Domestic Homicide Review 13

Adult's 1 Death - July 2022

Independent DHR Chair and Author - David Byford - July 2025

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Chapter 1

Domestic Homicide Review

1 **Introduction.** This Domestic Homicide Review (DHR 13) is commissioned by the Safer Solihull Partnership (SSP) in response to the death of victim (**Adult 1**), a male aged 38 years, which occurred in July 2022. It is alleged that his same sex partner (**Adult 2**), aged 37 years at the time of the homicide, was the perpetrator. Both were nationals from the same Eastern European country. They had been in a relationship with numerous reported domestic abuse (DA) incidents between themselves, both as the aggressor and as the victim, together with other Anti-Social Behaviour (ASB) and additional complex needs, including mental health concerns for Adult 2.

1.1 West Midlands Police (WMP) were called by paramedics to the couple's accommodation by West Midlands Ambulance Service (WMAS) who were already in attendance, as the injuries to Adult 1, who was in cardiac arrest, appeared consistent with strangulation. Adult 2 was arrested for assault by police at the scene as he had confessed both to police and paramedics to having pushed his partner to the floor before he went into the cardiac arrest. Adult 1 unfortunately died in hospital in the early hours of that morning.

1.2 Following notification of his death, the charges against Adult 2 were upgraded to murder as a forensic post-mortem result revealed pressure had been applied to the neck of Adult 1, believed to be the major operating cause of his death. Adult 2 was subsequently charged with Adult 1's murder and subsequently pleaded guilty and was convicted of manslaughter in March 2024. (See criminal proceedings outcome in Paragraph 2.59).

1.3 **Terms of Reference (TOR) - Summarised.** This DHR met the criteria under the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (3.1) (a) the incident involved 'a person to whom he was related or with whom he was or had been in an intimate personal relationship' (Home Office 2016)[1]. A fuller version of the terms of reference is available.

1.4 **Commissioning of the DHR.** The Chair of the Safer Solihull Partnership agreed that the criteria to conduct a DHR had been met and commissioned the review. David Byford, an Independent Safeguarding Consultant, was appointed as Independent Chair and Author of the DHR (See Biography in Appendix 3). The independent Chair had no relationship or connectivity with those agencies and services involved in the contact with Adult's 1 and 2 to ensure effective and objective challenge to all agencies involved in the review. This enabling appropriate independent analysis of the DHR case and processes.

1.5 **Purpose and Aim of the Domestic Homicide Review.** The aim of the DHR is to:

- Establish the facts that led to the incident in July 2022 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard adults.
- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

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[1] Agencies own local guidance and the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2016) is available at: www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

- Identify clearly what these lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- Prevent domestic abuse and homicide and improve service responses for all victims of domestic abuse, and their family by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.

1.6 Scoping period of the review. All individual management reviews (IMRs) and information reports focused on the contact that agencies had with Adult 1 and 2, their family members, between June 2017 when Adult 1 became known to NHS Birmingham and Solihull ICB Safeguarding Team. Also, from 2017 for Adult 2 when the first information is known of Adult 1 and 2's relationship, concluding at the time of Adult 1's death in July 2022.

1.7 Key lines of enquiry (KLOE). The review addressed both the 'generic issues' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and KLOE specific questions identified for this DHR which are detailed and analysed in Chapter 3 of this report.

1.8 Family involvement and the delay in completing the DHR. Family members of both Adult 1 and 2 were identified, however as potential witnesses in the criminal proceedings, the review did not approach them until the proceedings were concluded in October 2023. There was then a delay as there was a Crown Court, Newton Hearing held to determine the final sentencing as outlined (see paragraph 2.59), which concluded in March 2024. Once all the criminal proceedings were concluded, there was a further delay by WMP contacting the family of Adult 1, which SSP chased up regularly on behalf of the DHR and Independent Chair. They were eventually written to and invited to engaged with the review through interpreted letters translated into the family's own language. The DHR also contacted Adult 2's solicitor to arrange a meeting with him after his conviction for Adult 1's manslaughter. The DHR received no response from any of the parties. It was decided to allow them until the 20 September 2024 and, as there was still no response, it was reasonable to assume they have unfortunately declined the offer.

1.9 Subjects to the review.

- **Adult 1** - victim.
- **Adult 2** - perpetrator**.**
- **Adult 3** - Adult 1's brother.
- **Adult 4** - Cousin of Adult 1 and witness in the criminal proceedings.
- **Adult 5** - Adult 2's brother.
- **Adult 6 -** Adult 2's brother.

Comment. ***The pseudonyms were agreed by the DHR Panel as Adult 2 the perpetrator, or family members did not engage with the review process, therefore the DHR was unable to obtain their opinion. Usually, Adult 1 and Adult 2 are not always best practice pseudonyms and where possible, reviews should assign culturally appropriate pseudonyms to humanise the victim for ease of reading and should always be considered in assessing any future cases if necessary.***

1.10 Review Panel. The following agencies were members of the review panel: -
- **West Midlands Police (WMP).** Michael Fletcher, Detective Sergeant.

- **Birmingham and Solihull Integrated Care Board (BSoLICB).** Lorraine Longstaff, Designated Nurse Safeguarding Children & Adults.
- **Solihull Metropolitan Borough Council**. Caroline Murray, Interim Head of Commissioning - Public Health.
  Solihull Metropolitan Borough Council. Andrea Cooke, Senior Strategic Delivery Manager for Domestic Abuse, Sexual Abuse and Sexual Health.
- **Solihull Metropolitan Borough Council.** Caroline Himmons, Administrative Support.
- **Birmingham and Solihull Mental Health Foundation Trust (BSMHFT).** Yvonne Harwell, Birmingham and Solihull Mental Health Foundation Trust (Includes Solihull Integrated Addiction Services).
- **University Hospitals Birmingham (UHB).** Jane Lovell, Lead Nurse - Adult Safeguarding.
- **Solihull Community Housing (SCH).** Brenda Gallager, Safeguarding & Community Safety Project Manager.
- **Solihull MBC Adult Social Care (ASC).** Bethany Hutchinson, Head of Service Care and Support.
- **Black Country Health Care Foundation Trust (BCHFT).** Kudzi Mukandi, Interim Head of Safeguarding.
- **Black Country Integrated Care Board (BCICB).** Maria Fitzpatrick, Assistant Designated Nurse Walsall.

1.11 **Individual management reviews (IMR) and other reports.** The Agency authors of the IMRs and information reports were all independent of the review process and had no connections or association, including with the subjects, within the DHR. An Individual management review and comprehensive chronology was requested and received from the following organisations: -

- **Solihull MBC Trading Standards and Environmental Compliance, Economy & Infrastructure Directorate.**
- **Solihull Community Housing.**
- **NHS Birmingham and Solihull ICS Safeguarding Team.**
- **Birmingham & Solihull Mental Health Trust.**
- **West Midlands Police.**
- **University Hospitals Birmingham.**
- **Black Country Health Care Trust (BCHFT).**
- **Black Country Integrated Care Board (BCICB).**

Information reports only were obtained from:-

- **Solihull MBC Adult Social Care.**
- **West Midlands Ambulance Service (WMAS).**

1.12 **Methodology.** The following methodology was used in completing this review:

- **Review of agency scoping documents.**
- **Analysis of combined chronology of events.**
- **Formulation of the terms of reference.**
- **Identified specific Key Lines of Enquiry questions.**
- **Commission of IMRs and information reports.**
- **Held 6 DHR Panel meetings. First meeting held on 13 December 2022, after commissioning.**

- **The independent Chair conducted an IMR authors meetings to explain review expectations and process.**
- **Review of agency report submissions.**
- **Requested and reviewed postmortem report.**
- **Communication with LGBTQ+ community for advice.**
- **Extensive research of previous learning from statutory reviews, local and National DA and Suicide policies, procedures, and guidance.**
- **DHR Report, Executive Summary Learning Brief and a Learning note for training produced.**

1.13 **Diversity, Culture, Ethnicity and Deprivation.** The Equality Act 2010, of the nine protected characteristics only sexual orientation applied, as the subjects were in a same sex relationship and White Europeans. This was analysed in the KLOE questions posed in Chapter 3 and in the Findings in Chapter 4. There was careful consideration and communication with the LGBTQ+ community for advice who had no knowledge of the victim or perpetrator but agreed the findings of this report will be shared with them. Additional questions would have been asked of family members and Adult 2 if they had participated in the review process, as the analysis suggests in the narrative of the report, some family members were not happy with the same sex relationship. In respect of deprivation, Solihull a borough of West Midlands is generally affluent but 12 % of the population live in the most deprived 10% of neighbourhoods in England. Deprivation was not a factor.

1.15 **Impact of Covid-19.** Agencies were asked if the impact of Covid-19 affected their ability to respond to their needs. None of the agencies explicitly stated that there had been an impact. Agencies assessment of Covid-19 is detailed within Chapter 3.

1.16 **Abstract of Findings.** This DHR has identified the following 8 findings which, are further developed within the narrative of the review and encompassed in the 8 DHR Recommendations in Chapter 4 and within Individual Agency Recommendations in Appendix 1, as follows: -
Finding 1. Multi-agency working, referrals, professional meetings, sharing information, record keeping and communication concerns. (***DHR Recommendation 1*).**

Finding 2. Awareness of the Domestic Abuse Act 2021, Anti-Social Behaviour Guidance and CPS Evidence Led Victimless Prosecutions. (***DHR Recommendation 2*).**

Finding 3. Coercive, Emotional and Manipulative Control, to consider Situational Violence and Identifying a Care Provider. **(*DHR Recommendation 3*).**

Finding 4. Supervision, Professional Curiosity and Risk Assessments. **(*DHR Recommendation 4*).**

Finding 5. A Review of WMP Domestic Abuse investigations. (***DHR Recommendation 5*).**

Finding 6. Consideration of Mental Health and Mental Capacity Assessments for 'Best Interest' decisions. (***DHR Recommendation 6*).**

Finding 7. Capturing the Voice, Culture, Diversity, LGBTQ+, Sexual Orientation and Gender Bias.
and Hate Crime **(*Captured in DHR Recommendation 1 and Agency Recommendations in Appendix 1).***

Finding 8. Awareness and Promotion of the SMBC ASC Triage Process of Safeguarding Referrals, existing safeguarding referral pathways and expectations of safeguarding reporting to multi-agency partners. ***(DHR Recommendations 7 and 8).***

Chapter 2

Background and Chronology timeline of events

2 **Adult 1** was born in June 1984 and resided initially in his home country (redacted) with his mother and grandmother. He reportedly has a brother Adult 3 and cousin Adult 4 identified by WMP in their interaction and investigations involving both Adult 1 and 2. Adult 1 moved to the UK in or around 2012 followed by Adult 4 two years later. He first lived in London before moving to Lancashire following a fire at his London property. He then moved to Manchester before settling in Walsall where he moved between properties. He met Adult 2 whilst in Walsall around 2017 and they moved together to Solihull in 2021.

2.1 **Adult 2** was also born in the same country in 1984. Two brothers Adults 5 and 6, also reside in the UK. Adult 2 stopped working in August 2021. He was under Walsall Mental Health Services for the last year whilst there, having been diagnosed with major recurrent Depressive Disorder, moderate and post-traumatic stress disorder. He improved on medication but then did not take it regularly.

2.2 **Previous accommodation history.** Until their move to Solihull in 2021, between them, Adult 1 and 2 held private provider accommodation with shared facilities at three separate addresses within the Walsall area. SCH were not informed as to the reasons for them leaving each of these addresses**.**

2.3 **Domestic Abuse involving Adult 2 with previous partners.** This was the third same sex relationship that Adult 2 had been in. All three had been or were abusive relationships, identified during a mental health assessment which took place in December 2021. He had a history of trauma and little in the way of family support reportedly because of his sexual orientation. He was a current smoker and denied taking any drugs in the present. He did drink alcohol but preferred to avoid it when he could, as it made the voices that he heard as part of his mental illness more upsetting. He had anger issues, especially when he was under the influence of alcohol and a forensic history for minor offences and reactive behaviour when he was stressed or anxious. His relationship with Adult 1 caused him anxiety and stress. It was documented that they broke up once during their time together.
Comment. ***The alleged previous history of DA with different partners was a warning which professional curiosity may have identified earlier. Had enquiries been made, his relationship with Adult 1 which became more abusive, could have been a consideration for Adult 1 to be advised regarding Clare's Law to consider the risk, however this would only have identified issues known to the police. Whether it would have been accepted by Adult 1, who was also aggressive towards Adult 2, this DHR cannot definitively answer. WMP were however, unaware of the previous abusive relationships, as the information was not disclosed to them, a failure of communication and information sharing, a finding in this review.***

2.4 **GP - Adult 1.** In the periods 2017 to 2021 he attended four other Practices (GP Medical Practice 1 and GP Medical Practice 2) Walsall based, for insomnia, depressed mood, headaches, chest pain, high blood pressure and excessive alcohol intake which had started to affect his liver and his cholesterol levels. He did not report any of these problems to either of the two Practices he was registered with in Solihull (GP Medical Practice 3 and 4), but they were all documented in the previous records for the Clinical Staff of these Practices to see.

2.5 During the 11 months that Adult 1 was registered at GP Medical Practice 3, he did not attend any appointments. The only communication the Practice had with him was to send him texts to offer him the COVID vaccine and stop smoking advice. There were, however, three letters of communication contained in his health records from other agencies about him, all from April 2022,

regarding minor medical problems. He did mention to one Health Professional before a home visit by the GP for an infected foot, that his partner, Adult 2 was "not looking after himself."

2.6 **GP - Adult 2.** During the 11 months that Adult 2 was registered with GP Medical Practice 3 (June 2021 to May 2022) he attended the Practice three times. He saw a Health Care Assistant who took his blood and also conducted an ECG on him. These tests were part of monitoring him because he was being prescribed a particular anti-psychotic medication for his mental illness. In addition to this, the Practice received four letters of communication from Mental Health Services in Birmingham and one from Walsall. There was also an ambulance callout and two separate attendances to A and E on the same day in November 2021 as outlined below. GP Medical Practice 4**,** were notified by letter from A and E on the 9 June 2022, that he had taken an overdose of his anti-depressants and had been seen by Liaison Psychiatry. There is no letter from Liaison Psychiatry in the records detailing their assessment. There was also no follow up arranged by the Practice on receipt of this letter. GP Medical Practice 4 had not received any of Adult 2's previous medical records upon him registering with their Practice.

Sequence of Domestic Abuse and Anti-Social Behaviour events involving Adult 1 and 2

2.7 WMP's IMR makes an overview statement referring to the incidents they were called to, stating Adult 1 and 2 had a turbulent relationship and who would regularly argue late at night into the early hours of the morning. Many of their arguments occurred when the pair had been drinking. Both were known to have smoked cannabis on occasions and would take MCAT a mephedrone and powerful stimulant, prior to having sexual relations with third parties (this is not expanded upon).

2.8 Adult 1 felt Adult 2 was idle and would spend all his time on his laptop instead of looking for work and intended to leave him if he did not change his attitude and outlook on his working life. Adult 1 himself, worked remotely writing articles for a newspaper in his country of origin. He was also said to have started further education in order to upgrade his skills, wished to work as security on the doors of clubs and bars and was active around LGBT issues within the community.

2.9 Adult 1's cousin, described Adult 1 as being the dominant party within the relationship and believed Adult 2 had a psychological condition which caused him to hear negative voices that made him paranoid and for which he received medication. According to Adult 1, he took on the role of being Adult 2's carer a comment shared with professionals within contacts.

2.10 **Domestic Abuse Incident 1.** On Friday the 8 February 2019, Adult 2 called police stating he needed alternative accommodation for the night as they were staying at Mencap House in Walsall, which is supported living accommodation. The call was then ended by Adult 2, who could not be reached until two days later when he stated that he and Adult 1 had an alcohol-fuelled argument that had been sorted out. He disclosed that Adult 1 had anger issues, but the pair were seeking relationship counselling in order to help them manage the problem. The Domestic Abuse Harassment and Stalking (DASH) risk assessment was offered but he declined to complete one.
***Comment*. DASH was not mandatory at the time as recorded in the WMP IMR and is discussed further within the KLOE's in Chapter 3. WMP information made subsequently to the review states it was mandatory.**

2.11 **Domestic Abuse Incident 2.** On the 14 February 2019, Adult 1 called police reporting that Adult 2 was being aggressive. When police officers attended their accommodation, Adult 2's behaviour was erratic, and police suspected he had taken drugs of some kind. Limb restraints had to be applied in order to gain control of him who, once in the rear of the police van, spat on the walls. He was arrested to prevent a breach of the peace and for criminal damage to the police vehicle.

2.12 Whilst in custody, Adult 1 was visited at home. He explained that Adult 2 had returned home drunk and appeared to have a 'manic' episode. Adult 1 was sober and attempted to reason with Adult 2 but to no avail. He believed that Adult 2 had an undiagnosed mental health problem which had been exacerbated by the alcohol. In custody, Adult 2 was seen by the Healthcare Practitioner (HCP) in the police custody suite, once he had sobered up and was deemed fit, he was interviewed and received a caution for the criminal damage and was given a bind-over for breaching the peace and released.
***Comment*. No DASH at the time was recorded for this DA incident which was the second incident involving WMP and should have been subject to supervision oversight to ensure the DA incidents were being captured and appropriate action considered (See Recommendations 7 and 8 regarding referrals to the ASC Triage Process of Safeguarding Referrals system which if complied with, can address future professional practice).**

2.13 **Potential Hate Crime.** Two days later just before midnight, Adult 1 and 2 were set upon by a group of unknown males as they walked home. They were both punched and kicked by the males who then made off. Adult 2 sustained a fractured jaw. The couple believed they were attacked because they were gay, though this was not confirmed as the offenders could not be identified.

2.14 **Domestic Abuse Incident 3.** In March 2019, Adult 2's brother Adult 5 was residing at the same Home of Multi-Occupancy (HMO) as Adult 1 and 2 and an argument ensued between them. Adult 5 was pushed by Adult 1 and punched by Adult 2. Another resident called the police and Adult 1 and 2 were arrested. Adult 1 had to attend hospital to have a cut to his head treated. They both refused to state what had happened during their interviews. Once bailed, Adult 1 claimed that Adult 5 had stabbed him in the head and made homophobic remarks. Investigating officers attempted to progress the investigation, but neither side wished to engage and assist the investigation. Despite the fact the incident was of a domestic nature given Adult 2 and Adult 5 were brothers, it was not recognised as such by the officers and a DASH was not completed or offered which would have been good practice.
***Comment*. This DA incident did not enact DA policy by police to ensure that appropriate safeguarding action was being taken or considered. The repeat of DA incidents concerning Adults 1 and 2 were not actioned, even though this was the first DA with Adult 2's brother as a victim. An HMIC inspection of WMP's Approach to tackling DA in 2014 where good practice was recommended.**
https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/2014/03/west-midlands-approach-to-tackling-domestic-abuse.pdf

2.15 BCICB record in July 2019, the GP was made aware that Adult 2 divulged that they were experiencing DA and that ASC had already directed this to domestic abuse support services. An appointment was made at that time, but DA was never documented as being discussed at any subsequent appointment or followed up. *(*BCICB Agency Recommendation).

2.16 **ASB and incidents between Adult 1 with another resident.** By August 2019, they had moved to an HMO and in January 2020, Adult 1 had altercations with a fellow resident. The incident was said by Adult 1 to have been started by the other party who he alleged was homophobic following an argument over the state of the communal area. The female resident alleged that Adult 1 kicked her, and he further stated that she had damaged his property. Neither wished to pursue a formal allegation. The following month, on the 12 February 2020, Adult 1 called police reporting that the same female had stolen his phone, laptop and identity cards from his room and his complaint was met with a further counter-allegation of harassment. Each incident was recorded and allocated to WMP officers for progression, but once again, Adult 1 and the female resident withdrew their support and declined to proceed with the allegations and the case closed.
***Comment*. Home Office ASB guidance 2014 as revised in July 2022 should always be followed and contact made with the neighbourhood team, involving police, local authority ASB officers and their landlord, as there are actions available to address ASB as well as DA.**

2.17 **2020. Domestic Abuse Incident 4. Assault.** On the 17 April 2020, WMP received a third-party report of a fight at Adult 1's address. When officers attended, Adult 1 and 2 were present along with Adult 2's brother, Adult 6 and all were intoxicated. Adult 1 explained that he and Adult 2 had been arguing over the bills and Adult 6 had attempted to intervene, at which point Adult 1 was said to have punched Adult 6 in the face. Both Adult 1 and Adult 6 had injuries and Adult 1 was arrested on suspicion of assaulting Adult 6. Once all had sobered up, they were spoken to but refused to detail what had happened and the true facts could not be established from them or the original caller. A Domestic Abuse Risk Assessment (DARA), replaced the DASH and became mandatory, was attempted with Adult 2 but refused. The lack of information meant investigating officers did not make effective enquiries and the matter was filed.

2.18 The WMP IMR rightly questioned why only Adult 1 was arrested as both had injuries and it was remarked the pair had been fighting. Under the circumstances, it acknowledges that both could have been arrested on suspicion of affray and interviewed. There is nothing recorded within the investigation log or custody record to explain the decision to only arrest Adult 1. The history as recorded on WMP systems between the couple would have identified that he was in a same sex DA relationship. Even if this was not shared with attending officers by anyone at the location, a domestic abuse non-crime report should have been recorded given that Adult 1 stated the pair had been arguing, and to the point that Adult 2's brother felt the need to intervene.
***Comment.* The fact that Adult 2 declined information to complete a DARA should not have stopped the police at the scene completing and referring the risk assessment for further consideration. Communication and information sharing with other safeguarding partners and calling a professional meeting and to seek the assistance of an IDVA, should have been options considered.**

2.19 **Medication.** BCHFT in their IMR and within DHR Panel Meetings inferred that Adult 1 subsequently told their agency that after this incident he told a BCH practitioner that he informed police to take away his medication, as Adult 2 went on to allegedly take a drugs overdose.
***Comment.* This information was considered by the Panel, and it was clear that WMP had no reference in either their investigation log, incident log or custody record to either party asking officers to remove medication from the address in order to prevent either party from overdosing. The next call for police to attend the address was in May and there is no reference to either Adult 1 or 2 having taken an overdose during or after this incident known to police. It was explained by the WMP Panel representative that if such a request on any other occasion, the police officers present would have sought advice. The DHR is of the opinion, if it was reported to a BCH practitioner it should have been referred to WMP. If police were expected to take away a person's prescribed drugs and anything untoward then happened, police would be heavily criticised. The DHR agreed that it was unclear what information had been disclosed or not to the police at the time of their attendance and could not substantiate if the appropriate action by police officers was taken at the time on all known available information.**

2.20 **Domestic Abuse Incident 5 and Arson, a potential danger to life.** On the 29 May 2020, the DA incidents between Adult 1 and 2 had escalated to a dangerous level. They were heard to have had an argument at their property which led to Adult 2 taking his belongings and walking out. Moments later, a fire started outside Adult 1's room and a fellow resident had to extinguish it. Police were called and the resident who reported the argument had seen Adult 2 on the stairwell just moments before the fire started, suspecting that he had caused it. When officers attended, Adult 2 had already left the scene.

