Overview Report

Domestic Homicide Review[1] / Safeguarding Adults Review

into the Death of:

"Claire"

Month/Year of Death: July 2022

Independent Report Author: Allison Sandiford

[1] Soon after this 'Domestic Homicide Review' was commissioned, the name of such reviews was changed to 'Domestic Abuse Related Death Review', in order to better reflect all deaths which fall within their scope. The changes were brought into law via an amendment to the Victims and Prisoners Bill which received Royal Assent at the end of May 2024.

Contents

1. Introduction

1.1. This joint report examines agency responses and support given to a female who is referred to under the pseudonym of Claire (a resident of Shropshire) prior to the point of her death in July 2022.

1.2. In addition to this agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before her death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.3. The circumstances that led to this review being undertaken are that on a date in July 2022, Claire left a party at which her partner, Mr P[2], had ended their relationship. Claire broke into Mr P's home and after a short altercation whereby Mr P has reported that he was trying to get Claire out of his property, Claire locked herself in. Claire called the police reporting that Mr P had dragged her by the hair, and Mr P called the police reporting that Claire was *trashing his home*. Mr P later phoned the police again to report that Claire was now threatening suicide. The police arrived eight minutes later to find Claire deceased. Mr P was arrested and later released as not being involved in Claire's death.

1.4. Claire had previously attempted to take her own life and had been engaging with mental health services over an extended period of time. In 2020, Claire had been diagnosed with Emotional Unstable Personality Disorder.

1.5. Claire had been in previous relationships which were domestically abusive. Though Claire was unable to consistently report the incidents or seek help, it is apparent that she knew how to do so. No agencies reported any disclosures of domestic abuse whilst Claire was in her relationship with Mr P.

1.6. The review will fundamentally consider agencies contact/involvement with Claire from January 2020, when a number of domestic incidents were reported between Claire and a previous partner: hereafter known as Partner 1, until the day when Claire sadly died. However it will also focus upon events from around 2019 when the abuse in the previous relationship commenced and draw on earlier experiences where relevant to help build a fuller a picture of the history of abuse and the impact on Claire.

1.7. The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.8. The purpose of a Safeguarding Adults Review is clearly defined in the Care Act 2014. It is to promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. The lessons learnt for the case should be applied to future cases to ensure continuous improvement of practice.

1.9. It is not the purpose of this review to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation.

2. Timescales

[2] This is a pseudonym

2.1. Commencement of the review was initially delayed as the Partnership did not consider that the criteria for a Domestic Homicide Review had been met, given that the most recent partner was not identified as a perpetrator of abuse. Consequently, the Partnership opted to commission a Safeguarding Adults Review. However following guidance from the Home Office, it was advised that a Domestic Homicide Review should proceed, and after multiple correspondences with the Home Office, the Governance Group determined that a joint Domestic Homicide Review and Safeguarding Adults Review would be commissioned.
2.2. The review then began on the 14th of August 2023 and concluded on the 19th of April 2024. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. This review has taken slightly longer owing to accommodating several popular holiday periods, namely Christmas, New Year and Easter. Furthermore, timescales have been extended to allow Shropshire Safeguarding Community Partnership to explore avenues of contact with Claire's children and to accommodate delays in agency responses with regard to the final draft.
2.3. There was additional delay as the Overview Report and Executive Summary could not be agreed by the Community Safety Partnership until January 2025. This was because the process for signing off statutory case reviews was being reviewed and completed reports had to be held until decisions had been agreed by the Governance Group.
2.4. The Overview Report and Executive Summary were submitted to the Home Office on the 14th of January 2025.

3. Confidentiality

3.1. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.
3.2. To protect the identity of the individuals involved, the subject of this review (who was 48 years old at the time of her death), is referred to under the pseudonym[3] of Claire. Her partner at the time of her death (who was aged 44 years) is referred to under the pseudonym of Mr P[4].

4. Terms of Reference

Methodology

4.1. Shropshire's Joint Case Review Group recognised that this case met the criteria for a Safeguarding Adults Review under The Care Act 2014, which states that '*Safeguarding Adult Boards must arrange a Safeguarding Adults Review when an adult dies as a result of abuse or neglect, whether known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult.'*
4.2. However, upon consultation with the Home Office Quality Assurance panel, the Shropshire Joint Case Review agreed that the case would benefit from a joint Safeguarding Adults Review and Domestic Homicide Review on the basis that a combined review is important as Claire took her life by suicide, and there was significant previous domestic abuse in her life.
4.3. Following the receipt of agency chronologies and independent reports, an initial scoping and first panel meeting was held on the 14th of August 2023, where agency representation, terms of reference, the scoping period and the project plan were agreed.

[3] Pseudonyms were chosen by the Community Safety Partnership panel due to no successful contact being made with family.
[4] Both individuals are white British.

4.4. This was followed by the completion of supplementary agency reports, and the panel further met on the following dates to monitor the review process and contribute to the analysis and learning:

- 6th of November 2023
- 17th of January 2024

4.5. It was agreed not to convene a practitioner learning event for this review due to a number of professionals who had worked with Claire, no longer remaining in their roles and/or being available. Practitioners voices were heard through documentation and where possible individual consultation[5].

4.6. Whilst applying the principles of proportionality, learning from good practice, and engagement with families, the independent reviewer has followed both the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, as amended in December 2016 and the Safeguarding Adults Review Quality Markers identified by the Social Care Institute for Excellence

4.7. The panel identified the following key lines of enquiry for the review:

- What did professionals understand about Claire's lived experience and how was Claire's voice heard and responded to?
- What risk factors had agencies identified during previous involvement with Claire and how did this affect agencies responses to concerns within the scoping period?
- Could information sharing (within and between agencies) have been improved during the scoping period? And identify any missed opportunities for multi-agency referrals.
- Did professionals recognise and address all the concerns regarding mental health, domestic abuse, and substance use, and was consideration given to how one could potentially affect another? What would a good multi-agency response look like?
- How well did professionals explore Claire's understanding of domestic abuse, (including emotional abuse, physical abuse, sexual abuse, harassment and stalking, financial abuse, and coercive control) and what support was offered (both within the scoping period and historically) to support Claire to understand and manage her relationships?
- How did professionals explore Claire's substance use?
- Were there any missed opportunities to exercise professional curiosity?
- How has the Covid Pandemic impacted upon Claire and any support offered?
- Identify examples of good practice, both single and multi-agency.

Involvement of Family, Friends, Colleagues, Neighbours and Wider Community

4.8. Shropshire Safeguarding Community Partnership and the independent reviewer would like to offer their condolences to the family and friends of Claire.

4.9. The Partnership wrote to Claire's parents and Mr P to notify them of the review on the 12th of September 2023. A copy of the Home Office Domestic Homicide Review leaflet for family members was included.

4.10. In addition, when no response was received to the letter, the coroner contacted Claire's parents and requested that they contact Shropshire Safeguarding Community Partnership.

4.11. So far, there has been no response from either party. The reviewer and the Partnership understand and respect any decision not to be part of this process.

4.12. It has not been possible to send any communication to the children of Claire as their addresses are unknown. The independent reviewer will ask that if their whereabouts becomes known in the future, this review, its process, and its findings be explained to them in detail.

[5] The reviewer met virtually with a worker from Connexus – Domestic Abuse Support – who had worked directly with Claire.

4.13. A friend of Claire's was identified by Claire's domestic abuse support officer. Given the established relationship the domestic abuse support officer had with the friend, the support officer (who only had a contact telephone number for the friend) attempted to call them to inform them of the review and ask permission for their details to be passed to the independent reviewer with a view to them contributing to the process. However the officer's two calls were unanswered, and messages were not replied to. It was therefore agreed that the attempts should stop.

Contributors to the Review

4.14. The following have contributed to the review by way of agency reports.

- Shropshire Children's Social Care
- Staffordshire Children's Social Care
- Hobs Moat Medical Practice
- University Hospitals Birmingham
- Birmingham and Solihull Mental Health Foundation Trust
- West Mercia Police
- Shropshire and Telford and Wrekin Hospital Trust
- Shropshire Community NHS Health Trust
- West Midlands Ambulance Service
- West Midlands Police
- Warwickshire Police
- Midlands Partnership Foundation Trust
- Shropshire Domestic Abuse Service
- Claverley Medical Practice

4.15. All authors confirmed their independence. None have been directly involved with either Claire or Mr P.

The Review Panel Members

The membership of the Review Panel is;

- Allison Sandiford – Independent Reviewer
- Paul Cooper – Shropshire and Telford and Wrekin Integrated Care Board
- Christine Harris – Staffordshire Integrated Care Board
- Sonya Miller - Assistant Director, Children's Social Care
- Jennie Lowe – Principle Social Worker, Children's Social Care
- Cezar Sarbu – Service Manager, Adult Services
- Jordan Baker – Detective Inspector, West Mercia Police
- Wendy Bulman – Domestic Abuse Strategic Lead, Shropshire Council
- Sharon Conlon - Midlands Partnership Foundation Trust
- Claire Caddick – Superintendent, West Midlands Police

Author of the Overview Report

4.16. The report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with no links to Shropshire Safeguarding Community Partnership or any of its partner agencies.

4.17. Allison gained experience in domestic abuse and safeguarding both adults and children whilst working for a police service. Allison was part of a team responsible for the force's contribution to delivering Early Help, preventive support and problem-solving interventions for adults and children, in partnership with other key local and regional agencies. She represented

the force at strategy meetings and protection conferences to assess risk and negotiate actions with other agencies to instate interventions to safeguard individuals' lives. She also gained experience in chairing meetings, conferences, and partnership initiatives such as daily management risk meetings and Multi-Agency Risk Assessment Conferences.

4.18. In 2019 Allison completed the SILP Lead Reviewer Course[6] and has since conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews, both independently and with SILP.

4.19. Allison has also completed the Home Office online learning with regard to conducting Domestic Homicide Reviews and she has a positive attitude to continuing professional development and regularly attends training and seminars.

Parallel Reviews

4.20. The police have investigated the matter and concluded that Claire took her own life.

4.21. HM Coroner has formally ruled Claire's death as suicide.

4.22. Midlands Partnership NHS Foundation Trust informed Shropshire Safeguarding Community Partnership that they had undertaken a Serious Incident Level 1 Clinical Review. The recommendations made in the report can be found at Appendix 1.

Equality and Diversity

4.23. The independent reviewer has considered the nine protected characteristics under the Equality Act 2010 (age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation).

4.24. Claire was a white British female, and Mr P is a white British male. Both reside in the United Kingdom. They were in a relationship but were not married and did not reside in the same home. Claire has children, but they did not have any children together.

4.25. Whilst the review understands that domestic abuse can affect anyone, regardless of age, disability, gender identity, gender reassignment, race, religion or belief, sex, or sexual orientation, it is recognised that in the year ending March 2020, an estimated 1.6 million females aged 16 to 74 years experienced domestic abuse[7]. This is in comparison to an estimated 757,000 males.

4.26. Statutory guidance into when a Domestic Homicide Review should be completed was changed in 2016 to include cases where a victim takes their own life, but the extent of domestic abuse related suicide is only now beginning to emerge, encouraged by the work of campaigners such as the charity 'Advocacy After Fatal Domestic Abuse'. In February 2023 Agenda Alliance published the briefing paper, *Underexamined and Underreported*[8], which found that women who experienced abuse from a partner are three times more likely to have made a suicide attempt in the past year compared to those who have not experienced abuse. And sexual abuse puts victims at raised risk of self-harm, suicidal thoughts, and suicide attempts. These findings have led to fresh calls for all professionals across healthcare, justice, education, and welfare sectors to be trained to better understand and respond to women at risk of both domestic abuse from their partner, and of suicidal thoughts and suicide attempts.

4.27. Shropshire's Domestic Abuse Development Officer assisted the review panel to be better informed on issues relating to women experiencing domestic abuse and the support available.

[6] SILP is an approach to reviewing cases in the context of Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, Domestic Homicide Reviews and any other form of learning activity.

[7] Domestic abuse in England and Wales: November 2020 - GOV.UK (www.gov.uk)

[8] Underexamined and Underreported - Agenda Alliance

Dissemination

4.28. Once agreement for the final report has been given by the Home Office Quality Assurance Panel, this joint Domestic Homicide and Safeguarding Adults report will be available on the council website. The report will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 1998.

4.29. Upon publication, partner agencies will be made aware, and the action plan will be shared with the agencies involved and the Adult Statutory Case Review Group.

