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

OVERVIEW REPORT

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January 2026

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The Coronavirus-19 Pandemic

On the 31st of December 2019 the World Health Organisation (WHO) Office in the People's Republic of China picked up a media statement by the Wuhan Municipal Health Commission on cases of 'viral pneumonia' in Wuhan. The Country Office translated the media statement and passed it to the WHO Western Pacific Regional Office. At the same time, the WHO's Epidemic Intelligence Team picked up a media report about the same cluster of "pneumonia of unknown cause" in Wuhan.

On the 1st of January 2020 the WHO activated its Incident Management Support Team and on the 2nd of January informed the Global Outbreak Alert and Response Network (GOARN) about the cluster of pneumonia cases.

The UK Government issued a statement in Parliament on the 23rd of March 2020 stating that people 'must' stay at home, work from home, maintain social distance and that certain businesses must close. This has been described as the date when the first of a number 'lockdowns' and/or geographical tiered restrictions commenced in the UK.

The harm caused by the pandemic has been profound and distressing, and this has been exacerbated by the effect of the lockdown on usual social activity – socialising, schooling, shopping, going on holiday, and going to work. The effect on the public services has, at times, been almost overwhelming as the capacity to manage the impact of the pandemic has been tested to breaking point.

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 1. Background

This Domestic Homicide Review concerns the death of a young woman. For the purposes of anonymity, she is referred to in this Report as Mary. The incident occurred in August 2021.

Section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act) states:

> *(1) In this section "Domestic Homicide Review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:*
>
> *(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
>
> *(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.*

1.1 Incident leading to the Domestic Homicide Review

1.1.1 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. 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.

1.1.2 The Solihull Community Safety Partnership informed the Home Office in April 2022 that a DHR would be completed.

1.2 Significant people in this case

1.2.1 Both pseudonyms and the name for the subjects in this case have been chosen by the DHR Panel. The family of Mary will be given the opportunity to assign more appropriate names. The significant 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

1.3 The use of pseudonyms and involvement of Mary's family

1.3.1 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.

1.4 Purpose and conduct of the review

1.4.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act 2004. This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set out in the guidance.

1.4.2 This Review has been completed in accordance with the regulations set out by the Act referred to above, and in line with the latest revisions of the guidance issued by the Home Office in 2016 to support the implementation of the Act.

1.4.3 As described above, this particular case was referred by the West Midlands Police for the consideration of a DHR in accordance with Section 2, Paragraph 18, of the DHR Guidance.

1.5 The time-period under review

1.5.1 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**. However, the Panel, in communication with the agencies involved in the Review, requested that if any agency had any relevant information outside of this period, then this information should be included in the individual management review and chronology.

1.5.2 The parameters of the formal scope were removed because a number of agencies did hold records from 2016 concerning a number of subjects of this Review.

1.6 Proposed timescale

1.6.1 As noted, 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.

1.6.2 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.

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

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

1.6.5 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.

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

1.6.7 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.

1.6.8 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.

1.6.9 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.

1.7 Statement of Confidentiality

1.7.1 The members of the Panel were cognisant of the protocol concerning confidentiality. The submissions made by all participating agencies were confidential and were not for circulation to other agencies or professionals outside the DHR process.

1.8 The Conduct of the Review and methodology

1.8.1 At its first meeting, the DHR Panel approved the use of an Individual Management Review (IMR) and Chronology template. The Commissioning Officer from the Solihull Metropolitan Borough Council contacted each participating agency and invited them to make their submissions in accordance with the timetable established by the Panel. The level of compliance with this request was excellent.

1.8.2 The IMR Authors were not directly involved with the subjects of this case. IMR reports were quality assured by a senior manager from the participating agency and they countersigned the report.

1.8.3 Copies of IMRs were circulated to all the DHR Panel members prior to the scheduled meetings. The IMRs were then discussed and scrutinised by the Panel and significant events were cross referenced and any clarifications that were considered necessary from the IMR author were invited.

1.9 The Conduct of the Review (contributors and Panel members)

1.9.1 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.

1.9.2 The Panel received reports from agencies and dealt with any associated matters such as media management and liaison with the Office of the Coroner.

1.9.3 The Commissioning Authority (Solihull MBC) 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.

1.9.4 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.

1.9.5 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.

1.9.6 The agencies represented by 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.

1.9.7 Contributors to the Review

1.9.8 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

1.10 Parallel Reviews

1.10.1 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.

1.11 Coronial matters

1.11.1 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.

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

1.12 The Purpose of a Domestic Homicide Review

1.12.1 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.

1.13 The purpose of a DHR and the specific Terms of Reference and Key Lines of Enquiry for this Domestic Homicide Review can be found in Appendix 2

1.14 Equality and Diversity

1.14.1 The review panel was committed to the ethos of equality, openness, and transparency. The review panel considered all equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to Mary.

1.14.2 There was no evidence that Mary was directly discriminated against by any agency based on the nine protected characteristics described by the Equality Act 2010 *i.e., Disability, Sex (gender), Gender reassignment, Pregnancy and maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.*

1.14.3 The Panel considered the implementation of the Equalities Act and discussed the impact of the legislation on the services that were in contact with Mary. It

was noted that equality law recognises that bringing about equality may mean changing the way in which services are delivered. This is the 'duty to make reasonable adjustments' to the way things are done and the way services are provided in order to make them useable by everyone eligible to use them.

1.14.4 The Panel noted the guidance from the UK Government, stating that if an organisation providing facilities or services to the public or a section of the public, finds there are barriers to people in the way it does things, then it must consider making adjustments (in other words, changes). If those adjustments are reasonable for that organisation to make, then it must make them.

1.14.5 The Panel also noted that this duty is 'anticipatory', meaning that an organisation cannot wait until a person with a specific need covered by the legislation wants to use its services, but must think in advance (and on an ongoing basis) about what disabled people with a range of impairments, might reasonably need, such as people who have a visual impairment, a hearing impairment, a mobility impairment or a learning disability.

1.14.6 The question posed by the Panel for those agencies in contact with Mary was whether:

- the way it operated
- the physical feature of its premises, or
- the absence of an auxiliary aid or service

created a barrier which would have placed Mary at a substantial disadvantage compared with other people using the service.

1.14.7 Mary was of European heritage and had three young children.

1.14.8 Public Health research has found that people who live with a disability are more likely to experience domestic abuse, they also experience domestic abuse that is more severe, more frequent and lasts for longer periods[1]. Research has also suggested that people with disabilities experience domestic abuse in wider contexts and by greater numbers of significant others, including family members.[2]

1.14.9 The Panel learnt that Mary lived with a number of mental health and physical health conditions – some of which were long standing. These conditions included, but were not limited to, the following:

- Anxiety
- Depression
- Fleeting thoughts of suicide
    - Toward the end of the formal scope of this review, Mary also reported – on at least one occasion – an incident of auditory hallucination[3]
- Fibromyalgia
- Hashimoto's Disorder
- Chronic pain and fatigue

[1] *Disability and Domestic Abuse, Risk, impact and response*, Public Health England, 2015
[2] Hague, G., Thiara, R. and McGowan, P. Making the Links: Disabled Women and Domestic Violence. London. Women's Aid, 2007.
[3] Mary was not diagnosed or treated for any form of psychosis

- Mary also reported, on a number of occasions, that she had difficulty sleeping – informing her Doctor that she "….had difficulty settling her mind".

1.14.10 Two agencies represented on the Panel – West Midlands Police and Solihull Children's Services – noted that, at various points within the formal scope of the Review, Mary was recorded as having some degree of learning disability. However, neither of the agencies could clearly identify – with certainty – where the information had originated. Both West Midlands Police and Children's Services concurred that this information was shared with them by members of Mary's family (not by Mary herself), primarily her Father.

1.14.11 When the author of the Overview Report met with Mary's family (in December 2024), they confirmed that Mary did live with dyslexia.

1.14.12 The information concerning a possible degree of learning disability was shared at both of the multi-agency arrangements considered in this Review – the MARAC and the MASH.

1.14.13 Solihull Children's Services reacted positively to the information and ensured that the outcome from their assessments reflected the possibility that Mary may have had a learning difficulty. West Midlands Police recorded that whilst they noted in the record that Mary may have had a learning disability, there was never a requirement to appoint a specific advocate when responding to incidents involving Mary. None of the services involved in the Review – after checking their records – could confirm that Mary's learning disability was ever formally 'diagnosed'.

1.14.14 Both Mary's physical and mental health diagnoses led to Mary receiving a number of prescribed medications – including treatments that would help to manage a cardiological condition diagnosed in childhood, through to receiving prescribed medication to stabilise Mary's a mood.

1.14.15 The Panel noted, particularly, the issue concerning Mary's diagnosed cardiological condition and considered that living with anxiety and some degree of sleep disorder may well have exacerbated this matter. Mary's family informed the author that soon after the point when Mary was diagnosed with this condition (in childhood), she was severely bullied at School. The family recorded that Mary was pushed in front of a car and beaten very badly. The Police informed Mary's Mother that this incident had occurred.

1.14.16 Mary received regular medication reviews for the management of her mental health – receiving at least the minimum of one review each 12 months – and also regular medical reviews to assist in the management of her physical health conditions.

1.14.17 The Panel was also cognisant of the fact that a disproportionate number of women are the victims of domestic abuse and violence. The research conducted by SafeLives clearly demonstrates the threat of violence and terror experienced by women in everyday life. The key statistics collated noted the following:

- Women are much more likely than men to be the victims of high risk or severe domestic abuse;
- 130,000 children live in homes where there is high-risk domestic abuse.
- 62% of children living with domestic abuse are directly harmed by the perpetrator of the abuse;
- On average victims at high risk of serious harm live with domestic abuse for 2-3 years before getting help.

1.14.18 The research published by SafeLives also noted the following characteristics of the victims of abuse:

- **Low income**
- **Age:** Younger people are more likely to be subject to interpersonal violence. The majority of high risk victims are in their 20s or 30s.
- **Pregnancy:** Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incident of violence happened whilst they were pregnant
- **Separation:** Domestic violence is higher amongst those who have separated, followed by those who are divorced or single
- **Previous criminality of the perpetrator:** domestic abuse is more likely where the perpetrator has a previous conviction
- **Mental health issues:** 40% of high-risk victims of abuse report mental health difficulties

1.15 Dissemination of the Overview Report

1.15.1 The dissemination of the final Overview Report and Executive Summary will be undertaken in accordance with the procedure approved by the commissioning authority and the Home Office. The Overview Report and Executive Summary will be circulated to:

- The Solihull Community Safety Partnership (Safer Solihull)
- The Office of the Coroner
- The Office of the Police and Crime Commissioner for the West Midlands
- All agencies involved in the review
- The Office of the Domestic Abuse Commissioner
- Members of Mary's family (to be determined)
- The Office for Health Improvement and Disparities.
- Birmingham and Solihull Learning from Deaths Committee

Section 2. Background information – the facts

2.1 A pen picture of Mary – the focus of this DHR

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.

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. Mary 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 Mary's mental health.

Mary 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 Mary'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.

