihull Partnership, undertook this review. It considered information provided by a number of organisations in the form of individual management reports (IMR). This panel has also assisted the Chair in formulating recommendations based on their conclusions and those of the individual report writers.

1.4.2 The panel was comprised as follows:

Anne Cole: Independent Chair

[5] Section 9(3) Domestic Violence, Crime and Victims Act 2004

Det.Ch. Inspector:	West Midlands Police
Head of Service:	Staffordshire and West Midlands Probation Trust (now Community Rehabilitation Company Ltd)
Designated Nurse:	Solihull Clinical Commissioning Group also representing NHS England
Named Midwife:	Heart of England NHS Foundation Trust
Assistant Chief Executive	Birmingham and Solihull Women's Aid
Domestic Abuse Co-ordinator: (SMBC)	Solihull Metropolitan Borough Council
Community Safety Manager:	Safer Solihull Local Police and Crime Board and Solihull Metropolitan Borough Council.

1.4.3. None of the representatives had any direct connection to any of the subjects of the review prior to this event.

1.4.4. Consideration was also given to including a representative from Mental Health Services. The service expressed a preference for not being part of the panel and this was accepted although the panel reserved the right to co-opt someone later if information collated as part of the review indicated such a need. As no specific link to mental health problems was identified, this was not felt to be necessary.

1.4.5. The panel was assisted by administrative support from Solihull Metropolitan Borough Council.

1.4.6 The chair of the review panel, and author of this report, is independent of all the local agencies and professionals involved in the case, and of the Safer Solihull Partnership. She is a qualified and registered social worker who spent nearly 30 years working within Local Authority Social Services. Having begun her career as a generic social worker, she worked for many years as a middle and senior manager.

1.4.7 Most of her work was within Children & Families Services, specialising latterly in Safeguarding. She was also responsible for the establishment and management of a Safeguarding Adults Team and an active member of a number of partnership arrangements including the Multi-Agency Public Protection Arrangements Strategic Management Board; the Multi-Agency Risk Assessment Conference steering group; and the domestic abuse steering group as well as the Local Safeguarding Children Board (LSCB) and the Safeguarding Vulnerable Adults Board.

1.4.8 Since October 2009 she has worked as an independent manager/consultant: providing advice and support to LSCBs; chairing serious case review panels;

chairing and writing overview reports for domestic homicide reviews; undertaking management reviews and the investigation of complaints for adult services and also undertaking project work; practice audits; and peer evaluations within operational children's services.

1.4.9 In order to retain the anonymity of those involved, the family members have been referred to within this report as follows:

Adult 1	Subject of this review
Adult 2	Perpetrator and partner of Adult 1
Child 1	Child of Adult 1 and of Adult 2
Adult 3	Former partner of Adult 2
Adult 4	Brother of Adult 1
Adult 5	Mother of Adult 1 and current carer of child 1
Adult 6	Step Father of Adult 1
Adult 7	Friend of Adult 1

1.4.10 Individual Management Reports (IMR)s were requested from: West Midlands Police; NHS England (GPs' involvement), Heart of England NHS Foundation Trust; and Bromford Housing Association. Each author confirmed that they had not had any previous direct involvement and each report was authorised by a senior officer of the organisation in question. The findings of each report are confidential but have contributed to the overall findings of this review.

1.4.11 In addition; Information reports were requested from West Midlands Ambulance Trust; and from Child 1's former school which was provided by Education Services.

1.4.12 In addition, information was requested from a number of other organisation including the former Staffordshire and West Midlands Probation Trust; Birmingham and Solihull Women's Aid; NHS England; Solihull Integrated Addiction Services; Children's Service and West Midlands Fire and Rescue Service all of whom submitted 'nil returns' stating that none of those involved (Adult 1; Adult 2 or Child 1) were known to them.

1.4.13 The review panel recommended a set of terms of reference which were approved by the Partnership as follows:

i. To establish whether it was known, or could have been suspected that Adult 2 posed a serious risk to Adult 1 and whether any action could have been taken to prevent the homicide. To establish, therefore, whether the homicide was predictable or preventable.
ii. To identify how effective agencies were in identifying Adult 1's vulnerability to domestic abuse and whether risks were identified and appropriately managed.
iii. To identify how effective agencies were in identifying the risks that Adult 2 posed, and how effectively such risks were managed.
iv. To establish how well agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency working; practice;

policies; or procedures to improve the identification and protection of people subject to domestic abuse within Solihull.

1.4.14 To assist authors of individual management reports, these terms of reference were accompanied by 'key lines of enquiry' which the review panel asked report writers to consider:

(a) What knowledge did your agency have that indicated that Adult 1 might be a victim and Adult 2 a perpetrator of domestic abuse; and how did your agency respond to this information?

i. Were practitioners aware of and sensitive to the needs of the victim in their work and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a victim's welfare?
ii. Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of victim and acting on concerns about their welfare?
iii. What were the key relevant points/opportunities and decision making in this case in relation to the victim and family? Do assessments and decisions appear to have been reached in an informed and professional way?
iv. Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
v. How, when and why did your agency share information with others and what was the impact?
vi. Was the supervision and management of the case in your agency effective and did it follow agency (and inter-agency) policies and procedures?
vii. To what degree did the victim's understanding of the risks impact on decision making?
viii. Should the information known have led to a different response?
ix. Was anything known about the perpetrator? For example, were they being managed under MAPPA[6]?
x. Was it reasonably possible, without the benefit of hindsight, to predict, and once predicted, work to prevent, the harm subsequently suffered?

