Safer Solihull Partnership

Involving local people in keeping Solihull safe

Domestic Homicide Review

Under section 9 of the Domestic Violence, Crime and Victims Act 2004

In respect of the death of Adult 1 (April 2018)

Safer Solihull Partnership

Domestic Homicide Review 5

Executive Summary

The names of those subject to this review have been anonymised at the family's request.

Report produced by Simon Hill

(Independent Chair & Author)

January 2019

Introduction

1. The Independent Chair and Domestic Homicide Panel as well as the Safer Solihull Partnership and contributing agencies wished to put on record their condolences to Adult 1's family and friends for their tragic loss.
2. This summary outlines the process undertaken by the Safer Solihull Partnership domestic homicide review panel in reviewing the homicide of Adult 1, a resident of Solihull, prior to her death in April 2018.
3. The family members involved were offered the opportunity to nominate the pseudonyms to be used in the Domestic Homicide Review, in line with Home Office guidance and decided to use the following pseudonyms:

Parties	Relationship	Age at time of homicide
Adult 1	Victim	51 years old
Adult 2	Perpetrator	73 years old
Adult 4	Adult 1's daughter	
Adult 5	Adult 1's son	
Adult 6	Adult 1's sister	
Adult 3	Biological father of Adult 1's Son and father to Adult 1's Daughter	
Adult 7	Adult 2 's daughter from his second marriage	
Adult 8	Adult 1's close friend and neighbour	

4. The process began with an initial scoping of eleven agencies that may potentially have had contact with the victim or perpetrator. Thereafter in April 2018, a meeting of the Safer Solihull Partnership agreed that the criteria for a domestic homicide review had been met and informed the Home Office.
5. This review began in July 2018. Panel meetings were held on:
   - 16th July 2018
   - 08th October 2018
   - 06th November 2018
   - 13th March 2019
6. Throughout the process the Independent Chair of the Domestic Homicide Review and Advocacy After Fatal Domestic Abuse (AAFDA) advocate maintained regular communication with Adult 1's family.

Contributors to the Review

1. An Individual Management Review (Independent Management Review) and comprehensive chronology was received from the following organisations:
   - West Midlands Police
   - Birmingham and Solihull Clinical Commissioning Group
   - Birmingham and Solihull Mental Health NHS Foundation Trust
   - West Midlands Ambulance Service
   - University Hospitals Birmingham
   - Solihull Community Housing
   - Bromford Housing

2. All agencies Independent Management Review authors were independent of the events described in the reports and assurances to this effect were received from all agencies.

The Review Panel Members

Name	Agency	Title
Simon Hill	Independent	Independent Chair and report writer
Catherine Evans, later replaced by Loraine Longstaff	Birmingham and Solihull Mental Health Foundation Trust	Head of Safeguarding
Melanie Homer	Birmingham and Solihull Clinical Commissioning Group	Head of Safeguarding
DI David Sproson	West Midlands Police	Public Protection Unit Officer
Gillian Crabbe	Solihull Metropolitan Borough Council	Solihull Council's Community Safety and Partnerships Manager
Maria Kilcoyne	University Hospitals Birmingham	Lead Nurse, Safeguarding Adults
Caroline Murray	Solihull Metropolitan Borough Council	Solihull Council's Domestic abuse Co-ordinator

Author of the Overview report

1. The chair, Simon Hill, is a retired police public protection investigator with West Midlands Police, with twelve years' experience of child and adult safeguarding and major investigations in Edgbaston and Central Birmingham. He retired from the service in 2013. Prior to leaving the police service, he managed the Public Protection Review Team, responsible for writing the force's Independent Management Reviews and contributing to over thirty Domestic Homicide Review and child and adult Serious Case Reviews. He has chaired thirteen Domestic Homicide Reviews and adult Serious Case Reviews/Safeguarding Adult Reviews in the region. As a serving police officer, he has not worked in the Solihull area or had any professional involvement with the subjects of this DHR. He has not worked with any of the agencies involved with the Domestic Homicide Review.