2.21 Adult 1 was located in his room and was drunk and unable to provide a clear account. He did inform police that Adult 2 had mental health issues and the pair often argued. He insisted that Adult

2 would not have deliberately started the fire and denied there had been any physical violence between them. He refused to engage any further and would not allow officers to access CCTV footage at the location which was likely to have captured what had happened. He refused to complete a DARA and to provide a statement and declined to follow safeguarding advice given and insisted he wished to remain at the property. A warning marker was placed on the address to ensure that any future calls from the location would be treated as urgent. Adult 1 was graded as 'medium risk' by officers. The Review Team and panel representative agree that this should have been high risk.

2.22 Adult 2 was arrested later the same day after being located in the street. Adult 1 was contacted but would not assist police, even suggesting police had no right to arrest him. Adult 2 answered 'no comment' to all questions asked during his interview. The case was referred to the Crown Prosecution Service (CPS) who refused to charge Adult 2 to remain in custody and instead set a list of actions to be completed prior to them making a charging decision.
Comment. ***It is unknown why action was not taken for police at the scene themselves to investigate and seize any potential evidence to assist a prosecution. It was good practice and a positive arrest strategy taken when Adult 2 was arrested. Police had requested a DARA during this incident, however he refused to complete. The risk assessment was completed, however, police agree the risk grading was incorrect. The DARA should have been completed as far as possible whether Adult 1 wanted to assist the assessment or not. Supervision of this and the previous DAs should have been communicated with other agency partners to address the volatile relationship. This was a high-risk incident with a potential threat to life which the WMP IMR now agrees with, after deliberation within the DHR process. This case should have been referred to the MARAC.***

2.23 **Witness Intimidation by Adult 1 and notification of Adult 2's reported overdose.** Adult 2 was bailed to stay away from the address whilst enquiries were made with the owner of the HMO. Despite this he attended the address two days later. On the 31 May 2020 the same resident who reported the arson incident reported that Adult 2 was at the location and had threatened him. Also, Adult 1 was said to have told the resident to say that the fire had been caused by accident and made threats to "make him pay" if he did not. A witness intimidation offence was recorded, and Adult 1 was arrested for this on 25 June 2020. He told investigating officers that he needed to be with Adult 2 because he had Post Traumatic Brain Syndrome and had to care for him. He explained that he needed to collect his medication from a mental health clinic in Walsall and give it to him daily, adding that he had nobody else to help him and that his anxiety had worsened. Officers contacted staff at the clinic who confirmed that they had been involved with Adult 2, but he had been discharged from their clinic some three months earlier. He had been transferred to Early Intervention prior to being discharged to his GP on the 4 June 2020. The staff stated that although Adult 2 had attempted to overdose in April, the support from Early Intervention had seemingly been effective as no further issues had been reported to them and he had contact details for the Crisis Team and was in regular contact with his GP.

2.24 WMP released Adult 1 under investigation and his bail conditions were lifted. The arson was referred back to the CPS along with the witness intimidation for authority to charge. The CPS decided that there was insufficient evidence to prosecute Adult 2 for arson or Adult 1 for witness intimidation. The rationale for not proceeding to charge is not known to the DHR.

2.25 **Hate Crime.** On the 13 July 2020, they were both walking home from a party under the influence of alcohol when a group of strangers who had set fire to a nearby car, were racially abusive and assaulted them both. A passer-by intervened and the offenders made off. When police attended, they were difficult to engage with and the exact location could not be identified, hampering CCTV enquiries. Neither could describe the offenders or the vehicle in which they had made off in. Given

the minimal investigative opportunities and the vague and differing accounts provided by Adult 1 and 2, the decision was made to file the matter and no further action (NFA) was taken.

2.26 **ASB by Adult 1 towards a female cleaner.** On 21 December 2020, Adult 1 fell asleep on a chair in the communal area of their accommodation and the female cleaner woke him and he became aggressive and started to throw things around. Fearing for her safety, the cleaner fled the location and called the landlord who, in turn called police. When officers got to the location, Adult 1 was still being aggressive and was arrested for breaching the peace due to a fear of provocation and violence. He was sent to court the following morning and was bound over to keep the peace.

2.27 **2021. Disclosure of mental health concerns by Adult 2 to WMP.** On 20 January 2021, Adult 2 was arrested on suspicion of being drunk in charge of a vehicle. At the police station, he failed to provide a specimen of breath and was charged and bailed for court. Prior to his release, he was visited by the HCP and Liaison and Diversion (L&D) Team after he had shared that his mental health was under investigation. He informed the custody sergeant that he had been prescribed Mirtazapine and Quetiapine and attempted suicide in the April and June before, saying he had PTSD. He denied being alcohol dependent and informed an escort officer that he had been assaulted by unknown persons. He was advised to formally report this to a police officer who could record the matter, but he did not pursue this, and the circumstance of any possible assault is not known. Whilst the Liaison and Diversion Team deemed Adult 2 to be fit to be charged, they contacted his mental health worker who agreed to contact him later that day, which was good practice. On 28 July 2021, the case regarding him failing to provide a specimen of breath was discontinued at court as a result of an administrative issue. He was subsequently not convicted of this offence.
***Comment.* Both Adult 1 and 2's behaviour towards others and themselves persisted with aggression displayed by both with alcohol related concerns and additional concerns of Adult 2 taking prescribed medication and attempted suicide on a reported two occasions. The incidents and their behaviour was becoming more worrying in nature. The concerns for their DA and Adult 2's mental health were not risk assessed thoroughly or followed up with agencies who were working in silos.**

2.28 **Allegation of sexual assault made against Adult 2 and Witness Intimidation by Adult 1.** On 27 March 2021, a female called WMP from their shared accommodation in Solihull reporting that she had been sexually assaulted. She stated she had been in the communal area when Adult 2 grabbed her thigh and pulled her in towards himself from behind whilst making remarks that *"they could make a beautiful job together."* This was witnessed by the female's partner who also deemed the comments and assault to be sexual. Adult 2 was arrested but denied the allegation, stating it was false and made in an attempt to blackmail him. He was bailed pending further enquiries.

2.29 Adult 1 who was identified as a witness, was accused of intimidating the female, the second reported incident of intimidating a witness. She called WMP reporting that Adult 1 had sent her messages asking her to accept his apology and not have Adult 2 sent to jail as it would ruin his life. Following her report, Adult 1 was invited to the police station for a voluntary interview. He told the interviewing officer that he and Adult 2 had been staying at the location with Adult 2's brother when the alleged incident occurred. He explained that they had been having problems with the female who had been taking their food and the allegation was false and said the messages to the female were misinterpreted. He stated the female's friend had, in fact made threats to kill him. WMP state that whilst this was ethically recorded, (Police terminology to say they complied with the policy of recording an incident bit learning has been identified within Chapter 4), there was no supporting evidence and appeared to be a case of tit-for-tat; it was then filed. Adult 2 remained on bail for sexual assault.

***Comment*. Adults 1 and 2 were by now not only involved in DA between themselves and ASB at their accommodation but Adult 2's criminal behaviour was intensifying and was posing a serious risk to others, as was the behaviour of Adult 1.**

2.30 **Summary of Adult 2's involvement with BSMHFT**. Adult 2 was referred to BSMHFT services by his GP in July 2021. He was new to the area, having previously resided in Walsall and was under the care of Walsall Mental Health Services. At the time of the referral, Adult 2 complained of auditory hallucinations. The GP requested further assessment and management. This referral was passed to the local Community Mental Health Team (CMHT). A face-to-face assessment was arranged with a psychiatrist and an interpreter for December 2021. He was again assessed on presentation to hospital in November and for an assessment with a psychiatrist in December 2021 as discussed below.

2.31 **Hate Crime**. In October 2021, a resident made homophobic and racial comments. The resident was arrested and bailed whilst the investigation continued. They were not the only persons reporting such behaviour from the resident.

2.32 Adult 2 attended the emergency department (ED) at Birmingham Heartlands Hospital (BHH), part of University Hospitals Birmingham (UHB) on three occasions. The first two events were significant as he attended twice on 27 November 2021. On the first occasion Adult 2 left ED before any clinical assessment. His behaviour was described as "unusual" on the casualty card. A new missing patient procedure had been published in June 2021. The expectation would be to assess risk according to his presentation, search the immediate area, and utilise CCTV by security to see if there were any sightings of him leaving the department. There was no physical description of him recorded and staff gave this as a reason for not contacting the police. His contact details were on the casualty card however staff did not attempt to call him. His next of kin, was not recorded.

2.33 **Domestic Abuse Incident 6.** **Mental Health and DA reported concerns for Adult 2.** He returned to the ED approximately six hours later at 8.21 am on the 27 November 2021. The attendance was recorded as a "social problem" by ED admin staff. He had a groin pain and was hearing voices (ongoing from an assault a few years earlier) which were "*asking him to hurt others*." He was noted at Triage to be tearful and avoiding eye contact. He had drunk alcohol the previous day but denied taking drugs. He was on antidepressants and was struggling to sleep. He was referred to the Liaison Psychiatry Team and assessed by them that afternoon. There is no evidence that any questions were asked about his earlier attendance or that he was recognised as a missing patient by the emergency department and the liaison psychiatry. He stated he presented after being made homeless by his boyfriend Adult 1 of 4 years. It was noted that he was a patient of a local Mental Health Services as he suffered with anxiety and depression and was on prescription medication for this. He divulged that he had become aggressive the night before whilst intoxicated causing his partner to lock himself in the bathroom and call the police (no record in the WMP IMR). He said that Adult 1 had stated he could no longer cope with Adult 2's behaviour. His assessment stated he had a history or current risk of harm from others, but not to others, stating he denied thoughts to harm himself or others.

2.34 The Liaison Psychiatry Nurse documented that he was not keen to address his alcohol and aggression issue; denied any plans to hurt himself or others and denied hearing voices at the time and had an appointment with the community teams for the 9 December 2021 which he agreed he would keep. He was given details of the crisis team and for the Salvation Army homeless team. There were domestic abuse indicators that were evident from his description of the incident. He declined support for his aggression issue, but it is not documented that consideration was made of risk any to Adult 1. Both ED and mental health staff are familiar with supporting victims of DA, either at triage by the ED staff or by the mental health nurse at assessment. He also attended once more to the hospital on the 9 June 2022 with no safeguarding concerns reported to the review.

Comment. ***These attendances and the concerns for his current mental health and the disclosure of DA should have been correctly risk assessed and the DA referred, to ensure it was known to other safeguarding agencies to be explored further and was another missed opportunity. There was a disclosed level of fear; his partner had locked himself in the toilet as a place of safety and Adult 1 had indicated an end to the relationship 'I can no longer cope with his behaviour.' There was evidence disclosed that he was a perpetrator and a harm to his partner. If a male had disclosed, his female partner had locked themselves in a bathroom due to fear, it is possible, due to potential gender bias, this may have been managed differently by professionals at the time.***

2.35 **Landlord Eviction and Tenant disputes.** In the preceding months of Adult 1's death they were both tenants of a flat in Solihull from the 14 June 2021 until February 2022. This was a one-bedroom studio flat situated within a shared house, which they rented from a private landlord. They held an Assured Short-hold Tenancy Agreement for a fixed term of six months. Tenants do not have to leave if the term comes to an end, or if the landlord tells them to leave. In these circumstances the landlord must serve a Section 21 Notice and get a court order to evict (no fault eviction). In the case of Adult 1 and 2 their landlord served a Section 8 Notice, using criminal damage and Anti-Social Behaviour grounds to have them leave the premises.

2.36 **Alleged Hate Crime.** Adult 1 reported to SCH that a tenant had directed racist and homophobic abuse towards him and his partner. WMP record on the 21 October 2021, Adult 1 reported that the neighbour had called him and Adult 2 'queer' and told them he did not like (nationality redacted) people. SCH were told he had reported it to the police and had a crime reference number and informed his landlord, who did not listen and was ignoring them. He stated he was his partner's carer who had Asperger's, (the review is unsure whether Adult 1 was making his own diagnosis) and his partner gets scared and has panic attacks and was affecting his mental health. Analysis of the recorded conversation shows that Adult 1 was led towards the option of rehousing as a way out of the situation. Although the response mainly showed empathy around the experiences reported, there was an occasion when the advisor emphasised that it was a matter for his landlord and there was nothing that SCH could do. The advisor briefly mentioned an ASB route without explaining what this was. The option of making a referral to the neighbourhood services team who can offer support around hate crime was not given and would have been the correct procedure.
Comment. ***Further incidents of the same hate crime nature were reported in relation the perpetrator and also by other residents between 21 October 2021 to 16 January 2022. The suspect was arrested and made further offensive comments and was later charged with racially aggravated offences.***

2.37 Adult 2 was dealt with and spoken to by another SCH contact advisor who gave advice to him about their legal situation in that a landlord had to serve a section 21 notice before taking possession. He was satisfied with the advice and stated he understood the position better. Although in the first conversation Adult 1 had said he already had a crime reference number was now onto the police chat service to report it. In a second conversation with Adult 1, he stated that he was nervous, that English was not his first language, and although usually good, that day he had forgotten the language. The option of interpreting services to assist communication between the parties was not offered in either conversation. There is no documentary evidence of outcomes around risks or safety and no referral to the mental health service for Adult 2 as he disclosed, he was engaging with them, but this was not verified. *(The concerns of not referring to the neighbourhood services team or using the services of an interpreter are subject to an SCH Recommendation in Appendix 1*).

2.38 **Adult 2 reported voices and potential harm to other.** On the 29 November 2021, the Housing Options Service received the letter from Adult 1 seeking accommodation or assistance in retaining or obtaining accommodation, this constituted a homeless application under the homeless legislation. It stated they had been told by the landlord they must leave and contained information relating to their

reported incidents including moving to Solihull following medical advice to improve his partner's mental health, his upstairs neighbour's homophobic and racist behaviour. He disclosed Adult 2, received treatment for PTSD following an assault and anxieties which were difficult to deal with. He stated his partner has undiagnosed psychosis and will see a doctor in December. He stated that when alone Adult 2 heard voices saying, "*Adult 1 is murdered and that he kills himself to join him."* He also stated that in the past Adult 2 has poisoned himself and ended up in hospital and now reads books to help with suicidal ideas, so he is not dangerous to himself or others. He stated they felt persecuted and trapped and asked if the process of rehousing could be speeded up.

2.39 The telephone triage was completed on 30 November 2021 and a full assessment completed on 3 December 2021 with an interpreter on both calls. Adult 2 stated that he was under the mental health service at Newington Mental Health (Maple Leaf Centre) and Adult 1 did not identify any support needs and neither indicated any support needs in relation to the risk or experience of domestic abuse, drug or alcohol dependency or offending history.
Comment.* *There was however no risk assessment of the alleged concerns of Adult 2's statement made by Adult 1 that he himself is killed which, with the current murder charge, now appears prophetic. These concerns were both significant and high-risk and should have been referred and was a lack of professional curiosity. (See DHR and Agency Recommendations in Chapter 4).

2.40 **Adult 2 disclosures of previous DA with same sex partners.** On 9th December 2021, Adult 2 attended CMHT for an assessment with a psychiatrist. As planned, an interpreter was present. Adult 2 reported that he had not been well since he and his partner were physically assaulted in 2018 where he sustained a broken jaw. Adult 2 advised that he started to hear voices after this incident. When discussing forensic history, he disclosed a history of DA involving his two previous partners as well as his current partner, but this was not explored further. The plan following his assessment was to continue taking his antidepressant medication and to increase his dose of antipsychotic medication. It was also agreed that his case would be discussed with the clinical team to consider a referral for psychological support and a follow-up appointment with an interpreter.
Comment.* *The fact that he had disclosed previous and current DA with Adult 1, the psychiatrist should have considered the risk and shared the information as it was pertinent to the DA that was occurring.

2.41 **ASB and Landlord warning letter. Assault allegation**. On 17 December 2021, Adult 1 reported to police two days later that he was assaulted by a builder working on the property. SCH confirm in their contact that Adult 1 or 2 threw a brick at a 15-year-old apprentice and a relative of the child admitted hitting one of them in response. It was dealt with by the landlord removing the workers and neither parties pursued the incident further, and it is recorded that "The landlord was of the opinion that Adult 1 and 2 were playing the homophobia race card and they asked him to collude with them saying the neighbours were harassing them to support their homeless application." The landlord refused to agree and reported this to SCH. The landlord also provided a copy of a warning letter dated in October 2021 sent to Adult 1 and 2 referring to their noise levels, playing music and shouting in the early hours. There was learning for a SCH Housing Options Officer to have shown more professional curiosity in seeking clarification of the warning letter. Police did not progress the allegations.

2.42 **2022.** Their case was referred by SCH regarding the dispute with the landlord to the Environmental Health section within the Trading Standards and Environmental Compliance Team (ECT) because they enforce the landlord harassment provisions of the Protection from Eviction Act 1977 but not the Protection from Harassment Act 1997. Adult 1 and 2 wanted some assistance to be re-housed which SCH had already started. In January 2022 the tenant upstairs gave notice, removing the initial cause of homelessness. Active searches were made for suitable alternative accommodation

in the private sector, which was unsuccessful, as was attempts of mediation with the landlord to maintain their tenancy.

2.43 On the 11 January 2022, Adult 1 called WMP reporting he could hear a disturbance outside his address and that he feared for his safety. Officers attended and all was calm. It was established that he had not seen anyone and there was no damage to the property. The matter was ethically recorded and subsequently filed.

2.44 **Criminal Damage by Adult 2 at accommodation.** On the 13 January 2022, Police were called to the address as there was an incident of damage of spray paint to the stair walls by Adult 2 who said it was an accident. He phoned the SCH Contact Centre to report he and his partner had been asked to leave within 24 hours as a result. He apparently felt intimidated by the tenant upstairs and how a similar situation in the past had caused him to feel suicidal with attempts to kill himself. The SCH Advisor gave advice, sending an email to the Housing Options Officer and referred to him for his mental health concerns, but not the conversation relating Adult 2's similar circumstances in the past of his feelings of suicide, was not communicated. (SCH Agency Recommendation made).

2.45 **Cultivation of Cannabis by Adult 1.** Police attended the incident and located a small cannabis plant on the window sill inside Adult 1's flat. He admitted that he had grown the plant for his own personal use. He was referred to a Drugs, Alcohol rehabilitation and counselling service, as per a community resolution (out of court disposal record held on WMP systems) where he was required to complete a course. This matter was filed upon Adult's successful completion of the course.

2.46 **Hate Crime.** On the 16 January 2022, Adult 1 contacted WMP via webchat reporting that another resident had been racially abusive and made homophobic remarks towards him. He did not want any action as he and Adult 2 were in the process of moving out. The following day Adult 1, reported it to the SCH contact centre advisor of an incident that had occurred involving the tenant upstairs banging his door and allegedly mentions a knife but there is no record of a knife in the police records. He confirmed he called the police and stated the perpetrator was taken into custody and bailed to stay away from them, did not feel safe, and his mental health was affected.
***Comment**. Adult 1 appears to give a variance of the incident to both agencies as they were not working together and communicating as SCH should have liaised with police particularly if he was saying there was a knife involved, for the true facts to be determined and risk assessed.*

2.47 **ECT, Landlord Eviction process.** ECT in the meantime contacted their landlord. He confirmed that he had served a notice on them and that the reason for the notice was they had been causing problems and had committed criminal damage to the property, been growing cannabis and had been causing nuisance to other tenants by playing load music and being abusive. A landlord can seek possession of a property from a tenant under 2 sections of the Housing Act 1988 , Section 8 and Section 21 which is commonly referred to as a no-fault eviction whereas Section 8 requires one or more conditions to be met. In this case the landlord has cited criminal activity, nuisance and annoyance and sought an order to satisfy a court before carrying out an eviction.

2.48 **ECT, Referral to ASC and Police re Mental Health Concerns.** Adult 1 and Adult 2 considered the eviction and hostility shown by the other tenants in the residential block was as a result of their homosexuality. An ECT officer in conversation with Adult 2 on 17 January 2022 believed there were some significant mental health issues and recognised that Adult 2 was extremely vulnerable although he was receiving mental health support from another area. The ECT officer appropriately made the referral to ASC on 18 January 2022. Similarly, as the conversation with Adult 2 contained a threat to both other people and to himself, the same ECT officer made a referral to Police on the 19 January

2022. Both referrals made were acknowledged by ASC on the 19 January and by Police on the 28 January 2022.

2.49 ECT believed the landlord was thought to be a fair landlord and through serving the Section 8 notice, was following due process to get back possession of his property. ECT listened to both Adult 1 and 2 but there was no substantive investigation into the landlord harassment claims. They were not asked to provide a witness statement, which can be understood, as they could not provide any information which constituted harassment. In assisting with their request for re-housing, the ECT Officer considered that, if there was a risk, Adult 1 and Adult 2 would be moved out of an environment in which they considered they were being harassed.
Comment. ***The referral raised questions from agencies to the DHR that no action was taken by ASC to risk assess and share the information more widely to safeguarding partners. The triage system within ASC, did not identify the overall picture of the escalation of safeguarding events or possible carer responsibilities that Adult 1 was raising in his contacts with professionals. ASC confirm that the referral was about Adult 2's mental health assessment only and not safeguarding. No DA was reported on this occasion or other occasions which, confirms that multi-agency working was failing to communicate effectively regarding the risks within their DA relationship, (DHR Recommendations 7 and 8 address this).***

2.50 **Domestic Abuse Incident 7.** On 6 February 2022, Adult 2 called 999 reporting that Adult 1 had beaten him up at their home. During the call, Adult 1 could be heard shouting in the background as Adult 2 said he was drunk and had been beating him all evening. He had waved a lit cigarette lighter in his face which had caused some of Adult 2's hair to burn and was also punched in the face causing a cut to his lip. Adult 1 had jumped on his back when he tried to leave but he had managed to escape and call police. Adult 2 was outside when the police arrived, and Adult 1 was arrested inside the premises and was under the influence of alcohol. A Domestic Abuse Risk Assessment (DARA) was completed, and Adult 2 was graded 'medium risk'. He refused to provide a statement, informing police he wanted Adult 1 to get help for anger issues. He suspected that he was bipolar but was in denial about it. He confirmed that he himself had PTSD and that both of them drank alcohol and smoked cannabis. He declined referrals for support and a warning marker was placed on the address stating he wanted Adult 1 back at the address.