(b) What services did your agency offer to the victim? Were they accessible; appropriate; empowering and empathetic to their needs?

i. Were appropriate services offered or provide or relevant enquiries made in the light of assessments?
ii. Were practitioners sensitive to the needs of the victim?
iii. Were procedures sensitive to their ethnic; cultural; linguistic; and religious identity? Was consideration for vulnerability or disability necessary?
iv. When and in what way were the victim's wishes and feelings ascertained and considered?
v. Was the victim informed of options and choices and supported to make informed decisions?

[6] Multi Agency Public Protection Arrangements

vi. Were there identified needs unmet or needs which conflicted with the needs of others?

(c) Were there issues in relation to capacity or resources in your agency that impacted on the ability of the agency to provide services (to the victim, alleged perpetrator or any family member) or which impacted on the agency's ability to work effectively with others?

i. Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff sick leave have an impact on the case?
ii. Was there sufficient management accountability for decision making?
iii. Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of office services?

1.4.15 The panel also considered that there were a number of other enquiries which it would be helpful to undertake as part of the review:

- Enquiries to be made of Birmingham Local Authority in relation to previous incidents involving a former partner. The partner lived in Birmingham at the time of the incidents which dated back to 2000.
- West Midlands Police and Health Services to check for any other previous addresses which may be relevant and, if possible to ascertain when the alleged perpetrator moved to the address at which the event happened.
- When appropriate (in consultation with the Police) contact to be made with former work colleagues of Adult1 to ascertain whether domestic abuse was a known feature in the relationship.
- Information to be sought from Child1's school as they may have disclosed information to teachers etc.
- Any information available from education welfare and school psychology service is sought.
- Solihull Community Housing – homeless team to be asked to review their records re a possible homeless application from Adult 1 or Adult 2.
- Citizens Advice Bureau to be asked to check their records of possible support being given to Adult 1.
- The Council's noise team to be asked to check records of any reported incidents re the family home.
- Adult 1's employers to be asked to check their HR records to ascertain whether any concerns were known or recorded in respect of domestic abuse and any support given.

1.4.16 The review panel agreed that the time frame for the review should be the period: 1st January 2000 to 8th August 2013. The start date was selected as this was the first date that agencies identified relevant records relating to a previous relationship of Adult 2 with Adult 3. The 8th August 2013 has been determined as the end of the review period as this was the date of Adult 1's death.

1.4.17 Family members were advised that the review was being undertaken, but that they could not be directly involved until after the criminal proceedings had been concluded. At this stage, the point of contact for the family, Adult 4, indicated that they would wish to participate; however, when contacted again subsequently, the panel received no response.

1.4.18 At this stage mental health assessments were being undertaken in respect of Adult 2 and the panel agreed that he should not be contacted until the outcome of these was known. Adult 2 was subsequently found fit to plead and was convicted. Contact was then made with him regarding this review. See 2.8.17-18 below.

1.4.19 The on-going criminal proceedings also meant that the review could not be completed within the required timescale. The Home Office were advised of this and of the reason for the delay.

1.4.20 The review was undertaken largely by the panel reviewing Individual Management Reports (IMR) and information reports. Additional written clarification by authors was sought when necessary to ensure the quality of these reports and of the information available to the review. Some authors were also asked to address specific issues, notably that relating to links between different sorts of abuse, which had been raised elsewhere. The author of the report from the Heart of England NHS Foundation Trust also attended the panel, at their own suggestion, to discuss in more detail the assessment tool referred to in their report.

1.4.21 Once the review has been concluded, the overview report and action plan will be submitted to the Safer Solihull Partnership for approval and then submitted to the Home Office. Once finalised, these will be disseminated via the Solihull website together with an executive summary

2: The Facts

2.1 Adult 1 was killed in the early hours of 8th August 2013 at her home address which was within a block of flats. Also living at this address were her partner, Adult 2 and their child , Child 1 although the child was at that time staying with friends. (This was during the school summer holidays).

2.2 According to both the Police and the West Midlands Ambulance Service reports; both the neighbours and Adult 2 contacted the emergency services. Adult 2 in his 999 call is recorded as being in a distressed state and saying that he had stabbed his partner and cut her throat and was going to kill himself. He was still on the phone when the police officers arrived.

2.3 Adult 2 was arrested and charged on suspicion of murder and remanded in custody.

2.4 As noted above; as part of the subsequent criminal proceedings, mental health assessments were undertaken. At his trial Adult 2 claimed that his

judgement was impaired due to Alcohol Dependency Syndrome but the jury rejected this.

2.5 On 3rd September 2014, Adult 2 was convicted of murder and sentenced to life imprisonment with a requirement to serve at least 15 years.

2.6 The inquest in respect of Adult 1's death was closed on 5th November 2014 with no separate, independent verdict as the case had been heard in full in the Crown Court. There were no other, parallel, enquiries following this death.

2.7 Since child 1's mother's death, Child 1 has been cared for by family members.

2.8 Family Involvement

2.8.1 The family had nominated Adult 4 as their representative. The Police Family Liaison Officer delivered a letter from the Independent Chair advising the family of the review and containing information about advocacy and support in the form of leaflets. When initially contacted, Adult 4 indicated that once criminal proceedings were completed, the family would wish to be involved in this review. This included Child 1.

