

DOMESTIC HOMICIDE REVIEW - OVERVIEW REPORT

Solihull Community Safety Partnership

Report into the death of Craig

September 2022

Report produced by Simon Steel – Foundry Risk Management Consultancy Ltd

Report Completed June 2025

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Craig

The entire family shared similar sentiments. They described their Craig as a warm, gentle, and fun-loving person with a laid-back nature that made people naturally gravitate toward him. He had a fantastic sense of humour, often lightening the mood with his quick wit and infectious laughter. His ability to find joy in everyday moments made him a delight to be around, and his presence was a source of comfort and happiness for those who knew him.

Craig had an unwavering passion for cars, which was a defining aspect of his life. He loved everything about them, the mechanics, the design, and the thrill of driving. He spent countless hours working on cars, often turning a simple repair into a labour of love. His enthusiasm for cars wasn't limited to fixing them; he was also an avid follower of automotive reporting. He enjoyed staying up to date with the latest industry trends, innovations, and models, often discussing his insights with friends and family.

Driving was another one of his great joys. For him, being behind the wheel wasn't just about reaching a destination, it was about the journey itself. He particularly loved taking road trips, where he could explore new places and share adventures with his family. When his children were younger, he would plan holidays across Europe, packing up the car and embarking on memorable road trips. He relished the freedom of driving through different landscapes, discovering hidden gems, and creating unforgettable memories along the way.

1. Foreword

- 1.1 The Solihull Community Safety Partnership would like to express their condolences to all those affected by the sad loss of Craig. This review sincerely hopes the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening again in the future.
- 1.2 The independent chair of this Domestic Homicide Review panel would like to thank all agencies who contributed to the process in an open and transparent manner. This review has demonstrated that it is crucial to offer appropriate and timely help and advice to victims of domestic abuse, their families, friends, and professionals. The panel is confident that the learning points and recommendations will provide a platform to help agencies to implement measures designed to embed a preventative approach to addressing domestic abuse.
- 1.3 We all must do our utmost to take immediate action to protect victims and to deal effectively with the perpetrators of domestic abuse and the chair would urge everyone to take note and act on the findings of this review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline, and community level to help bring these types of incidents to an end.

2. Timescales

- 2.1 West Midlands Police (WMP) police referred this matter to the CSP on the 13th of September 2022. Following a review contact was made with the Home Office on the 11th of July 2023 informing them of the Partnership's intention to carry out a Domestic Homicide Review into this matter. A letter of reply and agreement was received on the same day.
- 2.2 The panel have discussed the delay in this process, and it has been confirmed that there was a transition of the DHR process to Public Health. Transition arrangements started at the beginning of July. With effect from 1st August, the completion of the transfer brought all aspects of domestic abuse together, with the DHR process and management, along with the support officer, the Community Safety Administrative Officer transferred from the Economy and Infrastructure Directorate to the Public Health Directorate.
- 2.3 The notification of a possible DHR review case was received by the CSP on 13th Sep 2022. Scoping with agencies took place during September/ October 2022 and an overview of the case presented to the CSP at a special DHR meeting on 12th October 2022. The CSP decision was to conduct a DHR.
- 2.4 Chairs were contacted for expressions of interest (EOI) regarding their ability to conduct a review. On the 9th of December, the DHR Executive group were presented with the results of the Chairs EOI. Due to the low numbers of candidate's availability, the group were unable to make a recommendation based on the replies received and proposed that a bespoke recruitment panel be established to make recommendations on the appointment. The panel was convened in the New Year 2023 and over several months made approaches to Chairs.
- 2.5 Due to low numbers of EOIs the appointment process was protracted. The reason being the high national demand for DHR/safeguarding reviews chairs. The number of available suitable chairs was insufficient for an appointment to be made expeditiously. After several attempts to solicit suitable chairs recommendations on an appointment

were made to the DHR Executive group members in May 2023, ratified by the CSP in June 2023 with formal appointment of Simon Steel started in June 2023. The CSP also recognises that it did not inform the Home Office when they made the decision to conduct this review, it is acknowledged that this was a one-off error at the time.

