Safer Solihull Partnership

Involving local people in keeping Solihull safe

Domestic Homicide Review

Under section 9 of the Domestic Violence, Crime and Victims Act 2004

In respect of the death of Adult 1 (April 2018)

Domestic Homicide Review 5

Safer Solihull Partnership

The names of those subject to this review have been anonymised at the family's request.

Report produced by Simon Hill (Independent Chair & Author)

January 2019

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Family statement

“Our Adult 1 was the glue to our family. She was the go-to member of the family that would go the extra mile with supporting the other family members. She was a loyal friend and very sociable. She was kind, caring and nothing was too much trouble when helping others.

Adult 1’s priority in life was her children. She never pushed herself into having a career as she would always put her children first.

She was a brilliant mother, sister, nanny and auntie. What has happened to Adult 1 should never happen to anyone, the hole it has left in our family has been enormous. We have spent the last twenty-three months adapting to a different norm. This has had massive effect on her children and grandchildren knowing that the traditions around birthdays, holidays and Christmases have now gone forever.

Adult 1 was close to her sisters and brothers and they had a bond that was created from the love of each other. She would be the one to arrange all the get togethers. Her birthday was an annual celebration, with a BBQ, where all her friends and family would attend. This was a tradition that had been going for many years but has now become too difficult to continue.

Adult 1 was hard working and made lots of new friends wherever she was. She would always do extra if it helped the organisation out and would support her colleagues. She was truly loyal. She was always in work other than when she took time out to look after her niece and nephew while their mom went to work, again always putting others first.

Adult 1 liked her holidays and socialising with people. She loved spending time with her grandchildren. She was always doing puzzles and sewing. She was a very house-proud woman and loved a good bargain especially at local markets.

This has been a difficult process for us all as a family, but we appreciate the opportunity of having an input to this review. We are heartened that this report contains a range of recommendations that could help others in the future. We would like to thank Simon Hill, Gillian Crabbe and the Domestic Homicide Review Panel. A special thanks to our AAFDA advocate, who has always been on hand to help us throughout the report and offer us words of advice.' "

1. Introduction

1. The Independent Chair and Domestic Homicide Panel wished to put on record their condolences to Adult 1's family and friends for their tragic loss.
2. This report of a Domestic Homicide Review examines agency responses and support given to Adult 1, a resident of Solihull, prior to her death in April 2018.
3. In addition to agency involvement, the review also examined the past to identify any relevant background information or trail of abuse before the homicide, whether support was accessed within the community and whether there were barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.
4. The Safer Solihull Partnership was notified of the death of the victim, Adult 1 in April 2018. The Community Safety and Partnerships Manager reviewed the circumstances of this case against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and recommended to the Chair of the Safer Solihull Partnership that a Domestic Homicide Review should be undertaken. The Chair ratified the decision to commission a Domestic Homicide Review on the 20th April 2018 and the Home Office was notified accordingly. The Independent Chair was appointed in June 2018.
5. This review considered agencies' contact with Adult 1 and Adult 2 (the perpetrator) from 1st January 2012, the year in which Adult 1 and Adult 2 married, up to the homicide in April 2018. However, Independent Management Review authors were asked to include in their chronology and consider any events or information prior to these dates, if they were considered relevant to the questions framed in the reviews terms of reference.
6. This review began in July 2018. Panels meetings were held on:
    - 16th July 2018
    - 08th October 2018
    - 06th November 2018
    - 13th March 2019

7. Throughout the process, the Independent Chair of the Domestic Homicide Review and Advocacy After Fatal Domestic Abuse (AAFDA) advocate maintained regular communication with Adult 1's family.

2. Confidentiality

1. The findings of this review are treated as confidential and are shared only with participating officers/professionals and their line managers.
2. The family members involved were offered the opportunity to nominate the pseudonyms to be used in the Domestic Homicide Review, in line with Home Office guidance. The family declined to use pseudonyms for those involved in this case, as an alternative, parties in review are identified using the following key.

Parties	Relationship	Age at time of homicide
Adult 1	Victim	51 years old
Adult 2	Perpetrator	73 years old
Adult 4	Adult 1's daughter	
Adult 5	Adult 1's son	
Adult 6	Adult 1's sister	
Adult 3	Biological father of Adult 1's Son and father to Adult 1's Daughter	
Adult 7	Adult 2 's daughter from his second marriage	
Adult 8	Adult 1's close friend and neighbour	

3. Terms of Reference

1. The review addresses 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 Adult 1 or prevent Adult 2 from being a perpetrator of homicide?
- How effective were agencies in identifying and responding to both need and risk?

- How effective were agencies in working together to prevent harm through domestic abuse in Solihull?
- What lessons can be learnt to prevent harm in the future?

2. Agencies' Individual Management Review Authors were asked to respond to the following questions in respect of their involvement with Adult 1 and Adult 2 during the period from January 2012 (being the year when Adult 1 and Adult 2 married), and the date of her death:

01. Provide a brief summary of the role of your organisation in responding to domestic abuse.

02. Were practitioners sensitive to the needs of Adult 1 and Adult 2, knowledgeable about potential indicators of abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

03. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective?

04. Provide a brief pen picture of Adult 1 and Adult 2, together with and any knowledge your agency had of their relationship and the relationship that either of them had with any other persons of interest. Please also include any previous relationships for either adult that appear to feature domestic abuse.

05. What needs and vulnerabilities did your agency identify in Adult 1 (the victim) and how did your agency respond?

06. Had Adult 1 disclosed to any practitioners or professionals and, if so, was the response appropriate?

07. What needs and vulnerabilities did your agency identify in Adult 2 (the perpetrator) and how did your agency respond?

08. *What threat and risks did your agency identify for either Adult 1 or Adult 2 and how did your agency respond? Consider identified threat and risk for this relationship and prior relationships as well as the potential for threat to other people.*
09. *If domestic abuse was not known, how might your agency have identified the existence of domestic abuse from other issues presented to you?*
10. *How well equipped were staff in responding to the needs, threat or risk identified for both Adult 1 and Adult 2. Were staff supported to respond to issues of domestic abuse, safeguarding, public protection and multiple and complex needs through:*
    - *Robust policies and procedures in domestic abuse, including policies of direct or routine questioning*
    - *Strong management and supervision*
    - *Thorough training in the issues and opportunities for personal development*
    - *Having sufficient resources of people and time*
11. *Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of Adult 1, Adult 2 and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?*
12. *Can you identify areas of good practice in this case?*
13. *Are there any service changes planned or happening that might have affected your agency's response?*
14. *Are there lessons to be learnt from this case about how practice could be improved?*
15. *What recommendations are you making for your organisation and how will the changes be achieved?*

Enquiries specific to this review

Birmingham and Solihull Clinical Commissioning Group and Birmingham and Solihull Mental Health Foundation Trust

- In relation to Adult 1, examine whether sufficient information was shared to ensure that all professionals supporting Adult 1 had an accurate understanding of her use of alcohol and her mental health vulnerabilities?

- It has sometimes been identified in Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DHRs) that agencies have failed to work to address alcohol use and/or alcohol abuse and mental health effectively because of the interrelationships between the two. Identify whether the apparent presence of the dual diagnosis, of the occasional use of alcohol and mental health vulnerabilities in relation to Adult 1 assisted or hindered a co-ordinated response to her needs?

- To what extent should/did this knowledge trigger direct/routine questioning around home circumstances and domestic abuse in line with NICE[1] guidelines PH 50 Domestic Violence and abuse: Multi-agency working (Feb 2014)

Housing

- What guidance, policy or procedures inform the level of enquiries made by your agency around home circumstances, when as in the case of either Adult 1 or Adult 2, they present to be re-housed?

[1] The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

In addition

Information reports:

- Requests to the employers of both Adult 1 and Adult 2 for information were considered but not deemed relevant to the Domestic Homicide Review.

(Chair's note: The Domestic Homicide Review was initially concerned that over a number of years, Adult 1 presented at hospital A&E departments with numerous work-related accidental injuries. The panel considered the view of the family, noting that because of the physical nature of Adult 1's jobs, these were probably genuine. The Panel agreed that it was likely to be unproductive to approach Adult 1's previous employers in this context.)

4. Methodology

1. The Safer Solihull Partnership commissioned the Domestic Homicide Review in April 2018 and held a preliminary meeting at that time. It was agreed that Adult 1's family should be consulted at the earliest appropriate time to offer them the opportunity to participate in the review.
2. All agencies in Solihull who had contact with the victim and the perpetrator were required to complete a scoping return detailing their involvement with Adult 1 and/or Adult 2. The Domestic Homicide Review panel then determined which agencies were required to provide substantive Individual Management Reviews or information reports.
3. At the conclusion of the Domestic Homicide Review, staff involved in the case will be debriefed and the Safer Solihull Partnership will disseminate the key learning from the review.

5. Involvement of family, friends, work colleagues, neighbours and the wider community

1. The family of the victim have been supported by an organisation called Advocacy After Fatal Domestic Abuse (AAFDA) that specialises in providing support to victims' families by guiding them through enquiries including Domestic Homicide Reviews and Mental Health Reviews. They also assist with, and represent families at Inquests, Independent Office for Police Conduct (IOPC) inquiries and other reviews.