2.8.2 As noted above, Adult 2 was convicted on 3rd September 2014 and following this Adult 4 was again contacted in writing at their home address, by the Chair of the Review. The family were offered the opportunity to meet with the Chair but they did not respond. Adult 4 was further contacted by telephone and a message left but there was no response to this either.

2.8.3 The panel acknowledged that for some families, the length of time in reaching this point of the review means that, to some extent at least; "life has moved on" and they no longer wish to participate. Accordingly, in the absence of a response from the family, the panel respected their wishes. They had already been advised that they would have the opportunity to read the completed report in due course prior to submission to the Home Office.

2.8.4 The only 'non-professional' views of the family and the relationship between Adults 1 and 2 available to the review, therefore, come from the statements of Adult 6, step father of Adult 1, and Adult 7, a friend of Adult 1 and neighbour of the family. These are detailed within the West Midlands Police report although the police were not in a position to corroborate this information.

2.8.5 From these statements it would seem that Adult 1 and 2 had some sort of relationship since 1994/95 and that Child 1 is their child. Child 1 was born in 1997 (although some reports state 1995). It is not clear what contact Adult 2 had with Child 1 initially but it appears that the family had been living together for approximately 10 years prior to the death of Adult 1.

2.8.6 Adult 7 stated that Adult 1 became concerned about the amount of alcohol Adult 2 was consuming and that "they" offered to take him to Alcoholics Anonymous although he refused. Adult 7 also reported an incident which occurred when Child 1 would have been about 9 years old whereby the child

was left on their own by Adult 2 all day (Adult 1 having left child 1 in his care whilst she was at work). When Adult 7 became aware of this, she contacted Adult 5 (Adult 1's mother) who came to care for the child. Adult 2 returned home after 5pm and was said to be drunk. Adult 1 was said not to like others getting involved in her relationship and this incident apparently led to a disagreement with her mother.

2.8.7 Adult 7 also reported a number of other occasions when Child 1 attended her home to 'get away'. According to Adult 7's statement, Child 1 told Adult 7 that they often heard her mother (Adult 1) crying in the toilet and that Adult 2 was taking money from both Child 1 and Adult 1, Child 1 is described by Adult 7 as having felt under emotional pressure not to tell Adult 1 about the money being taken.

2.8.8 Adult 7 stated that she also saw Adult 1 crying and was aware that Adult 2 was spending her money so that Adult 1 had to work longer hours to 'make ends meet'. Adult 7 advised Adult 1 to make an appointment and speak with her GP but Adult 1 apparently said that she would not do this as she struggled to open up to people about her feelings.

2.8.9 Adult 7 reported that when Child 1 was approximately 13 years old she (Adult 7) heard Adult 2 making derogatory remarks about Adult 1 and Child 1's weight. She believed that this caused Adult 1 and Child 1 great distress and led to them stopping eating and losing weight.

2.8.10 Adult 7 described Adult 1 as 'becoming low' and saw her as a person with no confidence and low self-esteem. She felt that this was the reason she was unable to leave Adult 2.

2.8.11 It would appear that in June 2013 Adult 1 was contacted by a previous boyfriend. Adult 7 believed this contact to have been platonic and to have been known to Adult 2.

2.8.12 In July 2013, it is reported that Adult 1 told Adult 2 that he needed to leave and gave him one month's notice to do so. No explanation is available as to why Adult 1 took this action at this particular time although Adult 7 understands that Adult 1 told Adult 2 that she no longer loved him and could not afford to support his alcohol problem any longer.

2.8.13 Adult 7 described Adult 2 as 'pleading' with Adult 1 to change her mind and she was told by Adult 1 that on one occasion Adult 2 threatened to self-harm by holding a knife to his wrist.

2.8.14 Adult 1 refused to change her mind, apparently stating that she had to put Child 1 first and that the on-going arguments were not a good environment for Child 1 to be in.

2.8.15 Adult 7 also stated that Adult 1 had told her that Adult 2 had been reading her text messages and Facebook conversations and had accused her of having an affair, which she (Adult 1) said was ridiculous.

2.8.16 At about this time, Adult 2 also began following Adult 1 to work and waiting for her until her shift was over. This was confirmed by Adult 1's former work colleagues in statements to the Police. They also noted that Adult 1 had told them that the relationship had ended.

2.8.17 As noted above, Adult 2 was contacted once the criminal proceedings were completed. The nature of the review was explained to him by letter and he was offered the opportunity to contribute. Conversations also took place between the Chair of the Review and Adult 2's Probation Officer and the Offender Supervisor within the prison.

2.8.18 Adult 2 did not respond to the invitation to participate and hence the panel has no additional information regarding his views other than the fact that he maintained throughout the criminal proceedings that he did not intend to kill Adult 1; had no recollection of the events of that night; and that his judgement was impaired due to alcohol dependency syndrome.

2.9 Agency involvement

2.9.1 As noted above, although a number of agencies were contacted regarding the subjects of this review (Adult 1; Adult 2 and Child 1), few had any previous involvement.

2.9.2 In respect of **Adult 1** these were Bromford Housing; Heart of England NHS Foundation Trust (HEFT); NHS England (G.P.); and Education Services (although only in relation to Child 1's school admissions).

