safe & sound

Dudley's Community Safety Partnership

Executive Summary of the Multi-Agency Review into the death of 'Charlie'[1]

In August 2021

Report produced for Dudley Safe and Sound by
Paula Harding
Independent Chair and Author
October 2023

[1] pseudonym

Contents

1. The Background

1.1. This review concerns the circumstances leading to death of Charlie, a 22-year-old woman and mother of a 2-year-old child. Although at the time of writing, the inquest into Charlie's death is awaited, the cause of death was thought to be from suicide. A criminal investigation found no evidence that any other person was involved in her death. However, it was known that Charlie experienced domestic abuse in her relationship.

1.2. Charlie grew up in a secure family home and was described by her family as a kind and gentle soul who always looked for the good in people. She met her partner online during her first year of sixth form in 2016. He was one year older than her and was her first boyfriend and vice versa.

1.3. From the early days of their relationship, her partner was observed to be controlling of Charlie: constantly calling and messaging her, monitoring her movements and telling her what to wear. As the relationship progressed, she spent more time with her partner and his friends, and his physical violence began.

1.4. Her partner experienced the suicide of his brother shortly before Charlie's death.

2. Summary of Chronology

2.1. Charlie had always been a highly motivated and hard-working young woman and commenced a degree course in September 2018. During her first year, when aged 19, she became pregnant and did not return to University. She was still working part-time and told a work colleague that she wanted a termination, but her partner would not let her.

2.2. Later in her pregnancy, Charlie was supported by a specialist perinatal mental health midwife as she was feeling low in mood and becoming withdrawn and socially isolated. She felt no connection with the baby and was undecided if she wished to keep it when it was born.

2.3. In May 2019, Charlie attempted suicide by taking an overdose. She told hospital staff that the overdose as a "cry for help" because of "increasing family issues" and feeling "unable to cope." Safeguarding referral were made to adult and children's services.

2.4. Charlie told her GP that she got on well with her partner and was protective to the baby. She was prescribed anti-depressant medication and referred to a local family support service. Although there was a 12 week gap in health visiting services, the GP was persistent in seeking engagement with Charlie until she moved out of the catchment in September 2019.

2.5. After the move, Charlie told health visitors that she was feeling better, and she was working as a 101 call operator for the Ambulance Service. She was routinely asked about domestic abuse a number of times which she denied, and the child was assessed as needing only universal health services.

2.6. After the pandemic started, in August 2020, Charlie's partner called the police the police and Charlie told them that her partner had kicked her in the stomach, and she responded by slapping him across the face. She declined to make a formal complaint but was assessed as facing standard risk. The incident was considered by the multi-agency Domestic Abuse Response Team (DART) and the family were referred to the health visiting team and family support worker for early intervention, and to CHADD for domestic abuse support, but CHADD did not appear to have received the referral.

2.7. Family Support were unable to contact Charlie and closed the case. Health visitors made contact with her six weeks later and Charlie minimised the reported domestic abuse, describing it as an argument and declined further support. However, Charlie told her friend how her partner had beaten her.

2.8. During the night, in January 2021, a silent call was made to the police, but in the background a man could be heard shouting at a child, and a woman was crying. The police tracked the phone to Charlie's parents, twenty miles away, but were diverted to an incident requiring an immediate response and were not able to return to Charlie's address again until the next morning. Charlie stated that the police had been called by mistake, that she had only a minor bruise and she declined to make a complaint. She was assessed as standard risk.

2.9. The DART referred her to the MASH and the IDVA and Charlie told each agency that she just wanted help for her partner whose mental health had been suffering since lockdown. Charlie agreed to accept support from Early Help services and the IDVA. Early help was also to speak with her partner concerning his mental health and the impact of domestic abuse upon his family. The health visitor was unsure who should take the lead on the early help work.

2.10. There was then a five week delay before the family support worker contacted Charlie, who by that time advised that she no longer needed support with her relationship. There was a further gap of eight weeks, before the Early Help Assessment was undertaken with a joint visit with a new family support worker and the health visitor and the assessment concluded that there were any concerns that could not be met by universal health visiting services.

2.11. In July 2021 Charlie moved back to her parent's home saying that there were too many problems in the house that she shared with her partner, and they could not afford it. and started working at a veterinary surgery. She had also enrolled at Wolverhampton University to study animal behaviour.

2.12. Charlie re-registered with her former Birmingham GP Practice. She had not been registered with any GP whilst in Dudley, so they were not aware of concerns in the

family. There was then a delay whilst health visitors in Dudley handed over details of her case, including details of the early help assessment and reports of domestic abuse, to Birmingham health visitors who were also not aware of the concerns in the family.

2.13. On the day before her death, Charlie was staying with her partner but had spoken with her mother about the escalating abuse. She was ambiguous about whether she intended to make the separation permanent. Her mother had advised her to throw things into plastic bags and they would fetch her, which she appeared to have done.

2.14. She was found deceased by her partner who told the police that she had wanted to reconcile but he felt they were rushing into it. Charlie's family, however, were concerned that she had showed no signs of suicidal thoughts and had been planning ahead. They considered that there were signs of a violent argument in the car and were surprised that the property was in such a state. They made allegations of her partner's coercive control of Charlie during their relationship, but the police were not able to find evidence to substantiate the allegation.

3. Key Findings

3.1 Indicators of Domestic Abuse

3.1.1 Although neither Charlie's family and friends, nor any individual agency, knew the whole picture, there were indicators of abuse that were not fully explored by agencies. We now know from Charlie's testimony that she was subjected to

- Physical violence: being beaten and kicked in the stomach
- Coercive control and surveillance: her movements were monitored; she had to check in with him constantly; he told her what to wear and she ''trod on eggshells around him
- Reproductive coercion: he would not let her terminate the pregnancy and although she did not appear to tell professionals they did not always routinely ask about domestic abuse

Learning Point: Reproductive Coercion
Practitioners must always consider the possibility of reproductive coercion when a teenage woman becomes pregnant. Health practitioners should routinely ask about domestic abuse, recognising the additional barriers that young women will face in being able to disclose their abuse.

- Economic abuse: Charlie unexpectedly dropped out of university after her child was born despite declaring her intention to return, and her family thought that it was because her partner did not like her attending

> **Learning Point: Educational Sabotage**
> By disrupting an individual's ability to gain educational qualifications, a domestic abuser extends their power and control over their partner. Tactics of educational sabotage could include telling a victim that they will fail; undermining a victim's abilities; demeaning their educational goals; controlling access to college; interfering with studying or doing homework; making a partner feel guilty for spending too much time on study; responding with jealousy, resentment and insecurity.

- There were other indicators of economic abuse present: Charlie was unable to continue to share a home with her partner because of financial problems and she had told her colleagues in the Ambulance Service that she had financial worries after her first suicide attempt. Practitioners need to be alert to indicators of economic abuse as economic abuse rarely occurs in isolation from wider forms of domestic abuse
- Separation: Charlie had recently taken steps to separate from her partner

> **Learning Point: Separation and help-seeking are dangerous periods** for victims of domestic abuse. For a perpetrator, their victim's help-seeking or separation represents their loss of control over them, and their violence and abuse often escalates as they try to re-establish their control.

3.2 Suicide and Domestic Abuse

3.2.1 Several agencies did not identify the links between suicide and domestic abuse

> **Learning Point: Suicide & Domestic Abuse**
> Coercive control, isolation and entrapment are tactics of perpetrators of domestic abuse which can lead to low self-worth, hopelessness, despair and suicide in their victims.
> Women presenting to services in suicidal distress or after self-harm should always be asked about domestic abuse.

3.2.2 Charlie's suicide occurred not long after her partner's brother, who was from a settled Traveller community, died by suicide. There are high levels of suicide within the Travelling community.

Learning Point: Exposure to Suicide Can Increase the Risk of Suicide
For some individuals, being exposed to a suicide death can provide an increased awareness of suicide as 'something that actually happens,' as well as 'something they too could do'. This will depend on the meaning that the individual makes of the experience and the context surrounding the death.

3.3 Barriers to Engagement

3.3.1 There were several times when Charlie declined to disclose the domestic abuse that she was experiencing, or she minimised and excused the abuse. There will be many reasons why women experiencing domestic abuse may not feel able to disclose their experiences and agencies experience barriers in engaging with a victim. These could include a victim's overwhelming fear of the perpetrator and a lack of understanding and uncertainty about agencies. Barriers can also be experienced as a result of a practitioners' lack of understanding about domestic abuse and coercive control, or in the manner in which they engage with victims. For Charlie, we found that she was frightened of her child being taken away from her.

Learning Point: Overcoming Fears
Victims of domestic abuse often fear that their children will be taken away by children's services, despite this being far from practitioners' minds. They will often have been told by their abusers that they are poor mothers and unable to cope without them, particularly if the abuse has already affected their mental health. Fears of child removal may be particularly prevalent in some minoritised communities, such as traveller families.
Practitioners need to be aware that these fears are common and work hard to dispel common myths, whether or not expressed, and promote confidence in agencies' desire to protect and support victims of domestic abuse to care for their children and keep the family safe.

3.3.2 At times, Charlie was encouraged to approach domestic abuse services. On one occasion the domestic abuse service did not appear to have received the referral.

Learning Point: Active Referrals
Accessing specialist domestic abuse services may feel daunting and overwhelming for victims of domestic abuse. Agencies need to consider how they let victims know about support exists and how they can support victims with active referrals.

3.3.3 There were several times when agency actions to engage with Charlie were delayed due to staff absences and Charlie no longer wanted their support when contacted.

Learning Point: Timely Engagement
The timing of our attempts to engage with a victim of domestic abuse is important. Victims face innumerable barriers to seeking help but when they reach out to services it will often be at times of crisis or significant threat.
In the absence of an immediate response, the barriers that they face will start to surface again. For example, the perpetrator will have more time to prey upon the victim's fears, provide excuses for their behaviour or show remorse. This often results in a victim declining further support or minimising their abuse

3.3.4 There were several periods where agencies were trying to contact Charlie without success. During many of these times, Charlie was working night shifts and was was also living between three homes. As a result, the standard approach of engaging with her would not have been effective.

Learning Point: How flexible and responsive are our services?
Many victims, because of work or other commitments, do not fit the model of working that is preferred by agencies. Do agencies have the opportunity to reflect when they are unable to make contact with a victim of domestic abuse and consider of there are specific circumstances that they need to consider and adapt to?

3.3.5 There were several times when practitioners did not exercise professional curiosity when they had contact with Charlie such as after her overdose and panic attacks; when she minimised the abuse or during the Early Help Assessment.

Learning Point: Professional Curiosity in Domestic Abuse
A robust understanding of domestic abuse is needed for assessments and responses to be effective. Practitioners need to understand the complex and nuanced pattern of coercive control in order to understand their own challenges to engage with victims and, for example:

- Why victims may minimise or deny the abuse they are experiencing
- How perpetrators intimidate, isolate and control their victims, stripping away their sense of self (Stark 2007:5)
- The impact that living with persistent fear, undermining, gaslighting may have on a person's mental health

3.4 Mental Health and Domestic Abuse

3.4.1 There were several occasions when Charlie declined help for herself but told professionals, who were responding to the domestic abuse, that she just wanted her partner to receive help for his mental health. It appeared that she interpreted, or perhaps hoped, that his abusive behaviour was a symptom of his mental health.

> **Learning Point: Mental Health is not a Cause of Domestic Abuse**
> It is the responsibility of all practitioners to engage with victims of domestic abuse and sensitively challenge their misconception that their partner's mental illness is causing their abusive behaviour.
> Domestic abuse victims need to understand that their abusers are responsible for their own behaviour in order that victims can effectively make safety plans for their own, and their children's, safety.

3.5 Domestic Abuse in the Traveller Community

3.5.1 Charlie's partner belonged to a family of settled travellers. It is not known how much he was influenced by traditional cultural expectations of gender roles and family honour. However there was a history of domestic abuse in his wider family.

> **Learning Point: Domestic Abuse in Gypsy, Roma and Traveller Communities**
> Whilst domestic abuse affects women from all ethnic and social groups, it is most commonly experienced within relationships or communities where there is support for strongly hierarchical or male dominated relationships, where male authority over women and children is culturally expected and condoned, and where there is a strong sense of family honour, such as in more traditional Gypsy, Roma and Traveller Communities. However, attitudes towards women amongst younger generations of Traveller communities are seen to be changing (Traveller Movement, 2017).

3.6 Young Victims of Domestic Abuse

3.6.1 Charlie began her relationship with her partner, her first relationship, whilst still a teenager and we have seen that she was subjected to coercive control very early in the relationship.

> **Learning Point: Young People** may not understand what constitutes abusive behaviours and, having less experience of relationships, were more likely to normalise abuse, possibly misconstruing controlling or jealous behaviour as love (Home Office, 2021).

3.7 Invisible Abusers

3.7.1 Throughout agency attention over the safety and well-being of the child, the emphasis was on Charlie's parenting and her responsibility alone to work with agencies rather than on the child's father to stop the domestic abuse. Although a family support worker made attempts to contact her partner by phone without success, there were indicators that staff may have been reticent about contacting a father who perpetrates domestic abuse for fear of triggering his violence towards the mother and putting her more at risk.

Learning Point: Invisible Fathers

In our assessments of children at risk or in need, it is more often the mothers' ability to keep children safe that has been the focus of agency attention, rather than the assessment and planning around the perpetrator of domestic abuse, usually the father. There may be many reasons for this. For example, sometimes the perpetrator deliberately hides from agency gaze; sometimes practitioners may be wary of provoking more domestic abuse by involving or confronting him; sometimes practitioners may be frightened themselves of an abuser.

Domestic abuse is a parenting choice of the perpetrator. Exposure to parental domestic abuse is domestic abuse of the child. Intervention is needed with the perpetrator to reduce the risk and harm to the child and mother through engagement, accountability and civil and criminal justice.

3.8 Crossing Boundaries

3.8.1 Charlie moved between Birmingham and Dudley, and there was a delay in providing health visitors in Birmingham with all the details of the history of domestic abuse and mental ill-health in the household.

Learning Point: Continuity of Health Visiting Care Across Borders

Victims of domestic abuse will often have to move across local authority boundaries in order to find somewhere safe to live. Verbal communication prior to the transfer of records from one area to another is vital in ensuring safe continuity of care for the child and ensure that the family's needs and risks can be picked up in real time when they move home.

3.9 The Impact of Covid-19

3.9.1 After Covid, more of Charlie's appointments and assessments were over the telephone, which may have hindered her ability to disclose domestic abuse.

Learning Point: Safe Enquiry
Health and social care services have made great strides in embedding safe enquiry about domestic abuse into their practice, whether this be routine, targeted or selective enquiry. However, following the Covid pandemic, more appointments, consultations and assessments are held remotely, and practitioners will be following the guidance requiring them to be sure that it is safe to make these enquiries on a case-by-case basis. Far fewer survivors of domestic abuse will now be asked about domestic abuse and agencies need to consider how they can maximise enquiry and mitigate risk.

4 CONCLUDING REMARKS

4.1 This review has considered the experiences of Charlie, a young woman experiencing domestic abuse and young motherhood in her first relationship and whose mental health suffered as a result with tragic consequences.

4.2 When examining agency responses, it can be seen that there were certainly pockets of good practice in agency responses to Charlie including the police's initial attempts to locate Charlie after a silent call had been made; the GP's pro-active and multiple attempts to contact Charlie after she had taken an overdose and the perinatal mental health midwife's engagement with Charlie whilst she was pregnant. However, when viewed collectively, we can see that this young, abused mother was let down by delays in services and by practitioners lacking the professional curiosity, knowledge and skills to explore what was really happening in her relationship and to sensitively confront her when she felt it necessary to minimise the abuse. In the absence of this assertive approach to domestic abuse, and inability to engage effectively with Charlie, assessments downplayed the risk that she faced and the needs of this young mother, who had asked for help, were not recognised as she moved between these two areas in the West Midlands.

5 RECOMMENDATIONS

5.1 Overview & System Recommendations

Recommendation 1: Police response times

Dudley Safe and Sound to seek from West Midlands Police and Crime Commissioner an analysis of West Midlands Police response times for domestic abuse incidents.

Recommendation 2: Suicide and Domestic Abuse

Dudley Safe and Sound to promote the connection between suicide and domestic abuse with the Dudley Suicide Prevention Partnership and jointly consider the recommendations for local areas promoted by the Zero Suicide Alliance, as follows:

- "Include Domestic Abuse as an explicit priority within your local multi-agency Suicide Prevention Strategy.
- Ensure your local Real Time Suicide Surveillance system asks specific questions about domestic abuse including: victim, perpetrator, children; the type of abuse; whether current or former relationship.
- Ensure domestic abuse training is completed by all mental health staff. (Consider making this a commissioning condition).
- Ensure mental health and suicide prevention training completed by all domestic abuse staff. (Consider making this a commissioning condition).
- Ensure provision of recovery (including trauma aware elements) programmes for female and male victims of domestic abuse in the months and years after the abuse has stopped.
- Undertake a detailed analysis of RTSS
- Undertake a detailed analysis of data held by Mental Health Services
- Consider revising risk assessments to ask the following questions of both the victim and the perpetrator: have you self-harmed? Have you felt suicidal? Have you made a suicide attempt? (and over different time periods)….
- Ensure that local suicide bereavement services are trained / experienced in supporting families after the suicide of a DA victim or perpetrator." (Kent and Medway Public Health, 2022)

Recommendation 3: Exposure to Suicide

Dudley Safe and Sound to forge links with the Black Country Healthcare NHS Foundation Trust and support the Trust in its endeavour to secure 'real-time-surveillance' data on suicide and supports the Trust to development a plan to promptly deliver support to family and friends, as appropriate.

Recommendation 4: Suicide amongst Gypsy, Roma, Traveller Communities

Dudley Safe and Sound to share the report of this review with Dudley Suicide Prevention Partnership to ensure that the heightened risk of suicide amongst Gypsy,

Roma, Traveller Communities and the ramifications of suicide are illustrated and feeds into the Suicide Prevention Strategy.

Recommendation 5: Referrals from DART

Black Country Women's Aid and CHADD to provide assurance to Dudley Safe and Sound that the pathway for referrals to specialist domestic abuse services from DART are effective and that there is feedback provided where engagement has not been possible with a victim of domestic abuse.

Recommendation 6: Coercive Control

Dudley Safe and Sound to seek from partner agencies (i) how they are promoting an understanding of coercive control within their workforce and (ii) what impact their workforce development on coercive control has had on their practice, including the impact upon the identification, risk assessment and response to domestic abuse

Recommendation 7: Domestic Abuse in the Traveller Community

Dudley Safe and Sound to ensure that activities to raise awareness and prevent domestic abuse in Dudley also target the Traveller community

Recommendation 8: Teenage Relationship Abuse

Dudley Safe and Sound to continue to provide and promote targeted messages to young people experiencing abuse in their relationships in their public communication channels, using language that is accessible to young people, and signposting them to the dedicated support that is available for them.

Dudley Safe and Sound to work with further and higher education establishments in their area to:

- promote awareness specifically about domestic abuse in young people's relationships and educational sabotage
- introduce direct questioning on domestic abuse when a pregnancy is disclosed by a young woman
- promote the specialist services that are available to those experiencing domestic abuse across the age range
- monitor the outcomes of their awareness raising in further and higher education through increased disclosure of domestic abuse by young people, recognising that domestic abuse is under-reported in this age range

Recommendation 9: Crossing Boundaries

Dudley Safe and Sound to share this report with Birmingham Community Safety Partnership to ensure that those issues which have relevance can be addressed across the two areas.

Recommendation 10: Undertaking Safe Routine Enquiry

Health and social care services in Dudley to advise Dudley Safe and Sound

(i) how remote working has impacted upon their ability to make safe enquiry into domestic abuse since the Covid pandemic and

(ii) how they now maximise opportunities for routine, selected or targeted enquiry into domestic abuse and mitigate risk.

5.2 Individual Agency Recommendations

5.2.1 Individual agencies have identified the following recommendations for their service.

Adult Social Care

- Develop Suicide Risk Process for front of house and MASH

Black Country Healthcare NHS Foundation Trust

- Health visitors currently document all family concerns on the child's records. Each family member particularly, parents should have their own records where concerns are documented. The records should be linked in the family management section of Rio.
- Risk assessments and care pathways to be routinely reviewed as part of the health visiting holistic assessment following incidents such as domestic abuse, mental health episodes and any other safeguarding concerns or changes in life circumstance that may impact on risk.
- The first domestic incident did not have health representation at the meeting. If there is no health representation at DART meetings there needs to be a clear assurance process in place to ensure all incidents are being disseminated in a timely way and acted upon within the appropriate timescales.
- Joint assessments to be considered if two agencies are involved in DART incidents and the lead agency to be identified and documented in the records

Birmingham Community Healthcare NHS Foundation Trust

- Assurance required within the health visiting service that process is applied when there are workforce absences.
- Safeguarding team to develop guidance for practitioners to apply and support professional curiosity practices. A working group to be commenced, lead by safeguarding head of service and named nurse safeguarding children to support the development of an aide memoir to enhance clinical practice.
- BCHC practitioners will have access to shared cared records. Access rights and remit are being escalated. This will allow practitioners access to read only information of any child or young person in relation to health and children services.

