SAFER SOLIHULL PARTNERSHIP

DOMESTIC HOMICIDE REVIEW INTO THE DEATH OF Mary IN AUGUST 2021

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

EXECUTIVE SUMMARY

Independent Author: **John Doyle**

January 2026

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Preface

The Chair and the members of the Domestic Homicide Review Panel offer their sincere condolences to the family and friends of Mary for their loss. The Chair and the members of the Panel would also like to extend thanks to those services who participated in the Review and assisted the Panel in its work.

The Panel also noted that suicide is not inevitable. Deaths by suicide usually follow a complex history of distress, trauma, and adversity, and occur not because someone wants to die, but because they feel they can no longer live in their situation.

Following the publication of the Government's first Suicide Prevention Strategy in 2012, local councils were given the responsibility of developing suicide action plans through their work with health and wellbeing boards. In Solihull, a multi-agency group is responsible for overseeing the delivery of the suicide prevention priorities, which include reducing the rates of suicide and applying the learning from those who have died by suicide.

This Review will contribute to that learning.

Section One
The Review Process

Incident leading to the Domestic Homicide Review

1.1 This Domestic Homicide Review concerns the death of Mary, who died in August 2021.

1.2 The West Midlands Police investigated the circumstances leading to the death of Mary and concluded that there was no evidence available that her death was a consequence of any third party involvement.

1.3 On a day in mid-August 2021, the West Midlands Ambulance Service received a 999 call concerning Mary. The West Midlands Police were already at the scene of the incident.

1.4 Mary was recorded by the Paramedics as deceased at the scene. The working hypothesis of the West Midlands Police was that Mary had taken her own life and there was no third party involvement.

1.5 The Solihull Community Safety Partnership informed the Home Office – on the xx of xx – that a DHR would be completed.

Significant people in this case

1.6 The pseudonyms in this case were chosen by the DHR Panel. The people referred to within this Overview Report are described, in brief, below:

Name	Age at the time of the critical incident	Relationship
Mary	25 years	Principal subject of this Review
MNA	Not applicable	Mary's Parent and key contact for the DHR Panel
Adult 2	Not applicable	Partner of Mary at the time of the incident.
Adult 3	Not applicable	Previous Partner of Mary
C 1	Not applicable	Child of Mary
C 2	Not applicable	Child of Mary
C 3	Not applicable	Child of Mary

The time period under Review

1.7 At the initial meeting of the Domestic Homicide Review Panel, held on the 9th of August 2023, the panel examined the history of interventions and incidents recorded by the DHR screening process and decided that all individual management reviews and information reports should focus on the contact that agencies had with Mary between the **1st of January 2017** and the time of the critical incident in **August 2021**.

1.8 However, the agencies and services invited to participate and make submissions to the Review were reminded that, if issues arose that were pertinent to the discussions of the Panel that fell outside this time frame, then

such information should still be submitted in order to provide context for the Review.

The Proposed timescale

1.9 The first meeting of the DHR Panel was held on the 9th of August 2023. The Panel met again in November 2023, December 2023, February 2024, April 2024, May 2024, July 2024 and finally on the 3rd of September 2024.

1.10 At the first meeting, the Panel agreed an outline timetable of objectives and actions, the terms of reference and IMR template. This set the course for the completion of the Review and the production of the Report.

1.11 At the second meeting, the Panel began the process of scrutinising the submissions received from participating agencies.

1.12 At the third meeting, the Panel continued to consider and scrutinise the submissions and clarifications from participating agencies.

1.13 At the fourth meeting, the Panel considered a number of other clarifications; the initial submission from the family of Mary, the draft chronologies and narrative.

1.14 At the fifth meeting, the Panel considered the submission made by the Bromford Housing Association, and considered the first 'draft of the Report.

1.15 At the sixth meeting, held in May 2024, the Panel considered the next draft of the Report, considered a number of outstanding actions, discussed engagement with Mary's family and outlined the amendments required for the next draft of the Report.

1.16 At the seventh meeting of the Panel, held on the 4th of July 2024, the Panel considered the revised draft of the Overview Report and began to formulate a number of recommendations.

1.17 At the eighth meeting of the Panel, held on the 3rd of September 2024, the Panel considered the final draft of the Overview Report and agreed that final amendments would be made electronically before submission to the next available meeting of the Safer Solihull Partnership.

The use of pseudonyms, the involvement and views of the family.

1.18 The Review Panel sought to involve Mary's family in the Review. When the Review commenced, the Commissioning Officer and the Author sent a letter to Mary's Mother to inform them that the Review had commenced.

1.19 Mary's Mother responded to the letter and made submissions to the Panel, providing, amongst other things, a "pen-picture" of her Daughter and clarifications concerning elements of the chronology.

1.20 In December 2024, the author of the Overview Report met Mary's family (her Mother and her Sister) and they decided on the name to be used for this Report. They settled on the name Mary.

Section two
A pen picture of Mary.

<u>This submission is from Mary's Mother. The Panel considered that it would remain as restricted circulation until the point of publication. At which point Mary's Mother was invited to decide if any of the content should be redacted.</u>

I am writing this with regard to our much loved Daughter, Mary.

Mary was born in the Summer of 1996 and was a very happy baby. Mary is our second child of 6. Mary has 3 sisters and 2 brothers. Mary was very loving and loved to help look after her siblings especially our youngest child, who is just under 10 years younger than Mary.

Mary loved to bring everyone together, so if there was any chance of a celebration, or a get together, Mary would be the one to plan it. Mary was the life and soul of the party. She would playfully tease her brothers and her sisters and she also taught her own children to do the same. Mary went all out at Christmas, birthdays and any holiday. She would get all of her neighbours and friends together at Halloween and make it fun for the children.

I live with a disability and Mary would come round to our home every day to make sure that I was OK. Mary would also take her Dad lunch *where he worked* in Sheldon as an excuse to pop and see him. Our youngest child was Mary's sister but they were also like mother and daughter. Mary would often turn up to our home and let us know that her sister was staying the weekend with her.

Mary lived with a number of health problems and had heart ablation surgery when she was a teenager. However, this never stopped Mary, even when this condition was compounded by receiving another diagnosis.