2. The Chair of the Domestic Homicide Review contacted family members by letter after the conclusion of the criminal proceedings. The letter included the Home Office information for family and friends about the Domestic Homicide Review process.
3. The family were given the option to speak to the Independent Chair of the Review in person, or by letter, or by any other suitable medium they might choose. They were satisfied with this level of engagement with the Domestic Homicide Review.
4. In December 2018, Adult 4 and Adult 6 met with the Independent Chair and the Safer Solihull Partnership Domestic Homicide Review Co-ordinator. They were supported by an Advocacy after Fatal Domestic Abuse advocate who was present for the meeting. The purpose of the Domestic Homicide Review was explained to them, as were the Terms of Reference for the review. Although the family had not yet engaged with the Domestic Homicide Review when the Terms of Reference were agreed (because the on-going criminal process precluded engagement with the family, who were prosecution witnesses) they were satisfied that the Terms of Reference were appropriate. They were also given the opportunity to suggest any areas of concern that were not yet being addressed. The Chair met with the family to consider the draft overview report on the 20th June, the 23rd September 2019, and the 26th January 2020. The family provided a final set of comments relating to the Domestic Homicide Review in February 2020, and saw the final version of the

Overview report following its presentation at the Safer Solihull Executive Board on the 5th March 2020.

5. Adult 4 and Adult 6 provided details of Adult 1's childhood and her life before and during her relationship with Adult 2. These views were crucial in understanding Adult 1's life and were an invaluable contribution to the learning.
6. The Chair and Domestic Homicide Review Coordinator also met in January 2018 with Adult 8, identified by the family as one of Adult 1's closest friends, who provided background from her perspective on Adult 1's professional life as well as her personality, attitudes and interests.

7. The review felt that the perpetrator may be able to contribute to the review and an invitation was delivered to him with the assistance of the Prison Governor. The perpetrator agreed to meet with the Chair. The Overview report includes comments from the perpetrator that were considered relevant and observations about his attitude to his life with Adult 1.

6. Contributors to the review

1. An Individual Management Review (Independent Management Review) and comprehensive chronology was received from the following organisations, all agencies Independent Management Review authors were independent of the events described in the reports and assurances to this effect were received from all agencies:

- West Midlands Police
- Birmingham and Solihull Clinical Commissioning Group
- Birmingham and Solihull Mental Health NHS Foundation Trust
- West Midlands Ambulance Service
- University Hospitals Birmingham
- Solihull Community Housing
- Bromford Housing

7. The Review Panel Members

Name	Agency	Title
Simon Hill	Independent	Independent Chair and report writer
Cath Evans (later represented by Loraine Longstaff)	Birmingham and Solihull Mental Health Trust	Head of Safeguarding
Melanie Homer	Birmingham and Solihull Clinical Commissioning Group	Designated Nurse for Safeguarding
DI David Sproson	West Midlands Police	Public Protection Unit Officer
Gillian Crabbe	Solihull Metropolitan Council	Solihull Councils Community Safety and Partnerships Manager
Maria Kilcoyne	University Hospitals Birmingham	Lead Nurse, Safeguarding Adults
Caroline Murray	Solihull Metropolitan Council	Solihull Councils Domestic abuse Co-ordinator

8. Author of the Overview report

1. The chair, Simon Hill, is a retired police public protection investigator with West Midlands Police, with twelve years' experience of child and adult safeguarding and major investigations in Edgbaston and Central Birmingham. He retired from the service in 2013. Prior to leaving the police service, he managed the Public Protection Review Team, responsible for writing the force's Independent Management Reviews and contributing to over thirty Domestic Homicide Review and child and adult Serious Case Reviews. He has chaired thirteen Domestic Homicide Reviews and adult Serious Case Reviews/Safeguarding Adult Reviews in the region. As a serving police officer, he has not worked in the Solihull area or had any professional involvement with the subjects of this Domestic Homicide Review. He has not worked with any of the agencies involved with the Domestic Homicide Review.

9. Parallel Reviews

1. The case was referred to HM Coroner, however no inquest was resumed.
2. Adult 1's homicide was not subject of any other parallel investigations since she was not open to the Birmingham and Solihull Mental Health Foundation Trust at the time of the homicide. This Domestic Homicide Review did not meet the criteria for an NHS England Mental Health Homicide Review.

10. Equality and diversity

1. The Domestic Homicide Review considered the nine protected characteristics under the Equality Act 2010:

- Age.
- Disability.
- Gender reassignment.
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity.
- Race.
- Religion or belief.
- Sex.
- Sexual Orientation.

2. The Domestic Homicide Review did not find any evidence that any of the protected characteristics were relevant to this review. The victim was of white European origin and was born and lived in the region for her entire life.
3. The review found no evidence that Adult 1 felt unable to access services, or that she encountered barriers of any kind. The review panel noted that the majority of domestic homicide victims are women and that studies have found that women aged over 40, (Adult 1 was 51 years old at the time of the homicide), are less likely

to contact specialist provision or call police. This tendency increases as women reach 55 years old.[2]

11. Dissemination

1. The overview report will be disseminated to agencies participating in the review, upon completion and quality assurance ratification from the Home Office.

12. Background information (the facts)

1. Adult 1 was 51 years old at the time of the homicide. She had two adult children; Adult 5, who in the period under review had a partner and children and lived locally, and Adult 4, who in the period under review lived with her at address 1, a Housing Association tenancy.
2. Adult 1 and Adult 2 (73 years old at the time of the homicide) had been in a relationship for around twenty-seven years. Adult 1 had a number of jobs in local shops and warehouses as well as working at the Airport. Adult 2 was a carpenter by profession and although he was retired for most of the period under review, he continued to do jobs for cash in hand.
3. Adult 2 had himself been married twice before. In the eighties, he married and had three children. Shortly after the conclusion of this relationship he met and married his second wife, who had a child of around seventeen months at the time. They also had a daughter together. They lived in Gloucester.
4. This relationship involved domestic violence and abuse by Adult 2 that culminated in a serious assault. Remaining Police records are scant, but it appears that Adult 2 assaulted her, punching her to the face and breaking her nose with part of an axe. In a previous incident, he also broke a milk bottle over a male victim's head and stabbed him in the leg with a chisel. He was convicted of grievous bodily harm in December 1987 and served a prison sentence.

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[2] Safe Later Lives: Older People and Domestic Abuse (October 2016)

5. Adult 1 and Adult 2 started their relationship in the early nineties. Adult 2 moved in with Adult 1 at start of the relationship. However, he maintained his own flat until their marriage in 2012 when he gave up his tenancy. The family saw this as a contributing factor, as he no longer had a place to go to 'defuse' the situation when the pair fell out.
6. In October 2017, the couple separated and for a period, Adult 1 chose to live with her son. Adult 4 remained at Address 1, as did Adult 2. Adult 2 sought a new Council tenancy of his own and was re-housed in January 2018 at Address 2. Adult 1 returned to her home (Address 1) in around January 2018.
7. Although they had separated, Adult 1 and Adult 2 remained in contact and met socially on occasion.
8. In early April 2018, on the evening before the homicide, Adult 1 and Adult 2 met for a meal and then went on for drinks at a local social club, where they met friends. It appears a disagreement ensued between Adult 2 and one of Adult 1's friends, who was vocal in her support of Adult 1 over the separation. Adult 1 and Adult 2 left, still arguing and went to Address 2, Adult 2's new flat. The argument continued and in the early hours of the morning, Adult 2 attacked Adult 1, beating her about the head, strangling her and stabbing her repeatedly in the torso. He then began calling and texting members of the family, as well as leaving voice messages in which he apologised for killing Adult 1 claiming, '*she had pushed him too far'.* Police were alerted and attended Address 2, where in spite of attempts to resuscitate Adult 1, she was pronounced deceased.
9. Adult 2 was arrested and taken to the Accident & Emergency of a local hospital because it was believed he had taken an overdose of Tramadol. He was later charged with the murder of Adult 1 and in August 2018, pleaded guilty and was given a life sentence with a recommendation he serve a minimum of thirteen years, four months in prison.

13. Chronology

1. Adult 1 had been three and her sister, Adult 6, eighteen months old, when they had moved to Birmingham with their father and stepmother. They grew up in a family of six girls, with four stepsisters. Three of the sisters were from their stepmother's previous relationship, and the youngest was the child of their father and stepmother. Adult 1 and Adult 6 had the same mother, but Adult 1 never knew her biological father. It was clear that Adult 1 and Adult 6 relied upon each other for comfort in a home where they experienced frequent physical abuse. Adult 6 reported being physically stronger than her sister and took on the role of protector of her sister.
2. According to Adult 6, the sisters grew up witnessing domestic abuse and violence towards their stepmother by their father. It was Adult 6's view that they were frequently physically abused by their stepmother in retaliation for the abuse she suffered at his hands. Sometimes, Adult 6 would take the blame for a minor transgression and '*take the beatings to protect Adult 1.'* Adult 6 reflected on the atmosphere in the home and remarked that they were never told that they were loved. She explained that Adult 1 and she had made a 'pact' never to let their children grow up in a loveless home and therefore placed a great emphasis upon their own family happiness, close ties and family 'get togethers'.
3. Their father was particularly abusive when he drank. Adult 4 described her grandfather as a '*horrid drunk'*. Adult 1 stayed at home until she was eighteen, when she married. Her husband, (now deceased) was extremely violent and Adult 1 was subjected to domestic abuse. They were married for only a year until Adult 1 discovered her husband's infidelity. According to Adult 6, when Adult 1 confronted him over this, he beat her, causing substantial bruising and injuries. He also sold all her personal possessions. Adult 1 returned to the family home.
4. At 23, Adult 1 was pregnant with Adult 4. The biological father did not want a child and left her to cope. Adult 1's father would not accept the pregnancy and made her move out. Homeless, Adult 1 was allocated a council flat. It was at this time that as a consequence of being homeless and vulnerable she apparently first self-harmed, cutting her wrists.