2.9.3 In respect of **Adult 2** these were West Midlands Police (WMP); Bromford Housing; Heart of England NHS Foundation Trust; NHS England (G.P); and West Midlands Ambulance Service (WMAS).

2.9.4 In respect of **Child 1** these were; Heart of England NHS Foundation Trust; NHS England (G.P); Education Services; and the child is named on the original tenancy agreement with Bromford Housing as living with mother (Adult 1).

2.9.5 **West Midlands Police** had no contact with Adult 1 or Child 1 prior to the incident on 8th August 2013. Adult 2 had previously been involved in three reports of domestic abuse between 2000 – 2003 by his ex-partner, Adult 3. This first contact is the reason for the start date of this review.

2.9.6 On 31st August 2000, Adult 3 contacted the Police to report that Adult 2 was refusing to leave the property and was drunk. Officers attended; established that no criminal offence had taken place and gave advice to both parties.

2.9.7 On 18th January 2003, Adult 3 contacted the police, saying that Adult 2 was harassing her and preventing her from getting on the bus. Officers attended and spoke with Adult 3. Adult 2 had already left the location. Adult 3 informed officers that the relationship with Adult 2 had ended that morning and that he had prevented her from getting onto the bus. Officers then took

Adult 3 to a different bus stop in case Adult 2 returned after they had left. Adult 3 did not make any formal complaint and no further action was taken. The attending officers identified that the matter was domestic abuse related and ensured that the appropriate systems were updated. It is not clear from the documentation whether the word 'harassed' was viewed as a 'course of conduct' as defined in the Protection of Harassment Act 1997 or merely taken to be a colloquial expression.

2.9.8 On 22nd March 2003, Adult 3 contacted Police to report that Adult 2 was stealing her car. Officers spoke with Adult 3 and the record generated was written up stating that 'no crime was being reported' and that it was a 'minor issue which was being sorted between themselves'. The attending officers identified that the matter was domestic abuse related and ensured that the appropriate systems were updated. In the absence of any written documentation to view it is not possible to say whether appropriate action was taken by the officers concerned.

2.9.9 Due to the length of time since the incidents occurred it has not been possible to view the original paper documents. The Police computerised CRIMES system has scant detail contained within it and does not indicate if any referrals were made to other agencies particularly in relation to the incident on 31st August 2000 which clearly indicates that Adult 2 was drunk.

2.9.10 On 21st April 2005 at 00:30hrs Adult 2 was arrested and charged with driving a motor vehicle with excess alcohol. There is nothing in the Police record to suggest that this incident was related to a domestic disturbance. It resulted following a routine stop check as Adult 2 was seen to be driving significantly below the speed limit.

2.9.11 The only other contact with the Police was following the 999 call made by Adult 2 on 8th August 2013. Following this a criminal investigation took place, resulting in Adult 2 being charged with murder; remanded in custody; and subsequently convicted.

2.9.12 The first contact that **Bromford Housing Association** had with Adult 1 was 1st August 2005 when she signed the tenancy agreement for the property in which the incident took place. The tenancy commenced on this date. Child 1 is recorded under 'persons who are not tenants who will be living with the tenant'. This is the only reference to Child 1. Adult 2 is not mentioned in the agreement and was never a tenant of the property. Despite this, there were a number of contacts between him and the Housing Association, the first being in January 2007.

2.9.13 Contacts with both parties related to repairs and also to neighbour disputes – both as complainants and alleged perpetrators of anti- social behaviour. Other contacts with Adult 1 related to rent issues, which continued throughout the period of the tenancy.

2.9.14 Bromford Housing have confirmed that this number of contacts is not unusual (over 100 entries in the chronology). They have also clarified that requests for

repairs or reports and complaints of anti-social behaviour are accepted from other household members e.g. Adult 2, but that matters relating to rent will only be discussed with the tenant, unless written authorisation to discuss this with another, named, person is received from them. In none of these entries is there any reference to concerns regarding domestic abuse.

2.9.15 On 6th August 2013, Adult 2 sought advice saying that Adult 1 was 'throwing him out'. On 7th August, the Housing Manager happened to see Adult 2 on the estate. She asked him if he had followed up on the advice given the previous day regarding registering for re-housing, to which he replied 'don't worry, that's all sorted'. The Housing Manager did not pursue this any further.

2.9.16 Although **Heart of England NHS Foundation Trust** had contact with all three family members, only those with Adult 2 are of any significance in relation to potential domestic abuse.

2.9.17 Child 1 received routine universal services from the Health Visiting and School Nursing services. The child's immunisations are noted in the relevant records. No concerns relating to wellbeing or engagement with services are recorded. Child 1 had contact with the Emergency Department (ED) at Heartlands Hospital but only for minor health issues.

2.9.18 Adult 1 had contact with the Emergency Department and the Cardiology Service during the time frame covered (the last occasion being September 2010). In none of these contacts was there disclosure of, evidence of or reason for concern about domestic abuse.

2.9.19 Adult 2 had a number of contacts with the Emergency Department (18) due to injuries and illnesses. Many injuries are noted to be work related.

2.9.20 The Emergency Department identified that Adult 2's alcohol consumption was problematic on three separate occasions: 18th October 2011; 5th October 2012; and 13th July 2013.

2.9.21 On the first occasion he was brought in by ambulance, intoxicated. Adult 2 had been found collapsed on a bench in Solihull. There were no injuries noted and he reported only having drunk 2.5 pints of beer in the morning. (He was brought in at 13.54hrs). A past history of alcohol abuse was noted and it was also noted that he lived with his partner.