4.30. The review has been assured by Shropshire Safeguarding Community Partnership that the learning will be disseminated using the following means:

- A communication plan will be developed ahead of publication.
- A Learning Briefing will be developed for dissemination to partner agencies and uploaded on to websites and intranets.
- Learning will be incorporated into any multi-agency learning events.
- Consideration will be given to a Learning Event, facilitated by Shropshire Safeguarding Community Partnership, to cascade learning to frontline staff.

5. Background Information (The Facts)

5.1. On a day in July 2022, a 999 call was received from Claire at 17.54 hours. Claire said that Mr P had ordered her out of his house and dragged her by her hair, but she had locked herself inside his address with the children (no children were found to be at the property). Claire stated that Mr P was under the influence of cocaine and *'involved in all sorts'*. She also said that a television had been thrown out of the window and that they had both been drinking.

5.2. At 17.55 hours Mr P contacted 999 to report that Claire had broken into his property and that he was concerned Claire was wrecking his house as she had thrown a television out of the window.

5.3. Mr P's property is close to the border of the police force areas and consequently the 999 call had been initially misdirected to Warwickshire Police. This review has been informed that this is not unusual, and it was quickly identified that it was West Midlands Police who covered the area. The incident was then referred to West Midlands Police as a high-risk on-going domestic incident, without detriment, at 17.58 hours.

5.4. At 18:00 hours a neighbour called the police having heard an argument between Claire and Mr P.

5.5. At 18.25 hours Mr P rang the police again to say Claire was now threatening suicide.

5.6. West Midlands' police officers arrived at the address at 18.33 hours and found Claire hanging from the shower rail by a dressing gown cord. Officers cut Claire down and commenced cardio-pulmonary resuscitation, but Claire was pronounced deceased by paramedics at 19.15 hours.

5.7. Mr P who had been outside the property when police officers arrived, was arrested for assault and the scene was held whilst officers gathered CCTV and 'ring doorbell' footage to establish a timeline of events.

5.8. Whilst being police-interviewed, Mr P said that he and Claire had been at a friend's house during the day and had drunk about three glasses of wine. Mr P said that he had asked a friend to tell Claire that he wanted to end the relationship. Claire then left the friend's house and headed for Mr P's property where she used ladders to gain access to the property through a window. Mr P admitted that he had pulled Claire's hair. He said he had been trying to remove her from his property.

5.9. Mr P tested negative for drugs in custody. He had been drinking but was not heavily intoxicated, which was contrary to what Claire had reported.

5.10. Mr P had been seen on CCTV in a shop during the time that the calls had been made to the police and as there were no visible marks on Claire's body the death was not deemed suspicious. Officers concluded that Mr P was not involved in Claire's death - which was later determined by HM Coroner as suicide.
5.11. At the time of her death Claire was a resident in Shropshire. She lived alone.
5.12. It has not been possible to establish the details of how or when Claire and Mr P began their relationship. It is known that Claire had previously been in domestic abusive relationships, but there is no reported domestic abuse within Mr P's previous relationships, and none reported between Claire and Mr P prior to the day of Claire's death. Mr P is known to live with depression and has been a heavy cocaine user. He had been open to addiction services since 2019 and had admitted to a relapse in April 2022.
5.13. However as mentioned, because of the significant previous domestic abuse in Claire's life and because Claire died by suicide, the Quality Assurance Panel felt that this case would benefit from a joint Safeguarding Adults Review and Domestic Homicide Review; the Domestic Homicide Review statutory guidance does not specify that it is only the most recent relationship that should be considered and there is no expectation that a Domestic Homicide Review should attempt to prove that a suicide was directly a result of domestic abuse. The Quality Assurance Panel also recommended a Domestic Homicide Review as it will ensure learning is identified that can be cascaded nationally.

6. Chronology

Who was Claire?

6.1. Claire first trained as a hairdresser and very soon, had her own salon. When she was 23, following the birth of her first child, Claire began to teach hairdressing and after approximately ten years, Claire re-trained as a teaching assistant[9].
6.2. Claire had been married twice. She has three children[10] (one from her first marriage and two from her second marriage). Claire reported her first husband to be controlling, and she disclosed to a domestic abuse worker during the scoping period of this review, that her first husband had physically assaulted her during the marriage. Claire's second husband reported verbal domestic incidents between Claire and himself to the police in 2012 and 2013 - which appears to be around the time that this marriage ended. It was also around this time that Claire started to experience problems with her mental health.
6.3. In addition to living with poor mental health, it is recognised that Claire used alcohol. In 2014 Claire was known to have crashed her car whilst under the influence of alcohol (and prescription drugs) and following her death, her parents retrospectively informed police officers that Claire had used alcohol for a long time.
6.4. Claire is known to have been a victim of domestic abuse from a partner she met after her marriages had ended. This relationship was extremely violent and in 2017 Claire's mother described Claire as having been *beaten up severely* and she described the perpetrator as *nasty* and *controlling*. It is also recorded that Claire's children disclosed that this man emotionally abused them, and it is known that home conditions deteriorated to an unacceptable level during this relationship. The couple would separate and reconcile frequently, but the relationship appears to have finally ended around 2018/2019.

[9] Claire had not worked as a teaching assistant for some time prior to the scoping period of this review and the details of her employer were not known. As such it was not possible to invite former colleagues to contribute to this review.
[10] Her older children did not live with her during the scoping period of this review and the youngest lived with both parents under a shared care agreement until they went to army college in September 2021.

6.5. Around September/October 2019, Claire started a relationship with Partner 1. This relationship was also abusive, and police were called to the first domestic incident in November 2019, seven weeks after the relationship had begun.
6.6. It is also now known that Claire had a relationship with a serving police officer (Partner 2) which started around the end of 2019.
6.7. Both of these relationships are further detailed within the overview section of this report.

The Children
6.8. As mentioned, Claire has three children (hereafter referred to as Child A, Child B and Child C respectively). All three children have been subject to domestic abuse incidents between Claire and her partners. They have also witnessed the effects of Claire's poor mental health and consequences of substance abuse. Children's Social Care have been involved with the family many times over the years.
6.9. Claire's mental health appears to have fluctuated in severity and as such the impact that it had on her daily life and her children's daily lives would have differed. It wasn't Claire's mental health condition that risked an impact on her children; it was how Claire's mental health affected her behaviour. For example, Child C is known to have witnessed Claire struggling with her mental health to the point that Claire became so distressed that she attempted to take her own life by throwing herself down some stairs.
6.10. Claire also struggled with alcohol. Consequently there would have been many times when Claire (without intention) became emotionally unavailable for her children and less responsive to their needs. Case notes evidence how alcohol contributed to Claire becoming unable to control her emotions and behaving in a way that was irrational and unpredictable. Police records have notably captured Child C's voice when they disclosed during an incident how they feared what their mother may do or say when under the influence of alcohol.
6.11. All domestic abuse (including emotional abuse and coercive control) will have a significant impact upon children. The psychological effects (for the children) can result in behavioural changes including challenging behaviour, withdrawal, and can cause a child to struggle to interact with other individuals, including their parents. A child who has experienced domestic abuse may become fearful of conflict, worried, anxious, and depressed. All of this can impact a child's development and lead to overactive stress responses.
6.12. During the scoping period of this review, the Domestic Abuse Act 2021[11] has recognised that children who experience domestic abuse are victims in their own right whether or not they have been present during incidents. The abuse perpetrated against Claire mostly occurred pre this legislation coming into force, but professionals involved with this review still recognised the effect of ongoing abuse on her children. This review has sought to incorporate the children's voices from agency records.
6.13. In summary, research has found that there is a greater risk of significant harm for children of all ages whose parents have mental health problems and are also experiencing domestic abuse or substance use[12].

7. Overview
This section of the report is factual and without analysis. It briefs the reader on the key episodes in the case during the scoping period:

Domestic Incidents with Partner 1

[11] The Act came in to force on 29.4.2021, however children to be seen as Victims came in to force on 31.1.2022.
[12] 01_11130_Prelims.indd (publishing.service.gov.uk)

7.1. At the beginning of the scoping period, following a report of a domestic incident between Claire, Child C and Partner 1; police arrested Partner 1. The attending police officers completed Domestic Abuse, Stalking, Harassment and Honour-based violence (DASH) Risk Assessments[13] with both Claire and Partner 1, assessing their risks to be 'medium' and they referred Claire to the Harm Assessment Unit[14]. The incident was discussed in a Domestic Abuse Triage Meeting[15], after which Claire was contacted by a social worker from Compass[16], who established that Child C[17] was safe with their father and that Claire was staying with a friend. The social worker asked Claire about the status of her relationship with Partner 1 and Claire told her that they had separated[18].

7.2. The day after the incident (following Partner 1 being released from custody with bail conditions not to attend Claire's address or contact Claire or Child C), Claire reported that Partner 1 was attempting to contact her by letter, telephone, and text. Partner 1 was further arrested for harassment[19].

7.3. The following day the court granted a Restraining Order to protect Claire, and sentenced Partner 1 to an eight week prison sentence, suspended for 18 months[20]. Claire was again referred to the Harm Assessment Unit, and the incident was discussed in another Domestic Abuse Triage Meeting.

7.4. Within days, Partner 1 was further arrested and sentenced to prison after Claire had reported further text messages[21]. Again, Claire was referred to the Harm Assessment Unit and discussed in another Domestic Abuse Triage Meeting.

7.5. No referrals were made to Adult Services in respect of Claire.

7.6. In March 2020 Claire disclosed further historic domestic incidents perpetrated by Partner 1 which included sexual abuse. A DASH Risk Assessment was completed at 'High', and a referral was made to the Harm Assessment Unit with onward referrals being made to health, education, and Children's Social Care. Following an earlier referral to Women's Aid in January 2020, an Independent Domestic Violence Adviser had referred Claire to Shropshire Domestic Abuse Services, and consequently, at this time, Claire had ongoing support from a domestic abuse worker. In addition she was subject to a Domestic Abuse Risk Management Plan monitored by the police and was due to be held at Multi-Agency Risk Assessment Conference the following month.

Suicide Attempt February 2020

7.7. At the beginning of February 2020 Claire was admitted to hospital with a fracture to her spine after she had attempted to end her life by throwing herself down the stairs. Because Child

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[13] The Domestic Abuse, Stalking and Harassment and Honour-based violence (DASH) risk assessment was endorsed by National Policing leads in 2009 to support and improve professional responses to cases of domestic abuse. It is a risk assessment tool, linked to the Duluth Power and Control Wheel (which is an earlier tool that helped explain the different ways an abusive partner can use power and control to manipulate a relationship). Its purpose is to ensure professionals employ a proactive response to a domestic situation by asking direct questions to assess risk.

[14] The Harm Assessment Unit is responsible for all vulnerable notifications coming to the attention of the police, involving adults, children, mental health, disability, domestic abuse and missing or absent persons, making appropriate referrals internal to the organisation and externally to statutory and voluntary agencies.

[15] Attended by Police, Children's Social Care (Children's Social Care professionals determined the level of need to be at Targeted Early Help - Level 3), Education and Health

[16] Compass is the front door for children's social care for receiving new enquiries regarding concerns for the welfare or protection of children and young people in Shropshire.

[17] Child C lived with both parents under a shared care arrangement.

[18] It was reflected upon how Claire had said this before but then resumed the relationship and Claire advised she had been *'foolish'*.

[19] A further Domestic Abuse, Stalking, Harassment and Honour-based violence Risk Assessment was completed for Claire and the risk was assessed as 'medium'.

[20] Claire had been initially unaware of the result as the Witness Care Officer did not contact her until he/she returned to work on the Monday.

[21] A Domestic Abuse, Stalking, Harassment and Honour-based violence Risk Assessment continued to deem a 'medium' risk.

C[22] had witnessed this incident, Children's Social Care spoke to Child C's father and school. The conversations assured the social worker that Child C was safeguarded.

7.8. Staff at the hospital were aware that Claire had self-referred to mental health services in January 2020 and was due to attend a planned clinic appointment with the Community Interventions Pathway[23]. Staff therefore contacted the mental health access team to request that the appointment be rearranged to a home visit (due to the injury sustained to Claire's neck).

7.9. Following the ensuing assessment of Claire, and discussion within the Community Interventions Pathway teams multi-disciplinary meeting, it was agreed that there was no presenting role for secondary mental health services and as primary care services were most appropriate to meet Claire's therapeutic needs at that time, Claire should be advised to self-refer to Improving Access to Psychological Therapies.

7.10. District nurses supported Claire in her home until her body/neck brace was removed at the end of April 2020.

Relationship with Partner 2

7.11. In May 2020 a friend of Claire's contacted the police via 999. She was concerned for Claire who had been drinking and was saying *it's too late now*. Officers, (one of whom was later identified as the aforementioned Partner 2) attended Claire at the home address. When officers attempted to arrest Claire for being drunk and disorderly, Claire disclosed the relationship with Partner 2.