5. Adult 1 then met Adult 3, although the relationship did not last long, Adult 3 remained involved with the family and treated Adult 4 as his child. Adult 4 was three and Adult 5 eighteen months old when Adult 1 met Adult 2. Adult 7, from Adult 2's second marriage, spent a lot of time staying with Adult 1 and Adult 4 and was like a sister to Adult 4.
6. However according to Adult 4 and Adult 6, the relationship between Adult 1 and Adult 2 was increasingly characterised by violent and abusive arguments. They would go out drinking and both Adult 1 and Adult 2 would, according to Adult 4, be '*vile with their tongues'.* There was some evidence of physical abuse witnessed by Adult 4, but also by Adult 1's closest friend. It does not appear however that physical abuse was a frequent occurrence, or if it was, it was effectively kept from Adult 4 and Adult 6.
7. Adult 4 recollected one occasion when she was around aged seven, where Adult 3 had looked after her and Adult 7, whilst her mother and Adult 2 went out. They apparently returned drunk. After Adult 3 left, an argument broke out and Adult 2 hit Adult 1 over the head with a phone. Police and paramedics were called and Adult 2 was arrested. (From information given by Police to the Domestic Homicide Review it does not appear he was cautioned or charged).
8. The only other physical confrontation she could remember seeing between her mother and Adult 2 was when she was an adult. After a violent argument at the top of the stairs at address 1, Adult 2 hit Adult 1 who retaliated by hitting him, causing him to fall down stairs.
9. Adult 8 told the Domestic Homicide Review's Independent Chair that she was aware that Adult 2 could be physically abusive, although because Adult 1 kept a lot to herself, she was unclear how frequently it occurred. On one occasion (in the years before they married) Adult 8 saw Adult 1 with a cut on her face. She had apparently had a row with Adult 2. Adult 8 immediately challenged him over this. It was Adult 8's view that Adult 1 may have kept later violent episodes from her to prevent her confronting Adult 2 again. She remained, however, someone that Adult 1 could turn to for support, even if she chose not to disclose much about her

problems. Later, after bad rows with Adult 2, Adult 1 would on occasion go to Adult 8's and stay overnight because her flat was near Adult 2's.

10. Adult 8 remembered that as Adult 1's relationship with Adult 2 deteriorated and she tried to assert her independence, Adult 2 challenged Adult 8 saying, '*you're trying to break up my marriage*'. Adult 8 was clear that in Adult 2's mind the problems in their relationship were always someone else's fault.
11. Adult 1's family and friends were clear from personal observations that although in the first years of the relationship, Adult 2 had been capable of kindness, Adult 1 was unhappy from early in the relationship. Her friends could not understand why she had started a relationship with a man so much older than herself who, Adult 8 said Adult 1 agreed she did not love. Adult 4 always felt that Adult 2 became increasingly resentful of the close bond she had with her mother.
12. Adult 1 had a circle of friends, including Adult 8, who would meet for drinks at a social club. Adult 2 clearly resented them, was jealous and tried to prevent her spending time with them. If he came out with the group, he would be sullen, giving Adult 1 *'threatening looks',* finding unconvincing pretexts for why they had to leave. Regularly, the friends would witness rows, where Adult 2 told Adult 1 to leave with him and she refused. He would storm off and they were clear that the cost of Adult 1's defiance would be verbal abuse and rows later.
13. Adult 4 and Adult 6, as well as Adult 8 and her friends, knew that although Adult 1 had jobs, (she had worked at local retail stores) and earned her own money, Adult 2 kept a tight control over finances. Her friends believed Adult 2 would restrict her access to money if she went out, so they would end up buying her drinks. (This was not a situation that Adult 4 was aware of.)
14. According to Adult 4, when Adult 1 was experiencing depression, Adult 2 took control of Adult 1's bankcard and she had to ask for money. In his discussion with the Chair, it became clear that he felt he had the right to control what she should buy, because he resented her online purchases. He did not believe there was any problem in restricting Adult 1's autonomy in this way.
15. This is a recognised element of coercive controlling behaviour described by Women's Aid; "*It's important to understand that financial abuse seldom happens*

in isolation: in most cases perpetrators use other abusive behaviours to threaten and reinforce the financial abuse. Financial abuse involves a perpetrator using or misusing money that limits and controls their partner's current and future actions and their freedom of choice. It can include using credit cards without permission, putting contractual obligations in their partner's name, and gambling with family assets. Financial abuse can leave women with no money for basic essentials such as food and clothing. It can leave them without access to their own bank accounts, with no access to any independent income and with debts that have been built up by abusive partners set against their names'. (The Domestic Abuse Act that came into force in 2021, includes all forms of economic abuse in the definition of domestic abuse.)

16. Adult 8 was aware that Adult 1 was drinking more heavily when they went out. She was clear that any binge drinking was a coping mechanism to mask her unhappiness. Adult 4 was away at University from 2006 to 2009 and although she came home frequently, it is probably true that Adult 1 missed the comfort and support she offered when her relationship with Adult 2 deteriorated.
17. There was a view shared by the family and friends who spoke to the Chair that the wedding to Adult 2 in 2012 had been understood by them as Adult 1 wanting to channel all her energies into a special day. When her father had died in 2010, she had inherited a small amount of money and she intended to use it for a special white wedding. Adult 4 and Adult 6 remembered how Adult 1 channelled all her energies into planning the wedding, and Adult 8 remembered how happy Adult 1 had been on her 'hen-do' in Spain.
18. After their wedding, Adult 2 and Adult 1 started to live together, and this coupled with a sense of anti-climax, led to a rapid deterioration in their relationship.
19. It does not appear (with the one exception described by Adult 4) that the Police had any reported involvement with Adult 1 or Adult 2, until the tragic events surrounding the homicide. All available evidence and research, as well as Domestic Homicide Review findings makes it clear however, that the absence of reported domestic abuse is not a reliable indicator of the extent of domestic abuse occurring in relationships. The descriptions of their married life given by family and

friends make it evident that Adult 2 was controlling and abusive. With hindsight it is apparent that the nature of many of Adult 1’s presentations to health professionals were a strong indication of potential domestic abuse in the relationship with Adult 2.

20. In adolescence and early adulthood, Adult 2 had a history of offences unrelated to domestic abuse and violence until the serious domestic assault upon his second wife in 1987. This can be seen with hindsight to have been an early indicator of risk to subsequent partners, but during the period under review, no agency, including police, had reason to find out or enquire into this early domestic abuse history.
21. There was no relevant agency involvement with Adult 2 in the period under Review. The Domestic Homicide Review will examine Adult 1’s life subject to Adult 2’s controlling behaviour and propose reasons why she may have felt either unable or unwilling to report abuse. The Review will identify any missed opportunities where professionals could have explored, in a safe way, Adult 1’s experience of abuse.
22. Adult 2 acknowledged to the Chair in his meeting with him, that he had a ‘quick temper’. He had also apparently been involved in a violent ‘road rage’ assault that the Domestic Homicide Review had not been made aware of.
23. However, over the span of the relationship between Adult 1 and Adult 2, Adult 1 had numerous contacts with health providers, including hospitals, GPs and mental health services which provided opportunities to safely ask questions of Adult 1 to establish whether she was experiencing domestic abuse. Some of the surrounding circumstances of the presentations to health professionals should have prompted this questioning and can be seen as missed opportunities to offer Adult 1 support and pathways to help.
24. This Domestic Homicide Review acknowledged that over the period under review, training of professionals around domestic abuse, and policy (both National and local), changed to reflect greater awareness of domestic abuse and coercive and controlling behaviours. The chronology of events considers the safeguarding opportunities and responses in context. In the analysis, the Domestic Homicide

Review establishes what changes have been made by health providers to properly equip their professionals with appropriate guidance and training in relation to domestic abuse. The review considers what remains to be done to improve the likelihood that faced with similar facts, health professionals would identify domestic abuse and provide a victim like Adult 1 with pathways to support.

25. Adult 1 presented at the hospital emergency department 15 times in the fifteen years between 2002 and November 2017. (This did not bring her within any accepted definition of a frequent attender[3] which is generally considered to be 5 or more times per year, however this seemed to the panel to be a troubling aspect of this case, given evidence that many women experiencing domestic abuse present at Accident & Emergency with injuries numerous times before being offered effective support. It is possible that some of the presentations explained by Adult 1 as accidental injuries were the result of domestic abuse.)
26. Adult 1 explained the first recorded presentation in September 2008 as a torn muscle at work. (It has not proven practicable to confirm this with workplace records. However, Adult 4 was clear that because of the heavy manual handling her mother was expected to do at warehouse jobs with national supermarket and household goods companies, the work-related injuries were probably genuine.)
27. In 2009 she presented with right-sided pain following a fall and in November with head and wrist injuries after an accidental fall down stairs.
28. Adult 1 gave the same reason for an injury presentation in August 2013. Adult 4 recalled that her mum disclosed to her that the incident and presentation was as a result of throwing herself down the stairs.
29. Over the following two years, Adult 1 disclosed to her GPs and to mental health professionals significant depressive symptoms and identified what she believed were the underlying causes of her low mood and thoughts of self-harm.
30. In April 2014, Adult 1 first disclosed to a GP that she had a 'poor relationship' with her husband. She also described what the GP noted as '*drinking huge amounts, approx. 32 units over the weekend.*' At a later consultation that year the GP

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[3] Royal College of Emergency Medicine. Best Practice Guidelines- Frequent Attenders in the Emergency Department August 2017

recorded that she was' *binge drinking when not at work'*. The GP noted she had been on anti-depressants for over 10 years. She was apparently experiencing '*significant anhedonia* [4] .'Adult 1 also mentioned being depressed over work changes. She was advised to seek counselling.