2.9.22 In October 2012, he attended with knee problems. The notes record; 'Noted to drink 8 units daily'. Recorded that he 'smelt of alcohol' FAST alcohol screen completed. Score was 4 Indicating increasing risk of harm from alcohol.' On this occasion, Adult 2 was given advice and literature relating to alcohol.

2.9.23 In July 2013, Adult 2 attended the Emergency Department with facial numbness, blurred vision in his right eye and headache. He was brought in by ambulance. It was noted that he was 'an alcoholic'; that he smoked; and that he lived with his partner.

2.9.24 On 23th November 2010, Adult 2 also attended with chest / rib discomfort. His explanation was that his injury had occurred during a 'play fight' with his partner (presumably Adult 1) the previous day. This explanation appears to have been accepted without further probing by staff; however, with the benefit of hindsight, additional questioning at this point *may* have elicited significant information as noted in 3.5 below.

2.9.25 On none of these occasions was Adult 2 asked whether children lived with him so that the impact of alcohol misuse on a child could be considered. This is also noted below in 3.5 as a 'missed opportunity'. The last contact was 23rd July 2013 when Adult 2 attended for surgery on his knee but this was cancelled due to his low sodium levels.

2.9.26 In terms of **GP contact**, the medical records show a consultation with Adult 1 relating to depression on July 4th 2002 for which anti-depressants were prescribed. The record indicates that she was a 'single mum' with a part-time job. The situation was reviewed on 30th July 2002 when the situation was described as 'much improved' although a further prescription was issued. There is no information available between 30th July 2002 and August 2008: presumably due to a change of address. These were the only contacts other than for routine issues. Her last attendance was 23rd September 2010.

2.9.27 Similarly, in relation to Child 1 most contacts relate to routine issues. The notable exception to this was a consultation with the GP on 6th August 2012 relating to anxiety. On this occasion Child 1 is reported to have been accompanied by 'dad'. The record indicates that Child 1 stated that they did not have anything on their mind and did not know why they were so stressed and anxious. The record concluded that the Child 1 was 'visibly relieved and calmed down' when told that the physical symptoms were likely to be stress and anxiety related.

2.9.28 Possible causes of the stress, other than a suggestion that this was related to school and exams, do not seem to have been explored further, nor is there any suggestion that Child 1 was offered the opportunity to speak with the GP alone. They would have been just 15 years old at the time. Other than one further appointment in January 2013 relating to a sore eye, this was the last contact between the GP and Child 1.

2.9.29 Adult 2 had many contacts with his G.P. and, although many were in response to work-related injuries, several related to alcohol.

2.9.30 In 2000 he requested 'stop alcohol' advice; was referred to Psychiatry in December 2001 but declined any further follow up; and was advised in November 2002 to reduce alcohol consumption.

2.9.31 No information is available in the records from December 2002 until September 2007.

2.9.32 In August 2008 Adult 2 registered with a new surgery. On this occasion it was recorded that 'he drinks 8 pints per week'.

2.9.33 On 17th August 2012 he attended with an on-going knee problem but was also advised regarding alcohol consumption as his consumption was recorded as being 42 units per week. On 27th February 2013 this is noted to have decreased to 16 units per week. All records of the level of alcohol consumption are as a result of self-reporting.

2.9.34 Although this is the last reference to alcohol; Adult 2 continued to attend the surgery and was last seen on 6th August 2013.

2.9.35 Adult 2 was also known to **West Midlands Ambulance Service** prior to August 2013. On the 12th July 2013 the Service was called to the home of a 47 year old male (Adult 2) who was complaining of facial numbness following a biopsy on his head. All observations were within normal limits and he was transported to hospital for further investigation.

2.9.36 As noted above, the hospital records show that on 18th October 2011 Adult 2 was also transported to hospital by ambulance. This event is not recorded in the report from West Midlands Ambulance Service as he was not transported from his home address and their monitoring system currently only allows searches based on the location where the patient is picked up.

2.9.37 With regard to **Educational Services:** Child 1 was a pupil at a secondary school from September 2008 until June 2013. The school had daily contact with the child and on occasions such as parent evenings it is assumed that there would have been contact with Adult 1 and possibly Adult 2, although this is unconfirmed by the school staff.

2.9.38 The school reports that there was no indication through contacts with Child 1 that they were affected by domestic abuse at home. There is no record of any disclosures of any kind. Child 1's attendance was excellent.

2.9.39 Child 1 previously attended two Primary Schools; one from September 2000 to July 2005 and the other from September 2005 to July 2008 following a change of address.

2.9.40 **Solihull Council Admissions Team** had contact with Adult 1 during 1999-2000 (Reception Place application), May – July 2005 (change of school application due to house move) and December 2007 – March 2008 (Secondary Transfer).

2.9.41 There is no record on any other **Children's Services** Systems (such as the Education Psychology Service or Children's Social Care) of engagement with any of the individuals included in this review.

2.9.42 As noted in1.4.13 above, the Terms of Reference also include a number of other enquiries specific to this review. Most resulted in a 'nil return'. Birmingham Services had no record relating to previous involvement, nor did Solihull Council's other services e.g. Housing requests or anti- social behaviour complaints.