Terms of Reference

1. The review addresses both the 'generic issues' set out in the Statutory Guidance, and the following specific issues identified in this particular case:
   - What decisions could have been made and action taken by agencies to prevent the homicide of Adult 1 or prevent Adult 2 from being a perpetrator of homicide?
   - How effective were agencies in identifying and responding to both need and risk?
   - How effective were agencies in working together to prevent harm through domestic abuse in Solihull?
   - What lessons can be learnt to prevent harm in the future?

2. Agencies Individual Management Review Authors were asked to respond to the following questions in respect of their involvement with Adult 1 and Adult 2 during the period from January 2012 (being the year when Adult 1 and Adult 2 married), and the date of her death:

01. Provide a brief summary of the role of your organisation in responding to domestic abuse.

02. Were practitioners sensitive to the needs of Adult 1 and Adult 2, knowledgeable about potential indicators of abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

03. Did the agency have policies and procedures for Domestic abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective?

04. Provide a brief pen picture of Adult 1 and Adult 2, together with and any knowledge your agency had of their relationship and the relationship that either of them had with any

other persons of interest. Please also include any previous relationships for either adult that appear to feature domestic abuse.

05. *What needs and vulnerabilities did your agency identify in Adult 1 (the victim) and how did your agency respond?*
06. *Had Adult 1 disclosed to any practitioners or professionals and, if so, was the response appropriate?*
07. *What needs and vulnerabilities did your agency identify in Adult 2 (the alleged perpetrator) and how did your agency respond?*
08. *What threat and risks did your agency identify for either Adult 1 or Adult 2 and how did your agency respond? Consider identified threat and risk for this relationship and prior relationships as well as the potential for threat to other people.*
09. *If domestic abuse was not known, how might your agency have identified the existence of domestic abuse from other issues presented to you?*
10. *How well equipped were staff in responding to the needs, threat or risk identified for both Adult 1 and Adult 2. Were staff supported to respond to issues of domestic abuse, safeguarding, public protection and multiple and complex needs through*
    - *Robust policies and procedures in domestic abuse, including policies of direct or routine questioning*
    - *Strong management and supervision*
    - *Thorough training in the issues and opportunities for personal development*
    - *Having sufficient resources of people and time*
11. *Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the Adult 1, Adult 2 and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?*
12. *Can you identify areas of good practice in this case?*
13. *Are there any service changes planned or happening that might have affected your agency's response?*
14. *Are there lessons to be learnt from this case about how practice could be improved?*
15. *What recommendations are you making for your organisation and how will the changes be achieved?*

Enquiries specific to this review

Birmingham and Solihull Clinical Commissioning Group (Clinical Commissioning Group) and Birmingham and Solihull Mental Health Foundation Trust

- In relation to Adult 1, examine whether sufficient information was shared to ensure that all professionals supporting Adult 1 had an accurate understanding of her use of alcohol and her Mental Health vulnerabilities?

- It has been sometimes identified in Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DHRs) that agencies have failed to work to address alcohol use and/or alcohol abuse and mental health effectively because of the interrelationships between the two. Identify whether the apparent presence of the dual diagnosis of the occasional use of alcohol and mental health vulnerabilities in relation to Adult 1 assisted or hindered a co-ordinated response to her needs?

- To what extent should/did this knowledge trigger direct/routine questioning around home circumstances and domestic abuse in line with NICE[1] guidelines PH 50 Domestic Violence and abuse: Multi-agency working (Feb 2014)

Housing

- What guidance, policy or procedures inform the level of enquiries made by your agency around home circumstances, when as in the case of either Adult 1 or Adult 2 when they present to be re-housed?