31. The Clinical Commissioning Group Individual Management Review highlighted this and another consultation in 2014 and five in 2015 where Adult 1 provided, '*some limited insight into her home circumstances and where domestic abuse should have been considered and pro-active enquiry may have given her opportunities to disclose and be offered specialist domestic abuse support services.*'
32. In July 2014, Adult 1 was referred by her GP to mental health services because of low mood. The GP also recorded that Adult 1 was drinking more but the records did not elaborate what this meant. In October, the GP noted that there had been contact from Healthy Minds[5] offering an appointment but Adult 1 stated she had not received the letter.
33. The engagement that Adult 1 had with secondary mental health services over the next three years followed a pattern of referral, discharge, and re-referral.
34. Patient care is provided by Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) following the Care Management & Care Programme Approach (CPA)/Care Support Policy. Following a '*comprehensive assessment of their health and social care needs including vulnerability',* Care Programme Approach is provided for patients on a number of criteria including dual diagnosis, history of self-harm. Care Programme Approach involves more intensive supervision by the Community Mental Health Team (CMHT). Care Support represents a lighter touch, with a lead clinician agreeing a care support plan with the service user that includes intended outcomes, and relapse prevention strategies. The service user would be reviewed every six months or as a minimum every twelve months.

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[4] People who experience **anhedonia** have lost interest in activities they used to enjoy and have a decreased ability to feel pleasure. It's a core symptom of major depressive disorder, but it can also be a symptom of other mental health disorders.

[5] Healthy Minds is an NHS primary care psychological therapies service that works closely with Birmingham GPs. HM offers advice, information and brief psychological talking therapies for people aged 16 and over, who are often feeling anxious, low in mood or depressed

35. A Psychiatric consultant from the Community Mental Health team saw Adult 1 in August 2014 and she spoke of childhood abuse from her stepmother, low mood and occasional binge drinking. She stated she first self-harmed when she was 21, (1987). She also disclosed that the accidental fall downstairs in 2013, had been deliberate self-harm, and a suicide attempt. She spoke of her 20-year relationship with Adult 2 and their marriage two years before. There is no evidence that this relationship was explored in any depth and the possibility of domestic abuse being a relevant trigger considered. The Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) Individual Management Review noted that there was a lack of professional curiosity at this and subsequent assessments and noted family details, particularly those of her husband, were not recorded.)
36. The consultation led to a review of Adult 1's anti-depressants and a recommendation that she self-engage with the Improving Access to Psychological Therapies Service for a psychological input. It appears that Adult 1 was not considered suitable by the Improving Access to Psychological Therapies service because *'she was currently experiencing difficulties with her alcohol consumption.'* The service felt she should first engage with Alcohol services to seek to reduce alcohol intake before therapeutic services would be of benefit. The review has not been able to establish the reason for this decision, as the Improving Access to Psychological Therapies team apparently have no record of Adult 1 being denied access to this service. (This information was drawn from the GP's notes and there is no reason to doubt their accuracy.) The BSMHFT have since suggested the reason may have been that she was already receiving psychological support from Solihull MIND. The GP did not advise Adult 1 (or it was not recorded), to engage with Solihull's alcohol services, but rather advised her to reduce her alcohol intake. There was apparently no referral made to Solihull Alcohol Treatment services.
37. Adult 1 was re-referred to mental health services by her GPs in December 2014 because of continuing low mood and self-harm. From January 2015, Adult 1's care was provided under Care Support rather than the more intensive Care Programme Approach.

38. She was assessed by a psychiatrist in February 2015, during which she disclosed she had taken an impulsive overdose with alcohol 'a *couple of weeks previously',* following an argument with her husband. The presence of self-harm, low mood and continued occasional binge drinking meant that she was now identified as at higher risk, requiring a consultation with a psychiatric consultant that the Community Mental Health team arranged. This medical assessment with a consultant was not finally organised until April. It seems very unfortunate that a patient with a recorded higher risk level was not seen more promptly and a further self-harm incident meant that the consultation was brought forward as a crisis response.
39. On the 2nd May 2015, Adult 1 took an overdose of medication, combined with alcohol and cut her wrists. The hospital records showed Adult 1 had been out and had drunk five pints. Once home, Adult 2 had caused an argument with Adult 1. She had apparently been playing a song that '*reminded her of her deceased father and said she wished she was with him.'* Adult 1's relationship with her father had not always been positive and it would appear that the memory represented a trigger for her own suicidal thoughts rather than an indicator of a deep sentimental attachment. This led Adult 2 to make insensitive and provocative comments. She went downstairs and cut her wrists.
40. During the admission, the Rapid Assessment Interface and Discharge Team (RAID) carried out an assessment that included Adult 1 denying she was experiencing marital problems. The team recognised however that her husband's taunts constituted 'psychological abuse' and recorded a possible threat. The University Hospitals Birmingham Independent Management Review found no record of a referral or signposting to Domestic Abuse support services. (However automatic referral from the hospital to domestic abuse services generally only occur for high-risk cases. Otherwise, women are given pathways for self-referral.)
41. The review and mental health assessment with a psychiatric consultant took place on the 6th May. Now discharged from hospital 'to the Community Mental Health team, the consultant advised Adult 1 to '*completely stop drinking alcohol in the medium term. This is with a view to reducing impulsivity.*'

42. She disclosed that she '*would be discussing the issues from the recent past with her husband. She feels that the relationship is 'stuck in a rut'.* The psychiatrist did not apparently make a referral to alcohol support service that might have prompted her engagement.
43. Although the psychiatrist's letter to the GPs described the fact Adult 1 had consumed six pints before the incident, there does not appear to have been a request for GPs to seek a referral to alcohol services. The GP's notes of the discharge make no mention of the consultant's aim to encourage Adult 1 to completely abstain from alcohol in the 'medium term.' Nor is there any evidence that Adult 1's use of alcohol was discussed in any of the six subsequent GP appointments (two of which were telephone encounters) between May and October 2015.
44. The discharge letter from the Community Mental Health Team to the GP described her saying '*communication poor between her and husband so tensions build up and come out as they did do last weekend*.' Adult 1 stated she was no longer suicidal and that she was being supported by her daughter, Adult 4, and Adult 2. (It is of note that the Clinical Commissioning Group Individual Management Review identified that in discussions with Adult 1 about her support, Adult 1 never gave Adult 2's name as providing support to her.)
45. In her mental health notes in May 2015 the team recorded '*there are stresses within her relationship with her husband. She feels that he always has to be right about everything. Stated she was unhappy about relationships she had had over years.*' She was apparently now engaging with counselling at Solihull MIND charity. (Both Adult 8 and Adult 4 informed the Review, that Adult 1 had been very positive about one particular counsellor). However, Solihull MIND have been unable to find any record that Adult 1 had engaged with their service.
46. At her next mental health Review at the end of May 2015, Adult 1 explained to the consultant psychiatrist that she had '*made up with her husband after the previous difficulties.* They had both identified; *'their drinking of alcohol as an issue for them*.' It does not appear that the couple's shared vulnerability when drinking alcohol was explored with a view to offering support to either Adult 1 or Adult 2.

47. In August 2015 at a third review with the Community Psychiatrist; Adult 1 claimed to have reduced her alcohol intake. On this basis, she was discharged to her GP's care.
48. In October 2015 Adult 1 again presented at Accident & Emergency with a further overdose, whilst under the influence of alcohol and with wrist lacerations. There was no direct questioning about domestic abuse during the hospital admission because it did not form part of hospital procedures. The Rapid Assessment Interface and Discharge team were told by Adult 1 she was due to attend Change Grow Live (CGL) Initiatives [6](Birmingham drugs and alcohol service). For her part, Adult 1 apparently acknowledged that, '*she has to stop drinking and that her sister has promised to support her in stopping*.'
49. If Adult 1 self-referred to the service, there is no indication that her GPs were aware and no record of communication between the service and primary care providers. The Birmingham and Solihull Mental Health Foundation Trust Independent Management Review acknowledged that there was no documentation that showed any liaison with their services. Adult 1 was not open to them nor was there any indication that a referral to support Adult 1 to access and engage had been made. The Domestic Homicide Review has found no evidence that Adult 1 ever attended any substance misuse alcohol treatment services either in Birmingham or Solihull.
50. The hospital, at the time, employed an alcohol-screening tool that was used in May and October 2015, but according to the University Hospitals Birmingham Independent Management Review, '*the score was inaccurate because she told staff that she doesn't drink and no further action was advised*.' The tool was discontinued in 2017, as learning from its' use suggested there was '*little benefit for patients*.'
51. In the consultation with a Rapid Assessment and Interface and Discharge Team specialist clinician during the October admission, Adult 1 apparently said '*her relationship with her husband was good and that he was supportive.*' This

[6] Crime Reduction Initiatives (CRI) were service providers of alcohol services at this time. In April 2016 they rebranded to Change, Grow, Live. In November 2016 alcohol services in Solihull were taken over by Solihull Integrated Addiction Service (SIAS)

consultation could have been an opportunity to discover more about what the problems had been and Adult 1's coping strategies. There is little evidence that Adult 2 was actually supportive of Adult 1; indeed a contributory factor for her self-harm in May 2015 had been his taunting of her.

52. Although she had an appointment with the Community Mental Health Team booked in November 2015, she did not attend and she was discharged to her GP.
53. There was no mental health involvement with Adult 1 in 2016 although she was seen by her GP and in A&E for headaches, another head injury at work, and pain in her abdomen/right side.
54. In a review with a practice nurse in November, Adult 1 was asked about alcohol consumption. This is the only evidence in the Clinical Commissioning Group chronology, that Adult 1's alcohol consumption was being addressed. It was recorded as 'monthly *or less 1-2 drinks, never has six or more drinks on one occasion.'*[7] The screening was probably in the context of a Quality Outcomes Framework which was in existence at the time and directed questioning around alcohol consumption[8]
55. In May 2017, Adult 1 presented to her GPs and then ambulatory care at the hospital with headaches and a bruised eyelid and stated she had experienced blurred vision the previous day. The GP was told there had been no head injury and accepted this account. There was no attempt to discuss potential domestic abuse with Adult 1. It does not appear that there were any direct questions around domestic abuse asked in Accident & Emergency either.