7.12. The officer was interviewed by investigators from the Independent Office for Police Conduct, and he admitted being aware of Claire's vulnerabilities and of knowing that the relationship was wrong. The Independent Office for Police Conduct panel determined that the officer had breached the Standards of Professional Behaviour, and the breach was found to be Gross Misconduct. The officer would have been dismissed without notice, but he had already resigned from the force.

7.13. Claire was appointed a designated Single Point of Contact to support her throughout the investigation[24] and was provided with monthly updates. However the period of time from the relationship being disclosed to the hearing date was two years which is a substantial time and encompasses most of the scoping period of this review. Also, following the investigation, the circumstances[25] were reported to the Crown Prosecution Service by the Independent Office for Police Conduct investigators and a court date was set for 2022.

Professional Response to Ongoing Concerning Behaviours.

7.14. In early June 2020, Claire disclosed to her domestic abuse worker that she had attempted an overdose[26]. She told the worker that she had been embarrassed by being prompted by the police to share events relating to her relationship with Partner 2.

7.15. Towards the end of June 2020, Claire was admitted into hospital having attempted a further overdose (two days after Partner 1 had been released from prison). The hospital mental health liaison team referred Claire to the crisis team who provided rapid assessment and intense treatment during the period of mental health crisis. In addition to planned daily contact (which was a mixture of face to face and telephone), Claire was offered open contact with the team and

[22] Child A and B were adults and did not live with Claire.

[23] This pathway provides assessment and evidence based time limited interventions for people who have complex mental health difficulties that are significantly impacting on daily life.

[24] The Independent Office for Police Conduct identified that Claire also had an Independent Domestic Violence Adviser, was subject to Multi Agency Risk Assessment Conference processes and that housing was supporting her.

[25] Abuse of Position for Sexual Purpose (misconduct in a Public Office) is a criminal offence.

[26] Checks established that Claire's youngest child was currently staying with their father who advised that the child wouldn't be returning to Claire anytime soon.

offered a review with a consultant psychiatrist. (This review led to a later diagnosis of Emotionally Unstable Personality Disorder and adjustments to Claire's medications.)

7.16. Once the episode of crisis was felt to have dissipated, the crisis team discharged Claire to the Community Interventions Pathway for longer term support and Claire was allocated a care co-ordinator who offered regular contact to support with the management of symptoms and medications, and to explore a structured response to support Claire in the regulation of her emotions. Claire was also offered a place on the Life Skills Group – a programme of intervention to enable individuals to develop strategies to manage their emotions.

7.17. On the 5th of July 2020, Claire reported damage to her window. An adult risk assessment, completed by attending officers, concluded a medium risk stating that Claire was vulnerable due to mental health issues, being an alcoholic, and being the victim in an ongoing Independent Office for Police Conduct investigation. A referral was made to the Harm Assessment Unit, but when the unit reviewed the referral, it was decided that despite needing support with both her mental health and alcohol use, and experiencing abuse, Claire did not meet the definition of an adult at risk. Notably the police enquiries indicated that Claire had possibly caused damage herself.

7.18. In November 2020 West Mercia Police were informed of an incident during which Claire fought with a female[27]. Both were reportedly heavily intoxicated. Both parties accused the other of assault[28], but Claire's injuries were considered more notable than those of the other female.

7.19. It is also clear that around this time Claire was struggling to organise her finances. She was attempting to claim Universal Credit from the Departments of Work and Pensions but was struggling with the paperwork.

7.20. In early December 2020, Claire reached out for an advanced payment but was informed that no advances were available to her at present. This was standard practice as Claire already had outstanding advances that hadn't been repaid. A week before Christmas, Claire was informed that she had been placed on the Limited Capability for Work and Work Related Activity group and that a payment for the arrears would credit her account within three days[29].

7.21. In March 2021 Child C contacted the police after an argument had occurred between Claire and Child A. Child C reported that Child A had left, but Claire, who was under the influence of alcohol, was being aggressive and chaotic. Claire could be heard banging on Child C's bedroom door and shouting that she would kill herself and burn the house down. Claire then attempted to end her life by throwing herself down the stairs before leaving the address. Child C disclosed, to the police call handler, that Claire was often drunk, and that they was living in daily fear of what Claire was going to say or do.

7.22. Attending officers located Claire and requested an ambulance to attend to her. The police officers established that Child C was safe in the care of their father, and adult and child risk assessments were completed (both medium). A referral was made to the Harm Assessment Unit which was shared with Children's Social Care. Claire was taken to hospital, and both the ambulance service, and the hospital, also referred the incident to Children's Social Care. No referral was made to Adult Services, but following contact with the hospital psychiatric liaison team, the hospital notified the Mental Health Access Team of the incident and Claire's allocated mental health nurse later reviewed Claire's mental health.

[27] Claire later confided in her domestic abuse worker that the fight had begun after she had raised a concern with the other female regarding the amount of alcohol that the other female had consumed with a mutual friend. Claire said that the female attacked her.

[28] Claire was found dead whilst the investigation was ongoing.

[29] Better practice at this time would have seen Claire being advised to claim for Personal Independence Payment.

7.23. Soon after this incident, Children's Social Care commenced a Social Work Assessment[30] and Claire started the aforementioned Life Skills Group. (Though Claire did not continue this course as its online format did not suit her.)

7.24. In July 2021, during a telephone review with a member of the Community Interventions Pathway team, Claire disclosed that though she *had her ups and downs,* she felt more stable – although she said that the monthly updates from the Independent Office for Police Conduct *affected her every time*.

7.25. In September 2021 Claire met with her care co-ordinator for a review of her care and reported variable mental health. She also disclosed that she had resumed "*drinking excessive alcohol leading to disinhibition and poor decision making"*. Claire recognised that binge drinking increased her risk of self-harm, overdose, and sedation and identified the likely triggers for drinking to be:

- The ongoing investigation into the relationship with the serving police officer - Partner 2,
- The commencement and recent unilateral cooling of a relationship,
- Child A having advised that they may be deployed to Afghanistan soon,
- Child C leaving home to go to Army College, and
- Ongoing pain in her arm, thought to be a result of the neck injury[31].

A plan was developed which included increased contact with a care co-ordinator, re-engagement with the Life Skills course when it became available face-to-face, and for Claire to try and engage in meaningful activities.

Relationship with Partner 3

7.26. Towards the end of 2021 Claire had a brief intimate relationship with a male to be known as Partner 3 whom she had connected with on a dating site and met a couple of times.

7.27. In December, Partner 3 reported to the police having received threatening messages. Partner 3 believed the messages were something to do with Claire as their relationship had ended. A DASH Risk Assessment was completed with Partner 3 at standard.

7.28. The messages soon stopped, and the police investigation was filed, stating that evidential difficulties[32] had prevented further action.

Ongoing Mental Health Care.

7.29. At the end of December 2021, Claire informed her care co-ordinator that she was feeling well. She said that she was now working three days a week at a hotel[33] (out of area), and this was helping. Within this meeting, though Claire noted that she might need support if the sexual assault case went to court[34] (it is suspected that Claire was referring to the ongoing investigation into Abuse of Position for Sexual Purpose regarding Partner 2), she agreed with being discharged from the Community Intervention Pathway. However, when the care co-ordinator telephoned Claire in March 2022, to inform her that the closure paperwork was about to be completed, Claire disclosed that she had been about to contact someone because *'she was not in a good place'*. Claire said that she had stopped her medication several weeks ago because she had been *feeling buoyant* having started a new relationship (it has not been possible to ascertain for certain if this

[30] The assessment completed with a recommendation that Child C could be supported by universal services as Child C was staying with their father.

[31] It has not been possible to ascertain for certain, but Claire is thought to have been referring to her spinal injury.

[32] No CCTV, witnesses, or recording of phone calls.

[33] The details of the hotel were not made known to this review, and no contact could be made with Claire's employer and/or colleagues to invite them to contribute to this review.

[34] Claire was advised who to contact if her mental health deteriorated.

is the relationship with Mr P, but it is expected to be) and was enjoying working. But since then Claire had experienced some pressures around her children and was expecting the current relationship to end. Claire said she had recommenced drinking and was experiencing intermittent suicidal thoughts.

7.30. Within a few days the care co-ordinator met with Claire to further assess and consider a support plan. At this meeting, both Claire and the care co-ordinator agreed that whilst Claire should recommence medication via her GP; she did not require ongoing care co-ordination. It was agreed that her case would be closed with a referral to the Wellbeing Improving Access to Psychological Therapies[35] service, however the care co-ordinator identified that Claire may not be accepted due to her mental health diagnosis. It was agreed that if this occurred, Claire could be referred to secondary mental psychological services.

7.31. In May 2022, following the referral having been declined, Claire undertook the first session of a two part psychology assessment. Claire engaged well with the assessment informing the assessor of her job at the hotel and of how the routine and structure was supportive for her mental health. She said that she planned to move to live at the hotel and eventually rent somewhere local to it. Claire also said that her relationship, which had started off turbulent, had improved.

7.32. During the second session in June 2022, Claire continued to report that she was doing well. However, because Claire was planning on moving out of the area to the hotel that she was working in, Midlands Partnership Foundation Trust was unable to offer her an ongoing service and Claire was discharged on the basis that she planned to move out of area within the next three months. Claire was advised to register with a GP Practice when she moved, and to seek a referral to local mental health services. She was also reassured that if she did not move - upon re-referral to the service, her assessment date would be honoured for the psychology waiting list.

7.33. The only further professional contact Claire had before she was found deceased the following month, was with the Department of Work and Pensions.

8. Analysis

This analysis section of the report examines information gained from agency chronologies, agency reports, consultation with professionals (where possible) and panel members. Within each section of analysis, the lesson learned is stated, along with (where the lesson remains unaddressed) a question for Shropshire Safeguarding Community Partnership to consider; the answers to which will drive Shropshire Safeguarding Community Partnership and its partner agencies to develop an action plan that will respond directly to the learning. The themes considered are:

- The Impact of Covid
- The Professional Response to Claire during the Scoping Period
- The Application of Professional Curiosity
- The Professional Understanding of the Link between Domestic Abuse and Suicide
- The Professional Understanding of Claire's Lived Experience

[35] Improving Access to Psychological Therapies is designed to make sure everyone can access therapy for low mood and a range of anxiety problems. The teams provide a range of recommended, evidence-based talking therapies for people who would like support for their mental health.

The Impact of Covid

8.1. In December 2019, a coronavirus emerged which was quickly labelled a pandemic. As the virus gained momentum, major disruption followed, with measures being introduced in an attempt to lessen its effects. The United Kingdom saw the Prime Minister announcing its first lockdown on the 23rd of March 2020.

8.2. As a result, professionals had to rapidly adapt to new working conditions which included many face-to-face appointments being replaced with telephone and virtual appointments[36] and many workers leaving the office to work from home[37]. Whilst dealing with the confusion of new conditions, professionals worked hard to maintain service and continuity for their patients and service users, but no one could escape the emotional distraction that the pandemic introduced. Everyone (including professionals) was understandably concerned for their own safety, as well as the safety of those around them.

8.3. The first lockdown started to be lifted in May 2020, but in an attempt to contain the virus, there followed months of restrictions across England which at times affected further closure of non-essential retail and hospitality, and personal restrictions of movement. And, on the 6th of January 2021, a rising number of coronavirus cases saw national lockdown restrictions being reintroduced. It wasn't until the 8th of March 2021, that England began a phased exit out of lockdown; the final step of which was delayed until the 19th of July 2021 to allow more people to receive their first dose of a coronavirus vaccine.

8.4. It is clear that over time, practices, and communications within the new working conditions became more effective and the ability of staff to adapt is praiseworthy, but this review must look at the resulting quality of care that was afforded to Claire.

8.5. Firstly it must be remembered that during much of this scoping period, the public was either obligated, or urged to, exercise caution regarding the Covid situation. Even at the times when not a legal requirement, any person pinged on the Test and Trace app, was expected to self-isolate at home. This meant that reduced staffing levels - one of the problems that had initially risen from the Covid pandemic continued to be a problem throughout the whole scoping period; as staff who had been exposed to the virus still had to self-isolate, and staff who had been unfortunate enough to contract Covid were off work.

8.6. Covid did not affect the professional response to the initial domestic incidents involving Claire and Partner 1 reported in January 2020, but it was soon after Claire began her subsequent engagement with the domestic abuse service that Covid became an issue. However, the domestic abuse service has informed this review that because face-to-face support is important for building the trusting relationship with clients and doing difficult work around a sensitive subject in a trauma informed way, special permission for face-to-face work was granted. Nevertheless measures were in place that meant the work was still impaired, for example social distancing and the wearing of masks. Also because school was closed, Child C was also always in the house, so conversation was sometimes difficult and often limited.