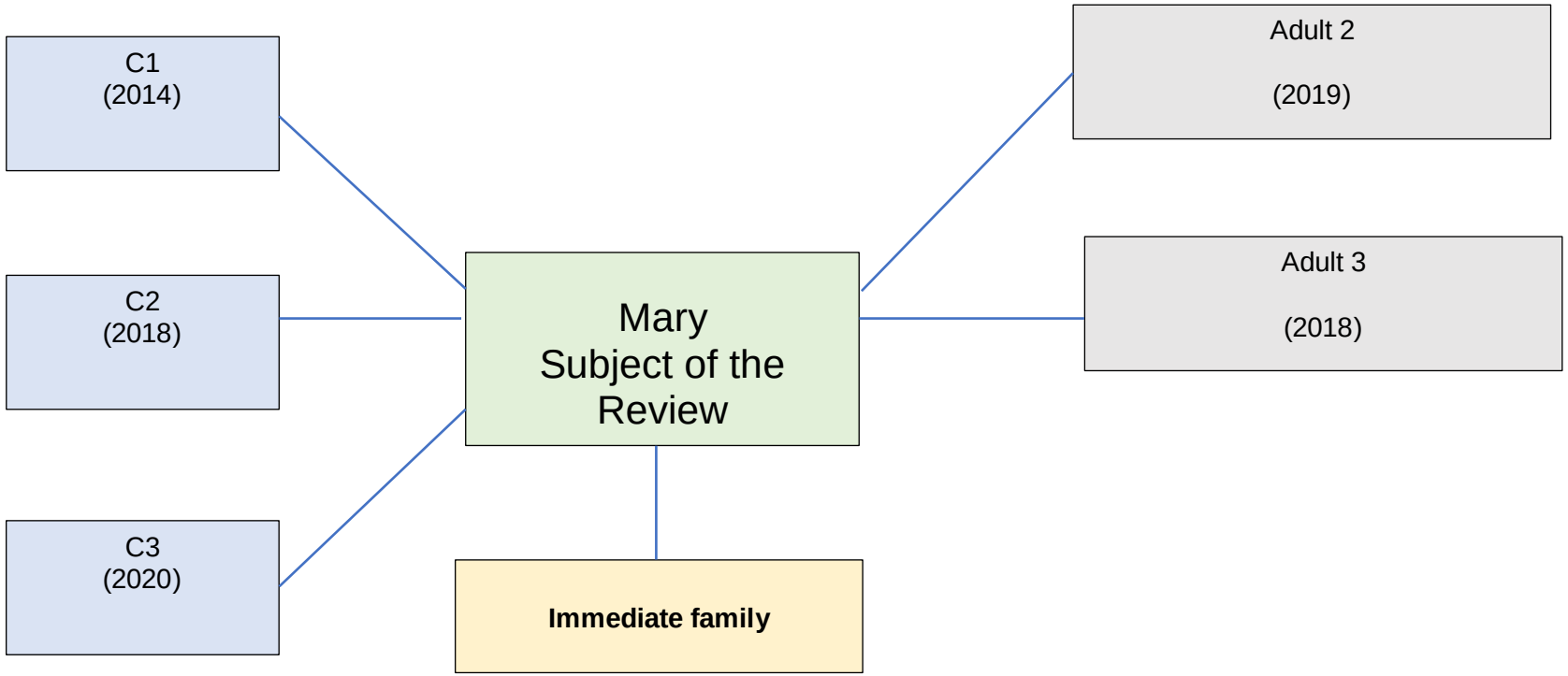
We had also spoken to the Police about the abuse that Mary and the children had suffered. However this also appeared to fall on deaf ears. The abuse the children suffered took over 18 months before we got answers after many complaints and calls to the Police. A Sgt *from West Midlands Police* dealing 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.

GENOGRAM FOR Mary



Section 3
Abridged 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.

Comments were made by the School Adviser at the time and these can be found in **Appendix 3**

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.

In late April (28th) a Social work Children and Family Assessment was completed. Part of this assessment considered parenting capacity and acknowledged Mary's vulnerability to harm from Perpetrators.

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.

In mid-March, B&S Women's Aid called Mary. Mary asked for her file to be closed as she said she did not require any ongoing support. Mary was advised of available support and Mary's risk was reviewed before closing the file. B&S Women's Aid provided updated address details to the Public Protection Unit (PPU) at West Midlands Police so that a marker could be placed on Mary's property before closing the file.

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.

On the 18th of May, Solihull Children's Social Care Service made a visit to Child 1. Mary and Child 1 were seen in the property of the maternal grandparents. Mary reported not being in a relationship with Adult 3. She reported being offered support by a mental health midwife in addition to other antenatal care.

On the 26th of June, the first meeting of the Child in Need Plan took place. The main actions were Mary being signposted to Women's Aid for support.

Towards the end of July, Child 2 was born.

On the 24th of August, a meeting was held and the Child in Need plan in respect of Child 1 and 2 was closed. The reasons for closure were:

- Mary's engagement with professionals;
- Advice from women's aid to Mary;
- A Police marker on the current address;
- Mary's accommodation issues were being addressed.

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.[4] Mary stated that the abuse ended last year and Mary now had a new partner, Adult 2.

[4] 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.

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. She reported that there was no contact with her previous, abusive partner and he did not know where she lived so she felt safe. Mary was referred to the Home Treatment Team. It was recommended that Mary's mental health care be managed by the Community Mental Health Team (CMHT), and that Mary should not be discharged back to her GP at that time.

Over the following 10 days, B&S MHFT made two home visits to Mary. On the first visit, Adult 2 was present whom she reported she had been in a relationship with for a year and he was very supportive. A medical review was agreed for the next day.

On the second visit, Mary was assessed as low risk of harm as she had support in place. Mary reported that Adult 2 was very supportive and stayed with her once a week. Mary said that her Parents lived 10 minutes away and were looking after the children. A referral was made including a request for a care co-ordinator (an allocated mental health practitioner).

On the 23rd of April, B&SMHFT undertook an assessment for Mary at her home. It was noted that a referral had been made to Children's Social Care following Mary's presentation at A&E on the 13th of April. The Health Visitor advised that they had liaised with Children's Services and that the referral had been closed and Mary had declined Early Help support. Mary's case was to be discussed at the Multi-Disciplinary Team and a perinatal medical review was to be booked. It was also agreed that the Health Visitor would visit every 4 weeks.

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

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 14th of May, the Perinatal Team Practitioner saw Mary at home. Adult 2 was also present. The eldest child was at school, the younger child was sleeping. It was noted that Mary was to have a home visit from the newly allocated Care Co-ordinator on the 15th of September 2019 and that the Perinatal service planned to monitor her mental health at the clinical base. It was agreed it would be useful to have a joint visit with the Care Co-ordinator so that Mary and all professionals involved in her care were aware of their involvement and contacts in respect of her care plan. Adult 2 reported that Mary was doing well and that he would be supportive to her and the children and that he was aware of who to contact if he had any concerns.

Mary's GP undertook a medication review, and engaged in correspondence with B&SMHFT.

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. It was recorded that Mary was sharing the care of the baby with Adult 2. Mary reported she was safe in her relationship and denied any domestic abuse. It was noted that her previous partner was visiting a woman in her apartment block but Mary stated this was no longer the case and she had not had any contact from him. 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.

On the 17th of December B&SMHFT noted that Mary attended clinic and reported a deterioration in her mood and was tired from looking after her children. It was recorded that she cared for her children well. It was recorded that she had good family support. It was agreed that Mary's medication would be amended and that a review would occur in 4-6 months.

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 26th of February, the calls made were unsuccessful – the calls made in April could not be connected or the number was said to be unavailable.

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 19th of May, Mary's GP completed a telephone-consultation (due to Covid 19 restrictions). Mary reported ongoing mental health issues of anxiety and depression. Mary was struggling to sleep, stating that she could not get her mind to settle, but that she was able to care for her children. Mary stated that her Partner (Adult 2) saw her daily and was supportive. Mary was worried that a lack of sleep would make her mental health deteriorate. The GP advised Mary to keep in contact with the Mental Health Team and advice was given on crisis management.

On the 1st of July[5], 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.

[5] 4th of July 2020: most remaining national restrictions are removed as pubs and restaurants re-open.

On the 7th of August, Mary contacted her GP requesting help with sleep as she was waking frequently in the night. Mary reported no suicidal thoughts, but stated she felt a little hopeless and helpless.

On the 20th of August[6,7] 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[8], 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[9], 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:

> "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

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[6] 14 August Lockdown restrictions eased further.

[7] 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

[8] 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

[9] 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

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 9th of February, Solihull Children's Social Care noted a multi-agency referral from Bromford Housing. Mary reported that Adult 3 had been trying to find out where she was living. She was worried for her safety. Mary was spoken to by a social worker. Level 3 early help support was offered to Mary, which was declined. The Housing Officer confirmed that they were fitting locks on the property. Staff from Women's Aid confirmed that they were offering support t Mary, completing their safety planning work and completing a risk assessment. They stated that they will also be liaising with housing and speaking to them and will also offer Mary the opportunity to go into a refuge if necessary

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 24th of February, the Duty Practitioner from the CMHT received a telephone call from Mary requesting medication as she said her GP would not prescribe her new medication without CMHT guidance. This matter was resolved. Mary also reported that she often had suicidal thoughts, but with no intent. The Duty Practitioner discussed this matter with the Doctor and, with Mary's agreement, it was decided that a new medication was to be prescribed.

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 18th of June, B&SMHFT received a telephone call from Mary reporting mood swings, excessive energy and at the same time, consistent low mood. Mary said she was experiencing suicidal thoughts but with no intent. Mary also said that she had stopped taking her medication and her sleep was very poor. Mary requested sleeping tablets and a trial of a mood stabiliser.

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 2nd of July, the Doctor from the CMHT completed a review with Mary. They recorded low mood, mood swings and poor sleep. Mary denied any intent to harm herself. Mary commenced a mood stabiliser prescription and she was referred to the Bipolar service (the referral was sent on the 16th of July) for a second opinion regarding a diagnosis.

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. No screening enquiries were undertaken and there was no record of any further discussion with Mary.

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 hearing voices telling her that her children weren't safe and to kill herself.

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, per se, 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 4: Combined narrative
Overview of what the services involved knew

Hindsight bias

The Panel recognised that hindsight bias can lead to over-estimating how obvious the “right decision” would have looked at the time. It would be unwise not to recognise that

a DHR will lend itself to the application of hindsight and that looking back to identify lessons often benefits from such practice. That said, the Panel made every effort to avoid this inherent bias and has, as best it can, viewed the case and its circumstances as it would have been seen by the individuals involved at the time.

All the agencies involved in this review provided candid accounts of their involvement in order to identify the lessons to be learned, which are considered later in this Report. The involvement of each agency is captured in different periods of time and it is important to note that some of the contacts that are reflected here and later in the report, hold more significance than others.

Birmingham and Solihull ICB – Submitting on behalf of general practice

The GPs were aware that Mary had been a victim of domestic abuse in the past. Mary was referred to and supported by the mental health team. The GP Practice always acted promptly to requests made by Mary and the Practice called Mary when there were no appointments available in order to re-arrange and re-book.

The contact between General Practice and Mary was characterised by:

- Good communication – including via telephone and text messages;
- Prompt referrals were made to other specialist services;
- Mary's notes make it clear that the GPs and the Practice staff had an understanding concerning both Marys physical and mental health needs.

Solihull Education Services (Schools and Early Years settings)

School A

Child 1 attended School (A) from October 2017 to March 2018. It appeared that no records were shared with the school by the nursery. However, contact was made regarding the involvement of the Solihull Specialist Inclusion Service.

At the end of January 2018, the School contacted Mary and discussed with her the information shared with them by the community midwife. Assurance was sought by the School that Mary felt safe collecting and dropping off at nursery, which she did.

School B

Child 1 attended School (B) from April 2018 to October 2018. Mary disclosed historic domestic abuse. The Designated Safeguarding Lead (DSL) and Deputy DSL made a home visit to Mary and Child 1. In November 2018, the School noted that, in accordance with information shared with them by Mary, Child 1 had not returned to school after the half term. The School made a telephone call to Mary who shared that she had moved to another part of the borough and so could not get Child 1 to School.

School C

Child 1 attended this School between November 2018 and July 2021; and Child 2 attended between September 2020 and September 2021.

Solihull Community Housing

Mary's involvement with Solihull Community Housing was as a tenant, a homeless applicant and a housing register applicant. Mary held a tenancy from 2015 to 2018.

Mary first approached the service as homeless on the 7th of March 2018. She was fleeing domestic abuse. Mary was offered a tenancy with the Bromford Housing Group, which commenced on the 2nd of November 2018.

As noted in the chronology, Mary approached the homelessness service for the second time on the 26th of January 2021. A Sanctuary Scheme referral was offered. Mary did not provide the additional information required for the Sanctuary Scheme and instead, on the 1st of March 2021, decided to withdraw her homeless application expressing that she wished to pursue the Housing Register application only.