In addition

Information reports:

- Requests to the employers of both Adult 1 and Adult 2 for information were considered but not deemed relevant to the Domestic Homicide Review.
  (Chair's note: The Domestic Homicide Review was initially concerned that over a number of years, Adult 1 presented at hospital A&E departments with numerous work-related accidental injuries. The panel considered the view of the family, noting that because of the physical nature of Adult 1's jobs, these were probably genuine. The Panel agreed that it was likely to be unproductive to approach Adult 1's previous employers in this context.)

[1] The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

Summary chronology

1. As a child, Adult 1 experienced physical abuse from her stepmother and witnessed domestic abuse towards her stepmother from her father. She grew up supported by her sister in a home with four stepsisters.
2. Adult 1 and Adult 2 (73 years old at the time of the homicide) had been in a relationship for around twenty-seven years at the time of the homicide. Adult 2 had himself been married twice before. In the eighties, he married and had three children. Shortly after the conclusion of this relationship he met and married his second wife, who had a child of around seventeen months at the time. They also had a daughter together. This relationship involved domestic violence and abuse that culminated in a serious assault. Adult 2 was convicted of grievous bodily harm in December 1987 and served a prison sentence.
3. Adult 2 moved in with Adult 1 however, he maintained his own flat until their marriage in 2012 when he gave up his tenancy.
4. Adult 1's family and friends were clear from personal observations that although in the first years of the relationship, Adult 2 had been capable of kindness, Adult 1 was unhappy from early in the relationship which was increasingly characterised by violent and abusive arguments. There was some evidence of physical abuse witnessed by Adult 4, but also by Adult 1's closest friend, Adult 8. It does not appear however that physical abuse was a frequent occurrence, or if it was, it was effectively kept from Adult 4 and Adult 6.
5. The Overview report identified how Adult 2 tried to control Adult 1 in her relationship with friends from whom she became increasingly isolated. The descriptions of their relationship given by family and friends make it evident that Adult 2 was controlling and abusive. With hindsight, it is apparent that the nature of many of Adult 1's presentations to health professionals were a strong indication of potential domestic abuse in the relationship with Adult 2. Adult 2 also kept a tight control over finances. Financial control is a well-recognised element of coercive controlling behaviour.
6. Over the years, friends identified Adult 1 was drinking more heavily when they went out. They felt any binge drinking was a coping mechanism to mask her unhappiness.
7. It does not appear (with the one exception described by Adult 4) that the Police had any reported involvement with Adult 1, until the tragic events surrounding the homicide.
8. Over the span of the relationship between Adult 1 and Adult 2, Adult 1 had numerous contacts with Health providers, including Hospitals, GPs and Mental Health services that should have provided opportunities to safely ask questions of Adult 1 to establish whether she was experiencing domestic abuse. These proved to be missed opportunities to offer Adult 1 support and pathways to help.
9. Adult 1 presented at the Hospital Emergency department 15 times in the fifteen years between 2002 and November 2017. Many of the presentations related to accidental falls or deliberate self-harm. This seemed to the panel to be a troubling aspect of this case, given evidence that many women experiencing domestic abuse present at A&E with injuries numerous times, before being offered effective support. (It is possible that some of the presentations explained by Adult 1 as accidental injuries were the result of domestic abuse.)