- Assurance required within Birmingham Forward Steps that the process for reviewing and documenting in records is as per BCHC record keeping policy.

Dudley Children's Services

- Family Support staff absence. Family to be re-allocated if Lead FSW/IFSW is absent from work for longer than 4 weeks.
- If telephone calls are unsuccessful in making contact with families, then consideration be given to undertaking an unannounced visit within an agreed timescale e.g duty visit to take place within one week of the last unsuccessful contact
- Early help services enhance a nuanced understanding of domestic abuse and move beyond an incident-based approach
- Early help services ensure that the perpetrator of domestic abuse is not invisible to assessments over the safety and well-being of the child
- Early help services understand the importance of timely referrals to specialist domestic abuse agencies when consent to do so has been received

Dudley Group NHS Foundation Trust

- To improve awareness in the Emergency Department of Domestic Abuse indicators and selective enquiry.
- Improve effective communication and information sharing between Psychiatric Liaison and DGHNHSFT staff
- Domestic Abuse Policy to be updated to reflect staff responsibilities when patient has taken an overdose, suicidal ideation, suicide attempts or self-harm and consideration around discharge

GP

- Professional curiosity is recognised as vital in completing a holistic assessment and is utilised by GP Practice clinicians

University Hospitals Birmingham

- Routine enquiry should be asked 3 times throughout pregnancy including the postnatal period when the patient is seen face to face, if the patient attends and is accompanied, staff are to try and create an opportunity and safe space to complete routine enquiry

West Midlands Police

- To provide assurance to Dudley Safe and Sound about the accuracy of their risk assessments in domestic abuse

- To report to Dudley Safe and Sound on the impact of the use of the 'child abuse App' on the identification and response to children when responding to domestic abuse incidents
- In order to secure greater engagement of victims with specialist domestic abuse services, West Midlands Police to explore whether adopting the 'opting in' approach, that has been implemented with victims of rape and serious sexual assault, would be similarly effective and could be implemented for all victims of domestic abuse.

Nottingham Trent University

- To introduce direct enquiry on domestic abuse during conversations concerning pregnancy and maternity for affected students.

Appendix: The Review Process

(i) Summary

The decision to undertake a domestic homicide review was made by the Chair of Dudley Community Safety Partnership, and the Home Office was notified of the decision on 30.09.2021. An independent chair and review panel were appointed, and the review was managed in accordance with the relevant statutory guidance.

The review panel members are listed below and all panel members were independent of this case. Terms of reference were drawn up and incorporated key lines of enquiry as featured below Agencies participating in this review are featured below as well as those who had no contact. The review panel met on five occasions and the Independent Chair met with the victims' family twice. Family members contributed to the terms of reference and considered the draft Overview Report. All comments by the family have been incorporated into the report.

The Overview Report was endorsed by the Dudley Community Safety Partnership on 09.10.23 before being submitted to the Home Office for approval.

(ii) Review Panel Members

Name	Role/Organisation
Paula Harding	Independent Chair
Christine Conway	Head of Adult Safeguarding, Dudley MBC Adult Safeguarding
Jane Atkinson	Designated Nurse for Safeguarding Adults, Dudley Integrated Health & Care NHS Trust
Jane Lovell	Team Lead, Adult Safeguarding, University Hospitals Birmingham NHS Foundation Trust
Jean Reid	Head of Supported Housing, CHADD
Julie Mullis	Head of Safeguarding, Dudley Group NHS Foundation Trust
Katriona Lafferty	Community Safety Officer, Dudley MBC Community Safety
Michael Loftus	Lead Nurse Adult Safeguarding, Birmingham Community Healthcare NHS Foundation Trust
Michael Bailey	Detective Inspector, West Midlands Police
Merryn Tate	Head of Adult Safeguarding, Birmingham City Council Adult Social Care
Natalie Solomon	Associate Director for Safeguarding, Black Country Healthcare NHS Foundation Trust
Nicola Hale	Head of Safeguarding, Practice and Quality Assurance, Children's and Young People Safeguarding and Review, Dudley Council Children's Service
Raj Lagan	Regional Head of Domestic Abuse Service, Black Country Women's Aid
Sarah Mantom	Designated Nurse for Safeguarding Adults and Children (Serious Violence Lead), NHS Birmingham and Solihull Integrated Care Board

(iii) Key Lines of Enquiry

The review should focus on events from May 2018 when Charlie began to receive maternity services. Information about earlier times was included for contextual information only.
The Review Panel considered both the generic issues as set out in the 2016 statutory guidance and identified and considered the following case specific issues:

Individual responses: How effective were practitioners in responding to the needs and risks faced by Charlie and her child and the threat posed by her partner?

- *To provide a pen picture of the victim and her family as known by agencies at the time of contact*
- *To analyse key episodes of agency involvement, to assess what needs, risk and threat each agency identified for the individuals/family and how each agency responded.*
- *How was the support of family, friends and wider networks understood as protective factors?*
- *If domestic abuse was not known, how might practitioners have identified the existence of domestic abuse from other issues presented to them, in accordance with NICE Quality Standard QS116 Domestic Violence and Abuse, available at https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse? For example, were there policies and procedures for direct, selective or routine questioning and how well were they implemented in this case and the rationale for decision making?*
- *Was the impact of mental health issues and risk of suicide effectively recognised and assessed and what action did agencies take in identifying and responding to these issues, including in compliance with medication?*
- *What barriers to engagement did agencies experience and how did they seek to overcome these barriers?*
- *In what ways, if any, were agencies' response influenced by issues of equality, diversity or vulnerability?*
- *How effective was agency supervision and management of practitioners involved and did managers have effective oversight and direction of the case and on case closure?*
- *Were there any issues in relation to capacity or resources within agencies that affected their ability to provide services to the individuals/family or to work with other agencies, or create delays?*

Multi-Agency Practice: how effective were agencies in working together to prevent harm and to meet individuals' needs, within and across borders?

- *How were roles and responsibilities understood and multi-agency protocols adhered to?*
- *Was there a shared ownership and approach?*
- *How effective was the co-ordination of services?*
- *How effective was communication, information sharing and sharing records?*
- *How effective was escalation between agencies?*
- *Did multi-agency systems present difficulties or challenges to the effective delivery of services to members of the family?*

What impact did the Covid pandemic have upon service responses and upon the domestic abuse experienced?

What good practice can be identified?

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

- *what lessons can be learnt to prevent harm in the future?*
- *How do the circumstances improve our collective understanding of domestic abuse and suicide?*

What recommendations are to be made and how will the changes be achieved?

- *Individual agency recommendations*
- *what system-wide, multi-agency recommendations need to be made?*

In addition, the following agencies are asked to respond specifically in their IMR to the following points in addition to those above:

- Dudley Group and Black Country Healthcare reports to identify who should do routine/selective enquiry on domestic abuse where a victim attends the Emergency Department but is referred swiftly to the psychiatric liaison team.
- West Midlands Police IMR to provide the background of any previous offences and criminal justice outcomes
- Dudley Children's Services and West Midlands Police IMRs to summarise their role in the DART processes in August 2020 and January 2021
- For GPs – how referrals and notifications were followed up

(iv) Agency Involvement in the Review

The following agencies who had had significant contact with the family were asked to contribute an IMR and chronology to the review: Birmingham City Council Adult Social Care, Birmingham and Solihull Integrated Care Board, Black Country Healthcare NHS Foundation Trust, Dudley MBC Children's Services, The Dudley Group and West Midlands Police

The following agencies with some contact, or contextual information concerning the family were asked to provide briefer information reports to the review: Birmingham Children's Trust, Birmingham Community Healthcare NHS Foundation Trust, Birmingham Healthy Minds, Black Country Women's Aid, Dudley Council Adult Services, Dudley Council Housing Services, University Hospitals Birmingham, West Midlands Ambulance Service and Nottingham Trent University.

The following agencies were contacted but confirmed that the family were not known to them, or that their involvement was not relevant to the review: Birmingham Women and Children's NHS Foundation Trust, CHADD, Dudley Integrated Health & Care NHS Trust, Dudley Council Revenues and Benefits and Probation Service

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Dudley's Community Safety Partnership

Multi-Agency Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of 'Charlie'

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ACRONYMS

DARA: Domestic Abuse Risk Assessment
DART: Domestic Abuse Response Team
DHR: Domestic Homicide Review
MASH: Multi-Agency Safeguarding Hub
PNC: Police National Computer

GLOSSARY

DART: A multi-agency team sitting within the Multi-Agency Safeguarding Hub which assesses all reports of domestic abuse from the police and other sources. It comprises the police, children's services, health services and Black Country Women's Aid

THRIVE+: an initial risk assessment used by the police to guide how an incident should be managed. Within the policy THRIVE is described as:

THREAT – A threat is communicated or perceived intent to inflict harm or loss against another person;
HARM – Harm is to do or to cause harm; to injure, damage, hurt – physical or psychological;
RISK – Risk is the likelihood of the event occurring;
INVESTIGATION – Investigation is the act or process of examining a crime, problem or situation and considering what action is required;
VULNERABILITY – Vulnerability is defined for the purposes of incident management as 'a person is vulnerable if, as a result of their situation or circumstances, they are unable to take care or protect themselves, or others, from harm or exploitation';
ENGAGEMENT – Engagement is where organisations and individuals build a positive relationship for the benefit of all parties.

CONTENTS

Preface

Members of the review panel offer their deepest sympathy to the family and to all who have been affected by Charlie's death. Family members have been offered the opportunity to provide a statement of the impact that these tragic events have had upon them, and they will consider contributing this prior to publication.

Acknowledgements

The Chair would like to thank Charlie's family for their contributions to the review at such a difficult time.

The Chair would also like to thank the panel and contributors for their commitment to the review and to improving services for victims of domestic abuse.

Use of pseudonyms

Family members were consulted on the use of pseudonyms in line with the statutory guidance. They would have preferred to use her real name but understood the particularly sensitive nature of reviews involving suicide and where a child is affected by the review. The family chose the name Charlie which was meaningful for them.

1. INTRODUCTION

1.1 Background

1.1.1. This review concerns the circumstances leading to the death of Charlie, a 22-year-old woman and mother of a 2-year-old child.

1.1.2. Although at the time of writing, the inquest into Charlie's death is awaited, the cause of death was thought to be from suicide. The post-mortem revealed that Charlie died by hanging and no-one else was in the home at the time. Criminal investigations took place into whether the death may have been caused by unlawful act manslaughter, whereby another person's actions such as coercive control, may have led to the death, but no evidence was available. However, it was known that Charlie experienced domestic abuse in her relationship, and this knowledge has triggered the statutory requirement for this review to take place.

1.2. Aim and purpose of the review

1.2.1. This review us undertaken on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). Statutory Guidance advised that:

> *"Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable." (*Home Office, 2016:8)

1.3. The purpose of a review is to:

" a. establish what lessons are to be learned from the … [suicide]… regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b. identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c. apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e. contribute to a better understanding of the nature of domestic violence and abuse; and

f. highlight good practice" (Home Office, 2016:6)

1.2.3 As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review should "articulate the life through the eyes of the victim …. situating the review in the home, family and community of the victim and exploring everything with an open mind" (Home Office, 2016:7).

1.4. Timescales

1.3.1. The death occurred in August 2021 and the decision to undertake a review was made by the Chair of Dudley Safe and Sound, Dudley's Community Safety Partnership, in consultation with affected agencies in September 2021. The Home Office was duly notified of the decision on 30.09.2021.

1.3.2. Thereafter the review was delayed until criminal investigation reached its conclusion in May 2022, with no charges being made in respect of any domestic abuse that Charlie experienced prior to her death.

1.3.3. The review panel went on to meet five times and the report was considered by the Domestic Abuse Local Partnership Board and family members had the opportunity to provide their comments before the final draft report was endorsed by the Community Safety Partnership on 09.10.23.

1.5. Confidentiality

1.5.1. This review has been anonymised in accordance with statutory guidance and only the Independent Chair and review panel members are named.

1.5.2. During the course of this review, the details have remained confidential, available only to participating professionals and their direct line management. This report has sought to extract sufficient detail from the victim's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

1.5.3. In order to protect the identities of the victim and her family, and in keeping with Home Office guidance, the use of pseudonyms was considered, and the family chose the name Charlie to represent their loved one.

1.6. Definition

1.6.1. The Domestic Abuse Act 2021 introduced a legal definition of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

(a) physical or sexual abuse
(b) violent or threatening behaviour
(c) controlling or coercive behaviour
(d) economic abuse
(e) psychological, emotional or other abuse (s1: Domestic Abuse Act 2021)[1]

1.6.2. What constitutes controlling or coercive behaviour is outlined in guidance issued by the Government under section 77 of the Serious Crime Act 2015:

> "Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
> Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."[2]

1.6.3. Economic abuse was considered within this review and is defined as any behaviour that has a substantial adverse effect on a person's ability to acquire, use, or maintain money or other property or obtain goods or services (s.3: Domestic Abuse Act 2021).[3]

1.6.4. In keeping with the growing body of literature on the relationship between domestic abuse and suicide (see below), and the statutory guidance, this review will refer to the term 'domestic abuse related suicide', irrespective of whether a direct or indirect causal link between the death and the abuse has been established.

[1] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted
[2] Home Office, (2020) Domestic Abuse Draft Statutory Guidance Framework.
https://www.gov.uk/government/publications/domestic-abuse-bill-2020-overarching-documents

[3] ibid

1.7. Methodology

1.7.1. The review followed the methodology required by the *Multi-Agency Statutory Guidance* (HM Government, 2016). 19 local agencies were notified of the death and were promptly asked to examine their records to establish if they had been approached by, or provided any services to, the family and to secure records if there had been any involvement. 14 agencies were found to have had relevant contact with Charlie and 5 local agencies had had no relevant contact.

1.7.2. Arrangements were made to appoint an Independent Chair and Author and agree the make-up of the multi-agency review panel.

1.7.3. The panel initially met in advance of the conclusion of criminal proceedings in order to set the terms of reference and identify any immediate concerns for agencies' practice. Once criminal proceedings had concluded, the police provided the findings from the criminal investigation and the panel went on to meet a further four times.

1.7.4. The terms of reference incorporated both key lines of enquiry and specific questions for individual agencies where necessary. It was identified that 6 agencies were to provide Individual Management Reviews (IMRs) and chronologies analysing their involvement and a further 8 agencies were to provide information reports due to the brevity of their involvement. Briefings were made available for IMR authors by the Independent Chair in order to support report authors in their task and maintain the focus on the key lines of enquiry.

1.7.5. All reports were written by authors who were independent of the delivery of services provided. Wherever possible, report authors presented their findings to the review panel in person and, where necessary, were asked to respond to further questions. The individual agency reports concluded with recommendations for improving their own agency policy and practice responses in the future and informed the multi-agency and thematic recommendations which followed.

1.7.6. Thereafter, the Independent Chair authored the Overview Report after consultation with the family and each draft was discussed and endorsed by the review panel before submission to the Community Safety Partnership. The draft Overview Report was endorsed by Dudley Safe and Sound prior to submission to the Home Office.

1.8. Involvement of family and friends

1.8.1. Charlie's family met with the Independent Chair and helpfully contributed to the panel's appreciation of Charlie and the circumstances of her life. The family were given the opportunity to consider the terms of reference. They were also provided with leaflets from the Home Office and specialist advocacy support services of Advocacy After Fatal Domestic Abuse and the Victim Support Homicide Service.

1.8.2. The family were updated as the review progressed and met again with the Independent Chair to consider the draft report at that time and given the opportunity to comment upon the report. After being given time to read the report, they advised that they were satisfied with it and its conclusions.

1.8.3. The Independent Chair met with Charlie's closest friend with whom she had grown-up. Although her friend had only seen Charlie occasionally in later years, they maintained regular contact by message and phone.

1.8.4. The Chair wrote to Charlie's partner, inviting his engagement in the review but no response was received, and he was deemed to have declined involvement.

1.9. Independent chair and author

1.9.1. The Independent Chair and Author is Paula Harding. She has over thirty years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs* in 2013. She has also completed the on-line training provided by the Home Office, as well as undertaken training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

1.9.2. Paula Harding worked for Birmingham City Council as the strategic lead for violence against women for more than a decade. Since leaving the statutory sector in 2016, Paula Harding has worked as an independent consultant, mainly engaged in chairing and authoring domestic abuse and safeguarding adult reviews. She has also worked with Women's Aid organisations to help improve their strategic planning and improve how they demonstrate outcomes from their work.

1.9.3. Although Paula Harding has not been employed by any agency in Dudley or Birmingham for the period in scope of this review, she was commissioned to undertake the Dudley Domestic Abuse Needs Assessment as this review was coming to a close. As this role was also analytical, it was considered to be complimentary to the review and not undermining of her independence in the review itself.

1.10. Members of the review panel

1.10.1. Multi-agency membership of this review panel consisted of senior managers and designated professionals from the key statutory agencies, and all were independent of the case.

1.10.2. Wider matters of diversity and vulnerability were considered when agreeing panel membership. Black Country Women's Aid and Churches Housing Association for Dudley and District (CHADD) who provided domestic abuse services in the area and brought their expertise to the panel. Consultation was held in the later stages of the review between the Independent Chair and a national expert in suicide prevention.

1.10.3. The review panel members were:

Name	Role/Organisation
Paula Harding	Independent Chair
Christine Conway	Head of Adult Safeguarding, Dudley MBC Adult Safeguarding
Jane Atkinson	Designated Nurse for Safeguarding Adults, Dudley Integrated Health & Care NHS Trust
Jane Lovell	Team Lead, Adult Safeguarding, University Hospitals Birmingham NHS Foundation Trust
Jean Reid	Head of Supported Housing, CHADD
Julie Mullis	Head of Safeguarding, Dudley Group NHS Foundation Trust
Katriona Lafferty	Community Safety Officer, Dudley MBC Community Safety
Michael Loftus	Lead Nurse Adult Safeguarding, Birmingham Community Healthcare NHS Foundation Trust
Michael Bailey	Detective Inspector, West Midlands Police
Merryn Tate	Head of Adult Safeguarding, Birmingham City Council Adult Social Care
Natalie Solomon	Associate Director for Safeguarding, Black Country Healthcare NHS Foundation Trust

Nicola Hale	Head of Safeguarding, Practice and Quality Assurance, Children's and Young People Safeguarding and Review, Dudley Council Children's Service
Raj Lagan	Regional Head of Domestic Abuse Service, Black Country Women's Aid
Sarah Mantom	Designated Nurse for Safeguarding Adults and Children (Serious Violence Lead), NHS Birmingham and Solihull Integrated Care Board

1.11. Time period and key lines of enquiry

1.11.1. The panel agreed that the review should focus on events from May 2018 when Charlie began to receive maternity services. Information about earlier times was included for contextual information only.

1.11.2. It was determined that review would address both the 'generic issues' set out in the Statutory Guidance, below as well as the following specific key lines of enquiry

(i) Individual responses: How effective were practitioners in responding to the needs and risks faced by Charlie and her child and the threat posed by her partner?

- *To provide a pen picture of the victim and her family as known by agencies at the time of contact*
- *To analyse key episodes of agency involvement, to assess what needs, risk and threat each agency identified for the individuals/family and how each agency responded.*
- *How was the support of family, friends and wider networks understood as protective factors?*
- *If domestic abuse was not known, how might practitioners have identified the existence of domestic abuse from other issues presented to them, in accordance with NICE Quality Standard QS116 Domestic Violence and Abuse, available at https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse? For example, were there policies and procedures for direct, selective or routine questioning and how well were they implemented in this case and the rationale for decision making?*
- *Was the impact of mental health issues and risk of suicide effectively recognised and assessed and what action did agencies take in identifying and responding to these issues, including in compliance with medication?*
- *What barriers to engagement did agencies experience and how did they seek to overcome these barriers?*
- *In what ways, if any, were agencies' response influenced by issues of equality, diversity or vulnerability?*

- *How effective was agency supervision and management of practitioners involved and did managers have effective oversight and direction of the case and on case closure?*
- *Were there any issues in relation to capacity or resources within agencies that affected their ability to provide services to the individuals/family or to work with other agencies, or create delays?*

(ii) Multi-Agency Practice: how effective were agencies in working together to prevent harm and to meet individuals' needs, within and across borders?

- *How were roles and responsibilities understood and multi-agency protocols adhered to?*
- *Was there a shared ownership and approach?*
- *How effective was the co-ordination of services?*
- *How effective was communication, information sharing and sharing records?*
- *How effective was escalation between agencies?*
- *Did multi-agency systems present difficulties or challenges to the effective delivery of services to members of the family?*

(iii) What impact did the Covid pandemic have upon service responses and upon the domestic abuse experienced?

(iv) What good practice can be identified?

(v) Are there lessons to be learnt from this case about how practice could be improved?

- *what lessons can be learnt to prevent harm in the future?*
- *How do the circumstances improve our collective understanding of domestic abuse and suicide?*

(vi) What recommendations are to be made and how will the changes be achieved?