2.51 In custody, Adult 1's mental health was discussed, and he was supportive of a referral for support. He was seen by the HCP who identified no acute concerns and deemed him fit to be interviewed. In interview, Adult 1 denied causing any harm and suggested he had sustained his injuries putting the rubbish out. He accepted he should not have been drinking because he was Adult 2's carer and wanted to go home to him. (Being his apparent carer was never followed up by any agency to this DHR). He did not undergo any form of mental health assessment and was released from custody with no further action taken against him and the matter was filed due to insufficient evidence.
Comment. ***The WMP IMR records that whilst the report stated that Adult 1 was supportive of referrals being made, it does not specify to whom or what support services were contacted and why.***

2.52 **Eviction.** Housing Options Officer involvement with the mental health service at this point included numerous emails and attempts to engage with Maple Leaf Centre but the communication was ineffective until a mental health worker was spoken to on the 21 January but there was no follow up or further contact between the two agencies. Adult's 1 and 2 moved out of their tenancy on 8 February 2022 after the eviction notice was successfully served. BSMHFT were also made aware by SCH that they were served notice to leave their home by the landlord due to escalating issues between Adult 1 and 2, with their neighbours, counter complaints about noise, racist and homophobic comments.

2.53 **Resident dispute.** On 27 February 2022, officers were called to their new and current HMO over a dispute about a stolen wallet. It was established that one of the residents had returned home to discover that his wallet containing cash was missing and suspected Adult 1 had stolen it. During a heated argument about this, the resident threw Adult 1's mobile phone, causing it to break. No party wished to make a formal complaint against the other and the case was closed.

2.54 **Adult 2 charged with sexually assaulting a female.** In March 2022 , Adult 2 was formerly charged with sexually assaulting the female victim from the previous year. He attended court on the 28 March 2022 where he pleaded 'not guilty.' (He was awaiting trial when arrested for Adult 1's murder).

2.55 Adult 1 attended the emergency department (ED) at Birmingham Heartlands Hospital (BHH) on the 12 April 2022 as his partner had told him that he might be very unwell, this exacerbated Adult 1's anxiety. He had long term abdominal pain, and recent vomiting. He was discharged after assessment, to be followed up by his GP with a probable diagnosis of gall stones. There was no suggestion of DA and Covid restrictions were still in place within the hospital, and he would have been seen alone.

2.56 **Domestic Abuse Incident 8. Drug Overdose by Adult 2.** On 9 June 2022, Adult 2 attended the emergency department at 11.31am presenting with an overdose of his mental health medication with suicidal intent. He and his partner (not recorded) called the ambulance. On his arrival to ED, he stated he regretted his actions and that it was an impulsive action after an argument. Once deemed medically fit he was referred to liaison psychiatry that afternoon. He did not disclose anything further but was reviewed by a psychiatric nurse who noted he was open to community teams and had an appointment booked for the 17 June 2022. He had taken the overdose impulsively following an argument with his partner when he had got angry, had a can of lager, and then took the tablets. He shared he was due in court that day (for the sexual assault charge) but had overslept due to the overdose. The nurses did enquire if he had taken the overdose to avoid going to court, but only confirmed he was not in court due to an issue with Adult 1, who was noted as a protective factor (no other details known). He denied any thoughts of harming himself or others and was referred back to the community team as he was looking forward to starting his treatment and his GP was informed.
Comment. ***The information regarding a potential DA incident between them both, does not seem to have been recognised as DA, therefore, other agencies including WMP were unaware of the incident.***

The Death of Adult 1

2.57 **Domestic Abuse Incident 9 and Homicide of Adult 1.** On a date in July 2022, just after midnight, WMAS called WMP after responding to a call from Adult 2 that his partner Adult 1 was in cardiac arrest. The premises was their HMO, consisting of separate rooms occupied by several residents. WMAS paramedics attempted to insert a breathing tube into Adult 1. The paramedics suspected that Adult 1 had been strangled due to the difficulty of inserting the medical apparatus. Paramedics were informed by Adult 2 that he had argued with and had pushed Adult 1 over which led to his cardiac arrest. Adult 2 confirmed the same version of events when police officers subsequently attended the venue a short time later. Adult 2 was arrested on suspicion of an assault on his partner and taken into police custody heavily intoxicated and not making sense when arrested. He was observed to have a scratch to his neck and bruising to his upper arm. In the meantime, Adult 1 was conveyed to Heartlands Hospital where he was sadly pronounced deceased at 1.53am that same morning. Adult 2 was then arrested on suspicion of murder. A post-mortem was later conducted on Adult 1 which, revealed pressure had been applied to his neck, and was the cause of his death.

2.59 **Police investigation and outcome.** The investigation was progressed by the homicide team under "Operation Winterhold." Following a mental health assessment, Adult 2 was deemed fit to be interviewed. During his legally represented interview, he stated that he and Adult 1 had an argument which became physical. He stated that he pushed Adult 1 in self-defence causing him to fall, bang his head and lose consciousness. He denied strangling him but stated he may have placed Adult 1 in a chokehold after Adult 1's cousin Adult 4 informed investigating officers that he had previously seen Adult 2 have Adult 1 in a chokehold in March 2022, a DA incident not known to services. Adult 2 denied any intention to kill Adult 1, but CPS authorised Adult 2's charge for murder.

2.60 In October 2023, at Birmingham Crown Court, Adult 2 pleaded guilty to manslaughter. Before he could be sentenced the case was adjourned for a Newton hearing (between the judge and other parties where there is a guilty plea, but factual issues need to be resolved) was arranged to take place on the basis of his plea. That was because no basis of plea had been submitted by the defence and they said they accepted the prosecution case, but the prosecution case was murder, and the defendant was pleading to manslaughter. The defendant admitted the act (albeit he has never explained how it was carried out) but denied intending to kill or seriously harm.

2.61 In March 2024, at the Crown Court, at the Newton hearing the issue was around pathology evidence. Would the victim have instantly been killed or injured initially and then died. This mattered to the defendant as witness evidence from a neighbour next door was that he heard shouting which then stopped. The prosecution say this is when the offence was committed and then the defendant did not call an ambulance for 20-25 minutes. The defence, it appeared, were attempting to mitigate the time delay. The Judge did not accept the idea submitted, that there was a reasonable delay in calling for the ambulance, and believed the delay was significant and that the victim was incapacitated by the actions of the suspect at the time. **Adult 2 pleaded guilty to the manslaughter of Adult 1, and the Trial Judge sentenced him to a nine-year custodial sentence.**

2.62 **Coroner's inquest.** There is only one histopathologist in the country and therefore was a delay in obtaining some of the medical evidence required for the court proceedings in the case. The coroner inquest was not resumed due to the criminal proceedings, as directed by the Home Office Senior Coroner, for Birmingham and Solihull Districts.

Chapter 3

Professional Practice and the Key Lines of Enquiry (KLOE) TOR Questions

3 The Individual Agency IMR authors were requested to address the KLOEs specified questions from the terms of reference, in order to capture the lessons to be learnt of their agencies professional practice. All information from the submissions were evaluated and incorporated where relevant in the narrative of key events in Chapter 2 and within both the DHR and Individual Agency Recommendations. A summary of the agency responses to the KLOE specified questions are: -

3.1 Working Together, Communication, information sharing and record keeping.

- **Was there effective working together between agencies, regarding communication and information sharing involved in the contact and interaction with Adult 1 (Deceased) and Adult 2 (Perpetrator)?**

3.2 **WMP.** There was little working together between agencies regarding communication and information sharing about contact and interaction.

- DA risk assessments were only ever graded as 'medium risk' as a result were not referred to MARAC.
- The arson incident, WMP acknowledge this should have been assessed as high-risk.
- Only after Adult 1's death was it known that Adult 2 had held him in a 'chokehold' in March 2022, four months prior to doing a similar action moments before Audit 1 died.
- When the first two DA incidents were reported to WMP in February 2019, alcohol and mental health were both identified as issues but there were no referrals for support for this.
- Adult 2 by the HCP whilst in custody was deemed fit for interview and did not record any concerns for his mental health. Following Adult 2's arrest for drunk in charge, the Liaison and Diversion (L&D) Team contacted his mental health worker.
- It is unclear from records whether WMP's Vulnerability Portal a referral pathway to support services was accessed.
- Adult 1 stated he was Adult 2's carer, there was no apparent acknowledgement that he may have needed support in assuming the role.

3.3 **ASC** received an online referral on 18 January 2022, from SMBC Environmental Health requesting a Mental Health Assessment for Adult 2. A second contact was received on 18 January 2022 from SCH relaying the same concerns. ASC One Front Door Duty contacted the initial referrer which was then passed to Birmingham and Solihull Mental Health Foundation Trust due to a previous history of mental ill health and presenting concerns regarding auditory hallucinations and threats to hurt and kill others.

***Comment.* This referral was subject to discussion in the DHR Panel Meetings and is addressed within the contents of the event in Chapter 2 and within the DHR Findings and Recommendations in Chapter 4. ASC were not informed of any DA incidents.**

3.4 **BSoLICB.** Health-to-health sharing of information identified learning; no letter from Liaison Psychiatry regarding their assessment of Adult 2 having taken an overdose of his antidepressants; no letter from WMAS regarding their attendance to see Adult 1 at home on 22 April 2022. Also, GP Medical Practice 4 did not have any of the medical records from GP Medical Practice 3 for Adult 2. There was also no communication at all between the Practices and other non-health agencies such as Police and Housing. Therefore, neither Practice was aware of any of the DA incidents or any housing problems Adults 1 and 2 were facing.

3.5 **UHB**. When Adult 1 attended the emergency department following the assault which led to his death in July 2022 it is clearly evidenced that information was shared between agencies to investigate the death. However, following Adult 2's absconding from ED on the 27 November 2022 there was no evidence of any multi-agency working in trying to locate him. On his return later that day, Liaison Psychiatry have recorded that they would inform his community teams and GP of his attendance and the subsequent plan but discharge letters from clinical teams will routinely only include brief information as psychiatry teams will share information separately.

3.6 **SCH**. There was not effective working between SCH, mental health services, GP's, and police, mainly relating to the timeliness of making referrals and providing timely feedback and information to enable judgements and decisions around levels of risk, support and homeless decision making. The impact of this ineffective communication is that the housing officer had not been given full information following her referral as to any assurance around safeguarding issues raised, including whether there were any further vulnerabilities that needed to be considered in terms of support or decision making.

3.7 **BCHCT.** Adult 1 was not known to Black Country Services as a patient. Adult 2 was known, and records indicate working together communication and information sharing with mental health services via presentations from 2018 to April 2020; liaison with Early Access Services in 2019 for an eye problem, Out Patients Clinic (OPC), his GP and Home Treatment Team (HTT) and Crisis communicated with the GP regarding physical and mental health, that included some details of Adult 1 in consultations and care plans. In March 2020 a referral was made to the Early Intervention (EI) including Psychology. Adult 2 engaged with a care co-ordinator and psychology regularly, although he missed some medical appointments. Psychology further supported a housing application in 2021. He was discharged following assessment with feedback to the GP and as he did not engage in the Care programme Approach (CPA) discharge process. The 'Did Not Attend' (DNA) policy was followed.

3.8 Adult 2, whilst in police custody (in May 2020 and January 2021), was risk assessed by police as suitable for a referral to the Liaison and Diversion team. BCHFT record police attended an incident on 17 April 2020 and arrested Adult 1 who it is suggested allegedly asked police, as a risk, to remove medication from Adult 2, due to intoxication and his mental health, however BCHFT report police did not remove the medication, which resulted, it is suggested Adult 2 taking a drugs overdose.
<u>Comment.</u> This incident about medication is addressed within Chapter 2 as police have no record of such a request. Evidence has been supplied to this review that implies Adult 1 was relaying different information to professionals about the same incidents. In any case, such an action of police taking a person's medication away would need authorisation. The panel could find no clear evidence to either party having taken an overdose during or after the incident attended by police. BCHFT now agree it was allegedly suggested with no evidence to the contrary. The BCH practitioner should have reported the matter to police at the time.

3.9 **BSMHFT.** SIAS clinicians, had a referral pertaining to Adult 1. They found there was not effective information sharing between agencies. The referral was received from the police, but it was limited information. It is assessed within the BSMFT IMR that Adult 1 was the perpetrator of domestic abuse and identified more professional curiosity should have been displayed. From interviews with the services that had contact with Adult 2 (CMHT and Liaison Psychiatry), there was limited contact with other agencies which should have been explored.

- **Was record keeping comprehensive and to a satisfactory standard?**

3.10 **WMP.** Record that offences were ethically recorded. As further allegations of additional offences were disclosed, these were recorded, reviewed, and pursued, or filed where appropriate, in line with WMP force policy. They disclosed that neighbours made homophobic and racist remarks with

the detail of each offence recorded. However, it is clear there were recording concerns such the use of drugs, yet only Adult 1 was recorded as receiving any form of rehabilitation for this. There was an assumption this may well have been addressed by other agencies but was not confirmed by WMP.

3.11 The WMP IMR confirmed, although DASH was not mandatory until it migrated to DARA in July 2019, DASH was still a tool that could have and ideally should have been used by officers responding to domestic incidents. However, WMP subsequently confirmed to this review that DASH was mandatory from November 2017. It is recorded that both Adult 1 and 2 would refuse to complete a DASH and no real record was made into why or what attempts were made to obtain detailed information for a risk assessment, a DASH should have been completed. WMP state the officers did make their own assessments; each time they were deemed to be 'medium risk.' A comprehensive DARA was completed with Adult 2 in February 2022 only, where it was identified that Adult 1 occasionally made threats to harm Adult 2 or his property which he cared about such as people, pets, or property. He said Adult 1 would push, slap, punch or kick and said that Adult 1 had only once threatened suicide. The IMR records whenever a DA incident was reported, intelligence checks were conducted with past events and incidents recorded within the live investigation log at the time. Decision-making was documented and made by the correct level of supervision within the appropriate department and the contact with both partners was recorded. When support was offered but declined, this was recorded.
Comment. ***WMP informed the review that checks were completed by officers and as per the high-risk definition, the correct classifications were recorded. WMP now acknowledge, had the arson incident been correctly graded as high-risk, all subsequent incidents would also have been graded as high-risk, with MARAC referrals. If checks had been diligently made throughout to assess the escalation of DA incidents, a referral could still have been made to the MARAC and ASC informed as it does not necessitate it has to be high-risk if safeguarding concerns exist.***

3.12 **SCH**. The actions on the case were comprehensively recorded and to a satisfactory standard. On occasions it would have been helpful if the rationale for some decision making was recorded, such as any outcomes of risk assessment.

3.13 **BCHFT.** Adult 1 has no patient records at Black Country Healthcare. Adult 2 has records dating back to 2018, when the first record indicates a presentation at A&E with low mood and suicidal thoughts where he was seen by the Psychiatric Liaison Team. There is a logical sequence of documentation which demonstrates referrals, assessments, communications via letters and RIO (computer recording system) progress notes while open to services. There is information to state, plans were shared with partners, teams and the patient and carer. (It does not say whether this was Adult 1 who was a possible self-appointed carer?).

3.14 **Capturing the voice of the subjects.**

- **Were the voices of both Adult 1 and 2 heard and was effective action taken to address any concerns?**

3.15 **WMP.** The voices of Adult 1 and 2 were heard. The history they provided to officers was recorded and consideration given to supporting both. When initially reluctant to speak with officers, further attempts to speak with both parties were attempted once they were sober. On an occasion, they were offered support in seeking alternative accommodation following domestic incidents and when altercations had occurred between them and neighbours. They were very clear about wishing to stay together. WMP state they had no legal power (with the exception of bail conditions imposed following the incident of arson) to make either leave the HMOs at which they were residing following domestic incidents. Bail conditions were imposed following the arson incident, but Adult 2 did not adhere to it, Adult 1 encouraged the breach of the conditions to the point he was not only found in

company with Adult 2, but he also intimidated a witness in the case in an attempt to change his statement given to police.
<u>Comment.</u> There was no safety planning considered. There was safeguarding action that could have been taken to require a perpetrator to leave an address and to instruct them to obtain help for their behaviour in both the Domestic Abuse Act 2021 using DVPO/DVPN's and the Home Office ASB Guidelines 2022 using a court injunction.

3.16 Adult 1 informed investigating officers that he was his partners carer and bail conditions prevented him from fulfilling this role which was said to have been having a detrimental effect on his mental health. This was taken into consideration when the decision was made to cancel Adult 2's bail conditions and shared with CPS. WMP Liaison and Diversion Team arranged for Adult 2's mental health worker to contact him after he informed them, he was under assessment.
<u>Comment</u>. It appears that no agency checked whether Adult 1 was actually the carer for Adult 2 and this review has not received information whether Adult 2 was asked the question.

3.17 **ASC**. Neither Adult 1 nor 2 were contacted by ASC, which was appropriate in the circumstances as there was no mention of DA in the referral received. ASC discussions were at a professional level to discuss who would be the most appropriate agency to respond when they received the referral.

3.18 **BSoLICB.** For both Birmingham GP Medical Practices 3 and 4, it was not always clear from the GP Practice medical records whether contacts with Adult 1 or Adult 2 were face-to-face or by telephone. Despite no further Covid lockdowns, many Practices have continued to use the telephone as the preferred method of contact with a patient, saving face-to-face encounters for conditions that require a physical examination, or if the patient requests one. Hearing the voice of both in the circumstances could have been improved, (BSOLICB Agency Recommendation in Appendix 1).

3.19 **WMAS.** On each occasion the adult's wishes were taken into consideration by establishing that they had capacity and consent for treatment by undertaking a diagnostic and functional test.

3.20 **SCH.** Contacts with the service were by telephone, emails, and letter with Adult 2 having most contacts. Overall, the voices of both Adult 1 and 2 were heard and effective action was taken to address concerns. An exception to this occurred on the very first contact when Adult 1 reported incidents of homophobic and racist abuse to the SCH Contact Centre. Analysis of the recorded conversation shows that he was led towards the option of rehousing as a way out of the situation rather than having it investigated through the ASB and Hate Crime procedure. Although the response showed empathy, Adult 1 was not given fully explained options that he could consider, particularly since he had stated that he wanted the problem resolved. Their requests for interpreting services were only taken up on two occasions which may have impacted on their voices not being understood.

3.21 **BSMHFT**. It was noted that Adult 1 did attend the latter part of the assessment that CMHT was undertaking with Adult 2. At this point, there was sufficient documentation to suggest there was DA within the relationship. Although it would have been difficult to see Adult 1 alone at this time to establish his views and concerns, there was a missed opportunity to obtain his personal details and contact information to establish contact with him at a later time to explore this and offer a DASH risk assessment. In terms of the contacts with liaison psychiatry, during the first assessment, Adult 2 advised that he had separated from his partner. As such, it was felt there would be no requirement to try and establish contact with Adult 1. However, on the second assessment with liaison psychiatry, his partner was referred to, as such there could have been more curiosity into their relationship.

3.22 **Professional curiosity displayed responding to allegations of crime, culture, and diversity. Issues.**

- **Were there any culture and diversity issues identified and what was the outcome?**

3.23 **WMP**. Both Adult 1 and 2 informed officers they were racially abused and received homophobic remarks from fellow residents and strangers in the street and these were investigated. English was not their first language; this was managed appropriately by officers who ensured their voices were heard with the assistance of an interpreter. There is no evidence to the review that cultural and diversity issues affected the WMP response to any incidents reported.

3.24 **SCH.** Both Adult 1 and 2, disclosed that English was a second language, they were a same sex couple, and Adult 2 was engaged with mental health services. SCH analysis finds that there should have been sensitivity to language requirements, particularly during their initial contacts with the contact centre. The offer of interpreting services to assist communication was not made when the contact service advisor called Adult 1 and 2 to discuss their housing application. Contact centre recordings and transcripts, show they both had a proficient command of the English language and references to making use of google translate should have alerted the advisor to make the offer of the interpreting service. The advisor who had spoken to Adult 2 following the spray paint incident did not act on the fact that he prefers to speak through an interpreter. The issues of their hate crime on the grounds of homophobic and racist abuse were being investigated through the homeless procedure. It would have been a more effective response to have been referred to the neighbourhood services team, who specialised in ASB investigations.

3.25 **BCHFT**. As Adult 1 and 2 were in a same sex relationship, there was some suggestion from professionals that the beliefs of family of Adult 2, some of whom, allegedly, did not agree with his sexuality and the influence of the strong catholic influences from his national background, did cause some feelings of judgement from the family. Interviews described how Adult 2 was able to go back to visit family however encouraged not to come with his partner. His brothers in the UK were also judgemental about his lifestyle. This may have impacted on feeling isolated or in need of help. RIO notes show discussions in Early Intervention and psychology regarding his culture, lifestyle choices and offered support to guide towards helpful strategies to manage his frustrations and consider support from other agencies. It appeared Adult 2 was more willing to engage in periods of chaos, but when things were ok, he did not pursue options so readily. Medical, nursing and support staff records recorded discussions including his diversity, culture, and contacts with police.

3.26 **BSoLICB.** There was no evidence in the medical records that any culture and diversity issues were identified by either Practice or even considered.