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[7] This enquiry was probably part of a Quality Outcomes Framework drive for alcohol screening, relying upon open and honest disclosure, rather than a considered response to the patient's history

[8] The Department of Health decides on measures, called indicators, every year, and gives GP practices points based on how they are doing against these measures.

The indicators change every year but in general they cover:

- Management of some of the most common chronic conditions, for example asthma and diabetes
- Management of major public health concerns, for example smoking and obesity
- Providing preventative services such as screening or blood pressure checks

56. In November 2017, Adult 1 was taken to Accident & Emergency following a third overdose; she explained she had taken Sudafed, Ibuprofen and Venlafaxine mixed with alcohol. She reasoned to Accident & Emergency staff and the Rapid Assessment and Interface and Discharge Team that this had been an impulsive reaction to the news her son might lose his job due to unauthorised absences. Further enquiries revealed she had been on '*on a break from her husband'* for the last four weeks. The next day Adult 1 was discharged stating she intended to return to Solihull MIND where she had a good relationship with one specific counsellor. She had no further involvement with mental health services.
57. Adult 1 was reviewed by her GP in January 2018. She reported she had split from her husband three months before and this had triggered her depression. Adult 1 disclosed she had been '*drinking heavily before Christmas but says had stopped now.'*
58. Adult 1 had no more relevant encounters with health professionals or any other agency before the homicide.

14. Analysis

1.1 Recognising the interrelationship between domestic abuse, substance misuse and mental health vulnerability and addressing them holistically.

1. The Domestic Homicide Review gathered an understanding of Adult 1's life primarily through the vital conversations with her family and friends, which helped the review panel to understand her lived experience. The agencies' Independent Management Reviews, through their conversations with professionals who had provided care to Adult 1, assisted the Domestic Homicide Review to identify whether she could have been supported more effectively.
2. During numerous appointments and assessments over the period under review, Adult 1 disclosed to her GPs, to Rapid Assessment and Interface and Discharge Team and Community Mental Health Teams adverse childhood experiences, binge

drinking, low mood, depression, impulsivity leading to self-harm, and a deep unhappiness. Difficulties in the relationship she experienced with Adult 2 were often mentioned, but were rarely explored by professionals in detail, as envisaged by the National Institute for Health and Care Excellence (NICE) guidelines.

3. Analysis of health professionals involvement with Adult 1, in this case, must be viewed against the guidance offered to them by the National Institute for Health and Care Excellence (NICE) in their recommendation to service commissioners on 'asking the question'[9] which states:

Health and social care managers and professionals should:

- *Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence and abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe and in a kind, sensitive manner.*
- *Ensure trained staff in…. mental health, ask users whether they have experienced domestic violence and abuse.* ***This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.*** (Chair's emphasis.)

4. Best practice was clearly established in 2014. All health care frontline staff should be trained to be able to ask the questions sensitively. GPs should be aware of known health markers as triggers for sensitive enquiry. Mental health professionals should routinely ask questions even where there are no indicators. Professionals within Accident & Emergency should be aware of the frequency with which women present with injuries resulting from domestic abuse and feel able to make safe enquiry relating the to the aetiology of the presentation. It is not enough to provide a person with the opportunity to disclose; they should be supported to do so with appropriate questions.

[9] National Institute for Health and Care Excellence (NICE) public Health Guidance 50 (Feb 2014) Domestic abuse: how health services, social care and the organisations they work with can respond effectively

5. The Quality Standard on Domestic Violence and Abuse [10] requires of providers (secondary and tertiary providers of health services) and commissioners (Clinical Commissioning Groups) that they '*ensure that health…practitioners are trained to recognise the indicators of domestic violence and abuse* 'and that practitioners '*recognise indicators of domestic violence and abuse and respond immediately. They make sensitive enquiry of people presenting with indicators of domestic violence or abuse about experiences as part of a private discussion and in an environment in which the person feels safe.* '
6. The Domestic Homicide Review was mindful that the NICE Guidance and Quality Standards referred to are not mandatory upon health providers, but best practice would be that relevant Health Trusts and Clinical Commissioning Groups adopt this guidance within their Domestic Abuse Policy and Procedures. This Domestic Homicide Review identified how far the Clinical Commissioning Group, Birmingham and Solihull Mental Health Foundation Trust and University Hospitals Birmingham had taken on board the NICE guidance and made efforts to embed it in practice during the period under review.
7. The Independent Management Review authors for the Birmingham and Solihull Clinical Commissioning Group, relating to Adult 1's GP care, Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) commenting on the Rapid Assessment and Interface and Discharge Team assessments in hospital and the Community Mental Health teams engagements thereafter, as well as University Hospitals Birmingham's relating to Accident and Emergency treatment, all identified some common features, as identified below, of their engagements with Adult 1.
8. In the period under review, the policy, procedure and practice of all three agencies had not yet 'caught up' with relevant NICE guidance. The Birmingham and Solihull Mental Health Foundation Trust, University Hospitals Birmingham, and Birmingham and Solihull Clinical Commissioning Group Independent Management Reviews all identified missed opportunities to make enquiry of Adult 1 relating to domestic abuse. At the time, none of the agencies had actively promoted this best

[10] NICE : Domestic violence and abuse QS 116 published 29 February 2016

practice to their frontline staff. It is unfortunate that some of these missed opportunities were nearly three years after best practice had been re-issued by NICE. It should also be acknowledged that the 2014 NICE guidance served to provide more detailed advice building upon previous guidance that had existed for several years. The need to 'ask the question' both routinely and when health indicators were present, had been detailed as early as 2000 in the Department of Health 'Domestic Violence: a Resource Guide for Health Professionals.'

9. As a consequence of these organisational shortcomings, the possibility that domestic abuse was the cause of much of Adult 1 vulnerability, seemed to be the 'elephant in the room'. Even when presented with obvious cues to make safe enquiry, domestic abuse was not really explored, merely noted, thus preventing appropriate exploration of the abuse that was present. It does not appear that Adult 1 herself acknowledged this as a real possibility as the source of her problems, concentrating instead upon her bereavements, and adverse childhood experiences. Yet Adult 1's lived experience illustrates why professionals need to 'ask the question' and not wait for a victim to disclose.
10. Adult 1's family felt that she would not have considered herself to be a victim of domestic abuse. (This is not an unusual observation from friends and family where women experience coercive controlling behaviour.) They did not feel she would have raised it as her central problem without prompting. In fact, some of the reasons she gave to professionals for her self-harm, (her son's job being at risk) appeared to be conscious or unconscious attempts to deflect attention from domestic abuse.
11. However, the close circle of friends who socialised regularly with Adult 1 were for their part increasingly aware of the impact Adult 2 had upon her. Adult 8 told the Independent Chair they all saw a physical deterioration in their friend over the years before the homicide; they recognised how Adult 2 would '*grind her down'*. Although Adult 1 was able to control her levels of drinking, Adult 8 recalled Adult 2's behaviour meant that '*she went back on the drink again. We knew it was her way of coping*.'

12. As Adult 1 planned the final split with Adult 2, according to Adult 4, she was '*flip-flopping… she did not know what to do*.' Adult 1 was apparently coming to terms with the considerable barriers, placed in front of her by Adult 2, to discourage her from leaving. Adult 4 recognised that her mother was pacifying him because when she did not contact him, Adult 2 harassed her by '*bombarding*' her with texts. He told Adult 4 in the final months before the homicide, 'I *love her and if she does leave me I will kill her before I let anyone else have her*.' Adult 8 said of this; '*We suspect he was one of those people who couldn't have her so no one could*.'
13. Adult 1's increasing determination to break away from Adult 2 marked, in the family's view, a decisive shift in the power and control balance between Adult 2 and Adult 1. It is perhaps also the case that Adult 1 was aware of the escalation in Adult 2's controlling behaviours and realised that she had to get away from him.
14. With hindsight, Adult 8 saw that Adult 2's controlling behaviours became worse as he grew older and the impact of the age difference became more evident. He was no longer in work due to ill health; Adult 1 was becoming, '*less reliant on him*.' When the split occurred Adult 8 recognised,' *he was older, in his 70s, he was losing everything, not working, losing his wife and home.'*
15. Apparently, in early 2018, Adult 2 accessed Adult 1's Facebook account and discovered messages exchanged with a friend from the pub. Adult 2 said to Adult 4 'I *know that guy from the pub likes her and I will kill him first*.' It appeared that the family saw these threats as bluster, since they doubted he would have the strength to intimidate anyone else, or for that matter, Adult 1. (This is a common reaction where abuse and risk of harm from older people is minimised.)
16. Criminologist Nils Christie [11] described the tendency for people to have a preconceived idea of the 'ideal victim'; someone who is vulnerable and therefore who elicits the most public sympathy when victimised. It is possible that when someone does not readily fit that preconception, (as was the case with Adult 1 and her family's miscalculation of her vulnerability) the potential risk they are running from an abuser is downplayed also.