Solihull MBC – Children's Services[10]
Mary engaged very well with this Service. However, the Child in Need (CiN) plan appeared to have ended without addressing some of the needs identified for the children in the initial assessment, and the reasons for closure included Mary's level of engagement and compliance with the plan, rather than change having been achieved.

Although there were 2 occasions when work had been recommended, and reference to some work occurring in 2017, there was not a full record of what had actually been completed.

University Hospitals Birmingham
Mary maintained contact with the Hospital throughout the formal scope of the Review and received support for her medical needs, and also support for two pregnancies.

Mary was known to various medical teams and domestic abuse was identified as a concern whilst Mary was pregnant with her second child. A Safeguarding referral was made for her children.

Mary accessed emergency care on three occasions – once for back pain and twice for mental health concerns.

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT)
Assessment of risk of domestic abuse:
Within the time frame of the review, the first report of Mary being a victim of domestic abuse was made in March 2017, when she was assessed in the Neuropsychiatry's Chronic Fatigue Syndrome (CFS) clinic. At this time, Mary advised that her relationship had recently broken down due to domestic abuse, and she had obtained a restraining order against the perpetrator. Mary described a long history of depression and anxiety, which appeared to have been exacerbated by her social situation. As noted in the chronology, Mary was referred back to her GP.

Mary was referred to B&SMHFT services again in March 2019 when she was 10 weeks in to her third pregnancy and she was referred on to the Perinatal Mental Health Team. When Mary was assessed, her history of being a victim of domestic abuse was explored. Mary reported that she had been a victim of domestic abuse in her relationship with two previous partners. In relation to her current partner; Adult 2, Mary

[10] The Panel noted that, due to the time between the incident and the Review, some of the practitioners involved no longer work for the service. The Panel also noted that there have been significant changes to processes and practice since the critical incident occurred.

described him as supportive and she denied there was any domestic abuse in their relationship.

A short time after this assessment, Mary was seen by staff in the Psychiatric Liaison Team because she had taken a deliberate overdose. On the following day, Mary was seen by staff from the Home Treatment Team.

Out of Hours Referral from the Psychiatric Liaison Team to the Home Treatment Team:
The outcome of Mary's assessment by the Psychiatric Liaison Team on the night of the critical incident was that she was to be referred to the Solihull Home Treatment Team. However, the referral did not reach the team and this was not identified until the following evening.

West Midlands Police
It is important to note that a significant number of the incidents described do not directly involve Mary. They involve Mary's previous Partners (prior to Adult 2). Consequently, the description of these incidents is very brief. The Panel took the view that providing any further details would detract from the main focus of the narrative – which is Mary. However, reference to the incidents is included to provide a clear description of why Mary was frightened by her previous Partner and their associates.

On the **15/02/2017,** a Child Abuse non-crime (CANC) was recorded. This incident was an amber MASH referral for Child 1 when Mary informed staff at the nursery that her ex-partner had assaulted her. A strategy meeting was held on 16th February 2017.

On the **08/03/2017** Mary called the Police to report that an ex-Partner had threatened to attend her flat and kill her and her friend. An officer attended and when Mary informed the officer of an earlier incident where her shoulder was dislocated, an ABH assault was recorded. Mary stated that she did not report the matter at the time due to fear of the ex-Partner. Mary would not provide a statement and declined to complete a Domestic Abuse Stalking and Harassment (DASH) assessment. A referral was made to the National Centre for Domestic Violence (NCDV) for assistance to obtain a non-molestation order. Mary was re-contacted on the 11th March where she confirmed she was not supportive of a prosecution and would not allow access to her medical records. She confirmed she was applying for a non-molestation order and hoped it would be in place by the following week. There was no evidence to meet the threshold for a charge or to consider a victimless prosecution.

On the **05/05/2017** the Birmingham Family Court issued a non-molestation order with conditions.

On the **26/01/2018** an amber MASH request for a strategy discussion was received. This was in relation to concerns for C1 and an unborn child (C2). Adult 3 had threatened to take the baby from her once born. Mary had not reported this to Police because she was scared.

It is recorded on the report that there was also a call from Mary's mother later that day, stating Adult 3 had assaulted Mary at Christmas but Mary had not made any disclosures of the assault to the attending officer. The officer contacted Mary a second

time and requested a visit to discuss this information, but Mary refused. The classification of the incident was changed from a harassment to an assault based on the information provided by Mary's mother.

On the **07/03/2018** a report was created following an amber MASH referral with a view to taking the case to an Initial Child Protection Conference (ICPC). The report referred to the allegation that Adult 3 had assaulted Mary on the 31st December 2017. On the 15th March 2018 the strategy discussion decision was a section 47 single agency investigation. It was established that since the request, Mary had moved from her property. It was agreed further assessments of Mary and her children were required.

On the **21/06/2021** West Midlands Police were contacted by Mary concerning the unauthorised taking of a motor vehicle. Mary reported that she was awoken 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. Mary refused to provide a statement or support any Police action. A DARA was completed and the risk assessed was standard.

Birmingham and Solihull Women's Aid

BSWA's interaction with Mary was relatively limited. BSWA engaged with Mary on her terms and provided information when she engaged with the support offered. Mary did not feel that ongoing support was required and this resulted in the first referral being closed in 2018, at her request, and the second (in 2021) being closed due to contact being lost.

During each contact there was evidence that risk was assessed and safety plans were put in place. BSWA noted that there was some evidence that Mary was either unwilling or not yet ready to talk about abuse. The Independent Domestic Violence Advocate (IDVA) from the housing service had intended to explore risk more thoroughly with Mary. However, this wasn't possible as Mary had disengaged from the service.

Mary was referred into BSWA's Multi-Agency Risk Assessment Conference (MARAC) team on the 14th of February 2018. Contact was established on the 21st of February. However, Mary wasn't able to engage with the service until a further call on the 9th of March. Mary's file was closed soon after this date, at Mary's request.

Mary was the referred into the BSWA housing IDVA service on the 27th of January 2021 by Solihull Community Housing. Contact was established on the 1st and 2nd of February and a request was made to the Landlord for home security measures to be put in place.

On the 9th of February, contact was received from Solihull Children's Service advising that they had received a safeguarding referral from the landlord (Bromford Housing). This contact outlined the support being offered and the engagement from Mary.

The next successful contact made by BSWA was on the 10th of February 2021 and again on the 15th of February. A text message was sent on the 2nd of March – simply to "check-in' – followed by an email on the 5th of March. Mary replied to the e-mail but didn't confirm a time to meet. Hence, this was followed up on the 9th of March and again on the 11th of March. Mary's case file was closed on the 18th of March due to a lack of contact. Relevant partners were kept informed and updated as required.

Bromford Housing Association
Mary was supported by two Neighbourhood Coaches during her contact with Bromford Housing. As part of the Neighbourhood Coach role, Bromford Housing complete an annual review with all customers. Bromford Housing noted that Mary engaged with Annual reviews on the following dates: 20.03.19, 27.03.20 and 19.10.20.

The Panel noted that the Neighbourhood Coach from Bromford Housing was contacted by Mary's Mother (after the critical incident) to discuss the tenancy and to share her thanks to the Coach for the support provided to Mary.

Section 5
Responses to the Key Lines of Enquiry[11]

It is important to note that the responses set out below are determined by the line of enquiry and the agencies that were able to respond to the enquiry.

[11] The lines of enquiry are contained within the Appendix

To avoid the burden of repetition, if an agency (listed elsewhere in this report) had no additional comment to make in response to a specific line of enquiry and had described their involvement more fully in the narrative and/or chronology, then no response is offered in this section.

It should be noted that a number of agencies have produced 'single agency action plans that address specific lines of enquiry. Hence, not all of the services involved in this review have made full submissions against each specific line of enquiry.

A Describe the nature of any contact your agency had with Mary.
It is important to note that the details concerning contacts with Mary are described in detail in the abridged chronology and/or the combined narrative. Hence, the responses recorded here are retained if they add additional contextual information and/or provide greater insight into the learning from the Review.

Additionally, the Panel noted that, when agencies described the information they had 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, it was very important to be aware of the fact that the Panel did not receive consent to consider confidential patient and client information specifically from the records concerning Adult 2, Adult 3 or Child 1, 2, or 3.

West Midlands Police
Mary was connected to 28 investigations in the West Midlands Police area, dating from 2008 to 2021. It is important to note that sixteen of these incidents were prior to the formal scope of this Review.

Also outside the formal scope of this Review, but pertinent to the discussions of the panel, it was noted that in 2015, Mary's father made a Clare's Law application on her behalf. He made the request as he was concerned for Mary, who he stated was a vulnerable adult. He reported that he suspected she was being controlled by her partner and that her partner was being violent towards her. Mary's Father suggested that Mary had depression and learning difficulties, but no more details regarding this were recorded at that time.

Birmingham and Solihull ICB (B&SICB) – for General Practice
Good communication with Mary was noted, particularly via telephone and text messages. Mary was prescribed appropriate medication for both her mental health and her physical health conditions.

As noted previously in the Report, the Panel noted that Mary received, as a minimum, an annual review of her mental health medication and an annual medical review.

Solihull Community Housing (Solihull Community Housing)
Mary made two housing register applications, thus:
Homeless approach – Housing Register application 1 – 7th of March 2018
A statutory homelessness duty was accepted on 24th May 2018. Mary was provided with a Band B priority on the Housing Register due to being eligible, qualifying and statutorily homeless.

Homeless approach – Housing Register application 2 – 9th of January 2020
On 13th January 2021, Mary submitted a medical self-assessment form to Solihull Community Housing, relating to her households' medical circumstances. This was assessed and a Band B medical priority was awarded on 17th February 2021. A further medical self-assessment form was submitted on 1st July 2021.

Children's Social Care
Solihull Children's Services had several periods of involvement with Mary's children. These directly involved Mary, who held parental responsibility and was the children's main caregiver.

The Panel noted that there were 4 referrals made, between 2019 and 2021, none of which led to involvement beyond initial checks and screening information. In summary this included:

- In April 2019, Children's services received a referral from hospital due to Mary being admitted to hospital following an intentional overdose.
- In October 2020, an action was generated via the MARAC process to make enquires to establish what contact Adult 3 was having with Child 2.
- In February 2021 a referral from the Housing department was received after Mary reported feeling worried for her safety because Adult 3 had been trying to find out where she was living.
- The last contact, prior to the critical incident, was a referral from Mary herself directly into children's services, asking for support to assist her housing move application. This was declined and Mary was signposted back to housing.

Solihull Education Service
Mary had contact with four education and early years services (3 schools and 1 nursery) during the timeframe of this review. Details are described in the chronology

University Hospitals Birmingham NHS Foundation Trust
University Hospitals Birmingham had a number of contacts with Mary, including appointments concerning cardiology, ante-natal care, endocrinology, pain management, respiratory medicine and via the emergency department.