- *Individual agency recommendations*
- *what system-wide, multi-agency recommendations need to be made?*

1.10.3 In addition, the following agencies are asked to respond specifically in their IMR to the following points in addition to those above:

- Dudley Group and Black Country Healthcare reports to identify who should do routine/selective enquiry on domestic abuse where a victim attends the Emergency Department but is referred swiftly to the psychiatric liaison team.
- West Midlands Police IMR to provide the background of any previous offences and criminal justice outcomes
- Dudley Children's Services and West Midlands Police IMRs to summarise their role in the DART processes in August 2020 and January 2021
- For GPs – how referrals and notifications were followed up

1.12. Equality and diversity

2.7.1 The review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010[4], as well as to wider matters of vulnerability for the victim.

1.12.1. Charlie was a 22-year-old, white, British, young woman who had a child when she was 19. Her partner was aged 23 when Charlie died. His family are part of the settled traveller community in Dudley.

1.12.2. The review therefore identified that protected characteristics of sex and gendered violence, young age, pregnancy and maternity as well as race (travelling community) should be considered. Issues of vulnerability including mental health for both Charlie and her partner were also considered.

1.12.3. The Review applied an intersectional framework in order to understand the lived experiences of the individuals concerned. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experience with local services and within their community.

1.13. Contributors to the Review

1.13.1. The following agencies who had had significant contact with the family were asked to contribute an IMR and chronology to the review:

- Birmingham City Council Adult Social Care
- Birmingham and Solihull Integrated Care Board
- Black Country Healthcare NHS Foundation Trust
- Dudley MBC Children's Services
- The Dudley Group
- West Midlands Police

1.13.2. The following agencies with some contact, or contextual information concerning the family were asked to provide briefer information reports to the review:

- Birmingham Children's Trust
- Birmingham Community Healthcare NHS Foundation Trust
- Birmingham Healthy Minds

[4] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

- Black Country Women's Aid
- Dudley Council Adult Services
- Dudley Council Housing Services
- Nottingham Trent University
- University Hospitals Birmingham
- West Midlands Ambulance Service

1.14. Agencies without contact

1.14.1. The following agencies were contacted but confirmed that the family were not known to them, or that their involvement was not relevant to the review:

- Birmingham Women and Children's NHS Foundation Trust
- CHADD
- Dudley Integrated Health & Care NHS Trust
- Dudley Council Revenues and Benefits
- Probation Service

1.15. Parallel reviews

1.15.1. A criminal investigation was undertaken concerning Charlie's experiences of domestic abuse prior to her death but there was insufficient evidence to progress to criminal proceedings.

1.15.2. At the time of writing, no date has been set for the inquest into Charlie's death but the Independent Chair and the coroner's office have maintained liaison throughout.

1.15.3. The review was aware of no other parallel reviews.

1.16. Dissemination

1.16.1. The following individuals and organisations will receive copies of this review:

- The victim's family
- Agencies directly affected by this review
- Dudley Safe and Sound and its agencies
- Dudley Domestic Abuse Local Partnership Board
- Birmingham Community Safety Partnership
- The coroner

- West Midlands Police and Crime Commissioner
- Domestic Abuse Commissioner for England and Wales
- Public Health England

2. BACKGROUND INFORMATION

2.1. Charlie grew up in a secure family home in Sutton Coldfield, alongside her twin brother who has severe cerebral palsy. She was described by her family as a kind and gentle soul who always looked for the good in people. Charlie had been highly motivated from an early age and became accomplished in judo, guitar and dance. This motivation and ethic of hard work continued into adulthood, and she worked consistently from a young age.

2.2. Charlie met her partner online during her first year of sixth form in 2016. Her partner was one year older than Charlie. He was her first boyfriend and vice versa. Her partner was from a traveller family who had settled amidst an established traveller community in the Dudley area, approximately 20 miles from where Charlie lived.

2.3. From the early days of their relationship, her partner was observed to be controlling of Charlie. For example, in 2017 Charlie went on holiday with a close friend. This was her first independent holiday without her parents and her partner did not accompany her. However, Charlie told her friend that her partner was constantly calling and messaging her whilst they were away, needing to know what she was doing and what she was wearing. He asked Charlie to take photos each day in order for him to approve her outfits and she often changed her outfit if he did not approve.

2.4. As the relationship progressed, her closest friend noted that Charlie spent more time with her partner and his friends in Dudley. Charlie told her friend about arguments with her partner which involved drunken pushing and shoving but she excused his behaviour saying that, as she had pushed him back, it was not a problem.

2.5. Her partner had two brothers one of whom later went on to die through suicide shortly before Charlie's death. Drugs, alcohol and domestic abuse were features of this wider family.[5]

2.6. Charlie had worked part-time at a national retailer's store since she was sixteen and her partner went on to hold various short-term jobs, including as a forklift truck driver

3 CHRONOLOGY

2018: Pregnancy

3.1 Early in 2018, Charlie became pregnant which surprised her closest friend as she had never expressed much interest in children. Indeed, Charlie was continuing to work part-time at a national retailer's store during her pregnancy and told a work colleague that she wanted a termination, but that her partner would not let her. She advised the GP that although the pregnancy was not planned and the result of a missed contraceptive pill, she was nonetheless happy about it.

3.2 Charlie engaged well with antenatal care during her pregnancy and her mother accompanied her to most of her appointments. Charlie informed the maternity staff that she felt well supported by her partner and family but that she had been snappy with her partner during the pregnancy and felt guilty about this.

3.3 Routine enquiry about domestic abuse was undertaken in maternity services when Charlie was 37 weeks pregnant. However, before this, whilst 27 weeks pregnant, Charlie disclosed to maternity staff that she had been feeling low in mood: that she felt no connection with the baby and was undecided if she wished to keep it.

3.4 A referral was made to the perinatal mental health midwife, and Charlie was seen one week later by the specialist mental health midwife and again at 4 weekly intervals thereafter and her GP was notified about the referral. She told the midwife that anxiety and depression had started whilst she was in university, and she felt that she had become steadily more withdrawn and socially isolated since and that this had become worse during her pregnancy. She described how, by being pregnant, she was not feeling herself and was starting to lose her personality. Despite her openness at this time, her family described how Charlie

[5] Information on the wider family history was known to the local authority.

would smarten herself up before her appointments with the perinatal midwife, and make herself appear that she was coping better than she was, for fear of losing her baby. At these times, her mother suggested that it would be better for the midwife to see Charlie as herself.

3.5 Whilst Charlie described improvement in her mood and anxiety levels as the weeks progressed, she felt that the pregnancy was still affecting her mood, and this was to be reviewed postnatally. However, Charlie declined further appointments when they were offered to her after the birth. Her family thought that this was because she was again frightened that her children would be removed by children's services as she had been warned of this by her partner's family.

3.6 During the pregnancy, her partner moved in with Charlie and her family for several months and during this time Charlie's mother noticed the partner's controlling behaviour towards her daughter.

September 2018 Commencing University

3.7 Charlie loved animals and from a young age had ambitions to work in animal conservation. In 2018, she accepted a place at Nottingham Trent University to study a degree in Wildlife Conservation and stayed living at home, travelling to university each day. Before starting her course, she advised the University that she was pregnant and met with them to discuss the management of pregnancy and maternity on her studies and agreed the dates of her maternity leave. She told the University that she had no concerns about her well-being and was living at home with supportive parents and her partner.

December 2018: Birth of the Child

3.8 After the child was born in December 2018, Charlie and her partner continued to live with Charlie's family who observed that her partner did not help to look after the child: they never observed him washing or bathing the child, but he played on his PlayStation for most of the day.

3.9 Health visitors saw Charlie and the child at home for routine assessments after the birth and at 6-8 weeks and, as no concerns were identified, they remained under Health Visiting Universal services.

3.10 Charlie was due to return to her studies in February 2019, but, uncharacteristically, she did not contact the university again and did not respond to their attempts to contact her. Her close friend observed that she had been

struggling to balance the demands of her course with her relationship even before her baby was born. It was known at the time, by her family, that her partner did not like her going to university.

May 2019: Overdose

3.11 In May 2019, West Midlands Ambulance attended to Charlie, who was staying with her partner and his family at the weekend. She had attempted suicide by taking an overdose of Co-codamol and Citalopram. Paramedics enquired about the attempt and Charlie disclosed that she was having family worries as her mother had recently been diagnosed with cancer and her father had suffered a stroke. She was also having financial worries. However, she stated she had no future plans or intention to take her life and it was a cry for help. She was taken to the Emergency Department of Russells Hall Hospital and the Ambulance Service submitted a safeguarding referral to Adult Social Care for Charlie and to Children's Services in respect of her child.

3.12 At the hospital, she was received by the Emergency Department (ED) triage nurse who recorded that Charlie was accompanied by her 'partner' and that her child was with his parents, where they often stayed. She described the overdose as a "cry for help" because of "increasing family issues" and feeling "unable to cope," but that she had no intention of taking her own life. It was not clear from the records whether this conversation was held in private but no direct questions about domestic abuse were asked.

3.13 The triage nurse completed a self-harm screening tool which recorded that she was not at immediate high risk of self-harm and notified the safeguarding team with minimal information. Charlie provided the same information to the ED doctor and again it was not recorded whether she was seen alone or asked about domestic abuse and she was referred to the Mental Health Liaison Team.

3.14 Both the triage nurse and the doctor identified safeguarding issues for the child arising from Charlie's overdose and a safeguarding referral was completed to both Birmingham and Dudley Children's Services as both addresses in Birmingham and Dudley were recorded.

3.15 Charlie told the Mental Health Liaison Team that it had been an impulsive overdose and how she had previously felt unable to cope or manage her emotions when she was pregnant. She denied any current active thoughts, plans or intent for self-harm or suicide and denied domestic abuse, which was routinely asked, and the assessment concluded that there was no current evidence of severe or acute mental illness and no current role for secondary mental health services. As

Charlie planned to move into the area shortly and would be registering with a local GP, she was given details regarding Dudley Talking Therapies. The Team were aware that safeguarding referrals had been completed by staff in the Emergency Department.

3.16 Dudley Adult Social Care's duty service called the hospital on the following Monday morning to find that Charlie had been discharged and made a referral to Charlie's GP, leaving a detailed message, and to Birmingham Adult Social Care, which was where Charlie was registered with a GP. Both Birmingham Adult Social Care and the hospital also notified Charlie's GP, advising of the overdose and her low mood since the birth of her child and the GP who contacted her directly the same day. Although she initially declined to come into the surgery or accept health visiting support, the GP persisted, and she met with the GP a week later. She described some of the family stresses but said that she got on well with her partner, was protective to the baby and, whilst had thoughts of suicide, had no plans to do so. She was prescribed anti-depressant medication and given the details for Acacia, a local family support service, but she did not pursue this referral.

3.17 In the meantime, Charlie had texted the health visiting team saying that she was feeling progressively worse with post-natal depression and would like to talk with someone. Unable to reach her, the health visitor advised the GP who confirmed that she was being prescribed medication for low mood.

3.18 Still unable to make contact, the health visitor contacted both Birmingham and Dudley Children's Services for advice and asked their own Trust's safeguarding lead for information, although the background to Charlie's overdose was not shared. It transpired that the health visitor had the wrong address for Charlie and, having been advised of the correct address, undertook an unannounced home visit and met with Charlie's mother who had been encouraging her daughter to meet with the health visitor or GP. The health visiting service made several attempts to contact Charlie before the health visitor began a long-term absence and there was a 12-week delay in re-allocation of the case.

3.19 In the meantime, the GP was able to reach Charlie by phone after several attempts in July 2019. She reported that she did not always take her medication as it gave her headaches and was booked for a face-to-face review of her medication which she did not attend. She was written to asking to re-book, but the GP Practice did not have any further contact with her. Later, they sent a letter advising her to register with a local GP when it was known that she had moved out of the GP's catchment area.

September 2019: Moving to Brierley Hill

3.20 When the health visitor contacted Charlie by phone in September 2019, Charlie reported feeling better: she was working and had moved to Brierley Hill. The health visitor advised Black Country Healthcare, who provide health visiting services for Dudley, of the move and included details of Charlie's mental health history in verbal and written handover, per guidance.

3.21 In November 2019, Charlie and the child were visited by the new health visitor at her partner's family home where they were living, and the health visitor observed the child's good development. Charlie discussed the overdose that she had taken in the previous May as well as her concerns for her partner's mental health. The health visitor routinely asked Charlie about domestic abuse which she denied. She advised the health visitor that she was a 101 operator and the health visitor assessed the family's need for only universal health services.

3.22 In December 2019, the health visitor visited Charlie and the child at the new family home and the child passed all the developmental milestones in the routine 9-12-month development review that was undertaken. The health visitor asked Charlie again about domestic abuse which she denied.

3.23 When the pandemic started in January 2020, Charlie continued to work shifts at the Ambulance Service as a call handler.

August 2020: Report to the Police

3.24 In the early hours of one morning in August 2020, Charlie's partner contacted the police saying, "Me and the Misses have had a scuffle" and that Charlie had "kicked off" at him when he returned from the pub. The call taker recorded that a female could be heard shouting in the background and repeating the phrase, "… just come around and sort it out."

3.25 Charlie advised the attending officers that she was angry with her partner when he arrived home. Her partner had kicked her in the stomach, and she responded by slapping him across the face, at which point her partner called the police. Charlie declined to make a formal complaint and it was not known whether the alleged assault had resulted in visible injury as police officers did not record whether they had asked her if she had visible injuries or ask her to show them her stomach area if it was covered by clothing.

3.26 Charlie's partner agreed to go to stay with his mother who had arrived at the scene. The police assessed the risk to Charlie as standard and recorded a crime of common assault with her partner listed as the offender. It was recorded that

'referrals were considered but were not necessary in the circumstances.' In the absence of a formal complaint, any history of abuse or evidence being available, the matter was reviewed by a supervisor and filed pending Charlie making a formal complaint in the future.

3.27 Although the police did not record where the child was at the time of the incident, the incident was considered by the multi-agency Domestic Abuse Response Team (DART), comprising the police, children's services, health services and Black Country Women's Aid, checked for previous history and found no previous reported incidents or record of her partner on the Police National Computer. However, they considered that the threshold was met for Early Help intervention in line with Level 3 of Dudley's Threshold Guidance and Framework for Support[6] and committed to refer Charlie to the health visiting team and to CHADD for domestic abuse support. Whilst Black Country Women's Aid made a referral by email to CHADD on the following day, CHADD could not identify having received it.

3.28 A decision was made for a family support worker to visit the family home and visits were made ten and fifteen days later without success. The referral did not contain a phone number for Charlie and in the absence of contact and without consent having been gained for the referral, the Senior Practice Supervisor for Family Support closed the case.

3.29 One month after the report, a second health visitor from Black Country Healthcare tried to contact Charlie by phone eventually reaching her two weeks later and six weeks after the reported incident. Charlie minimised the reported domestic abuse, describing it as an argument. Although the health visitor had more detail of the assault, Charlie's account was accepted without question, and she declined further support from the health visitor. The child remained subject to universal health services, without escalation to universal plus services as might have been expected. [7]

3.30 Shortly after this incident, Charlie video-called her friend in a very upset state and told her that her partner had beaten her. Indeed, her friend saw the bruises on her arm and asked her to bring her child and come and stay with her. Charlie declined, but her friend noted that after this incident, Charlie became more closed

[6] Available at https://dudleysafeguarding.org.uk/children/professionals-working-with-children/safeguarding-children-procedures/

[7] At this point there was a history of mental health concerns with Charlie and an episode of domestic abuse which should have initiated a higher level of health visitor input. It is unclear why the risk was not reassessed at the time. The pre-school standard operating procedures (2017, updated 2021) advise that if there is mild to moderate mental health and domestic abuse, children should receive the universal plus care pathway

and only spoke generally about arguments that she had with her partner, thereafter.

January 2021: Silent Call to the Police

3.31 During an evening in late January 2021, a silent 999 call was made to the police but in the background a man could be heard shouting at a child, and a woman was crying. It sounded like the man was shouting and swearing but it was unclear what was being said. An upset woman's voice could be heard in the distance saying to 'get off'. The line was kept open to listen in case of further comments and the police undertook subscriber checks on the number. They found that it was registered to Charlie's father, but they were able to identify that the phone's location was elsewhere at the time and sent a dog unit to Charlie's address.[8] The house was quiet on arrival and there were no signs of disorder.

3.32 Officers from another area of the Force then attended Charlie's parents' home, twenty miles away, where the phone was registered. Her mother called Charlie in the officers' presence to check on her welfare and she confirmed that she was at her home address.

3.33 Charlie's mother provided background information and police checks revealed the previous domestic incident reported in August 2020. She told Charlie that police officers would be returning to her address to check that she and the child were safe. However, the officers from Sandwell and Dudley police were diverted to an incident requiring an immediate response and the night shift controllers struggled to resource the matter but continued to try to call Charlie's phone to update her, but there was no reply.

3.34 Police officers were not able to return to the address again until the early shift started work on the following morning, at which point Charlie told them that her partner had tried to snatch her phone and caused a small bruise to her left forearm as he did so. Charlie stated that the police had been called by mistake and she declined to make a complaint, provide a statement or engage with the Domestic Abuse Risk Assessment. She explained that her partner suffered from depression, for which he took medication, but that lockdown was having a negative effect on his mental health. Other than going to see his doctor, which she had planned, she said that she did not know what to do. By this time, her partner had gone to stay at his mother's address, as Charlie thought, to cool off.

[8] Charlie's family advised that she had downloaded the OneScream App, which is a voice activated personal safety App, onto her mobile phone but it was not this App that alerted the police on this occasion.

3.35 Charlie was offered safeguarding advice and was encouraged to contact Black Country Women's Aid. She was also advised to contact the doctor if her partner's mental health was affecting her. Officers recorded the incident as a crime of assault and assessed the risk as standard.

3.36 A supervisor then reviewed the matter and noted that THRIVE+ risk assessment had been considered but from the information known at the time there were no immediate concerns for Charlie. The case was forwarded to the Public Protection Unit who informed Charlie that, in the absence of a complaint and in the light of her injury being minor, that the matter would be filed unless she wanted to pursue a complaint later.

3.37 As a child was known to be of the household, the police shared information with partner agencies through the DART where it was determined that the threshold was met for intervention at level 3, with MASH and IDVA referrals. The IDVA from Black Country Women's Aid contacted Charlie by phone but she declined support for herself but wanted help for her partner's mental health. She was advised to speak to the GP, provided with basic safety advice and her case closed.

3.38 Children's Services undertook lateral checks with other agencies and the previous report of domestic abuse was noted. They spoke with Charlie by phone who repeated her concerns for her partner who was struggling with his mental health and was not taking his medication. She thought that when he was taking his medication, he was fine. In terms of their circumstances, Charlie advised that the couple had recently moved from Birmingham, and she was working as a call assessor for the Ambulance Service locally, whilst her partner was working as a fork-lift driver. Charlie went on to say that she had been reluctant to engage with CHADD domestic abuse service previously because a close relative worked there. However, she would now accept support from a Health Visitor or Early Help services.

3.39 The MASH Team Manager made a decision to progress to Early Help intervention at Level 3 with the plan for a family support worker to complete an Early Help Assessment; for support from the health visitor; for Charlie to engage with domestic abuse support, and for her partner to be spoken with concerning his mental health and the impact of domestic abuse upon his family.

3.40 Over the following days, Birmingham Children's Trust shared information concerning the overdose and a Multi-Agency Assessment Meeting was held from which Charlie was advised that a family support worker had been allocated. The health visitor visited Charlie at home a week later and discussed the domestic abuse and the mental health support that Charlie felt was needed for both her partner and herself. The health visitor was unsure of whether the family support worker or herself were taking the lead on the early help work and therefore no

plan of care was created by the health visitor to address the issues that Charlie had raised beyond arranging a 2-year developmental check for the child.

3.41 Charlie's concerns for her partner's mental health were repeated when she spoke with the family support worker during the following week. She reportedly felt that if her partner could manage and cope with his depression, then the domestic abuse would not happen. However, her safety plan was to go to her mother's house if anything did happen in the future. She again agreed to a referral to Women's Aid.

3.42 The family support worker tried to contact her partner on the following day without success. The worker also phoned the GP but was unable to get an answer before going on planned extended leave for the next five weeks, trying again during the week of their return to work. By the time of the family support worker's return, Charlie advised that she no longer needed support with her relationship.

3.43 In early April 2021, the family support worker commenced the Early Help Assessment by video call but, experiencing difficulties getting hold of Charlie, was unable to complete it before leaving the local authority a couple of weeks later.

3.44 When the new family support worker was appointed mid-May 2021, conversations were held with the health visitor who advised that the family had made progress; the violent incident had been an isolated incident; the home was a little cluttered but not of concern, and that she had advised Charlie to play with her child and take the child to the park.

3.45 After experiencing some difficulties in contacting Charlie, the family support worker and health visitor undertook a joint home visit at the end of May 2021. Charlie advised that her partner's brother had died through suicide which was why she had been hard to contact. Charlie advised that they were registered with a GP and that her partner seemed better as he was taking his medication. She advised that she no longer felt that she needed family support from Children's Services but was happy to continue with the health visitor's input: a view that was supported by the health visitor. The Early Help Assessment was completed; behavioural advice given to Charlie concerning the child; referrals made in respect of the child's development and the case closed with approval of the senior practice supervisor from Children's Services. It was considered that there was no indication that there were any concerns that could not be met by universal health visiting services.