2.9.43 The one enquiry that was not responded to was that made of Adult 1's employer regarding their staff support policies. There is no suggestion that the company were in any way negligent, nor indeed, from Police statements taken from colleagues at the time, that they would have been aware of the problems. The review felt however that there was a more general issue to be addressed in terms of employers' awareness and support to staff and this is followed up within the conclusions and recommendations below.

2.9.44 In view of the information available from the Police enquires made at the time; the review did not independently follow up the question of colleagues' awareness of any concern. Approximately 20 former colleagues were spoken to and many provided statements. None of the colleagues were aware of difficulties at the time but in hindsight could see that Adult 2's behaviour ('hanging around' during Adult 1's shifts) could be seen as controlling and *may* indicate a risk to Adult 1 from him.

3: Analysis

3.1 The Terms of Reference agreed by the Board refer to the effectiveness of agencies in identifying, analysing and responding to risk and vulnerability; the provision of services in response to this; the quality of inter-agency working practice and policies and any action necessary to improve this.

3.2 It appears, however, that at no time during this relationship did Adult 1 seek support from any identified agency for any form of domestic abuse; few agencies were involved with any members of the family; and no disclosures were made by any other concerned individual. It has not been possible, therefore, to address those aspects of the terms of reference relating to responses to victim and perpetrator other than in hypothetical terms.

3.3 The police response to Adult 3's (Adult 2's former partner) reports of domestic abuse would appear to have been inadequate; however, the review panel recognises that since this time West Midlands Police have introduced clearer and more robust domestic abuse policies, procedures and training aimed at improving the response and safety of domestic abuse victims. Concerns regarding the response to domestic abuse remain however, as seen in the Inspection Report of 2014[7]: West Midlands Police are noted to have no definition of a 'repeat' incident and are below the national average for incidents considered as crimes.

3.4 Reports made by Adult 3 demonstrate that alcohol was a feature in Adult 2's life as far back as 2000. Each individual management review report (IMR) however (with the exception of Education Services who had no contact with Adult 2) also refer to issues relating to alcohol abuse. Whilst it is acknowledged that alcohol misuse does not cause domestic abuse or child abuse: when it is present alongside these, there is an increased risk of harm. None of the practitioners involved appear to have made this link or considered the impact on any children within the household.

[7] Everyone's Business: improving police responses to domestic abuse HMIC 2014

3.5 The Heart of England NHS Foundation Trust report in particular notes that Adult 2 was screened using the 'FAST' assessment tool which is 'a means of identifying and providing appropriate intervention around problem drinking'. The tool does ask about home circumstances but not about children or vulnerable adults whom the Trust has acknowledged is a potential lost opportunity. This agency also raised specifically the issue of staff time / resources to undertake any more in-depth assessment within the Emergency Department, and raised the question of the need for clarity regarding roles and responsibilities between different professionals. Within their report this lack of time is given as the probable explanation for not pursuing the 'play fighting' event referred to at 2.9.24 above. Similarly, when Adult 2 was declined surgery in July 2013 due to low sodium levels, no further analysis appears to have taken place with regard to the cause of this.

3.6 Bromford Housing was also aware of Adult 2's alcohol issues but there is no record that at any time anyone considered this to be a risk to others. It was confirmed that policies were in place for staff to record incidents or concerns and that these would then be discussed with their line manager.

3.7 All agencies stated that they had policies and procedures in place to address various aspects of safeguarding, including domestic abuse, and that training was in place to disseminate these. This raises the question of the compliance with such policies and the success of training in implementation. Several also highlighted recent developments in responding to domestic abuse and these are referred to in section 5 below.

3.8 Research would suggest[8] that ending an abusive relationship is a key risk factor within domestic homicide. What is not clear is whether Adult 1 felt at risk when she made her decision to end this relationship.

3.9 The only person to have had some knowledge of the family dynamics appears to have been Adult 7 (Adult 1's friend). Both Adult 1 and Child 1 disclosed behaviour to Adult 7 that indicated there were problems that were causing at the very least emotional and financial distress to Adult 1 and Child 1.

3.10 In 2003, Adult 3 reported that Adult 2 was 'harassing' her, and when Adult 1 sought to end this relationship, Adult 2 began following her to work. Such behaviour that is commonly reported as being adopted by perpetrators of domestic abuse and is featured in a significant number of domestic homicides.

3.11 None of the reports provided to the review identified any issues in relation to equality, diversity or special needs in relation to any family member which should be taken into account.

3.12 The panel note, however, that, as the number of domestic homicides being reviewed increases, the number of women aged 40 – 61 years being killed is higher than expected. This group is also the least likely to report abuse, as

[88] Femicide Census http://www.womensaid.org.uk/page.asp?section=00010001001400130010#women

identified by referrals to MARAC[9]. It would appear, therefore, that there are further issues to be considered nationally in relation to the age profile of domestic abuse victims and those subsequently subject to domestic homicides[10].

4: Lessons learnt

4.1 Other than the two specific references from Heart of England NHS Foundation Trust and NHS England, outlined in 6.6 and 6.7 below; none of the Individual Management Report (IMR) authors identify any lessons for their organisation as a result of this review. Some specifically comment that this is not possible as Adult 1 was not identified as being at risk or Adult 2 as being such a risk.

4.2 What reports did identify, however, was that a number of developments have taken place within the timeframe of the review and even since the death of Adult 1. These are considered below.