B&S Mental Health Foundation Trust
Mary's first contact with Birmingham and Solihull Mental Health Trust (B&SMHFT) services was in 2015 when she seen by the Psychiatric Liaison Team at the Queen Elizabeth Hospital with mild depressive symptoms. Within the scope of the Review, BSMHFT engaged with Mary concerning the following matters:

- In March 2019, Mary was referred with feelings of low mood and anxiety. Mary was allocated to Practitioner 1's case load and in April 2019 Mary's antidepressant medication was increased. Less than a week later, Mary took an overdose and was referred again to the Psychiatric Liaison Team;
- Following their assessment, Mary's care was briefly transferred to the Home Treatment Team. Following assessment by the Home Treatment Team, Mary's care was transferred back to the Community Perinatal Mental Health Team, and she was also referred on to the Community Mental Health Team;
- Under the Community Mental Health Team, Mary was aligned to the Care Programme Approach (CPA), which is an increased level of support for service users who are assessed to have complex issues or who have a high-risk profile;

- Mary went on to receive support from both teams. There is also evidence of a joint care plan review and liaison with other professionals, including Health Visiting and Midwifery Services;
- Following the birth of her third child in November 2019, Mary attended a review with Practitioner 1. Mary declined the support available from the perinatal service, stating that she was well supported by her partner and her family. Hence, she was discharged, at her request. However, she remained under the care of the Community Mental Health Team (CMHT);
- In July 2020, the CMHT altered Mary's level of care from CPA to 'Care Support' and so she was removed from the nursing case load. Care Support is a model of care for service users whose needs are deemed to have fewer complexities. Mary continued to be offered medical reviews and had access to advice and support in between medical reviews;
- In August 2020, Mary was prescribed an additional medication. Changes to Mary's anti-depressant medications were also made at this time and managed accordingly, following further medical review;
- In February 2021, Mary contacted a duty practitioner and reported that she had stopped her antidepressant. She felt that this and her other medication was ineffective. In response to the deterioration in her mood, her antidepressant was changed and her other medication, to reduce symptoms of agitation, continued.
- In June 2021, Mary and her Mother had contact with duty practitioners due to Mary having stopped taking her anti-depressant medication. Mary reported to be feeling very low, and that she was experiencing suicidal ideation, though she had no intent or plan to act on this. She reported that she was experiencing highs and lows in her mood, and she requested a trial of a mood stabiliser. This information was forwarded to the Doctor and her follow up review was brought forward to early July.
- At this time, the Doctor was seeking to determine if Mary could be diagnosed as having Bi-polar Disorder, as this was the clinical impression that had been formed.

On the night prior to the critical incident, Mary presented to the A&E Department. She was complaining of low mood and suicidal thoughts, she denied any current intent to act on these, although she reported that she had taken a mixed overdose whilst she was away with her family on holiday. Mary was assessed by two nurses from the Psychiatric Liaison Team who advised her of the potential benefit of further assessment via admission to the Psychiatric Decisions Unit. This is an assessment area which provides for the assessment and development of treatment plans for more complex service users who are in crisis and are accessing emergency services.

Mary declined admission as she reported that she felt she would be better to go home and sleep in her own bed after her long journey from Scotland. She had been advised that the Psychiatric Decisions Unit was not a ward, and it did not have beds. Mary was hopeful that if she went home, she might be able to sleep, and she reported to be happy to receive crisis intervention via the Home Treatment Team, whom she had seen before. An assessment of risk was made prior to Mary's discharge and whilst a risk of suicide was noted, she denied any intent to act on this and she reported that she had given her medication to Adult 2, to reduce the risk of her taking an overdose. She was advised that she would be contacted by the Home Treatment Team the following day and a referral was sent to them that night, via email. A note was also made in the Psychiatric Liaison Team's diary for the day shift co-ordinator to contact

the Home Treatment Team the next morning to confirm their receipt of the referral, which was the usual process for out of hours referrals.

The Panel learnt that on the following evening, when the Psychiatric Liaison Team Nurses came back on to shift, they noted a bounce back email alerting them that Mary's referral had not reached the Home Treatment Team. The nurses also noted that the task in the diary for the day shift co-ordinator had not been ticked off as complete. The Psychiatric Liaison Team nurses subsequently contacted the Home Treatment Team who immediately attempted to contact Mary.

B&S Women's Aid (BSWA)
Mary was referred into the housing IDVA service (hosted by BSWAID) on the 27th of January 2021 by Solihull Community Housing. Contact was established on the 1st of February 2021 and home security measures were requested from Bromford Housing.

The next successful contact was on the 10th of February 2021 and then again on the 15th of February. A text was sent on the 2nd of March – checking in – followed up with an email on the 5th of March. Mary replied to this, but didn't confirm a meeting time so this was followed up again on the 9th of March, again on the 11th of March and the case file was closed on the 18th of March, due to a lack of contact.

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

B&S Mental Health Foundation Trust
BSHMHT staff did have contact with Mary's children between April-December 2019, but there is no evidence of there being any direct conversations or interactions with the children and none of the children were known to BSMHFT as service users in their own right.

Children's Social Care (Children's Social Care)
Solihull Children's services had active contact with Child 1 at two points in time:

- a social work assessment carried out between February and April 2017. During this period Child 1 was visited and seen at home on one occasion (23rd February 2017) where they were seen to be 'happy and content'.
- A social work assessment and subsequent Child in Need (CIN) plan, over a seven-month period in 2018. Child 1 was visited on four occasions at home over this time.
- Child 2 was visited at home alongside Mary, and their sibling Child 1 in August 2018.

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)?

B&S Mental Health Foundation Trust

The first reference of Mary having been subject to any domestic abuse was recorded in March 2017, when she attended a medical assessment in the chronic fatigue syndrome clinic.

Mary's history of being a victim of domestic abuse was next recorded in March 2019, when she was referred to B&SMHFT by her GP. Mary reported on multiple occasions that she had been a victim of previous domestic abuse from Adult 3[12].

University Hospitals Birmingham
University Hospitals Birmingham was aware of records of domestic abuse. A safeguarding referral was made for Mary on 25th of January 2018 as she had disclosed domestic abuse from Adult 3. Mary did not report any incidents of domestic abuse involving Adult 2.

B&S Women's Aid
Mary was referred into the service as a high risk victim of domestic abuse, and this matter was heard at MARAC**.** On the 14th of February 2018, the IDVA completed a DASH and safety planning was completed with Mary.

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?

B&S Mental Health Trust
Mary's history of mental health care and support has been described in previous sections of this report. Following her assessments under secondary care mental health services, Mary's formal diagnosis was recorded as Emotional Dysregulation. The Panel learnt that there are varying reasons why someone may develop emotional dysregulation, including early childhood trauma. Mary's diagnosis was under review at the time of her death, and a diagnosis of Bi-polar Affective Disorder was being considered.

At her last contact with the Psychiatric Liaison Team, the impression of Mary formed by the Nursing staff was of Emotionally Unstable Personality Disorder (EUPD) of which emotional dysregulation is a feature.

ICB – for General Practice
Mental health support and appropriate referrals were made to Mental Health services throughout the scoping period. Letters received from the Mental Health Team were evident within the GP notes.

Solihull Community Housing (Solihull Community Housing)
When Mary completed her first homelessness application, she disclosed a number of physical health conditions and a concern regarding additional needs for Child 1. The second Medical Form, received by Solihull Community Housing on the 1st July 2021, referred to a number of physical health conditions as well as a number of mental health problems.

[12] The Panel noted that a number of agencies may have formed the impression that the abuse was historical – simply because Mary informed them that she lived with abuse from a previous partner

Children's Social Care (Children's Social Care)
Mary appeared to be open in discussions with Children's Services about her emotional and mental wellbeing. Information was also gained from other professionals concerning Mary's mental health issues. Two weeks prior to her death, Mary contacted Children's Services directly and shared the following note:

> 'I have had help from yourselves due to domestic violence and being made homeless, however the flat that I am now in is causing severe anxiety and affecting my mental health due to the fact that the person who inflicted the domestic violence *[naming Adult 3]* now possibly knows where I live …. *Comments have been* made and I am now extremely nervous.'

This referral was closed with no action taken after a manager's decision that the referral did not 'meet the threshold' for a housing letter of support, and Mary was advised to contact the Housing Service with advice that they can request information directly from Children's services with Mary's consent.

E. **Was your agency in contact with members of the extended family of Mary, Adult 2 or Adult 3 or their friends or colleagues? *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 current time we have not received consent to receive the confidential patient and client information specifically from the records concerning Adult 2, Adult 3 or Child 1, 2, or 3.***

B&S Mental Health Trust
On 26 November 2019, Mary attended a review with Practitioner 1. Mary had all three children with her, and she was also accompanied by her Mother. Mary was reported to be sharing the care of the new baby with Adult 2, and her parents were also supporting her. Following this review, and as per her request, Mary was discharged from the Perinatal Mental Health Team, but she was to remain under the care of Practitioner 2, at the Community Mental Health Team for ongoing support.

In February and June 2021, Mary's Mother contacted the Community Mental Health Team, and had discussions with a duty practitioner, reporting that Mary was struggling with her mental health.

Solihull Community Housing
When Mary approached as homeless on the 7th March 2018, she disclosed she was staying with her Mother until a homeless assessment was carried out. It is documented that Mary's mother spoke to the Housing Options Officer on 22nd March 2018.

Children's Social Care
Mary's parents had involvement, particularly within the period of the assessment and Child in Need plan in 2018 in respect of Child 1 and Child 2. Mary's parents were also described by other professionals as being part of her support system. For instance, a referral following Mary's overdose in April 2019 noted that she was accompanied by both parents to the hospital.

Education
The education settings had a number of contacts with Mary's parents, concerning, primarily, the care of Child 1 and their attendance at School and Nursery.

University Hospitals Birmingham
Mary's mother is noted to attend when Mary's babies were born and was noted as very supportive.

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?**

West Midlands Police
As noted, Mary's father made a Clare's Law application on her behalf in November 2015.

On the 26/01/2018 Mary's mother, contacted the Police to report that Mary had been assaulted by Adult 3. Mary had already been in contact with officers, stating that Adult 3 had been contacting her family via messages, which was causing her harassment. Mary was contacted, but declined to engage with officers.

Children's Social Care
There was limited recorded discussion of information sharing from Mary's (extended) family directly with children's services about the safety of Mary, or risk from Adult 2 or 3. The only direct example of this on file was a telephone call to Mary's Mother during the social work assessment in 2018. The account described Mary's Mother acknowledging that the behaviour from Adult 3 to her daughter was unacceptable. She did not believe he was a current risk, but had advised Mary that Adult 3 should not go to her flat.

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?**

B&S Mental Health Trust
In addition to Mary's history of being a victim of domestic abuse and her mental heath needs, Mary was reported to have various physical health conditions (these are described in the 'Equalities and Diversity' section of this Report).

ICB for General Practice
The author of the submission made reference within the chronology to 'children being referred to as a protective factor' and it was noted that, on occasion, Mary stated that she was struggling to cope with the care of her children and her mental health.

Solihull Community Housing
During Mary's homeless application in March 2018 she disclosed a number of pertinent points, including:

- Domestic abuse;

- A number of health conditions;
- That Child 1 had additional support needs

During Mary's second homeless application on 26th January 2021, Mary disclosed that Adult 3 had made threats to her and her children. As a result of the disclosures, Solihull Community Housing made a referral to a Housing IDVA (provided by Birmingham and Solihull Women's Aid); made investigations with the West Midlands Police around reported incidents to progress the investigations being made by Solihull Community Housing; and a sanctuary referral was offered, though this was declined.

Children's Social Care

The assessment in 2017 noted:

> 'Mary has learning needs and may need support to understand why we are worried and how to protect herself and Child 1. Mary shows good understanding of the risks and is willing to work to enhance her understanding of safe and healthy relationships'.

The assessment in 2018 noted:

> 'Mary potentially has some learning difficulties and is vulnerable to predatory and abusive males'.

Mary's mental health needs, although acknowledged, do not appear to have been explored in great depth. Mary's history of positive engagement with mental health support appears to have led to an assumption (not expressed in the record) that any mental health needs would be identified and supported, without more professional curiosity being asserted from Children's services. This is particularly relevant on two occasions. Specifically:

- Following Mary's overdose in 2019, there were no agency checks with either the mental health team working with Mary, nor the school attended by Child 1. Mary said that she was worried that her overdose would lead to her children being taken from her. This could have been explored with the agencies mentioned to understand more about the children's experience;
- When Mary made contact directly, in July 2021, she described feelings of 'severe anxiety' and her mental health being impacted by worry about risk from Adult 3. Because the surface reason for the contact was Mary asking for a letter of support for a housing move, the response dealt with this as the sole issue. However, this missed an opportunity to employ professional curiosity and explore, in more depth, the feelings that Mary was openly sharing.

University Hospitals Birmingham

Mary's mental health was a complex issue. During her pregnancies, Mary received antenatal care from University Hospitals Birmingham. She had a safeguarding referral completed for her children whilst pregnant with Child 2. As already described, during pregnancy with child 3, Mary was asked about domestic abuse on 3 occasions antenatally and once postnatally and no disclosures were made.

H. **Did your service complete appropriate assessments of risk and, where necessary, make referrals to other appropriate care pathways. If so, briefly describe them.**

B&S Mental Health Trust
The risk assessment recorded in Mary's clinical record was "Level 1- Risk Screening Tool", which is the standard risk assessment tool used throughout B&SMHFT. Mary's Level 1 Risk Screening Tool was initially completed in 2015, on her first contact with BSMHFT services. It was reviewed a further 12 times during her episodes of care, 9 times during the formal scope of this review.

In November 2019, Mary's risk of domestic abuse was assessed again by Practitioner 1 and was reflected in the update which was made to her Risk Screening Tool. Mary's Risk Screening Tool was next updated following her assessment by the Psychiatric Liaison Team, in August 2021.

The Panel learnt that, if there are any changes in presentation, then the risk assessment tool should be updated. If any service user is seen every 12 months then the assessment tool should be updated.

As noted, Mary had stepped down from the Care Programme Approach, but still had contact with the service so that she could make contact with the service in between formal clinical reviews.

West Midlands Police
During the scope of the Review, DASH and then DARA[13] assessments were completed as per West Midlands Police policy at all of the incidents attended. Referrals were regularly offered to Mary within the time frame, particularly to the National Centre for Domestic Violence (NCDV).

Solihull Community Housing
Within the formal scope of this Review, Mary was provided with a statutory homelessness duty because she clearly satisfied the legislative requirements. Mary was eligible, homeless unintentionally, in priority need and had a local connection. In discharging the duty, Solihull Community Housing supported Mary to access the housing register, and shortlisted her for the property with Bromford Housing.

Children's Social Care
The author of the submission noted that in 2018 Mary was advised – within the Child in Need plan for Child 1 and 2 – to seek support from Women's Aid, which Mary did by calling the helpline. Whilst this was a positive step, there is no clear evidence that the multi-agency plan supported her to follow up on the advice she was given or convert this into an ongoing safety plan. Mary stated that she had ended the relationship, and she was clear that she intended to have no contact with Adult 3. Nevertheless, the Panel noted that this was an important point, given that Adult 3 may have had ongoing links to Mary, via Child 2.

Education
The case files reviewed indicated several occasions when MASH (Multi-Agency Safeguarding Hub) enquiries and referrals would have been appropriate, but were not made. These involved concerns for Child 1 and Child 2 rather than Mary. It should be noted that School B signposted Mary to B&S Women's Aid.

[13] The Panel learnt that West Midlands Police is noted as one of the early adopters of the Domestic Abuse Risk Assessment (DARA) procedure.

In January 2021 Mary shared with school C that there were concerns that Adult 3 had found out where she lived. Mary shared that additional security was being added to the house and new locks were being fitted. They checked in with Mary the next day and School C made staff aware that Adult 3 must not be allowed to collect Child 2.

University Hospitals Birmingham
Safeguarding referrals were made for Mary's children when domestic abuse was disclosed, notably during Mary's pregnancy with Child 2, and when Mary attended the Emergency Department reporting thoughts of suicide.

In accordance with longstanding guidance, routine domestic abuse enquiries were completed by the Maternity services and appropriate risk assessments were completed in conjunction with social care prior to Mary being discharged home with Child 2. Mary's safety was considered by maternity services when discussing Domestic Abuse and it was confirmed that during her pregnancy with Child 2, she was living in a safe place (with her mother). During her pregnancy with child 3 she confirmed the baby's father was not abusive and that she was seeking a restraining order against Adult 3.

B&S Women's Aid
On the 14th of February 2018 the IDVA completed a DASH. Mary described that her partner exhibited jealousy, not control and had been trying to contact her via friends on social media. Safety planning was completed with Mary.

On the 1st of February 2021, it was recorded that an initial risk assessment and safety planning had been conducted. However, the service was unable to complete a DASH as Mary wasn't able to commit to the appointment time due to her children being at home with her. Before this could be explored further and the appointment re-booked, BSWA lost contact with Mary.

I. **What actions (if necessary) did you take to safeguard Mary (and her dependents) and do you consider these actions were appropriate, timely and effective?**

B&S Mental Health Trust
During her care under B&SMHFT, Mary's history of domestic abuse was assessed and recorded. However, Mary was always very clear that domestic abuse – of any kind – was not a feature in her relationship with Adult 2.

West Midlands Police
Mary reported two domestic incidents within the time frame of the Review. On the first reported incident (08/03/2017), Mary would not make a complaint or support a prosecution. The officers made a referral to the NCDV and Mary confirmed she had applied for a non-molestation order.

The second domestic incident Mary reported was on the 26/01/2021 where Mary made a call to Police regarding an unidentified ex-partner contacting her new neighbours to ask where she lived. No criminal offences were identified and safety advice was offered.

Solihull Community Housing
In 2018, Mary and Child 1 were provided with temporary accommodation in line with Section 188 of the Housing Act 1996 and were provided with permanent accommodation to discharge Section 193 of the Housing Act 1996. The service had reason to believe and were later satisfied that it was not reasonable for Mary and her child to reside in their last settled property due to the risk of domestic abuse.

Children's Social Care
Solihull Children's services undertook a social work assessment in 2017, after receiving information from Child 1's nursery about Mary reporting physical assault. The assessment recognised the need for support to be given to Mary, in the form of 'sessions on Domestic Violence, developing a safety plan and signposting to services'. This was positive, although the assessment did not detail what outcome was required from these interventions, or recommend that they were undertaken within a formal plan.

A referral in 2018 was subject to the MASH process. The subsequent social work assessment was completed. It was child focussed and analytical regarding the impact on Child 1.

A strategy discussion also took place within this period. This was appropriate to the information held, in respect of Mary and Adult 3 maintaining a relationship. The assessment appropriately recommended that the children were to be supported via Child in Need plans. The assessment made relevant recommendations about elements of the plan, including work to support awareness of domestic abuse, safety planning for Child 2 and Adult 3, and support to ensure a tenancy move and Child 1's school.

In February 2021 a referral from a Housing professional led to Children's Services undertaking initial screening to gain more information. This screening process included the triangulation of information from both Housing and Women's aid. Mary was spoken to directly, and offered intervention via Early Help support. However, Mary declined this help.

Education
On one occasion, School B made a home visit to Mary who shared her concerns that her ex-Partner had found out where she lived. They also checked that she and her child were safe.

Both School A and School B logged concerns around Child 1's attendance. It should be noted that the two schools are at opposite ends of the Borough of Solihull. The schools were tenacious in their attempts to contact Mary and ensure that she and Child 1 were safe. This included calls to Mary's parents, ensuring Children's Services were aware of the issue and conducting their own safe and well checks.

All three schools felt that they were developing a trusting relationship with Mary. Channels of communication were open and positive. From the information the schools had, the actions of schools A and B seem appropriate and proportionate.

The Panel noted that the nursery and School C appear to have missed opportunities to make referrals/enquiries to the MASH arrangement.

University Hospitals Birmingham
Safeguarding referrals were completed in a timely manner and Mary was asked about her safety. An alert was added to her maternity records to share information regarding Domestic Abuse, and also to the records of the children.

Safe discharge destinations were considered when concerns were raised and actions were appropriate, timely, and in keeping with Trust procedures

B&S Women's Aid
Mary had been considered by the MARAC in 2018 and the IDVA provided feedback to Mary on the outcome of the discussions. However, Mary didn't feel there were any ongoing support needs.

A referral into the housing IDVA service was made in 2021. This occurred due to concerns Mary had raised with Solihull Community Housing that the perpetrator could find her due to a photo on social media. B&SWA supported Mary by providing appropriate safety planning and advice about accessing temporary accommodation or refuge. The IDVA requested security measures in the home as Mary wanted to remain in her home. A referral into Children's services had already been made by the landlord.

J. Was Adult 2 and/or Adult 3 known to your agency as a perpetrator of domestic abuse or violence?

The Panel noted that there was no consent to disclose confidential information about Adults 3. However, Mary disclosed to a number of agencies that Adult 3 was a perpetrator of domestic abuse against her. There were no records held by any agency in contact with Mary to indicate that Adult 2 was a perpetrator of abuse.

K. **If so, what actions were taken to assess their risk to themselves and/or to others?**

Specifically, West Midlands Police, Solihull Community Housing, University Hospitals Birmingham, Children's Social Care, B&SWAID and other agencies provided support to Mary when she disclosed incidents of domestic abuse and violence and/or when she was fleeing domestic abuse and seeking safer accommodation.

L. **Were there any other issues that may have increased the risks and vulnerabilities of Mary?**

The Panel noted that Mary's mental health, her physical health, her accommodation and social care needs, and her fear of Adult 3 (in particular) have been detailed in previous sections of this report. It was recognised by the Panel that these complex issues would magnify Mary's vulnerability.

M. **Does your agency have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding services?**

The Panel was encouraged to note that all of the agencies involved in this Review had a suite of policies and procedures in place to support appropriate responses to adult and child safeguarding, domestic abuse and violence and for escalating concerns. These can be found in **Appendix 4**

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?**[14]

B&S Mental Health Trust (B&SMHFT)
On review of Mary's records, there is no evidence that at any time during her care under B&SMHFT, that Mary lacked the capacity to make decisions or that the application of the Mental Health Act or Mental Capacity Act was required.

With regard to the Mental Capacity Act, capacity is assumed unless proved otherwise. At all times when this should have been considered – specifically Mary's contact with B&SMHFT's urgent or acute care services, the Home Treatment Team and the Psychiatric Liaison Team – she was deemed to have capacity to make her own decisions and there was no indication that this needed to be formally assessed.

West Midlands Police
Mary did not present to the service as requiring an appropriate adult or requiring an assessment for mental capacity. Officers were able to interact with Mary without raising any concerns. The author of the submission noted that officers had requested statements from Mary when she was the victim of crime, with no mention of a requirement for video interview, which would be used if a victim or witness required assistance in communicating when providing their evidence and presenting that evidence in any court case.

The Panel noted that for the remaining agencies involved in the Review, there were no recorded concerns regarding Mary's ability to make decisions. Additionally, her records did not indicate that it was ever necessary to admit Mary to Hospital under any section of the Mental Health Act.

O. **What impact did the management of the initial phase of the COVID-19 pandemic have on your service?**

Following the outbreak of the COVID-19 pandemic, all of the services in this Review implemented measures to reduce the spread of infection, in line with the UK Government's guidelines. By way of example, non-essential, face to face visits were replaced by telephone contacts. These were followed up by calls to parents/family/

[14] As noted in the chronology, Mary was bullied at school. This was confirmed by her Mother when she met with the Author. The Panel noted the advice from the Home Office QA Board that, in these circumstances, Mary may have been eligible for support via Sections 16 and 17 of the Youth Justice and Criminal Evidence Act 1999. This would have been due to her physical and mental health needs and the possibility that she may have been an intimated witness.

carers where appropriate. Service users were seen face to face if it was felt that there were mental health concerns and risks that could not be managed in any other way.

All urgent and emergency contacts were to follow the same process of service users calling first by phone and then staff assessing the situation on the basis of clinical need.

West Midlands Police

Police Officers were still attending all incidents as required and entering people's homes to take details of incidents where necessary. If details could be taken via the phone they would be, rather than exposing officers to the risk of infection.

The Police did note that there was an increase in reported domestic incidents to Police during this period. Figures suggest a 28.7% increase, year-on-year and a 30% increase overall since 2019/2020. This increase in reported domestic abuse incidents was set against a back drop of well-documented budget cuts for West Midlands Police by the government and an associated reduction in officer numbers at that time.

During the Covid pandemic the West Midlands Violence Reduction Partnership produced an advice, support and guidance page to advise communities. It acknowledged that it was a frightening and unsettling time for many young people and those who were already at a heightened risk of violence. The Violence Reduction Unit was working to assist local violence reduction partners to adapt to the new situation and ensure help was available.

Education settings

During the periods of restricted movement, visits to children were adapted so that some were carried out by 'doorstep' visiting, or some by phone. It was unknown how long the lockdown rules would remain in place and responding appropriately to safeguarding visits meant processes had to be regularly reviewed and adapted.

Families were also frequently affected by COVID, meaning that there was ongoing risk that children would not be seen for this reason. Overall, COVID added a risk that children were less visible to the service than they would have been in normal times. In education settings, the following children were expected to be allocated places in school from 23/3/20 (according to DfE Guidance):

> "Vulnerable children include children who are supported by social care……".

And

> "…children who have safeguarding or welfare needs, including child in need plans, on child protection plans, 'looked after' children, young carers, disabled children and those with education, health and care (EHC) plans".

Schools used their professional judgement when identifying children who fitted into the 'safeguarding and welfare needs' category. The Panel learnt that School C did not invite Child 1 into school at this time as they felt that concerns regarding domestic abuse were historic.

Summary Analysis

Engaging with the Police

There are clear policies and procedures in place for West Midlands Police including a Domestic Abuse policy which includes the completion of the DARA assessment, a description of the MARAC process, MASH referrals and the referral portal for other pertinent issues.

There was little domestic abuse or violence between Mary and Adult 3 reported to the Police. However, having viewed the antecedent events concerning Adult 3, it is entirely possible that Mary suffered abuse that went unreported.

However, there was nothing in the records held by the Police to suggest Mary had any contact with Adult 3 after the beginning of 2018.

The submission from Children's Social Care does note reference to Mary being reluctant to speak to the Police, particularly with regard to domestic abuse incidents in 2017 and 2018. Not feeling able to do this would potentially increase risk, and the author of the submission was not able to see from the available records how or if these feelings were addressed with Mary. She reported to the health visitor, and children's services in February 2018 that she was scared of the Police, but no further details were recorded.

Engaging with Primary Care

In their submission, Mary's General Practitioner had screened all of the available information and there was no mention of domestic abuse, other than with her ex-partner, Adult 3. Mary spoke about her Mother and her current partner, Adult 2, being a support to her and to her children.

The author of the submission correctly noted that there needs to be further exploration around the reasoning why children are noted as being a "protective factor". It was not clear from the notes that there was an opportunity to explore this matter further.

Engaging with the Education Services

The author of the submission noted that there was evidence to suggest that awareness of potential indicators of domestic abuse was inconsistent across the education providers referred to in this Report. The impact of domestic abuse upon Mary and Child 1 appears to be poorly understood by at least one education setting, particularly when the abuse referred to was assumed to be historic. There were a number of opportunities for education settings to make links and these were missed.

The author of the submission also noted that record keeping was variable. Where it was most effective, incidents were documented carefully, the voice of the child was evident, there was clarity around the decisions made, actions that needed to be taken and in a number of cases, notes refer to the outcomes achieved from the activity delivered. This was good practice. When this didn't happen, however, it is unclear how information made available was, if at all, acted upon.

Additionally, records were not always passed between settings as Child 1 moved from one School to another around the Borough. This led to schools not understanding the

extent of the domestic abuse experienced by Mary and Child 1 and therefore some of the Education settings relied heavily upon the information shared by other agencies. However, there does appear to be one or two occasions when information was not shared directly with the nursery/school either by Children's Services, the Police, or partners in the Health Service. This meant that the Education settings were not always fully aware of the extent of Mary's mental health needs and vulnerabilities.

The Panel did note, however, that the Education settings showed awareness of the DASH and the MARAC procedures and arrangements.

Engaging with housing and accommodation

The actions taken by the housing options team were appropriate and in accordance with policies of Solihull Community Housing. The staff within the team appear to have conveyed empathy through their interactions with Mary and sought to safeguard her and her children as much as possible. Solihull Community Housing discussed and offered support through the Sanctuary Scheme and a referral to Birmingham and Solihull Women's Aid.

The Panel learnt that Solihull Community Housing has an internal cross service Managers Group called SEDA (Safeguarding, Exploitation, and Domestic Abuse) which has recently been strengthened to improve oversight of safeguarding activities and assurance. A role of this group is to discuss case reviews and explore any learning that comes from them. In addition, Solihull Community Housing are now members of the Domestic Abuse Housing Alliance (DAHA), who work with social housing providers to improve the response to domestic abuse through membership, accreditation, training, and regional networking around best practice.

Engaging with Children's Social Care, Supporting Mary and her Children, hearing the voice of the Child

The Panel took the time to note that, since the events described in this Review took place, there have been some significant changes and improvements to practice and procedure within Children's Social Care. These improvements clearly suggest that, if similar circumstances were to arise in 2024, the context we would note would be markedly different.

It is the case that a number of organisations making submissions to this Review noted that Mary was seen as 'engaging well' with the services offered and this was always considered to be a positive thing by professionals working with her. The author of the submission from Children's Social Care considered whether this may have led to less scrutiny from the professionals involved, or that some interventions were more, for want of a better term, 'superficial'. By way of example, the Children in Need (CiN) plan appeared to have ended without addressing some of the needs identified specifically for the children in the assessment. The reasons for the closure included Mary's level of engagement, rather than change having being achieved.

The impact of Mary's wellbeing on her children was a central issue, and there were some missed opportunities to explore this or, potentially, offer more support.

When the author met Mary's family, they informed him that Mary was always concerned that the services would remove her children from her care. This perspective

would, without doubt, have had an impact upon Mary's engagement with the services made available to support her and her children.

In July 2021, Mary e-mailed a Social Worker in the children's social care service and requested a letter of support for re-housing. The decision was made to close the referral with no further action. No screening enquiries were undertaken and there was no record of any further discussion with Mary. The pertinent question for the Panel in this matter is: where is the threshold referred to actually set?

As already noted, whilst there were a number of occasions when work was undertaken, there are no clear records to describe what was achieved. However, the Panel did acknowledge that this should be understood in its proper context. These incidents and the response to them occurred 6 years prior to this Report and recording practices have changed significantly since that time. There is now an expectation that all visits are recorded on case notes and direct work is clearly described and copies attached to the relevant record. There is still progress to be made to embed this practice, but significant changes have already been achieved.

In terms of practice, the author of the Children's Social Care submission noted two areas where additional focus and consideration could have been helpful in this case. The first is a more active awareness of mental health and the impact that mental health conditions may have on functioning and need. The author of the submission also linked this to the need for trauma awareness, and trauma informed practice, particularly bearing in mind Mary's history of experiencing abusive relationships, the bullying she was subjected to at School and the involvement of CAMHS from an early age.

The Panel also noted a concern regarding an understanding of the level of Mary's learning difficulty, reported by the Police and Children's Social Care. Although it was acknowledged, there was no explicit detail given about what difference this made to any intervention, or whether any change in approach was required. The Panel recognised why this may be more complex if there was no formal diagnosis or cognitive assessment. But a degree of general awareness regarding the complexities of mental health conditions, learning difficulties and domestic abuse, and the number of professionals involved with Mary at different times would have been beneficial.

The author of the submission also noted that, at the time when the service was engaged with Mary, a more consistent use of standardised practice tools, such as the DASH, would have helped to monitor her risk. Ideally, an easier process for agencies to share completed DASH assessments would make these improvements even more effective.

There were a number of good examples of multi-agency sharing of information, but there was the occasional inconsistency. The MARAC process correctly identified risk to Mary on at least three occasions (one out of timeframe of this review) including one occasion which prompted proactive contact. In one social work assessment, information was not triangulated adequately with other agencies. This is something which should be monitored. However, recent changes to the assessment, and Children in Need meeting forms should enable better tracking of participation.

In terms of child centred practice, it seems to be the case that the children were not consistently focussed upon in their own right. They did not always receive direct intervention, conversation, or consideration in safety planning. What this meant for Child 1, 2 and 3, is that they were not fully considered as victims of domestic abuse, despite the impact of having to move home; avoid at least one violent person; and experience their mother's anxiety and fear. Additionally, it is likely that Child 1 saw his mother being attacked.

Throughout the time period covered by this Review, there were some examples of better practice, including writing directly to the child, but there were more examples where the child's experience is not visible. There is now more expectation around such practices, including writing to the child directly, a clear focus on the child's experience, and support for their involvement.

Engaging with Secondary Healthcare Services

University Hospitals Birmingham (UHB) provided healthcare services for Mary throughout the scoping period.

Whilst pregnant with her second child, Mary disclosed domestic abuse from Adult 3 and she consented to a safeguarding referral for her unborn and her older child. The Midwifery Service from University Hospitals Birmingham worked alongside Children's Social Care to maintain Mary's safety and ensure that once her baby was born, their discharge was safe.

The Trust has a team of specialist midwives, including domestic abuse midwives, who support pregnant women who endure domestic abuse. Additionally, these midwives are actively engaged with the MARAC process.

During her third pregnancy, Mary was asked on three occasions about domestic abuse. This is in accordance with NICE guidance (to ask all pregnant women, if it is safe to do so). On each occasion she was clear that she was not experiencing domestic abuse from Adult 2 (Mary described them as supportive). Mary did disclose that she had lived with domestic abuse with a previous Partner.

Engaging with mental health care services

Assessment of risk of domestic abuse:

Within the time formal scope of this review, the first report of Mary being a victim of domestic abuse was made in March 2017. At this time, Mary advised that her relationship had recently broken down due to domestic abuse, and she had obtained a restraining order against the perpetrator.

Mary was referred to the Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) services in March 2019. She had history of depression, which worsened in the perinatal period, and she was referred on to the Perinatal Mental Health Team. When Mary was assessed, her history of being a victim of domestic abuse was explored. She reported that she had been a victim of domestic abuse perpetrated by Adult 3, whom she had a restraining order against, and she had also moved address. In relation to her current partner, Adult 2, Mary described them as supportive and she denied there was any domestic abuse in their relationship. Following the assessment, the service liaised with the children's Health Visitor.

Soon after this contact, Mary was seen by the Psychiatric Liaison Team following a deliberate overdose. During assessment, Mary reported that she was not in contact with Adult 3, he did not know where she lived and she felt safe. Mary was seen by the Home Treatment Team, and she confirmed that her previous partner had been abusive, but he was not part of her life or the lives of her children.

In June 2021 both Mary and her Mother contacted the Community Mental Health Team and had conversations with duty practitioners. Mary and her Mother reported that Mary was not complying with her medication, her mood was deteriorating, and there were episodes of suicidal ideation, albeit without any plan or intent. There is a record in the clinical notes that Mary's risks were reviewed by a Doctor in July 2021, but the specific details of this were not transferred onto Mary's Risk Screening Tool. Neither was Mary's case bought to the Multi-Disciplinary Team (MDT) meeting, for oversight and input by the wider team. It appears that in this case some decisions with regard to Mary's care were made in isolation from other professions in the MDT. The MDT would have supported the process of risk identification and assisted with the formulation of a management plan The report author considers that these instances would have required Mary's Risk Screening Tool and management plan to have been updated. This is, therefore, contrary to the expected standards outlined in the organisation's policy.

There were no further references to domestic abuse in Mary's clinical records until her final contact with B&SMHFT services in August 2021, when she presented to the Emergency Department and was seen again by the Psychiatric Liaison Team.

During the visit in August 2021, Mary denied any domestic abuse, and she referred to her now ex-partner, Adult 2, in terms of being a protective factor. The nurses advised the author that Mary was asked whether domestic abuse had been a feature in Mary's relationship with Adult 2 and she stated that domestic abuse had never occurred in her relationship with Adult 2.

The Panel did acknowledge that the mental health service – as with all public services – are operating under severe capacity constraints. This was certainly the case at the time and this was compounded by the impact of the COVID Pandemic. Practitioners did not (and still do not) have the time to complete in-depth assessments as the primary focus is on addressing the immediate concern that is presented to them. The report author is also aware that medics in Community Mental Health Teams face similar time constraints in that they have high case loads and busy out-patient clinics. This will affect their ability to update all the relevant sections of clinical records. However, it should be noted that this is the expected standard of the organisation and if this is an issue then this should be escalated via the usual route of management supervision.

The review author considers that due to the rotation of duty practitioners, it is the case that, occasionally, the history of a service user with whom they are having contact is not fully known.

The report author also considered that because Mary's Risk Screening Tool was not formally reviewed or updated, there was a potential gap in the longitudinal assessment

of the risks posed to her, including the risks of domestic abuse. There was no evidence of routine enquiry or assertive exploration of Mary's social circumstances between the step down of her care level in July 2020, and her assessment in the Emergency Department in August 2021. This is contrary to the expected practice of B&SMHFT clinicians, as per the organisations Domestic Violence and Abuse Policy (2020).

The decision to discharge Mary from the Psychiatric Liaison Team to the care of the Home Treatment Team was made by the two nurses who completed her assessment in the A&E Department. Due to Mary's level of distress and suicidal ideation, the author of the submission from B&SMHFT sought an expert opinion as to whether it was appropriate to discharge Mary to the Home Treatment Team at this time, without a psychiatric medical review. The opinion of the expert was:

> "…if there was a reasonable expectation that medical assessment would be done by the Home Treatment Team within 24 hours, then it was acceptable to refer the patient to the Home Treatment Team on this basis. In my experience, patients with this level of risk/distress are often referred by the Psychiatric Liaison Team to a Home Treatment Team and they are seen within 24 hours by a medic. Clearly, this referral was not picked up by the Home Treatment Team and therefore a medical review did not take place. The Psychiatric Liaison Team should have tried to seek collateral information from family members/those close to the patient - the only source of information they had was her and she was tearful and distressed. She said that she had left her children with her parents/partner - collateral information from those who knew her would have been something important to obtain. If the collateral information gave rise to concern, then a medical review could have been undertaken in A&E rather than being left to the Home Treatment Team".

The author of the submission has considered that it is not known if Mary would have consented for her parents to be contacted, or if the information they may have given would have changed the plan to discharge her to the care of the Home Treatment Team. But it may have helped to inform the assessment of her situation, her risk profile and management and safety plan, and therefore this was a potential missed opportunity.

When the author of the Review met with Mary's family, it was apparent that they were very disappointed not to have received a 'phone call concerning this specific consultation. The family impressed upon the author that – in circumstances such as these – the family must be seen as an asset to the service providers, a means by which the outcome of a service may be improved.

The CPA Review Process

In July 2020, Mary's level of care was altered from Care Programme Approach (CPA) to 'Care Support'. The usual and expected process when changing the level of care received by a service user is outlined in B&SMHFT's Care Management & CPA/Care Support Policy (2019). In brief, this means that there should be a Multi-Disciplinary Team (MDT) discussion including a review of a service user's care, risk profile and management plan to ensure that a safe and appropriate decision is made. The circumstances of Mary's step down to Care Support was explored by the author of the submission from B&SMHFT. The opinion of the author was that this was not the appropriate course of action considering that, at this time, Mary was still struggling with her mood, the UK was under COVID-19 restrictions, and Mary had admitted to

struggling to look after her children. Therefore, she would still have benefited from the oversight and support of having an allocated practitioner acting as a Care Co-ordinator.

The author of the submission has been advised that an audit has since been undertaken against the Community Mental Health Team's compliance with the organisation's CPA policy, and no further issues have been identified, which supports the conclusion that this instance was likely the individual practitioner's misunderstanding of the process.

Engaging support from Women's Aid

Birmingham and Solihull Women's Aid interactions with Mary were relatively limited. There was a willingness to provide information and support when Mary engaged with the service. However, it was noted that Mary didn't feel that ongoing support was required and this resulted in the first referral being closed, at her request, in 2018 and the second contact, in 2021, being closed due to contact with Mary being lost.

During each contact there was evidence that risk was assessed and safety plans were put in place. The focus was around the immediate presenting need and there was some evidence that Mary was either unwilling or not ready to talk about the abuse in a more complete way. The housing IDVA had intended to explore risk more thoroughly with Mary however this wasn't possible as Mary dis-engaged from the service.

Section 6
Good practice

Throughout the work of the Review and the production of this Overview Report, references have been made to examples of good practice exercised by the services in contact with the subjects of this case. It should be stressed that in this Review, 'good practice' is defined as practice which accords with the standards set by the professional bodies of the staff delivering the service. It is not always about 'going the extra mile'. The Panel wished to focus upon a number of these examples and these are set out below. The learning from the Review is described in later Sections.

West Midlands Police
West Midlands Police identified a number of points of good practice concerning this Review, including:

- A DASH/DARA was completed at each incident as required;
- Officers attempted to engage with Mary multiple times when she initially stated she did not wish to make a complaint. Contacting any victim can help build trust and will help encourage the victim to make a formal complaint;
- It was noted during one contact that Mary would most likely not make a complaint against Adult 3 because she was scared of future repercussions, i.e. it appeared she wanted help but was too scared to provide a statement. It was good practice to acknowledge this fact and not just dismiss the case as a lack of interest.

ICB for General Practice
The Integrated Care Board noted that the GP practice was responsive to any contact received from Mary and made appropriate referrals for second opinions and further investigation for both Mary's physical and mental health.

Education
Schools and education providers form positive relationships with parents and are well placed to offer support and regular 'check-ins'. This included home visits by school B when Mary disclosed her concerns about Adult 3 finding out where she lived. All four settings noted Mary's gratitude and appreciation of their support

Attendance concerns for Child 1 were followed up tenaciously by the schools and curiosity was shown when Child 1 was not in school. When social workers were involved, this information was shared with Children's Services.

Solihull Community Housing
The housing options team effectively worked with Mary and kept in regular communication with her throughout her homeless application. Each time Mary approached the service, the housing options team appropriately assessed her needs and the needs of her children in order to safeguard her.

Additionally, appropriate domestic abuse referrals were discussed with Mary and when there was no contact from Mary, the housing options officer sought to follow this up accordingly. Moving forward, it would be beneficial if different types of communication are considered, i.e. email, letter and telephone call etc, particularly when the person

concerned does not respond and the service has reason to believe they are at high risk of harm.

Finally, there is evidence of multi-agency working throughout the case. The housing options team engaged with Police and children services as appropriate.

Children's Social Care

Solihull Children's Social care noted a number of examples of good practice, thus:

- There was proactive consideration of Mary and her children, triggered by the MARAC process. The MARAC process in October 2020 had heard information about Adult 3, in respect of a separate partner, and identified that he had other children, including Child 2. On the basis of this, the MARAC actions instigated a check with Mary to understand what contact she and Child 2 had with Adult 3, and considered any support needs. Although this did not lead to any further involvement, the active consideration of other children by the MARAC process is helpful to monitoring children who are potentially at risk.
- In February 2021 a referral from a Housing professional led to Children's services undertaking initial screening to gain more information. This particular screening process had improved because it sought information from both Housing and Women's Aid, and Mary was spoken to directly, and offered intervention via Early Help support. Although Mary declined this help, the response and support was appropriate to the referral.

University Hospitals Birmingham

University Hospitals Birmingham identified an example of good practice, and an example where improvement could be made, outlined below:

- Mary was asked about DA during both pregnancies in the scoping period. When disclosed, a timely and accurate referral was made to children's services. Her safety was ensured, and she was safely discharged. Routine enquiry was completed 3 times in her second pregnancy;
- With regard to improvement, University Hospitals Birmingham noted that staff should be recording they are asking about Domestic Abuse when patients attend with mental health presentations. This routine enquiry should be made when it is safe to do so; and
- Staff should consider other agencies that can support and offer referral, for example, the Police, MARAC, and the IDVA service.

B&S Mental Health Foundation Trust

Mary's initial and ongoing assessments completed by Practitioner 1 from the Community Perinatal Mental Heath Team were of good quality. The recording of their involvement with Mary was detailed and provided context as to the rationale for clinical decision making. There was ongoing enquiry into Mary's risk of domestic abuse and strong evidence that the "Think Family" principes were applied by this practitioner. The Practitioner recorded the names and dates of birth of Mary's children, previous and current partners for risk assessment purposes and liaised with other professionals involved with the family, including Health Visiting and Midwifery services to gain a comprehensive view of the family's needs. When Practitioner 1 saw Mary's children, they recorded their observations of Mary's care and interactions with the children as well as the home conditions, and when they identified needs in relation to social issues

such as financial concerns, appropriate referrals for Early Help intervention were offered.

When it was noted that Mary's referral to the Home Treatment Team had not been delivered, staff from both teams took immediate action, and on review of timescales, the Home Treatment Team attempted to contact Mary within minutes of speaking to the Psychiatric Liaison Team.

B&S Women's Aid

There is evidence of good support and safety planning being carried out including appropriate liaison with other agencies involved. The service was delivered within a woman centred, consent based approach and it was certainly the case that in 2018, the service was able to provide information about re-referring if the need arose.

Section 7
Lessons learnt from this case by the agencies submitting information.

Learning lessons from a Domestic Homicide Review is, amongst other things, a combination of reflection, professional scrutiny, policy review and practice development. Set out below are some of the lessons learnt that have been identified by the Panel and by the agencies that had contact with Mary and her family and submitted information to the Review.

These lessons, and the matters raised by the scrutiny of the Panel, help to refine the emerging themes and the action plan agencies will be expected to address at the end of this Review. The proposed lessons to learn are set out below by those agencies that have identified specific opportunities for development:

West Midlands Police
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.

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.

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
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
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.

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.

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

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.

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

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.

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.

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.

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

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.

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.

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.

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.

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.

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

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.

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.

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

University Hospitals Birmingham
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.

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
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
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.

Evidence of working with partners to better support Mary. There was very little evidence of any analysis of the needs of Mary's children or any concerns noted about the children. However, whilst there was no direct contact with the children, neither of the services referred into provide support to children so this wasn't necessarily expected. There was already a referral into children's services and the IDVA had liaised with the social worker.

Section 8
Events and incidents and identifying emerging themes.

This section of the Overview Report is a consideration of the responses to a number of key incidents described by what the services knew about Mary, the responses to the key lines of enquiry, coupled with observations from the Panel.

The Panel considered the key elements from the aforementioned sections of the Report for some time in order to distil the information shared by the agencies during and prior to the formal scope of the Review.

This consideration illuminated a number of complex points upon which the circumstances that led to the death of Mary appear to turn. These points 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 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[15]. 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 Panel was encouraged to note that Child Safeguarding policies across Solihull have been reviewed and updated in light of the Domestic Abuse Act 2021.

[15] 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 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

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 9
CONCLUSION

9.1 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.

9.2 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.

9.3 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.

9.4 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.

9.5 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.

9.6 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 10
Recommendations

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.

Full article: The Interplay among Parents' Stress, Nonparental Childcare, and Child Language Development among Low-Income Toddlers (tandfonline.com) - useful couple of paragraphs at the beginning about socio-economic stress and parental stress.

Mom Power: preliminary outcomes of a group intervention to improve mental health and parenting among high-risk mothers | Archives of Women's Mental Health (springer.com) - again, couple of useful paragraphs towards the beginning on maternal trauma and mental health impacts.

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.

Appendix 2

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.

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

NOTE:
Please note that the Panel does not have consent to receive details from any specific records regarding any other members of the family of Mary. If the records you hold concerning Mary include coincidental information disclosed by Mary concerning Adult 2, Adult 3, Child 1, Child 2 or Child 3 or any other member of the family, 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), or the Author of the Report.

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?

Appendix 3

1. **Care, Guidance and support.** The school has a strong pastoral structure that has been an area of real investment by the school hence the provision made is outstanding. Pastoral managers and Heads of Year are very knowledgeable about their students with the student achievement manager ensuring rigorous monitoring procedures are used effectively, in particular that vulnerable groups of students are identified and supported appropriately. Evidence shows there is considerable support with the year 6/7 transition and at key points in a students career support/counselling is made available. Student mentors play a key role in the school.
2. **Safeguarding** is a priority for the school. The school has excellent systems for safeguarding and this was recognised by Ofsted. The school have completed and returned the LA child protection audit. The school takes e-safety seriously with many opportunities being made available to students to ensure they fully aware of all issues. Parents are also kept informed via an annual meeting and the distribution of e-safety practical advice leaflets.
3. **Behaviour and Attendance.** The school gains student feedback regularly utilizing surveys/questionnaires to gauge opinion and then follows up issues raised. For example as a consequence of Tellus 4 survey results the school have identified an area of refocus as anti-bullying.