3.46 In mid-July 2021, Charlie messaged her friend to say that she was moving back to her mother's home as there were too many problems in the house that she shared with her partner, and they could not afford it. She re-registered with her

former Birmingham GP Practice and a week later had a telephone consultation with her GP regarding irregular periods and intermittent lower abdomen pain. She advised that she was having regular unprotected sexual intercourse with her partner but had tested negative for pregnancy in May. She was asked to have her bloods taken for a repeat pregnancy test, but she did not attend the two appointments made.

3.47 At the end of the July, Birmingham Community Healthcare was notified that Charlie was moving back to Birmingham and left a message for the Brierley Hill health visitor to call back and handover the case, but this did not appear to have been done. Over the following month, the Birmingham health visitor tried several times to contact Charlie by phone and at her parent's home, to no avail.

3.48 After she had moved back, Charlie started to talk more with her mother about her relationship and about how her partner's behaviour was getting worse, and he was becoming violent with other people. She still stayed with her partner in Dudley at times, but her mother suggested that she just throw everything into bin bags, and they would pick her up whenever she wanted.

August 2021

3.49 At the beginning of August 2021, Charlie had started working at a veterinary surgery. She had also enrolled at Wolverhampton University to study animal behaviour. Although she had not been able to see her friend so much during the Covid pandemic, she texted her for the last time arranging to meet at the weekend.

3.50 Later that month, a couple of days before her death, Charlie met with her father, and he described her as cheerful and bubbly: talking about her work which she was clearly enjoying.

3.51 On the day before her death, Charlie spoke with her mother on the phone advising that she and her partner were going to pick up a new bed on the following day and she seemed happy and upbeat.

3.52 On the day of her death, Charlie did not contact work to say that she wouldn't be coming in, as would be her normal behaviour. Her uniform was in the dryer and ready to wear, suggesting that she had been planning to go to work. She was found by her partner who contacted emergency services.

Family concerns about the death

3.53 After the death Charlie's family inspected the car and suspected that there had been a serious argument on her final day, as the passenger side of the car had been kicked in; the internal grab handle above the door had been ripped out; there was coca cola all over the driver's side of the car and there were large kitchen knives under the passenger seat. The family were also concerned about the state of neglect in Charlie's home.

3.54 Police officers had their body worn video cameras activated when attending the reported death. However, they did not consider that the property could be described as squalid and, for example, noted that the bathroom did not appear particularly dirty. This description differed from that of the victim's family who visited Charlie's home after the death and observed the house to be a filthy state with have half-drunk bottles of alcohol and take-away chicken strewn everywhere. Charlie was a vegetarian who rarely drank alcohol. There were also boxes of prescription drugs with unknown names, and indications that there may have been some kind of sex work going on.

3.55 Images of Charlie's home were seen by the review panel and revealed significant clutter in every room and a punch mark on one of the doors. The family reflected on what they had seen and wondered whether the house had been used as a party house by her partner and his friends. Significantly there were numerous bin bags filled with Charlie and her child's things, suggesting to them that Charlie was trying to leave and had done what her mother had suggested by packing her things quickly and ready to go.

3.56 The Police had found nothing apparent at the address to suggest foul play or suspicious circumstances and, on the basis was not considered to be a crime scene. Although no-one was implicated in the death, a criminal investigation took place concerning allegations of her partner's coercive control of Charlie during their relationship. A police investigation, and full review by a Detective Inspector, found insufficient evidence to proceed with the investigation.

4. OVERVIEW OF AGENCY INVOLVEMENT

4.0 This section considers the Individual Management Review and Information Reports completed by individual agencies and the outcomes of discussions with the review panel concerning improvements to services in the future.

4.1 West Midlands Police

4.1.1 The Police reflected upon the two incidents reported to them in a six-month period between 2020 and 2021. Both incidents resulted in crimes being recorded with her partner as the offender and Charlie as the victim, despite her partner having called the police on the first occasion. The police's accurate identification of the victim was recognised by the panel as good practice.

4.1.2 Both incidents were recorded as standard risk and officers were unable to engage Charlie to provide a statement or to complete the risk assessment. At neither time were they aware of the extent of domestic abuse that Charlie was experiencing, as this has only become apparent to agencies after her death. Nevertheless, West Midlands Police reflected that from the information that they knew, that the second report could have been graded as a medium risk as it was the second reported incident in six months and the victim had not been the one to make the report on either occasion. The Force has therefore been asked to provide assurance to the Community Safety Partnership about the accuracy of risk assessments in domestic abuse.

4.1.3 Although Charlie declined referrals to support services herself, the police recognised that for other issues[9] they have developed their practice requiring victims to opt out of referrals rather than having to opt in. This has been shown to be more successful in enabling victim engagement with support services. West Midlands Police have committed to exploring this method of referral in domestic abuse and the report will consider this alongside wider barriers to engagement.

4.1.4 On the second report, the police went to some lengths to track down the phone, which was registered to Charlie's father, and enlist the help of Charlie's mother in locating her daughter. However, they reflected that it would have been beneficial to have taken and recorded more background information from Charlie's mother and recognised that there had been a lack of professional curiosity at this time. The police have recognised this as a learning point.

[9] For example, West Midlands Police require victims of rape and serious sexual assault to opt out of referrals rather than opt in.

4.1.5 The attending officers did not record that they had checked the location and well-being of the child. However, information was shared with partner agencies concerning the child's exposure to domestic abuse and the police met with other agencies to discuss the child's needs through the DART process. Since this time, (October 2022) a new application has become available on mobile devices to assist responding officers in ensuring that the voice of the child is recorded and listened to, and child protection issues identified. Recognising this to be a good practice development, West Midlands Police have been asked to report to Dudley Safe and Sound on the impact of the use of the 'Child Abuse App' on the identification and response to children when responding to domestic abuse incidents.

4.1.6 The Police recognised that there were delays in attending both incidents. Officers attended after 33 minutes rather than within 15 minutes required for an emergency response. There was also a delay in attending the second incident where, having worked hard to identify and locate Charlie's phone as the silent call on the evening in January 2021, the Police had insufficient resources to deploy officers to attend to her until the following shift the next morning.

4.1.7 West Midlands Police provided evidence to the review of the alarming increase in domestic abuse reporting and domestic abuse related crime that they are faced with. In the year that the Police responded to reports of domestic abuse for Charlie, there had been a 29% increase in domestic abuse reported incidents and a 39% increase in domestic abuse related crimes compared to the previous year and these increases have continued since. These figures were set against a backdrop of reducing police budgets, the associated reduction in the number of officers and the effects of the Covid-19 pandemic which will be considered further in the report.

Recommendation 1: Police response times

Dudley Safe and Sound to seek from West Midlands Police and Crime Commissioner an analysis of West Midlands Police response times for domestic abuse incidents.

4.2 Dudley Adult Social Care

4.2.1 Dudley Adult Social Care responded to one referral from the Ambulance Service following Charlie's overdose in May 2019. The duty team contacted the hospital to find that Charlie had been discharged to her home in Birmingham and referred to

the MASH, Birmingham Adult Social Care and the GP but did not attempt to contact Charlie further.

4.2.2 Adult Social Care has committed to introduce a suicide risk process for their own services and for the Adult Multi-Agency Safeguarding Hub which, amongst other things, will involve attempting contact with the individual at least three times, which was welcomed by the review. Consideration over best practice when agencies are not able to engage a victim is given for all agencies in the thematic section of the report which follows.

4.3 Dudley Children's Services

4.3.1 Children's Services were notified after each of the reports of domestic abuse were made to the police. The notifications were screened through both DART and MASH, and the Early Help service was assigned to respond.

4.3.2 There was a delay in screening the initial contact, which led to delays visiting the family home. However, there were significant delays involved in progressing the Early Help Assessment from the second referral and as a result of annual leave arrangements, mother and child were not seen until eight weeks after the contact had been received and then by video call. As the worker left and the case was left unallocated for a month, there was a further seven-week gap until the next home visit was arranged to complete the assessment. There did not appear to have been interim arrangements put into place to manage the case during these periods and Children's Services reflected that these delays and lack of continuity of care may well have been impactful on Charlie moving from her position of welcoming help and referrals to domestic abuse services, to no longer wanting support. The Service has committed to ensuring that interim arrangements are in place for families in situations where practitioners are absent from work; to provide greater opportunities for timely engagement and to ensure timely referrals to domestic abuse services when consent has been provided.

4.3.3 The Service reflected that they need to find more effective ways of engaging with domestic abuse victims and perpetrators and taking a more persistent approach. In this case several attempts were made to contact the young parents by phone without success but visits to the family home, and joint visits with other professionals were not considered. These may be more effective in terms of gaining traction, seeing families, and building relationships where individuals may feel more able to speak about their experiences and the struggles they are facing.

4.3.4 The initial visit being carried out by video call would likely have impacted upon the service's ability to build a relationship with the family, but it likely also impacted upon the quality of the assessment. Overall, the Early Help Assessment was seen to have lacked detail and professional curiosity. The assessment was completed following one visit to the family home and without speaking with her partner. There were key concerns which did not appear to have been explored with Charlie during the visit including:

- Whether there had been any further unreported violent incidents or exploration of coercive control
- Her disclosure concerning her own mental health and her previous overdose
- her partner's mental health, particularly following his brother's suicide
- The nature of her support network
- Her relationship with the paternal family, particularly as the paternal grandmother had been present during the first reported incident of domestic abuse

4.3.5 The assessment lacked a triangulation with other agencies and was heavily reliant upon Charlie's self-reporting of domestic abuse. The assumption being that, as she had not reported, that there were no ongoing risks. However, not having built a relationship with Charlie, it would not have been possible to consider or assess whether she was being subject to coercive control and minimising the abuse.

4.3.6 There could have been more robust checks at the point the contacts were received. For example, checks on the system would have shown that there was a history of concerns relating to drug misuse, alcohol misuse, poor mental health, and domestic abuse in her partner's wider family. The Service has therefore committed to improving the quality of assessment of risk in situations where there is domestic abuse, applying professional curiosity and a more nuanced understanding of domestic abuse beyond an incident-based approach. This would include exploring the wider, complex vulnerabilities with families beyond the presenting risk of domestic abuse, for example poor mental health, substance misuse, isolation, life stressors, family relationships, and issues relating to ethnicity and culture. It would also require that perpetrators of domestic abuse are not invisible to assessments over the safety and well-being of children.

4.3.7 The service reflected upon the barrier to engagement when Charlie withdrew her consent for future involvement and concluded that in situations where consent is

withdrawn then there may need to be a meeting to consider the impact of this on the risk level: whether universal services are enough or whether more services are then needed.

4.3.8 The review recognised that the design of Early Help should lend itself to the whole family approach and away from the incident- based responses that characterised domestic abuse responses, and that there had been great strides made in recent years by the service. Full recommendations for this service are listed below.

4.4 Primary Care

4.4.1 Charlie had been registered with the same GP Practice[10] since she was a child. During the period from 2018 onwards, Charlie had both face-to-face and telephone contacts with the GP.

4.4.2 The GP Practice responded swiftly to the Adult Social Care notification of Charlie's poor mental health since the birth of her child, contacting her the same day. They also demonstrated some persistence in encouraging Charlie to attend for a face-to-face appointment despite her reticence. Once meeting with her, the GP explored much of the context of her overdose and low mood, and her home environment. The GP was also proactive in contacting Charlie when she did not attend appointments or had declined help, effectively sharing information with the health visitor at this time.

4.4.3 Charlie made no direct disclosure of domestic abuse to the GP or Practice staff and the Practice was not made aware of domestic abuse by any other agency. Indeed, reports to the police about domestic abuse were made during the 13-month period when neither Charlie nor her child were registered with a GP, whilst she lived in Dudley.

4.4.4 However, there were a number of presentations that could have been indicators of domestic abuse, as identified by the National Institute for Health and Care Excellence (NICE) Quality Standard on Domestic Abuse (QS116). For example, no direct questioning of domestic abuse was undertaken when the GP was presented with Charlie's unplanned teenage pregnancy; her overdose; depression; menstrual irregularities and regular unprotected sex. [11] The GP explored the unplanned pregnancy with her, and they did not consider that further enquiry on domestic

[10] The GP Practice concerned is a collective of GP surgeries.

[11] Full list of presentations that may be indicators of domestic abuse can be found ar https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse

abuse was needed as she had already commented on the positive nature of the relationship. Neither did they think that it appropriate to make routine enquiry during a telephone consultation with a new patient and the issue of remote consultations is considered further in the thematic section which follows. Nonetheless, there remained times relating to Charlie's mental health when direct questions could have been asked and naming domestic abuse during selective enquiry was considered by the panel to be important.

4.4.5 The surgery became an IRIS 'domestic abuse informed practice' in January 2019 and direct questioning on domestic abuse would have been being introduced to the Practice shortly after Charlie's child was born. IRIS is an evidence-based programme of domestic abuse training and support to help GP Practices to spot the signs of domestic abuse, ask about the abuse and refer to specialist domestic abuse workers aligned to each practice.[12] The Programme, which is recommended by the domestic abuse statutory guidance (Home Office, 2021) has had a high take-up amongst GPs in the area and has been made available to all practices, funded through Dudley Integrated Care Board, which was seen as good practice.

4.4.6 Whilst the GP Practice has an up-to-date domestic abuse policy, as would be expected of an IRIS aligned GP Practice, it does not contain any clarity on direct questioning and seeing patients on their own. Indeed, it was not recorded whether Charlie was seen alone for all or part of her consultations. The practice will be updating its domestic abuse policy and procedure accordingly

4.4.7 When the Practice was informed about Charlie's referral to the peri-natal mental health midwife, there was no indication of follow-up or liaison in response to the notification. At the time, the process was not in place to bring all relevant notifications, which would include mental health concerns, to the attention of a GP. This process has since been put in place.

4.4.8 Although there were times when the context of Charlie's mental health was explored, there was little evidence of a Think Family approach considering the parent, child and young family as a whole and the GP Practice has recognised this as a learning opportunity to develop staff member's professional curiosity. The Practice has recently introduced the role of safeguarding co-ordinator who will be seeking to strengthen the Think Family approach and professional curiosity around risk. The Practice is also reviewing its system of alerts between a parent

[12] See https://irisi.org/wp-content/uploads/2021/04/What-is-IRIS-for-GPs-and-PCNs.pdf for further information on the IRIS Programme

and child's records to ensure that information on risks is known across the family's records.

4.5 Hospitals

4.5.1 Charlie was seen at hospitals in both Birmingham and Dudley during the period explored for this review.

University Hospitals Birmingham NHS Foundation Trust

4.5.2 Charlie was known to maternity services at University Hospitals Birmingham between May and December 2018 and was seen regularly for maternity care.

4.5.3 As Charlie developed low mood and anxiety during her pregnancy and felt unconnected to the baby, she was referred to the Perinatal Mental Health Midwife who met with Charlie on three occasions during which her mood improved but she felt was still being affected by the pregnancy and she was to be reviewed again after the birth, by which time she declined their involvement.

4.5.4 Charlie was asked about domestic abuse once when she was pregnant. Guidelines require routine enquiry on domestic abuse to be asked on three occasions during a pregnancy and guide staff to create opportunities to ask about domestic abuse safely when women are accompanied to their appointments by others. The need for routine enquiry would have been particularly pertinent in Charlie's case as her low mood and anxiety were themselves indicators of domestic abuse. Likewise, when she was 27 weeks pregnant, Charlie disclosed that she might not want to keep the baby and had domestic abuse been enquired about at that time, Charlie may have had the opportunity to disclose that she had wanted a termination earlier but had been coerced into not doing so. The issue of reproductive coercion is considered further in the thematic section of this report.

4.5.5 The Trust have made a recommendation to ensure that routine enquiry on domestic abuse is undertaken three times throughout the pregnancy and staff to try to create opportunities for safe enquiries when women are accompanied to their appointments.

4.6 Emergency Department Services at Russells Hall Hospital

Dudley Group NHS Foundation Trust

4.6.1 Charlie was taken to the Trust's Emergency Department (ED) at Russells Hall Hospital following an overdose and saw at least four members of staff during her four hours in ED. There was neither documented evidence to indicate that any staff had considered the link between overdoses, self-harm, suicide attempt, suicide ideation and domestic abuse, nor indications of professional curiosity when she disclosed "increasing family issues" and "being unable to cope". The Trust reflected that this should have triggered the staff to ask Charlie directly and in private about domestic abuse. Indeed, although the Trust's Domestic Abuse Policy requires staff to make every effort to see the patient alone and in private to ask about domestic abuse, it was unclear from the documentation whether Charlie was ever spoken to alone.

4.6.2 Since this time, the Trust has recruited a domestic abuse co-ordinator, introduced selective enquiry about domestic abuse in the ED and appointed an Independent Domestic Violence Advisor in the ED in keeping with the recommendations from the Pathfinder Toolkit[13]. Their recommendations concerning improving selective enquiry in domestic abuse were made within this context of an ongoing programme of improving service responses to domestic abuse which was welcomed by the review panel.

Black Country Healthcare NHS Foundation Trust

4.6.3 After being seen by the Emergency Department staff, Charlie was referred to the Mental Health Liaison Team which was provided in the hospital by Black Country Healthcare NHSFT.

4.6.4 All information around this attendance was placed on the child's records and not immediately accessible and the Trust has therefore made a recommendation to ensure that all members of a family have their own individual but linked records.

4.6.5 During her assessment by the Mental Health Liaison Worker, Charlie denied any further plans for self-harm or suicide and spoke about her overdose as having been impulsive. Charlie was asked whether she had any concerns about domestic abuse but did not disclose any. Routine enquiry being embedded in mental health liaison in this way was seen as an essential part of the process in the Emergency

[13] The Pathfinder Toolkit can be found at https://www.standingtogether.org.uk/blog-3/pathfinder-toolkit

Department as individuals subject to swift triage when received by the Department might not see other staff for the question to be asked.

4.6.6 The assessment concluded that there was not a role for secondary mental health services, but as she was moving to the Dudley area, she was signposted to Dudley Talking Therapies. However, staff in the Emergency Department were not notified of the outcome of the assessment and the GP was therefore not notified of the mental health assessment.

Domestic Abuse Services in the Emergency Department

4.6.7 Since this time, Independent Domestic Violence Advisors from Black Country Women's Aid are co-located in the Emergency Department of Russells Hall Hospital, and this was seen as good practice.

4.7 Health Visiting Services

4.7.1 As she moved between the two areas, Charlie's child received health visiting services in Birmingham, from Birmingham Community Healthcare NHS Foundation Trust, and in Dudley, from Black Country Healthcare NHS Foundation Trust.

4.7.2 Health visitors offer different levels of service depending upon the individual child and family needs. All families can receive 'Universal Services' which are provided as a right and monitor the development of children under 5. Families are assessed as needing a 'Universal Plus' service when they have additional needs, and 'Universal Partnership Plus' when a safeguarding risk for the child has been identified requiring a statutory local authority and multi-agency response. Charlie and her child received 'Universal' health visiting services from both agencies.

Birmingham Community Healthcare NHS Foundation Trust

4.7.3 Birmingham Community Healthcare provided health visiting services following the birth of the child in December 2018 and, after completing initial assessments for a new baby and at 6-9 weeks, attempts were made to contact Charlie after her overdose in order to undertake a reassessment of maternal mental health, to no avail. Although the health visitor contacted both Birmingham and Dudley Children's Services for advice, the contact between the health visitor and the Trust's safeguarding nurse in July 2019 lacked professional curiosity into the background and reasons for the overdose and important information about maternal mental health was not shared.

4.7.4 It was considered likely that had health visitors been able to engage Charlie meaningfully during this time, then the family would have been offered a 'Universal Plus' service and consideration been given to referrals to specialist services for postnatal depression and anxiety. Had a risk assessment been undertaken, this could have resulted in a referral to Birmingham Children's Trust by the health visitor and increased professional oversight of this family. The Trust has committed to develop guidance for practitioners to apply and support professional curiosity in practice.

4.7.5 Despite the health visitor communicating well with the GP whilst seeking contact, there went on to be a 12 week-lapse in health visitor contact after her health visitor's long-term absence and before a new health visitor was allocated. The Trust considered that a lack of management oversight at that time may have contributed to this delay. Local changes have already been implemented to address this and the Trust has committed to provide assurance that these have been effective.

4.7.6 When a telephone assessment was eventually undertaken in September 2019 prior to her move to Dudley, Charlie advised the health visitor that her mental health had improved, and she was being well supported by her partner and the assessment for Universal health visiting services therefore remained unchanged when the case was transferred to the next area.

4.7.7 The Trust also reflected upon how information was being recorded across child and adult records and found that information regarding maternal mental health and the service's inability to engage, was recorded only on the child's record and not on the mother's which meant that parts of the service, such as Early Years outreach services, would not have access to this information and was not in keeping with the Trust's record keeping policy and a recommendation has been made on this matter.

4.7.8 The health visiting service had not been made aware of key information regarding risks to Charlie and the child and this is considered in the thematic section which follows.

Black Country Healthcare Home Visiting Service

4.7.9 Black Country Healthcare provided health visiting services to the young family from November 2019 when they moved into their area from Birmingham, initially seeing Charlie and the child on their own. Routine enquiry on domestic abuse was undertaken on the first two visits and, although Charlie had been open in

disclosing her previous overdose and the challenges around her partner's mental health, there was a lack of professional curiosity displayed around the context for her overdose and her current circumstances and needs.