- 2.6 Simon Steel was commissioned to provide an Independent Chair (hereafter ‘the chair’) for this review on the 29th of August 2023. The completed report was passed to the Community Safety Partnership (CSP) in June 2025. It was submitted by the CSP to the Home Office Quality Assurance Panel in September 2025.
- 2.7 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was extended for several reasons:
- As outlined above
 - Since August 2023 there have been multiple meetings between the chair, panel members and authors to discuss the content of the IMR’s.
 - To support engagement with Craig’s family.

3. Methodology

- 3.1 This report uses the cross-government definition of domestic violence and abuse This review commenced after the Domestic Abuse Act receiving royal ascent in April 2021 and defines domestic abuse as:

- The Behaviour of a person (A) towards another person (B) if.
 1. A and B are each aged 16 or over and are personally connected to each other and
 2. The behaviour is abusive.
- Behaviour is abusive if it consists of any of the following:
 1. Physical or sexual abuse.
 2. Violent or threatening behaviour.
 3. Controlling or coercive behaviour.
 4. Economic abuse.
 5. Psychological, emotional, or other abuse.

It doesn’t matter whether the behaviour consists of a single incident or a course of conduct.

Two people are Personally Connected to each other if any of the following applies.

1. They are, or have been, married to each other.
2. They are, or have been, civil partners of each other.
3. They have agreed to marry one another (whether or not the agreement has been terminated).

4. They have entered into a civil partnership agreement (whether or not the agreement has been terminated).
5. They are, or have been, in an intimate personal relationship with each other.
6. They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2)).
7. They are relatives.

It is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse, psychological, physical, sexual, financial, and emotional.

Controlling behaviour is a range of acts designed to make a person subordinate and dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation and forced marriage and is clear that victims are confined to one gender or ethnic group.¹

This review has followed the statutory guidance. On notification of the death, agencies were asked to check for their involvement with any of the parties concerned and secure their records. It was during this scoping process that chronologies were collated and combined. This overview was reviewed by the chair and Individual Management Reviews (IMRs) were requested from Child Social Care (CSC), Education, WMP, ICB (General practice) and reports requested from BSWAID, Midwifery and SIAS.

Document Reviewed

In addition to the combined chronology and IMR's, various documents and open source research has been carried out including:

- o Website for commissioned service for domestic abuse support
- o Home Office Documents referring to key findings from analysis of previous DHR's.
- o Citizens Advice document regarding "What is Public Sector Equality Duty".
- o Safer Solihull website – Domestic Homicide Reviews
- o Screening women for inter-partner violence in healthcare settings (Review), Cochrane Library. 2015
- o The Royal College of Nursing – Roles and Responsibilities of Health care staff.

Panel Meetings

Review Panel meetings took place on 13th of September 2023, 18th of October 2023, 30th of January 2024, 28th of February 2024 and the 16th of April 2024. The chair held several

¹ <https://www.gov.uk/government/news/new-definition-of-domestic-violence>

individual agency discussions with panel representatives, and authors to seek clarification on points within agency IMR's and review Key Lines of Enquiry.

4. Contributors to the Review

4.1 The following agencies and the contributions to this review are:

Agency	Contribution
West Midlands Police	Chronology and IMR
Solihull Metropolitan Borough Council Childrens Services	Chronology and IMR
Integrated Care Board (ICB) for general practice	Chronology and report
Solihull Metropolitan Borough Council Education	Chronology and IMR
Nottingham University Hospitals NHS Trust (Midwifery)	Chronology and IMR
Birmingham & Solihull Women's Aid (BSWAID)	Chronology and IMR
Solihull Integrated Addiction Services (SIAS)	Chronology and IMR

4.2 Quality and Independence of the IMR authors. The IMR's were prepared by authors who were independent of any service delivery or case management regarding Craig or Mavis. The IMR's were comprehensive and allowed the panel to analyse the contact with Craig & Mavis. The detail ensured that the panel were able to identify learning and recommendations for this review and where necessary, follow-up meetings were held, and questions sent to agencies. Responses were received, prior to, or at, subsequent panel meetings.