[11] Nils Christie ' the Ideal Victim'

17. During his conversation with Adult 2 in prison, the Chair pointed out the evident long history of unhappiness in the relationship. When asked to describe what part the perpetrator felt he had played in the breakdown, he denied any responsibility, blaming Adult 1's childhood, the adverse influence of other people, on her unhappiness. The Chair asked the perpetrator to describe which elements of his own behaviour Adult 1 had complained about over the years. He sat in silence and when pressed, said he could not recollect any.
18. It is a very common trait of domestic abusers that they will accept no blame for the consequences of their abusive behaviours. Adult 2 was clear he felt he had been generous and understanding and seemed to be in wilful denial. The combined impact of the perpetrator's wilful controlling behaviour and lack of empathy for Adult 1's needs, seemed to the Review to be at the heart of her unhappiness.
19. A failure to recognise coercive and controlling relationships as abusive behaviour remains common both amongst professionals but also the community. It is for that reason that professionals must have a clear understanding of this type of domestic abuse, to help victims to see it for themselves and 'unlock' the possible trigger for self-harm, low mood, depression, and an increased use of alcohol.
20. Crucially this Domestic Homicide Review confirmed what has been found in previous Domestic Homicide Reviews[12] and studies[13]; that where a person presents with mental health vulnerabilities and an increased/harmful use of alcohol, professionals need to be aware that domestic abuse may be the trigger and that attempting to address any one presenting problem in isolation is likely to be ineffective. All the more reason for safe enquiry relating to domestic abuse to be undertaken.
21. The practice of the GP's in this case was clearly supportive of Adult 1 in relation to her depressive symptoms and they secured access to crisis mental health support in a timely way. Yet Adult 1's use of alcohol seems, with hindsight, to have been a

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[12] Domestic Homicide Reviews KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS December 2016

[13] Stanley N, Cleaver H, Hart D (2010) "The Impact of Domestic Violence, Parental Mental Health Problems, Substance Misuse and Learning Disability on Parenting Capacity" The Child's World. 2nd edition, London: Jessica Kingsley Publishers

trigger for impulsive self-harm and for domestic arguments but seems not to have been addressed with the same level of commitment. It is well recognised that many women turn to alcohol as a coping mechanism when experiencing domestic abuse and health professionals need to be alive to this possibility.

22. In spite of repeated evidence that Adult 1's drinking was linked to self-harm episodes, and the direct advice of the Community Mental Health Team psychiatrist that Adult 1 should aim to abstain from alcohol completely, there appeared to be no agreed plan shared between primary care and secondary mental health services to support her to address her levels of drinking.
23. Although after the Improving Access to Psychological Therapies service declined Adult 1's referral, the mental health team still indicated engagement with alcohol services may be a better pathway, it does not appear to have been consistently followed up. It was noted by the domestic homicide review that Improving Access to Psychological Therapies was not a service provided by the Birmingham and Solihull Mental Health NHS Foundation Trust, so they had no influence on Adult 1's apparent ineligibility. There is no record of Adult 1's GP's ever suggesting she engage with alcohol services, or if they did, it does not appear to have been recorded.
24. There appeared to be an over reliance upon self-disclosure and an overly optimistic acceptance of Adult 1's assurances that she had reduced her alcohol intake. The repeated self-harm episodes, where Adult 1 took overdoses with alcohol, should have at least triggered a detailed review of her alcohol use. Studies have shown that victims living with anxiety and depression may consequently experience difficulty in engaging with services.[14] (The Domestic Homicide Review will develop in section 14 'supporting women with complex needs' the current preferred response in Solihull and Birmingham to these complex related needs.)
25. In relation to Adult 1's mental health, the care provided by the Birmingham and Solihull Mental Health Foundation Trust appeared to be appropriate and supportive, but was less effective in its response to the complex family circumstances and the interrelated nature of all the presenting problems. Most

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[14] Blue light Research (2016) Page 12

specifically, there was no evidence that psychiatrists and practitioners did more than touch upon the possibility that there was domestic abuse within what they knew to be a relationship that was troubled.

26. The Care Programme Assessment (CPA) framework, in place since 2011, included a clear question about current or historic violence and abuse and a requirement to explain why this has not been asked.
27. The Birmingham and Solihull Mental Health Foundation Trust Independent Management Review acknowledged that NICE guidance was not embedded during the period under review because it was not until 2015 that the Trust introduced a named nurse for domestic abuse following the appointment of a new Head of service for Safeguarding. It was at this point that, '*the development of Domestic Violence and Abuse policy was initiated and a clear commitment organisationally to embedding the principles of routine enquiry, identification and response into core mental health practice*.' The Birmingham and Solihull Mental Health Foundation Trust Independent Management Review explained, '*in 2014 and 2015 there could be no expectation that all staff would be asking routinely about domestic violence and abuse specifically. It would be dependent on individual practitioner's knowledge and skills*.'
28. In relation to the GPs who saw Adult 1, there appeared to be an incomplete understanding of the significant impact of domestic abuse upon mental health and its linkages with the consumption of alcohol. They apparently failed to explore Adult 1's low mood, depression or her marital disharmony as a possible indicator of the presence of domestic abuse and did not explore this area using framing questions that their professional bodies and NICE guidance requires, or if they did, did not record the fact.
29. It is the Chair's view drawn from being involved in numerous Domestic Homicide Reviews in the region that this shortcoming in responses would not have been unique to this practice and would have been widespread across GP surgeries.
30. Although guidance on supporting patients at risk from domestic abuse had been available from the Royal College of General Practitioners for some years before the period under review, including joint guidance with Coordinated Action Against

Domestic Abuse, (now Safe Lives) first issued in 2012, the relevant Clinical Commissioning Groups could not point, in 2014- 15 (the period of Adult 1's most frequent presentations), to the kind of early identification and support they have promoted recently. (Developed below in section 14.1.2.1)

31. The Clinical Commissioning Group Independent Management Review author spoke with two of the key GPs still at the practice that supported Adult 1. There was evidence that the practice had since sought to raise their domestic abuse awareness. They showed a reflective attitude, acknowledging that with hindsight, some presentations (the eye injury in May 2017 being an example) needed closer scrutiny and would prompt them now to '*ask the question'*. They showed insight in relation to GP presentations post-separation, and the increased risk of domestic abuse for victims at this sensitive time. The Practice signed up with IRIS[15] in 2018, and subsequently made numerous domestic abuse referrals. (Improvements to GP training and identification of domestic abuse that have been made in Birmingham and Solihull in the last 24 months are described in section 14 below.).
32. The Domestic Homicide Review has concluded that whilst the healthcare Adult 1 received was timely and appropriate, it is far from certain that she had encountered opportunities and sufficiently supportive situations to disclose domestic abuse with appropriate sympathetic questioning by either her GP's or the Mental Health Team. In the absence of any recorded evidence or direct testimony from the professionals involved, it must regrettably be concluded that such routine or selective enquiry may not have occurred in Adult 1's case. Given that Adult 1 never disclosed domestic abuse to her family, it is not certain she would have done so had she been asked by any of the professionals she encountered. However, had professionals been better prepared, and consistent in their approach to empathetic enquiry, Adult 1 may have felt safe and able to disclose details about the relationship and abuse she was being subjected to.
33. It is therefore important that the agencies contributing to this review can demonstrate that policy and practice has changed and that it is having a positive

[15] Identification and Referral for Improved Safety (IRIS) is a general practice-based domestic violence and abuse (DVA) training support and referral programme

impact upon practice. At the very least, best practice would require that in similar circumstances patient records of both GP's and Mental Health services would show that Adult 1 was asked questions about domestic abuse at least once, but ideally on several occasions. Without evidence that professionals had addressed this issue in this case, domestic abuse remained at best an unresolved but obvious risk.

34. The NICE guidance gives both commissioners and providers guidance on suitable measures of effective implementation. In the NICE Quality Standard of 2016, the quality measure is a **structure**; '*evidence of local arrangements to ensure that people presenting to frontline staff with indicators of possible domestic violence and abuse are asked about their experience in a private discussion'*
35. The **process; '***is the proportion of people presenting to frontline staff with indicators of possible domestic violence or abuse who are asked about their experience in a private discussion***.'**
36. Thereafter following disclosure, the quality standard **structure**: states '*referral to specialist support for people experiencing domestic violence and abuse requires evidence of local referral pathways and evidence that specialist support services are available'.* **Process**: *proportion of people who disclose that they are experiencing domestic violence or abuse who are referred to specialist support services.*
37. Whilst all training that raises general awareness of domestic abuse is helpful the specific skills needed to carry out safe enquiry (or routine enquiry in the case of Adult Mental Health Services) need to be a distinct part of a training session. This area is a specific module when Identification and Referral for Improved Safety (IRIS) trains participating GP practices. Professionals do need to be given ideas of 'framing questions' and the kind of targeted questions they should consider afterwards. The University Hospitals Birmingham Independent Management Review author explained that NICE guidance on appropriate framing questions in a conversation will be used by the Trust as best practice in guidance to all Accident and Emergency staff. They will be encouraged to make use of them as part of their routine practice.

38. The Domestic Homicide Review is aware that the accessing of mandatory Safeguarding training is the responsibility of individual GPs practices, and that Domestic Abuse and Level I and II Safeguarding training online is provided by NHS England. Public Health England commissioned *Against Violence and Abuse (*AVA) to refresh their free e-learning modules to align with the NICE guidelines on domestic violence and NHS professionals, and provide free access to level 1 and level 2 training
39. The NICE Guidance 50 (2014) and QS 116 (2016) and West Midlands Domestic Abuse and Violence Standards (September 2015) are the current benchmark for best practice in health settings and in the light of their review's finding, the Clinical Commissioning Group and Birmingham and Solihull Mental Health Foundation Trust should consider best practice guidance to remind professionals of the expectation that they will ask the questions of patients who present with indicators of domestic abuse.

1.2 Supporting women with complex needs

1. There was a lack of joined up working when faced with the multiple triggers for Adult 1's low mood. Whilst each agency could probably provide a cogent explanation of how they had addressed their specific area of care, there was no real sense that all professionals had a joint understanding of the combined impact of all the presenting problems.
2. This Domestic Homicide Review has also identified that Adult 1's complex needs were not effectively addressed. She experienced anxiety and depression for many years (caused in part by traumatic childhood experiences and by the abuse she was subjected to by Adult 2 for around 27 years) and some problematic alcohol use accompanied by impulsive self-harm episodes. It is very likely that her experience of domestic abuse in early adulthood had an impact upon Adult 1's wellbeing. In addition, whilst she never reported domestic abuse in relation to Adult 2, the compelling evidence available to the review from family friends and the Independent Management Reviews of agencies involved with her,

demonstrates that she experienced domestic abuse characterised by coercive and controlling behaviour.