8.7. Claire was subject to a Multi-Agency Risk Assessment Conference during the Covid period. Though Multi-Agency Risk Assessment Conference continued to risk assess and action plan throughout the Covid pandemic, the process was affected; West Mercia police have informed this review that because they didn't utilise Microsoft Teams, the meetings had to convene by telephone and there is little doubt that participants found it harder to engage with the process.

[36] In the absence of face-to-face work with both service users and colleagues, virtual communication platforms such as Zoom and Microsoft Teams started to be utilised. At first, different sectors used different virtual platforms which stilted inter-agency communications and not everyone had access to computer stations or all of the equipment that they needed. Those that did weren't always familiar with the communication tools and had to rapidly learn how to use them.

[37] Although there was a certain amount of relief at the safety and flexibility of working from home, staff had to quickly adapt their home living spaces to the needs of multiple family members working from home whilst simultaneously attending to their children's educational needs.

8.8. Claire was also referred to the Harm Assessment Unit on many occasions during the Covid pandemic. The Harm Assessment Unit staff were working from home during Covid, and meetings were conducted via telephone. However, the Harm Assessment Unit supervision have informed this review that they considered this period of time to be productive, and they commented that there was never an occasion when staff were not contactable by other agencies.

8.9. It was May 2020 when Claire disclosed her relationship with the serving police officer (Partner 2) and due to Covid, the Independent Office for Police Conduct contact with Claire during their investigation was undertaken over the telephone. It has not been possible to ascertain whether Claire still felt sufficiently supported, or whether there was any impact on Claire due to not being able to see any of the professionals conducting the investigation face-to-face.

8.10. Similarly, in line with the national guidance, the Community Mental Health Services conducted their consultations via telephone during the Covid pandemic. Although there is nothing documented to suggest that Claire struggled to engage with mental health services in this way, it is known that she did sometimes find the virtual format difficult, for example, Claire told professionals that she was finding it hard to engage with the Life Skills Course because it was virtual[38].

8.11. As is widely known, the pandemic put the NHS under extreme pressure. Emergency Departments in hospitals, whilst utilising agency staff to manage staff absences, saw an increase in the amount of people attending. Nevertheless Claire was always seen in hospital when in need.

8.12. Claire's overall experience of the frontline police service does not seem to have been adversely affected by the Covid pandemic. Police officers still attended Claire's home address and spoke with her face-to-face. Similarly, despite Covid creating resource problems for the ambulance service and demand increasing, an ambulance attended Claire on every request.

8.13. Claire had contact with the Department of Work and Pensions during the scoping period of this review. The Department of Work and Pensions has informed that during the peak of the Covid pandemic their contacts were made via phone or electronic journal and that Claire, and her assigned work coach emailed each other regularly.

8.14. Within the scoping period of this review, Claire did not accept any support regarding her alcohol use. Though it cannot be confirmed, panel members have wondered whether this decision may have been affected by the Covid offer as Shropshire Recovery Partnership (the alcohol service at the time) was not offering face-to-face appointments for their adult clients due to Covid[39].

Learning 1: Though it is not possible to ascertain for certain how Claire felt about face-to-face contact with professionals being replaced by telephone/virtual communication, it is known that Claire found it harder to engage with the Life Skills Course online.

8.15. However, panel has assured this review that virtual communications are currently only used in emergency situations or if it is deemed more suitable for an individual who has requested it[40].

8.16. What mustn't be overlooked is that whilst professionals worked hard to support Claire the best they could during the pandemic, possibly the most significant issue for Claire could have potentially been its personal effects and this is explored later in the report when her lived experience is considered.

[38] It was agreed that she would disengage from the course until it was available face-to-face.

[39] Other potential barriers to Claire accepting alcohol use support are discussed later in the report.

[40] The Life Skills course is currently offered by a variety of means which includes virtual or face-to-face and is determined by the needs and wishes of the individual.

The Professional Response to Claire during the Scoping Period.

8.17. When the first domestic incident (during the scoping period of this review) was reported in January 2020, police attended the property and completed a DASH Risk Assessment with Claire, which determined her to be at 'medium risk'. Amongst other things, Claire disclosed during the assessment that she was on anti-depressants and was feeling lower than normal[41].

8.18. Police officers clearly used their professional judgment in identifying Partner 1 as the primary perpetrator on this occasion, but given that during the same incident, Partner 1 accused Claire of burning his clothes, officers could have potentially also recorded an arson/criminal damage offence. This would have ensured that an independent investigation of Partner 1's allegation was also had. It was good practice that Partner 1 was offered a DASH Risk Assessment, but records show that Partner 1 refused because he had been arrested.

8.19. As per standard practice following the incident,

- a gazetteer warning[42] was placed on Claire's address[43].
- officers referred Claire to the Harm Assessment Unit, and
- the following day, the incident details were shared with Children's Social Care, education, and health professionals in a Domestic Abuse Triage meeting which determined the level of need at Level 3[44].

8.20. This level of need directed Children's Social Care to contact Claire and discuss support options for the family. A referral was also actioned in the meeting to probation services as Partner 1 was current to the service. It was decided that no referrals were required for adult services (no onward referral to adult services or mental health services was completed by the Harm Assessment Unit either) - but given that Claire had disclosed a deterioration to her mental health, consideration could have been had to signposting Claire to mental health support. It was good practice that a domestic abuse risk officer who had noted that both parties had been previously subject to Risk Management Plans[45] with previous partners, and that there had been previous incidents between themselves, consequently attempted to contact Claire on the same day of the meeting and again on the following day. Unfortunately the contacts were unsuccessful - but Claire was referred to Women's Aid.

8.21. Whilst it is positive that referrals for support around domestic abuse were made, Claire had demonstrated more than one need of support (although her alcohol use may not have been apparent at this time, it was known that she was experiencing deteriorating mental health). Best practice could have seen a wider thinking approach to Claire's needs being had. A good starting

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[41] Police Officers exampled excellent use of the DASH Risk Assessment but whilst the DASH is an essential tool when considering thresholds for Multi-Agency Risk Assessment Conference referrals, professionals must make a conscious effort not to over-rely on its findings and should not hesitate to make further safeguarding referrals where there is evidence of other vulnerabilities.

[42] A marker on the police database.

[43] It has not been possible to confirm the details of what was on the gazetteer warning owing to data now having dropped off the police systems.

[44] Domestic Abuse Triage Threshold and actions – For standard or low level risks - (Level 1) no action will be taken but Children's Social Care (Compass admin) will record the information on LCS Domestic Abuse workspace and EHM general notes. (Level 2), a letter offering support to the victim will be sent, information will be recorded on EHM, no other action taken. An action for health, education or HAU may also be made and if so the health, education or HAU representative will feedback those actions to health, education, HAU colleagues within the local communities as appropriate. For medium risks - (Level 3) an early offer of help should be the outcome and as such social care will record and create the contact form which will then be reassigned to a Compass Social Worker to establish contact with the family and discuss support options. An action for health, education or HAU may also be made and if so the health, education or HAU representative will feedback those actions to health, education, HAU colleagues within the local communities as appropriate. For high risk - (Level 4) cases (following consideration of the risk and protective factors) a recommendation for a referral will be the outcome and for s.17 threshold the parent will be contacted to discuss the concern and seek consent and for s.47 threshold a strategy meeting will be convened (consent in these cases is not required). An action for health, education or HAU may also be made and if so the health, education or HAU representative will feedback those actions to health, education, HAU colleagues within the local communities as appropriate.

[45] A Domestic Abuse Rosk Management Plan offers police a chronological list of domestic related incidents and is a digital record of all police contact and safety planning. It is not routinely shared with other agencies.

point could have been an action for liaison with Claire's GP, which may have concluded a referral to mental health support being offered to Claire.

8.22. A GP's involvement with the Domestic Abuse Triage meetings was discussed with the review panel members and the review learned that GP Practices are not included within the membership. However, every morning the Harm Assessment Unit sends a spreadsheet highlighting the subjects of the days meetings to agencies who are unable to physically attend – whilst it is recognised that the name of a person's GP may not always be known, moving forward, could the GP be included in the circulation of this spreadsheet where possible?

8.23. Furthermore, the review learned that none of these 'virtual' memberships are ever updated of the meeting outcomes. Is this something that could be rectified?

Learning 2: Multi-agency information is not routinely shared between GP Practices and other professionals/agencies.

Question 1: How can Shropshire Safeguarding Community Partnership seek assurance of consultation being had between partner agencies and clients' GP Practices, to improve multi-agency information sharing with, and from, GPs?

8.24. Following Partner 1 being released from custody with bail conditions, Claire reported that he was attempting to contact her. It was good practice that Partner 1 was further arrested and again, a DASH Risk Assessment was completed with Claire, a referral was submitted to the Harm Assessment Unit, and a Domestic Abuse Triage meeting convened (outcome Level 1), but still no referral was deemed necessary to any adult services. In contrast, it is notable that after Partner 1 had disclosed feeling anxious and depressed whilst in police custody, the health care professional[46] signposted Partner 1 to talking therapies, providing leaflets and numbers. However, Partner 1 had also been noted to be experiencing alcohol withdrawal but there is nothing in the records to suggest that any alcohol support services were discussed.

8.25. Partner 1 presented at court the following day (which was a Saturday) where he received a suspended custodial sentence and was made subject to a restraining order. He subsequently breached the restraining order by contacting Claire and attending her address, but Claire had not been made aware of the court outcome.

8.26. As part of this review, a Supervisor in Witness Care has been spoken with and asked to clarify the process by which a victim is updated on a court result. The review has learned that usual practice would see contact being attempted with a vulnerable victim within 24 hours of court, but as mentioned, Partner 1's court date was a Saturday, and it wasn't until the Monday that a Witness Care Officer was allocated and contacted Claire. Consequently, Claire had not heard of the court result on the day that she reported Partner 1 was further attempting to contact her.

8.27. This review has been informed that the Victim Advice Line can be utilised to provide victims with updates on weekend remand cases but that since the courts have moved onto the Common Platform (their case management system) issues have arisen around communicating court results which have resulted in delays. The review has been assured that results are currently now being sent to the Victim Advice Line on Saturdays by email, which has offered a solution to the problem, but that the next step is to address the Victim Advice Line's direct access to the Common Platform so that they will no longer rely on emails.

8.28. The DASH Risk Assessment undertaken when Claire reported this further contact, highlighted physical/psychological abuse and Claire disclosed how Partner 1 would threaten violence, constantly text and call, damage property and wait for her at various locations. Given

[46] In 2018 West Mercia Police introduced Liaison and Diversion Teams across the force custody suites. This is a service provided by NHS England to the custody suite 7 days a week, generally between 8am and 8pm. The teams are made up of social workers and mental health practitioners. The team signposts individuals to where various help and support can be obtained to divert the person out of the criminal justice system. They are based in both the custody suite and as well as the community for follow up.

this, consideration could have been given to other offences in relation to stalking, economic abuse and/or criminal damage. However Partner 1 was consequently given a custodial sentence because he had breached his restraining order, so there was still a positive outcome without other offences.

8.29. A further Domestic Abuse Triage meeting which was convened, deemed the risk to be at Level 1 and continued to reason referrals to adult services not necessary. This decision may have conceivably been influenced by the knowledge that Claire was now subject to a Domestic Abuse Risk Management Plan and had been referred to Shropshire Domestic Abuse Services, but equally, the fact that three meetings had convened in a short space of time should have been recognised as an indicator of Claire's increased risk and need of support.

8.30. The effect of the latter two Domestic Abuse Triage meetings having determined their outcome Levels at 1 must be considered; Level 1 resulted in the meeting information being recorded as a case note as opposed to warranting police contacting Claire to discuss her needs (Level 2) or warranting a social worker to make contact (Level 3). Therefore the Level 1 outcomes affected no further discussions of needs and/or available support being afforded to Claire. Though this review recognises that any offer of support may have been declined by Claire, she may well have found herself more able to accept support at this later date.

Learning 3: Whilst the Domestic Abuse Triage Meeting ensured that Claire and her family were offered support regarding domestic abuse, insufficient consideration was given to other vulnerabilities and consequently referrals to other agencies, who could offer Claire support in other areas of need, were missed.

Learning 4: The latter outcome threshold Levels from the Domestic Abuse Triage Meetings did not reflect that multiple referrals potentially represented an increased need of support.