Appendix 4
Examples of relevant policies:

a. B&S Mental Health Trust has a specific Safeguarding Adults Policy (RS 26) that should be applied and operated in conjunction with both Chapter 14 of the national statutory guidance document "Care and Support Statutory Guidance" (The Care Act, DoH 2014) and with the Safeguarding Adults Procedures endorsed by the Local Safeguarding Adults Boards which serve the areas covered by BSMHFT.
b. WMP has procedures are in place to identify, refer and escalate concerns of DA to safeguarding services either directly if necessary, but also through the referral portal and within the DARA assessment.
c. The ICB has safeguarding policies and procedure in place and a safeguarding advice line. The practice included in this Review is also an IRIS trained practice
d. SCH operates in accordance with the Council's Corporate Safeguarding Policy. Staff are required to fully read and understand the Corporate Safeguarding Policy and to complete mandatory training in line with Council requirements. Mandatory corporate training requirements for safeguarding in the Housing Options Team include the following:
    Safeguarding Foundation,
    Safeguarding Adults,
    Safeguarding and Child Protection for Non Children's Service Workers,
    Domestic Abuse Awareness.
e. CSC have MARAC, MAPPA, Clare's Law and Sarah's Law information sharing procedures in place. Adult safeguarding and adult services referral process are embedded in practice.
f. School services provide assurance that they are compliant with Keeping Children Safe in Education through the annual completion of a self-assessment procedure
g. UHB has policies and procedures to identify, refer and escalate concerns to appropriate services. For example:
    Adult Safeguarding Policy & Procedure
    Children Safeguarding Policy and Procedure
    Domestic Abuse Procedure
h. B&S Women's Aid noted that when a risk of imminent or serious harm and/or other high risk indicators are identified, they are assessed with management oversight. Decisions are then made regarding MARAC and children's/adults safeguarding. Any women identified as being a repeat referral are flagged with service managers for discussion as well as all cases of recent physical assaults against women.

DHR 11 – Recommendations – Action Plan						
1	**Theme: Practice and Process**					
	Recommendation	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Target Date**	**Progress/Outcome**
	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	**Childrens Services**	* *To note that these improvements were referred to in the 'lessons learnt'. Hence, as per the Home Office Guidance – 2016 – these should be familiar to the Service.* The Panel representative from Children's Social Care to provide an update on the progress being made concerning the delivery of each improvement.	Childrens Services SMBC	September 2025	Throughout 2024 we have rolled out bespoke outcome focussed plans and planning workshops to our workforce with the last workshop being delivered in December 2024 and we will continue these throughout 2025 with the next workshop is planned for March 2025. All of our forms on the Children's Services Liquid Logic recording system have been developed to focus on outcomes and we undertook a dip sample audit on plans in October 2024 and have further dip sample audits planned in to 2025 We are seeing increased evidence of the voice of the child in our plans and planning and assessments and this is also reflected in findings from children's Services single agency audits and also multi-agency audits completed and the SSCP have also issued guidance in this area to partner agencies Our QA work is telling us the voice of the child is becoming stronger in our work and we have seen an increase in children and young people attending child protection conferences month on month since early 2024 We have a dip sample audit planned in January 2025 focussing on Children and Family Assessments and including the voice of the child

						and also a dip sample audit in February 2025 around domestic abuse and identification and assessment of risk Early work took place towards the end of 2024 with our workforce colleagues to plan, commission and then roll out in to 2025 trauma informed practice and motivational interviewing to our workforce to upskill them in this area of practice and this will be a key feature of our workforce offer in 2025 Our frontline practitioners continue to seek advice and guidance from the 2 Domestic Abuse specialist practitioners from Way through who are based within the service and also offer specific training each month on a range of domestic abuse issues. There remains a evidenced based perpetrator programme in place locally although work is taking place across the West Midlands region led by the OPC in this area Our Way through colleagues will and do advise practitioners in safety planning around domestic abuse linked to specific individuals Our assessments have improved over time to consider parental mental health and the impact on children and we are due to undertake a themed dip sample in January 2025 relating to our assessment work and the identification of risks
2.	**Theme: Practise & Process**					

	Recommendation	Scope of recommendation	Actions to take	Lead Agency	Target Date	Progress/ Outcome
	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).	Childrens Services SCH	* *To note. This recommendation is referred to in the 'lessons learnt' and hence will be familiar to the service. <u>However</u>, it was not listed as an current area of improvement.* The Panel representative from Children's Social Care to provide an update to the Partnership on the action required to describe the threshold and to describe what new or existing arrangement will be used to 'triangulate' and share relevant information concerning the needs of the client.	Childrens Services	April 2025	There is currently a multi-agency threshold document in place that is due for refresh by the SSCP in line with the work taking place around early help and earliest help. Where there are specific housing needs Children's Servies will work closely with our housing colleagues linked to assessment and planning Our Children and Family Assessments have been developed to ensure information is gathered from other agencies as part of the assessment process
3.	**Theme: Process, Procedure & Training**					
	Recommendation	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Target Date**	**Outcome**
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.		SCH	* To note that this matter was referred to in the 'lessons learnt'. Hence, as per the Home Office Guidance – 2016 – this invitation should be familiar to the Service.	SCH	Implemented	See below
			Ensure there is a process for 'prompt referral';		Implemented	SCH employ a Mental Health Advice and Support Worker who delivers advice and guidance to all staff and where appropriate direct intervention

					with a customer. All staff can make a referral to the MH Officer through a simple online referral form . Staff alert the MH officer where they are actively involved in a case and support from the MH Officer would be beneficial with joint interventions. The MH Officer makes a judgement as to whether a safeguarding referral is needed; as will all front line officers. Not all cases will meet the threshold for statutory services but SCH will always err on the side of caution and make a referral if they become concerned about an individual's behaviour. Housing applications, where a customer has indicated they have a disability that is affecting their housing either through identification of a disability or through additional notes on their application form, SCH send a link to the customer to complete a medical self-assessment. Where needed, Officers will support the applicant through the process. Where the individual is of concern to an Officer either as a result of behaviour or critical information provided on an application form, they will make the relevant safeguarding referral to Adult Social Care and/or involve SCH's MH Officer
		Ensure that a full chronology of contacts with clients is maintained;		30/05/25	Review of current process to be completed
		Provide mental health training to all staff;		Implemented	SCH employ a Mental Health Advice and Support Worker who delivers operational specific MH training to all front line practitioners. The roll out of the training programme included both direct

					Community Safety staff and all of the wider business teams. All staff undertake mandatory mental health awareness e-learning training
		Ensure that there is a process in place to act appropriately when ASB is referred to on the application for accommodation.		30/05/2025	ASB policy in place and action plans produced when a case is identified however a review of the process for issues are referred to during the housing application stage to be completed
4.	**Theme: Training & Process**					
	Recommendation	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Target Date**	**Outcome**
	The Panel recommends the Safer Solihull Partnership: o Supports the ambition to offer IRIS training to every GP Practice within the Solihull area; o Seeks assurance from the ICB that a process for the accurate and effective coding of domestic abuse is available within each Practice	**ICB**	***** *To note: when resources allow the training to be expanded and/or enhanced* IRIS Training – This is undergoing a full review by the ICB procurement team and the Lead for serious violence The safeguarding admin and champions within the GP practices will be responsible for ensuring that domestic abuse is coded correctly within their systems.	**ICB**	September 2025 Complete	Audits have been undertaken in the last quarter across a number of practices and evidence that staff are aware of the coding
5.	**Theme: National Best Practise Guidance**					
	Recommendation	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Target Date**	**Outcome**
	The Panel recommends the Safer Solihull Partnership: Invites the University Hospitals Birmingham NHS Foundation Trust	**UHB** **BSMHFT**	*BSMHFT and UHB can evidence that they are taking steps to deliver the standards contained within the guidance*	**BSMHFT** **UHB**	Ongoing	*UHB* Routine enquiry is undertaken in maternity services and sexual health. Selective enquiry is completed in all other areas. There is a regular audit programme which supports this activity

	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.		* *The Panel did recognises that it can be very challenging to provide clear objective evidence of certain elements of the guidance and standard (for example, partnership working, 'routine enquiry') and that there may be limitations due to the clinical recording systems that are currently in place.* The Panel did discuss inviting the Domestic Abuse Board (or the equivalent in Solihull) and/or the Learning from Deaths Committee to act as the Partnership arrangement for assessing the delivery of the guidance and standard			All mandated safeguarding training for clinical staff includes advocacy with enquiry and the importance of partnership working. The safeguarding teams are co-located to support in appropriate working across adults and children and ensure a think family approach is used Safeguarding supervision is offered in sexual health, children's services and EDs and this is supported by a regular on-site presence, particularly in the emergency departments The Trust intranet pages provide resources for all staff supported by an advice line provided in office hours *B&SMHFT:* *The Safeguarding Team promote Partnership Working and routine enquiry in all contacts with our clinical staff. Both are themes that run through all BSMHFT's Safeguarding Training for Children and Young people and Adults to all qualified staff. BSMHFT have dedicated domestic Abuse training where the rationale for Routine Enquiry is explored further, this is also promoted with BSMHFT's Think Family Standard (see previous recommendation).* • *The Safeguarding Team offer Safeguarding supervision to clinical teams (statutory for all CAMHS services) where we reflect on the importance of both partnership working and routine enquiry.* • *B&SMHFT also has a dedicated Safeguarding website accessible to all practitioners in BSMHFT where there is a host of safeguarding information and resources including 7 minute Briefing on Routine Enquiry.*

						• *B&SMHFT offer an advice line available Mon/Fri to assist all practitioners with safeguarding concerns where we promote the importance of partnership working and Routine Enquiry.* Each Guidance is reviewed periodically, the Clinical Effectiveness Team contact each subject matter lead such as BSMHFT safeguarding team to review specific NICE guidance and report back what work is being carried out. This is then reported through QPES (Quality Patient Experience and Safey) Committee for assurance. NICE Guidance PH50 and NICE Quality Standard are in effect with in BSMHFT. Link to NICE baseline assessment tool below: Tools and resources | Domestic violence and abuse: multi-agency working | Guidance | NICE Link to NICE guidance QS116 below: https://www.nice.org.uk/guidance/qs116
6.	**Theme: Best Practice**					
	Recommendation	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Target Date**	**Outcome**
	The Panel recommends the Safer Solihull Partnership: Seeks assurance from the agencies and professionals supporting this Review that the key elements	Solihull Safeguarding Adults Board: Engagement & Prevention Sub Committee	Ensure local alignment to the 8 national suicide prevention priorities, Suicide prevention in England: 5-year cross-sector strategy - GOV.UK	Solihull Suicide Prevention Action Group (SMBC)	December 2026	The current Solihull Suicide Prevention Strategy is 2023 – 2026. The Solihull Suicide Prevention Action group has oversight of the strategy and meets quarterly. The Solihull Safeguarding Adults Board: Engagement & Prevention Sub Committee, also meet quarterly.

	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.	**Theme: Training and Policy**					
	Recommendation	**Scope of recommendation**	**Actions to take**	**Lead Agency**	**Target Date**	**Outcome**
	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.	**Education**	** To note that this matter was referred to in the 'lessons learnt' and single agency action plan. Hence, as per the Home Office Guidance – 2016 – this recommendation should be familiar to the Service it applies to.* Once the regional police-led review of Operation Encompass has taken place, update local guidance and share with schools. Provide education specific DA training in addition to the SSCP offer through and external provider plus DSL days.	**Education**	March 2025 February 2025	Progress outcome can not be provided until after the review has taken place Two trainings sessions have taken place that are DA sector specific. The final one is in February. Other DA training is promoted to schools. For the second year running, DA will feature as a workshop at the DSL conference.