Mary also lived with depression since she was a teenager. Her depression seemed to get worse after suffering bullying when she attended *secondary* school in Solihull. Marya was taken out of the school due to a suicide attempt. However, she then went on to complete her level 3 hair dressing at college. Mary loved to do her friends hair and her sisters.

Mary always wanted to have a diagnosis for her mental health but sadly due to the constant changing of her mental health consultants, no diagnosis was made and Mary felt that she was not being treated correctly and was unable to be supported due to this. Mary came to us many times and told us about the mental health team and how they were not listening to her. I called the mental health team on a number of occasions due to Mary being in floods of tears and worried about her mental health. There was one occasion when we had a call with a mental health doctor and the situation got so bad that Mary broke down and refused to speak to him due to not being listened to.

Mary has suffered from domestic abuse in her relationships. She did manage to break away from these but, sadly, this also impacted her mental health.

Mary has 3 children and even though she struggled with her mental health she was an amazing mum dedicating all of her time to her three children.

Mary had to flee from one relationship while pregnant with her second child due to suffering from threats to kill and abuse. These threats came from *Adult 3*. Mary did notify the Police at the time bit she felt that she was not being listened to. She managed to get emergency accommodation. Not long after, she gave birth to her second child. Mary then moved to another property in Solihull; however this property was also very cramped and Mary was trying to move, especially as she had, by this time, her third child.

Mary left her last relationship (with Adult 2). We believe that she ended the relationship because she found out that her youngest child – who was 19 months at the time – was slapped by their father and also her eldest child was also being verbally and physically abused. Mary did not feel that she was able to go to social services as she was worried that her children would be removed from her care. Mary always put her children first and always said how they were her world.

All of this had a huge impact on Mary's mental health. Sadly her mental health got worse during the COVID lockdown where any support she was getting was reduced, even though she was very vocal about her thoughts and worried with regard to her mental health. I also spoke to the mental health team with regard to these concerns about Marya's mental health.

Marya was an amazing daughter, mother, sister and friend. She was loved by many people and even though she struggled herself she would always smile and make other people laugh, especially if they were feeling down. Many friends have said that Mary was an Angel who loved everyone and everything.

Mary sat with one of her friends all through the night due to her friend having suicidal thoughts. Mary's friend said at Mary's funeral that she would not be alive today if Mary had not shown her the love and support that she needed at that time.

Mary, while supporting her friends sadly felt that the mental heath team were not listening to her with regard to her fears and thoughts and this sadly lost Mary's trust. Mary felt she could not ask for help from other agencies – again – due to being let down before.

In August 2021, Mary sadly took her own life. Mary had driven home from Scotland after receiving 'phone calls and messages from her previous partner, *Adult 2*. This had a huge impact on Marya's mental health as she had thought she was going to spend the week with her siblings, her children and her parents for a holiday. She had asked for help from the hospital and the mental health team and while she was in hospital she was receiving messages from her previous partner (Adult 2) and his friend telling her that she needed to come home for the children. One message from *Adult 2's* friend stated "if she was his girlfriend she would be thrown in the canal by now". This, we believe, was a reason why Mary's did not stay in hospital and left hospital thinking that help would be there for her the next morning as arranged. Sadly this help never came.

Following the critical incident, we didn't receive a call or a visit from the Police. We found out what had happened through a family member, who had found out from social media on the day following Mary's death. We then drove home from Scotland while begging the Police for answers as to what had happened. However after many phone calls we still had no details until my husband drove to the Police station as soon as we arrived home.

We had also spoken to the Police about the abuse that Mary and the children had suffered. However this also appeared to fall on deaf ears. The abuse the children suffered took over 18 months before we got answers after many complaints and calls to the Police. A Sgt *from West Midlands Police* dealing with these allegations finally said that they felt there was no abuse from *Adult 2* towards the children. However during a meeting with the children's social worker and *Adult 2, Adult 2* admitted to physically and verbally abusing *Child 1* and smacking *Child 2*. In one incident, when we were on holiday in Scotland, we believe that *Adult 2* had smacked *Child 1* so hard their thigh was bruised. Adult 2 was alone with *Child 1* at the time and Adult 2 told us that *Child 1* had fallen and hurt their leg on the table. We are now working with *Adult 2* who is allowed supervised visits with *Child 2*.

Three children have lost an amazing mother and we have lost our daughter. Mary was a breath of fresh air. She was so loving and caring and no matter how much time goes by we cannot and never will recover from her passing and the way in which she passed. We have been left heart broken. We honestly feel that we still have no answers and that Mary's death could have been prevented. Women should not fear losing their children, they should not fear going to agencies for help and that help does not come.

We also feel that the way in which Mary's death was told to us should have been more professional. It should not have taken family members to tell us, nor should they have to explain to Police that we should be informed.

Nothing will bring Mary back. However if we can prevent another family from suffering from such a great loss by ensuring that all agencies (including the Police, Social Services, and others) support women in these circumstances. For example, services need to ensure that pressure is not being put on women by abusive partners to leave hospital and other care service. If that could happen, then this review will have proven that agencies have learnt from their mistakes. It will also give us some hope that others will not suffer in the way Mary has. However I do not feel that as of yet lessons are being learnt and mistakes are being rectified.

Contributors to the Review

2.1 The following agencies made submissions to the Panel:

Agency	Nature of submission
Solihull Education Services (Schools and Early Years)	IMR and Chronology
Solihull Community Housing	IMR and Chronology
Solihull MBC – Children's Services	IMR and Chronology
University Hospitals Birmingham	IMR and Chronology
Birmingham and Solihull Mental Health NHS Foundation Trust	IMR and Chronology
West Midlands Police	IMR and Chronology
Birmingham and Solihull Integrated Care Board	IMR and Chronology
Birmingham and Solihull Women's Aid	IMR and Chronology
Bromford Housing Association	Short Report

Parallel Reviews

2.2 The Panel noted that the Birmingham and Solihull Mental Health NHS Foundation Trust conducted a 'Root Cause Analysis Report' into the circumstances leading to the critical incident. This report was completed in November 2021 (three months after the incident occurred). It should also be noted that the lead officer for that Review attended the Panel and described the process undertaken and the recommendations made.

Coroner's Inquest

2.3 As a matter of courtesy, the Office of the Coroner was informed by letter (from the Author and commissioning authority) that the Domestic Homicide Review was taking place and the expected time frame of the Review.