10. Adult 1 disclosed to her GPs and to Mental Health Professionals significant depressive symptoms and identified what she believed were the underlying causes of her low mood and thoughts of self-harm.
11. In April 2014 Adult 1 first disclosed to a GP that she had a 'poor relationship' with her husband. She also described what the GP noted as '*drinking huge amounts, approx. 32 units over the weekend.*' The DHR noted this and another consultation in 2014 and five in 2015 where Adult 1 provided some limited insight into her home circumstances. These were opportunities where domestic abuse should have been considered, pro-active enquiry may have given her an opening to disclose and be offered specialist domestic abuse support services.
12. In July 2014, Adult 1 was referred by her GP to Mental Health Services because of low mood. The engagement that Adult 1 had with secondary Mental Health services over the next three years followed a pattern of referral, discharge, and re-referral.
13. A Psychiatric consultant from the Community Mental Health team saw Adult 1 in August 2014 and she spoke of childhood abuse from her stepmother, low mood, and occasional binge drinking. She stated she first self-harmed when she was 21, (1987). She also disclosed that an accidental fall downstairs in 2013, had been deliberate self-harm, and a suicide attempt. She spoke of her 20-year relationship with Adult 2 and their marriage two years before. There is no evidence that this relationship was explored in any depth and the possibility of domestic abuse being a relevant trigger, considered.
14. The consultation recommended that she self-engage with the Improving Access to Psychological Therapies Service for a psychological input. It appears that Adult 1 was not considered suitable by the Improving Access to Psychological Therapies service because *'she was currently experiencing difficulties with her alcohol consumption.*' The service felt she should first engage with Alcohol services to seek to reduce alcohol intake before therapeutic services would be of benefit.
15. Adult 1 was re-referred to Mental Health in December 2014, because of continuing low mood and self-harm. She was assessed by a psychiatrist during which she disclosed she had taken an impulsive overdose with alcohol 'a *couple of weeks previously',* following an argument with her husband. The presence of self-harm, low mood and continued occasional binge drinking meant that she was now identified as at higher risk, requiring a consultation with a psychiatric consultant that the Community Mental Health Team arranged. Once again, these disclosures were not explored.
16. In May 2015, Adult 1 took an overdose of medication, combined with alcohol, and cut her wrists. The Hospital records showed Adult 1 had self-harmed after taunts from Adult 2.
17. The Rapid Assessment Interface and Discharge Team (Rapid Assessment and Interface and Discharge Team) carried out an assessment that included Adult 1 denying she was experiencing marital problems. The team recognised however that her husband's taunts constituted 'psychological abuse' and recorded a possible threat. The University Hospitals Birmingham Independent Management Review found no record of a referral or signposting to Domestic Abuse support services.
18. A subsequent review and mental health assessment with a psychiatric consultant took place in May. The consultant advised Adult 1 to '*completely stop drinking alcohol in the medium term. This is with a view to reducing impulsivity*.' She disclosed that she '*would*

be discussing the issues from the recent past with her husband. She feels that the relationship is 'stuck in a rut'.

19. The psychiatrist did not apparently make a referral to alcohol support service that might have prompted her engagement. In the discharge letter to the GP there was no request for GPs to seek a referral to alcohol services and the notes make no mention of the consultant's aim to encourage Adult 1 to completely abstain from alcohol.
20. There was no evidence that Adult 1's use of alcohol was discussed in any of the six subsequent GP appointments (two of which were telephone encounters) between May and October 2015. These were significant missed opportunities
21. At her next Mental Health Review at the end of May 2015, Adult 1 explained to the consultant psychiatrist that she had '*made up with her husband after the previous difficulties.* They had both identified; *'their drinking of alcohol as an issue for them*.' It does not appear that the couple's shared vulnerability when drinking alcohol was explored with a view to offering support to either Adult 1 or Adult 2.
22. In August 2015 at a third review with the Community Psychiatrist; Adult 1 claimed to have reduced her alcohol intake. On this basis, she was discharged to her GP's care.
23. In October 2015 Adult 1 again presented at A & E with a further overdose, whilst under the influence of alcohol and with wrist lacerations. There was no direct questioning about domestic abuse during the hospital admission because it did not form part of Hospital procedures.
24. The Rapid Assessment Interface and Discharge team were told by Adult 1 she was due to attend Change Grow Live (CGL) Initiatives [2](Birmingham drugs and alcohol service). If Adult 1 self-referred to the service, there is no indication that her GPs were aware and no record of communication between the service and primary care providers. The Domestic Homicide Review has found no evidence that Adult 1 ever attended any substance misuse alcohol treatment services either in Birmingham or Solihull.
25. In May 2017, Adult 1 presented to her GPs and then Ambulatory Care at the Hospital with headaches and a bruised eyelid and stated she had experienced blurred vision the previous day. The GP was told there had been no head injury and accepted this account. There was no attempt to discuss potential domestic abuse with Adult 1. It does not appear that there were any direct questions around domestic abuse asked in A & E either.
26. In October 2017, although they had separated, Adult 1 and Adult 2 remained in contact and met socially on occasion.
27. In November 2017 Adult 1 was taken to A&E following a third overdose; she explained she had taken Sudafed, Ibuprofen and Venlafaxine mixed with alcohol.
28. In early April 2018, on the evening before the homicide, Adult 1 and Adult 2 met for a meal and then went on for drinks at a local social club, where they met friends. It appears a disagreement ensued between Adult 2 and one of Adult 1's friends, who was vocal in her support of Adult 1 over the separation. Adult 1 and Adult 2 left, still arguing and went to address 2, Adult 2's new flat. Apparently, the argument continued and in the early hours of the morning, Adult 2 attacked Adult 1, beating her about the head,