4.7.10 Although the health visiting service was invited, they did not attend the first DART meeting, and this may have contributed to the delay in contacting Charlie thereafter. However, having contacted her, there appeared to have been no in-depth exploration of the domestic abuse report and Charlie's apparent minimisation of the abuse was left unchallenged. Moreover, it was unclear why the potential risks to the family arising from maternal and paternal mental health and domestic abuse did not prompt a re-assessment of risk and initiate a higher level of health visiting input. The pre-school standard operating procedures (2017, updated 2021) advised that if there is mild to moderate mental health and domestic abuse, children should receive the 'Universal Plus' care pathway and this has led to a recommendation by the Trust.

4.7.11 It was reflected that there was a lack of continuity of care arising from the number of health visitors allocated over time and that the lack of re-assessment of risk may have been because the health visitor was new to the caseload or because of the limitations to health visiting imposed in response to Covid-19. This lack of continuity of care appeared to account for the absence of earlier referrals to mental health and domestic abuse services that Charlie had requested. Moreover, as the case was assessed as 'Universal' it would not have received the same degree of case oversight as those considered more complex. Clarity over the circumstances was further obscured as the mother and child records were separate but not linked.

4.7.12 By the time of the second DART notification, Charlie consented to early help and wanted mental health support for both herself, and for her partner. However, accessing support was not explored as the health visitor did not identify themselves as the lead professional and this had not been identified in the DART meeting. It was reflected that there were numerous opportunities for the health visitors to explore the impact of domestic abuse on this young family, as well as to explore the needs around mental health and substance misuse that arose and how these needs may be addressed. Moreover, as the health visitor had not picked up on the issues over mental health or domestic abuse, there was no liaison with the GP, except in respect of immunisation. Had GP liaison have been pursued, then it may have come to light that the child had not been registered with a GP for 13 months. There was also some delay before liaison was held with the family support worker and the relationship between early help and health visiting at this time is considered further in this report.

4.7.13 The Trust has committed to address the need to routinely review risk assessments and care pathways; to ensure representation at DART meetings and to link mother and child records.

4.7.14 Overall, there appeared to be a lack of confidence from the Trust's health visitors in exploring domestic abuse with Charlie and using the information that they held as a means to sensitively probe her apparent minimisation of the abuse she was experiencing. The Trust reflected that during Covid, e-learning had necessarily dominated training for health staff, but there had since been a return to face-to-face training which was recognised as being more effective in building practitioner confidence around discussing and questioning in domestic abuse. The Trust has committed to provide evidence-based assurance that actions to build professional curiosity and confidence to address domestic abuse have been effective in the identification, protection and support to children and families experiencing domestic abuse.

4.8 West Midlands Ambulance Service

4.8.1 The Ambulance Service were called upon to respond to Charlie on only one occasion in 2019 when she had taken an overdose. The crew exhibited professional curiosity by exploring in detail the context for the suicide before taking her to hospital and making referrals to Adult Social Care for Charlie and to Children's Services in respect of the child, which was good practice. However, in the absence of records and in view of the passage of time, it was not possible for staff to be called upon to recall whether the attempted suicide gave rise to routine enquiry on domestic abuse.

4.8.2 Since this time, West Midlands Ambulance Service have provided training to staff on the links between suicide and domestic abuse and have committed to recirculate their '7-minute' briefing to staff as a result of this review.

4.9 Nottingham Trent University

4.9.1 Charlie attended Nottingham Trent University for the first term of her degree course but did not return after her maternity leave as expected and did not respond to subsequent attempts to contact her during and following her planned leave. The University provided a detailed account of how they tried to contact her and provide options for her return.

4.9.2 Although Charlie had met with the University prior to starting her course to discuss her pregnancy, and how the University could support her studies during this time, no disclosures of domestic abuse were made, and no safeguarding concerns raised during her period of study.

4.9.3 The University went on to provide details of how they promote awareness of domestic abuse amongst the student population and the wide range of support available to students that may be experiencing domestic abuse. This includes working closely with their local specialist domestic abuse service as well as their own specialist 1:1 services, counselling and support. Each academic year, the University holds sexual and domestic abuse campaigns for students and staff with local services, including the police, promoting disclosure of abuse and advertising the services that are available.

4.9.4 Since the time Charlie attended, Nottingham Trent University has strengthened its approach to domestic abuse and sexual violence by requiring all students to attend a mandatory workshop on 'Consent' during her first month at University, which was seen as good practice.

4.9.5 The only point that the University was asked to consider was introducing direct questioning over domestic abuse into conversations with students who become pregnant during the course. It is well evidenced that pregnancy accompanies higher risk of domestic abuse, and that reproductive coercion and educational sabotage could each be part of the abuse that a young woman may experience in an unplanned pregnancy. Direct questioning around domestic abuse for pregnant women within health settings has been found to be extremely beneficial in breaking down the barriers to disclosure and there is a particular value in naming domestic abuse at such times, by staff trained to respond.

5. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS

5.0 Following on from the analysis of individual agencies' responses, this section explores the thematic, multi-agency and system analysis that arises from the circumstances leading to Charlie's suicide.

5.1 Indicators of Domestic Abuse

5.1.1 A key function of multi-agency reviews is to contribute to a better understanding of domestic abuse (Section 7, Multi-Agency Statutory Guidance, 2016). Through the testimony of family and friends and through Charlie's own disclosures to

different agencies, the review was able to piece together a picture of Charlie experiences which included a wide range of domestic abuse. Whilst neither her family and friends, nor any individual agency, knew the whole picture, there were indicators of abuse that were not fully explored by agencies.

Physical violence

5.1.2 Charlie was subjected to physical violence which she described as "pushing and shoving" (2017); being "kicked in the stomach" (August 2020); "being beaten" (October 2020).

5.1.3 However, beyond the physical abuse, Charlie experienced many different forms of coercive control which noticeably affected her. Indeed, her family observed that Charlie's behaviour was very different when she was in her partner's company. They observed her taking care to respond to her partner's moods: 'treading on eggshells' around him and having to respond to his every whim. When she was away from his company, she could appear cheerful and bubbly and back to her old self when her anxiety was not at the fore.

5.1.4 It is important to understand each aspect of coercive control as each will have a different trajectory of escalation and a different relationship with physical violence and risk (Outlaw in Sharp-Jeffs & Learmouth, 2017:5).

Surveillance and Control

5.1.5 From the earliest time in the relationship, Charlie's partner was monitoring her movements. For example, whilst she was on holiday, he required her to check-in with him constantly and seek his approval on what she was to wear each day.

5.1.6 Monckton-Smith (2022) describes the timeline of a domestic abuse related suicide and, whilst many aspects of Charlie's experiences are untypical, the strong influence of her partner from an early stage in the relationship is a common feature.

Reproductive Coercion

5.1.7 Charlie told her work colleague that her partner would not let her terminate the pregnancy, but she did not appear to have disclosed this to agencies or to her family. Reproductive coercion refers to a type of domestic abuse in which an individual's reproductive choices, such as deciding whether they can use contraception, become pregnant, or continue with a pregnancy, are decided by someone else (Miller et al., 2010).

5.1.8 Charlie was asked about domestic abuse when she attended midwifery appointments, although not as often as she should have been. The GP also explored the context to her pregnancy with her, but explicit enquiry about domestic abuse is needed in these circumstances, even where it is known that a woman will be routinely asked elsewhere within the care pathway, for example, in maternity services.

Learning Point: Reproductive Coercion
Practitioners must always consider the possibility of reproductive coercion when a teenage woman becomes pregnant. Health practitioners should routinely ask about domestic abuse, recognising the additional barriers that young women will face in being able to disclose their abuse.

Economic Abuse

5.1.9 Charlie had been well-motivated and hard working from a young age: always achieving well in school and ambitious to work with animals. It was therefore a surprise to her family that she dropped out of Nottingham Trent University. Although Charlie's attendance at University was disrupted by her pregnancy and birth of her baby in the first year of her course, she had expressed her motivation to continue her studies and her family thought she was pressured to give up her course because her partner did not like her attending, and this could be seen as educational sabotage.

5.1.10 Educational sabotage is a form of coercive control and economic abuse which is unique to students, and which directly affects an individual's emotional well-being, self-efficacy, focus and concentration (Voth Schrag and Edmond, 2017). Tactics of educational sabotage could include telling a victim that they will fail; undermining a victim's abilities; demeaning their educational goals; controlling access to college; interfering with studying or doing homework; making a partner feel guilty for spending too much time on study; responding with jealousy, resentment and insecurity (Sanders, 2015; Voth Schrag & Edmond, 2017). Not every tactic will be employed by an abuser, and it is not known whether her partner used such tactics upon her. Nonetheless, practitioners and educational institutions need to be alert to the possibility of educational sabotage.

Learning Point: Educational Sabotage
By disrupting an individual's ability to gain educational qualifications, a domestic abuser extends their power and control over their partner (Voth Schrag et. al., 2020). Tactics of educational sabotage could include telling a victim that they will fail; undermining a victim's abilities; demeaning their educational goals;

controlling access to college; interfering with studying or doing homework; making a partner feel guilty for spending too much time on study; responding with jealousy, resentment and insecurity (Sanders, 2015; Voth Schrag & Edmond, 2017).

5.1.11 Although Charlie spoke to the University about the support she was receiving at home from her parents and partner, she was not directly asked about domestic abuse when the pregnancy was known, and the University have been asked to introduce direct questioning into their procedures at such times.

5.1.12 Domestic Abuse Statutory Guidance highlights the significant role and expectations of higher education providers in tackling violence against women (Home Office, 2021:85) In this case, Nottingham Trent University were able to demonstrate a wide range of awareness raising activities around domestic abuse as well as a wide range of services for those experiencing it. The important role of education providers is considered further below.

5.1.13 There were other indicators of economic abuse present:

- Charlie had moved out of the home she shared with her partner and told others that she could not afford it;
- Charlie had told colleagues in the Ambulance Service that she had financial worries after her first suicide attempt.

5.1.14 Practitioners need to be alert to indicators of economic abuse as economic abuse rarely occurs in isolation from wider forms of domestic abuse (Sharp-Jeffs and Learmouth,2017)

Separation

5.1.15 Shortly before her death, Charlie had made the move back to her parent's home, although she continued to stay with her partner at regular intervals. She spoke with her mother for the first time about her partner's violence and how it was escalating to others as well as to herself. Thereafter there was some ambiguity over her plans, which is not unusual in such circumstances. On the one hand, Charlie was talking more openly about the domestic abuse and listening to her mother's advice to throw all her belongings into bags, and they would fetch them, and it appeared that she was taking this advice.[14] On the other hand, she

[14] Because numerous black bags were located in her home

contacted her parents and appeared upbeat about having gone shopping for a bed with her partner on the day of her death, indicating some plans for reuniting.

Learning Point: Separation and help-seeking are dangerous periods for victims of domestic abuse. For a perpetrator, their victim's help-seeking or separation represents their loss of control over them, and their violence and abuse often escalates as they try to re-establish their control (Home Office, 2021).

In recognition of this, the government has changed the law allowing many more victims of domestic abuse access to justice. On 5 April 2023, controlling or coercive behaviour, that takes place after a relationship has ended, became a criminal offence

5.1.16 Charlie had been concerned for her partner's escalating violence in the period before her death and there was evidence that a serious argument had taken place between them in the car on the day of the tragedy. These factors indicate that Charlie was facing an escalation in the abuse at the time of the suicide.

5.2 Suicide and Domestic Abuse

5.2.1 Learning from reviews into domestic abuse related suicides is still relatively new, and accurate data on its prevalence not yet available (VKKP,2021; Home Office, 2022).[15] However, previous research has demonstrated significant links between domestic abuse and suicidality (Munro & Aitken, 2018; McManus et al, 2022). Unsurprisingly, considerations of suicide are not uncommon experiences for those experiencing domestic abuse. Extensive research undertaken with women using Refuge's services (n=3,500) found that 24 per cent had felt suicidal at one time or another; 18 per cent had made plans to end their life and 3 per cent had made at least one suicide attempt (ibid).

5.2.2 Overall, it has been estimated that 1 in 8 of all suicides and suicide attempts by women were due to domestic abuse (Walby, 2004). This equates to an estimated 9-10 suicides of women per week through domestic abuse (Monckton-Smith, 2022:19) and has led commentators to refer to domestic abuse related suicides as 'slow femicides' (Walklate et al,2020).

[15] At the time of writing research commissioned by the Home Office is awaited: Dangar, S., Munro, V. & Young Andrade, L. (forthcoming). *Learning legacies: An analysis of [redacted] reviews in cases of domestic abuse suicide.* Home Office.

5.2.3 The characteristics of women's suicidality share much with their experiences of domestic abuse, including isolation and entrapment; hopelessness and despair (Aitken and Munro, 2018). Domestic abusers use coercive and controlling strategies that result in low self-confidence and self-worth and cause mental health concerns amongst their victims. At their most extreme, reviews have found that some perpetrators have actively encouraged suicide amongst women who died in that manner (Monckton-Smith, 2022:27).

5.2.4 Charlie was asked about domestic abuse by the Mental Health Liaison Team when she attended the Emergency Department following an overdose. However, she may have benefitted from being asked again at different times, but questions about domestic abuse weren't asked by professionals from other agencies when they came to know about the overdose.

Learning Point: Suicide & Domestic Abuse
Coercive control, isolation and entrapment are tactics of perpetrators of domestic abuse which can lead to low self-worth, hopelessness, despair and suicide in their victims.
Women presenting to services in suicidal distress or after self-harm should always be asked about domestic abuse (McManus et al., 2022.*The Lancet*).[16]

5.2.5 There were antecedent risk factors in Charlie's experiences which were common to other known domestic abuse related suicides of women during the years in which Charlie died.[17] These included: having a history of coercive control; the perpetrator's mental ill-health and prior police involvement in domestic abuse. However, in other ways, the circumstances were not similar: in particular, her abuser was not a high risk or serial perpetrator. Tragically the method of apparent suicide, by hanging, was the most common method of death by suicide for domestic abuse victims, accounting for 55% of cases across the years 2020-2022 (Monckton-Smith, 2022). It has also the most common method of suicide for all women under the age of 25 (Appleby et al, 2019).

5.2.6 The review heard how Dudley was committed in its Domestic Abuse Strategy[18] to the prevention of domestic abuse related deaths through suicide and that bespoke multi-agency training on the issue was being developed by Black Country Women's Aid. However, the review panel's attention was drawn to unique and

[16] https://doi.org/10.1016/S2215-0366(22)00151-1
[17] The years included in this study were 01.04.2020 to 31.03.2022
[18] https://www.dudleysafeandsound.org/_files/ugd/970b20_c7e7d01c1a4a4193922af3f316731d26.pdf

current research being undertaken under the Zero Suicide Alliance, by Kent and Medway Public Health, into the links between domestic abuse and suicide. Using Real Time Suicide Surveillance (RTSS) data supplied by Kent Police, their research has shown that approximately 30 per cent of all suspected suicides in their area over a three-year period, between 2019 and 2022, had been impacted by domestic abuse: either as a victim, perpetrator or as a young person affected by the abuse. As a result of sharing their findings nationally, they have made a series of recommendations that areas may wish to consider in order to strengthen their understanding and response to suicide domestic abuse.

Recommendation 2: Suicide and Domestic Abuse

Dudley Safe and Sound to promote the connection between suicide and domestic abuse with the Dudley Suicide Prevention Partnership and jointly consider the recommendations for local areas promoted by the Zero Suicide Alliance, as follows:

- "Include Domestic Abuse as an explicit priority within your local multi-agency Suicide Prevention Strategy.
- Ensure your local Real Time Suicide Surveillance system asks specific questions about domestic abuse including: victim, perpetrator, children; the type of abuse; whether current or former relationship.
- Ensure domestic abuse training is completed by all mental health staff. (Consider making this a commissioning condition).
- Ensure mental health and suicide prevention training completed by all domestic abuse staff. (Consider making this a commissioning condition).
- Ensure provision of recovery (including trauma aware elements) programmes for female and male victims of domestic abuse in the months and years after the abuse has stopped.
- Undertake a detailed analysis of RTSS
- Undertake a detailed analysis of data held by Mental Health Services
- Consider revising risk assessments to ask the following questions of both the victim and the perpetrator: have you self-harmed? Have you felt suicidal? Have you made a suicide attempt? (and over different time periods)….
- Ensure that local suicide bereavement services are trained / experienced in supporting families after the suicide of a DA victim or perpetrator." (Kent and Medway Public Health, 2022)

5.2.7 It was noted that Charlie's suicide occurred not long after her partner's brother had also died by suicide. There is some evidence to indicate that Travellers are a high-risk group for suicide, and it is widely reported that suicide is over six times higher amongst Travellers than in the general population (AITHS, 2010). Whilst

Charlie was not herself from a traveller family, she had a close relationship with one and there is evidence to suggest that those who have known someone who has died by suicide may be at greater risk of suicide themselves (Shields et et. 2017; Milkin et al,2019).

Learning Point: Exposure to Suicide Can Increase the Risk of Suicide
For some individuals, being exposed to a suicide death can provide an increased awareness of suicide as 'something that actually happens' as well as 'something they too could do'. This will depend on the meaning that the individual makes of the experience and the context surrounding the death (Milkin at al, 2019).

Recommendation 3: Exposure to Suicide
Dudley Safe and Sound to forge links with the Black Country Healthcare NHS Foundation Trust and support the Trust in its endeavour to secure 'real-time-surveillance' data on suicide as well as supports the Trust to develop a plan to promptly deliver support to family and friends, as appropriate.

Recommendation 4: Suicide amongst Gypsy, Roma, Traveller Communities
Dudley Safe and Sound to share the report of this review with Dudley Suicide Prevention Partnership to ensure that the heightened risk of suicide amongst Gypsy, Roma, Traveller Communities and the ramifications of suicide are illustrated and feeds into the Suicide Prevention Strategy

5.3 Barriers to Engagement

5.3.1 We have seen that there were several times when Charlie declined to disclose the domestic abuse that she was experiencing, or she minimised and excused the abuse.

5.3.2 There will be many reasons why women experiencing domestic abuse may not feel able to disclose their experiences and agencies experience barriers in engaging with a victim. These could include a victim's overwhelming fear of the perpetrator and a lack of understanding and uncertainty about agencies. Barriers can also be experienced as a result of a practitioners' lack of understanding about domestic abuse and coercive control, or in the manner in which they engage with victims.

Fear of losing her child

5.3.3 It was recognised by the family that the perinatal midwife had built the strongest rapport with Charlie whilst she was pregnant, but that Charlie had declined further appointments as soon as the child was born. It transpired that, unbeknown to agencies, Charlie was frightened that if services became involved, then she would risk her child being removed by children's services and that this was a significant reason why she masked the reality, minimised the abuse and told professionals about how supportive her partner was. There was no evidence that agencies had given Charlie any indication that this might happen, but her partner's family appear to have warned her that this would be the outcome of agency involvement. Indeed, this may well have been their particular experience and a common fear within the traveller community (Ministerial Working Group on Gypsies and Travellers, 2019).

5.3.4 It is possible that Charlie may also have feared losing her child to the child's father and his family, particularly if her mothering was being undermined. Earlier research into West Midland's reviews into domestic abuse, highlighted that women's fear of losing children to the care system was a significant barrier to them seeking help and the threat of children being removed to care is often held over victims by their abusers (Neville and Sanders-McDonagh's, 2014).

Learning Point: Overcoming Fears

Victims of domestic abuse often fear that their children will be taken away by children's services, despite this being far from practitioners' minds. They will often have been told by their abusers that they are poor mothers and unable to cope without them, particularly if the abuse has already affected their mental health. Fears of child removal may be particularly prevalent in some minoritised communities, such as traveller families.

Practitioners need to be aware that these fears are common and work hard to dispel common myths, whether or not expressed, and promote confidence in agencies' desire to protect and support victims of domestic abuse to care for their children and keep the family safe.

Making referrals or signposting to services?

5.3.5 Enabling a victim to have support from a specialist domestic abuse agency who have the skills and experience in building trusting relationships with victims, is critical to keeping victims safe. The review recognised that whilst victims accessing

support themselves was ideal, in so far as they would be both empowered and ready to access that support, those initial contacts may well feel daunting and overwhelming for many victims and become a barrier to receiving the support and protection they need.

5.3.6 West Midlands Police recognised that one way in which they could overcome these barriers would be in asking a victim if referrals can be made on their behalf, rather than by merely signposting them to sources of support. They have found this to be far more successful in enabling engagement of victims of sexual violence to access specialist support when implemented in that field.

Individual Agency Recommendation for West Midlands Police: Engaging Victims with Specialist Support

In order to secure greater engagement of victims with specialist domestic abuse services, West Midlands Police to explore whether adopting the 'opting in' approach, that has been implemented with victims of rape and serious sexual assault, would be similarly effective and could be implemented for all victims of domestic abuse.

Learning Point: Active Referrals

Accessing specialist domestic abuse services may feel daunting and overwhelming for victims of domestic abuse. Agencies need to consider how they let victims know about support exists and how they can support victims with active referrals.

