Domestic Homicide Review 13 – The Death of Adult 1 in July 2022

Executive Summary and Learning Brief

1 Introduction. This Executive Summary and Learning Brief relates to the Domestic Homicide Review (DHR 13) report commissioned by the Safer Solihull Partnership (SSP) and completed in response to the death of victim (Adult 1) a male aged 38 years, which occurred in July 2022. It was 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. Adult 2 was subsequently pleaded guilty and was convicted of manslaughter in March 2024.

1.3 Terms of Reference (TOR) and Commissioning. 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 full version of the terms of reference was agreed and completed. 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.

1.4 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.
- 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] 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

1.5 **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.

1.6 **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 the KLOE specific questions set by the review. Individual agency IMR responses to the KLOEs are comprehensive and analysed in Chapter 3 of the full report which addressed the following questions: -

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

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?

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

Assessing risk and mental capacity.

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

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?

Good Practice.

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

Decision making and missed opportunities.

- Was there appropriate decision making in your agency's contact with Adult 1 and 2?
- Were there any missed opportunities to protect both Adult 1 and 2?
- Were there any barriers to professional practice due to COVID.

Recommendations for learning.

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

1.7 **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 to describe the only subjects to the DHR. Adult 2 the perpetrator, together with family members declined to engage with the review process therefore the DHR were unable to obtain their opinion as to any names to use.***

1.8 **Family involvement and delays for DHR completion.** Family members of both Adult 1 and 2 were identified, however as potential witnesses in the criminal Crown Court proceedings which concluded in October 2023, they were not approached by the DHR. There was then a delay as a Crown Court, Newton Hearing was called to be held to determine the final sentencing, 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. They were 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. No one responded to the requests made.

1.9 **Review Panel Membership and Individual management reviews (IMR) and information reports.** Panel member representatives and agency IMRs were received from the following organisations who participated in the review. The Agency authors of the IMRs and information reports were all independent of the review process and had no connection or association, including with the subjects, within the DHR.: -

- **West Midlands Police (WMP).** Michael Fletcher, Detective Sergeant.
- **Birmingham and Solihull Integrated Care Board (BSoLICB).** Lorraine Longstaff, Designated Nurse Safeguarding Children and 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.

1.10 **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 six DHR Panel meetings. The first meeting was held on 13 December 2022, after commissioning.**
- **The independent Chair conducted an IMR authors meetings to explain review expectations and process.**
- **Practitioners event.**
- **Review of agency report submissions.**
- **Requested and reviewed postmortem report.**
- **Communication with LGBTQ+ community and male DA services considered for advice.**

- **DHR Report, Executive Summary Learning Brief and a Learning note for DA training produced.**

1.11 **Diversity, Culture, Ethnicity; the Impact of Covid-19 and Deprivation.** The Equality Act 2010 in the United Kingdom protects individuals from discrimination based on nine protected characteristics which in this DHR, Sexual Orientation applies, as the subjects were in a same sex relationship. 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 the DHR will be shared with them. This is also subject to analysis and comments within Finding 7, together with recommendations made within Chapter 4 and were effectively addressed within the full DHR Report. If similar circumstances should arise in future cases, the input of a LGBTQ+ specialist, as well as a specialist in Eastern European culture as was the case in this DHR, will and should always be considered. Both Adult 1 and 2 were males in a same sex relationship and White Europeans. Diversity, Culture and ethnicity concerns were identified (Equality Act 2010) and have been addressed and analysed in the KLOE questions posed in the full DHR 13 report. Services to LGBTQ+ and advice was made by the review and services for male DA victims was discussed and a is a finding in the review. In respect of Covid 19, agencies explicitly stated that there had been no impact on their professional practice. 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. This factor did not come into the equation when analysing the relationship between Adult 1 and 2.

1.12 **Circumstances of the case.** 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 three properties.

1.13 Adult 2 was also born in the same country in 1984. Two brothers apparently also resided 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 did not take it regularly. Adult 1 and 2 met whilst in Walsall around 2017 and moved to Solihull together in 2021. Until their move to Solihull, Adult 1 and 2 held private provider accommodation with shared facilities at three separate addresses within the Walsall area. The review has no information about their reasoning for leaving these premises. It is known, however, this was Adult 2's third same sex relationship. All three had been or were abusive relationships, as Adult 2 confirmed during a mental health assessment which, took place in December 2021.