[2] Crime Reduction Initiatives (CRI) were service providers of alcohol services at this time. In April 2016 they rebranded to Change, Grow, Live. In November 2016 alcohol services in Solihull were taken over by Solihull Integrated Addiction Service (SIAS)

strangling her and stabbing her repeatedly in the torso. He then began calling and texting members of the family, as well as leaving voice messages in which he apologised for killing Adult 1 claiming, '*she had pushed him too far'.* Police were alerted and attended address 2, where in spite of attempts to resuscitate Adult 1, she was pronounced deceased.

Analysis

Recognising the interrelationship between domestic abuse, substance misuse and mental health vulnerability and addressing them holistically.

1. During numerous appointments and assessments over the period under review, Adult 1 disclosed to her GPs, to Rapid Assessment and Interface and Discharge Team and Community Mental Health Teams adverse childhood experiences, binge drinking, low mood, depression, impulsivity leading to self-harm, and a deep unhappiness. Difficulties in the relationship with Adult 2 were often mentioned but were rarely explored by professionals in detail, as envisaged by the National Institute for Health and Care Excellence (NICE) guidelines.
2. In the period under review, the policy, procedure, and practice of all three agencies had not yet 'caught up' with relevant NICE guidance. The Birmingham and Solihull Mental Health Foundation Trust, University Hospitals Birmingham, and Birmingham and Solihull Clinical Commissioning Group Independent Management Reviews all identified missed opportunities to make enquiry of Adult 1 relating to domestic abuse. At the time none of the agencies had actively promoted this best practice to their frontline staff.
3. Because of these organisational shortcomings, even when presented with obvious cues to make safe enquiry, domestic abuse was not really explored, merely noted, thus preventing appropriate exploration of the abuse that was present. It does not appear that Adult 1 herself acknowledged this as a real possibility as the source of her problems, concentrating instead upon her bereavements, and adverse childhood experiences. Yet Adult 1's lived experience illustrates why professionals need to 'ask the question' and not wait for a victim to disclose.
4. Adult 1's family felt that she would not have considered herself to be a victim of domestic abuse. They did not feel she would have raised it as her central problem without prompting.
5. Adult 1's increasing determination to break away from Adult 2 marked, in the family's view, a decisive shift in the power and control balance between Adult 2 and Adult 1. It is perhaps also the case that Adult 1 was aware of the escalation in Adult 2's controlling behaviours and realised that she had to get away from him.
6. A failure to recognise coercive and controlling relationships as abusive behaviour remains common both amongst professionals but also the community. It is for that reason that professionals must have a clear understanding of this type of domestic abuse, to help victims to see it for themselves and 'unlock' the possible trigger for self-harm, low mood, depression and an increased use of alcohol.

