Shropshire Safeguarding Community Partnership

Executive Summary

Domestic Homicide Review[1] / Safeguarding Adult Review into the Death of: "Claire[2]"

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.

[2] A pseudonym

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1. The Review Process

1.1. Shropshire's Joint Case Review Group recognised that this case met the criteria for a Safeguarding Adult Review under The Care Act 2014, which states that '*Safeguarding Adult Boards must arrange a Safeguarding Adult 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.'*
1.2. 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 Adult Review and Domestic Homicide Review on the basis that a combined review is important as (the female referred to under the pseudonym of) Claire took her life by suicide and there was significant previous domestic abuse in her life.
1.3. This joint report examines agency responses and support given to Claire, a resident of Shropshire, prior to the point of her death.
1.4. 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.
1.5. The circumstances that led to this review being undertaken are that, following a party at which Claire's partner, Mr P, had ended their relationship, Claire broke into Mr P's home. Mr P has reported that he tried to get Claire out of his property, but she locked herself in. Claire then 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.
1.6. Claire had previously attempted to take her own life and had been engaging with mental health services over an extended period of time. Claire had been diagnosed with Emotional Unstable Personality Disorder.
1.7. 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.
1.8. 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.
1.9. The purpose of a Safeguarding Adult 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.
1.10. 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.

Timescales

1.11. 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.
1.12. 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.
1.13. 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.
1.14. The Overview Report and Executive Summary were submitted to the Home Office on the 14th of January 2025.

Confidentiality

1.15. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.
1.16. 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].

Methodology

1.17. 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.
1.18. 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

[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.

1.19. It was agreed not to convene a practitioner learning event for this review due to limited professionals who had worked with Claire, remaining in their roles and/or being available. Practitioners voices were heard through documentation and where possible individual consultation[5].

1.20. 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 Adult Review Quality Markers identified by the Social Care Institute for Excellence

1.21. 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.

Contributors to the Review

1.22. The following have contributed to the review by way of agency reports[6].

- Shropshire Children's Social Care
- Staffordshire Children's Social Care
- Hobs Moat Medical Practice
- University Hospitals Birmingham
- Birmingham & Solihull Mental Health Foundation Trust
- West Mercia Police
- Shropshire & Telford & 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

1.23. Agencies were asked to give accounts of their contact with Claire and/or Mr P prior to Claire's death. The accounts of involvement with Claire cover different periods of time prior to her death and some accounts

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

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

have more significance than others. All of the agencies responded, and all had had contact with either Claire, Mr P, or Claire's children.

1.24. The Review Panel Members were:

- Independent Reviewer
- Representative from Shropshire & Telford & Wrekin Integrated Care Board
- Representative from Staffordshire Integrated Care Board
- Assistant Director, Children's Social Care
- Principle Social Worker, Children's Social Care
- Service Manager, Adult Services
- Detective Inspector, West Mercia Police
- Domestic Abuse Strategic Lead, Shropshire Council
- Representative from Midlands Partnership Foundation Trust
- Superintendent, West Midlands Police

Parallel Reviews

1.25. The police have investigated the matter and concluded that Claire took her own life.
1.26. HM Coroner has formally ruled Claire's death as suicide.
1.27. Midlands Partnership NHS Foundation Trust informed Shropshire Safeguarding Community Partnership that they had undertaken a Serious Incident Level 1 Clinical Review[7].

2. Equality and Diversity

2.1. 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).
2.2. 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.
2.3. 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[8]. This is in comparison to an estimated 757,000 males.
2.4. 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*[9], 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.

[7] The recommendations made in the report can be found at Appendix 1.
[8] Domestic abuse in England and Wales: November 2020 - GOV.UK (www.gov.uk)
[9] Underexamined and Underreported - Agenda Alliance

2.5. 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.

3. Conclusions and Recommendations Arising from the Review

3.1. The review explored:

- 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
- Good Practice

Conclusions

3.2. 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.

3.3. Claire sought help for, and engaged with, support around her domestic abuse experiences and her mental health.

3.4. 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.

3.5. 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.

3.6. 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.

3.7. In consequence over time, Claire believed that her only way out was suicide.

3.8. The lessons learned from this joint Safeguarding Adult Review and Domestic Homicide Review commissioned by Shropshire Safeguarding Community Partnership are as follows:

	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. 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[10].		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. --- The latter outcome threshold Levels from the Domestic Abuse Triage Meetings did not reflect that multiple referrals potentially represented an increased need of support.	Yes 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 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. 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		

[10] 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.

		(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. PIT Stop will convene daily. It will be multi-agency[11] 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[12] 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 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. 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.		
5	The Harm Assessment Unit is working in silos when the unit grades and makes decisions regarding onward referrals without multi-agency oversight.	Partially 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.	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	No	3	How can Shropshire Safeguarding Community Partnership and its partner agencies: • raise practitioners' awareness of alcohol use,

[11] To date commitment has been confirmed from Shropshire Community Health, Adult Safeguarding, We Are With You, Youth Justice, Early Help, Education and Probation.
[12] Compass is the front door of Children's Social Care.

	should consider the implications for the person including providing them with information about support services.			• 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 This learning point is not unique to this review. Numerous Safeguarding Adult Reviews have highlighted the need for professional curiosity in safeguarding adults with care and support needs[13], and a Research in Practice briefing[14] 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.	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?

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

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

		• 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. Shropshire Safeguarding Community Partnership has assured this review of Professional Curiosity guidance[15] 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[16]. 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. 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.		
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	Partially 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	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?

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

[16] 268 practitioners attended the Professional Curiosity event in November.

	identify the level of despair Claire faced and her risk of suicide.	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.		

4. 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