8.31. This review has been informed that it has now been recognised that the daily Domestic Abuse Triage has a focus on children and not the wider family, or adults, concerned in an incident. As such the needs of adults are not being routinely considered and referrals for support not always made. In the case of Claire, at each of the Domestic Abuse Triage meeting, focus was on the risks to Child C, and therefore recognition of Claire's alcohol use and mental health needs weren't discussed outside of the context around the safety of Child C. This gap in the system has been noted, and it has been recognised that improvement is required to ensure a whole family approach is taken which will include consideration and discussion of all adults and children support needs, and safeguarding concerns.

8.32. As a result of this, and learning from other statutory reviews, the Domestic Abuse Triage Meetings are changing from March 2024, and will be replaced by Partnership Integrated Triage meetings (PIT Stop). PIT Stop is based on a Humberside model which was deemed good practice with the Care Quality Commission, the HM Inspectorate of Constabulary, and the Office for Standards in Education.

8.33. PIT Stop will convene daily. It will be multi-agency[47] but led by the police who will set the agenda and chair/minute the meetings. The families discussed will be those who have come to police attention, and this will include all incidents including Domestic Abuse. Consequently PIT Stop will replace the Domestic Abuse Triage, the Child incident Triage and the Multi Agency triage – identified at level 2 and 3 (any that meet level 4 will be referred directly into Compass[48] without delay). PIT Stop aims to focus on the whole family and get the right support in at a much earlier time which should reduce inappropriate referrals and result in fewer repeat

[47] To date commitment has been confirmed from Shropshire Community Health, Adult Safeguarding, We Are With You, Youth Justice, Early Help, Education and Probation.

[48] Compass is the front door of Children's Social Care.

contacts. Police and Children's Social Care will jointly review the process monthly, and a formal review will be undertaken at six months to assess effectiveness.

8.34. In addition the review has been assured that Domestic Abuse Leads will be training domestic abuse PIT Stop members to remember to consider the history of the individuals being discussed in meetings and to think about any vulnerabilities.

8.35. With regards to the support offered to Claire regarding domestic abuse, this review has been advised that contact wasn't ever achieved by Women's Aid but that their Independent Domestic Violence Adviser referred Claire to Shropshire Domestic Abuse Services on the 5th of February 2020 and also safeguarded Claire by means of referral for a Multi-Agency Risk Assessment Conference[49].

8.36. The allocated domestic abuse worker from Shropshire Domestic Abuse Services has informed this review that she *refused to give up,* and successful contact was eventually had with Claire on the 14th of February 2020. Thereafter Claire engaged with ongoing support work until December 2020 when the case was closed[50].

8.37. This work proved invaluable; in Claire's first contact with the domestic abuse worker, Claire shared how isolated she felt living where she did and how this was affecting her mental health. Consequently the support work included helping Claire with housing options, alongside exploring Claire's understanding of domestic abuse.

8.38. Claire had previously completed the Freedom Programme and therefore was aware of the different facets of domestic abuse. Accordingly the worker, whilst recapping on the aspects of abuse, concentrated on discussing with Claire how she could recognise abuse within her relationships and identify the impact that it had upon her. Warning signs of abuse were also covered, as was support with identifying her feelings. In these sessions Claire disclosed that she felt unloved and neglected as a child, as such, coping mechanisms were explored.

8.39. During the discussions with her domestic abuse worker Claire disclosed further incidents of historic abuse by Partner 1 and in March 2020, Claire reported these historic incidents of abuse to police. Officers again referred Claire to the Harm Assessment Unit and onward referrals were made to other relevant police forces. In relation to a response to the risks to Child C, referrals were made to health, education, and Children's Social Care. A DASH risk assessment determined that Claire was frightened of Partner 1's release from prison and consequently a TECSOS alarm[51] was issued to Claire and a security assessment was undertaken on her address.

8.40. The offences that Claire now disclosed, had happened three months earlier, therefore there were few forensic opportunities and though a thorough investigation was had by police officers, there was insufficient evidence to prosecute. The investigation was filed with no further action in November 2020. At this time, officers considered Claire's welfare and were assured by Claire having been initially supported from an Independent Domestic Violence Advisor and having ongoing support from Shropshire Domestic Abuse Services. However consideration could have been given to offering Claire the support of an Independent Sexual Violence Advisor. This would have provided her with a tailored person-centred support package given the fact she had been victim of sexual offences.

8.41. With regards to Claire's ongoing work with her domestic abuse worker, this came to an end a few weeks after police had closed their investigation.

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[49] The Multi-Agency Risk Assessment Conference convened at the beginning of April 2020. This review has been unable to confirm the specific content of the meeting as due to funding cuts there is no minute taker for Multi-Agency Risk Assessment Conferences but has been informed that attending professionals were assured by the fact that a Domestic Abuse Risk Officer had oversight of the Risk Management Plan and that safeguarding was ongoing.

[50] With the offer to support Claire with any Independent Office for Police Conduct interview/trial, if required

[51] The TecSOS handset initiates a 999 call when the victim activates the device.

8.42. Discussion was had within a panel meeting, regarding whether there should have been direct contact between the police and the domestic abuse worker - and if there had, would Claire's work with the domestic abuse worker still have come to an end when it did.
8.43. The review has been informed that it was Claire who updated the domestic abuse worker of the investigation concluding and no direct communication was had at this time between the domestic abuse worker and the police. However the review was further informed that it was unlikely that any direct communication would have made any difference, as case closure was a joint decision between Claire and the domestic abuse worker.
8.44. Nevertheless this review recognises that good practice would see a domestic abuse worker (if they had any concerns) seeking an individual's permission to contact the police on their behalf and vice versa.

8.45. Though at this time professionals may have been assured that Claire's risk of domestic abuse was being managed, her ongoing vulnerable mental health throughout the scoping period is evidenced as,

- On the 24th of January 2020, Claire self-referred to Improving Access to Psychological Therapies stating that she wanted some support as she was finding her emotions difficult to manage. When an allocated worker from Improving Access to Psychological Therapies contacted Claire on the 28th of January 2020 to triage the referral, Claire disclosed how she had overdosed on drugs on the 11th of January 2020 and advised that she had attempted self-harm when she was arrested and taken into custody on the 21st of January 2020, following inflicting criminal damage to her neighbour's car. Notably - the police have no record of any self-harm whilst Claire was in custody, but it is possible that Claire was referring to actions she took upon release. Following her contact with Improving Access to Psychological Therapies, Claire was offered a clinic appointment with the Community Interventions Pathway and (on the 30th of January 2020) met with her GP to discuss/review her medication.
- In early February 2020 (prior to her appointment with the Community Interventions Pathway), Claire attempted by her own admission, to end her life by throwing herself down the stairs[52]. This incident also evidences Claire's alcohol use as she admitted in hospital that she had been drinking between one and two bottles of wine a day for the last six months (this information was shared with the GP). Prior to hospital discharge, Claire's appointment with the Community Interventions Pathway was rearranged to become a home visit. (Following assessment the Community Interventions Pathway Team agreed that there was no presenting role for secondary mental health services.)
- In May 2020, a friend reported a concern for Claire to the police after Claire had said to her *it's too late now*.

8.46. When officers (as a result of the friend's concern) attended Claire's address in May 2020, she was found to be heavily intoxicated and due to her being vocal and swearing towards officers, attempts were made to arrest her. As officers went to arrest Claire, she shared that she was in a relationship with one of the officers present. Over the following two days, a statement was taken from Claire regarding the relationship, and the Independent Office for Police Conduct began an investigation. Claire was appointed a Single Point of Contact and received monthly updates on the investigation (it was agreed that these would be by letter to allow her to open them with a friend for support). The investigation took two years to conclude.

[52] Resulting in a fracture to Claire's thoracic spine (T1)

8.47. Claire's mental health continued to be a concern (the impact of the investigation upon Claire's mental health and wellbeing is evident in records[53]) and towards the end of June 2020, Claire attended the Emergency Department of the hospital having attempted an overdose. The hospital mental health liaison team referred Claire to the Crisis team who following assessment and initial treatment during the period of mental health crisis, offered Claire daily and open contact.

8.48. Police officers next became aware of Claire's vulnerable mental state on the 5th of July 2020 when Claire reported damage to her window. An adult risk assessment, completed by attending officers, concluded a medium risk stating that Claire was vulnerable due to mental health issues, being an alcoholic, and being the victim in an ongoing Independent Office for Police Conduct investigation. A referral was made to the Harm Assessment Unit, but when the unit reviewed the referral, it was decided that despite needing support with both her mental health and alcohol use, and experiencing abuse, Claire did not meet the definition of an adult at risk. Because the criteria was not deemed to have been met, no onward referrals were made to adult services and there was no follow up regarding Claire's mental health or alcohol use. It was however good practice that despite investigation, when the circumstances around the damage were never able to be established, Claire's Risk Management Plan was extended for a further four weeks to offer her reassurance.

Learning 5: The Harm Assessment Unit is working in silos when the unit grades and makes decisions regarding onward referrals without multi-agency oversight.

8.49. This review has been reassured that work is already being undertaken into how multi-agency statutory processes are being followed within the Harm Assessment Unit protocols.

Question 2: How can Shropshire's Harm Assessment Unit and partner agencies assure Shropshire Safeguarding Community Partnership that multi-agency decision-making, in line with statutory processes, is followed within the Harm Assessment Unit in the future?

8.50. On the 10th of July 2020, once the episode of crisis was felt to have dissipated, the crisis team discharged Claire to the Community Interventions Pathway and Claire was allocated a care co-ordinator to whom she remained open for most of the scoping period.

8.51. Further stress for Claire which had the potential to affect her mental wellbeing, is identifiable over the next few months within the Department of Work and Pension records. Claire was applying for Universal Credit but following her completing the required questionnaire, she was informed that it had not been received. In October 2020, Claire told the Department of Work and Pension that she was finding the *situation very distressing, and* it had *reduced her to tears*. She said that *writing down what had happened to her was traumatising and causing flashbacks*.

8.52. The Department of Work and Pension has informed this review that when Claire expressed her distress with the situation, her Department of Work and Pension work coach messaged her regularly and upon the questionnaire not being received, a service centre colleague took personal responsibility to look for the form. When it arrived the colleague ensured that it was processed quickly.

8.53. This review has been assured that Department of Work and Pension staff receive mental health training to ensure vulnerable claimants are supported and this includes when to invoke a six point plan for anyone declaring suicidal intent or intent to self-harm. Claire made no declaration and consequently the six point plan was not deemed to be required. The Department of Work and Pension also revealed that it has systems which identify during calls and in journal

[53] In early June 2020, Claire reported to her domestic abuse worker that she had attempted to overdose and continued to say that she had been embarrassed by having to share the details of the relationship with Police Officers, and in July 2021, during a telephone review with an Associate Specialist from the Community Interventions Pathway, Claire reported that the monthly updates from the Independent Office for Police Conduct *affected her every time*.

messages, key words that could indicate a claimant is distressed. If identified individuals are contacted to check on their welfare and relevant support is offered. This review has not been informed of any key words having been identified within Claire's communications.

8.54. In August 2020, Claire was diagnosed with Emotional Unstable Personality Disorder by a consultant psychiatrist to whom she had been referred by the hospital mental health liaison team in June 2020[54]. Whilst the GP was notified of the diagnosis, there was no reason to share this any wider. And as good practice would ask agencies to always assess clients on their presenting needs, not having knowledge of any formal diagnosis would never have affected the support offered to Claire.

8.55. Alcohol had and did continue to affect Claire's behaviours. Whilst documentation evidences much good practice exampled by the domestic abuse worker, panel members have wondered whether there was potentially a missed opportunity within this support offer to refer Claire to Shropshire Recovery Partnership.

8.56. This was discussed directly with the domestic abuse worker who explained that when her contact with Claire commenced, Claire had recently injured her spine and was consequently wearing a neck brace and being prescribed strong pain management medication. Subsequently, Claire was not drinking alcohol around that time and alcohol hadn't particularly featured within their conversations.

8.57. This review has established that though the domestic abuse worker learned of Claire throwing herself down the stairs in February 2020, it wasn't ever shared with her that alcohol had been a contributing factor. Similarly, details weren't shared with the domestic abuse worker when in May 2020, Claire's friend reported a concern for Claire to the police. Claire disclosed the details of this incident to the domestic abuse worker herself and though she mentioned that she had been drinking red wine, Claire's focus was upon having taken a cocktail of medication, and that the incident overall was an isolated cry for help.

8.58. In November 2020, Claire fought with a female. The police report notes that Claire was heavily intoxicated, but the domestic abuse worker has informed this review that again it was only Claire who told her the details of this incident. Claire had told the worker that she had visited a friend and found her friend heavily intoxicated with another female. Claire said that out of concern for her friend, she had challenged the other female about the amount of alcohol that was being consumed and the other female then assaulted her. There was no mention of Claire having consumed alcohol. This incident occurred at the end of the domestic abuse worker's engagement with Claire - the case was closed in December 2020.