7. Crucially, this Domestic Homicide Review confirmed what has been found in previous Domestic Homicide Reviews[3] and studies[4]; that where a person presents with mental health vulnerabilities and an increased/ harmful use of alcohol, professionals need to be aware that domestic abuse may be the trigger and that attempting to address any one presenting problem in isolation is likely to be ineffective.
8. In relation to the GPs who saw Adult 1 there appeared to be an incomplete understanding of the significant impact of domestic abuse upon mental health and its linkages with the consumption of alcohol. They secured access to crisis Mental Health support in a timely way in relation to Adult 1's depressive symptoms. Yet Adult 1's use of alcohol, seems with hindsight, to have been a trigger for impulsive self-harm and for domestic arguments but seems not to have been addressed with the same level of commitment. It is well recognised that many women turn to alcohol as a coping mechanism when experiencing domestic abuse and health professionals need to be alive to this possibility.
9. Despite repeated evidence that Adult 1's drinking was linked to self- harm episodes, and the direct advice of the Community Mental Health Team psychiatrist that Adult 1 should aim to abstain from alcohol completely, there appeared to be no agreed plan shared between primary care and secondary mental health services to support her to address her levels of drinking. There appeared to be an over reliance upon self-disclosure and an overly optimistic acceptance of Adult 1's assurances that she had reduced her alcohol intake. The repeated self-harm episodes, where Adult 1 took overdoses with alcohol, should have at least triggered a detailed review of her alcohol use.
10. In relation to Adult 1's mental health, the care provided by the Birmingham and Solihull Mental Health Foundation Trust appeared to be appropriate and supportive but was less effective in its' response to the complex family circumstances and the interrelated nature of all the presenting problems. Most specifically, there was no evidence that psychiatrists and practitioners did more than touch upon the possibility that there was domestic abuse within what they knew to be a relationship that was troubled.
11. They apparently failed to explore Adult 1's low mood depression or her marital disharmony as a possible indicator of the presence of domestic abuse and did not explore this area with the kind of questions that their professional bodies and NICE guidance requires, or if they did, did not record the fact.
12. It is the Chair's view drawn from being involved in numerous Domestic Homicide Reviews in the region that this shortcoming in responses would not have been unique to this practice and would have been widespread across GPs surgeries.
13. Although guidance on supporting patients at risks from domestic abuse had been available from the Royal College of General Practitioners for some years before the period under review, the relevant Clinical Commissioning Groups could not point in 2014- 15 (the period of Adult 1's most frequent presentations) to the kind of early identification and support required.

[3] Domestic Homicide Reviews KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS December 2016

[4] Stanley N, Cleaver H, Hart D (2010) "The Impact of Domestic Violence, Parental Mental Health Problems, Substance Misuse and Learning Disability on Parenting Capacity" The Child's World. 2nd edition, London: Jessica Kingsley Publishers

14. The Domestic Homicide Review has concluded that whilst the healthcare Adult 1 received was timely and appropriate, it is far from certain that she had encountered opportunities and supportive situations to disclose domestic abuse with appropriate sympathetic questioning by either her GPs or the Mental Health Team.
15. It is therefore important that the agencies contributing to this review can demonstrate that policy has changed and that it is having a positive impact upon practice. At the very least, best practice would require that in similar circumstances patient records of both GPs and Mental Health services would show that Adult 1 was asked questions about domestic abuse at least once, but ideally on several occasions. Without evidence that professionals had addressed this issue in this case, domestic abuse remained at best an unresolved but obvious risk.
16. The NICE Guidance 50 (2014) and QS 116 (2016) and West Midlands Domestic Abuse and Violence Standards (September 2015) are the current benchmark for best practice in health settings and in the light of their review's finding, the Clinical Commissioning Group and Birmingham and Solihull Mental Health Foundation Trust should consider best practice guidance to remind professionals of the expectation that they will ask the questions of patients who present with indicators of domestic abuse.