5: Developments

5.1 As noted above, a number of individual management reports and also panel members from various organisations have identified developments that have taken place within the timeframe of the review in respect of attitudes and responses to domestic abuse.

5.2 Whilst it is not claimed that any of these would have altered the outcome in this particular case, it was considered to be important to acknowledge these within the Overview Report as matters which may influence future incidents.

5.3 Perhaps the most significant development has been a re-focussing on domestic abuse within Solihull, as seen by the re-investment in the domestic co-ordinator post by the Local Authority. A designated post has been able to progress the establishment of a number of initiatives under the auspices of the Safer Communities Partnership.

5.4 These include:

- The establishment of the Domestic Abuse Priority Group and the creation of a Domestic Abuse Commissioning Plan, now in its second year (see 1.2.11)
- Increased access to specialist information, advice and support
- The appointment of a 'young people's advocate'
- The development of a number of training packages, particularly in relation to schools
- The launch of a publicity campaign within the Borough

5.5.1 other initiatives include;

- The development of a workforce development strategy (2015 -2017) which encompasses minimum training requirements from induction training for all staff to more specific training for staff who come into contact with women,

[9] Multi Agency Risk Assessment Conferences

[10] Femicide Census http://www.womensaid.org.uk/page.asp?section=00010001001400130010#women

children and young people experiencing abuse, or men who use violence. This strategy covers a number of organisations and will be led by the Domestic Abuse Priority Group.

- The provision of services, including counselling, to those affected by domestic abuse Emotional Wellbeing and Mental Health Service for Solihull Children and Young People.
- The joint commissioning, together with the Police and Crime Commissioner, of regional research and the development of an Action Plan in response to this.
- An Action Plan, developed by West Midlands Police in response to the recent HMIC inspection[11] to address concerns raised (see 3.3 above). All those sentenced to more than one day to be supervised on release by the probation services, for a minimum of 12months. [12]

6: Conclusions and recommendations

6.1 Having considered all the information available, it is the opinion of the review panel members is that this death could neither be predicted nor prevented, for reasons outlined in section 3 above. As there has been no family involvement in the process, it is not possible to comment on whether the same view is held by them, or to consider any conclusions or recommendations from them.

6.2 The focus of most domestic homicide reviews is to consider whether, having become aware of a risk, agencies responded appropriately, both as single agencies and jointly. In this case no risk was identified in advance and therefore this question does not arise.

6.3 The questions which remain however are:

- whether the risk could or should have been identified by professionals in contact with the family;
- whether others (such as family, Adult 7 and work colleagues) who have subsequently expressed concerns knew how to draw attention to these and;
- whether, had they done so, services would have been in place and accessible to respond to them.

6.4 This is the first domestic homicide review commissioned by the Safer Solihull Partnership. In considering the questions posed above, there would appear to be a degree of uncertainty on the part of this Partnership as to their roles and responsibilities in relation to domestic abuse generally. This is addressed further within the recommendations to the Partnership.

[11] Everyone's Business: improving police responses to domestic abuse HMIC 2014

[12] Offender Rehabilitation Act 2014

6.5 Recommendations from individual agencies

With regard to individual agency responses, only two management reports: from NHS England and the Heart of England NHS Foundation Trust (HEFT) identified issues to be addressed.

6.6 The issue for NHS England related to the consistency amongst Practice staff in implementing the existing domestic abuse policies. This is addressed by a recommendation:

'*In order to ensure that practice staff are consistent in applying the domestic abuse policies related to staff and patients the practice requires systems in place to monitor and review this'*

This recommendation and the accompanying actions have been incorporated into the overall action plan for the review.

6.7 In respect of Heart of England NHS Foundation Trust, the issue related to the need to improve the assessment of individuals in respect of their alcohol consumption and of the impact of this on their home circumstances. The Trust made a recommendation to address this:

'Assessment, particularly in respect of alcohol consumption, needs to be improved. In order to achieve this a number actions need to be undertaken to ensure that the well-being of patients and their family members is safeguarded.'

This was accompanied by an action plan for implementation which outlined these actions and which is included in the action plan for this review.

6.8 Review recommendations

With regard to the recommendations from the Review to the Safer Solihull Partnership 4 key areas were identified:

- Increased knowledge of the inter-linkage between different forms of abuse;
- the need to fully implement and embed any new developments into mainstream structures; processes and practice (including funding);
- the knowledge and understanding of employers of the issue of domestic abuse, and of their responsibilities in respect of staff who may be subject to this;
- the maintenance and improvement of services currently available to prevent, identify and respond to domestic abuse within the Borough

6.9 It could be argued that there is one overarching recommendation relating to the roles and responsibilities under S17 Crime and Disorder Act and that the rest are actions flowing from this. It has been agreed, however, are each significant in their own right and should be identified as separate recommendations

6.10 Recommendation 1

Although not addressed as an issue or 'lesson learnt' in other reports, the review panel was concerned at an apparent lack of awareness among practitioners of the potential links between alcohol abuse and other forms of abuse such as domestic abuse or child protection issues (or the impact on vulnerable adults although this was not a feature in this case) and hence a failure to recognise the risk. It requested a number of individual management report authors to consider this further and they confirmed that this issue was addressed within the training materials provided to their staff. Accepting this to be the case, it raises the questions of the success of such training and the structural mechanisms e.g. supervision, to re-enforce and support this awareness, and of the cross referencing between training provided by each of the relevant partnerships.[13]