- **Was professional curiosity displayed when addressing the reported concerns of domestic abuse, anti-social behaviour, racial and discrimination of their sexual orientation, landlord disputes and eviction concerning Adults 1 and 2 and were they appropriately dealt with?**

3.27 **WMP.** Were aware that the couple frequently moved address. It is not documented within any of the reported incidents that they were evicted from any of the known properties at which they lived or stayed. SCH were liaised with in January 2022 by officers investigating the racially aggravated harassment report against them. When reports of disorder, arson and assault were reported, responding officers did use professional curiosity; they searched for suspects, examined the scene for damage and ignition tools and observed and explored visible injuries on the complainant and suspects**.**

3.28 **BSoLICB**. Neither GP was aware of any reported concerns of anti-social behaviour, racial or discrimination of their sexual orientation, landlord disputes or evictions. Practice 3 were aware that

Adult 2 had told Mental Health Services that he was in an abusive relationship. They did not contact Adult 2 as there was an expectation that Mental Health Services would have provided appropriate support upon his disclosure to them, although this was not specifically documented.

3.29 UHB. ED Staff did not ask further about Adult 1 following Adult 2's disclosure of his aggression the previous evening in his conversation to liaison psychiatry. It is not recorded that this was disclosed DA until he was seen by the psychiatric nurse and as he had been discharged directly from psychiatry, this may not have been known. The UHB domestic abuse procedure in place on the date of attendance, addresses perpetrators but in the context of the victim being the patient. It includes details of support agencies for perpetrators of domestic abuse. It is not clear whether they would have asked more had the victim been a female.

3.30 SCH. Adult 1 did not identify any support needs, however, information passed to the housing officer should have given rise to professional curiosity around the presence of DA. This includes the landlord's warning letter to them and the disclosure by mental health services of reports of drug and alcohol misuse and arguments between them on in November 2021 when the police were called.

3.31 BCHCT. Referrals were made regarding DA as staff were curious about physical signs of abuse and distress symptoms of recurrent crisis need and the Home Treatment Team often at weekends. A concern was highlighted for further consideration following injuries noted in police custody by Liaison and Diversion and this was later pursued, and a DASH tool utilised by the psychologist did not indicate a referral to the MARAC. There were suspected concerns regarding possible hate crimes, and the service did seek Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ+) abuse support but did not find this in the Black Country area at the time. Enquiry was made to Women's aid, but this was not providing a specific service for male abuse related to sexuality. This was felt by practitioners to be a gap in local service availability as only out of area services were available. (DHR Recommendation).

3.32 BSMHFT. Contact with Adult 1, identified that there were safeguarding concerns highlighted on the initial referral to them with mention of DA. They advise that their usual process with any referral that has a safeguarding query is to pass the referral by their team's Safeguarding Lead in order for those concerns to be reviewed. It did not happen in this case. There was also a lack of curiosity regarding concerns of abuse faced due to housing issues or the difficulties that both adults had experienced relating to racial abuse or sexual orientation, and in relation to concerns of DA.

- **Was there action taken by another agency which impacted on the services of your own agency which the DHR should address?**

3.33 WMP. Their IMR considers there was no known action taken by any other agency that impacted on the service of the WMP. The review panel is of the opinion, however, that the lack of information sharing between agencies would have been an issue.

3.34 BCHFT. Reported that when police allegedly left the medication with Adult 2, after being warned by Adult 1 it could be a risk to Adult 2, this had a health impact contributing to the subsequent overdose. Subsequent DHR panel discussions were held. The panel were unable to confirm this alleged report and has been addressed within Chapter 2.

3.35 BSoLICB. Their IMR considered that the actions taken by WMP and Housing to not share information about their interactions with Adult 1 and Adult 2 and to not consider checking with the GP Practice as to whether there were any medical concerns is significant according to BSoLICB. It kept the Practices in the dark as to what was going on in the personal lives of Adult 1 and 2 with no

consideration of the impact on their physical and mental health. It would have been expected practice to have shared such information.

3.36 SCH. Suggest better communication and information sharing by WMP about the extent of their involvement with Adults 1 and 2 would have assisted with professional judgement, risk assessments and homeless decision making. This did not however, stop SCH requesting the information and if it was not forthcoming escalate this to a supervisor to address.

- **Did your agency exhaust all possible avenues to ensure Adult 1 and 2 were safeguarded and the allegations effectively investigated? If not, what should have been considered?**

3.37 BSoLICB. General Medical Practice 3, when made aware that Adult 2 was a victim of domestic abuse in the letter sent to them by Mental Health, no action was taken, or assessment made to determine if he needed safeguarding. The GP Safeguarding Lead said it is reasonable for General Practice to assume that Mental Health Services would have provided the appropriate support to Adult 2 upon his disclosure of domestic abuse and believes that partner agencies should not pass their safeguarding responsibilities onto Primary Care. However, the panel believes it would have been good professional practice to have checked to see whether the support was being received.

3.38 WMP. State they could have made more referrals in support of Adult 1 and 2's relationship. Sadly, it appears that they never truly understood the impact of their behaviours and domestic abuse was seemingly having on one another. Had they received professional support they may have had the opportunity to change their relationship; education on recognising the signs of abuse and the effects of alcohol and drug abuse and their mental health may have encouraged alternative and less harmful patterns of behaviour towards each other.
<u>Comment.</u> WMP could have considered advice from an IDVA and to refer them both for drug and alcohol misuse. Their escalating DA incidents could have been referred to the MARAC as medium risk cases can, using professional judgement, however as stated the risks were correctly assessed prior to the arson incident. (Adult 1 did complete a short drugs awareness course after being arrested for cultivating cannabis but not for alcohol). Officers have access to referral pathways to ensure that individuals can obtain support which supervision does not seem to have identified. Good practice was conducted to assist with MH concerns when in custody which, was shared and followed up with mental health providers.

3.39 ASC. Whilst ethnicity was clearly identified within the referrals from Environmental Health with respect to both, it was in the context of the ongoing dispute between neighbours. The referral indicates that SCH were aware of the tensions between neighbours and were looking at a solution in moving the couple to new premises. This would not require further investigation. There were no other culture and diversity issues identified within the brief contacts between professionals. Domestic Abuse was not part of the referral for Adult 2, on the 19 January 2022.
<u>Comment.</u> By agencies not effectively communicating DA and there having been no opportunity for ASC to consider holding a strategy discussion or to call a professionals meeting, valuable information about their same sex and DA relationship and collective ASB, aggression, drug, and alcohol misuse in particular which fuelled physical and verbal arguments between them, were missed opportunities to take safeguarding action.

3.40 SCH. Neighbourhood Services Team deal with cross tenure ASB, including hate crime which the contact centre staff have access to. This directs questions around tenure, details of the incident, frequency, reports to the police, crime number, witnesses, other agencies involved with the result that the details of the ASB and Hate Crime will be passed to the ASB duty officer with an aim to respond within 3 days. Had the enquiry been directed towards the Neighbourhood Services Team the service

response to the Hate Crime report would have provided a joined up quicker response to address the issues and make safeguarding referrals by identifying risks. This did not occur, and this vital function was missed. An ASB Problem Solving Panel has since been created consisting of SCH Neighbourhood Services, WMP Neighbourhood Teams, ASC, SMBC Environmental Health and other agencies as appropriate. Complex cases such as Adults 1 and 2 could be referred into this panel. There was ineffective of joint working with the police and mental health services around risk assessment and safeguarding and not followed up or explored by the Housing Options Officer.

3.41 BCHFT. Early contacts did not have knowledge of any DA issues or concerns regarding relationship safeguarding concerns until noted in police custody. While in Early Intervention it was noted there were some signs of unease in the relationship and incidents which were potential signs of abuse, black eye, and bruises. A DASH tool was used as Adult 2 was deemed to be a potential victim of domestic abuse in the home, but the tool indicated no need for a MARAC referral, so no further action was taken. There is no indication of specific discussion regarding reporting incidents to the police which could have been considered or raising the gap in service around male LGBTQ+ or Male abuse support is not noted in any records. Psychology worked through the safeguarding concerns and liaised with the trust safeguarding department who shared the DASH tool. Adult 2 had capacity and options of safety measures, support, and reporting systems through with psychology with police reporting was part of the discussions. Adult 2 following disclosure of DA from Adult 1, did not wish to do anything about this and was aware of his options in psychology sessions. He had capacity to make decisions.

3.42 Assessing risk and mental capacity.

- **Were appropriate risk assessments carried out and positive action taken? If not, what action should have been considered?**

3.43 WMP. DASH and DARA were considered, offered, and would be required in order to assess the risk both posed to each other. However, the review is aware that no DASH and only one DARA was completed by police. Risk assessments were conducted when they were in custody by the HCP and documented. The WMP IMR acknowledges there were opportunities for additional referrals to be made, as it was known to WMP that they were receiving support at various times for mental health. They were always considered to have capacity by officers and the HCP's who met with them. Bail conditions were imposed and lifted, and warning markers were placed on their address. They insisted on being together. There was no consideration for applications for Domestic Violence Protection Notices or Orders, DVPN/DVPOs.
Comment. ***DVPN/DVPOs are now Domestic Abuse Protection Notices and Orders DAPN/DAPOs under the DA Act 2021 . They are not yet fully enacted in every police area. It is only currently used as a trial in some forces. WMP did request to be a part of the trial, however they were not selected and still use DVPO/DVPN's. Due to the number of DA incidents known and those not possibly reported, the nine DA opportunities prior to the homicide, together with the other significant concerns, the purpose of a MARAC was not fully utilised by a correct assessment of DA. The levels of risk for the MARAC together with DVPO's and DAPO's, who have similar safeguarding powers, are detailed within Chapter 4.***

3.44 BSoLICB. No risk assessments were carried out by General Medical Practice 3 or 4.

3.45 SCH. There is no documentary evidence of any risk assessment outcomes, however records suggest that the Housing Options Officer was relying on police information to guide decision making on the homeless duty test. The Housing Options Team had information that they were engaging with mental health services, but no action was taken to seek information directly from the service to

establish any vulnerabilities, there is no record that an assessment was asked from the police about the couple's personal safety at the address and for any update.

3.46 **BCHCT**. There is evidence of risk assessments having been undertaken. Risk assessments followed the trust identified tools with review and updates as required. Capacity was considered throughout assessments and indicating capacity was intact across teams and agencies.

3.47 **BSMHFT**. Adult 1 did not have an assessment. Adult 2's had assessments into his mental state and plans made were appropriate to his presentation, mental capacity was assumed and there was no evidence to challenge this. CMHT did not complete a risk assessment following their assessment with Adult 2. Liaison psychiatry did complete risk assessments following their contacts. All services advised that their staff are compliant with BSMHFT's statutory and mandatory safeguarding. There was lack of curiosity from all three services (all had disclosure of domestic abuse) into exploring this further.

- **What assessments of Adult 1 or 2 were carried out into any mental health and mental capacity concerns which may have been present, and what was the outcome?**

3.48 **WMP** were not involved in any formal mental health assessment. When officers and the HCPs met with Adult 1 and 2, they did not record any concerns about either individual not having capacity. No mental health team was requested to attend either the custody suite or to their addresses by WMP because it was not deemed to be required. Adult 2 shared that his mental health was 'under investigation' and the Liaison and Diversion Team subsequently contacted his mental health worker who was best equipped to support him at that time. There is nothing recorded to suggest that his mental health worker raised concerns about mental capacity, and he was released from custody following a pre-release risk assessment that did not identify any additional mental health concerns.

3.49 **UHB**. Neither Adult 1 nor Adult 2 had capacity assessments on any attendance, however this would not be expected as they did not raise any concerns about their ability to make decisions. In November 2021 the liaison psychiatry nurse has documented that Adult 2 appeared to have full capacity and insight and was orientated to time place and person, his cognitive function appeared intact.

3.50 **BSoLICB.** The consultations that General Medical Practices 4 had with Adult 1 and Adult 2 did not raise any issues or concerns that would warrant assessment of mental capacity.

3.51 **WMAS**. In their limited contact, there was no concern regarding capacity.

3.52 **SCH**. Adult 2 was open to mental health services and no assessment of mental capacity was considered. Following a referral to mental health services, he did not have a psychotic diagnosis, but had PTSD following an assault, he had heard voices for a long time, and was seen by a Doctor.

- **Are your staff aware of the signs and symptoms of domestic abuse including physical, emotional, and coercive control if present, in order to identify safeguarding concerns at an earlier stage?**

3.53 **WMP** are aware of the signs of DA including physical, emotional, and coercive control if present and are able and equipped to identify safeguarding concerns even at an early stage. All officers within the WMP are provided mandatory training in relation to domestic abuse. The latest mandatory training package was disseminated in September 2022. The Domestic Abuse Risk Assessment (DARA) is a tool for frontline police officers responding to domestic abuse. The tool also helps to make

judgements about the risk of serious harm so that the appropriate protection can be provided as early as possible. Coercive control training packages have been available since 2015. WMP have recently re-written the domestic abuse policy, which was released on 23 April 2023, focusing on equality, diversity and ensuring inclusivity in all matters of domestic abuse and continues to be completed in respect of Violence Against Women and Girls (VAWG) this does not detract from work being conducted in respect of recognising and understanding that men can be victims of domestic abuse, also ensuring that male victims should be treated equally in reports of this nature regardless of gender,
Comment. **Although t*he WMP IMR states the DASH was not mandatory in WMP at the time (we now know it was), DASH was widely used by other local authority's police and safeguarding partnerships as recommended by the College of Policing as good practice and has since been replaced by the DARA system for risk assessments. Nevertheless, professional curiosity and supervision oversight should have identified WMP were not effectively identifying risk with the prevalence of the DA incidents, including the arson incident which should have been recorded as high-risk.***

3.54 **ASC.** No risk assessments were undertaken as part of the brief interaction between professionals. No assessment of capacity was carried out as part of this referral and there was no mention of DA or acts of violence from Adult 2 on any other party, only that he was in dispute with his neighbours and had thoughts of hurting others.

3.55 **BSoLICB**. Historically, many medical schools had not incorporated any safeguarding lectures in the curriculum until 2020 when the General Medical Council (GMC) made it mandatory that they should. Birmingham and Solihull, then CCG, now ICB since July 2022, has been funding the IRIS programme since 2014 with an expectation that all Practices will sign up to the training. Although IRIS only supports female victims currently, they do include a pathway for male victims and perpetrators of abuse. BSolICB are planning to fund a similar service for male victims of domestic abuse, hopefully in 2023. Primary Care Staff are able to access DA training from other local sources.

3.56 General Medical Practice 3 is an IRIS trained Practice, having been trained in 2021. They have booked a session of IRIS refresher training in February 2023 for staff that missed the first session in 2021 and for all new staff. General Medical Practice 4 has arranged IRIS training to take place. None of the clinicians at General Medical Practice 4 have had any significant domestic abuse training, or any other safeguarding training, within their medical or nursing training. One GP attended one session specifically on domestic abuse in 2021 which has prompted her to make active enquiry when she sees young women with mental health issues. She said that she does not ask men. BSoLICB have addressed these concerns with their individual Agency Recommendations to the DHR.
Comment. ***Gender Bias was an identified theme for agencies and their practitioners in the review.***

3.57 **SCH.** DA awareness training supports staff to understand domestic abuse. Unfortunately, during this period SCH did not hold systematic records of staff training. This has changed now with the introduction of the learning pool. There has been mandatory safeguarding training which all staff have to complete. The SCH Housing Options officer's role, would be to undertake DASH risk assessment and attend MARAC meetings, made referral to sanctuary scheme, and work with IDVAs. During 2022, officers within Housing Options Service and other parts of business have received Level 3 DA training which covers the signs and symptoms of domestic abuse including physical, emotional, and coercive control. There has been no training on Hate Crime for the Contact Centre staff within the last 3 years, (see SCH Agency Recommendations in Appendix 1 that addresses these training issues).

3.58 **BCHFT.** There is evidence that staff were curious about DA and evidence that Adult 2 denied this in his early assessments but then began to disclose DA issues later to services.

3.59 Compliance with policies and procedures.

- **Were all local and national policies and procedures and learning from previous statutory reviews followed or considered, to ensure support and safeguarding was continually provided to a professional standard of care?**

3.60 WMP. All local and national policies and procedures were followed by responding and investigating officers. Whilst it would have been advantageous to have recorded certain actions in more detail within some of the incident and investigation logs, the action that was taken in each circumstance was in line with procedure. In relation to previous learning, multi-agency working has been identified as requiring improvement and recommendations made, however there was no multi-agency working in relation to this case. WMP never received or made Vulnerable Adult (now adult at risk) referrals.

3.61 ASC. The initial referral was sent in via the online portal. The urgency of the referral was recognised quickly and passed on to the appropriate services within 24 hours.

3.62 BSoLICB. Two common themes in statutory reviews, and local audits, that come up repeatedly are lack of professional curiosity and information sharing. However, there was no evidence to suggest that this knowledge has changed Primary Care's way of working. The backlog created by the COVID lockdowns, a shortage of GPs, means it is not practical for the majority of GP Practices to increase appointment times. Active enquiry into DA is not made every time a patient attends alone. When a GP attended Adult 1 at home for his foot infection, he gave an explanation how it happened. Within the medical records, Adult 1 had described two other different reasons. There was no professional curiosity by the GP to establish the correct version of events. Barriers to safeguarding partners sharing information with Primary Care, particularly non-NHS agencies such as Police, ASC, and Housing, exist.

3.63 UHB. It is not documented that the ED staff were aware of Adult 2 being a perpetrator of DA and as such they would not have accessed the DA procedure. The missing person procedure was not followed when Adult 2 first absconded from ED on 27 November 2021.

3.64 SCH. A lack of information sharing between agencies indicates further learning and support is required to embed good practice. The role of the internal cross service Managers Group called SEDA (safeguarding, exploitation, and domestic abuse) has recently been strengthened to improve oversight of safeguarding activities and assurance. In addition, SCH are now members of DAHA who work with social housing providers to improve responses to DA, accreditation, and training.

3.65 Good Practice.

- **Was there good practice identified within your agency's interaction with Adults 1 and 2?**

3.66 Despite the learning identified in this DHR, it is acknowledged there has been some very good agency and practitioner good practice highlighted within the narrative of this report and within Individual Agency IMRs. This includes : -

- **BCHFT.** There is good evidence of referrals being addressed and communication between services was consistent in assisting the pathway of Adult 2. There is clear multi-disciplinary and partnership working recorded where the couple were kept informed of care plans, actions, and the services to contact when needed.
- **BCICB.** Adult 2 when complexity or difficulties were recognised and met in his case, appointments were flexible with extended appointment lengths and joint appointments with GPs and Primary Care Mental Health Nurse. During the COVID period there remained a good level of access to general practice, allowing the use of E-consult, SMS text messages,

telephone calls and face to face appointments. Referrals were timely manner and advice was sought from secondary care appropriately and medications following an overdose, the supplies were reduced to limit potential availability and aid safety. There is clear evidence of enquiries around risk to self and risk to others at consultations.

- **BSMHFT**. CMHT in contact with Adult 2 highlighted that the team were responsive to social concerns and brought the medical appointment forward and noted that the psychology assessment considered external pressures and rearranged this with the adult. The liaison psychiatry team in contact with Adult 2 highlighted that assessments were followed up with notification to the CMHT.
- **BSOL.** Both GP Practices use Additional New Patient Registration forms to capture information regarding factors that can affect physical and mental health but also to identify any vulnerability safeguarding factors such as being homeless or having care and support needs. They still carry out new patient checks, send texts to patients' mobiles to remind them of, or allow them to change, appointments or to give them appropriate health information. When GP Medical Practice 4 received notification about Adult 1's as he could not attend, due pain in his foot, the GP conducted a home visit.
- BSOL state the summary letter provided by Walsall Mental Health Services to GP Medical Practice 3 in Solihull was also an example of good practice and information sharing. Adult 2 was being prescribed an anti-psychotic medication which can damage the liver and kidneys and also affect the heart. They contacted him by text asking him to make an appointment to attend the Practice. When he did not respond, the Practice sent him a text with another appointment, which he attended.
- **SCH**. The housing options officer kept in close contact with the couple over their housing situation to prevent homelessness. The Contact Centre staff overall took time to listen to Adult 2's concerns about his housing situation and showed empathy.
- **WMP.** The IMR records that policy and procedures were followed at all times with every incident reported, was recorded in line with Home Office Counting Rules. Risk assessments were conducted concerning domestic abuse, safety, mental health, and drug abuse.
- **Trading Standards & Environmental Compliance.** It was recognised that Adult 2 was extremely vulnerable although he was receiving mental health support from another area, he was sufficiently safe not to have a local referral made to ASC on 18 January 2022. Similarly, as the conversation with Adult 2 contained a threat to both other people and himself. ASC made a further referral to the Police on 19 January 2022 was made.
- **UHB.** Both Adult 1 and 2 were seen in a timely manner and had their presentation addressed. Adult 2 was referred and seen by psychiatry before discharge.

3.67 **Decision making and missed opportunities.**

- **Was there appropriate decision making in your agency's contact with Adult 1 and 2?**

3.68 **WMP.** Decisions had to be made taking into consideration a number of factors; their safety as a couple and as individuals, their mental health, drink, and drug habits and ultimately, whether any criminal offences had occurred that were capable of being progressed to the stage of prosecution or other suitable positive outcome. Both were at times difficult to engage with and often hindered the investigation process, sometimes through reluctance and other times due to intoxication, but mainly because they wished to remain as a couple. Once both parties were sober, they wished to reconcile. This meant it was not possible to prosecute either party. There was never enough evidence available to put forward a victimless prosecution on behalf of them both. There appears no consideration was given for safety planning with both parties which would have been good practice.
Comment. ***CPS evidence led victimless prosecutions is an option if sufficient investigation and evidence from witnesses, forensics, the use of police body worn cameras of the scene and the first account recorded, (especially in the arson case which incorrectly graded as medium risk and not***

high-risk and was not therefore referred to MARAC), contact with an IDVA to effect contact or LGBQ+ professionals for advice and support were other options. In this case, the WMP confirmed CPS advice was sought when the evidence was sufficient, and Clare's Law did not apply. There were several occasions with police involvement, who appear to have been dealing with each reported DA incident independently of each other, to consider Clare's Law. This is, however, reliant on all agency information being known, such as when Adult 2 disclosed in an assessment that his two previous relationships prior to Adult 1 were also abusive, an identified weakness in agencies communicating and sharing of information, a finding in this review.