5. Review Panel Members

Role/Job Title	Agency
Independent Chair and Author	Foundry Risk Management Consultancy Ltd
Detective Sergeant	West Midlands Police IMR team
Senior Strategic Delivery Manager for Domestic Abuse, Sexual Abuse and Sexual Health	Solihull Metropolitan Borough Council

Head of Service, Safeguarding and Quality Assurance	Childrens Services Solihull Metropolitan Borough Council
Head of Service Care and Support	Adult Social Care Solihull Metropolitan Borough Council
Administrative Support	Solihull Metropolitan Borough Council
Interim Head of Commissioning Public Health	Solihull Metropolitan Borough Council
Lead Nurse – Adult Safeguarding	University Hospital Birmingham
Senior Public Health Specialist Adults and Mental Health	Solihull Metropolitan Borough Council
Designated Nurse Safeguarding Children & Adults (Lead for Adults)	Birmingham & Solihull integrated Care System
Senior Education Improvement Adviser	Solihull Metropolitan Borough Council
Community Safety Manager	Solihull Community Housing
Solihull Refuge Manager	Birmingham & Solihull Women's Aid
Named Nurse for Domestic Abuse	Birmingham Solihull Mental Health Services inc Solihull Integrated Addiction Services

6. Author of the Overview Report

- 6.1 Simon Steel was appointed by the Solihull Community Safety Partnership as Independent Author of this Domestic Homicide Review panel. Simon is a retired Thames Valley Police Detective. He has considerable experience in the field of domestic abuse, Public Protection and Safeguarding. His experience includes specialist, strategic and generic investigative roles across the Thames Valley. He has also led complex Domestic Homicide Investigations.
- 6.2 Since retirement, Simon has established his own consultancy business and has now chaired multiple Domestic Homicide Reviews. Simon has been subcontracted by Foundry Risk Management who have a long history of chairing reviews.
- 6.3 Simon has also worked as the Head of Adult Support for an autism charity within the voluntary sector who are commissioned by local authorities and Integrated Care Boards (ICB). Simon has also worked as a Learning Disability and Autism Champion for an ICB. Simon believes his work alongside statutory, non-statutory and voluntary sector organisations provides him an enhancement to his policing portfolio.

- 6.4 Simon has completed Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse (AAFDA) in 2022. In August 2024 Simon successfully completed the new Home Office approved training delivered by AAFDA. Simon has also completed a CPD in 2024 hosted by AAFDA regarding suicide in Domestic Abuse.
- 6.5 Simon has no connection with the Solihull Community Safety Partnership.

7. Equality and Diversity

- 7.1 The review panel considered all 9 protected characteristics under the Equality Act 2018 as follows:
- Age
 - Disability
 - Gender Assignment,
 - Marriage and Civil Partnership.
 - Pregnancy and Maternity
 - Race
 - Religion and Belief
 - Sex
 - Sexual Orientation.
- 7.2 The panel reflected upon each of these in evaluating the various services provided to Craig. It is incumbent on this review to consider the duty on public authorities to; remove or reduce disadvantages suffered by people because of a protected characteristic, meet the needs of people with protected characteristics, encourage with protected characteristics to participate in public life and other activities ².
- 7.3 Each protected characteristic was analysed by both individual agencies and the panel, against policies and procedures that were in place at the time of the death of Craig. The protected characteristics that the panel agreed was pertinent to this review was sex and disability (anxiety & depression).
- 7.4 The Centre for Social Justice ³ report that men are often overlooked as victims of Domestic Abuse. The truth is that one third of DA victims are men. Despite representing such a significant proportion of victim's men are silenced by the hostility and incredulity when they open up to police and safeguarding services. Support agencies often overlook cases involving the abuse of men and overlook cases involving female abusers.
- 7.5 Men who experience domestic violence and abuse face significant barriers to getting help and access to specialist support services, according to a study by researchers at the University of Bristol's Centre for Academic Primary Care and Centre for Gender and Violence⁴. The study, funded by the National Institute for Health Research, looked at what stops men in abusive relationships from seeking help and how services could be improved to make help-seeking easier.