2.4 The Panel noted that the Area Coroner for Birmingham and Solihull issued a Regulation 28 Report (Prevention of Future Deaths) in this case.

Review Panel Members

2.5 Following the notification of the death of Mary, the Safer Solihull Partnership informed the Home Office that they would undertake a Domestic Homicide Review and to commission this Review under the auspice of the Solihull MBC.

2.6 Panel members were appointed based on their seniority within relevant and appropriate agencies and their ability to direct resources to the review and to oversee implementation of review findings and recommendations. The members of the Panel were selected by their agency because they had no direct service contact with any of the subjects of the Review.

2.7 The members of the Panel were independent. They had no direct connection to the subjects of the Review, they had no operational or supervisory involvement in the case and no immediate line management responsibility for the authors of the IMR and Chronology submissions.

2.8 The views and conclusions contained within this overview report are based on findings from documentary submissions and transcripts and have been formed to the best of the Review Panel's knowledge and belief.

2.9 The members of the Panel are described in the table below:

Agency
DA Service, Public Health, Solihull MBC
DHR Team, Public Health
West Midlands Police Review Team
Safeguarding Service and Senior staff, University Hospitals Birmingham NHS Foundation Trust
Public Health, Solihull MBC
Public Health, Solihull MBC
Education Service, Solihull MBC
Safeguarding Service and staff – Integrated Care Board
Solihull Community Housing, Community Safety Partnership
Senior Nursing service, Birmingham and Solihull Mental Health NHS Foundation Trust
Children's Services
West Midlands Police Investigating Team
West Midlands Ambulance Service
Solihull Community Housing Service
Birmingham and Solihull Women's Aid
Education, Outcomes and Intervention Service
Solihull Adult Social Care
Independent Author

***** For the avoidance of risk and to the protect their safety, the names and precise roles of the members of the Panel are not included in this Report.

The Author of the Overview Report

2.10 The Commissioning Authority (Solihull Council) appointed an independent Author, John Doyle, to oversee and compile the Review. John has extensive experience in public health management and has acted as author in several DHRs. John has completed the Home Office training concerning the completion of DHRs. John spent thirty years in public service and, having achieved registration at Consultant level with the UK Public Health Register, left the NHS in 2013. John had no connection with the subjects of the Review, no connection with any of the agencies involved in the review and no connection with the Commissioning Authority.

Section three
The Terms of Reference

3.1 The Panel noted that the over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity; and
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

3.2 The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

The Key Lines of Enquiry

a. Describe the nature of any contact your agency had with Mary.

b. Describe, if appropriate, the nature of any contact you had with Child 1, Child 2 and/or Child 3.

c. Did your agency know or have reason to suspect that Mary was subject to any form of domestic abuse or assault at any time during the period under review (or prior to the formal scope of this Review, if the information is pertinent).

d. Had any mental health issues been disclosed by Mary – or any of the subjects listed in this Review? Did any other agency in contact with them inform your agency of a diagnosis of any mental illness?

e. Was your agency in contact with members of the extended family of Mary, Adult 2 or Adult 3 or their friends or colleagues?

NOTE:

When describing the information you have regarding Mary, this may include, coincidentally, information about Adult 2 and/or Adult 3; and about Child 1, Child 2 and/or Child 3. However, at the time of writing, the DHR Panel does not have consent to receive any confidential patient/client information specifically from the records concerning Adult 2, Adult 3 or Child 1, 2, or 3. Please use your discretion when deciding to share this with the Panel or seek advice from your information governance office, the commissioning authority (Solihull MBC)

f. Did any member of the extended family (or friend, or colleague) share with you any information concerning the safety of Mary or any potential risk from Adult 2 or Adult 3?

g. Was your agency aware of any additional complexities of care and support required by Mary and were these considered by your agency or, to your knowledge, any agency in contact with them?
h. Did your service complete appropriate assessments of risk and, where necessary, make referrals to other appropriate care pathways. If so, briefly describe them.
i. What actions (if necessary) did you take to safeguard Mary (and their dependents) and do you consider these actions were appropriate, timely and effective?
j. Was Adult 2 and/or Adult 3 known to your agency as a perpetrator of domestic abuse or violence?
k. If so, what actions were taken to assess their risk to themselves and/or to others?
l. Were there any other issues that may have increased the risks and vulnerabilities of Mary?
m. Does your agency have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding services?.
n. Was the interface between the application of the Mental Health Act and the Mental Capacity Act considered by your agency and/or by the agencies you were working with?
o. What impact did the management of the initial phase of the COVID-19 Pandemic have on your service?

Section four
Summary Chronology

Pre-scope
Having considered the information shared by Mary's Mother (described in the previous section), the Panel sought information from the School attended by Mary and from the child and adolescent mental health services (CAMHS).

Fortunately, there were members of staff still working at the School who recalled Mary's attendance as a Pupil. For the purpose of context and clarity, the School noted the following points:

- Mary presented with a number of issues that had an effect on her physical and mental health;
- There were incidents of bullying at School. These were managed by the families involved, with the support of specialist services. As a consequence, a number of pupils were suspended. Social media, particularly Facebook – was a significant problem and a contributory factor in the bullying behaviour.
- It was noted that Mary did not start year 11 – CAMHS were involved and she was deemed unfit for school. Alternative provision was sought but this didn't happen. Mary was taken off the School roll at the end of the Autumn term 2011.

Within the formal Scope

2017
In mid-March (13th), Mary attended an appointment for a medical assessment via the Chronic Fatigue Syndrome (CFS) clinic. She reported that she had separated from her partner due to domestic abuse and she now had a restraining order in place against him. Mary reported symptoms of low mood and anxiety and stress. Mary did not meet the criteria for a diagnosis of CFS and she was discharged to the care of her GP.

2018
On the 25th of January, Mary had a face-to-face appointment with the midwifery service. Mary disclosed domestic abuse. Also on the 25th of January, it was recorded that Mary disclosed historic Domestic Abuse to School A (the first school attended by Child 1). The community midwifery service made appropriate referrals, including a referral to the children's social care service.