3.69 **BSoLICB**. There were several missed opportunities. New patient checks are carried out by both GP Medical Practice 3 and 4. The emphasis is, and has always been, on the patient's physical health and appointments are limited. The IMR author discussed the national option about public funding as a missed opportunity for establishing domestic abuse and other safeguarding risks for Primary Care which is outside the priorities of this DHR and should be progressed outside the review.

3.70 The mass vaccination COVID clinics it is recognised that many vulnerable people who had not been seen by any professional since the first lockdown in March 2020, were going to be seen for their first Covid vaccination, and they were also going to be seen alone due to the "One Patient" rule. This was an ideal opportunity to ask about domestic abuse which was missed.

3.71 General Medical Practice 4, were aware Adult 1 was worried about his partner, but this did not prompt any follow up. The Practice maintains that they do not have the capacity to call up every patient where concerns are highlighted after being seen by other safeguarding partners. Both GP Medical Practice 3 and 4 have been subject to Care Quality Commission (CQC) inspections, Practice 3 in 2022 and Practice 4 in 2018 and 2020. Both Practices independently made the same points of high demand for appointments and being under resourced. They did not have capacity to be proactive and call patients with vulnerability factors such as mental health and substance misuse as this would have a knock-on effect on the patients trying to be seen with acute problems. They also had an expectation other agencies such as Mental Health services and A & E Departments should deal with safeguarding concerns that are raised to them and not pass them onto General Practice.

3.72 **UHB.** Adult 2 was included in all decisions about the follow up for his mental health concerns.

3.73 **SCH.** This was a complex case with both presenting as victims of hate crime whilst also facing allegations of tenancy breaches. SCH's assessment involved communication with the private landlord and the police. Information from the police suggested there was no evidence that the applicants were being harassed initially. This changed in January 2022, when the police confirmed that the neighbour had been arrested because of racist remarks. Following SCH's investigations and police action against the neighbour, the landlord continued to serve notice on the grounds of Adult 1 and 2's behaviour and SCH were working towards assisting them with suitable accommodation. The Housing Options Officer found decision making relating to the circumstances of this case challenging. This decision may have been made easier with effective working and communication across the agencies.

3.74 **BCHCT.** Decisions can be seen to have been made considering risk, behaviour, capacity, choice, and support availability.

- **Were there any missed opportunities to protect both Adult 1 and 2?**

3.75 **WMP**. The author in the IMR records they did not identify missed opportunities to protect Adult 1 and 2. The IMR however, does suggest that further referrals could and should have been made and considered missed opportunities. Officers responded to and acted on information obtained,

attempted, and conducted risk assessments when they were needed. Safety measures were implemented, advice was given, and referrals made. During the review process WMP do accept that the arson incident should have been graded as high which would have led to MARAC discussion and multi-agency working and all subsequent incidents would have then been graded as high-risk.

3.76 BSoLICB. After receipt of the letter from Mental Health on 10 December 2021 and following their assessment of Adult 2 that he was currently in an abusive relationship, General Medical Practice 3 did not contact him to offer him support. The Administrative Staff missed coding the history of DA and the letter was not passed to the GP Safeguarding Lead to review. Also, after the receipt of the letter from A & E on 9 June 2022 stating that Adult 2 had taken an overdose, General Medical Practice 4 did not contact him regarding support and that he had been assessed by Liaison Psychiatry. There was an expectation that they were providing him with adequate support. (Assumption is a theme in this DHR see Chapter 4).

3.77 SCH. The initial route to dealing with the hate crime report was applying for rehousing, which is not in accordance with the ASB policy. If the referral had been made to the Neighbourhood Services Team, the reports of hate crime may have been established and the relevant information shared. Once it was referred to the Housing Options Team, when threatened with homelessness, there was a lack of professional curiosity and missed opportunities to explore interventions or support through multi agency working.

3.78 BCHCT. There was no evidence of a carers assessment. There were alcohol incidents; no consideration of events; a history of assault and reference to head injury and reference to an MRI but there was no further information regarding outcomes or readdress for this; no evidence of any referral for ASC despite a recommendation from Liaison and Diversion with the presence of mental health and Adult 2's complex needs and help for his PTSD. Despite chaotic and unstable periods there were periods of stability such as in latter stages following discharge from the Home Treatment Team. Having no access to an LGBTQ+ local network for support with abuse, may have contributed to relapse or crisis episodes. There was an unconfirmed missed opportunity by police to safeguard Adult 2 by considering safe storage of his medication based on the disclosure of Adult 1 and no follow up with reference to Adult 2 possible ADHD and autism. (WMP were not informed of the medication request, as discussed in Chapter 2).

3.79 BSMHFT. For all services, there were missed opportunities relating to professional curiosity as there was awareness of DA within the relationship. There was a lack of exploration and no attempt to capture the view of Adult 1. The services that undertook assessment with Adult 2 felt as though the psychiatric plans were suitable in response to the presented mental health concerns.

- **Were there any barriers to professional practice due to COVID?**

3.80 WMP. COVID resulted in a number of WMP officers and staff working from home which meant that some enquiries were not expedited in timely a fashion due to restrictions in place. The officer investigating the racially aggravated harassment had a period of sickness due to COVID and this delayed the investigation for a short time. The investigation continued and COVID did not have any adverse effect on the professionalism of responding or investigating officers.

3.81 BSoLICB. At the time of the first COVID lockdown, to prevent risk to patients and staff, all appointments changed to telephone consultations and where required, and possible, to virtual consultations. Although many Practices are now seeing patients face-to-face again, General Practice 4, still use telephone encounters as the preferred first choice. This makes asking about DA harder as it can never be completely known whether the patient is on their own to enquire.

3.82 **SCH**. During and after November 2021, the Contact Centre Service and lines were open and accessible. The team were operating home and office working. The team now operate a group chat to enable support to be given to advisors when they have a query, and the response is good. The Housing Options Service had no face-to-face customer contact due to covid restrictions.

3.83 **BCHCT**. There are letters and records which indicated appointments were offered in alternative ways due to 'Covid Precautions.' Staff continued to be offered face to face appointments and alternatives such as telephone and video calls to add choice if appropriate or chosen by Adult 2.

3.84 **BSMHFT**. All services advised there were no barriers to professional practice secondary to Covid-19.

- **Are there any single agency recommendations for future learning identified from your agency assessment of the DHR that requires implementation, to improve professional practice?**

3.85 Agencies to the review have identified lessons to be learnt and contributed to the DHR Recommendations in Chapter 4 and made Individual Agency Recommendations in Appendix 1.

Chapter 4

Themes, Findings and DHR 13 Recommendations

4 This chapter outlines the themes and findings identified from the analysis of professional practice and from agencies responses to the Terms of Reference KLOE specified questions required to be addressed within the previous chapter. The overriding DHR Recommendations (7 and 8) for the effective use of the Solihull MBC Triage Process of Safeguarding Referrals below if effectively utilised by agencies, would address the majority of learning in the DHR Recommendations and within Individual Agency Recommendations in Appendix 1. The Findings and DHR Recommendations are as follows: -

4.1 FINDING 1 - Multi-agency working, referrals, professional meetings, sharing information, record keeping and communication concerns.

4.2 **What are the issues and what should be considered?** There were numerous missed opportunities for the concerns of their deteriorating domestic abuse relationship. Agencies worked in silos with no effective multi-agency working, many making assumptions without checking the facts, believing other agencies were working with them to address their complex needs within Adult 1 and 2's deteriorating relationship with escalating DA. No agency throughout the process sought to hold or call a professional meeting to capture the wider aspect of Adult 1 and 2's case, even though there were numerous allegations of DA and other crimes reported. No referral was determined as high risk to warrant a MARAC meeting therefore vital safeguarding information went undetected. Safeguarding should always be considered when DA is present, regardless of whether it meets the MARAC threshold. Police dealt with the criminal issues but were not successful in prosecuting Adult 2 for the arson offence as the CPS declined to prosecute (no rationale has been provided) but they did prosecute him for the sexual assault upon another female resident and was awaiting to stand trial at the time of the homicide. These complex needs together with their alcohol and toxic relationship with their ASB towards others was increasing in voracity.

4.3 Only Adult 1 completed a short drugs rehabilitation course for cultivating cannabis plants found by police attending a DA incident. There was no other referral to drugs and alcohol misuse services to provide help for Adult 1 and 2's relationship with their reported drunken physical arguments and their misuse of controlled drugs. On two occasions, Adult 1 attempted to pervert the course of justice by intimidating witnesses including the witness to Adult 2's arson allegation. By this time their relationship was not only impacting on their lives but the lives of others they lived with. There were nine known reported DA incidents (WMP reported seven of those), without urgent action being taken. By not communicating and sharing information, no effective risk assessments were carried out. Professional practice failed to assess the escalation of worrying concerns.

4.4 There was a distinct lack of communication between services, with a need for an improvement of multi-agency working between agencies and with some concerns raised in their IMRs regarding other agencies, (as addressed within Paragraphs 3.33 to 3.36). Agencies should always consider SSP or their own escalation policies if there are multi-agency working concerns that need to be addressed and challenged. An analysis of all agency IMRs, some agencies identified record keeping was not always comprehensive and where relevant to their own agency, recommendations have been made (see Appendix 1). WMP made no recommendation for record keeping but reported it could have been more thorough and this learning has been noted within their IMR. The following recommendation is made to support and overarch the agency recommendations in Appendix 1 for all participating agencies in the DHR to comply with.

DHR Recommendation (1) for Solihull Safeguarding Partners and Agencies to the DHR

Multi-agency working, professional meetings, sharing information, record keeping and communication concerns

Solihull Safeguarding Partners and participating agencies in the DHR, should reassure SSP they will ensure: -

- **A multi-agency meeting will be called, or a strategy discussion held where applicable, to make certain, risk assessments and communication between practitioners, consider the full facts of an adult at risk or associated adult, in order that necessary safeguarding action is taken.**
- **Professionals should be encouraged to challenge the decisions or actions by another agency in a safeguarding enquiry. Practitioners should raise the concerns to their line manager and if the matter is unresolved should use either the SSP Escalation Policy[2] or their own agencies escalation policy to address the issue in question.**
- **Remind supervisors and practitioners through training, of their responsibilities of effective information sharing, risk assessments, comprehensive record keeping, and communication, that it is imperative for safeguarding and the protection of adults at risk.**

4.5 **Finding (2) - Awareness of the Domestic Abuse Act 2021, Anti-Social Behaviour Guidance, and CPS Evidence Led Victimless Prosecutions**

4.6 **What are the issues and what should be considered?** Agencies need to consider legal literacy and powers, in exercising their multi-agency safeguarding functions. Professionals must have the necessary knowledge of the policy and powers in order to support an adult at risk. These include CPS to conduct an evidence led victimless prosecution when a victim does not wish to support criminal proceedings if possible. Also, very pertinent to this review is the awareness of the Domestic Abuse Act 2021 (enacted 29 April 2021). This gives police new powers including a Domestic Abuse Protection Notice (DAPN) that provides immediate protection following a domestic abuse incident and a new civil Domestic Abuse Protection Order (DAPO). These will replace the existing DVPO and DVPN's when they are rolled out across England, (DAPN/DAPOs, are still not fully enacted nationally) and consolidates existing protection orders which were relevant during the scoping period of the DHR. A DAPN can be issued by the police, requiring a perpetrator to leave the victim's home for up to 48 hours as in the previous DA Policy of 2014, for immediate protection. As with the current DVPO system with the WMP area, police can make an application for a Protection Order to a Magistrates' Court. (A DAPO can also be applied for by a third party in family court proceedings, such as a social worker, as the DAPO will help prevent offending by forcing perpetrators to take steps to change their behaviour, including seeking mental health support or drug and alcohol rehabilitation. A breach of a DAPO is now a criminal offence).[3]

4.7 To remove a perpetrator out of the life of the adult at risk, is of course reliant on the person engaging with safeguarding professionals, however, the manipulation and control of an abuser must be challenged if identified. Practitioners conversant with the legislation and the powers available should be aware that a DVPO (DAPO) if in place against the abuser, a victim may feel reassured to engage and work with professionals.

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[2] Solihull Dispute and Escalation Procedures. https://www.safeguardingsolihull.org.uk/lscp/wp-content/uploads/sites/3/2021/09/LSCP-Dispute-Resolution-Escalation-Procedures-May-2020.pdf

[3] Recommendation 2 is based on current practice but expected to be relevant and reflected in the future, due to changes in the DA Act 2021 legislation.

4.8 The Home Office ASB Guidance, July 2022 for the ASB reported incidents, have similar community protection orders together with court injunctions available to impose constraints on a perpetrator in order to protect adults and persons at risk. This is a tool which can be more effectively used and allows the victim a degree of breathing space to consider their options with the help of other support services. SCH identified that their housing officer did not share the concerns to the Police Neighbourhood Team who work with the Local Authority and SMBC and private landlords. Police also did not identify and manage some call outs as ASB. There were three concurrent issues at play, the DA between both Adult 1 and 2, with some expansion to a family member, and repeated ASB/hate crime in their accommodation. Each strand was not consistently managed in accordance with established processes, and the impact of the collective was not considered ASB for proactive action to be carried out. The legislation and guidance also contains a condition prohibiting the perpetrator from molesting the victim. Since Adult 1's death, an ASB Problem Solving Panel has been created consisting of SCH Neighbourhood Services, WMP Neighbourhood Teams, Adult Social Care, SMBC Environmental Health and other agencies. The following recommendation is made: -

DHR Recommendation (2) for Solihull Safeguarding Partners and Agencies to the DHR

Awareness of the Domestic Abuse Act 2021, Anti-Social Behaviour Guidance, and CPS Evidence Led Victimless Prosecutions

It is recommended that the safeguarding partners and voluntary agencies involved in the DHR reassure SSP that in adult at risk cases the following initiatives are considered and where relevant, enacted:

- **Practitioners to enact existing Domestic Violence Protection Notices and Orders (to be known in the future, when rolled out in England, as DAPN and DAPO's) that consolidates protection orders and non-molestation orders under the Domestic Abuse Act 2021.**
- **Utilise Home Office ASB Guidance 2022, community protection notices, orders, and court injunction initiatives in cases of persistent ASB incidents.**
- **Police in DA cases, where there is sufficient evidence, when the victim does not or is unable to support a criminal prosecution, to consider CPS evidence led victimless prosecutions, if it is appropriate for the case, in order to protect an adult at risk.**

4.9 **Finding (3) - Coercive, Emotional and Manipulative Control and Identifying a Care Provider**

4.10 **What are the issues and what should be considered?** Section 76 of the Serious Crime Act 2015 makes it an offence of Controlling or Coercive Behaviour in an Intimate or Family Relationship. The DA Act 2021 also now provides a wide-ranging legal definition of domestic abuse which incorporates physical violence, including emotional, coercive, or controlling behaviour, economic abuse, and safeguards for victims. Professionals therefore need to recognise the signs and symptoms of Coercive, Emotional and Manipulative Control. Adult 1 and 2 were both a victim and perpetrator in their relationship. The legislative powers apply equally to them both according to the circumstances of the DA incident. This review has not identified significant coercive control, but Adult 1 assumed a controlling role over Adult 2. He was the person assuming a prominent and also the apparent caring role, for Adult 2. It was also recorded that Adult 1 was also a perpetrator and not solely a victim of DA, as Adult 2 was also a victim of DA from Adult 1. Adult 2 said when they argued, often after consuming alcohol, he would leave their home until the situation cooled down. Whether this was submissive behaviour, this DHR cannot answer. Any control or assumed care by Adult 1 over Adult 2, was not explored from the information obtained by agencies.

4.11 The ongoing physical assaults between Adult 1 and 2, without family and friends engaging with the DHR, the review are unable to assess the presence of other forms of DA behaviour perpetrated by either adult on each other. Inconsistent engagement with agencies, and also weak professional curiosity has led to a gap in understanding the dynamics in Adult 1 and 2's relationship.

Professionals must be alert to coercive control as multiple agencies knew DA was a factor, but no one asked about how it was being perpetrated outside of physical violence, therefore the review was unable to gather any insight into economic abuse or psychological abuse due the lack of professional curiosity.

4.12 Adult 1 was informing professionals he was the carer for his partner, but this was never challenged. A carer, their responsibilities and authority, must always be confirmed, as was in Adult 2's case, when they have mental health and other complex needs, to ensure the right person is providing the right care. It must also be considered in terms of safety. Relying on a partner to help with your care and support needs, who may be abusive, is a barrier to safety and can increase the power imbalance further. Incidences when each of the adults were a victim and perpetrator, professionals need to consider situational violence and the role of violent resistance alongside intimate partner violence. Johnson typology describes four types: (1) Intimate terrorism; (2) Violent resistance; (3) Situational couple violence; and (4) Mutual violent control.[4]

DHR Recommendation (3) for Solihull Safeguarding Partners and Agencies to the DHR

Coercive, Emotional and Manipulative Control, to consider Situational Violence and Identifying a Care Provider

It is recommended that safeguarding partners and voluntary agencies involved in the DHR reassure SSP that they will ensure staff: -

- **Know their powers or action to take when the signs and symptoms of coercive, emotional, and manipulative controlling behaviour of an adult at risk are identified, in conjunction with the Domestic Abuse Act 2021.**
- **To be alert to situational violence and the role of violent resistance alongside intimate partner violence as describe in Johnson (2008) typology of intimate domestic violence.**
- **Enquiries must be conducted as to the suitability of the role of a carer, where safeguarding concerns of domestic abuse and other serious concerns have been raised to ensure compliance with Local and National Safeguarding Adult Policy and Procedures and the outcome shared with relevant agencies to support practice.**

4.13 **Finding (4) - Supervision, Professional Curiosity and Risk Assessments**

4.14 **What are the issues and what should be considered?** Risk Assessments. There was a persistent concern for the domestic abuse within Adult 1 and 2's same sex relationship. There were ten reported DA allegations (eight reported by police) between them. The last of which was the homicide of Adult 1, committed by Adult 2. The DA allegations together with ASB, and other criminal allegations reported, together with Adult 2's reported mental health, should have ensured a DASH (now DARA) risk assessment was completed for the DA incidents by police. The WMP IMR stated that it was not mandatory at the time, but it is accepted good practice nationally and it has been confirmed it was mandatory. The reasoning given was that the subjects did not want to assist with a risk assessment. Even so, a partially completed DASH could have been completed and the facts referred for a supervisor to consider the DA for further exploration, due to the lack of engagement. Although they were completed on professional judgement, considering the repeat DA with MH and substance misuse, professionals must be mindful it can be interpreted as victim blaming when the onus is placed on victims to engage with safeguarding processes, and not doing so can result in a weaker response. The quantity of reported DA incidents should have merited a referral to the MARAC and the option of using the services of an IDVA considering their toxic relationship and their complex needs. There are specialist community support that can be accessed without MARAC. Only one DARA risk assessment was completed by police and one DASH by a psychiatrist which, suggests agencies only respond to

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[4] M. P. Johnson, 2008 typology of domestic violence.

high-risk cases. There should be a pathway for the management of all DA as both assessments were determined as medium risk and not escalated. The DHR questioned why the arson incident was not high-risk. Adult 2 allegedly started a small a fire outside their room in the shared house which was witnessed and extinguished by another resident. This was a potential risk to life after an argument between themselves. WMP acknowledged that it should have been assessed as high-risk and therefore a missed opportunity to refer to the MARAC.

4.15 Levels of risk. Agencies can have different interpretations of the levels of risk to always expect consistency. Victims and persons at risk may tell different practitioners a variance of information about the same incident, as in this review by Adult 1 who gave three different accounts how he sustained an injury which his GP did not verify. DA and other risk assessments are subjective, relying on professionals understanding DA, the situation, and their own judgement. Effective risk assessments are dependent on practitioners' level of training and awareness. This review believes the focus is not to simply accept the risk assessment of another agency but to ensure that when they are in contact with a DA or other victim, they conduct and report their own agency risk assessment. The dynamics of recognising DA, even when risk assessments are shared, they still need to be reviewed.

4.16 Supervision and Professional Curiosity. There does not appear to have been consistent supervision oversight of the escalation of DA and other criminal allegations. WMP, it must be acknowledged, attended, and dealt with the incidents individually but there was no professional judgement made to consider the seriousness of the mounting DA and other allegations occurring. This was silo incident working with missed opportunities regarding the building of the pattern of abuse. The incidents should have raised the profile of concern. The College of Policing believed that it was good practice to complete a DASH which, did not occur in Adult 1 and 2's case and avoided additional supervision scrutiny. The mounting number of DA incidents would place their relationship into a high-risk category and was a missed opportunity to explore further and to meet the MARAC threshold. There was a lack of professional curiosity which features throughout this review that individual agencies have acknowledged in their IMRs.

DHR Recommendation (4) for Solihull Safeguarding Partners and Agencies to the DHR

Supervision, Professional Curiosity and Risk Assessments

It is recommended that safeguarding partners and voluntary agencies involved in the DHR reassure SSP that their supervisors and staff will ensure: -

- **Agencies should conduct their own risk assessment and not rely on the interpretation of another agency and refer to the MARAC if an agency professional considers it a potential risk requiring action to be taken.**
- **A domestic abuse case or any safeguarding referral should not be closed without supervision oversight, to ensure that all available action, levels of risk assessments and safeguarding plans are completed with the rationale recorded.**
- **More professional curiosity must be displayed to ensure that practitioners consider all aspects of domestic abuse of an adult at risk, to protect their health and well-being, utilising the supportive services of an IDVA, other support services and to address incident led responses to ensure they are comprehensively risk assessed where necessary.**

4.17 **Finding (5) - A Review of WMP Domestic Abuse investigations**

4.18 **What are the issues and what should be considered?** The quality of the police domestic abuse investigations. There was an expectation that police would complete a DASH risk assessment report whose aim is, (a) to save and change lives through early identification, (b) intervention and prevention, (c) identify risk and needs, (d) ensure an effective investigation, (e) create a common language across

agencies to refer a case to risk management meetings such as the MARAC, (f) information sharing and (g) decision making. No DASH was completed and only one DARA was later completed. The fact there were numerous DA incidents which did not merit a more thorough assessment, were failed opportunities to take effective safeguarding action. Escalation was not recognised or effectively scrutinised. Wolverhampton Safeguarding Together SAR for PAT in 2022, authored by the DHR 13 Independent Chair and Author, makes a similar recommendation regarding the quality of WMP DA investigations requiring improvements which, was accepted by the Safeguarding Board and WMP Senior Management. In particular the following relevant research was identified: -

4.19 Learning from HMICFRS inspections and complying with WM Crime Commissioner Policing Priority for Hidden Crimes. There are inadequacies in practice in this review which mirrors the findings from previous recognised serious concerns in reporting and investigating allegations of domestic abuse identified by the HMICFRS Police inspections 2017 and reinspection 2018 of WMP. There was also a local Police Crime Commissioner 2019 initiative of a policing priority of tackling "Hidden Crimes" (including domestic abuse). There was further national learning within a HMICFRS 2020 inspection for GMP regarding serious concerns for investigating domestic abuse for police, (Links are contained for reference within the bibliography in Appendix 2). This DHR is an opportunity to review processes of domestic abuse and to comply with the previous inspections and priorities to ensure police effectively deal with DA, and lessons are learnt.

4.20 The review was informed that West Midlands Police engage in quality assurance panels and conduct dip samples of domestic abuse investigations on a monthly rotational basis. This ensures that good practice is being adhered to and that lessons are being learned and enacted within investigations. WMP have recently their updated DA Policy (April 2023). It is anticipated it will ensure learning from previous and this review, are taken into consideration and together with the DHR and following recommendation for WMP, this course of action will address the identified issues for learning in this review: -

DHR Recommendation (5) for West Midlands Police

The quality of WMP DA and ASB Investigations

It is recommended that West Midlands Police, reassure SSP that they will: -

- **Ensure their supervisors and staff are cognisant of domestic abuse and anti-social behaviour guidance, in order to recognise and take remedial action to address any increase in the volume and intensity of incidents, utilising current DA and ASB legislation and other available powers.**
- **To ensure the continued dip sampling of the quality of WMP domestic abuse investigations to ensure good practice and lessons are being learnt, including from previous statutory reviews, HMICFRS inspections, and complying with Local and National Safeguarding Adult Policies and Procedures.**

4.21 **Finding (6) - Consideration of Mental Health and Capacity Assessments for 'Best Interest' decisions**

4.22 **What are the issues and what should be considered?** The mental capacity of Adult 2 as per the Mental Capacity Act 2005, was assumed by many agencies. However, it is known that in some cases, the worsening of mental illness or a relapse in someone's mental health could result in them experiencing fluctuations in their mental capacity. The use of alcohol may also bring about temporary changes in a person's ability to make specific decisions at the time. The carrying out of an MCA or obtaining the advice from a mental health professional should always be considered when a person's ability to make a decision Is impaired, even temporarily. A person with fluctuating capacity can give

varying responses to different professionals depending on the current circumstances. Both Adult 1 and Adult 2 himself, disclosed concerns about Adult 2's mental health. He had some suicidal ideation and took a prescribed medication overdose on several occasions. These worrying and complex concerns for Adult 2's mental health was a constant presence in their relationship together. The Health Care Professional (HCP) in the custody suite, considered Adult 2 had capacity to be interviewed and when there were concerns, his mental health worker was contacted.

4.23 Adult 2 notified his mental health worker and professionals of hearing voices and harming people imagining Adult 1 being killed and saying his family wanted to kill him. In his interviews with police, he was assessed at the time to have mental capacity. This review knows that he did not readily engage with his mental health worker consistently and was taking anti-depressants for his condition. Mental health and capacity can be linked, and practitioners should always consider the main principles in the Mental Capacity Act 2005 and where there are concerns and if necessary, seek advice from a professional with experience in mental health and mental capacity assessments such as an IMCA. This is an additional safety factor as the DA incidents and erratic behaviour with Adult 2's mental health concerns continued.

DHR Recommendation (6) for Solihull Safeguarding Partners and Agencies to the DHR

Consideration of MH and MCAs

It is recommended that safeguarding partners and voluntary agencies involved in the DHR, reassure SSP that in adult at risk cases where there is a possible concern of poor mental health and a lack of mental capacity, they must ensure that a Mental Capacity Assessment is always considered or seek the advice from a Mental Health Professional or Independent Mental Capacity Advocate, to ensure the 'best interest' decision is being taken and their risk is assessed, as capacity can fluctuate according to a person's complex needs.

4.24 **Finding (7) - Capturing the Voice, Culture, Diversity,+, Sexual Orientation and Gender Bias**

4.25 **What are the issues and what should be considered?** Adult 1 and 2 who were male immigrants living together in a same sex relationship, reported hate crime and abuse from others and police action was taken. They also made counter allegations against third parties when allegations of assault and ASB was made against them by other residents from their shared accommodation. The DA incidents which were numerous, did not activate a full investigation to fully understand the DA between them. They declined to assist police with their reported DA, wanting to return to their relationship, normally after an intoxicated DA incident. Their voices were heard and recorded within agency records but, one GP who was DA trained in 2021, would prompt an active enquiry when seeing young women with mental health issues but the GP, similarly did not ask men.

4.26 The DHR Panel believed their DA may have been dealt with more positively if they were in a male and female relationship with suggested unconscious gender bias. This is not confirmed by information to the review, but practitioners need to be mindful of a person's sexual orientation and offer appropriate support by professionals and from voluntary organisations such as LGBTQ+ practitioners to ensure their life experiences are known, respected, with advice and support obtained. LGBTQ + services and services for male victims of DA were available as a single provider but since April 2023 have been incorporated into the primary specialist community service. Both Adult 1 and 2 were not directed to male DA support. The role and pathway required will be strengthened by Finding and DHR Recommendation 1 above. LGBTQ+ are funded by the Office of the Police and Crime Commissioner (OPCC), and additional capacity has also been added in the April 2023 commissioned specialist service. Despite no apparent availability, there was still assistance in neighbouring local authorities that could have been sought for advice and support if necessary. The hate crime was

centred around the couple's belief that they were subjected to hate crime which was homophobic against their sexual orientation. The family dynamics was not known in any detail and cannot be addressed with the family, or Adult 2 who have not participated in the review particularly when it is reported Adult 2's family did not agree with his same sex relationship.

4.27 Due to their ethnicity, a possible approach to their community for advice and assistance could be a consideration as a means of possibly understanding their culture but would need consent. Although English was not their first language, it has been confirmed that both had a good understanding of English. They asked on occasions when being dealt by SCH for an interpreter, but this was not always accommodated and is addressed by an agency recommendation. Other agencies including police and the mental health services were mindful that when a person's first language is not English, the use of an interpreter must be considered and obtained if one is asked for. **(No DHR Recommendation is made, as there is agency recognition and understanding of culture and diversity, the use of interpreters, consideration of LGBTQ+ and other support services to be contacted if required, as acknowledged in Agency Recommendations within Appendix 1).**

4.28 **Finding (8) – Awareness and Promotion of the SMBC ASC Triage Process of Safeguarding Referrals existing safeguarding referral pathways and expectations to multi-agency partners.**

4.29 **What is the evidence to consider this recommendation?** This DHR 13 is supporting Solihull Safeguarding Partnership in addressing the numerous identified lessons that need to be learnt from this review in order to address professional practice. The themes that emerged, highlighted a weakness in multi-agency working. In respect of Solihull, Safeguarding Partnership agencies systems and processes in place, did not recognise the toxicity and escalation of Adult 1 and 2's DA and other complex safeguarding concerns within their relationship, to provide a co-ordinated safeguarding action plan. There was a distinct lack of referrals made to ASC who were unaware of the couples worrying DA relationship therefore, safeguarding opportunities were missed.

4.30 **What action needs to be taken to ensure that adults at risk are protected and supported?** In order to support potential victims, perpetrators when required, and professionals in the execution of their duties, it is strongly recommended that Solihull MBC and Solihull Safeguarding Partnership promote, reinforce, and require all safeguarding partners and voluntary organisations to be aware of and to utilise the Solihull MBC Adult Social Care, Triage Process of Safeguarding Referrals within the Adults Duty Team (ADT). After due consideration by the review panel, it was accepted the ASC triage process performs the function of an Adult Multi Agency Safeguarding Hub (MASH) which some local authorities have organised to suit their own organisational setup and local needs. There is no single MASH model across the West Midlands.

4.31 **What are the advantages of ASC Triage Process?** The Solihull MBC ASC Triage Process of Safeguarding Referrals, functions similar to a MASH which is a single point of contact and a front door to all safeguarding. The team oversee the screening of all safeguarding referrals and decisions are made regarding safeguarding thresholds and the next steps required to ensure the immediate safety of the person is made within 72 hours, this includes liaison with all relevant professionals. The ASC triage process have a local multi agency information sharing protocol and escalation process that supports the effective triage of all referrals. The ADT also provide consistent representation at the Solihull MARAC. The process will improve the quality of information for earlier action to be identified, in order to support and protect adults at risk. In the case of DHR 13, no Domestic Abuse safeguarding referrals were received by Solihull Adult Social Care, this suggests there is a gap in professional awareness and a lack of compliance with existing processes and expectations. The following recommendations are made to address this finding: -

DHR Recommendation (7) for Solihull Safeguarding Partners and Agencies to the DHR

Awareness of the SMBC ASC Triage Process of Safeguarding Referrals, existing safeguarding referral pathways and expectations to multi-agency partners.

It is recommended that the Solihull MBC Safeguarding Partners, and voluntary organisations, reassure Solihull Safeguarding Partnership that their staff are made aware of and ensure that adult at risk safeguarding referrals are diligently submitted to the SMBC ASC Triage Process of Safeguarding Referrals within the Adult Duty Team, for screening and necessary action to be completed.

DHR Recommendation (8) for Solihull MBC Adult Social Care

Promotion of the SMBC ASC Triage Process of Safeguarding Referrals existing safeguarding referral pathways.

It is recommended that the Solihull MBC Adult Social Care: -

- **Promote the awareness of the SMBC ASC Triage Process of Safeguarding Referrals within the Adult Duty Team, including the existing safeguarding referral pathways for the expectations and information of multi-agency partners.**
- **To ensure greater visibility on Solihull MBC's website of the Triage Process of Safeguarding Referrals which should be readily accessible to multi-agency safeguarding partners, agencies, and professionals.**

Chapter 5

Conclusions

5 **Predictable and Preventable.** This DHR has identified Adult 1 and 2's complex and domestic abuse relationship was recognised by some of the agencies but there was no effective agency safeguarding responses who, failed to work together. The concerns have been acknowledged and the review has received extensive and supportive information from agencies to ensure that lessons are learnt. Their relationship, with both displaying anger issues between themselves as recorded in the narrative and anger towards others, especially when intoxicated, with the reported mental health concerns and the likelihood of the couple's relationship becoming more volatile and dangerous, was predictable. The review is unaware if there were any ongoing DA abusive tactics engaged by either adult against the other. Notably the preceding months before Adult 1's death, they had conflict and ASB with other residents and were evicted; Adult 1 attended ED with anxiety; two DA incidents occurred both each as a victim and perpetrator against the other in March 2022; another DA incident occurred where Adult 2 held Adult 1 in a chokehold (reported after his death); Adult 2 was charged and attended court for sexual assault, and he took a drugs overdose. These worrying complexities in their day-to-day life, was likely impacting on trauma, their physical and mental health in an unhealthy relationship. If action had been taken earlier, as identified in this report, the DHR cannot definitively answer whether the homicide of Adult 1 could have been prevented**,** but there is a strong possibility.

5.1 **Non-Engagement and Family participation request.** Significant attempts to support and give advice to both Adult 1 and 2 was not always readily accepted. This could be due to their complex needs and circumstances effecting them, which can often be compounded by homelessness, their sexual orientation, their view how they were being perceived, the threat of eviction, their volatile relationship, amongst other personal experiences affecting them. Importantly their family dynamics was not fully known or explored. Addressing such safeguarding and DA challenges, is an ongoing national problem and extremely difficult for professionals to deal with. The right course of action and right person or persons, to gain the confidence of the victim or potential perpetrator for the support and advice to be accepted is required, for their own and others protection. The DHR wrote letters, (translated into their native language) to family members and Adult 2, with an offer to participate in the review at the conclusion of the criminal proceedings. As stated previously, no responses were received so important questions as to culture, diversity or any of views they may have had, were unable to be asked.

5.2 **Multi-Agency Working.** No one practitioner or agency can possibly resolve the difficult challenges in safeguarding. It requires a joined up multi-agency and methodical approach with appropriate risk assessments, extensive research of background history, effective communication and sharing of information. The DHR has acknowledged there were elements of good practice by some agencies and professionals. It is further recognised that extensive resources and input by agencies was made in their interaction with Adults 1 and 2. If there had been effective communication and information sharing, with a joined up multi agency working approach, there may have been a potentially better outcome. A practitioner's event could not be arranged due to the impending criminal court on the advice of WMP. Learning events can be considered and a DHR 13 learning note has also been prepared to assist any proposed SSP and Agency training events.

5.3 **Professional responsibility**. Local and National safeguarding legislation and guidance changes are updated frequently. It is incumbent therefore, on all professionals working with and for the health and welfare of others, to have a personal and professional responsibility to keep themselves updated on information that supports and protects persons at risk in society. Solihull Safeguarding Partnerships are displaying an inquisitive and determined approach to ensure that all agencies and organisations

have the most up to date knowledge. This DHR has provoked new and forthcoming safeguarding implementations to improve professional practice as outlined in the narrative.

5.4 Submission, publication and dissemination of the DHR 13 Report. This report is submitted to the Solihull Safeguarding Partnership. A DHR action plan will follow the conclusion of this review, with recommendations implemented or in the process of implementation, during the review process, in order to save time, ensuring the learning is efficiently promulgated. A condensed Executive Summary and Learning Brief, has also been prepared for the information of the Home Office, safeguarding practitioners and interested parties. A decision as to the publication of the DHR 13 report will be subsequently made by the Safer Solihull Partnership. The report will be disseminated to LGBTQ + services and services for male victims of DA available as a single provider but since April 2023 has been incorporated into the primary specialist community service, for their information.

Appendix 1

Individual Agency Recommendations

WMP.

Recommendation 1. Increase knowledge of referrals for vulnerable adults and increase use of referral portal. Increase officers' general knowledge of vulnerability; what it entails, types of vulnerability and how to manage vulnerability when it is identified.

Recommendation 2. A mandatory video training package will be created with instructions on when to use the portal, how to use the portal and the potential outcomes following referrals made via the portal.

BCHFT.

Recommendation 1. To ensure there is a process for carer's assessments to be offered as mandatory if a carer is identified and included in any active process.

SCH.

Recommendation 1. Undertake Hate Crime awareness training for Contact Centre Staff

Recommendation 2. Define the routes to give an effective response to Hate Crime following initial report.

Recommendation 3. Develop professional curiosity through training and development for identified staff.

Recommendation 4. Housing Options Officers to buddy and shadow Neighbourhood Officers at partnerships to improve networks.

Recommendation 5. Hold Joint Team Meeting Event(s) with Mental Health Service centre.

Recommendation 6. Introduce a buddy system between Housing Options Staff and Neighbourhood Staff.

Recommendation 7. Undertaking timely and dynamic risk assessments.

Recommendation 8 . Brief all staff on Interpreting services and how to offer and access them.

Recommendation 9. Produce Guidance for SCH staff for clarity working with GPs and how to make referrals.

BSOL ICB.

Recommendation 1. GP Medical Practice 4 to receive IRIS training and become an IRIS Practice. (Identification and Referral to Improve Safety) specialist DA programme and training for GP's.

Recommendation 2. GP Medical Practice 3 to receive refresher IRIS training.

Recommendation 3 Both Practices to have a Was Not Brought/ Did Not Attend policy.

Recommendation 4. Both Practices to Improve Record keeping by Clinicians and Administrative Staff

Recommendation 5. GP Medical Practice 4 to Link Households

Recommendation 6. GP Medical Practice 3 to train of Staff who are responsible for coding of Mental Health Disorders

Recommendation 7. Both Practices to have a policy on following up vulnerable patients upon receipt of any correspondence, including A and E letters, which highlights abuse or mental health concerns (even if they are under Secondary Care).

Walsall ICB.

Recommendation 1 - Feedback to GP Practice regarding the good practice identified.

Recommendation 2. Remind GPs at their forums that it is important to ask about DA at every appointment after there has been disclosed and a flag should be added to the patient record.

UHB.

Recommendation 1. DA - Meeting to be arranged with Trust IDVAs to discuss perpetrator pathway.

Recommendation 2. DA - Perpetrator pathway to be written and agreed at Board.

Recommendation 3. Update Missing persons procedure (Datix system).

Recommendation 4. Audit of those who leave ED before assessment.

BSMHFT.

Recommendation 1. A review of the current domestic abuse policy and consideration to be given to gender bias within this - Update domestic abuse policy to include guidance regarding recognition of gender bias and to see victims of DA face to face rather than telephone /video contact.

Recommendation 2. An audit to identify evidence that routine enquiry and appropriate use of risk management tools is taking place during clinical contacts with service users. - Dip Sample audit – sample identified from MARAC.

Recommendation 3. A review into seeking to establish why routine enquiry does not appear to be embedded within practice. - Survey Monkey Questionnaire to ask clinicians if they ask routine enquiry and if not why.

Recommendation 4. To develop a network of 'safeguarding supervisors' with a view to additional training and support into clinical areas.- To train all safeguarding supervisors in routine enquiry and share the learning form themes form DHR's.
Recommendation 5. BSMHFT Staff to offer face to face appointments where domestic abuse is a factor, BSMHFT to review current policy for face to face versus remote video/ telephone contacts.
ASC, Environmental Services and WMAS - No agency recommendations.

Appendix 2

Bibliography, Glossary and Acronyms

Bibliography

The following legislation, documentation and guidance was consulted for the process of completing this DHR (see also legislation and guidance within the report and inserted footnotes for additional research material):

- *Care Quality Commission (2010) Guidance about compliance: Essential standards of quality and safety. What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008, London: CQC*
- *Care Act 2004,*
- *Equality s Act 2010*
- *European Convention on Human Rights (ECHR)*
- *Human Rights Act 1998*
- *Mental Capacity Act 2005.*
- *Mental Health Act 1983. Supporting Community Order Treatment Requirements February 2014. National Offender Management Service (NOMS).*
- *NHS England Safeguarding Adults pocket guide.*
- *WM Regional Domestic Abuse and Standards, DVPN and DVPO's – https://westmidlands.procedures.org.uk/pkost*

Glossary

CPS – Prosecuting cases for older victims of crime
https://www.cps.gov.uk/legal-guidance/older-people-prosecuting-crimes-against
Gov.UK - DVPN and O's
https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010
HMICFRS. Inspection GMP
https://www.justiceinspectorates.gov.uk/hmicfrs/news/news-feed/greater-manchester-polices-service-to-victims-of-crime-a-serious-cause-for-concern/
HMICFRS Inspection WMP
https://www.justiceinspectorates.gov.uk/hmicfrs/publications/west-midlands-crime-data-integrity-re-inspection-2018/
NICE - MCA
https://www.nice.org.uk/guidance/ng108/chapter/recommendations#assessment-of-mental-capacity
SCIE – Recognising Abuse
https://www.scie.org.uk/files/safeguarding/adults/prevention/Recognising-and-responding-to-domestic-violence-and-abuse.pdf
SCIE - Sharing information.
https://www.scie.org.uk/safeguarding/adults/practice/sharing-information
Solihull DA Policy 2022 to 2025
WM Crime Commissioner – Hidden Crimes
WM DVPN and DVPO's
http://westmidlandspcp.co.uk/wp-content/uploads/2019/03/ITEM-06-HIDDEN-CRIMES-WMPCP-25-MAR-2019.pdf

Acronyms

Acronyms are included within the narrative of the report.

Appendix 3

David Byford - Summarised Biography.

David was a Senior Investigating Officer (SIO) in the Metropolitan Police Service (MPS), responsible for investigating crimes against children and young persons, as well as homicide and other serious crime. He has received both Judicial and Police commendations for his leadership, professionalism, and investigative ability in conducting serious criminal investigations. In 2003 with a colleague, he developed the London wide, MPS Specialist Crime Review Group (SCRG) serious case review process, now called Local Child Safeguarding Practice Reviews (LCSPR). The SCRG are responsible for completing all statutory reviews in the MPS.

He has carried out numerous nationally sensitive and bespoke reviews, including a successful review concerning the Home Office Pathologist in the case of Regina v Sally Clark for the Attorney General (AG), Lord Goldsmith, where he reviewed over 70 homicide cases with 59 reports completed. As a consequence, on the direction of the AG, the Director of Public Prosecutions formed a professional team including David who researched and wrote the CPS Disclosure Manual for expert witnesses. He has provided expert advice in a murder trial at the Central Criminal Court into the death of a baby, where a medical expert criticised safeguarding services. David advised the prosecution barrister that the evidence given was not based on fact or within the experts own professional knowledge and his testimony was accepted evidentially within the trial and the perpetrator was convicted with no criticisms of safeguarding professionals or agencies.

After retiring as a Police Officer in 2006, he was again employed by the MPS as a Senior Review Officer, to continue his responsibility for the MPS SCR responses for all 32 London Boroughs. He personally completed or reviewed over 150 statutory SCR's and other bespoke high profile serious case reviews. David also acted as an adviser on SCRs to the MPS, the Association of Chief Police Officers (ACPO) now the NPCC, Police Nationally, Local Authorities, Health and Education Departments and Local Safeguarding Partnerships. In 2010, he conducted an ACPO National Review for the Child Exploitation and Online Protection (CEOP) Centre for SCRs nationally on how police should complete statutory reviews. The report was accepted, with subsequent advice and presentations given nationally to numerous Police Services, Central and Local Government Associations and he was also asked to speak to Police Scotland, which was being formed. He made a presentation to the judiciary, police, and representatives from the Procurator Fiscal Office (PFO) and gave advice on managing parallel processes where there is a statutory child review and an ongoing criminal investigation. The PFO changed policy to allow the parallel processes to be completed together which, was not previously sanctioned by the PFO.