² <https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/>

³ [Why are men often overlooked as victims of domestic abuse?](#)

⁴ [2019: Male victims of domestic abuse | Centre for Academic Primary Care | University of Bristol](#)

- 7.6 The researchers analysed interview-based studies of men in heterosexual and same-sex relationships and organised their findings into a series of themes. Fear of not being believed or being accused as the perpetrator, embarrassment at talking about the abuse, and feeling ‘less of a man’ were found to be key reasons why men did not seek help.
- 7.7 Men also worried about the welfare of their partner, damaging their relationship or losing contact with their children if they opened up to someone outside their personal network of family and friends. Others lacked the confidence to seek help as a result of the abuse. The study also found that men were often either not aware of specialist support services or felt they were not appropriate for male victims of abuse. When men did seek help, they did so usually when their situation had reached a crisis point.
- 7.8 Confidentiality was very important to those seeking help from services, as were trust, seeing the same person over time, and a non-judgemental attitude. There were mixed views about how easy it was to open up to health professionals, such as GPs, but men consistently expressed a preference for receiving help from a female professional.
- 7.9 Disability: Safelives Safe and Well reports⁵ highlights domestic abuse can have a severe and long-lasting impact on mental health and survivors often find it difficult to access the support they need. Victims and survivors with mental ill health are also more likely to have other complex needs. We must see the whole picture for every victim, survivor and family so that everyone can be free to live the lives they want to live. An analysis of DHRs⁶ reveals where a vulnerability was recorded those most often noted of the victims, for 34% a vulnerability was mental ill-health. The panel has recognised the lack of visible services available to male victims of domestic abuse within Solihull. It is against the background of concerns raised in such reports, that the review will consider the circumstances of Craig’s death.

8. Dissemination

- 8.1 Once finalised by the Review panel the Executive Summary and Overview Report will be presented to the Safer Solihull Partnership (SSP). Upon approval they will be sent to the Home Office for Quality Assurance.
- 8.2 The recommendations will be owned by Safer Solihull Community Safety Partnership (SSCSP), who will be responsible for disseminating learning through local professional networks as well as managing progress of the Action Plan which is created at the conclusion of this review and in response to the recommendations that have been made.
- 8.3 The following individuals and agencies have been identified as recipients of both reports.

Agency
Safeguarding Children Partnership

⁵ [Domestic abuse and mental health spotlight - SafeLives](#)

⁶ [Key findings from analysis of domestic homicide reviews: October 2019 to September 2020 \(accessible\) - GOV.UK](#)

Safeguarding Adults Board
The Office of the Police and Crime Commissioner
The Domestic Abuse Commissioner
Multi-Agency Domestic Homicide Review Oversight Group
The Family (agreed edited version)
All Panel Members

- 8.4 In approaching learning and recommendations, the Review Panel has sought to do two things. First, to try and understand what happened and consider the issues in Craig's life that might help explain the circumstances of his death. Second, to use this case to consider a wider range of issues locally, including provision for male victims of domestic abuse.

9. Lessons to be Learnt

- 9.1 The review identified several learning points that build upon agency IMRs. Information provided by the agencies involved in this review would appear to demonstrate that there are several themes that need to be considered because of Craig's death. There are various themes within the review, each of these have been explored, during this process and the various learning points and recommendations are intended to support victims and survivors facing similar difficulties and challenges. In approaching these learning points and recommendations the Review Panel has sought to try and understand what happened and recognise the issues in the life of Craig.
- 9.2 The themes identified are:
- Services for male victims of domestic abuse (the panel identified there were reciprocal allegations of domestic abuse, however the panel identified a disparity in support and service provision for male victims (when compared with the support and service provision available for female victims)
 - Understanding the role of a male victim and improving the pathway for male victims

10. Recommendations

- 10.1 Op Encompass – Review of information sharing, including identifying victim and perpetrator
- 10.2 Recognition of self-harm and suicidal ideation as indicators of domestic abuse victimisation
- 10.3 Recognition that mental health needs are potential indicators of victims of domestic abuse. Agencies to raise awareness based on the research findings around potential indicators of victims of DA.

- 10.4 Recognition that problems with alcohol use is potentially an indicator of domestic abuse.
- 10.5 improve the male pathway and responses to male domestic abuse victims in Solihull.
- 10.6 Address potential bias and assumptions around male victims.
- 10.7 Improve the quality and consistency of capturing children's lived experiences during safeguarding assessments where domestic abuse is a feature