8.59. A few months after this incident, in March 2021, Claire was reportedly under the influence of alcohol when she argued with Child A and attempted to end her life by throwing herself down the stairs. At this time Child C disclosed to the police call handler that Claire was often drunk, and they were having to look after themselves. Child C also said that when Claire wasn't drinking, *she was really good, but something switched in her mind when she drank alcohol.*

8.60. Police officers located Claire. It was good practice that officers attempted to explore alcohol use with Claire, but Claire declined consent for a referral at this time. However, it should be recognised that police officers' interactions with Claire were limited to when they were responding to incidents, and consequently, at the times when officers were offering Claire referrals to support services, she would potentially have often been in a state of anxiety, or still

[54] Claire said that she "*could identify with the criteria for diagnosis" and* was "*keen to learn more about it and how to positively manage her life in a more consistent manner".*" According to the Priory Group a person with emotionally unstable personality disorder, may struggle with: Impulsivity, Mood swings, An overwhelming fear of abandonment, Extreme anxiety and irritability, Anger, Paranoia, and suspicion of others, Feeling empty, hopeless, and worthless, Suicidal thoughts, Self-harm, Having a pattern of unstable or shallow relationships, Rapidly changing your opinions of other people, Dissociation.

under some influence of alcohol. It is therefore comprehensible that Claire may not have been in the best frame of mind to consider support. Nevertheless, the effect of her declining a referral affected no follow up action being taken by any agency.

8.61. Following this incident an officer completed an Adult Risk Assessment[55] at medium risk (and a Child Risk Assessment was completed for Child C – also medium risk). A referral was made to the Harm Assessment Unit, and the information was shared with Children's Social Care. Though Claire was now open to the Community Interventions Pathway team, the Harm Assessment Unit stated that there was no indication of Claire being open to mental health services. The unit also stated that Claire hadn't requested any support for her alcohol use and that there were no other recent incidents which detailed drinking for Claire.

8.62. This review has been assured that whilst there is no co-location of adult safeguarding services and police colleagues there is a close relationship. As such it is not clear why the Harm Assessment Unit were unaware that alcohol had been a factor within a number of incidents that had been known to professionals the previous year, i.e., February 2020, May 2020 and within the fight in November 2020.

8.63. No further referrals were made by the Harm Assessment Unit.

8.64. As a result of this incident in March 2021, Children's Social Care completed a Social Work Assessment[56] around Child C. The assessment clearly identified Claire's mental health, alcohol use and the domestic abuse. Following completion of the assessment, Children's Social Care were assured that many resilient and protective factors had been identified for Child C, and it was decided that no further action was required as Child C was safeguarded by their father and supported by universal services.

8.65. However it is not clear how, or whether, Children's Social Care had given appropriate consideration as to whether Claire was sufficiently supported. It is possible that assumptions were made that Claire was able to manage her own situation without further support, and/or that Claire's needs were overlooked by Children's Social Care whose focus was upon Child C. This disconnect between children's and adults services has been identified in other reviews commissioned in Shropshire and the actions plans developed in their response will support learning in this practice area.

8.66. Case notes show that Claire had also disclosed her alcohol use to mental health services when,

- in July 2021 Adult Mental Health Services shared with Claire's GP that Claire was *tending to get drunk and angry*. The notification sent to the GP shared that Claire's medication was to continue but no other actions were identified. And,
  in September 2021 Claire disclosed to her care co-ordinator that she had resumed "*drinking excessive alcohol leading to disinhibition and poor decision making"*. And that she recognised that binge drinking increased her risk of self-harm, overdose, and sedation.

8.67. This review has been informed that health records indicate that accessing support to address alcohol use was discussed with Claire, but that she hadn't wished to seek help. However it is notable that documentation lacks detail to evidence any professional consideration/discussion of the barriers that Claire may have faced in relation to accessing alcohol support.

[55] Notably, on this occasion, Claire was deemed to fit the criteria for Adult at Risk.

[56] This assessment which was undertaken was as a result of the 7th concern that had been reported to Children's Social Care within the scoping period of this review. This is mentioned because this number of concerns evidences that professionals are adept at recognising safeguarding concerns for children when they are subject to domestic abuse and/or parental mental health and substance use.

8.68. Panel mooted how hard it would have been for professionals to recognise the repeated involvement (and extent) of alcohol in Claire's life, as professionals (other than the police) were not seeing Claire under the influence of alcohol and were only learning of alcohol consumption from Claire herself. Consequently many professionals only learned what Claire was willing to tell - and it is usual for individuals to mostly downplay and minimise their alcohol use. This is evidenced by the domestic abuse worker who informed this review that when Claire had told her about the incident whereby, she had thrown herself down the stairs in distress, whilst Claire admitted to having used alcohol in the evening, the focus of discussion was steered upon the cocktail of prescription drugs and the suicidal ideation.

8.69. However, best practice would have seen professionals who had offered Claire referrals for support with her alcohol, considering other ways to engage Claire in alcohol services when she declined to consent to referrals.

Learning 6: When Claire declined alcohol support services, she was left to manage her recovery alone; if someone refuses referral to specialist support services to deal with alcohol problems agencies should consider the implications for the person including providing them with information about support services.

8.70. This review has been informed by the Community Safeguarding Partnership that engagement has subsequently taken place with the local alcohol support services and when a person now refuses to accept a referral there is an option for the agency who wished to make the referral to receive direct advice from the alcohol support service - which can include approaches to overcome the person's reluctance to accept help.

Question 3: How can Shropshire Community Safeguarding Partnership and its partner agencies:

- **raise practitioners' awareness of alcohol use,**
- **educate practitioners around identifying individuals who require support, and**
- **help non-specialist professionals to support those who decline alcohol services?**

8.71. In 2015 Alcohol Concern launched the Blue Light Project[57] which sought to support hard-to-reach drinkers, such as Claire, who fit into three criteria: alcohol dependent, a burden on public services and non-engagement with treatment. The Blue Light approach *challenges the belief that only drinkers who show clear motivation to change can be helped* and sets out tools and techniques that can be used with this group. At the heart of Blue Light is a manual[58], which sets out the key principles and contains a range of advice and tools for working with clients who are not in contact with services. Blue Light training supports professionals in applying the principles and tools and helps local areas set up the multi-partner forums and protocols needed to embed the programme.

The Application of Professional Curiosity

8.72. Professional curiosity is an essential pre-cursor to identifying and managing risk. But whilst practice to include an application of professional curiosity is embedded in safeguarding adult policies and in the Care Act 2014, there is no clear definition of what professional curiosity really looks like.

8.73. The British Association of Social Work Professional Capabilities Framework[59] offers some guidance where it states that those entering the profession will: '*apply imagination, creativity and curiosity to practice*'. This ethos must be adopted by all professionals who must remember that professional curiosity begins by asking questions, challenging information, and attempting to connect with people in order to enable better understanding of their situations.

[57] The Blue Light Project | Alcohol Change UK
[58] The-Blue-Light-Manual.pdf
[59] (PCF, 6) (British Association of Social Workers, 2018 p.26)

8.74. Evident within the documentation provided to this review is a notable lack of professional curiosity regarding in particular, Claire's alcohol relationship with alcohol and declination of support services.

8.75. As mentioned, the domestic abuse worker built a good relationship with Claire, and the service has examined their responses to Claire with regards to whether workers could be more professionally curious within their practice. The service has recognised that there were potentially missed opportunities for the domestic abuse worker to be more professionally curious regarding Claire's relationship with alcohol when Claire was discussing her lifestyle and disclosing incidents. Similarly, mental health services recorded Claire's references to excessive drinking habits yet there is nothing recorded to evidence further professional curiosity into this.

8.76. There were also opportunities for agencies to demonstrate better professional curiosity with regards to Claire's risk of domestic abuse throughout the scoping period of this review. For example, more professional curiosity could have been shown when Claire spoke of new relationships. In March 2022, Claire informed her Community Interventions Pathway Care Coordinator that she had started a new relationship, but it has not been possible to ascertain for certain if she was referring to Mr P because no further details of the partner or the relationship were recorded. Claire said at this time that she expected the relationship to imminently end and spoke of problems stemming from jealousy. Could more curiosity have been shown into whether she needed any other type of support?

8.77. Similarly the Shropshire Community Health Trust has reflected a lack of professional curiosity in relation to domestic abuse. There is mention in their notes to Claire informing a nurse that her partner was in prison for breaking the terms of a restraining order. At this time, a Domestic Abuse alert should have been applied to Claire's record, but this didn't happen and as the episode of care progressed there was a lack of recognition of the domestic abuse by subsequent nurses during interactions. This was even though the nurses were aware that a domestic abuse advisor was engaging with Claire during the time of their care.

8.78. This review has also been informed that there was no reference to indicate that Claire was a current victim of domestic abuse within her GP Practice records. There is also little evidence of any GP evidencing professional curiosity into Claire's circumstances where circumstances potentially resulting from domestic abuse may have occurred. For example,

- On the 21st of January 2020 during a face-to-face consultation, Claire said that she was "…not sleeping well due to ex-boyfriend being arrested…". No further relationship discussion is documented - could more curiosity have been shown at this appointment as to why he had been arrested and whether she needed any other help and how she was managing?
- On the 30th of January 2020: during a face-to-face consultation, Claire said that "…she would like a letter to give to housing for a move as her assailant is in prison now but will likely do more once he is out" Though Claire on this occasion was advised to speak with a victim support officer, no further relationship discussion is documented.
- On the 20th of February 2020: during a face-to-face consultation, Claire mentioned that her partner was in jail, but no further relationship discussion is documented.
- On the 23rd of August 2020 the orthopaedic service brought to the attention of the GP Practice within a referral letter that Claire had fractured her spine, having been pushed downstairs by ex-partner.
- Records evidence that on the 8th of March 2021 an argument that Claire had with her child and ex-husband is brought to the attention of the GP Practice, but it is not clear how this information was passed or whether this incident was ever discussed directly with Claire.

- There are also multiple further references within correspondence from Mental Health Services to Claire discussing her domestic abuse history with them.

8.79. In addition, the Practice informed the review that it hadn't received any information request or correspondence regarding the Multi-Agency Risk Assessment Conference. Clearly this needs addressing, and the review would refer to Question 1 and ask that Multi-Agency Risk Assessment Conference is to be included in considerations. But references were made to Multi-Agency Risk Assessment Conference within correspondence when on the 24th of March 2020, Adult Mental Health Services brought to the attention of the GP Practice that Claire was supported by Women's Aid/Victim Support and that a Multi-Agency Risk Assessment Conference had been raised. And, in addition, the Multi-Agency Risk Assessment Conference result was passed to the GP Practice in June 2020.

8.80. This review has been informed that it appears that the information was either not seen by the Practice team or if seen, the importance and associated risk was not identified. Good practice would have seen for Claire's record to be coded, and her risk made clear for all subsequent consultations. This would potentially have allowed opportunistic enquiry at future appointments.

8.81. More professional curiosity could have also been had by healthcare professionals (i.e., Claire's GP and mental health professionals) into Claire's lived experience and of who, if anyone, her fluctuating mental health, and suicidal ideations may affect. On more than one occasion, Claire spoke to healthcare professionals of her need to care for her child, but there is no evidence of any professional curiosity into the child's safety. Nor, other than when Claire presented at the hospital emergency department, was any action ever taken to inform safeguarding services.

Learning 7: All safeguarding training should sufficiently incorporate and reinforce the need to be professionally curious.

8.82. This learning point is not unique to this review. Numerous Safeguarding Adults Reviews have highlighted the need for professional curiosity in safeguarding adults with care and support needs[60], and a Research in Practice briefing[61] has identified that the *structure and service values of an organisation or partnership will have a deep impact on the likelihood that curiosity will thrive*. The briefing examines eight key areas that leaders could focus on to develop the conditions for professional curiosity to flourish:

- Involving people who use services – adapting practice to meet people's needs and outcomes.
- Time and capacity – creating space for professionals to reflect.
- Structure and working practices – maximise opportunities for managers to use strength-based practice frameworks to encourage professionals to focus on the individual and their situation.
- Supervision and support – provide good quality supervision which offers reflection, critical analysis, and respectful challenge.
- Legal and safeguarding literacy – enable practitioners to make connections between legal rules and professional practice.
- Learning and development – provide programmes of learning and development.
- Open culture – encourage challenge from frontline practitioners and promote innovative practice.
- Partnership working – share information, bring together different perspectives, manage difficulties between professionals.

This is a helpful list against which Shropshire could audit/review their system.