David retired from the MPS in September 2014 and is now the Managing Director of his own Safeguarding Consultancy and is an Independent Lead Reviewer/Author and Chair for LCSPRs, DHRs and SARs. A large number of David's reviews have been published nationally with many cited in national learning and one review regarding human trafficking, was referenced in the National and Borders Act 2022. Two recent reviews completed in 2023, include a non-statutory review regarding an anti-social behaviour murder and a combined LCSPR, murder of an innocent man and the lawful fatal shooting of the murder suspect by armed police, both cases received national media interest. Also completed, for a Safeguarding Partnership in 2023, was a thematic review of over 40 of their LCSPRs, SARs, DHRs and non-statutory reviews and requested and completed 10 learning briefing documents for their SARs, with additional recommendations identified which were accepted for lessons to be learnt. David is independent of, and has no association with, any of the agencies that participated in DHR 13.

DHR 13 – Recommendations – Action Plan

This is a working document and subject to change.

1	**Theme: Multi-agency working, referrals, professional meetings, sharing information, record keeping and communication concerns.**				
1.1	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**
1.1	Partners to demonstrate they are working in accordance with West Midlands Adult Safeguarding procedures, Section 6.	Participating agencies in the DHR	Presentation to the LSCP and SSAB of the learning and recommendations identified Learning brief created and cascaded through the local domestic abuse board The West Midlands Safeguarding procedural guidance is circulated to all partners. Action around reassurance, accountability and feedback to go to SSAB	All	professional meetings/strategy discussions which improves safeguarding. Practitioners have an improved understanding of their roles and responsibilities to effectively communicate & share information. Enabling relevant agencies to have the full range of available information to support victims and tailor the casework appropriately. safeguarding concerns are reported in line with expected practice as detailed in the WM Adult Safeguarding Procedures.

1.1	**Progress Report**	**Complete/ Target to complete**
1.1	**ASC** The West Midlands Adults Safeguarding Procedures are the foundations of what we apply to all of our safeguarding practice and process. Safeguarding recording forms, practice guidance and a practitioner's toolkit have all been designed in accordance with the procedures. A safeguarding competency framework is in place to monitor application of the procedures to practice. A safeguarding audit process forms part of our routine monitoring and governance of safeguarding practice, ensuring that the procedures are being adhered to. Regular reporting of safeguarding practice and standards is in place to both senior management and Solihull Safeguarding Adults Board.	Complete

1.1	**BCHFT** Domestic Abuse policy updated and ratified in March 2025. Policies and procedures are in line with the West Midlands procedures and link is within the policy. West Midlands procedures are referenced within L3 Domestic Abuse training package	Complete
1.1	**BCICB** All policies and procedures for adult safeguarding are in line with West Midlands Safeguarding Procedures. Adult safeguarding training for GP's and bespoke training on domestic abuse reference these procedures. Safeguarding referrals are audited periodically.	Complete
1.1	**BSMHFT** BSMHFT's Safeguarding Adults Policy is consistent with both Chapter 14 of the national statutory guidance document, "Care and Support Statutory Guidance" (The Care Act, DoH, 2014) and with the Safeguarding Adult Procedures endorsed by the local Safeguarding Adults Boards serving the areas covered by BSMHFT."	Complete
1.1	**BSOLICB** Policies and procedures are in line with the West Midlands procedures and are referenced within our training packages and briefings.	Complete
1.1	**SCH** SCH operate to the West Midlands procedures which are accessible to all employees directly through the SCH intranet site. SCH participate in the full range of multi-agency case conferences relating to individual cases and have membership on the appropriate Boards and Groups across SSAB and DAPB. SCH have adopted the Council Safeguarding Policy and have an independent Customer Domestic Abuse Policy. Relevant updates are circulated to all staff through various methods including team meetings, emails, intranet, and monthly Core Brief. Safeguarding activity is oversee by SCH's SEDA Group (Safeguarding, Exploitation and Domestic Abuse)	Complete
1.1	**UHB** Safeguarding adults policy has been updated with link to updated West Mids Procedures- publication June 25. Trust safeguarding team works alongside social care colleagues and health colleagues to address safeguarding concerns Safeguarding team audit all safeguarding referrals for quality and provide targeted education and support when required.	30/06/25
1.1	**WMP** WMP have a number of policies and procedures in place which concern the safeguarding of adults, including the Domestic Abuse Policy (Revised in 2024) and Right Care Right Person (RCRP), live since February 2024 (for revision in September 2025). These are readily available to WMP officers/employees.	Complete

RCRP was created in line with the national approach agreed by the Home Office and Health Partners in order to give clarity to WMP officers and police staff where their role requires them to assess and/or respond to calls for service. The policy is necessary to ensure that WMP are delivering a service to communities in such a way that they get the right service and care from the right service provider.

It is intended to ensure where the most vulnerable members of the community contact WMP in time of need that they receive help and assistance from the Most Appropriate Agency (MAA).

If there is a clear safeguarding concern in relation to a vulnerable adult within the definition of the Care Act 2014, the RCRP will not apply.

WMP officers and employees have clear guidance on how and when to raise and refer safeguarding concerns in line with policy, whether via the WMP Vulnerability Portal, directly to partner agencies or to ASC.

Figures show that between January 2024 and January 2025, WMP made 507 requests to partners for strategy discussions, 103 of these related to the following 'offence description':

Assault with injury, assault with intent to cause serious harm, assault without injury, attempted murder, coercive controlling behaviour, domestic incidents, hate incident, murder, stalking

All 12 meetings requested for matters that occurred in Solihull within this time were completed.

10 of the 12 were requested by officers within the Public Protection Unit.

1.2	Recommendation	Scope of recommendation	Actions to take	Lead Agency	Expected Outcome
1.2	SSP to seek assurance from all partners that staff understand and are utilising the Safeguarding Referrals process by. Adhering to Local and National Safeguarding Adult Policy and Procedures.	Partners and participating agencies in the DHR	SMBC domestic abuse professionals flow chart to be reviewed and updated. Agencies to review the effectiveness of their escalation policy and procedures, ensuring unresolved matters are	All	Strengthened workforce with improved professional judgement and curiosity. Confident workforce around DA and signposting to supportive services Honesty, openness, and constructive challenge when there is disagreement between agencies.

	Foster an environment for safe & professional challenge within multi-agency working. Monitoring and reviewing cases prior to closing them.		utilising SSAB escalation policy and are professionally challenged. To ensure they are signposting to correct outside support and agencies. SSAB to provide a summary of the partners level of engagement with the escalation policy and outcomes.		

1.2	**Progress Report**	**Complete/ Target to complete**
1.2	**ASC** ASC have explicit practice guidance in line with the West Midlands Adults Safeguarding procedures with a particular focus on safeguarding thresholds, we also have a local performance indicator to monitor the timeliness of concern decision making. Practitioners routinely engage and seek input from partners (where appropriate) as part of safeguarding information gathering and enquiries and where appropriate liaise with the Solihull Safeguarding Adults Board to escalate any concerns regarding partner engagement. We have a local multi agency information sharing protocol and escalation process that supports effective triage The safeguarding case file audit process includes a specific question to monitor multi agency working.	Complete
1.2	**BCHFT** Staff are aware of escalation processes and the Safeguarding Team are readily available for support and guidance. Safeguarding Referrals are annually audited by the Safeguarding. 7-minute briefings are shared across the Trust via Safeguarding Champions and the Safeguarding Newsletter including Making a Referral and Professional Curiosity. All Safeguarding referrals are added to the Trusts incident management system 'Ulysses' with oversight from the Safeguarding Team.	Complete
1.2	**BCICB** Staff are trained how to make appropriate referrals and are encouraged to use local escalation processes (Fast Policy) They have access to the ICB safeguarding team for support.	Complete

	All Gp practices are IRIS (Iris is a specialist domestic abuse training, support and referral programme for GP's) trained and receive regular training updates. In Feb 2025, BCICB offered bespoke Gp training event on Domestic abuse. The Gp practices participate local multi-agency audits to assess the impact of training.	
1.2	**BSMHFT** Staff understand how to make a referral, where to access the Policy and Procedure, also if they are concerned about safeguarding response know who to escalate too. Within our audit schedule we also have a question on the escalation so will therefore be able to identify any gaps.	Complete
1.2	**SCH** Practitioners know how to make a referral to other agencies which are identified as a result of either mandatory training, during the course of case investigation/home visits, through risk assessments, or through personal housing assessments. All staff have direct supervision should they need to escalate a concern	Complete
1.2	**BSOLICB** Staff understand how to make a referral, where to access the Policy and Procedure, also if they are concerned about safeguarding response know who to escalate too. Within our audit schedule we also have a question on the escalation so will therefore be able to identify any gaps.	Complete
1.2	**UHB** Safeguarding adults policy has been updated with link to updated West Mids Procedures- publication June 25. This includes escalation processes Domestic abuse policy has been updated to reflect new Strategy Safeguarding intranet pages changes being made to create Sharepoint to allow for closer oversight within safeguarding team Trust safeguarding team works alongside social care colleagues and health colleagues to address safeguarding concerns Safeguarding team audit all safeguarding referrals for quality and provide targeted education and support when required	30/06/25
1.2	**WMP** WMP have escalation processes in place to ensure unresolved matters reach a conclusion. There are no authority levels within the RCRP policy, however escalations can be made to the WMP Vulnerability Hub in Force Contact when operating hours allow, and/or any concern can also be escalated to trained supervisors in line with normal chains of command for incidents where it is unclear whether we have a statutory responsibility or whether we are the most appropriate agency.	Complete

	With regards to mental health, WMP have an AMHP escalation policy. In most cases, matters are escalated in the first instance to the Inspector, then a Chief Inspector, Superintendent and finally, the Force Duty Executive Manager, who will seek legal advice prior to any further onward referral to the Local Government & Social Care Ombudsman. Escalation polices are readily accessible via the WMP intranet.	

2.	**Theme: Awareness of the Domestic Abuse Act 2021, Anti-Social Behaviour Guidance and CPS Evidence Led Victimless Prosecutions.**				
2.1	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**
2.1	WMP to review their process for responding to incidents of domestic abuse, to provide reassurance that DVPN's/DVPO's are embedded as a safeguarding resource, where applicable.	Currently only for WMP, and to expand to relevant partners identified in DAPN/DAPO guidance, when released.	The revised 2024 MARAC Operating Protocol and multi-agency training outlines roles and responsibilities to include consideration of DVPN/DVPO/Victimless prosecutions West Midlands Police to improve the initial investigative response to reports of domestic incidents West Midlands Police to improve and increase use of civil orders to reduce risk of domestic abuse offending e.g. DVPN / DVPO / SPO Initial attending officers to embed VOWSIO (victim,	WMP	Increase number of applications for ASBOs / CRASBOs. Practitioners will enact existing Domestic Violence Protection Notices and Orders (to be known in the future, when rolled out in England, as DAPN and DAPO's) that consolidates protection orders and non-molestation orders under the Domestic Abuse Act 2021, when applicable. Improved proactive case management for high risk and high level ASB cases where multi-agency support is required to tackle an issue, obtaining the most appropriate and best outcome, and utilising the wide range of ASB powers Measure of number of officers who attend Operation Vanguard masterclasses and investigation conferences Increased attendance at CPD sessions/Vanguard Masterclasses

			offender, witnesses, scene, intelligence, other considerations) at the outset of investigations to improve the initial response to domestic abuse. Delivery of continuous professional development to frontline officers to reinforce use of VOWSIO principles to improve the initial response to domestic abuse. Refresh DVPN/DVPO understanding within West Midlands Police. Increase number of applicants for DVPNs from within a wider range of teams Refresh ASBO/CRASBO understanding within West Midlands Police.		Measure of number of officers who attend Operation Vanguard masterclasses and investigation conferences. Continued improvement of domestic abuse investigation standards assessments (measured via monthly quality assessment thematic tool)

2.1	**Progress Report**	**Complete/ Target to complete**
2.1	All partners attending MARAC have knowledge of DVPN/DVPO/Victimless prosecutions and utilise this knowledge in MARAC meetings to consider these against individual cases. Ensuring staff and partners understand DVPOs. There has been a significant amount of work, training and awareness to officers and staff within WMP to understand the criteria for a DVPO application.	Complete

	All filing rationales must include why a DVPO has not been applied for when there is no further action. The application process had been reviewed and streamlined. Understanding orders that are active within our communities. Within WMP all DVPO's, also stalking protection orders and non-mols, are put onto Connect, the investigation system, with the physical order being stored there and the conditions visible. PNC is updated with the order details. A search is available to search for DVPO's, SPO's and Non-mols within Connect. Officers can understand the number of active orders that are active on their LPA. DVPOs for DARA high risk victims are going to be shared via the secure MARAC partners distribution list form this week. Work with Probation Services is taking place to share active DVPOs themselves, so they can understand which of their clients are subject to a DVPO.				
2.2	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**
2.2	SCH and WMP work together to review their process for responding and managing incidents which are defined as persistent ASB.	WMP/SCH	Improved proactive case management for high risk and high level ASB cases where multi-agency support is required to tackle an issue.	WMP	Obtaining the most appropriate and best outcome and utilising the wide range of ASB powers.
2.2	**Progress Report**				**Complete/ Target to complete**
2.2	**WMP** West Midlands Police (Solihull Local Policing Area Neighbourhood Team) have a monthly meeting with the Local Authority to discuss ASB priorities, and a weekly meeting with Safer Solihull partnership around hotspot patrols. The top ten ASB hotspots/victims are discussed as an agenda item at local TTCG. We are routinely identifying ASB issues which cannot be managed through BAU and opening PMPs for them. For example, we have just opened one for persistent begging in Shirley. We have opened a PMP (Proactive Management Plan) for Green Hill Way in Shirley to track our activity working with the Housing Association to target ASB offenders. Currently, there are 32 open PMP's as the smallest LPA. The more challenging ASB issues have recorded SARA (Scanning, Analysis, Response, Assessment) plans and that all Supervisors and some staff are undergoing bespoke training in this art.				Complete
2.2	**SCH**				Complete

	Persistent ASB cases are managed in accordance with Home Office ASB Guidance 2022, utilising community protection notices, orders, and court injunction where applicable	

2.3	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**
2.3	WMP to always consider ELP concerning domestic abuse. When a victim does not want or is unable to support a criminal prosecution, all sources of information, lines of enquiry and available evidence must be explored and this reviewed prior to filing.	WMP	Investigators and their supervisors to ensure that all available material is reviewed and an ELP considered prior to filing any report of a domestic abuse nature, utilising guidance from the Supervisor Review Guidance Template published via Operation Vanguard Delivery of continuous professional development to investigators and supervisors reinforce use of investigation plans that consider ELP's in relation to domestic abuse.	WMP	Continued improvement of domestic abuse investigation standards assessments (measured via monthly quality assessment thematic tool) Measure of number of officers who attend Operation Vanguard masterclasses and investigation conferences

2.3	**Progress Report**	**Complete/ Target to complete**
2.3	**WMP** Cases involving a reluctant victim will not be filed on the basis that the victim does not wish to pursue a complaint or support a prosecution. The evidential threshold will still need to be met; however, in the event that it is, CPS will be consulted with a view to obtaining charges within cases that are not supported by the victim. An evidence-led prosecutions guide and toolkit has been produced and is available to all officers and staff within West Midlands Police. It is an eight-page guide and details a description of an evidence-led prosecutions, enquiries to be conducted by the first responder, the necessity of body won video evidence and describes 'res gestae' evidence (a statement made by a person so emotionally overpowered by an event that the	Completed September 2024

	possibility of concoction or distortion can be disregarded”). The guide details how an evidence-led case is to be built and lists common interest factors for and against prosecution, giving a balanced view that can be applied in the circumstances. As well as the above, in July 2024 a force wide message was placed on the WMP intranet: Our new force Victims Strategy ensures we put victims at the heart of everything we do and deliver a service we can be proud of. As part of this, there’s a large amount of work ongoing to raise awareness around the use of evidence-led prosecutions, particularly in cases of domestic abuse. If you’re pursuing an evidence-led prosecution, you should consider gathering the following evidence: Res Gestae evidence is focussed on gathering the words and emotion of the victim at the point of call. This can be so closely associated with the incident taking place, or having just taken place, that it can be admitted as Res Gestae evidence and accepted even if the victim will not support a prosecution. Attending officers capturing good quality accounts on Body Worn Video (BWV), as well as scene imagery. Photos of injuries and providing descriptions of injuries in statements. Offer to take a Victim Personal Statement, even if they choose not to provide an evidential one.	

3.	Theme: Coercive, Emotional and Manipulative Control, to consider Situational Violence and Identifying a Care Provider				
3.1	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**
3.1	SSP to seek assurance from all partners that they know the signs and symptoms of coercive, emotional, and manipulative controlling behaviour of an adult at risk and that they understand their role and responsibilities in responding.	Solihull Safeguarding Partners and participating agencies in the DHR	Coercive and controlling behaviour to continue to be a focus area in DA multi agency training sessions. Single agency training Single agency pathways and how are these checked for compliance.	All	Increase in identification of non-physical domestic abuse. Strengthened domestic abuse aware workforce

3.1	**Progress Report**	**Complete/ Target to complete**
3.1	**ASC** Mandatory Domestic Abuse Act training is in place for all frontline practitioners, this includes a focus on coercive, emotional and manipulative behaviours.	Complete
3.1	**BCHFT** The Trusts Level 3 Domestic Abuse and Level 3 Safeguarding training packages include coercion and control. This is also included in the Domestic Abuse Policy.	Complete
3.1	**BCICB** All Gp practices are IRIS trained, the specialist DA training considers all aspects of DA, including coercive and controlling behaviour are discussed as part of the training offer. This is included in policies and procedures.	Complete
3.1	**BSMHFT** DA & safeguarding training packages include coercion and control, there are also Policy and procedures in place, staff briefings. Audit schedule includes questions on staff knowledge & understanding of DA.	Complete
3.1	**SCH** All front line practitioners have undertaken DA level 1, 2 or 3 training appropriate to their role, as well as mandatory e-learning training. There is a Customer Domestic Abuse Policy in place and SCH are members of DAHA. Cases are subject to a percentage of audit by Managers with homeless cases offered an independent external case review for appeals in line with homelessness legislation.	Complete

3.1	**UHB** Coercive and controlling behaviour remains a focus in al DA training, policy and procedure	Complete
3.1	**BSOLICB** DA & safeguarding training packages include coercion and control, there are also Policy and procedures in place, staff briefings. Audit schedule includes questions on staff knowledge & understanding of DA.	Complete
3.1	**WMP** Between 2018 and 2021, WMP had several policies in place, and had provided officers with an abundance of training and material in order to equip and prepare them for responding to and investigating domestic abuse, and recognising the signs of coercive and controlling behaviour (CCB). The Public Protection Unit and Major Crime Unit now investigate the more complex and organised crime types. This is already having a positive impact on outcomes. In April 2023 the positive outcome rate for total recorded crime was 6.6 per cent. This increased month on month and sat at 9.5 per cent as of September 2023. As of September 2024, this figure is 11.3%. Outcome rates for domestic-based crime sit at 12%. In 2024, the WMP Domestic Abuse Policy was revised and now pays further detail to building evidence-led cases and identifying, investigating and seeking prosecutions for non-fatal strangulation and coercive and controlling behaviour. Last year, WMP officers and employees also completed mandatory training in relation coercive and controlling behaviour under Operation Vanguard, ensuring further that the signs of such continue to be recognised and recorded. Operation Vanguard was launched by Assistant Chief Constable Bell following the PEEL review in 2023. The inspection identified WMP required improvement in the quality of several areas of investigation and to date, remains a Force priority under this on-going operation. The main areas of focus through Vanguard which apply to all crimes, including domestic-related incidents are, response attendance times, the use of investigation plans, delays to investigations, the exploitation of investigative opportunities, general effectiveness of investigations (including the actions of attending officers responding to calls for service), improvement of the service given to victims in line with victim Codes of Practice, the way crimes are finalised and the overall effectiveness of supervision. This is monitored via monthly supervisory reviews completed on all open investigations, to identify how the investigation should be progressed and ensure it is progressing appropriately. Inspectors will complete three-monthly reviews on officer's reports within their teams.	Complete

	To ensure this is taking place, Inspectors and Chief Inspectors dip-sample reports. This is being conducted under QATT (Quality Assurance Thematic Testing), which takes supervisory officers through a series of questions which identify whether improvements are being made in investigations. The process identifies good and bad practice, whilst ensuring quality investigations are taking place. At present, approximately 1000 investigations are reviewed each month across the force. The importance of reviewing all material gained during the primary investigation remains a key feature of Vanguard's strategy for improving the quality of domestic abuse investigations, including those run on an evidence-led basis. In August 2024, mandatory training on investigative interviewing was rolled out by the Chief Superintendent for Vanguard. The training focused on the importance of planning and preparing for witness and suspect interviews and directs interviewing officers to the importance of recognising risk, vulnerability and signs of CCB, and reviewing all available material. Between January 2022 and January 2025, 10,138 offences of CCB-related offences were recorded within the WMP force are, 511 of which occurred in Solihull. The recording of such crimes has remained consistent between the three-year-period, with no peaks or troughs in the data, suggesting WMP have and continue to identify such offences.					
3.2	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**	
3.2	Partners to recognise, understand and respond to vulnerability when not clear who is the primary victim and perpetrator	Solihull Safeguarding Partners and participating agencies in the DHR	Reviewing the content and context of the training around perception of victim and perp and the requirement of professional curiosity to be included within all training.	All	Increase in identification of non-physical domestic abuse. Strengthened domestic abuse aware workforce	
3.2	**Progress Report**					**Complete/ Target to complete**
3.2	**BSOLICB** DA & safeguarding training packages and professional curiosity covered					
3.2	**ASC** Safeguarding training material and a bespoke professional curiosity practice guidance is available to all frontline practitioners. Bespoke training has also been delivered with a further session focussed on professional curiosity arranged for March 2025. Application of learning to practice is monitored through a safeguarding competency framework and case file audit process. Further					Complete

	monitoring and analysis is completed by the Safeguarding Team Manager who considers safeguarding concerns that have not progressed to enquiry, with recent analysis highlighting the application of consistent and thorough professional curiosity and evidence-based decision making	
3.2	**BCHFT** Domestic Abuse Policy includes guidance re perpetrators including information for signposting. Professional Curiosity is covered in all Safeguarding training, 7-minute briefings regularly shared and promoted in Safeguarding Supervision sessions.	Complete
3.2	**BCICB** All GPs are IRIS trained; Safeguarding training packages also include professional curiosity. We have developed a 7-minute briefing on professional curiosity, and this has been shared with all staff.	Complete
3.2	**BSMHFT** DA & safeguarding training packages and professional curiosity covered	Complete
3.2	**UHB** DA procedure to be updated to include perpetrator signposting	30/06/25
3.2	**WMP** The WMP intranet has a dedicated site Public Protection site and holds WMP policies, procedures, toolkits and go-to-guides for officers responding to and investigating adult abuse in domestic and non-domestic settings. The information is accessible to all officers/employees via hand-held devices or desktop devices and whether on scene or not. Of note, on the site there is a readily available guide to 'Recognising and Responding to Vulnerability-related Risks', produced by the College of Policing. This focuses and offers guidance on recognising individuals at risk of harm and understanding the vulnerabilities of all those they encounter, whether deemed a victim or a suspect, rather than thinking only about risk in relation to individual forms of harm to one person over the other, owing to their victim/suspect status. The guidance promotes interaction with vulnerable people in a way that maximises opportunities for disclosure in any setting, whether that be the home or a custody suite. It explains barriers and reasons why individuals may not disclose their vulnerability, and quotes research conducted into this. It directs officers/employees to consider cultural influences, situational factors, general perceptions of the police and other agencies, past experiences and pre-existing negative perceptions of authority figures, including a lack of trust in authority. In addition to research, the guide includes a Vulnerability Assessment Framework, developed by academics at the University of Central Lancashire and included in Authorised Professional Practice. The framework can be used to guide their identification of vulnerability by observing and noting an individual's appearance, behaviour, communication, danger and environmental	Complete

	circumstances. Such observations are to be applied when responding to individuals when there is an overlap between the victim and perpetrator, in order to fully consider the relationship dynamic. The guide encourages officers to remain open, receptive, unbiased and fair, and avoid making assumptions, thus ensuring officers use adopt a procedurally just approach.					
3.3	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**	
3.3	All partners to identify the suitability of the role of a carer, where safeguarding concerns of domestic abuse and other serious concerns have been raised to ensure compliance with Local and National Safeguarding Adult Policy and Procedures.	Solihull Safeguarding Partners and participating agencies in the DHR	professionals to consider implications on vulnerable individuals where there are care and support needs of individuals within a DA relationship and apparent caring responsibilities within the relationship	All	Improved practice, demonstrated by an increase in referrals to adult safeguarding in cases where the perpetrator has formal and informal caring responsibilities.	
3.3	**Progress Report**					**Complete/ Target to complete**
3.3	**<u>ASC</u>** ASC have trained a cohort of champions in regards to neglect, this includes a focus on multi- generational abuse. Champions have disseminated learning to their teams. Training has also been delivered in relation to Adult Child to Parent abuse, supporting to upskill and broaden the understanding of perpetrators of domestic abuse to the wider ASC workforce.					Complete
3.3	**<u>BCHFT</u>** Think Family approach is promoted across the Trust, through safeguarding training and safeguarding supervision – encouraging staff to consider all members of a family / household that may have care and support needs. At each mental health assessment practitioners are required to complete 'All about me' questionnaire which includes family / household members.					Complete
3.3	**<u>BCICB</u>** The quality of GP referrals to adult social care is audited to identify any gaps in learning for future training. Safeguarding training supports the learning around the think family approach.					Complete

3.3	**BSMHFT** Safeguarding training – covers Think family approach, consider those in home that may have care and support needs. Audit covers this too.	Complete
3.3	**SCH** Where there is any Safeguarding concern within a Household including a carer, the appropriate safeguarding referral would be made Through the appropriate channels. SCH hold an inclusive service register which identifies any vulnerabilities within a household and these are kept up to date as reasonable and proportionate as possible.	Complete
3.3	**UHB** UHB submits numerous safeguarding referrals for patients who are enduring domestic abuse, including when the carer is a patient and have processes in place to support carers.	Complete 31/12/24
3.3	**WMP** WMP understands that a person can be vulnerable for a range of reasons. These include mental health, housing, financial difficulty, substance misuse and domestic violence , to name but a few. Age, disability, gender and other protected characteristics can also give rise to vulnerabilities. WMP officers will respond to identified vulnerabilities and safeguarding concerns accordingly. If an individual is identified, formally or informally, as being a carer for a vulnerable adult, and it is deemed by the officers that said carer does not/will not/is incapable of providing the appropriate level of support to the vulnerable adult, they will raise their concerns via the appropriate channels. Officers are equipped with the WMP Vulnerability Portal, which is readily accessible via the Force Intranet and personal hand-held devices to make referrals for anyone they deem to be vulnerable. This can include information about an identified carer, in any capacity, and the officer's own assessment of the carer's ability to perform their role as such. The portal is in addition to other pathways for support which relate to Domestic Abuse and Child Abuse, e.g., MARAC, MASH and ASC referrals. It is for use in addition to and not in replace of these.	Complete
3.3	**BSOL ICB** Safeguarding training – covers Think family approach, consider those in home that may have care and support needs. Audit covers this too.	

3.4	Recommendation	Scope of recommendation	Actions to take	Lead Agency	Expected Outcome
3.4	Consideration to cultural identity & sexuality and the impact this has on a person's lived experience and how this is explored.	Cultural competence	Training around professional curiosity around cultural identity and sexuality.	All	Improved practice demonstrated by an increase in referral on DA in same sex relationships.

3.4	Progress Report	Complete/ Target to complete
3.4	**ASC** Training has been delivered in relation to LGBT Experience of Domestic Abuse. This aligns with a strong directorate focus of equality, diversity and inclusion. Safeguarding recording and reports capture a person's ethnicity and sexual orientation.	Complete
3.4	**BCHFT** Professional curiosity is embedded within all training that is offered by BCHFT, to all staff. Cultural competency, gender identity, lived experiences are bespoke sessions that will be incorporated into the bespoke training agenda	Complete
3.4	**BCICB** Professional curiosity is part of all training to staff. As part of the IRIS training there is awareness raising around same sex couples, A summary of this DHR was also the focus of the GP forum in November 2025 in order to raise awareness of same sex couples experiencing domestic abuse. A learning video is being shared across primary care teams. This will be part of an additional training event in March to over 100 GP's	Complete
3.4	**BSMHFT** DA & Safeguarding training - There is an increased awareness of DA and same sex couples and is discussed at practice meetings, supervision and when we have undertaken audits recently this was also an opportunity to raise awareness. We have also promoted cultural competency training that was advertised via one of the safeguarding boards too. Further work required on raising awareness therefore target date will be July 2025.	07/2025
3.4	**SCH** cultural awareness was sufficiently covered in previous training and all SCH front-line practitioners undertake mandatory equality and diversity training including new starters to the organisation, and have undertaken either level 1, 2 or 3 Domestic Abuse training which includes cultural identity and sexuality.	Complete
3.4	**UHB**	Complete

	Members of the safeguarding team have attended training on cultural competency and have shared this within the wider team. A 7-minute briefing on cultural competence has been created and shared.	
3.4	**BSOL ICB** DA & Safeguarding training - There is an increased awareness of DA and same sex couples and is discussed at practice meetings, supervision and when we have undertaken audits recently this was also an opportunity to raise awareness. We have also promoted cultural competency training that was advertised via one of the safeguarding boards too	Complete
3.4	**WMP** The 'Recognising and Responding to Vulnerability-related Risks', guide, produced by the College of Policing, additionally directs officers to consider how factors including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, can impact on an individual's vulnerability. It explains how officers must develop and use advanced communication skills to establish trust quickly, build rapport and encourage individuals to be open about their lived experiences, which in turn promotes the confidence to disclose. The guide again refers to evidence to support this. suite.	Complete

4.	Theme: Supervision, Professional Curiosity and Risk Assessments.				
4.1	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**
4.1	SSP to seek assurance from all partners that their supervisors and staff are conducting and/or reviewing risk assessments and using the scoring guidance and professional judgement to identify where a MARAC referral is required.	Solihull Safeguarding Partners and participating agencies in the DHR	West Midlands MARAC operating protocol to be circulated and agencies to assess both competency and level of compliance. Single agency pathways are reviewed and how are these checked for compliance. MARAC Training to be provided. Review and update risk assessment. Ensure sufficient capacity in MARAC training	SMBC Public Health Domestic Abuse	70% of referrals into MARAC have an accompanying DASH/DARA risk assessment. 50% of accepted referrals into MARAC are based on professional curiosity. Improved effective and timely management of risk. Strengthened workforce with improved professional judgement and curiosity.

4.1	**Progress Report**	**Complete/ Target to complete**
4.1	**ASC** A specific prompt to the DASH risk assessment tool is included in the safeguarding recording forms ensuring that workers explicitly consider and apply the DASH risk tool in contacts in which domestic abuse is believed to be or has been present. The mandatory Domestic Abuse Act training includes content on the MARAC remit and process. ASC have a MARAC lead and routinely attend and contribute to MARAC. The safeguarding practitioners toolkit also includes advice, guidance and forms on making MARAC referrals.	Complete
4.1	**BCICB** MARAC processes, referral and risk assessments form part of training. There has been a recent review on information sharing following MARAC and this is an ongoing focus to ensure primary care have timely outcomes to inform risk.	Complete
4.1	**BSMHFT** Staff understand how to make a MARAC referral using DASH risk assessment and /or professional judgement. MARAC referrals and DASH/Young Person DASH are available to all staff on BSMHFT's Safeguarding website along with guidance on how to complete and refer	Complete
4.1	**BSOLICB**	Complete

	MARAC & understanding /responding to risk is business as usual in that we have an Interpersonal Violence Team (IVT) that attend all the MARAC meetings and share outcomes/notifications with the GP's, Risk awareness, Think Family is covered in the training and our policies and procedures. Staff can also contact the IVT nurses and/or our safeguarding advice support duty line.	
4.1	**SCH** SCH attend all MARAC meetings and front line practitioners are trained and confident in DASH referrals.	Complete
4.1	**UHB** DASH risk assessments and referrals to MARAC at UHB are completed by midwives who are well supported by the safeguarding midwife team, or the safeguarding teams. This ensures risk assessments are robust and accurate.	Complete
4.1	**WMP** DARA is a mandatory risk assessment, used when West Midlands Police manage a crime or non-crime in respect of domestic abuse. It is a risk assessment tool for first responders attending domestic abuse incidents. It contains a set of 18 questions that are asked of the victim to help first responders understand what level of harm that victim may be at risk of from that perpetrator. It helps identify any coercion and control and can identify high risk behaviour. The DARA applies to people who have attained the age of 16 and over. Officers can access this risk assessment via an app on their mobile devices. It is expected that a DARA is offered to all victims of domestic abuse when attending a domestic abuse incident. Each DARA is reviewed by a supervisory officer. High risk cases are referred to MARAC as a matter of course; however, officers and staff are aware of the ability to refer cases to MARAC using professional curiosity in the event that, whilst the risk may not be graded as high, concerns are raised that require referral to MARAC.	Complete

5.	Theme: A Review of WMP Domestic Abuse investigations				
5.1	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**
5.1	Assurance is provided to SSP that supervisors and staff are. - cognisant of domestic abuse and anti-social behaviour guidance, - can recognise and take remedial action to address any increase in the volume and intensity of incidents, - are utilising current DA and ASB legislation and other available powers.	WMP	Full investigations will be conducted into domestic abuse incidents and cases will not be filed until a supervisor has reviewed the evidence.	WMP	As a result of the above, full investigations will be conducted into domestic abuse incidents and cases will not be filed until a supervisor has reviewed the evidence.
5.1	**Progress Report**				**Complete/ Target to complete**
5.1	WMP have a Strengthened domestic abuse workforce. WMP monitoring the outcome and repeat DA incidents. More Perpetrators are being held to account and victims feel safer.				Complete
5.2	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**
5.2	WMP commit to continued dip sampling of the quality of WMP domestic abuse investigations to ensure good practice and lessons are being learnt, including from previous statutory reviews, HMICFRS inspections, and complying with Local and National Safeguarding Adult Policies and Procedures.	WMP	To ensure that this is taking place, Senior Leadership Team officers dip-sample reports. This is being conducted under QATT (Quality Assurance Thematic Testing). This will take supervisory officers through a series of questions and is useful for forces to show where improvements are being made in investigations.	WMP	Continued good practice and lessons to be learnt.

5.2	**Progress Report**	**Complete/ Target to complete**
	It will identify good and bad practice and ensure that quality investigations are taking place. Every month, the reviewing staff within the force receive approximately 10 QATT investigations each to review, meaning approximately 1000 investigations are reviewed each month across the force. The reviewing officers go through a series of 80 questions. There are four pillars of investigation that the questions are based on, one of which is suspect management. The Inspector will score the investigation at the end of the questions. This ensures that any trends can be identified across the force, or even for an individual officer. The aim is that investigations will improve through work being completed across the force under Operation Vanguard and standards of investigations can then be assessed via the QATT reviews.	Ongoing

6.	Theme: Consideration of Mental Health and Mental Capacity Assessments for ‘Best Interest’ decisions.

6.1	Recommendation	Scope of recommendation	Actions to take	Lead Agency	Expected Outcome
6.1	SSP to seek assurance from all partners that supervisors and staff are confident to. • identify poor mental health • ask the right questions around mental health • are aware of the pathway	Solihull Safeguarding Partners and participating agencies in the DHR	Audit to find out if staff have been trained in basic Health MH Capacity. Awareness of pathways	All	Increase in enquires and referrals to mental health professionals. Partners have a process and are knowledgeable to seek advice and signpost to Mental Health Professional or Independent Mental Capacity Advocate

6.1	Progress Report	Complete/ Target to complete
6.1	**ASC** Mandatory training regarding the Mental Capacity Act 2005 is provided to all ASC frontline practitioners, this includes exploration of the principles and approach to best interest decision making. ASC also have a Mental Capacity competency framework which practitioners are expected to record to demonstrate learning and application of this to their practice. In addition, more general training regarding mental health awareness is available for both employees and managers, which includes consideration of the questions and approach to take in regard to discussions about mental health.	Complete
6.1	**BCHFT** As a Mental Health Trust, staff are trained and competent regarding mental capacity, MCA, DOLs, and mental health. If staff are not mental health trained there is opportunity to become a mental health first aider to develop skills related to identifying issues regarding mental wellbeing.	Complete
6.1	**BCICB** Staff are aware of mental health pathways. Refresher training is being provided on MCA.	Complete
6.1	**BSMHFT** Core business.	Complete
6.1	**BSOL ICB** Good progress is being made, vulnerabilities is included in their safeguarding huddle/MDT, there is a new practice manager in post who is keeping tabs on the actions and the only thing that is outstanding is to gather supporting evidence such as the audit but will be done	05/2025
6.1	**SCH** Mandatory e-learning for mental health awareness fin place for all staff. Mental Health Advice and Support Worker now in post at SCH who has delivered a number of training and awareness sessions to front line practitioners including contact centre. Referral	Complete

	information available to all staff who are aware of the referral process, specific tab added to intranet enabling staff to staff to make a quick referral on behalf of a customer.	
6.1	**UHB** UHB has a suite of training for mental health training on how to apply the mental health act is provided via eLearning for medics and patient facing staff. There is also a vulnerabilities study day which includes mental health training. Bespoke targeted training is available on request or as an outcome of an identified learning need. Information on MH pathways is available for all staff on Trust intranet. Staff can refer to the Psychiatric Liaison Team (PLT) via Trust electronic patient records. This team is on site and sees patients at the front door (in emergency departments) as well as those admitted to wards. UHB is involved at a system wide level in the implementation of RCRP	Complete
6.1	**WMP** West Midlands Police are currently undergoing additional training in Right care Right Person, giving an understanding into RCRP itself, S136 MHA legislation, mental health advice, escalation processes, risk assessments, S135(1) and (2) of the Mental Health Act amongst other subjects, improving the knowledge of staff when dealing with people who are potentially in crisis. We also have access to various mental health training modules via College Learn (NCALT) which includes Mental Health and the police - Initial Response. In addition to this, the Mental Health Tactical Advisory Unit are part of the Vulnerability Hub within Force Contact. Missing Person officers and call handlers also make up the Vulnerability Hub as we try to ensure that MH concerns are sent to the most relevant agency, trained and more equipped to deal with Mental Health patients. Within the force intranet, there is a Vulnerability Portal which is used to enable officers to make referrals when required. There are a broad range of referrals that can be made, including mental health, alcohol, drug use and a number of other concerns. The referral is received by the local Partnerships Team and is referred externally to the most appropriate agency.	Complete

7.	Theme: Awareness and Promotion of the SMB ASC Triage Process of Safeguarding Referrals, existing safeguarding referral pathways and expectations to multi-agency partners.				
7.1	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**
7.1	SSP to seek assurance from all partners that supervisors and staff are confident to identify adults at risk and submit a safeguarding referral where appropriate. Partners have a process and are knowledgeable about the SMBC ASC Triage Process	Solihull Safeguarding Partners and participating agencies in the DHR	Undertake a review of agencies who are completing adult safeguarding referrals.	All	There is an increase in appropriate safeguarding referrals received into the ASC triage process from across the partnership. Strengthened workforce by Improved practice to adults at risk Safeguarding and referrals Partners have a process and are knowledgeable about the SMBC ASC Triage Process

7.1	Progress Report	Complete/ Target to complete
7.1	**ASC** Core Business	Complete
7.1	**BCICB** Training is in place for recognition and referral, staff are making appropriate referrals. The ICB complete audits of GP referrals to adult social care.	Complete
7.1	**BSMHFT** Staff understand how to make a safeguarding referral, all safeguarding Polices, training and supervision includes support on how to identify risk. There is an assurance framework in place that will aim to highlight any gaps in clinical knowledge.	Complete
7.1	**BSOLICB** Safeguarding adults again business as usual for us and is everyone's responsibility, training in place, appropriate policies and procedures, audits undertaken around staff knowledge and understanding of process and how applied in practice.	Complete
7.1	**SCH** All SCH staff have access to make an adult safeguarding referral directly through SCH website and are confident to do so having undertaken mandatory e-learning safeguarding training.	Complete

7.1	**UHB** All UHB staff are required to complete mandatory safeguarding training at a level commensurate to their role. UHB submitted 3557 (across a number of local authorities) safeguarding referrals in 2023-24, all of which are quality assured by the adult safeguarding team. Concerns about appropriateness are identified and addressed with individual areas through education and support.				Complete
7.1	**WMP** In the event that officers attend an incident and an adult at risk is identified, officers are trained and well-versed in the use of the referral portal. The portal can be used to signpost individuals who need support from a partner agency, for issues not limited to mental health, drugs and alcohol use. Officers are informed that, if their conversation or dealings with an individual highlight urgent requirement for safeguarding, the portal is not to be used and more immediate steps are to be taken to ensure that safeguarding is in place for the individual.				Complete
7.2	**Recommendation**	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Expected Outcome**
7.2	Promote the awareness of the SMBC ASC Triage Process of Safeguarding Referrals within the Adult Duty Team, including the existing safeguarding referral pathways for the expectations and information of multi-agency partners. To ensure greater visibility on Solihull MBC's website of the Triage Process of Safeguarding Referrals which should be readily accessible to multi-agency safeguarding partners, agencies, and professionals.	All Partners	To consider through Google Analytics any concerns regarding the visibility or access to ASC's adult safeguarding webpage and on-line professionals safeguarding referral form. To provide support and guidance to partner organisations to assist with awareness and promotion of ASC's safeguarding referral pathway and expectations.	ASC	The adult safeguarding 'report a concern' webpage to feature within the top 5 most visited Adult Social Care pages.
7.2	**Progress Report**				**Complete/ Target to complete**

7.2	**ASC** The Adult Safeguarding Team Manager routinely discusses the safeguarding referral and triage process within partner meetings and has and continues to provide dedicated support to partner agencies to enhance understanding when requested or a need is identified. The safeguarding web pages have recently been updated to provide clearer information. From a review of the councils webpage activity, the adult safeguarding 'report a concern' webpage consistently features in the top 5 visited Adult Social Care pages.	Complete

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Caroline Himmons
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9th July 2025

Dear Caroline,

Thank you for resubmitting the Domestic Homicide Review (Adult 1) for Solihull Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in June 2025.

The QA Panel felt that overall, this was a thorough and considered report, with strong learning and recommendations. It was well written and easy to read; the red highlighting of each of the domestic abuse incidents was particularly useful. The Panel also commended the way recommendations for different agencies were set out in Appendix 1 and felt that this provided clarity for agencies. Finally, they noted that having public health representation on the panel and the practitioner event the panel held were examples of good practice.

The QA Panel acknowledged that most of the issues raised in the previous feedback letter have now been addressed the Home Office is content that on completion of the changes below, the DHR may be published. **Area of development**

- The Equality and Diversity section does not identify all of the specific protected characteristics pertinent to this case. The Panel acknowledged that equality and diversity considerations are considered throughout the review, but it would be useful to have a clear section which outlines each relevant characteristic and provides context and research to the ways in which they are be pertinent to the review.

- Thank you for explaining the operational meaning of ‘ethically recorded’. As it was unclear to the Panel it would be useful if it could be explained in the text or in a footnote for future readers of the review who may be unfamiliar with the term.

Please consider the following feedback for future reviews:

- Adult 1 and Adult 2 are not best practice pseudonyms. It would have been helpful to assign culturally appropriate pseudonyms which help to humanise the victim and support ease of reading. It is best practice to use pseudonyms even in reviews which do not have family involvement.

- The panel communicated with members of the LGBTQ+ community, but it is unclear what their input was. It would have been helpful to have some LGBTQ+ representation directly on the panel. The review would also have benefited from further LGBTQ+ specialist input to address barriers to accessing support, as well as a specialist in Eastern European culture.

- The statutory guidance layout is not followed in the overview or executive summary, making the report difficult to follow at times (for example without a narrative combined chronology and a dissemination list). Please ensure that the statutory guidance is followed for any future reviews undertaken.

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