On the following day, the West Midlands Police noted an amber MASH request for a strategy discussion (the MASH is the Multi-Agency Safeguarding Hub. It is a multi-agency arrangement established to discuss risk and vulnerability and to respond to concerns for residents in Solihull). The MASH agreed an outcome for children's services to complete an assessment. Birmingham and Solihull Women's Aid (B&S Women's Aid) also noted a referral received into the Multi-Agency Risk Assessment Conference (MARAC) from West Midlands Police.

At the beginning of March, Solihull Community Housing noted that Mary approached them as homeless, noting that she was fleeing domestic abuse. Mary was interviewed. The Housing Options Officer agreed a homelessness duty and re-housed Mary and Child 1.

On the 16th of April, a Children and Family Assessment was completed. The assessment identified a risk of recurring domestic abuse and a likelihood of this pattern continuing without intervention. The assessment recommended that Child 1 and Child 2 (unborn at this point) be subject of a Child in Need plan.

Towards the end of October, Solihull Community Housing noted that Mary had been awarded a Band B priority on the housing register and was later offered a Bromford Housing Group tenancy. Mary's tenancy started on 2nd November 2018. Later in November, Child 1 was enrolled at School C

2019

In February (6th), Mary's GP recorded that Mary reported flashbacks to when she was physically abused in the previous year; that she wakes in the night; and was keen for counselling.[1] Mary stated that the abuse ended last year and Mary now had a new partner, Adult 2.

On the 19th of March, Birmingham and Solihull Mental Health NHS Foundation Trust (B&SMHFT) recorded a referral from Mary's GP requesting an assessment because Mary was reporting to have depression and was 10 weeks into her third pregnancy. The referral was discussed in the Perinatal Team's multi-disciplinary team (MDT) meeting. It was agreed that a home assessment would take place.

On the 9th of April, B&SMHFT noted that Mary was seen at home for assessment. Mary reported that her current partner (Adult 2) was supportive; she felt safe in their relationship and denied any domestic abuse. Mary reported that she had been a victim of domestic abuse in previous relationships. Positive observations of the home conditions and Mary's interactions with her youngest child were recorded. Medication options were discussed. It was agreed that the practitioner would liaise with the Health Visitor to see if any additional support was available and to clarify safeguarding actions.

On the 13th of April, Mary was seen at Solihull A&E Department following a mixed overdose due to an increase in low mood, poor sleep, panic attacks at night when thinking about her abusive ex-partner. During the assessment, she was seen alone and was asked how she felt about her pregnancy. She was encouraged to discuss any concerns, but she denied that she had any other concerns to share. She described her parents and current partner as very supportive, and her partner stayed with her once a week.

Over the following 10 days, B&S MHFT made two home visits to Mary.

On the 7th of May, B&SMHFT visited Mary at home. Her oldest child was at school, her younger child noted to be sleeping in their cot. Adult 2 was present. Mary reported that she had been advised by a relative that the father of her youngest child had commenced a relationship with a woman living in the flat very close to where Mary

[1] The Panel learnt that counselling is not provided by B&SMHFT. However, Birmingham Healthy Minds (BHM) is B&SMHFT's Primary Care Mental Health Service that GPs refer into for talking therapy. There was no evidence of a referral from the GP or a self-referral from Mary to BHM.

lived and this had raised her anxiety. She planned to contact her housing officer for advice and was also considering contacting the Police and Women's Aid for advice.

On the 10th of June, B&SMHFT noted that Mary's Care Programme Approach (CPA) review was completed at home. Mary advised that she neither wanted nor needed any additional support stating that her family and Adult 2 were supportive. It was agreed that the Community Mental Health Team (CMHT) practitioner would liaise with the Health Visitor to ensure that the needs of all of the family members were being considered. It was agreed to:

- Continue Mary's medication;
- The CMHT Practitioner would visit every 3 weeks;
- The CMHT Practitioner would liaise with the Health Visitor and Midwife;
- Mary would receive monitoring for additional support;
- There would be a Perinatal review in 6 weeks;
- Information from the CPA review would be shared with the Health Visitor , the Midwife and the CMHT Doctor.

On the 28th of August, Mary was seen at home by the CMHT Practitioner. The children were present and Adult 2 was away at work. Mary reported to be coping well and was taking her children out when Adult 2 was not at work.

Mary was seen by her GP Practice on the 21st of November. It was recorded that Mary reported that her low mood was worse, she was tearful, had poor concentration and a lack of motivation. Mary did report passing suicidal thoughts, but she was clear she had no plans and no intent. Medication compliance was recorded as good.

On the 26th of November, B&SMHFT (Perinatal Team Practitioner) attended a face-to-face appointment with Mary. All 3 children were present. It was noted that Mary was responsive to the children's needs and supported by her mother with their care. Mary requested to be discharged from the Perinatal Team to the continuing care of the Community Mental Health Team (CMHT). A Medical review with the CMHT was arranged for the 17th of December. A letter was sent to the professionals involved in her care. Mary was to be referred back to the Perinatal Team if any of those professionals had any concerns.

2020

On the 9th of January, Mary completed an online housing register application for a larger property. The Tenancy team reviewed the application and awarded Mary a Band D.

Between the 10th of January and the 28th of April B&SMHFT made attempts to contact Mary on eight occasions – the majority by telephone and one by a visit to Mary's home address. The attempts were made by a CMHT Practitioner. Each time, if Mary was not able to respond, a voicemail was left. Following calls on the 10th of January and the 30th of January, Mary responded to the voicemail and called back.

From the 10th of January to the 7th of May, there were no significant contacts with Mary or her family. It was noted by the Panel that, during this period of time, regulations were in place to manage the initial phase of the COVID Pandemic.

When the author met with Mary's family, they informed him that during the early phase of the management of the COVID Pandemic, Mary's Sister was staying with her and that Mary was still seeing the services, those that she was usually in contact with, on a monthly basis.

On the 7th of May, B&SMHFT completed a medical review by telephone. Mary reported variable mood and it was noted that Mary stated that on occasion it had been a struggle to care for her children, but Mary reported that they were well. Mary reported regular contact with Adult 2, who was living with his mother, as well as support from her family and friends.

On the 1st of July[2], a CMHT Practitioner from B&SMHFT called Mary on the telephone. She reported that her mood was stable but that it had plateaued and wanted to consider a different medication. Mary stated that she felt able to keep herself safe and reported to be supported by Adult 2 and her Mother.

On the 20th of August[3,4] Mary reported to the Doctor at the CMHT that she had mood swings and a lack of energy. Mary denied any thoughts of self-harm. Changes were made to Mary's medication and it was agreed to arrange a follow-up appointment in 3 months.

On the 11th of December[5], the Duty Practitioner at the CMHT returned a call to Mary. Mary reported a deterioration in mood, increased anxiety, poor sleep and dissatisfaction with the effectiveness of her medication. The Duty Practitioner sought advice from the Doctor and this was relayed to Mary. The Doctor advised a change to the medication and for the Practitioner to make a follow-up call the following week.

2021

On the 22nd of January[6], Mary submitted a medical form to Solihull Community Housing, with a request for alternative housing due to the additional needs of Child 1. A band B medical priority was awarded by the Medical Advisor within Solihull Community Housing.

On the 26th of January, Bromford Housing Group opened a safeguarding case for Mary. The Neighbourhood Coach from Bromford Housing made a referral to the Solihull MASH team because Mary disclosed to the Coach the following information:

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[2] 4th of July 2020: most remaining national restrictions are removed as pubs and restaurants re-open.

[3] 14 August Lockdown restrictions eased further.

[4] 14th of September 'Rule of six' – indoor and outdoor social gatherings above six banned in England. 22nd of September PM announces new restrictions in England, including a return to working from home and 10pm curfew for hospitality sector

[5] 2nd of December, Second lockdown ends after four weeks and England returns to a stricter three-tier system of restrictions; 15th of December PM says Christmas rules will still be relaxed but urges the public to keep celebrations "short" and "small"; 19th of December PM announces tougher restrictions for London and South East England. Christmas mixing rules tightened; 21st of December Tier 4 restrictions come into force in London and South East England; 26th of December, more areas of England enter tier 4 restrictions

[6] 4th of January PM says children should return to school after the Christmas break, but warns restrictions in England will get tougher. One the 6th of January 2021: All areas of England are moved into Tier 4's stay at home restrictions. This is the third national lockdown

> "Previous DV had occurred around two years ago (~2019). Mary was worried that her ex-Partner now knew where she lived (due to family members making contact with a neighbour)".

Mary's family informed the author of the Overview Report that Adult 3 had generated false Face-Book accounts and was 'terrorising' Mary to the point where she became frightened not only for herself, but also for her family.

Mary alerted the Police, who, at that stage, could not take any action as no incidents had occurred. The Neighbourhood Coach requested additional locks for security, as requested by Mary. On the same day, Mary approached the homeless service for a second time, advising that she was in fear of Adult 3. Mary and her 3 children were offered temporary accommodation by the Housing Options Officer. However, this offer was not accepted by Mary. Housing Options were discussed with Mary and she initially agreed to accept a referral to The Sanctuary Scheme. However, she later requested to withdraw this referral and did not continue with her homelessness assessment.

B&S Women's Aid recorded that a referral had been received by the Independent Domestic Violence Advocate (IDVA) hosted by Solihull Community Housing. A call was made to Mary and a call was made to Bromford Housing to discuss security measures.

On the 11th of February, B&SMHFT received a telephone call from the Mother of Mary who reported Mary was struggling with her mental health, her anxiety was bad and she was struggling with housing issues. A telephone call was made to Mary who reported her mood was very low, she was anxious, her medication did not appear to be effective, that her suicidal thoughts were getting worse and frightening her. Mary reported that her children were her protective factor. A request was made for an urgent medication review. B&S Women's Aid also made a call to Mary to discuss concerns and offer support.

On the 4th of May, the Doctor from the CMHT completed a further medication review with Mary over the telephone – noting low mood, and poor sleep. The Doctor recorded that Mary had no thoughts of harm to self or others. On the same day, a referral to the 'Aids and Adaptations' section of Bromford Housing was made by the Neighbourhood Coach for a 'Super-Secure' front door for Mary's address.

On the 21st of June, West Midlands Police were contacted by Mary. She reported that she had been woken up by her partner (Adult 2) who asked to borrow her car. She did not give him permission to use it as she required it for the school run. Adult 2 then left the room. Mary looked out through the window and saw Adult 2 in her car. Mary informed Adult 2 that if he drove off she would contact the Police and the relationship would be over. Adult 2 drove away in Mary's car. Mary called the Police to report this and Adult 2 returned during the call. Adult 2 got into his own vehicle and left the location again. When the author of the Overview Report met with Mary's family, they informed him that Mary's Mother had called Adult 2 and advised him to return Mary's car and that if he did not, she would call the Police.

A short while later, B&SMHFT received a call from the Mother of Mary reporting that Mary was getting worse and needed medication. Mary's Mother advised that both she

and Mary felt Mary had bi-polar disorder but was not medicated for this. BSMHFT noted that bipolar disorder would be discussed at the next medical review.

On the 1st of July, Solihull Community Housing received a further medical form from Mary reporting physical health problems that were getting worse as a result of the current property. Additional information was requested.

On the 28th of July, Mary sent an email to the children's social care service. Mary requested a letter of support for housing. The content of her email included her sharing feelings of 'severe anxiety'. She referenced previous involvement due to domestic abuse, and described a living space which she felt was not suitable for the children. The decision was made to close the referral with no further action. The manager of the service recommended that Mary be advised that, unfortunately, this did not meet the threshold for a housing support letter to be submitted.

Towards the middle of August, during the night-shift, Mary presented to the A&E Department and was referred to the Psychiatric Liaison Team. Mary reported low mood and suicidal thoughts; that she had taken an overdose whilst on holiday with her family, and then driven home that day by herself. She reported that her medication was ineffective, that she had been self-harming, and was hearing voices.

When the author of the Overview Report met with Mary's family, they cast some doubt over the suggestion that Mary did take a deliberate overdose whilst still on holiday with her family. The family questioned the suggestion because it would be unusual and very out of character for Mary to drive such a long distance on her own with her children in the car.

Mary was offered a one-off medication – a prescription medicine to settle her agitation. The medication was prescribed and dispensed, but Mary declined the medication. Mary was assessed as having the capacity to make this decision. Mary was then offered a transfer to the Psychiatric Decisions Unit, which she declined. Mary told the staff that what she wanted to do was to go home to her own bed and try to get some sleep. She was reported to be positive about her recovery. Mary stated that her children were: "her world and gave her a reason to live and recover". Mary denied any further plan or intent regarding suicide. Mary was agreeable to engage with crisis support via the Home Treatment Team – who would contact her the following day.

Mary was given crisis telephone numbers should she require any support through the night and she was discharged from the Psychiatric Liaison Team. A referral was made to the Home Treatment via email, and a diary task was recorded for the day shift co-ordinator to contact the Home Treatment Team and confirm receipt of the referral.

A short time later, the critical incident occurred.

Section five
Key issues arising from the Review

These themes are not in any order of priority:

Enduring mental and physical health difficulties
Mary endured a long period of mental health difficulties. This included reports of anxiety, low mood and there were also reports of self harm. Within the formal scope of this Review, Mary also disclosed episodes of suicidal ideation.

The Panel also learnt that Mary was bullied when she was at School. The circumstances describing these adverse events are described in the chronology. It is recognised, of course, that events such as these can have a lasting and significant impact on mental health in adulthood.

Additionally, the Panel learnt that Mary was diagnosed with a number of physical health conditions, some of which she lived with from a young age.

The impact on children
Taking account of the published literature, the impact upon the children living in the property with Mary and her Partner(s) may have been significant. Children are also the victims of domestic abuse when they are in the same household and witness such incidents being perpetrated against their Parent. Coupled with other factors, there may have been a significant impact on Mary's parenting capacity – not her competence to be a parent, but her resilience to cope, and her confidence to manage the circumstances she found herself in.

The Panel underlined the key point that services should not consider that children are a protective factor for parents[7]. Whilst this view may be maintained by the Parent(s) – for reasons that are understandable – the opposite is always true: parents should protect their children.

The stress of relationships and ex-Partners
There was certainly a significant degree of stress generated by Mary's ex-partners. This was particularly the case with Adult 3.

There are a number of incidents, set out in the chronology, that describe Adult 3 making threats to Mary and her children, using social media platforms to intimidate Mary, using the same platforms to pester the friends of Mary to disclose her whereabouts.

Disclosures of abuse, recognising abuse and responding to it
Mary made disclosures concerning domestic abuse. Referrals were made to B&S Women's Aid and the IDVA Service. There is a need to understand that domestic abuse can happen even though the person is no longer in a relationship with the person that abused them

[7] NSPCC paper (parents with Mental Health problems; learning from case reviews, 2015) advised that children should not be considered protective factors and risk can increase where this is the case.

The Panel was aware that Mary's ex-partner did use social media in order to make attempts to discover where Mary lived. Again, the Panel assumed that this would undoubtedly cause distress and fear. The Panel also considered that this fear (or terror) may have been magnified – not just because it was an ex-partner making the attempts to find her, but also by the knowledge that there were people in close proximity to her informing her ex-partner of her whereabouts and her daily activity. This active 'seeking' by the ex-partner and the proactive sharing of information would be an egregious burden to bear.

Securing a mental health diagnosis and treatment

Mary had a recorded diagnosis of Emotional Dysregulation at her last medical review (under the Community Mental Health Team – CMHT). Mary had queried whether she had Bi-polar Disorder, and a referral was made to the Specialist Bi-Polar Service. This referral was declined as the service was not a diagnostic service. However, the Panel acknowledged that Bi-Polar Disorder was being considered as a diagnosis at the time of Mary's death.

The Panel was advised that Mary was not formally diagnosed with EUPD. This was the *impression* following her assessment with the Liaison Psychiatry Team the day before the critical incident occurred. This assessment, completed by nursing staff, is not within the remit of nursing staff to diagnose. However, they can record their *impression* based on the presentation of symptoms at the assessment.

As a part of the discussion concerning this matter, the Panel noted that EUPD is a complex diagnosis. The manifestation of EUPD may effect the way that patients can present to clinicians; there may be inconsistencies; it may be complicated by incidents of domestic abuse; it may affect the perception of precisely how much insight a patient may have into their mental health and, if a patient does have insight, it may affect their confidence, to act on that self-awareness.

Response to Mary by services in contact with her

There were two MARAC referrals within the scope of this Review. The Panel did note the following points:

a. There was no active involvement from the adult social care service;
b. There was an escalation of safeguarding concerns for Mary's children, but not for Mary;
c. It was not clear if Mary would have been eligible for a 'Section 42' triage process;

Response to Mary's children by services in contact with the family

The Panel noted that there was no consent to consider matters that were included within the specific and confidential records of each child. However, the Panel, when reviewing the information concerning Mary, would inevitably receive what may be termed peripheral information about the children as a coincidence of receiving information about Mary. The Panel noted that:

- Sharing information between early years and education settings is extremely important. This should include contemporaneous information as well as important historical information.
- The production of 'SMART' action plans is a cornerstone of the procedures for protecting children and such practice should be recognised and promoted.

Section six

Conclusion

The Domestic Homicide Review Panel that completed this Review recognised, of course, that this Review concerned a suicide. In these circumstances, where no homicide had occurred, the West Midlands Police and the specialist homicide staff from other Support services were not in a position to allocate resources to support Mary's family and her friends. Consequently, in comparison to other Domestic Homicide Reviews, there was no direct face-to-face contact with an experienced professional who could introduce the Domestic Homicide Review process to any of Mary's family. This placed the Panel in the position of attempting to make direct contact with Mary's family. Setting aside the effort made by the Panel to make a mindful introduction to the process, it was, nevertheless, an invitation that was received 'out-of-the-blue'. It was, fortunately, very fruitful and the Panel extends its sincere thanks to Mary's Mother and Sister for their help in completing the Review and for sharing their perspective on the Review and the Recommendations it makes, their recollections of Mary and for their patience.

The West Midlands Police investigated the circumstances leading to the death of Mary and concluded that there was no third party involvement in her death. The Panel did receive submissions that suggested that Mary was the subject of domestic abuse and violence by a number of previous Partners. The degree, frequency and type of abuse she endured is described elsewhere in this Report.

When considering this Review for Mary, the Panel noted that, when working with Mary, a number of agencies recorded some key characteristics, including an extensive history of depression and anxiety, and an extensive history of physical health conditions that required management throughout her life.

The Panel noted that Mary had a clear insight into her mental and physical health conditions and was very open and willing to engage with the many services made available to support her.