Supporting women with complex needs

1. There was a lack of joined up working when faced with the multiple triggers for Adult 1's low mood. This Domestic Homicide Review has also identified that Adult 1 had complex needs that were not effectively addressed. She experienced anxiety and depression for many years (caused in part by traumatic childhood experiences and by the abuse she was subjected to by Adult 2 for around 27 years) and some problematic alcohol use accompanied by impulsive self-harm episodes. It is very likely that her experience of domestic abuse in early adulthood had an impact upon Adult 1 wellbeing. In addition, whilst she never reported domestic abuse in relation to Adult 2, the compelling evidence available to the review from family friends and the Independent Management Reviews of agencies involved with her, demonstrates that she experienced domestic abuse characterised by coercive and controlling behaviour.
2. In Birmingham and Solihull, a recent review of repeat/serial high-risk cases at Solihull Multi Agency Risk Assessment Conference (MARAC)[5] identified that most frequently, the MARAC victims had complex needs, and specifically they had often experienced a 'trio of vulnerabilities.' Where alcohol abuse and mental health vulnerability (the dual diagnosis) were identified, domestic abuse was also often reported. Whilst not causing domestic abuse, harmful levels of alcohol use and mental ill-health by victim and/or survivor place women at greater risk. They can lead to more severe abuse by perpetrators and increase dependency by victims. This dependency makes it difficult to implement positive interventions to reduce risk. Existing services are not person-centred, set up to provide concurrent interventions across multiple needs. Victims with

[5] MARAC Multi Agency Risk Assessment Conference

dual diagnosis commonly have a weak history of engagement with agencies and are often described as 'hard to reach'.

3. There is still considerable stigma attached to domestic abuse and the complexities of drug or alcohol use compounds this. To address this, in August 2017, as part of a pilot, Birmingham and Solihull Women's Aid (BSWA) recruited a specialist in domestic violence to work co-located with Solihull Integrated Addiction Service (SIAS). The Solihull based umbrella organisation comprises specialist mental health, alcohol and substance misuse organisations.
4. This initiative is primarily aimed at women where the dual diagnosis and domestic abuse were present and who often were at a level of risk that reached Multi Agency Risk Assessment Conference (MARAC). The resource has allowed practitioners from Solihull Integrated Addiction Service and Birmingham and Solihull Women's Aid to work together. The model is flexible to respond to victim's wishes so they can meet substance (drug and alcohol) issues and domestic abuse specialists separately or together at their appointments, or a single practitioner from either agency can continue as a key worker but gain direct advice and guidance on a shared plan from their counterpart.
5. The Domestic Homicide Review noted the number of presentations made by Adult 1 to A&E over the years in which she was in a relationship with Adult 2. Whilst her work life involved heavy lifting and manual work, there remains a lingering suspicion that some presentations may have been non-accidental injuries; either self-harm or domestic violence related.
6. The Review concluded that continued funding for hospital IDVAs could reduce the risk to women with complex needs, by offering appropriate support and referral pathways. This is the subject of recommendation four.

Changes made within key agencies to improve identification of domestic abuse and vulnerabilities around dual diagnosis

The changes made are listed by agency in the overview report.

Conclusions

1. This Domestic Homicide Review concluded that Adult 1 had endured domestically abusive relationships in two marriages as well as adverse childhood experiences and these contributed to her low mood and depression, self-harm and occasional binge drinking. With hindsight it is reasonable to conclude that during the period under review she should have been recognised by health professionals as having complex needs, requiring the kind of holistic approach now recognised as best practice.
2. There is a need to identify opportunities to ask the question of potential victims of domestic abuse. None of the contributing agencies had apparently embedded this best practice in their respective policy or practice. Consequently, no agency recognised the extent of domestic abuse although they all recognised that Adult 1 and Adult 2's relationship had problems. (Recommendation one)

3. There was extensive evidence of silo'ed practice. With hindsight the use of alcohol appears to have been consistently evident in rows and self-harm incidents along with entrenched problems of depression and low mood. Yet there is no evidence that Adult 1 was supported by alcohol support services through referrals.
4. This Domestic Homicide Review concluded that women with such complex needs are best served by the kind of services currently commissioned in Solihull; a joined-up approach that allows for multiple needs, particularly those that are inter-related to be identified and managed.
5. It is likely that Hospital Independent Domestic Violence Advisers are another way of ensuring that women like Adult 1, with complex needs, are offered support sooner, reducing the impact of domestic abuse upon their mental health, but also providing a platform to address the behaviours of drinking alcohol in a more effective way. (Recommendation Four)
6. The Birmingham and Solihull Clinical Commissioning Group described in their Individual Management Review the effectiveness of the Identification and Referral for Improved Safety (IRIS) initiative within many of Solihull's GP Practices. The second recommendation of this Domestic Homicide Review would be that Commissioners recognise the need for certain key domestic abuse support initiatives to be sustained by being considered part of mainstream funding commitments. (Recommendation 2)
7. Changes to the legal and criminal justice system have made domestic abuse victims safer. However, there remain within society cultural norms and entrenched views that normalise the non-physical elements of domestic abuse. It is a finding of this Domestic Homicide Review that often the victim of coercive and controlling behaviours but also their friends and family struggle to identify non-physical abuse within domestic abuse.
8. This Domestic Homicide Review would recommend the newly appointed Domestic Abuse Commissioner to consider including in any action plan the need for a sustained and concerted approach to address behaviour change and cultural norms. (Recommendation three)

15. Lessons to be learnt

What do we learn?

- **Health agencies that are encouraged to 'ask the question' of people presenting with health indicators of domestic abuse, had not yet attempted to embed this practice in their local arrangements, policy or procedure during the period under review.**
- **In the period under review, Mental Health professionals apparently were not routinely 'asking the question' of patients concerning domestic abuse, as directed by best practice.**
- **Even where in this case, their patient described marital/relationship disharmony this did not tend to prompt Health professionals to explore the possibility of domestic abuse. This suggests that there is a need for reinforcement of this best practice within key agencies (recommendation one).**

- **That Health professionals faced with mental health concerns, alcohol misuse and domestic abuse did not approach this trio of vulnerabilities in a holistic way but tended towards silo'ed practice and single incident led practice.**
- **That the identification of some of the coercive and controlling non-physical forms of domestic abuse still poses a challenge of recognition not only amongst, professionals, but also family, friends, and the wider community.**
- **That women with complex needs are more likely to disclose to hospital Independent Domestic Violence Advisors than other community-based support workers**
- **That a holistic support plan for domestic abuse, drug or substance misuse and mental health is likely to lead to better outcomes for individuals.**
- **That health professionals may not recognise the full impact of alcohol abuse when a patient presents in ways that do not fit their traditional image of how a patient who is 'alcoholic' will present.**
- **That women of 55 years old and above fall within an age group that are less likely to report domestic abuse and are more likely to excuse or tolerate its' impact.**

16. Recommendations

Recommendation No:1	Relevant agencies listed should provide assurance to the Safer Solihull Partnership that they have in place local arrangements to ensure that their professionals 'ask the question' of people presenting with the health indicators of domestic abuse (in line with NICE Guidance and Quality Standards) together with suitable audit tools or measurements to demonstrate a change in outcomes.
Recommendation No:2	The Safer Solihull Partnership seeks assurance from the Commissioners of the IRIS project within GP surgeries that funding will be given due consideration beyond the current agreed period and that in order to embed this service, it will be brought into mainstream funding in the future.
Recommendation No:3	The Safer Solihull Partnership would propose to the Domestic Abuse Commissioner that any Action Plan to address domestic abuse recognises that lasting and permanent change cannot be achieved without a sustained and concerted approach to address behaviour change and cultural norms.
Recommendation No:4	This Domestic Homicide Review noted the effectiveness of hospital-based IDVAs in supporting women with complex needs experiencing domestic abuse. The Safer Solihull Partnership would seek assurances from the commissioners of these services that they will be recommissioned in hospitals in Solihull.