1.14 WMP report Adult 1 and 2 had a turbulent relationship from the time they met in Walsall in 2017 and when they moved to Solihull in 2021 and 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 and on occasions, would take MCAT, a mephedrone and powerful stimulant.

1.15 There were ten reported DA incidents between them with both as the victim and perpetrator. Eight of the DA incidents together with other reported ASB, hate crime and criminal allegations were attended to by police, the last DA incident being the homicide of Adult 1, in July 2022. Adult 1 and 2 also reported they were victims of hate crime due to their sexual orientation, appropriately investigated by police.

1.16 There were two reported incidents of ASB and other incidents in February 2020, between Adult 1 with a female resident, alleged as homophobic following an argument over the state of the communal area. The female resident counter alleged that Adult 1 kicked her, and he stated that she had damaged his property. Each incident, Adult 1 and the female withdrew their allegations, and the police closed the case.

1.17 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. Adult 2 was arrested by police but after an investigation the CPS did not authorise any charges. Adult 1 was arrested for witness intimidation of the arson witness, allegedly requesting

the witness not to proceed against Adult 2. During a conversation with police, Adult 1, gave a notification of Adult 2 taking an overdose. Adult 1 also suggested to investigating officers that he needed to be with Adult 2 because he had Post Traumatic Brain Syndrome and had to care for him. The fact Adult 1 was saying repeatedly to professionals that he was the carer for Adult 2, was never followed up by or assessed by professionals.

1.18 A hate crime, was reported on 13 July 2020, as 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. This incident remains undetected.

1.19 In December 2020, Adult 1 displayed ASB and aggressiveness towards a female cleaner at his accommodation. He was arrested and at court the following morning and was bound over to keep the peace.

1.20 Mental Health concerns by Adult 2 to WMP. In 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 Health Care Professional 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. The driving case was withdrawn due to a technicality and Adult 2 was referred to mental health services.

1.21 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. Adult 2 was arrested for the offence and was subsequently charged with sexual assault in March 2022. Adult 1 was spoken to again regarding witness intimidation by police, as he attempted to ask the female victim not to proceed against Adult 2, which he denied, and no further action was taken.

1.22 Adult 2 was referred to Birmingham and Solihull Mental Health Services (BSMHFT) by his GP in July 2021 for his mental health. His GP requested further assessment and management and was passed to the local Community Mental Health Team (CMHT) with an interpreter for December 2021. He was again assessed on presentation to hospital in November 2021 and a face-to-face assessment was arranged with a psychiatrist with an interpreter in December 2021.

1.23 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.

1.24 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. Their landlord served a Section 8 Notice, using criminal damage and Anti-Social Behaviour grounds to have them leave the premises. The couple made a cross allegation of racist and homophobic abuse against another resident. They were assisted by Solihull Community Housing and the Environmental Service regarding their eviction by their landlord. Both SCH and Environmental Services had concerns for Adult 2's mental health and made separate referrals to ASC and WMP

1.25 In December 2021, Adult 2 attended the Community Mental Health Team (CMHT) for an assessment with a psychiatrist. 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.

1.26 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 which was mutually resolved by the landlord. 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. Police did not progress the allegations. Prior to their eviction, there was an allegation of criminal damage by Adult 2 at the accommodation. When police attended, they located a small cannabis plant on the window sill inside the flat which Adult 1, admitted that he had grown the plant for his own personal use. He was referred to a drugs, alcohol rehabilitation and counselling service, as a community resolution, which he attended and completed.

1.27 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 perpetrator was arrested by police. Adult 2 stated he did not feel safe, and his mental health was affected. The couple were evicted in February 2022 and then were both subsequently concerned in a resident dispute and ASB at their new accommodation.

1.28 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 for the offence when the homicide occurred.

1.29 On 9 June 2022, Adult 2 attended the emergency department presenting with an overdose of his mental health medication with suicidal intent. He and his partner (which was not recorded) called the ambulance. On his arrival to ED, he stated he regretted his actions and that it was an impulsive act after an argument.

1.30 **Police murder investigation and outcome.** On the day of the homicide in July 2022, Adult 2 was arrested. The investigation was progressed by the homicide team under "Operation Winterhold." Following a mental health assessment, Adult 2 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, (Adult 1's cousin Adult 4 informed investigating officers for the subsequent murder trial 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.

1.31 At Birmingham Crown Court in October 2023, Adult 2 pleaded guilty to Manslaughter. Before he could be sentenced, 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. This 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.

1.32 In March 2024, at the Crown Court, the issue in the Newton hearing 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 explanation 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 was then sentence for Manslaughter and received a nine-year custodial sentence. The coroner inquest, which was on hold, was not resumed due to the criminal proceedings, as directed by the Home Office Senior Coroner, for Birmingham and Solihull Districts.

1.33 **Abstract of Findings.** This DHR analysed the IMRs, and the information supplied to the review, and identified eight findings and DHR Recommendations, which are summarised as: -

1.34 **Finding 1. Multi-agency working, referrals, professional meetings, sharing information, record keeping and communication concerns.**

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

- **A multi-agency meeting will be called, or a strategy discussion held where applicable, to make certain, risk assessments and communication between practitioners considers 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.**

1.35 Finding 2. Awareness of the Domestic Abuse Act 2021, Anti-Social Behaviour Guidance and CPS Evidence Led Victimless Prosecutions.

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

- **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.**

1.36 Finding 3. Coercive, Emotional and Manipulative Control, to consider Situational Violence and Identifying a Care Provider.

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

- **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 in compliance with Local and National Safeguarding Adult Policy and Procedures are considered and the outcome shared with relevant agencies to support practice.**

1.37 Finding 4. Supervision, Professional Curiosity and Risk Assessments.

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

- **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.**

1.38 Finding 5. A Review of WMP Domestic Abuse investigations.

DHR Recommendation (5) for West Midlands Police

[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

- **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.**

1.39 Finding 6. Consideration of Mental Health and Mental Capacity Assessments for 'Best Interest' decisions.

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

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.

1.40 Finding 7. Capturing the Voice, Culture, Diversity, LGBQT+, Sexual Orientation and Gender Bias and Hate Crime.

The DHR Panel believed the couples DA, although they were listened to by professionals, 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+ professionals 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 any male DA support. The role and pathway required of available support will be strengthened by the Finding and DHR Recommendation 1 above. LGBTQ+ are funded by the OPCC, and additional capacity has 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 and against their sexual orientation. The family dynamics was not known in any detail and would have been addressed with the family if they had participated in the review, but they and Adult 2 did not respond to the DHR invitations. There was agency recognition and understanding of culture and diversity, the use of interpreters when a person's first language is not English and the need to consider contacting LGBTQ+ and other support services in the future. These factors are acknowledged and captured in DHR Recommendation 1, and within Agency Recommendations which will feature in the Solihull DHR 13 Action Plan, accompanying the review. ***(No recommendation is therefore made).***

1.41 Finding 8. Awareness and Promotion of the SMBC ASC Triage Process of Safeguarding Referrals, existing safeguarding referral pathways and expectations to multi-agency partners.

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.

- **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.**

1.42 **Conclusions.** 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 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. Adult 1 and 2's relationship, with both displaying anger issues between themselves, as recorded in the narrative and anger towards others, especially when intoxicated. Together with the reported mental health concerns and the likelihood of the couple's relationship becoming more volatile and dangerous, this was predictable.

1.43 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 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 (which was only reported after Adult 1's death) and with Adult 2 being charged and after attended his first hearing at court for sexual assault, he took a drugs overdose. These worrying complexities in their day-to-day life, was likely impacting on 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.

1..44 **Publication and dissemination of the DHR.** The Final DHR 13 Report and this Executive Summary and Learning Brief have been prepared for the information of the Home Office, safeguarding practitioners and interested parties. The reports were both signed off by the Safer Solihull Board on the 6th November 2024. A decision as to the publication of the DHR 13 report will be subsequently made by the Safer Solihull Partnership. A DHR action plan accompanies the reports for this review, with details of recommendations implemented or in the process of implementation commenced during the review process in order to save time, ensuring the learning is efficiently promulgated. The reports will be disseminated to LGBTQ + services, and services for male victims of DA now incorporated into the primary specialist community service since 2023.

David Byford
Independent DHR Chair and Author.
July 2025