This was a tragic case for the Panel to review. The information received described a woman who lived for many years with depression and anxiety, lived with physical health problems and also lived with abuse and violence for a number of years. It appeared that the circumstances that Mary lived with – and had lived with – became so grievous to endure, she decided to take her own life.

Mary was a loving Mother, Daughter, Sister and a friend to many. The Panel offer their condolences to Mary's family and her friends.

Section seven
Lessons to be learned by the agencies submitting information.

West Midlands Police

7.1 Following an inspection by His Majesty's Inspectorate of Constabulary, Fire and Rescue Service (HMICFRS) in June 2023, West Midlands Police has already begun to address the issue of poor-quality investigations. The West Midlands Police has implemented a new model into how crime is investigated and by which departments. Local investigation teams now investigate a broader range of crimes including neighbourhood crimes. Training has been developed to assist officers in achieving higher quality investigations.

7.2 This change has already had a positive impact on outcomes. In April 2023 the positive outcome rate for total recorded crime was 6.6%, by September 2023, the figure was 9.5%. To further improve the quality of investigations the force will be addressing:

- Response attendance times.
- The use of investigation plans.
- Delays to the investigations.
- The exploitation of investigative opportunities.
- The general effectiveness of investigations.
- The use of victim contracts, in line with Victim Codes of Practice.
- The way crimes are finalised.
- The overall effectiveness of supervision.

7.3 Though not a specific issue concerning the West Midlands Police, when the author of the Overview Report met with Mary's family, they expressed concern that they discovered what had happened to their Daughter by receiving a call from Mary's Sister. The family were in Scotland (on a holiday – from where Mary had returned home a day earlier) and returned home as soon as they received the dreadful news.

ICB for General Practice

7.4 The Author of the submission from the Integrated Care Board noted that the ICB need to consider the children being referred to as a "protective factor". This was the case when Mary was clearly struggling with her emotions and her mental health. A situation magnified by her enduring physical health conditions.

Education

7.5 The Education settings noted the way the nursery and schools developed positive relationships with Mary and Child 1. Schools, of course, see children and often parents every day and are therefore well-placed to provide emotional support. This is particularly the case where schools are engaged on particular issues, for example, good information sharing by the community midwife with school A meant that they could explain processes to Mary and ensure that she understood what was happening.

7.6 Nursery/schools have been reminded about expectations around the transfer of safeguarding files, timescales and the need to respond if files are not

received. Incidents requiring MASH referrals/enquiries have also been identified and discussed with the nursery/schools.

7.7 Domestic abuse training has been signposted for staff and links have been sent for suicide awareness training.

7.8 The links between childhood trauma and children's behaviour, risks associated with abusive relationships ending and victim blaming language are being addressed through the design of a specific training opportunity. Additionally, record keeping and making referrals will be addressed at the forthcoming DSL conference.

7.9 Potential opportunities to safeguard Child 1 were missed. There was often a lack of professional curiosity being shown. There was no evidence of professional dialogue and/or supervision which may have led to better decision-making.

Solihull Community Housing

7.10 Solihull Community Housing noted that, ideally, cases of this nature should be dealt with face to face rather than over the telephone. However, due to the pandemic all interactions with Mary were via the telephone.

7.11 Solihull Community Housing did note that good multi-agency working was demonstrated throughout this case. In addition, it is apparent that the staff acted in a timely manner to ensure that Mary and her children's housing needs were dealt with promptly, particularly in view of the serious risks posed to them by Adult 3 and that appropriate alternative safe accommodation was quickly sought.

7.12 Where ASB was identified on the second medical self-assessment form, a referral should have been made to the Solihull Community Housing Neighbourhood Services Team for investigation. This would have triggered a call to the Bromford Housing Group to make them aware.

7.13 It is important for staff to document all discussions as part of their standard case management procedure to ensure a consistent chronology is maintained. Additionally, where mental health is identified through medical self-assessment forms, closure should only occur following confirmation with the individual concerned.

Children's Social Care

7.14 Working with children and adult victims of Domestic Abuse needs more consistency, both internally within Children's services and in joint working with other services. Intervention directly delivered by Children's services needs a clear framework, a structure with a clear recording and monitoring format. As per the domestic abuse Act, support for children who live in a family where abuse occurs, need to be considered as they are victims in their own right.

7.15 If families consent, then it should be considered as a default position to share information about the advice and interventions provided by other services, such

as those provided by Women's Aid. Consideration should be given to including review information from the DASH and any information concerning coercive control. This information should be used to monitor change within a standardised domestic abuse pathway and this process should be built into the case management system.

7.16 There was an absence of work with the perpetrator of Domestic Abuse. Without careful and informed practice, language and planning can be 'victim blaming' or place a burden on the victim to compensate for the risk from perpetrators. Although Children's Services must place paramount consideration on a child's safety, this is an area for improvement. Some of this is already being actively worked on. For example, there is currently a perpetrator working group, whose aim is to trial an offer for perpetrator intervention by the end of 2023. Children's services also have an improved domestic abuse mandatory training programme, which all staff are expected to attend.

7.17 When Mary sought help directly (two weeks prior to the incident occurring), there was a failure to speak meaningfully to Mary. Better practice would have been to show professional curiosity. She was not spoken to directly by a social worker and the lack of conversation did not allow for any understanding of the children's experience of her current state of mind. Had this been done, there may have been a more constructive or considered response.

7.18 However, processes have been now changed so that all referrals are screened by a social worker, and screening involves triangulation with other agencies. It is assumed by the Panel that if Mary made contact at this point in time, she would have been spoken to directly by a social worker. There is also a daily domestic abuse triage meeting, and an IDVA is based within the MASH team, who would be in a position to contribute to referrals involving domestic abuse concerns, including offering signposting and advice.

7.19 Whilst noting these improvements, there is still learning to be gained from this Review in terms of exercising a greater degree of 'professional curiosity'.

7.20 It was noted that the Midwifery service was involved and supported Mary and contributed to the Children's services assessment and plan. But other agencies sharing information with Children's services is not always consistent or focussed. There are already plans for improvement in this area. There will be senior management oversight to allow more audit and practice development in this area.

7.21 CIN plans were unclear, the outcomes not adequately recorded and evidence of achievement was not clearly recorded. Plans need to be outcome focussed to prevent ending any intervention due to compliance rather than any meaningful change.