Timely Interventions

5.3.7 There were several times when agency actions were delayed due to staff absences. For example, in 2019 when Charlie's mental health was deteriorating, there was a 12-week lapse in the response from Birmingham's health visitors due to staff absence. After the first report to the police in August 2020, there was a month delay before the Dudley health visitor contacted her. After the second contact with the police in January 2021, there was an 8-week delay in the Early Help Assessment being started by video call and a further 7 weeks until it was completed with a home visit. We have seen that each affected agencies have considered the individual circumstances of the various delays and have put in place systems to address the risk of such delays and lack of continuity of care in the future.

5.3.8 Beyond these significant delays, there were also at times a lack of immediacy of a response. For example, after the report to the police in August 2020, it was 10 days until the family support worker contacted Charlie. In January 2021, the police

could not return to Charlie's home and complete their assessment of the situation until the next day because of staffing pressures. Whilst these may not appear to be significant delays, there are implications for any delay on the ability of an agency to effectively engage with a domestic abuse victim. In each of these examples, having had time to reflect, or time for her abuser to influence her, Charlie went on to deny or minimise the abuse.

Learning Point: Timely Engagement
The timing of our attempts to engage with a victim of domestic abuse is important. Victims face innumerable barriers to seeking help but when they reach out to services it will often be at times of crisis or significant threat.
In the absence of an immediate response, the barriers that they face will start to surface again. For example, the perpetrator will have more time to prey upon the victim's fears, provide excuses for their behaviour or show remorse. This often results in a victim declining further support or minimising their abuse

5.3.9 That is not to say that agencies always have the resources to be able to respond with the immediacy that they would like, or that would maximise their chances of engagement. However, agencies may benefit from reflecting on how they organise the timeliness of their responses for maximum effect in cases of domestic abuse which rely so heavily on victim engagement, particularly when children are affected.

Flexibility

5.3.10 There were several periods where agencies were trying to contact Charlie without success. During many of these times, Charlie was working night shifts as the Ambulance Service contact centre and was asleep during the daytime. She was also living between three homes. As a result, the standard approach of engaging with her would not have been effective.

Learning Point: How flexible and responsive are our services?
Many victims, because of work or other commitments, do not fit the model of working that is preferred by agencies. Do agencies have the opportunity to reflect when they are unable to make contact with a victim of domestic abuse and consider of there are specific circumstances that they need to consider and adapt to?

Secure referral pathways

5.3.11 There were times when actions required were not undertaken, or not fulfilled. For example, in August 2020, the DART required that Black Country Women's Aid refer Charlie to CHADD for specialist domestic abuse support and whilst the email referral was sent, it did not appear to have reached them. However, there was no accountability or feedback on this unfulfilled action.

5.3.12 In February 2021, whilst waiting for the Early Help Assessment, Charlie agreed to a referral to Black Country Women's Aid, but this was not done by the health visitor, in part because it was not clear from the DART who should be leading on the case.

5.3.13 These were missed opportunities to engage Charlie with specialist domestic abuse support at times when she was more likely to engage and be able to receive the support of experienced domestic abuse workers who would have had time to build a trusting relationship with her.

Recommendation 5: Referrals from DART

Black Country Women's Aid and CHADD to provide assurance to Dudley Safe and Sound that the pathway for referrals to specialist domestic abuse services from DART are effective and that there is feedback provided where engagement has not been possible with a victim of domestic abuse.

Professional Curiosity into Coercive Control

5.3.14 There were several times when practitioners did not exercise professional curiosity when they had contact with Charlie and therefore opportunities were missed for effective engagement and disclosure of domestic abuse. For example, after Charlie had taken the overdose in May 2019, the Dudley health visitor did not explore the context for the overdose and her subsequent panic attacks and anxiety nor the impact of the move to her partner's family. After disclosing domestic abuse to the police in August 2020, Charlie minimised the incident when talking with the Birmingham health visitor, and this was not explored further or challenged with the information that the health visitor already held. Thereafter, the Early Help Assessment relied upon Charlie's ability to disclose domestic abuse but did not explore either her experiences of coercive control or the mental health of either parent. Nor did they identify what support networks they had

5.3.15 Without understanding the insidious and underlying patterns of coercive control, it is argued that practitioners will not be able to draw upon professional curiosity and not be able to effectively engage with the victim. This leads to ineffective and

partial assessments of the level of risk the family are facing and an inability to effectively protect and support victims of abuse.

Learning Point: Professional Curiosity in Domestic Abuse

A robust understanding of domestic abuse is needed for assessments and responses to be effective. Practitioners need to understand the complex and nuanced pattern of coercive control in order to understand their own challenges to engage with victims and, for example:

- Why victims may minimise or deny the abuse they are experiencing
- How perpetrators intimidate, isolate and control their victims, stripping away their sense of self (Stark 2007:5)
- The impact that living with persistent fear, undermining, gaslighting may have on a person's mental health

Recommendation 6: Coercive Control
Dudley Safe and Sound to seek from partner agencies (i) how they are promoting an understanding of coercive control within their workforce and (ii) what impact their workforce development on coercive control has had on their practice, including the impact upon the identification, risk assessment and response to domestic abuse

5.4 Mental Health and Domestic Abuse

5.4.1 There were several occasions when Charlie declined help for herself but told professionals, who were responding to the domestic abuse, that she just wanted her partner to receive help for his mental health. It appeared that she interpreted, or perhaps hoped, that his abusive behaviour was a symptom of his mental health.[19] The review found no evidence that her thinking around this was discussed or sensitively challenged.

5.4.2 It is not uncommon for victims to think that *"If only he got help, it would be better."* Whilst a perpetrator's mental health has featured in a significant number of similar reviews nationally (Chantler, 2020), it is only a small minority of domestic abuse perpetrators that have been experiencing psychosis and not been

[19] (to be redacted) For reasons of reducing the potential for conflict over contact arrangements for the child between the two families, the Independent Chair did not seek Charlie's partner's consent for his medical records to be included within the scope of this review, However, there were no indicators that her partner suffered from a serious mental illness.

responsible for their actions. However, it was recognised that there were common misconceptions about mental health being a cause of domestic abuse and abusive behaviour minimised as a result.

Learning Point: Mental Health is not a Cause of Domestic Abuse
It is the responsibility of all practitioners to engage with victims of domestic abuse and sensitively challenge any misconception that their partner's mental illness is causing their abusive behaviour.
Domestic abuse victims need to understand that their abusers are responsible for their own behaviour in order that victims can effectively make safety plans for their own, and their children's, safety.

5.5 Domestic Abuse in the Traveller Community

5.5.1 Charlie's partner belonged to a family of settled travellers and lived amongst a community of settled travellers in the area.[20] We have seen and acknowledged that the extent to which he, and his family, were influenced by the wider culture of the Traveller community is not known, and in turn, as Charlie was often staying with his family, the extent of their influence over Charlie is not known either. Nonetheless, it is important to recognise that there may have been cultural influences that contextualised Charlie's experiences. For example, we have seen that the family had strongly held fears that the involvement of Children's Services would mean that children would be removed from their care, and Charlie also acquired those fears.

5.5.2 Whilst domestic abuse and violence against women affects women from all ethnic and social groups, "…it is most commonly experienced within relationships or communities where there is support for strongly hierarchical or male dominated relationships and where male authority over women and children is culturally expected and condoned" (United Nations, 2006). Whilst traditionally characterised as highly patriarchal with clearly defined gender roles, a strong sense of family honour and high levels of domestic abuse (EHRC, 2009), attitudes towards women amongst younger generations of Traveller communities are seen to be changing (Traveller Movement, 2017).

5.5.3 It would be wrong to make any assumptions that her partner was influenced by these more traditional notions of gender roles and masculinity which are the

bedrock of violence against women, as each family will be different. However, there was a history of domestic abuse in her partner's family and the family were undoubtedly rocked by the trauma of having lost her partner's brother to suicide. Moreover, research has indicated that domestic abuse victims from Traveller communities may be particularly isolated and experience significant barriers to accessing information, service and protection from domestic abuse (PaveePoint, 2011; Traveller Movement, 2017)[21].

Recommendation 7: Domestic Abuse in the Traveller Community

Dudley Safe and Sound to ensure that activities to raise awareness and prevent domestic abuse in Dudley also target the Traveller community with the aim of increasing disclosure of domestic abuse from victims of domestic abuse within this community.

5.6 Young Victims of Domestic Abuse

5.6.1 Charlie began her relationship with her partner, her first relationship, whilst still a teenager and we have seen that she was subjected to coercive control very early in the relationship. At the same time, the bereaved family reflected that Charlie was very young in her ways and not worldly wise.

5.6.2 Teenage relationship abuse is widespread. Research has indicated that approximately 50 per cent of young people reported experiencing emotional abuse; approximately 20 per cent reported experiencing physical violence, with young women experiencing more severe physical violence (Stonard, cited in Barter, 2017). The Statutory Guidance observes that teenagers may not understand what constitutes abusive behaviours and, having less experience of relationships, were more likely to normalise abuse, possibly misconstruing controlling or jealous behaviour as love (Home Office, 2021).

5.6.3 Dudley Safe and Sound was able to demonstrate much work that was going on locally to address teenage relationship abuse including, for example, dedicated prevention work on domestic abuse in schools within the Relationship and Sex Education programme and community theatre activities; young people's Independent Domestic Violence Advisors (IDVAs) in both Women's Aid[22] and the

[21] Good practice on working with Traveller domestic abuse survivors is available from the Traveller Movement at https://travellermovement.org.uk/policy-and-publications/a-good-practice-guide
[22] https://blackcountrywomensaid.co.uk/services/information-for-children-and-young-people/

local authority; domestic abuse workers in the family safeguarding hubs. In these ways it was evident that teenage relationship abuse was already high on the agenda of the Partnership. However, drawing upon Charlie's experiences, the Community Safety Partnership was keen to ensure that this work extended to further and higher education.

Recommendation 8: Teenage Relationship Abuse

Dudley Safe and Sound to continue to provide and promote targeted messages to young people experiencing abuse in their relationships in their public communication channels, using language that is accessible to young people, and signposting them to the dedicated support that is available for them.

Dudley Safe and Sound to work with further and higher education establishments in their area to:

- promote awareness specifically about domestic abuse in young people's relationships and educational sabotage
- introduce direct questioning on domestic abuse when a pregnancy is disclosed by a young woman
- promote the specialist services that are available to those experiencing domestic abuse across the age range
- monitor the outcomes of their awareness raising in further and higher education through increased disclosure of domestic abuse by young people, recognising that domestic abuse is under-reported in this age range

5.7 Invisible Abusers

5.7.1 Throughout agency attention over the safety and well-being of the child, the emphasis was on Charlie's parenting and her responsibility alone to work with agencies rather than on the child's father to stop the domestic abuse. Although a family support worker made attempts to contact her partner by phone without success, there were indicators that staff may have been reticent about contacting a father who perpetrates domestic abuse for fear of triggering his violence towards the mother and putting her more at risk.

5.7.2 The need for an informed change of approach in safeguarding and protecting children from domestic abuse has been understood serious case/child practice reviews for more than a decade:

"Learning from these serious case reviews, it is our view that a step-change is required in how we as professionals and as a society understand and respond to domestic abuse. We need to move away from incident-based models of intervention to a deeper understanding of the ongoing nature of coercive control and its impact on women and children. …. [W]hen working with cases in which domestic abuse is a feature, it is essential that the abusive partner is included in the assessment and planning, not leaving the responsibility for protection solely in the hands of the mother. This requires a robust level of challenge to abusive partners to take responsibility for their actions, and where they are not doing so, the recognition that the child will remain at risk" (Brandon et al, 2016).

5.7.3 The need to include domestic abusers and the impact of their coercive control in assessments and safety planning around children's safety has been made all the greater since the introduction of the Domestic Abuse Act 2021. The Act has enshrined in law that children are victims of domestic abuse if they see, hear, or experience the effect of the abuse (Section 3). Dudley Children's Services had recognised the need to address the lack of focus on fathers and had provided internal practice guidance and training for staff, but it is important that all practitioners working with children appreciate the need to maintain a focus on the domestic abuser.

Learning Point: Invisible Fathers

In our assessments of children at risk or in need, it is more often the mothers' ability to keep children safe that has been the focus of agency attention, rather than the assessment and planning around the perpetrator of domestic abuse, usually the father. There may be many reasons for this. For example, sometimes the perpetrator deliberately hides from agency gaze; sometimes practitioners may be wary of provoking more domestic abuse by involving or confronting him; sometimes practitioners may be frightened themselves of an abuser.

Domestic abuse is a parenting choice of the perpetrator. Exposure to parental domestic abuse is domestic abuse of the child. Intervention is needed with the perpetrator to reduce the risk and harm to the child and mother through engagement, accountability and civil and criminal justice. [23]

[23] See, for example, the Safe and Together model https://supportingfamilies.blog.gov.uk/2023/01/17/domestic-abuse-adopting-a-whole-family-approach/ and https://safeandtogetherinstitute.com/the-sti-model/model-overview/

5.8 Crossing Boundaries

5.8.1 After Charlie had moved from Birmingham to Dudley, and an incident of domestic abuse was reported to the police, Dudley Children's Services requested and received information from Birmingham Children's Trust. Later, when she moved back to Birmingham in the month before her death, Charlie was declining support and the Early Help assessment had concluded that the family no longer needed support beyond universal help-visiting and therefore there was no multi-agency referral expected and the system relied upon information on the previous risks known by agencies to pass between the health visitors in the respective areas. However, there was no record of the Dudley health visitor undertaking a verbal handover with the receiving health visitors in Birmingham, despite them requesting one.

5.8.2 Health visiting policies recognise that verbal communication prior to the transfer of records from one area to another is vital in ensuring safe continuity of care for mother and child. Indeed, by this time domestic abuse and Charlie's mental health concerns were well known to Dudley agencies and had this information filtered through to the Birmingham health visitors then, once engagement with the family had taken place, it may have signalled an escalation for Birmingham agencies and the need for multi-agency management of risk to Charlie and her child at that time.

5.8.3 As this is already a requirement of their policy and procedures, Black Country Healthcare NHS Foundation Trust have committed to provide assurance to Dudley Safe and Sound that there is safe continuity of care from health visitors for families with young children when they move out of the Dudley area.

Learning Point: Continuity of Health Visiting Care Across Borders
Victims of domestic abuse will often have to move across local authority boundaries in order to find somewhere safe to live. Verbal communication prior to the transfer of records from one area to another is vital in ensuring safe continuity of care for the child and ensure that the family's needs and risks can be picked up in real time when they move home.

Recommendation 9: Crossing Boundaries
Dudley Safe and Sound to share this report with Birmingham Community Safety Partnership to ensure that those issues which have relevance can be addressed across the two areas.

5.9 The Impact of Covid-19

5.9.1 National arrangements to manage the spread of Covid-19 pandemic in late March 2020 generated local and national concern that the lockdown would escalate and intensify the risk and harm from domestic abuse for the victims and children affected. The fear was of a perfect storm of victims and children being locked-in with their abusers; being less visible to protective services and reduced help being available to victims (Bates et al, 2021:18). Indeed, the first report to the police about domestic abuse was made 3 months after the first lockdown and her death occurred a further 12 months after that whilst some restrictions were still in place

5.9.2 National guidance was swiftly provided to public services about how to manage services during the pandemic, and domestic abuse services in particular. Whilst emergency services were still provided in person, many other public services were provided remotely, either by telephone or video call and guidance was issued by NHS England not to ask direct questions about domestic abuse unless it could be certain that the victim was on her own and it was safe to do so. Health services were guided to seek opportunities to have in-person meetings when indicators of domestic abuse were present. Having made such great strides in routine, selective and direct questioning, health and social care agencies were again restricted in early identification and opportunities for engagement with victims was in many ways hindered by this more remote contact.

5.9.3 For Charlie, this meant that more of her appointments were over the telephone, including a health visitor assessment, an Early Help Assessment and, when she moved back to Birmingham shortly before her death and a new patient consultation with the GP Practice. The review heard how some of these consultations were, to some extent, hindered by being over the telephone.

5.9.4 Although arrangements to manage Covid-19 have eased, it is hard for agencies to imagine returning exclusively to face-to-face work and, for many service users and service providers alike, telephone and video appointments would now be their preference.

Learning Point: Safe Enquiry

Health and social care services have made great strides in embedding safe enquiry about domestic abuse into their practice, whether this be routine, targeted or selective enquiry. However, following the Covid pandemic, more appointments, consultations and assessments are held remotely, and practitioners will be following the guidance requiring them to be sure that it is safe to make these enquiries on a case-by-case basis. Far fewer survivors of domestic abuse will now be asked about domestic abuse and agencies need to consider how they can maximise enquiry and mitigate risk.

Recommendation 10: Undertaking Safe Routine Enquiry

Health and social care services in Dudley to advise Dudley Safe and Sound

(i) how remote working has impacted upon their ability to make safe enquiry into domestic abuse since the Covid pandemic and

(ii) how they now maximise opportunities for routine, selected or targeted enquiry into domestic abuse and mitigate risk.

6. CONCLUDING REMARKS

6.0 This review has considered the experiences of Charlie, a young woman experiencing domestic abuse and young motherhood in her first relationship and whose mental health suffered as a result with tragic consequences.

6.1 When examining agency responses, it can be seen that there were certainly pockets of good practice in agency responses to Charlie including the police's initial attempts to locate Charlie after a silent call had been made; the GP's pro-active and multiple attempts to contact Charlie after she had taken an overdose and the perinatal mental health midwife's engagement with Charlie whilst she was pregnant. However, when viewed collectively, we can see that this young, abused mother was let down by delays in services and by practitioners lacking the professional curiosity, knowledge and skills to explore what was really happening in her relationship and to sensitively confront her when she felt it necessary to minimise the abuse. In the absence of this assertive approach to domestic abuse, and inability to engage effectively with Charlie, assessments downplayed the risk that she faced and the needs of this young mother, who had asked for help, were not recognised as she moved between these two areas in the West Midlands.

6.2 The Independent Chair was nonetheless pleased to recognise the significant improvements that have been made in the multi-agency response to domestic abuse within Dudley since she undertook the first review in the area. In particular, the response of health services in the early identification of domestic abuse through the IRIS Programme and the co-location of domestic abuse services within the hospital Emergency Department were seen to be progress in the right direction for improving the safety and support to adult and child victims of domestic abuse victims, in the future.

7. RECOMMENDATIONS

7.1 Overview & System Recommendations

Recommendation 1: Police response times

Dudley Safe and Sound to seek from West Midlands Police and Crime Commissioner an analysis of West Midlands Police response times for domestic abuse incidents.

Recommendation 2: Suicide and Domestic Abuse

Dudley Safe and Sound to promote the connection between suicide and domestic abuse with the Dudley Suicide Prevention Partnership and jointly consider the recommendations for local areas promoted by the Zero Suicide Alliance, as follows:

- "Include Domestic Abuse as an explicit priority within your local multi-agency Suicide Prevention Strategy.
- Ensure your local Real Time Suicide Surveillance system asks specific questions about domestic abuse including: victim, perpetrator, children; the type of abuse; whether current or former relationship.
- Ensure domestic abuse training is completed by all mental health staff. (Consider making this a commissioning condition).
- Ensure mental health and suicide prevention training completed by all domestic abuse staff. (Consider making this a commissioning condition).
- Ensure provision of recovery (including trauma aware elements) programmes for female and male victims of domestic abuse in the months and years after the abuse has stopped.
- Undertake a detailed analysis of RTSS
- Undertake a detailed analysis of data held by Mental Health Services
- Consider revising risk assessments to ask the following questions of both the victim and the perpetrator: have you self-harmed? Have you felt suicidal? Have you made a suicide attempt? (and over different time periods)….
- Ensure that local suicide bereavement services are trained / experienced in supporting families after the suicide of a DA victim or perpetrator." (Kent and Medway Public Health, 2022)

Recommendation 3: Exposure to Suicide

Dudley Safe and Sound to forge links with the Black Country Healthcare NHS Foundation Trust and support the Trust in its endeavour to secure 'real-time-surveillance' data on suicide, and also support the Trust to develop a plan to promptly deliver support to family and friends, as appropriate.

Recommendation 4: Suicide amongst Gypsy, Roma, Traveller Communities
Dudley Safe and Sound to share the report of this review with Dudley Suicide Prevention Partnership to ensure that the heightened risk of suicide amongst Gypsy, Roma, Traveller Communities and the ramifications of suicide are illustrated and feeds into the Suicide Prevention Strategy.

Recommendation 5: Referrals from DART
Black Country Women's Aid and CHADD to provide assurance to Dudley Safe and Sound that the pathway for referrals to specialist domestic abuse services from DART are effective and that there is feedback provided where engagement has not been possible with a victim of domestic abuse.