The review, therefore, makes the following recommendation:

> The Safer Solihull Partnership should ensure that all those working in the area of domestic abuse; have knowledge of the inter-linking between this and other forms of abuse: child protection, adult protection, alcohol abuse and safeguarding generally; to ensure that these risks are appropriately addressed.
>
> In order to achieve this, the Safer Solihull Partnership should: support the completion of the domestic abuse workforce development strategy; endorse the domestic abuse standards agreed between the Local Safeguarding Children Board; the Safeguarding Vulnerable Adults Board and the Domestic Abuse Priority Group; require constituent members or those whom they commission on their behalf, to undertake annual self-assessments; alert other boards to the issue of linkages and to suggest that similar activities are undertaken by their members, in particular, the Public Health Partnership: and establish a short term cross- partnership group to review current arrangements to strengthen these where necessary.

6.11 In order to obtain support for potential victims; individuals, victims themselves or others who become aware of people being victimised need to know where to seek this. They also need the confidence that their concerns will be treated seriously and sensitively.

6.12 The Partnership has already embarked on a publicity campaign aimed at improving awareness of domestic abuse among the general public; challenging commonly held myths; and providing practical information on how to draw their concerns to the attention of others. Part of the campaign includes a focus on raising awareness amongst young people but the circumstances of this review, together with the outcome of recent national

[13] Safer Solihull Partnership; Local Safeguarding Children Board; Solihull Adult Safeguarding Board; Public Health Partnership

research referred to above (3.12), would suggest that older women should also be targeted.

6.13 Recommendation 2

The review was pleased to be able to include references to other recent developments made in respect of a number of agencies' responses to domestic abuse and commends the individual organisations for this. The review panel is aware, however, that such developments are not ends in themselves and, therefore makes the following recommendation:

> The Safer Solihull Partnership should ensure that the recent developments described by a number of organisations in relation to domestic abuse have been implemented and are embedded within their structures; processes; and practice. (These developments can be found in section 5 of the Overview Report)
>
> In order to achieve this, the Safer Solihull Partnership should require members to provide a current position statement to the Board regarding the implementation of the developments within their organisation; and require agencies to monitor progress via their individual action plans (where this is not already the case).

6.14 Within current services or planned developments, there appears to be little relating to the management of perpetrators. However, the review panel were conscious that the template provided to authors of the individual management reports did not specifically address this. Rather than make any assumptions, the panel has undertaken to correct this by revising the template for the next review; before seeking to make any recommendation to the Partnership in respect of perpetrators.

6.15 Recommendation 3

A specific issue was raised in this review regarding the role of employers in supporting those caught up in domestic abuse. In this case, no disclosures were made; no concerns were expressed by colleagues; and no evidence of abuse appears to have been recognised within the workplace, despite Adult 2's behaviour being recognised subsequently as a potential indicator. The review, therefore, acknowledges the same point as for the general public namely: that awareness and knowledge of how to raise concerns is an essential precursor to doing so. Companies, therefore, need to have policies and procedures in place and publicity within the workplace to promote these.

6.16 Whilst acknowledging the limitations on placing requirements on private organisations, the review, being mindful of the Home Office Publication 'Public Health Deal'[14], makes the following recommendation:

[14] Public Health Deal: https://responsibilitydeal.dh.gov.uk/pledges/pledge/?pl=46

That the Safer Solihull Partnership should identify any opportunity that it, or its constituent members, have to increase the knowledge and understanding of employers of the issue of domestic abuse, and of their responsibilities in respect of staff who may be subject to this, to ensure that staff are better supported.

In order to achieve this, the Safer Solihull Partnership should include a specific tactic/ strand within the domestic action plan in relation to the responsibilities of employers; and require its members to review the standard specification for contracts issued by their agency to ensure that all new and existing contracts include a requirement for either a Domestic Abuse workplace policy or a statement of approach and management to be included in the specification.

6.17 From discussions within the panel and the experiences of organisations in a number of areas, the panel is particularly aware that commissioning bodies are currently in a difficult position: attempting to manage service delivery within ever tightening resources. The panel was made aware of examples of services being de-commissioned; match funding for specific provisions being withdrawn; mainstream budgets being reduced; services unable to secure long term sustainable funding; and the increasing difficulties faced by those presenting business cases for any further developments. These difficulties are exacerbated by the fact that tackling domestic abuse is not underpinned by statutory duties and that this, therefore, has to compete with other pressing issues. The review panel is mindful, however, that there is little to be gained in improving awareness and accessibility (Recommendation 3) unless there are adequate services available to respond to the needs identified.

6.18 Recommendation 4

The panel is convinced that the impact of domestic abuse is so wide, not only in terms of the victim and perpetrator but also their families and wider community; and so long lasting, particularly when children are caught up in the conflict[15], that it remains important, despite acknowledging the current difficulties, to make the following recommendation:

The Safer Solihull Partnership should to do all in its power to maintain and improve the services currently available to prevent, identify and respond to domestic abuse within the Borough.

In order to achieve this, the Safer Solihull Partnership should set a budget in a timely manner; oversee this; escalate concerns directly with any responsible authority not fulfilling its responsibility and commitment to this; arrange for the budget for domestic abuse to be included on Solihull's Risk Register; and write to the Home Office to seek national minimum standards for domestic abuse services.

[15] Included in definition of harm: Adoption & Children Act 2002