7.22 The author also noted that more options for learning and understanding concerning mental health and impact on parenting would be useful.

University Hospitals Birmingham

7.23 Since Mary disclosed domestic abuse, University Hospitals Birmingham has employed 2 IDVAS from Women's Aid to work in the Trust with both patients and staff. They work alongside the staff in the Emergency Department to deliver training and education regarding how to ask about Domestic Abuse and providing the correct support.

7.24 There is also an ongoing programme of training which includes asking about Domestic Abuse. Currently, the Emergency Department training is at 91% for mandatory training and 93% for enhanced training. Asking about Domestic Abuse will be included in the risk assessment procedure and this requirement is currently in progress with the relevant IT team as an automatic prompt.

B&S Mental Health Foundation Trust (BSMHFT)

7.25 The Mental Health Trust noted:

- The importance of following BSMHFT's Care Programme Approach policy to ensure appropriate and safe decision making when considering a 'step-down' to Care Support;
- The importance of reviewing social situations and the impact of this on mental health upon duty contacts and medical reviews, in context of assessing risk and formulation of risk management plans, as per BSMHFT's risk management policy and when there is evidence of deterioration in a service user's mental wellbeing. These service users should be brought to an MDT meeting for team discussion to support care and risk management planning;
- Need for clear guidance/ process for out of hours referrals to Home Treatment Teams be outlined in urgent care Standard Operating Procedures;
- It is best practice to seek collateral information from family/ people close to the service user where possible in order to support care and risk management planning

B&S Women's Aid

7.26 Risk and safety planning was evident throughout the record of contacts with Mary. When Mary engaged with the service, it was a positive experience and Mary shared information willingly and told the service what she needed.

Section eight
Recommendations from the Review

The Solihull Community Safety Partnership (known as: "Safer Solihull Partnership") will be the body to oversee the progress made to deliver these recommendations.

1. The Panel recommends the Safer Solihull Partnership:

Seeks assurance that the 'roll-out' of the current improvements being delivered by the Children's Social Care Service are delivered. That in circumstances such as those described in this review, improvements include:

- recording SMART outcomes on client records;
- seeking and recording the voice of the child (to comply with the Domestic Abuse Act 2021 – to see children as victims of abuse);
- becoming better informed about the impact of mental health on parenting;
- to become trauma informed in practice; and
- working with Perpetrators of domestic abuse and violence

2. The Panel recommends the Safer Solihull Partnership:

- Invites the Children's Social Care Service to be explicit with regard to the threshold for providing support to a client who directly requests assistance with re-housing; and
- To receive an assurance that the services involved in providing the assistance with re-housing have an agreed process for triangulating information from other services (this will include assurance that there is an effective arrangement for sharing information with other services where it is necessary and appropriate).

3. The Panel recommends the Safer Solihull Partnership:

Invites the head of the Solihull Community Housing Service to clarify the procedure for supporting, or not, an applicant who has a diagnosed mental health condition, or conditions, who is seeking appropriate accommodation.

4. The Panel recommends the Safer Solihull Partnership:

- Supports the ambition to offer IRIS training to every GP Practice within the Solihull area;
- Seeks assurance from the ICB that a process for the accurate and effective coding of domestic abuse is available within each Practice

5. The Panel recommends the Safer Solihull Partnership:

Invites the University Hospitals Birmingham NHS Foundation Trust and the Birmingham and Solihull Mental Health NHS Foundation Trust to provide assurance that NICE Guidance PH50 and NICE Quality Standard 116 are in effect in the services offered to patients and staff.

6. The Panel recommends the Safer Solihull Partnership:

Seeks assurance from the agencies and professionals supporting this Review that the key elements contained within the Confidential Inquiry into Suicide and Mental Health are being delivered across Solihull (including, for example, real time surveillance of suicide, etc)

7. The Panel recommends the Safer Solihull Partnership:
Liaise with the Solihull Education Improvement Service to develop and deliver a programme of training for DSL's and Deputy DSL's.

Single agency Actions

8. The Panel recommends the Safer Solihull Partnership:
Invites the Integrated Care Board to work with the Safer Solihull Partnership to develop and deliver a plan to assist practitioners to challenge the notion that children are a "protective factor" for their parents. Evidence from this and other Reviews suggests that this perspective, if offered by parents who are enduring mental health problems and/or domestic abuse and violence, should trigger an enhanced degree of professional curiosity and an offer of support to those parents.

The Panel recognised that a number of Single agency changes have been proposed and/or delivered since the time that the critical incident occurred.

9. The Panel recommends the Safer Solihull Partnership notes the following developments and actions:

1. That communication between NHS Hospital Trusts and Children's Social Care Services has improved. The Trusts now use the 'NHS portal'. The portal initiates the first contact and ensures that the correct contact is made

2. Nurses now attend all meetings of the Multi-Agency Risk Assessment Conference (MARAC). They have access to shared care records and can see all of the relevant health related information (including some 'cross-border' information). They can share information and then, following the MARAC meeting, they can send GPs a MARAC notification informing them of the incident, any concerns raised, and any actions that are required

3. Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) recognised the issue concerning 'collateral information' not being sought from Mary's family prior to her discharge from the Psychiatric Liaison Team. They have agreed to lead on a piece of work to raise the profile of family engagement in urgent care services and devise an action plan and assurance process. It is anticipated that a report to consider the next steps will shortly be completed. **The Panel recommends the Safer Solihull Partnership receives a timely update on the progress toward achieving this goal**

4. Birmingham and Solihull Mental Health NHS Foundation Trust has complied and responded to the **Regulation 28** ruling delivered by the Office of His Majesty's Coroner.

Appendix 1

Bibliography

Mental Health and Wealth: Depression, Gender, Poverty, and Parenting | Annual Reviews - the "results" section gives quite a good overview.

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Domestic and family violence and parenting: mixed methods insights into impact and support needs (apo.org.au) - DV and parenting

Intimate partner violence victimization and parenting: A systematic review - ScienceDirect - DV and parenting

Parenting stress: A novel mechanism of addiction vulnerability - ScienceDirect - this article specifically correlates parenting stress with increased vulnerability to substance abuse.

Mental Health and Wealth: Depression, Gender, Poverty, and Parenting | Annual Reviews - maternal depression and intersectionality with other issues e.g. poverty etc