Recommendation 6: Coercive Control
Dudley Safe and Sound to seek from partner agencies (i) how they are promoting an understanding of coercive control within their workforce and (ii) what impact their workforce development on coercive control has had on their practice, including the impact upon the identification, risk assessment and response to domestic abuse

Recommendation 7: Domestic Abuse in the Traveller Community
Dudley Safe and Sound to ensure that activities to raise awareness and prevent domestic abuse in Dudley also target the Traveller community

Recommendation 8: Teenage Relationship Abuse
Dudley Safe and Sound to provide and promote targeted messages to young people experiencing abuse in their relationships in their public communication channels, using language that is accessible to young people, and signposting them to the dedicated support that is available for them.
Dudley Safe and Sound to work with further and higher education establishments in their area to:

- promote awareness specifically about domestic abuse in young people's relationships and educational sabotage
- introduce direct questioning on domestic abuse when a pregnancy is disclosed by a young woman
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- monitor the outcomes of their awareness raising in further and higher education through increased disclosure of domestic abuse by young people, recognising that domestic abuse is under-reported in this age range

Recommendation 9: Crossing Boundaries

Dudley Safe and Sound to share this report with Birmingham Community Safety Partnership to ensure that those issues which have relevance can be addressed across the two areas.

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Health and social care services in Dudley to advise Dudley Safe and Sound

(i) how remote working has impacted upon their ability to make safe enquiry into domestic abuse since the Covid pandemic and

(ii) how they now maximise opportunities for routine, selected or targeted enquiry into domestic abuse and mitigate risk.

7.2 Individual Agency Recommendations

- **Birmingham Community Healthcare NHS Trust**
  - Assurance required within the health visiting service that process is applied when there are workforce absences.
  - BCHC safeguarding team to develop guidance for practitioners to apply and support professional curiosity practices. A working group to be commenced, lead by safeguarding head of service and named nurse safeguarding children to support the development of an aide memoir to enhance clinical practice.
  - BCHC practitioners will have access to shared cared records. Access rights and remit are being escalated. This will allow practitioners access to read only information of any child or young person in relation to health and children services
  - Assurance required within Birmingham Forward Steps that the process for reviewing and documenting in records is as per BCHC record keeping policy.

- **Black Country Healthcare NHS Foundation Trust**
  - Information sharing and record keeping related to parental concerns are to be clearly evidenced and documented within individual records. Any risks pertaining to or impact on parental capacity should be considered as part of any ongoing assessments conducted by BCHFT staff across the Trust when considering transferrable risks
  - Risk assessments to be routinely completed as part of the health visiting holistic assessment following incidents such as domestic abuse, mental health

episodes and any other safeguarding concerns or changes in life circumstance that may impact on risk.
  - If there is no health representation at DART meetings there needs to be a clear assurance process in place to ensure all incidents are being disseminated in a timely way and acted upon within the appropriate timescales
  - Joint assessments to be considered if there are 2 agencies or more involved in or aware of DART incidents.
  - To provide evidence-based assurance that actions to build professional curiosity and confidence to address domestic abuse have been effective in the identification, protection and support to children and families experiencing domestic abuse.
  - To provide assurance that there is safe continuity of care from health visitors for families with young children when they move out of the Dudley area. The Trust to provide evidence that verbal handover is systematically being done prior to the transfer of health visiting records from one area to another

- **Dudley Council Adult Social Care**
  - Develop Suicide Risk Process for front of house and MASH

- **Dudley Council Children's Services - Early Help**
  - Family support staff absence. Cases to be monitored by line manager during staff absence. Cases are RAG rated in respect of known risks and contact is maintained with families through the use of the duty system operated within each Family Support Team. Consideration given to re-allocate cases if RAG rating is RED or staff absence is longer than 4 weeks.
  - Agreed contact levels with families should be maintained and a dynamic risk assessment carried out if contact is unsuccessful. This should include consideration of undertaking a home visit where it is assessed it is required.
  - All Family Support staff to complete the Domestic Abuse Basic Awareness training as part of their induction plans. Opportunities for staff to develop and enhance their skills and understanding of domestic abuse and suicide prevention are considered within staff supervision and annual reviews. A system of monitoring staff development uptake is developed and regularly shared with line managers.
  - Early help services continue to adopt a 'whole family' approach which should include perpetrators of domestic abuse in all Early Help Assessments and plans
  - Early help services understand the importance of timely referrals to specialist domestic abuse agencies when consent to do so has been received. Where there are barriers to referral to certain services, alternative options need to be explored to meet the needs of service users.

- **Dudley Group NHS Foundation Trust**
  - To improve awareness in the Emergency Department of Domestic Abuse indicators and selective enquiry.

- Domestic Abuse Policy to be updated to reflect staff responsibilities when patient has taken an overdose, suicidal ideation, suicide attempts or self-harm and consideration around discharge

- **Primary Care**
  - Develop practitioner's professional curiosity and recognise it as vital in completing a holistic assessment and is utilised by GP Practice clinicians
  - The Domestic Abuse Policy update that is now due includes the addition of direct questioning and the documenting of when a client is seen alone or the parties present
  - Alerts are considered in relation to identifying the risks and needs of the patient including a link between a parent and child's records

- **University Hospitals Birmingham NHS Foundation Trust**
  - Routine enquiry should be asked 3 times throughout pregnancy including the postnatal period when the patient is seen face to face, if the patient attends and is accompanied, staff are to try and create an opportunity and safe space to complete routine enquiry

- **West Midlands Police**
  - To provide assurance to Dudley Safe and Sound about the accuracy of their risk assessments in domestic abuse
  - To report to Dudley Safe and Sound on the impact of the use of the 'Child Abuse App' on the identification and response to children when responding to domestic abuse incidents
  - To explore whether adopting the 'opting in' approach, that has been implemented with victims of rape and serious sexual assault, would be similarly effective and could be implemented for all victims of domestic abuse.

- **Nottingham Trent University**

  - To introduce direct enquiry on domestic abuse during conversations concerning pregnancy and maternity for affected students.

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DUDLEY DHR9 COLLATED ACTION PLANS

Please note: This action plan is a live document and subject to change as outcomes are delivered

Table of Contents

Individual Agency Recommendations

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Birmingham Community Healthcare NHS Trust

Recommendation 1: *Assurance required within the health visiting service that process is applied when there are workforce absences.*						
Desired outcome from the recommendation: Applied process that protects the trust and children and families under BCHC						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	• Application of Approved priority matrix to mitigate service risks. • Weekly escalation report articulating workforce absences in each district and mitigations put in place. This will include support across districts, support from partners • Regular oversight reporting of unallocated cases and mitigation put in place.	Local	Locality Operational Managers report into weekly leadership meeting chaired by BFS Deputy Director	• Service Prioritisation Matrix presented for approval through governance processes, • Meetings in place with senior oversight of workforce in each district • Weekly escalation reporting including oversight of unallocated cases	May 2023	Action complete Action complete Action Complete

Recommendation 2: BCHC safeguarding team to develop guidance for practitioners to apply and support professional curiosity practices. A working group to be commenced, lead by safeguarding head of service and named nurse safeguarding children to support the development of an aide memoir to enhance clinical practice.						
Desired outcome from the recommendation: All practitioners to utilise the aide memoir to support the assessment of children and families which identify need and risk.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Develop guidance	Local	BCHCNFT Safeguarding head of service	Professional curiosity now built into training packages for children's cases. BCHC Conference on the 26/4/23 7-minute briefing paper focussing on professional curiosity is being launched at the Safeguarding Conference.	April 2023 April 2023 May 2023	Complete. 19/4/23. Complete 26/4/23. Complete 19/4/23.

Recommendation 3: BCHC practitioners will have access to shared cared records. Access rights and remit are being escalated. This will allow practitioners access to read only information of any child or young person in relation to health and children services .						
Desired outcome from the recommendation: Effective information access to support reassessment of need when a risk has been identified.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Access rights and remit escalated	Local	Head of Service - Safeguarding	BCHC staff now have access to the shared care records. Some acute partner agencies yet to join.	May 2023	Complete 19/4/23.

Recommendation 4: Assurance required within Birmingham Forward Steps that the process for reviewing and documenting in records is as per BCHC record keeping policy.						
Desired outcome from the recommendation: Process of significant carer and child's record are reviewed and recorded in to ensure information is evidenced and available to support assessment of need.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Review of record keeping group as a forum to monitor record keeping standards.	Local	Lead Nurse BFS	Recording Group review of TOR, membership and reporting structure.	December 2022	Informed of Completion 17/10/23. The group will continue to be reviewed as part of record keeping compliance.
1.2	Record Keeping audit in place and identified learning is disseminated through the service for improvements.	Local	Head of Early Years Practice	Refresh of annual audit. System of oversight of recommendations in place.	March 2023	Informed of Completion 17/10/23. Audit completed annually with monthly focus on record keeping by senior managers for monitoring.
1.3	Support offered to individual practitioners based on identified learning needs.	Local	Head of Early Years Practice	Support offered to all staff. Targeted approach where individual needs are identified and application of reasonable adjustments where required.	November 2022	Informed of Completion 17/10/23. Individual support is in place as required through managers and clinical practice support staff
1.4	New streamlined electronic assessment form to be launched to minimise duplication and error.	Local	BFS Business Improvement Manager	Assessment form launched and embedded into practice. Record keeping audit cycle to measure impact on record keeping standards.	April 2023	Informed of Completion 17/10/23. Care planning element of assessments are recorded on the main body of electronic patients

						notes, eliminating the use of separate care plans. Acronym TRAP will be used for all patient contacts (Type, Reason, Assessment, Plan).

Black Country Healthcare NHS Foundation Trust

Recommendation 1:
Information sharing and record keeping related to parental concerns are to be clearly evidenced and documented within individual records. Any risks pertaining to or impact on parental capacity should be considered as part of any ongoing assessments conducted by BCHFT staff across the Trust when considering transferrable risks.

Desired outcome from the recommendation:
For all members of the family to have their own individual records and for all family members known to the Trust to be linked on Rio.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	Health visitors currently document all family concerns on the child's records. Each family member, particularly parents should have their own records where concerns are documented.	Local	Health Visiting Service Lead Head of Safeguarding	Parents to have individual records related to their own health needs.	1st July 2023	Standing Operational Procedure - Health Visiting Caseload Management, in place and revised in April 2023. Team Leaders and Health Visitors use this procure to manage caseloads and transfers. This action is closed
1.2	MHLS is to ensure information sharing processes include informing relevant BCHFT services when informing the GP of any relevant safeguarding information for children or adults at risk under their care. (Perinatal Services/ Health visiting)	Local	Operational Service Lead MHLS Associate Director for Safeguarding	Update information sharing processes to include other internal BCHFT services who may have responsibility of care for the Adult or wider family members.	1st April 2023	 MHSL Operational Policy.docx Shared electronic patient record system is also utilised enabling full sharing of information; Family Management module in RiO.

						This action closed
1.3	The Trust is to utilize the family management section of the Rio system so that can be linked for family members known to BCHFT services	Local	Associate Director for Safeguarding	Rio system family management system set up across the Trust	1st July 2023	All Divisions are now encouraged to use the family links within RiO system to enhance the Think Family module. This action closed

Recommendation 2: *Risk assessments to be routinely completed as part of the health visiting holistic assessment following incidents such as domestic abuse, mental health episodes and any other safeguarding concerns or changes in life circumstance that may impact on risk.*						
Desired outcome from the recommendation All families to receive appropriate support when there is a clear identified risk or change to family circumstances that can impact on children or any other adults at risk within the household.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
2.1	Health Visiting Service to consider and apply how risks are routinely assessed and reviewed, as part of the service offer.	Local	Health Visiting Service Lead Head of Safeguarding	Clear process in place and embedded within 4 months to provide assurance against the action.	1st July 2023	Standing Operational Procedure - Health Visiting Caseload Management, in place and revised in April 2023. Team Leaders and Health Visitors use this procure to manage caseloads and transfers. This action is closed

Recommendation 3:
If there is no health representation at DART meetings there needs to be a clear assurance process in place to ensure all incidents are being disseminated in a timely way and acted upon within the appropriate timescales.

Desired outcome from the recommendation *To be assured that if there is no DART health representation that cases are allocated to health appropriately and managed by health in a timely way*

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
3.1	An audit is to be conducted to review this recommendation to ensure incidents are being disseminated in a timely way and within the appropriate timescales.	Local	Associate Named Nurse for Dudley & Walsall	Audit to be conducted within 4 months to ensure that incidents are disseminated and addressed in line with the DART Standard Operating Procedure.	1st July 2023	A Domestic Abuse audit was by Lead Nurse For Adults in July 2023, however no DART cases were identified. Associate Named Nurse for Dudley & Walsall to conduct and audit and in relation to the audit by December 2023. Not completed due to capacity within the Safeguarding Team. Re- Audit planned for July 2024 BCHFT Single-Agency Audit Programme 202 Domestic Abuse Audit July 2023.docx Action complete for BCHFT.

Recommendation 4: *Joint assessments to be considered if there are 2 agencies or more involved in or aware of DART incidents.*

Desired outcome from the recommendation: There is increased co-ordination of services to protect and support victims of domestic abuse and increased engagement with victims.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
4.1	BCHFT Representative is to inform Head of Safeguarding where cases such as these arise to ensure a joint approach or assessment is considered with CSC, where appropriate. This is to be updated with the DART SOP.	Local	Head of Safeguarding	Joint assessments are to be embedded, where appropriate.		This has been embedded in the internal DART SOP in draft awaiting ratification, however 0-19 services have no transferred to Shropcomm from 1st April 2024.

Recommendation 5: To provide evidence-based assurance that actions to build professional curiosity and confidence to address domestic abuse have been effective in the identification, protection and support to children and families experiencing domestic abuse.						
Desired outcome from the recommendation: That more adult and child victims are protected from domestic abuse through indicators of domestic abuse being identified and responded to safely and effectively by staff. That staff are curious around the context of risk within a family; Think Family'; use information that they hold to generate safe discussion on domestic abuse; building trusting relationships with victims and sensitively challenging them if they feel the need to minimise their experiences.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
5.1	The uptake of Domestic Abuse Training which is delivered monthly to be monitored and non-compliance with the Trust Safeguarding Training Strategy	Local	Head of Safeguarding	Domestic Abuse Training Compliance to be 85% by December 2023	December 2023	Trust compliance at the end of Q3 2023-2024 was **81.11%** And **83.92%** by end of Q4 2023-2024. Training compliance will be reviewed and monitored monthly throughout 2024-2025.

	to be escalated to the relevant Manager					DA Training compliance.xlsx **26.6.24-** Not yet at 85% compliance however is on upward trajectory. **Remains open action.**
5.2	The Domestic Abuse and Safeguarding Training has been recently refreshed and includes professional curiosity and learning from recent DHRs. Training package to be reviewed and refreshed 6 monthly	Local	Associate Named Nurses	Analysis of 6 months Domestic Abuse Training evaluation in November 2023 to demonstrate impact in developing confidence in responding to domestic abuse and to inform refreshed training material	November 2023	Ongoing review monthly and annual training evaluation. Sept 2023/ March 2023/24 evaluation completed. Domestic Abuse Training Evaluation & This action is closed for BCHFT

Recommendation 6: To provide evidence that verbal handover is systematically being done prior to the transfer of health visiting records from Dudley to the receiving area						
Desired outcome from the recommendation: There is safe continuity of care from health visitors for families with young children when they move out of the Dudley area.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**

6.1	Health Visiting Service Lead to review the current handover protocol and ensure this is applied across the BCHFT Health Visiting Service.	Local	Health Visiting Service Lead Head of Safeguarding		**Dec 2023**	Health Visiting Service has transferred to Shropshire Community Trust This action is closed for BCHFT

Individual Agency Recommendations

Dudley Council Adult Social Care

Recommendation 1: Develop Suicide Risk Process for front of house and MASH						
Desired outcome from the recommendation: Clear process underlined by good practice and risk mitigation						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Task and Finish group to discuss and develop	Local	Team Manager AS	Meetings to discuss and develop draft	Oct 2022	07/10/22

Dudley Council Children's Services -Early Help

Recommendation 1: Family Support staff absence. Family to be re-allocated if Lead FSW/IFSW is absent from work for longer than 4 weeks.						
Desired outcome from the recommendation: Families have continuity of support from Early Help Services						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Family to be re-allocated if Lead FSW/IFSW practitioner is absent from work for longer than 3 weeks.	Local	Head of Service	Targeted Early Help (THE) team leader will review whether families require a visit or contact when the allocated FSW/IFSW is not in work due to annual leave or sickness that lasts more than 2 weeks. A manager decision will be recorded and evidenced on file by the team leader. This should outline the managers analysis and decision making regarding the need for contact with the family and record clear actions for duty FSW actions. If the allocated practitioner is not expected to return to work within 3 weeks, the family will be re-allocated to a new practitioner. Team Leader will record the actions to be undertaken by the new practitioner on the child's file and speak directly with the new worker.	**July 24**	Work has started and is ongoing

				Family Hub Managers – will review whether families require a visit or contact when the allocated Family Hub worker is not in work due to annual leave or sickness that lasts more than 2 weeks. Family hub Workers will inform families that they can drop-in to any of the 5 family hubs at anytime while they are off on leave and Family Hub Managers will inform families if their allocated workers is off work ill for a period of 2 weeks. If the allocated Worker is not expected to return to work within 3 weeks, the family will be re-allocated to a new practitioner. Family Hub Managers will record the actions to be undertaken by the new practitioner on the child's file and speak directly with the new worker Monthly performance challenge meetings will review workloads; sickness and absence and any need to re-allocate families.		

Recommendation 2: If telephone calls are unsuccessful in making contact with families, then consideration be given to undertaking an unannounced visit within an agreed timescale e.g duty visit to take place within one week of the last unsuccessful contact						
Desired outcome from the recommendation: For families whose consent to receiving support may be wavering, particularly those who are subject to coercive control, greater opportunities for engagement are provided in a timely fashion.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Where outcome of DART and Front Door review determines that a family requires support from TEH (level 3); Contact will be made with the family within 3 days and home visits undertaken within 5 days. If consent to work with TEH cannot be obtained by the Front Door, transfer to TEH should take place and TEH will seek consent by undertaking a visit to the family within 5 working days	Local	Head of Service	Practice standards relating to initial contact and visits to families to be completed and signed off. Performance standard to be discussed with all TEH team leaders and practitioners as part of Service development sessions, supervision and performance challenge.	**Dec 23**	Work has started and is ongoing

Recommendation 3: Early help services enhance a nuanced understanding of domestic abuse and move beyond an incident-based approach

Desired outcome from the recommendation Early Help services understand that when an incident of physical abuse is reported then

- This will often not be the first incident of physical domestic abuse and victims will often minimise their experiences
- There will usually be a range of domestic abuse and coercive control underlying the reported incident which will often significantly impact upon the child's welfare and safety

As a result of the improved understanding, Early Help services have a more nuanced approach to domestic abuse and seek meaningful engagement with the non-abusing parent and explore the real nature of abuse and coercive control that they may be experiencing.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	All TEH team leaders and practitioners to undertake the basic domestic abuse awareness course with BCWA Family hub Staff to undertake domestic abuse awareness course with BCWA	Local	Head of Service	All staff to attend by Sept 24	**Oct 24**	Work has started and is ongoing

Recommendation 4: Early help services ensure that the perpetrator of domestic abuse is not invisible to assessments over the safety and well-being of the child

Desired outcome from the recommendation Early Help services actively seek engagement with perpetrators of domestic abuse and ensure that they understand the impact of their abuse upon their family and that the threat that they pose to their family is fully assessed and reviewed

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	Early Help Assessments that have a Domestic Abuse feature to explicitly evidence assessment of the perpetrators views and understanding.	Local	Head of Service	EH audits have been undertaken as routine practice audits for 6 months. Service Manager to dip sample audits relating to DA in THE – September 24	**Dec 23**	Work has started and is ongoing

	Plans for engaging perpetrators should be explicitly identified as an outcome of the EHA and progress evidence through supervisory discussions with the Team Leader.					

Recommendation 5: Early help services understand the importance of timely referrals to specialist domestic abuse agencies when consent to do so has been provided						
Desired outcome from the recommendation Early Help services • understand the value and significance of independent domestic abuse services to victims of domestic abuse (adult and children) and • understand the need to provide services in a timely fashion once consent has been gained as victims will often be subject to coercive control and fear and may either be prevented from accessing services or waiver on how confident they are in keeping them safe,						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Early Help Assessments and plans to consider whether a referral should be made to a specific Domestic Abuse service – including at point of step-down	Local	Head of Service	EH audits have been undertaken as routine practice audits for 6 months. Service Manager to dip sample audits relating to DA in TEH	**Dec 23**	Work has started and is ongoing

Individual Agency Recommendations
Dudley Group NHS Foundation Trust

Recommendation 1: To improve awareness in the Emergency Department of Domestic Abuse indicators and selective enquiry.						
Desired outcome from the recommendation: Emergency Department staff to be better equipped to identify and act when patients attend with indicators of domestic abuse						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Domestic abuse coordinator to meet with ED consultant and Named Doctor for Safeguarding Adults to discuss most effective method of increasing awareness	Local	*Domestic Abuse Coordinator*	Meeting arranged	Nov 2022	**Completed 2/11/23.** The DA coordinator has since left the Trust, however the hospital IDVA continues to raise awareness within ED regarding indicators of DA and selective enquiry by attending huddles to deliver key messages and regular walk abouts in the department having conversations with staff as part of her routine work. The IDVA attends the monthly ED drop-in safeguarding supervision sessions provided to ED staff by the safeguarding team.
1.2	Work with Trust communications team to create materials for distribution and distribution methods	Local	*Domestic Abuse Coordinator*	Materials created	Jan 2023	**Completed 2/11/23.** The DA coordinator has since left the Trust. The IDVA has

						been to other wards/departments in the Trust to deliver posters. A patient safety bulletin has been produced and is due to be distributed to staff this month. A poster has been created for all wards/departments regarding DA – indicators and enquiry questions.
1.3	ED IDVA and Trust Domestic Abuse Co-ordinator to build programme of bitesize domestic abuse training to ED staff	Local	*Domestic Abuse Coordinator*	Materials distributed	Feb 2023	DVA awareness delivered on the 13th October 23 to 12 members of ED. This is a monthly teaching session organised by the safeguarding team. The IDVA is connecting in with the Deputy Matron in ED to set out specific teaching for ED staff.