[60] Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk)

[61] The importance of professional curiosity in safeguarding adults. Helen Thacker, Dr Ann Anka and Bridget Penhale Published 9.12.2020.

8.83. Shropshire Safeguarding Community Partnership has assured this review of Professional Curiosity guidance[62] which is regularly circulated and referred to, and of an Exploring Professional Curiosity learning event having taken place for practitioners since the scoping period of this review in November 2023. Attendance of such events is monitored through Eventbrite[63].

8.84. In addition the Shropshire Safeguarding Community Partnership Learning and Development Officer is providing a 2 hour online briefing on Professional Curiosity, and this is to be recorded and available for all professionals and volunteers across Shropshire to access on YouTube.

8.85. Shropshire Safeguarding Community Partnership is assured of the quality of its training through careful planning and research which provides the content and resources, And prior to delivery, the learning is quality assured through peer feedback, observation and evaluation from qualified teaching and safeguarding professionals with knowledge in this area.

Question 4: How can Shropshire Safeguarding Community Partnership ensure that professional curiosity training is kept current and that the training is effecting a competent workforce which is generating change?

The Professional Understanding of the Link between Domestic Abuse and Suicide

8.86. It is known that Claire attempted suicide on multiple occasions but given that studies[64] have shown that less than half of people disclose their suicidal ideation or behaviours, it is reasonable to assume that Claire may have attempted suicidal on many more occasions than she disclosed.

8.87. Notably, this review has been unable to find testimony within the documentation and case notes provided, of any professional gaining a true, consistent understanding of the reasons behind Claire's overdoses and suicide attempts, but Claire's attempts were, according to Professor Williams[65] a *'cry of pain'* more likely where *feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible*[66].

8.88. This theory examples the great psychological pain it is reasonable to assume that Claire was suffering and highlights the need for professional curiosity into her situation. Particularly as a key finding, observed across a number of studies, is that previous suicidal behaviour, regardless of cause, is one of the most robust predictors of future suicide,[67] with some research indicating that a completed attempt often follows an uncompleted attempt within an average of one year[68].

8.89. As previously mentioned in this report, research now shows us that victims of abuse by a partner are also more than three times as likely to self-harm and at more than double the risk of having suicidal thoughts.

8.90. A number of agencies knew that Claire experienced domestic abuse and suicidal ideation.

- The police were aware of both, having attended incidents of domestic abuse and of suicidal intention where Claire had thrown herself down the stairs.
- Children's Social Care was aware from their records and assessment.

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[62] https://www.shropshiresafeguardingcommunitypartnership.co.uk/media/fd5dcot1/approved-professional-curiosity-guidance-inc-additional-covid_19.pdf

[63] 268 practitioners attended the Professional Curiosity event in November.

[64] Disclosure of suicidal ideation and behaviours: A systematic review and meta-analysis of prevalence - PubMed (nih.gov)

[65] Williams, J. M. G. (1997). The Cry of Pain. London: Penguin

[66] Rasmussen, S.A., Fraser, L., Gotz, M., MacHale, S., Mackie, R., Masterton, G., McConachie, S & O'Connor, R.C. (2010) 'Elabo-rating the Cry of Pain model of suicidality: Testing a psychological model in a sample of first-time and repeat self-harm patients.' British Journal of Clinical Psychology 49: 15–30.

[67] World Health Organisation (2016) Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm.

[68] Bostwick, M, Pabbati, C., Geske, J., & McKean, A (2016) 'Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew.' Am J Psychiatry 173(11): 1094–1100.

- The information was available to the GP Practice in case notes and
- Claire had disclosed domestic abuse, and suicide attempts to both the domestic abuse worker and her mental health Care Coordinator.

8.91. In addition, the DASH Risk Assessments which were completed with Claire should have evidenced whether Claire felt depressed or was having any suicidal thoughts.

8.92. Interestingly, West Mercia Police has informed this review that following a review undertaken in partnership between Cardiff University, the College of Policing and University College London which showed that the previous DASH risk tool was not optimally suited to the initial assessment completed by the first officers on scene, they have now replaced the DASH Risk Assessments with the Domestic Abuse Risk Assessment (DARA). Whilst it is good that the DARA has increased focus on coercive and controlling behaviours, given what we now know about the link between domestic abuse and suicide, it is concerning that the question *are you feeling depressed or having suicidal thoughts* is no longer included. However, the College of Policing has stated that the DASH risk assessment will continue to be used further along in investigations and by some partner agencies like social services.

8.93. As established, professionals addressed the risk of domestic abuse by ensuring that support offers were in place by means of a domestic abuse worker, and for example, an alarm, and a house safety assessment. And there was oversight of this support by means of a Domestic Abuse Risk Management Plan and a Multi-Agency Risk Assessment Conference.

8.94. Professionals also attempted to address the risk of suicidal ideation by offers of support to Claire for her mental health by means of referrals, medication, and courses.

8.95. But the link between the domestic abuse and the risk of suicide went unrecognised. Potentially this could be because following the domestic incidents in January 2020 with Partner 1, no more incidents were disclosed until the day of Claire's death - other than a verbal incident between Claire and Child A in March 2021. However, the relationship between Claire and Partner 2, was noted to have caused Claire harm; and given that this investigation was ongoing throughout most of the scoping period, this abusive relationship would have remained very current for Claire.

8.96. Nevertheless, the length of time since the last reported incident shouldn't influence the support offer, particularly because no disclosure of abuse doesn't mean that abuse isn't happening. But also because the risk of suicide for victims of domestic abuse is known to extend to after the direct abuse has ended.

8.97. In summary, knowing that Claire was a victim of domestic abuse and was experiencing fluctuating mental health, which often resulted in disclosed suicidal ideations and/or suicide attempts, necessitated a lengthier professional focus on Claire regarding the long-term implications and impact upon her mental health.

8.98. During the scoping period of this review, domestic abuse workers were not undertaking any specific mental health training, but this review has been assured that more recently Public Health have started to meet regularly with We Are With You[69], Shropshire Domestic Abuse Services, Women's Aid, Midlands Partnership Foundation Trust, and Parental Education Growth Support (PEGS)[70], to discuss how pathways and training between services can be strengthened and to explore how working practices may complement each other or unintentionally produce barriers. The aim of these meetings is to increase access to services for all, to identify gaps which can then be addressed, and to evidence good practice which can be harnessed and shared.

Learning 8: The link between domestic abuse and suicidal ideations was not recognised by the professionals working around Claire.

[69] With You is a charity providing free, confidential support to people experiencing issues with drugs, alcohol, or mental health.
[70] PEGS has been set up to support parents, carers and guardians who are experiencing child to parent abuse.

Question 5: How can partner agencies assure Shropshire Safeguarding Community Partnership that the risks associated with suicide attempts is encompassed within domestic abuse and safeguarding training?

The Professional Understanding of Claire's Lived Experience

8.99. Prior to the scoping period of this review it was known by all agencies that Claire had experienced domestic abuse as there had been much agency involvement over the years and she had been subject to previous Multi-Agency Risk Assessment Conferences. It was also known by Children's Social Care and healthcare professionals that Claire lived with poor mental health and had attempted suicide.

8.100. In January 2020, both the domestic abuse and the poor mental health were current issues known by all who attended the Domestic Abuse Triage meeting; and, within a short time after, domestic abuse services, and the healthcare professionals who were attending to Claire's care following her spine injury.

8.101. Though positive action was taken by police officers which included face-to-face communications, and a Children's Social Care social worker discussed Claire's relationship with her, the domestic abuse worker was the first professional to listen to Claire, and to learn of, and document, Claire's lived experience. There is a wealth of information within the case notes which evidences how well the worker listened to Claire and encouraged her to talk about her experiences and voice her opinion.

8.102. Similarly Children's Social Care later obtained a good report of Claire's views within their Social Care Assessment undertaken in March – May 2021. Within the assessment, Claire's mental health is explored, her dispute with her neighbours is detailed, her relationships with Partner 1 and Partner 2 and her worries about Child C joining the army.

8.103. Interestingly, though the scoping period of this review encompasses the Covid pandemic, this review has not seen any documentation which evidences how Claire felt during lockdown, how it affected her daily living, or how she coped with the restrictions. Was she able to see her children? Who was in her 'bubble'?

8.104. It was particularly important to explore Covid with Claire as it is known that people with mental health conditions are highly susceptible to stress, and that a person, influenced by their emotional responses to external stresses, might potentially attempt to 'self-medicate' by means of drugs and/or alcohol – risking further deterioration of their mental health.

8.105. It has not been possible to confirm whether Claire's alcohol use increased during the pandemic, but the lockdowns did see an overall increase in people's alcohol consumption. In July 2021 Public Health England released a paper called 'Alcohol consumption and harm during the Covid 19 pandemic[71]'. The findings show an increase in the heightened risk level of alcohol consumption from 2020 to 2021. This increase in alcohol consumption during Covid 19 also saw a rise in alcohol-related deaths. Fatalities relating to alcohol rose by 20% in 2020, going from 5819 in 2019 to 6983 in 2020. Deaths from a rise in behavioural and mental disorders, due to alcohol, rose from 2019 to 2020 at 10.8%.

8.106. This review has questioned whether Claire was at higher risk of suicide during the Covid restrictions given her suicidal ideations. But whilst it is known that more people sought mental health support during the pandemic, the University of Manchester scientists[72] found a broadly similar suicide rate from April to October 2020 to that seen between January and March. Using real-time surveillance data (which records suicides as they occur but before an inquest is held) academics studied suicides in areas of England covering around a quarter of the population. They found that the suicide rate between January and March 2020 was 125.7 per month

[71] Alcohol consumption and harm during the COVID-19 pandemic - GOV.UK (www.gov.uk)

[72] Suicide in England in the COVID-19 pandemic: Early observational data from real time surveillance - The Lancet Regional Health – Europe

compared to 121.3 per month between April and October. Comparing 2020 to 2019, the data showed a total of 633 suicides between April and October 2019, compared to 637 during the same months in 2020.

8.107. In addition, to how Covid affected, or did not affect, Claire's alcohol consumption and mental health; the environment created by Covid, increased Claire's risk of domestic abuse. Whilst Claire wasn't knowingly living with anyone at the time of the first lockdown, it remains unknown as to what relationships she was having, or how much time any partner was spending with Claire inside her home address.

8.108. When the first 'lockdown' was announced in March 2020, charities, such as Women's Aid, highlighted the increased risk of harm and isolation for those affected by domestic abuse. Because domestic violence is often a hidden crime that is not reported, data can only provide a partial picture of the actual level of domestic abuse experienced. But the Office for National Statistics report that in mid-May 2020, there was a 12% increase in the number of domestic abuse cases referred to victim support. Between April and June 2020, there was a 65% increase in calls to the National Domestic Abuse Helpline, when compared to the first three months of that year.

8.109. Without doubt 2020 and 2021 must have been difficult years for Claire. Alongside the Covid pandemic, she,

- Experienced domestic abuse and harassment from Partner 1 and bravely supported police prosecution,
- Reported sexual abuse from Partner 1 and bravely supported police prosecution, but after eight months was informed that there was insufficient evidence to prosecute,
- Dealt with the emotional fear of Partner 1 being released from prison following his imprisonment,
- Disclosed a relationship with a serving police officer (Partner 2) and supported the ongoing Independent Office for Police Conduct investigation which took two years to complete,
- Experienced fluctuating mental health and suicidal ideations,
- Was diagnosed with Emotional Unstable Personality Disorder,
- Suffered a spinal injury,
- Following her spinal injury, suffered financial hardship, and struggled with her claim for Universal Credit,
- Was being investigated for assault following a fight with a female, and
- Experienced neighbour disputes.

8.110. Though professionals were very good at managing and understanding Claire's immediate concerns (for example, the police prosecuted Partner 1 and investigated Partner 2, domestic abuse services supported Claire to feel safe, the health practitioners responded to mental health crises and addressed Claire's physical health when she injured her spine, the Department of Work and Pensions supported Claire to obtain the financial assistance she was eligible for) few professionals had the full picture of Claire's lived experience as outlined in the previous paragraph.

8.111. It could be argued that the domestic abuse worker held the full picture but when this service stopped in December 2020, the information stayed with the service. And as previously noted, Children's Social Care gleaned considerable information when they undertook the assessment in 2021, but their information was used to support their decision-making process around Child C and wasn't shared.

8.112. It was May 2022, when Claire undertook a Psychological Assessment, before anyone else learned more of Claire's lived experience and unfortunately this work was disrupted by an imminent house move and wasn't ever continued.

8.113. Understanding Claire's lived experience was crucial as it illustrated her repeated patterns of abusive relationships, fluctuating mental health, recurring suicidal ideations and binge drinking (her parents say Claire's alcohol use was longstanding).
8.114. Claire's desperation is reflected in the events of her final day. She clearly felt so trapped by her circumstances that she believed that her only way out was suicide.
8.115. This review hopes that its reflection upon professionals' understanding of Claire's lived experience will serve as a driver of change moving forward and that her history will lead us to better practice.
Learning 9: Safeguarding planning was affected as a result of no professional gaining a vital understanding of Claire's lived experience. Better understanding of Claire's lived experiences would have helped identify the level of despair Claire faced and her risk of suicide.
8.116. There are existing systems and processes which support professionals to better learn about a person's lived experiences such as multi-agency meetings, and this has already been recognised by Shropshire Safeguarding Community Partnership and its partner agencies. Consequently professionals from all agencies are being supported to recognise circumstances which trigger a multi-agency meeting and supported to identify who to invite. Notably, it doesn't just have to be the professionals who are already involved with a person who should be invited – it's the people who could be involved.
Question 6: How can partner agencies assure Shropshire Safeguarding Community Partnership that their practitioners are being trained to explore and document individual's voices and lived experiences and how can they evidence that this is being incorporated in practice?

9. Good Practice

9.1. Professional discussion around Claire, has highlighted examples of good practice[73] from the professionals involved. Examples are included within the body of the report and include,

- It was good practice that partner 1 was offered a DASH.
- It was good practice that a domestic abuse risk officer who had noted that both parties had been previously subject to Risk Management Plans with previous partners, and that there had been previous incidents between themselves, consequently attempted to contact Claire.
- It was good practice that despite investigation, when the circumstances around the damage were never able to be established, Claire's Risk Management Plan was extended for a further four weeks to offer her reassurance.
- The domestic abuse worker built a good relationship of trust with Claire.

10. Conclusions

10.1. Claire experienced domestic abuse within multiple relationships and reported further incidents with new partners during the scoping period of this review. In addition, Claire was known to live with alcohol use and mental health concerns.
10.2. Claire sought help for and engaged with support around her domestic abuse experiences and her mental health.

[73] Good practice in this report includes both expected practice and what is done beyond what is expected.

10.3. Though Claire was offered support for her alcohol use, the true extent of Claire's common consumption of alcohol within incidents was not recognised and her declination of alcohol services wasn't ever fully explored.
10.4. Overall, professionals responded well to Claire's immediate concerns. Domestic abuse incidents were responded to by police and domestic abuse services, and health practitioners responded to mental health crises, but the link between Claire's domestic abuse experiences and her suicidal ideations was not recognised.
10.5. Professionals did not ever gain a full understanding of Claire's lived experiences and repeated abusive relationships, fluctuating mental health, recurring suicidal ideations and binge drinking.
10.6. In consequence over time, Claire believed that her only way out was suicide.

11. Lessons to be Learnt and Recommendations[74].

11.1. The lessons learned from this joint Safeguarding Adult Review and Domestic Homicide Review commissioned by Shropshire Safeguarding Community Partnership are highlighted in bold text throughout this report, but for reference are repeated here:

	Learning	**Has the learning been addressed?**		**Question**
1	Though it is not possible to ascertain for certain how Claire felt about face-to-face contact with professionals being replaced by telephone/virtual communication, it is known that Claire found it harder to engage with the Life Skills Course online.	Yes – see paragraph 8.15		None required
2	Multi-agency information is not routinely shared between GP Practices and other professionals/agencies.	No	1	How can Shropshire Safeguarding Community Partnership seek assurance of consultation being had between partner agencies and clients' GP Practices, to improve multi-agency information sharing with, and from, GPs?
3 and 4	Whilst the Domestic Abuse Triage Meeting ensured that Claire and her family were offered support regarding domestic abuse, insufficient consideration was given to other vulnerabilities and consequently referrals to other agencies, who could offer Claire support in other areas of need, were missed. ----------	Yes – see paragraphs 8.31 - 8.33		

[74] By way of questions.

	The latter outcome threshold Levels from the Domestic Abuse Triage Meetings did not reflect that multiple referrals potentially represented an increased need of support.			
5	The Harm Assessment Unit is working in silos when the unit grades and makes decisions regarding onward referrals without multi-agency oversight.	Partially – see paragraph 8.49	2	How can Shropshire's Harm Assessment Unit and partner agencies assure Shropshire Safeguarding Community Partnership that multi-agency decision-making, in line with statutory processes, is followed within the Harm Assessment Unit in the future?
6	When Claire declined alcohol support services, she was left to manage her recovery alone; if someone refuses referral to specialist support services to deal with alcohol problems agencies should consider the implications for the person including providing them with information about support services.	No	3	How can Shropshire Safeguarding Community Partnership and its partner agencies: • raise practitioners' awareness of alcohol use, • educate practitioners around identifying individuals who require support, and • help non-specialist professionals to support those who decline alcohol services?
7	All safeguarding training should sufficiently incorporate and reinforce the need to be professionally curious.	Partially – see paragraphs 8.82 – 8.85	4	How can Shropshire Safeguarding Community Partnership ensure that professional curiosity training is kept current and that the training is effecting a competent workforce which is generating change?
8	The link between domestic abuse and suicidal ideations was not recognised by the professionals working around Claire.	No	5	How can partner agencies assure Shropshire Safeguarding Community Partnership that the risks associated with suicide attempts is encompassed within domestic abuse and safeguarding training?
9	Safeguarding planning was affected as a result of no professional gaining a vital understanding of Claire's lived experience. Better understanding of Claire's lived experiences would have helped identify the level of despair Claire faced and her risk of suicide.	Partially – see paragraph 8.116	6	How can partner agencies assure Shropshire Safeguarding Community Partnership that their practitioners are being trained to explore and document individual's voices and lived experiences and how can they evidence that this is being incorporated in practice?

12. Appendix 1

Recommendations of the Serious Incident (Including Root Cause Analysis) Level 1 – Clinical Review

- All professionals involved in the care and / or treatment of a service user / patient should be invited to CPA reviews in line with Trust CPA Policy which recommends formal, multi-disciplinary and multi-agency review.
- Where a patient / service user discloses information about a change they have made in their prescribing regime, this information should be shared with the prescribed in a timely manner.
- All professionals involved in the care and / or treatment of a service user / patient should be informed of the patient/service user's discharge from care coordination / discharge from the service in a timely manner.
- Where potential risks for current / future self-harm are identified, timely actions should be taken to mitigate these: in this instance: continued collection of prescribed medications which was not being taken.
- For health professionals to liaise with the patient's/ service user's prescriber where recommencement of medication is considered / required after a period of self-cessation.
- Where it is identified that there is a pattern to a patient / service user's contacts with services / acts of deliberate self-harm, for health professionals to discuss these in detail with the patient / service user and include these details within the Risk Profile

13. Appendix 2

Home Office

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Lisa Gardner
Development Officer
Business Unit
Shropshire Safeguarding Community Partnership
Shrewsbury Business Park
Shrewsbury
SY2 6QT

9th December 2025

Dear Lisa,

Thank you for resubmitting the Domestic Homicide Review (Claire) for Shropshire Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in December 2025.

It was noted that the report is well written, easy to follow and demonstrates compassion and understanding regarding the complex issues Claire faced and how she coped with them. Although there is no specific tribute to Claire, the report attempts to convey a sense of who she was. There was a good range of dissemination methods outlined in section 4.21 and the analysis includes a strong section on understanding Claire's lived experience.

There are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Before publication, please review and implement the following feedback:

- Child C's gender is revealed in a footnote on page 12, please remove to improve anonymity.
- The chronology remains very brief. For future DHRs more information and context about the victim's life should be included.
- To note for future DHRs, condolences would usually appear at the outset of the report, if possible, following a pen portrait from a family member or friend.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Team

14. Appendix 3

Multi-agency Action Plan - Claire

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
1.How can Shropshire Safeguarding Community Partnership seek assurance of consultation being had between partner agencies and clients' GP Practices, to improve multi-agency information sharing with, and from, GPs?	Local	Include question regarding information sharing with and from GPs in future multi-agency audits. GP practices to utilise recommended codes they have for Domestic Abuse	SSCP Business Unit ICB Named GP for Safeguarding and	MACFA on trigger trio to consider information sharing with GPs. Reporting end of March 2025. Partner agencies in specialist support services have been tasked with sharing and triangulating information with each other, social care and GPs. ICB have circulated the Royal College of GP Standards and recommended codes to be used to all GP Practices.	31/12/24	**Completed April 2025**
2.How can Shropshire's Harm Assessment Unit and partner agencies assure Shropshire Safeguarding Community Partnership that multi-agency decision-making, in line with statutory processes, is followed within the Harm Assessment Unit in the future?	Local	Undertake an audit of recent cases to establish if multi-agency decision making is present.	Shropshire Harm Assessment Unit	This review has been reassured that work is already being undertaken into how multi-agency statutory processes are being followed within the Harm Assessment Unit protocols.	31/12/24	**Completed**

3.How can Shropshire Safeguarding Community Partnership and its partner agencies: • raise practitioners' awareness of alcohol misuse, • educate practitioners around identifying individuals who require support, and help non-specialist professionals to support those who decline alcohol services?	Local	Delivery of multi-agency training regarding alcohol misuse, content to include how to support those who decline services.	Learning & Development and SSCP Learning & Development Officer Shropshire Recovery Partnership	The ACSRG has agreed that this will be transferred to the system wide workstream and action plan as part of the Blue Light Alcohol Project Group. The work of this group is to develop dynamic and robust approach to address concerns about alcohol dependency and support frontline practitioners in their understanding, confidence and legal literacy when working with individuals who are alcohol dependant. The Service Manager of SRP has made contact with ASC Teams and Shrop Com (in the first instance) and attended Team Meetings to discuss how her service can provide consultations to staff who are working with dependant drinkers who will not actively engage in support with their alcohol misuse. Relationships built and practitioners have telephoned SRP for advice. Training to be offered in future to teams about role of SRP.	28/02/25	Completed 18/07/25
4. How can Shropshire Safeguarding Community Partnership ensure that professional curiosity training is kept current and that the training is effecting a	Local	Training package to be regularly updated. Gather evidence of improvements in exercising professional curiosity	SSCP Learning & Development Officer	Shropshire Safeguarding Community Partnership has assured this review of Professional Curiosity guidance which is regularly circulated and referred to, and of an Exploring Professional Curiosity learning event having taken place	28/02/25	**Completed June 2025**

competent workforce which is generating change?		in the Case Reviews Learning Log.		for practitioners since the scoping period of this review in November 2023. Attendance of such events is monitored through Eventbrite[75]. In addition, the Shropshire Safeguarding Community Partnership Learning and Development Officer is providing a 2 hour online briefing on Professional Curiosity, and this is to be recorded and available for all professionals and volunteers across Shropshire to access on YouTube. A regional Professional Curiosity guide is being produced for all practitioners. This will be hosted on all local websites. The train with us Team offers a professional curiosity training course and will provide evaluation feedback. Learning from Case Reviews webinars with messages about professional curiosity included. Breakout rooms for practitioners to discuss professional curiosity.		

[75] 268 practitioners attended the Professional Curiosity event in November.

				Partnership agencies are being asked to provide detail on how they exercise professional curiosity.		
5.How can partner agencies assure Shropshire Safeguarding Community Partnership that the risks associated with suicide attempts is encompassed within domestic abuse and safeguarding training?	Local	Review training packages for domestic abuse and safeguarding training to ensure that the risks associated with suicide attempts is included.	Learning & Development & SSCP Learning & Development Officer	The development officer for domestic abuse training has developed and is delivering training specific to this. This is available to the partnership workforce. The SSCP training officer and Joint Training Manager delivered a safeguarding update, which included the links between suicide and domestic abuse, and the course has rolling dates through 2025.	31/12/24	**Completed December 2024**
6.How can partner agencies assure Shropshire Safeguarding Community Partnership that their practitioners are being trained to explore and document individual's voices and lived experiences and how can they evidence that this is being incorporated in practice?	Local	Agencies can utilise user by experience boards to support practitioners to recognise the importance of capture this information within records. Agencies conduct case audits regularly. These audits should include checks that individuals' voices are captured within these records. Arrange multi-agency meetings.	All agencies	There are existing systems and processes which support professionals to better learn about a person's lived experiences such as multi-agency meetings, and this has already been recognised by Shropshire Safeguarding Community Partnership and its partner agencies. Consequently, professionals from all agencies are being supported to recognise circumstances which trigger a multi-agency meeting and supported to identify who to invite. Notably, it doesn't just have to be the professionals who are already involved with a person who should be invited – it's the people who could be involved.	31/12/24	**Completed December 2024**

		Gather evidence of improvement and good practice through the Case Reviews Learning Log.				