3. A recent review of repeat/serial high-risk cases at Solihull Multi Agency Risk Assessment Conference (MARAC)[16] identified that most frequently, the MARAC victims had complex needs, and specifically they had often experienced a 'trio of vulnerabilities'. Where alcohol use and mental health vulnerability (the dual diagnosis) were identified, domestic abuse was also often reported. Whilst not causing domestic abuse, harmful levels of alcohol use and mental ill-health by the victim can place women at greater risk. They can lead to more severe abuse by perpetrators and increased dependency by victims. This dependency makes it difficult to implement positive interventions to reduce risk. Existing services are not person-centred, set up to provide concurrent interventions across multiple needs. Victims with dual diagnoses commonly have a weak history of engagement with agencies and are often described as 'hard to reach'. It is clear that Adult 1 was not known to agencies as a victim of domestic abuse, because she chose not to, or was unable, to disclose any abuse she was experiencing. Practitioners also failed to connect the presenting symptoms and to consider the causes. The Family recalled with evident frustration, that following one of the hospital admissions for self-harm, a doctor said to Adult 1 "*back here again, you silly girl*?" The family believe that this then created a barrier to future disclosure.
4. Stark (2007) tells us how abusers regularly degrade their victim, telling them they are stupid and useless. This demonstrates the important role that language has as both an enabler or a barrier.
5. There is still considerable stigma attached to domestic abuse and the complexities of drug or alcohol use compounds this. In 2016 analysis of Domestic Homicide Reviews [17] found that victims of domestic abuse who use alcohol problematically are often viewed negatively. As a result of these findings, Solihull Council made a bid in 2016 to the Department for Communities and Local Government (DCLG) aimed at improving access for women experiencing the combined impact of

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[16] MARAC Multi Agency Risk Assessment Conference

[17] Domestic Abuse and change resistant drinkers: preventing harm. Learning the Lessons from Domestic Homicide Reviews. Part of Alcohol Concern's Blue Light Project in partnership with AVA's Stella Project 2016

mental health, substance misuse and domestic abuse. The bid was successful and in August 2017, as part of a pilot, Birmingham and Solihull Women's Aid (BSWA) recruited a specialist domestic violence worker to work co-located with Solihull Integrated Addiction Service (SIAS). The Solihull based umbrella organisation comprises specialist mental health, alcohol and substance misuse organisations.

6. This initiative is primarily aimed at women where the trio of vulnerabilities are present and often, as a consequence, reached Multi Agency Risk Assessment Conference (MARAC). The pilot provided the resources to develop a multi-faceted approach to reduce some of the observed barriers and allow for a co-ordinated, manageable shared plan that would not overwhelm women but provide them with a holistic support plan. It recognised that professionals often seek to address the symptoms or the presenting issue as a priority in isolation rather than holistically.
7. The resource has allowed practitioners from Solihull Integrated Addiction Service and Birmingham and Solihull Women's Aid to work together. The model is flexible to respond to victim's wishes so they can meet substance (drug and alcohol) issues and domestic abuse specialists separately or together at their appointments, or a single practitioner from either agency can continue as a key worker but gain direct advice and guidance on a shared plan from their counterpart.
8. Emerging findings indicate this is a good model. The 'cross-pollination' between agencies has up-skilled practitioners, providing staff across all the participating agencies with an up to date understanding of issues. Additional funding received meant this initiative continued into 2020. It appeared to the Domestic Homicide Review that had Adult 1 been referred to the SIAS services she may have been offered the comprehensive level of support she needed.

1.2.1 Supporting Women with Complex needs within Hospitals

1. The Domestic Homicide Review noted the number of presentations made by Adult 1 to Accident and Emergency over the years in which she was in a relationship with Adult 2. Whilst her work life involved heavy lifting and manual work, there remains a lingering suspicion that some presentations may have been non-accidental

injuries; either self-harm or domestic violence related. It is a strong belief of the family that because of the age gap between Adult 1 and Adult 2 there may have been a perception that Adult 2 was not seen as a threat physically.

2. A study by Safe Lives, the domestic abuse support charity[18] identified that where hospitals have Independent Domestic Violence Advisors (IDVAs) available to staff and patients, they are far more likely to provide the kind of support women with complex needs need to access. The study noted; '*Victims engaging with hospital IDVAs seemed to be accessing effective support at an earlier point – hospital IDVA clients had experienced abuse for an average of 6 fewer months than victims engaged with a local service.* '
3. The reason for this earlier engagement seems to be that hospital IDVAs are more likely to encounter women attending hospital as a consequence of complex health issues;
    - *Prevalence of complex needs, vulnerabilities and unrecognized abuse in the hospital victim population may be higher than the victim population accessing local services, because victims are attending hospital primarily for urgent health issues which may or may not be related to the domestic abuse experienced.*
    - *Victims may be more likely to disclose domestic abuse to the hospital IDVAs (compared to other agencies where disclosure may be perceived to have negative consequences). Victims may also be more likely to disclose other information due to the health setting e.g. alcohol/ drug related issues*.
4. It is worth noting that the study concluded that women who are experiencing domestic violence and drank alcohol were less likely to disclose to their GP, because some felt 'dismissed' because of their drinking behaviours.

[18] A Cry for Health: why we must invest in Domestic abuse Services in Hospitals

1.3 Changes made within key agencies to improve identification of domestic abuse and vulnerabilities around dual diagnosis

1. This Domestic Homicide Review has identified that the three agencies that had regular contact with Adult 1; Birmingham and Solihull Clinical Commissioning Group for the GP's, University Hospitals Birmingham for Accident and Emergency and Birmingham and Solihull Mental Health Trust for Secondary Mental Health all pointed to their agency practice in 2019 being substantially enhanced and now likely to lead to earlier identification of domestic abuse and the complex vulnerabilities Adult 1 presented with. These measures are summarised by each agency below:

Birmingham and Solihull Mental Health Foundation NHS Trust

- Domestic Abuse Policy (2017) reflects NICE Guidance 2014 and Quality Standards 2016. This lays out key standards around identification and response to domestic violence and abuse.
- Policy supported by Practice Guidance launched 12th October 2018; this encourages direct routine questioning around domestic abuse. Guidance encourages practitioners to take a "Think Family Approach", exploring the context of someone's life, including the nature of relationships and family dynamics. Practitioners are reminded to routinely record family details. The Guidance explains the impact of coercive and controlling behaviour and why it is not a just a simple process for people to remove themselves from those relationships.
- Named nurse for Domestic Abuse offers supervision/reflective practice sessions and Safeguarding Facilitators (within the Corporate Safeguarding Team) are about to start a process of regular drop-in sessions to the Mental Health Hubs across the organisation.
- All Safeguarding Team members attend professional's meetings, multi-disciplinary clinical meetings as well as team meetings to promote the Policy and Practice Guidance and support across all safeguarding issues.

- The number of calls received by the Safeguarding Team suggests staff are identifying issues sooner, asking and exploring directly and taking action to support and safeguard where domestic abuse is a feature of the lives of the people they are working with.
- Identification of domestic abuse is recorded on 'Eclipse' (the Trust's Serious/ Untoward Incident recording system) to ensure it is seen as a serious threat.
- Policy encourages the use of the Domestic Abuse Stalking and Harassment (DASH) risk indicator checklist.
- Annual Themed Safeguarding Conferences. In March 2019 a Domestic Abuse theme emphasised learning from Domestic Homicide Reviews.
- Audit to ensure policy is embedded in 2019.

University Hospitals Birmingham (Heartlands, Good Hope, Solihull)

- Domestic Abuse Policy. A 2016 consultation and feedback leading to a re-launch.
- Association of Directors of Adult Social Services- 'Domestic abuse: a Guide to support Practitioners and Managers' circulated.
- Introduction of an Adult Safeguarding Nurse, Adult Safeguarding Domestic Abuse lead, supported by a Personal Assistant.
- NICE questions to be used routinely in Accident and Emergency.
- Enhanced Observation Bundle launched in August 2017 used for patients that present with self- harm/mental health concerns/risk of absconding. (Although not used in Adult 1's presentation in 2017, recent audits suggest that it is now widely used and is effective)
- A new alcohol screening tool 'Preventing ill health-risky behaviour' alcohol and smoking module to help staff screen patients is due to be approved at Information Technology Board and rolled out in 2019.

Birmingham and Solihull Clinical Commissioning Group

- The Deputy Designated Nurse for Safeguarding to provide a Practice Team Briefing to the GP surgery in this case to enhance understanding of learning in relation to identification of Domestic Abuse and dual diagnosis
- Practice signed up to Identification and Referral for Improved Safety (IRIS) in early 2018. IRIS is a general practice-based training and support referral programme. Training was provided to all staff between September and November 2018.
- IRIS rollout across Solihull will be audited by the Clinical Commissioning Group from April 2019
- Practice now has a Domestic Abuse Policy that includes the use of Domestic Abuse Stalking and Harassment risk assessment.
- The GP Practice involved with Adult 1 in the year 2018-2019 made 16 referrals to the IRIS Team. In the year 2019-2020 there were three referrals made in quarter 2 and four referrals in quarter 3.
- The GP Practice involved with Adult 2 completed IRIS Training in January 2019 and made the following referrals: quarter 1 (one), quarter 2 (four) and quarter 3 (three).

15. Conclusions

1. This Domestic Homicide Review concluded that Adult 1 had endured domestically abusive relationships in two marriages as well as adverse childhood experiences and they contributed to her low mood and depression, self-harm and occasional binge drinking. With hindsight, it is reasonable to conclude that during the period under review she should have been recognised by health professionals as having complex needs, requiring the kind of holistic approach now recognised as best practice, and described in section 14.1.2 of this report.
2. It is very regrettable that in spite of relevant guidance on early identification of domestic abuse through safe questioning being circulated to the key

agencies before the period under review, (and therefore by extension the health professionals supporting Adult 1), none of the contributing agencies had apparently embedded this best practice in their respective policy or practice. This was in part because the agencies had not yet put in place Safeguarding teams of adequate size for the task in hand.

3. It seems reasonable to conclude that the NICE restatements of the best practice in 2014 and 2015, although largely embedded across all three key agencies in 2019, were not addressed with the speed they deserved. It is crucial that to provide reassurance, all three agencies introduce suitable quality assurance frameworks to ensure such routine questioning is now taking place, leading to both referrals and pathways to support, as well as encouraging patient self-referral when they feel ready. The Domestic Homicide Review has received assurances that this shortcoming has been addressed and audits across all three key agencies form part of their Individual agency recommendations. This Domestic Homicide Review's first recommendation will address this area.
4. All three agencies were therefore relying upon their professionals to ask questions based largely upon their own personal levels of professional expertise and understanding of the signs of possible domestic abuse in a presentation. Consequently, no agency recognised the extent of domestic abuse although they all recognised that Adult 1 and Adult 2's relationship had problems. It is for this reason that this Domestic Homicide Review is clear that none of the frontline professionals should view any failures as individual ones, but rather as organisational weaknesses.
5. The family and friends of Adult 1 were clear that she experienced domestic abuse that was occasionally physical but that she was also controlled and coerced by Adult 2 who was abusive. That she never sought support from Domestic Abuse support groups perhaps was because no professional had actively attempted to refer her, even where they knew that the relationship

was poor. Studies[19] have shown that, '*a common reason for not seeking formal help is the victims' belief that the abuse wasn't serious enough to warrant support*.' Whilst Adult 1 may not have considered herself a victim of domestic abuse, holistic work on her complex needs may have helped her to recognise the part domestic abuse actually played. Adult 1 understood that Adult 2's coercive and controlling mind set meant that he would not allow her to separate and achieve a clean break; she therefore maintained a level of contact with Adult 2. Sadly, this is a period of increased risk for victims of domestic abuse.

6. There was extensive evidence of silo'ed practice. With hindsight, the use of alcohol appears to have been consistently evident in rows and self-harm incidents along with entrenched problems of depression and low mood. Yet there is no evidence that Adult 1 was supported by alcohol support services through referrals. Although the GPs were aware of this as an issue for Adult 1, there was no robust enquiry. It fell to a practice nurse at the GPs to apparently make the only recorded enquiry about Adult 1's alcohol intake and this was probably in the context of routine screening.
7. A study of Domestic Homicide Reviews involving 'change-resistant drinkers'[20] noted that the term alcohol denoted in many professionals' mind the '*traditional image of the alcoholic*.' This belief may hinder identification and referral. The study explained; '*It is vital in the context of domestic abuse that inappropriate understandings of what is an alcohol problem do not impede intervention. If workers are looking for people who match a particular stereotype the risk associated with other patterns of problematic alcohol abuse will be undervalued. The key question for workers is not 'is this person an alcoholic or have an alcohol problem? Instead the focus should be 'Is this persons' drinking causing a problem in the context of his or her life?' If it is, action needs to be taken.'*

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[19] Fugate et al, 2005

[20] Domestic Abuse and change resistant drinkers: preventing harm. Learning the Lessons from Domestic Homicide Reviews. Part of Alcohol Concern's Blue Light Project in partnership with AVA's Stella Project 2016

8. There was a degree of naivety in mental health professionals who, whilst noting Adult 1's accounts of engagement with alcohol services, did not check this out. This appeared weak practice, given that Improving Access to Psychological Therapies (IAPT) could not provide cognitive behavioural therapies because of the declaration of alcohol use. (Whilst the BSMHFT did not provide IAPT services, mental health professionals could still have endeavoured to establish whether Adult 1 was engaging with appropriate substance misuse services.)
9. This Domestic Homicide Review concluded that women with such complex needs are best served by the kind of services currently commissioned in Solihull; a joined-up approach that allows for multiple needs, particularly those that are inter-related to be identified and managed. It is to be hoped that an appropriate joint needs evaluation will ensure that this useful service is seen as a public health benefit, as well as providing cost savings and receives sufficient support to be re-commissioned.
10. It is likely that hospital Independent Domestic Violence Advisers are another way of ensuring that women like Adult 1, with complex needs, are offered support sooner, reducing the impact of domestic abuse upon their mental health, but also providing a platform to address the behaviours of drinking alcohol in a more effective way.
11. Interventions by Hospital Independent Domestic Violence Advisers described in the 'Cry for Health Report'[21] previously referenced are not only more effective in securing support for women with complex needs but are cost effective. The report stated' *Hospital-based Independent Domestic Violence Advisors save public money. Our evaluation included an analysis of the potential cost savings of Hospital Independent Domestic Violence Advisors service provision. An annual saving to the public purse of £2,050 per victim in health service use was estimated. This consisted of savings of £2,384 in hospital use balanced against rises of £98 in mental health service use, £64 in general*

[21] A Cry for Health: why we must invest in Domestic abuse Services in Hospitals

practice use, and £74 in alcohol/drug service use. An increased cost of £282 p.a. in social service use was also calculated. '.

12. In spite of this, provision of such quality support becomes a 'post code lottery' due to local and national instability in relation to domestic abuse funding, competing as it does at a disadvantage with statutory functions in a time of austerity.
13. Similarly, the Birmingham and Solihull Clinical Commissioning Group described in their Individual Management Review the effectiveness of the Identification and Referral for Improved Safety (IRIS) initiative within many of Solihull's GP Practices. Funding for the programme has been guaranteed for 2019-21 but with no certainty for the future. The second recommendation of this Domestic Homicide Review would be that Commissioners recognise the need for certain key domestic abuse support initiatives to be sustained by being considered part of mainstream funding commitments.
14. Over the last four decades, society's response to male violence against women has been revolutionised. Responding to women's fight for equality within society there has been a development of community-based support services for women who are victims of sexual or physical violence. At the same time there has been a growing awareness, recognition, and documentation of the different types of abuse. Changes to the legal and criminal justice system have made victims safer. However, there remain within society cultural norms and entrenched views that normalise the non-physical elements of domestic abuse.
15. It is a finding of this Domestic Homicide Review that often the victim of coercive and controlling behaviours but also their friends and family struggle to identify non-physical abuse within domestic abuse. Almost a decade has passed since domestic abuse was identified as a Public Health issue and included in a wider determination of health in the public health framework, yet it could be argued that this has not had a universal impact upon prevention and awareness.

16. In January 2019 the Government published 'Transforming the Response to Domestic Abuse: consultation Response and Draft Bill' It noted that '*victims of domestic abuse are far more likely to confide in family and friends than in the police or agencies*' and pointed to the Women's Aid project 'Ask Me' designed to raise community awareness. Respondents to the consultation consistently stressed the importance of improved understanding and awareness among the wider public
17. This Domestic Homicide Review would endorse these observations and recommend the newly appointed Domestic Abuse Commissioner to consider including in any Action Plan the need for a sustained and concerted approach to address behaviour change and cultural norms.

16. Lessons to be learnt

1.4 What do we learn?

- **Health agencies that are encouraged to 'ask the question' of people presenting with health indicators of domestic abuse, had not yet attempted to embed this practice in their local arrangements, policy or procedure during the period under review.**
- **In the period under review, Mental Health professionals apparently were not routinely 'asking the question' of patients concerning domestic abuse, as directed by best practice.**
- **Even where in this case their patient described marital/relationship disharmony this did not tend to prompt Health professionals to explore the possibility of domestic abuse. This suggests that there is a need for reinforcement of this best practice within key agencies (recommendation one).**
- **That health professionals faced with the trio of vulnerabilities (mental health, alcohol misuse and domestic abuse) did not approach these complex needs in a holistic way but tended towards silo'ed practice and single incident led practice.**
- **That the identification of some of the coercive and controlling non-physical forms of domestic abuse still poses a challenge of recognition not only amongst professionals, but also family, friends and the wider community.**
- **That women with complex needs are more likely to disclose to hospital Independent Domestic Violence Advisors than other community-based support workers**
- **That a holistic support plan for domestic abuse, drug or substance misuse and mental health is likely to lead to better outcomes for individuals.**
- **Those health professionals may not recognise the full impact of alcohol abuse when a patient presents in ways that do not fit their traditional image of how a patient who is 'alcoholic' will present.**
- **That women of 55 years old and above fall within an age group that are less likely to report domestic abuse and are more likely to excuse or tolerate its' impact.**

17. Recommendations

Recommendation No:1	Relevant agencies listed should provide assurance to the Safer Solihull Partnership that they have in place local arrangements to ensure that their professionals 'ask the question' of people presenting with the health indicators of domestic abuse (in line with NICE Guidance and Quality Standards) together with suitable audit tools or measurements to demonstrate a change in outcomes.
Recommendation No:2	The Safer Solihull Partnership seeks assurance from the Commissioners of the IRIS project within GP surgeries that funding will be given due consideration beyond the current agreed period and that in order to embed this service, it will be brought into mainstream funding in the future.
Recommendation No: 3	The Safer Solihull Partnership would propose to the Domestic Abuse Commissioner that any Action Plan to address domestic abuse recognises that lasting and permanent change cannot be achieved without a sustained and concerted approach to address behaviour change and cultural norms.
Recommendation No:4	This Domestic Homicide Review noted the effectiveness of hospital-based IDVAs in supporting women with complex needs experiencing domestic abuse. The Safer Solihull Partnership would seek assurances from the commissioners of these services that they will be recommissioned in hospitals in Solihull.