Recommendation 2: Domestic Abuse Policy to be updated to reflect staff responsibilities when patient has taken an overdose, suicidal ideation, suicide attempts or self-harm and consideration around discharge						
Desired outcome from the recommendation: Staff working in the Emergency Department use selective enquiry relating to suspected domestic abuse						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Research best practice recommendations and scope practice in other NHS Emergency Dept re selective enquiry	Local	*Domestic Abuse coordinator*	Best practice identified	Nov 2022	**Completed 2/11/23.** The DA Coordinator left the organisation 12 months ago and there is no evidence that this has been completed. The policy currently includes selective enquiry and when to consider (mental health presentations are included). The policy is currently being updated and the mental health element and staff responsibilities will be strengthened in the new document.
1.2	Domestic abuse policy to be updated to include best practice	Local	*Domestic Abuse coordinator*	Policy updated	Dec 2022	Policy has been reviewed and presented at DGFT Internal Safeguarding Board in January 2024 for approval. **Completed and available on DGFT intranet for staff to access- April 2024**  DGFT Domestic Abuse Policy April 20

Recommendation 3: Improve effective communication and information sharing between Psychiatric Liaison and DGHNHSFT staff						
Desired outcome from the recommendation: *PLT to document the outcome of their assessment, including questioning about domestic abuse in the electronic patient record.*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Lead for Mental Health and Complex Vulnerabilities to agree process and procedures for documentation with Black Country Healthcare	Local	*Lead for Mental Health and Complex Vulnerabilities*	System in place and being utilised	Nov 2022	**Completed 2/11/23.** PLT document on electronic patient record when they have reviewed a patient.
1.2	Domestic abuse co-ordinator and the named nurse for safeguarding to liaise with Black Country Healthcare safeguarding team to gain assurance regarding PLT staff's knowledge and confidence in asking about domestic abuse	Local	*DA Co-ordinator and Named Nurse*		Nov 2022	**Completed 2/11/23.** Update from the hospital IDVA- PLT do ask routine enquiry question but on a basic level. The IDVA is liaising with the PLT lead to provide the team with further guidance in relation to the questions asked to illicit the best response from victims.
1.3	ED IDVA to meet with PLT staff and ensure they are aware of her role and how she can support patients experiencing domestic abuse who the team have identified	Local	*ED IDVA*		Nov 2022	**Completed 2/11/23.** IDVA has met with PLT to raise awareness of her role and how to make a referral. The IDVA reports a good relationship and communication with PLT and they are making referrals to the

						IDVA where they have identified DA.

Individual Agency Recommendations

Primary Care

Recommendation 1: Develop practitioner's professional curiosity and recognise it as vital in completing a holistic assessment and is utilised by GP Practice clinicians						
Desired outcome from the recommendation: Utilising professional curiosity ensures that there are additional opportunities to explore the needs and risks and provides the appropriate forum for patients to make disclosures						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Staff are to review the 7-minute briefing available for professional curiosity produced by the ICB	Local	*Safeguarding coordinator*	Discussed and shown/read the 7 min briefing, at all sites and noted in the minutes of each site by the team leaders. (All Clinical staff at last PLT 4/5/23)		04-05-23 completed
1.2	An audit is completed to ensure all staff confirm the training has been completed	Local	*Safeguarding coordinator*	We will gain assurance from our smart survey	31-12-23	31-12-23
1.3	The domestic abuse policy for the surgery is due for review, there is to be consideration made in referencing professional curiosity within the update.	Local	*Safeguarding Lead GP*	The domestic abuse policy has been reviewed and updated. Professional curiosity has been integrated.	31-05-23	31-05-23 Completed

Recommendation 2: The Domestic Abuse Policy update that is now due includes the addition of direct questioning and the documenting of when a client is seen alone or the parties present						
Desired outcome from the recommendation: All contacts clearly indicate within documentation that a patient was seen alone or the identity of the other parties present						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	The domestic abuse policy is to be reviewed by the practice considering the identified learning	Local	*Safeguarding coordinator and safeguarding lead GP*	The policy has been updated in ref to direct questioning and to consider documenting if a patient is seen alone or not. And the link inserted. GPs are adding to the tabbed journal where needed.		Completed September 2023
1.2	The use of direct questioning is to be highlighted	Local	*Safeguarding lead GP*	The policy has been updated in ref to direct questioning and to consider documenting if a patient is seen alone or not. And the link inserted. GPs are adding to the tabbed journal where needed.		Completed September 2023
1.3	The documentation of a patient being alone, or the parties present is referenced within the guidance	Local	*Safeguarding lead GP*	The policy has been updated in ref to direct questioning and to consider documenting if a patient is seen alone or not. And the link inserted. GPs are adding to the tabbed journal where needed.		Completed September 2023
1.4	The reviewed domestic abuse policy is to be shared with the Practice staff	Local	*Safeguarding coordinator/Practice manager*	The DA policy has been uploaded to TeamsNet with		Completed September 2023

	members with an evidence log of those who confirm the update has been reviewed by the individual.			added log, updating clinical leads Addition of 7-minute briefing; maintaining professional curiosity document following a domestic homicide review. SCGP commitment to screening for DVA in routine and scheduled care - i.e smear and HRT/contraception appointments. Nurses have already picked up two DA in a smear and that is at just one site.		

Recommendation 3: Alerts are considered in relation to identifying the risks and needs of the patient including a link between a parent and child's records						
Desired outcome from the recommendation *Clinicians who access records are clearly aware of the current risk to the patient and the Think Family Agenda and are therefore able to utilise professional curiosity in relation to the risk ensuring a holistic approach to assessment*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	The practice is to identify the current alerts and links that are used by the practice	Local	*Safeguarding coordinator*	3 All codes have been reviewed and updated as well and the safeguarding templates. The safeguarding codes needed by the GPs have been added to the safeguarding templates so correct choices can always be made.		Completed September 2023
1.2	The practice is to review the alerts and links that are available to be utilised and review any gaps that the additional alerts may support	Local	*Safeguarding coordinator and safeguarding lead GP*	3 All codes have been reviewed		Completed September 2023

				and updated as well and the safeguarding templates. The safeguarding codes needed by the GPs have been added to the safeguarding templates so correct choices can always be made.		
1.3	Training is to be provided regarding the changes to coding for the patients	Local		Discussions had within the practice and meetings	Ongoing	Completed September 2023

Individual Agency Recommendations

University Hospitals Birmingham NHS Foundation Trust

Recommendation 1: Routine enquiry should be asked 3 times throughout pregnancy including the postnatal period when the patient is seen face to face, if the patient attends and is accompanied, staff are to try and create an opportunity and safe space to complete routine enquiry						
Desired outcome from the recommendation: this will give pregnant women multiple opportunities to disclose any domestic abuse and access appropriate support						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	All patients to be have Routine Enquiry during pregnancy	Local	*Maternity Safeguarding team*	Will be determined within the Maternity Domestic Abuse Audit	Ongoing	Quarterly audits completed and shared with Safeguarding Board This remains high on the maternity safeguarding agenda and in their action plan
1.2	Staff to attend their yearly safeguarding training update, this will include an update on Domestic Abuse and Routine Enquiry	Local	*Maternity safeguarding team*		Ongoing	Completed- training includes DA. Trust wide compliance at end of 2023-24 85%
1.3	Routine Enquiry Audit	Local	*Specialist midwife for domestic abuse*		Ongoing	Quarterly audits completed and shared with Safeguarding Board

Individual Agency Recommendations
West Midlands Police

Recommendation 1: To provide assurance to Dudley Safe and Sound about the accuracy of their risk assessments in domestic abuse						
Desired outcome from the recommendation*: To ensure that the risk faced by victims of domestic abuse is accurately assessed.*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	WMP use DARA, a Domestic Abuse Risk Assessment for first responders providing a thorough risk/needs assessment in all cases of domestic abuse. WMP are to ensure that all risk assessments are an accurate reflection of risk assessments within domestic abuse and feed this information back to Dudley Safe and Sound.	Local	*Supt. Inglis (DA lead) via Review Team*	Dip-sampling will take place of domestic abuse reports to ensure that DARA is being completed thoroughly and correctly and ensures that the risks to victims are documented correctly.	February 2024	On-going – update required

Recommendation 2: West Midlands Police to report to Dudley Safe and Sound on the impact of the use of the 'Child Abuse App' on the identification and response to children when responding to domestic abuse incidents						
Desired outcome from the recommendation: *To ensure that response officers identify when there are children in the household who may be exposed to domestic abuse and that information on children is shared with relevant partner agencies to keep children safe*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**

2.1	The Child Abuse App is called 'AWARE' and is a guide for officers responding to all incidents where a child is present/involved. It directs the officer to assess the child's Appearance, Words, Activities and Behaviour, Relationship Dynamics and Environment. The guide explains what to look for when assessing the individual strands of AWARE and urges officers to consider more than the basics and ensure professional curiosity from officers. WMP are to ensure that the app is used when relevant and make referrals to Children's Services and will report back to Dudley Safe and Sound.	Local	*Supt. Foster (Child Abuse lead) via Review Team*	Dip-sampling will take place of domestic abuse reports to ensure that details of children are documented correctly and referrals made.	February 2024	On-going - report on impact required by DALPB

Recommendation 3: To explore whether adopting the 'opting in' approach, that has been implemented with victims of rape and serious sexual assault, would be similarly effective and could be implemented for all victims of domestic abuse.						
Desired outcome from the recommendation: *To secure greater engagement of victims with specialist domestic abuse services*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**

3.1	To determine whether an opting-in approach to victims of domestic abuse with regard to engaging with specialist domestic abuse services.	Local	*Supt. Inglis (DA lead) via Review Team*	Discussions to take place with relevant officers in-force to determine whether such an approach is feasible and, in the event that it is, identify how best to achieve this.	May 2024	On-going

Multi-Agency Recommendations

Recommendation 1: Dudley Safe and Sound to seek from West Midlands Police and Crime Commissioner an analysis of West Midlands Police response times for domestic abuse incidents.

Desired outcome from the recommendation: To ensure that reports of domestic abuse to the police in Dudley are responded to promptly

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	WMP to provide updates on a quarterly basis to Dudley's Domestic Abuse Local Partnership Board (DDALPB) to include target time frames, where these are being reached and reasons for why they may not be	Local	*Gill Davenport (chair of DDALPB)*	To receive reports to DDALPB on a quarterly basis	ongoing	Ongoing

Recommendation 2: Suicide and Domestic Abuse

Dudley Safe and Sound to promote the connection between suicide and domestic abuse with the Dudley Suicide Prevention Group and jointly consider the recommendations for local areas promoted by the Zero Suicide Alliance, as follows:

- "Include Domestic Abuse as an explicit priority within your local multi-agency Suicide Prevention Strategy.
- Ensure your local Real Time Suicide Surveillance system asks specific questions about domestic abuse including: victim, perpetrator, children; the type of abuse; whether current or former relationship.
- Ensure domestic abuse training is completed by all mental health staff. (Consider making this a commissioning condition).
- Ensure mental health and suicide prevention training completed by all domestic abuse staff. (Consider making this a commissioning condition).

- Ensure provision of recovery (including trauma aware elements) programmes for female and male victims of domestic abuse in the months and years after the abuse has stopped.
- Undertake a detailed analysis of RTSS
- Undertake a detailed analysis of data held by Mental Health Services
- Consider revising risk assessments to ask the following questions of both the victim and the perpetrator: have you self-harmed? Have you felt suicidal? Have you made a suicide attempt? (and over different time periods)….
- Ensure that local suicide bereavement services are trained / experienced in supporting families after the suicide of a DA victim or perpetrator." (Kent and Medway Public Health, 2022)

Desired outcome from the recommendation: to more accurately assess the nature and prevalence of suicides and domestic abuse, provide effective responses and a joined up approach to preventing suicide and domestic abuse between Dudley Safe and Sound and Dudley Suicide Prevention Partnership

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
2.1	To convene a task and finish group to consider the recommendations for local areas promoted by the Zero Suicide Alliance. This will include members from both Dudley's Domestic Abuse Local Partnership Board and Dudley's Suicide Prevention Group	Local	*Kat Lafferty (Community Safety Team) to convene initial meeting*	• Task and finish group to meet Terms of reference and action plan developed. • Further realistic timescales to be agreed in respect of the action plan. • Action plan delivered	February 24	Some work has already begun within the borough around and suicide and DA, decision made between DALPB and Suicide Prevention group to refer relevant actions to suicide prevention group to ensure completion and negate need for separate group – ongoing work to address actions

Recommendation 3: Exposure to Suicide

Dudley Safe and Sound to seek assurance from Dudley Suicide Prevention Group that support is available to families exposed to suicide, especially where domestic abuse is known to the household.						
Desired outcome from the recommendation: prevention of suicide amongst peers and families exposed to suicide						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
3.1	To convene a task and finish group as above to identify support available and promote as appropriate across agencies and communities. This will include members from both Dudley's Domestic Abuse local Partnership Board, Members of Dudley's Suicide Prevention Group	Local	*N/A*	Identification of Support available Promotion of support available	August 24	Decision made between DALPB and Suicide Prevention group to refer relevant actions to suicide prevention group to ensure completion and negate need for separate group Dudley's Suicide prevention group to share with safe and Sound relevant support available in relation to Suicide

Recommendation 4: Suicide amongst Gypsy, Roma, Traveller Communities Dudley Safe and Sound to share the report of this review with Dudley Suicide Prevention Group to ensure that the heightened risk of suicide amongst Gypsy, Roma, Traveller Communities and the ramifications of suicide are illustrated and feeds into the Suicide Prevention Strategy.						
Desired outcome from the recommendation: to prevent suicide amongst Gypsy, Roma, Traveller Communities						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**

4.1	DDALP / CSP to share report with the Suicide Prevention Group with a caveat that we are awaiting Home Office quality Assurance process and the final report will be shared when published	Local	*Kat Lafferty (Community Safety Team)*	Report to be agenda item at Suicide Prevention Group	Following publication	12.12.23 Agreed with Suicide prevention group Chair to share report following publication
4.2	To ensure that the heightened risk of suicide amongst Gypsy, Roma, Traveller Communities and the ramifications of suicide are considered as apart of the task and finish group (above) Action Plan	Local	*Suicide and DA Task and finish group chair*	Work stream to be included in task and finish action plan	Feb 24	It is proving difficult to build trust and rapport, particularly with the traveller communities, but the suicide prevention group will be referencing this as a concern in the updated suicide strategy

Recommendation 5: Referrals from DART

Black Country Women's Aid and CHADD to provide assurance to Dudley Safe and Sound that the pathway for referrals to specialist domestic abuse services from DART are effective and that there is feedback provided where engagement has not been possible with a victim of domestic abuse.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
5.1	To continue with regular pathway meetings and ensure that feedback on the process is gathered and this feedback is acted upon	Local	*Kat Lafferty (Community Safety Team)*	Report to DDALPB annually on the process and any action that has been taken	ongoing	Referral pathways have been reviewed and regular pathway meetings are taking place between key partners

Recommendation 6: Coercive Control

Dudley Safe and Sound to seek from partner agencies (i) how they are promoting an understanding of coercive control within their workforce and (ii) what impact their workforce development on coercive control has had on their practice, including the impact upon the identification, risk assessment and response to domestic abuse

Desired outcome from the recommendation: to ensure that all agencies in the partnership are contributing to the identification and multi-agency response to coercive control.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
6.1	Partner agencies provide assurance to DDALP that they are promoting Coercive control within their workforce	Local	*Gill Davenport (Chair of DDALPB)*	Evidence of promotion taken place via reports to DDALPB	July 24 Board	All partners on board requested to updated in advance of July DALPB meeting (23.04.24)
6.2	Partner agencies to inform the DDALPB of the impact the workforce development has had on their practice	Local	*Gill Davenport (Chair of DDALPB)*	Evidence of practice impact via reports to DDALPB	July 24 Board	Information received from some partners, all partners on board requested to updated in advance of July DALPB meeting (23.04.24)

Recommendation 7: Domestic Abuse in the Traveller Community

Dudley Safe and Sound to ensure that activities to raise awareness and prevent domestic abuse in Dudley also target the Traveller community

Desired outcome from the recommendation: to reduce harm and prevent domestic abuse within the Traveller community

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
7.1	To identify officers and / or organisations to support with developing and delivering some	Local	*Gill Davenport*	To provide communications / activities to raise awareness of	March 24	Information already available, work taking place to identify

	specific communications to the traveller community within the borough		*(Chair of DDALPB)*	Domestic abuse within traveller communities		how to effectively signpost via appropriate routes

Recommendation 8: Teenage Relationship Abuse

Dudley Safe and Sound to provide and promote targeted messages to young people experiencing abuse in their relationships in their public communication channels, using language that is accessible to young people, and signposting them to the dedicated support that is available for them.

Desired outcome from the recommendation: to reduce harm and prevent domestic abuse within young people's relationships

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
8.1	To develop and promote targeted messages to young people experiencing abuse in their relationships in their public communication channels, using language that is accessible to young people, and signposting them to the dedicated support that is available for them	Local	*Kat Lafferty (Community Safety Team) and DMBC CAPA*	To co-produce with young people, appropriately targeted communications that are shared as part of the Safe and Sound Communications plan and Child Friendly Dudley	November 24	To include in 24 / 25 CSP Communications plan

Recommendation 9: Crossing Boundaries

Dudley Safe and Sound to share this report with Birmingham Community Safety Partnership to ensure that those issues which have relevance can be addressed across the two areas.

Desired outcome from the recommendation: to ensure that those issues which have relevance can be addressed across the two areas.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
9.1	To share report with Birmingham Community Safety Partnership, with a caveat that we are awaiting Home Office quality Assurance process and the final report will be shared when published	Local	*Gill Davenport (Chair of DDALPB)*	Report shared	Dec 24	Agreed to share when published - key agencies in Birmingham have sight of report from being on panel

Recommendation 10: Undertaking Safe Routine Enquiry

Health and social care services in Dudley to advise Dudley Safe and Sound

(i) how remote working has impacted upon their ability to make safe enquiry into domestic abuse since the Covid pandemic and

(ii) how they now maximise opportunities for routine, selected or targeted enquiry into domestic abuse and mitigate risk.

Desired outcome from the recommendation: to ensure that arrangements for routine, targeted and selective enquiry within health and social care settings are consistently undertaken and undertaken safely

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
10.1	DDALPB to request report from Health and Social Care services in Dudley in respect of routine enquiry following the Covid pandemic, to include learning and assurance that processes are working effectively	Local	*Gill Davenport (Chair of DDALPB)*	Reports received by DDALPB from Childrens and Adults Services and Health Services	July 24	Partners requested to submit assurance in advance of July DALPB meeting (23.04.24)

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23rd April 2024

Dear Katriona,

Thank you for submitting the Domestic Homicide Review (DHR) report (Charlie) for Dudley Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20th March 2024. I apologise for the delay in responding to you.

The QA Panel stated that this is a good, well-structured review which is sensitive, and well researched. The family was involved, and Charlie's voice was heard throughout the review. There was good domestic abuse (DA) expertise on the panel from the third sector. However, there does not appear to have been representation from public health/suicide prevention, which might have been useful and added a different perspective.

The review shows sensitivity, a good understanding of domestic abuse and a probing identification and analysis of the strengths and weaknesses in agency contacts. The recommendations are clearly drawn from and relate to the learning and are SMART.

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

Areas for final development:

- The date of completion of the report is missing from the front page of both the overview report and the executive summary.

- Paragraph 3.12 states the sex of the child, compromising anonymity, this should be removed.

- Stating specifically where the deceased worked could compromise her anonymity. It may be better to state 'a national retailer' or something similar.

- The Equality and Diversity section of the report is exceptionally brief, with no further consideration of the identified characteristics (sex, age, race and pregnancy and maternity). Whilst equality and diversity issues are, in part, woven throughout the review – this section could be strengthened to better outline and explore the protected characteristics identified.

- The Chair should consider adding a statement confirming independence from the agencies and individuals involved.

- In addition to the education sabotage form of economic abuse, that Charlie moved out of the home she shared with her partner and told others they could not afford it (3.46) and the financial worries she shared with paramedics after her first suicide attempt (3.11), could be considered other signs of economic abuse.

- Section 1.8 does not mention whether the family were invited to attend a panel meeting. It is also not stated whether the family were provided with the Home Office DHR leaflet. Additionally, it would be helpful to know if it was considered inviting Charlie's employers during the review period to contribute.
- Given this case relates to a suicide, it would be useful to see Public Health England on the dissemination list.
- Some of the action plan requires updating as some actions are missing, as are completion dates and outcome information.
- Footnote 21 is missing.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel