safe & sound

Dudley's Community Safety Partnership

Dudley DARDR15

Domestic abuse related death review of the death of Lisa.

Overview Report

Author: Kevin Gee

Commissioned by:

Dudley's Community Safety Partnership

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Contents.

Lisa:

Lisa was a woman of Romani Gypsy heritage, growing up in a close-knit family with four sisters and a brother. She was known for her generosity and warm-hearted nature, always looking for the good in others. Lisa took pride in her appearance and her home; she enjoyed having “nice things” and maintained both her home and herself to a high standard.

A talented cook, Lisa delighted in preparing meals for special occasions, with Christmas being a particular favourite. Despite challenges in her early education her parents chose to home tutor her rather than send her to a “special needs” school. Lisa learnt to read and write under their guidance.

Lisa had one child, and Lisa’s devotion to her child was evident. Though, like any parent and child, they sometimes clashed, she cherished her child deeply. She was actively planning for her child’s upcoming birthday in June, even considering a car as a possible present.

The loss of her mother in 2020 was a significant blow, and Lisa struggled to cope with her grief. She sought support through prescription medication and possibly attended grief counselling sessions. In the period following her mother’s death, her sisters noticed changes in Lisa’s behaviour. She altered her appearance, opting for a shorter, coloured hairstyle—a marked change for someone who had always preferred her hair long. Lisa also began to spend more on her appearance, investing in hair, make-up, clothes, and, according to one sister, botox treatments.

Throughout, Lisa remained a caring and thoughtful individual, devoted to her family and keen to make those around her feel loved and valued.

The Chair and the members of the Review Panel offer their sincere condolences to the family of Lisa for their loss.

1. Introduction.

1.11 The chairs of the Dudley Community Safety Partnership (CSP) have commissioned this review in response to the death of Lisa. Lisa’s death would appear to be as the result of an overdose of Codeine, Zopiclone and Pregabalin. The inquest into Lisa’s death was held in March 2025. The death falls within the statutory parameters for a Domestic Abuse Related Death, (DARD)[1] review as Lisa was believed to have been in an abusive relationship prior to her death with a male named Adam.

1.12 At the time of her death Lisa was 51 years of age. She had seemingly been involved in a short-term, intense relationship with Adam, whom she had met when both were residents of a local housing facility. Lisa had one child, Child 1, from a previous

[1] As there was not a homicide, and in line with National thinking, this review has been referred to as a DARD review rather than a Domestic Homicide Review, (DHR).

relationship aged 17 years. At the time of her death, Child 1 was living with Lisa's sister.

1.13 The names used within this report are pseudonyms, used to protect the victim and her family's identity. The pseudonym for Lisa was chosen in consultation with The Traveller Movement to ensure the names were culturally appropriate and taken from a list of the most popular names for the year of Lisa's birth. The name used for the alleged perpetrator, Adam, is also a pseudonym and was chosen from a list of the most popular male names from his year of birth. Addresses are also referred to in general terms throughout the report for the same purposes.

1.14 Lisa was known to various services over the course of her lifetime. Lisa had a long history of anxiety and depression, for which she had been prescribed medication from her GP. Lisa also suffered from Osteoarthritis. Lisa had also previously come to the attention of Police in 2004 where she had been charged with Harassment relating to an ex-partners Mother. For this Lisa received a conditional discharge.

1.15 From 2022 Lisa's engagement with services increased significantly, with interaction with Health, Adult and Children's Social Care, Police, and Housing support services. These interactions were to do with concerns for Lisa's wellbeing, concerns over her relationship with Child 1 and being a perpetrator of domestic abuse towards Child 1, and homelessness.

1.16 Adam had previously been in a long-term relationship and had a child from that relationship (Child 2). The relationship had seemingly broken down, with Adam's mental health being one of the contributory factors. Adam is not known to Police but has had interactions with a number of services. Adam was previously in the Armed Forces and so potentially suffered from Post Traumatic Stress Disorder (PTSD). From 2022 onwards, Adam twice presented in Mental Health crisis. On both occasions he admitted to abusing alcohol, class A drugs and not taking his prescribed medicine. Adam was also being assisted by Housing Services into independent living.

1.17 Towards the end of May 2024, staff at the housing facility, where Lisa was resident, were unable to contact Lisa which raised their concerns. Staff used a fob and entered her room; they found her lying in bed, unresponsive. Staff called West Midlands Ambulance Service (WMAS) who attended and pronounced life extinct. Police arrived a short while later. Nobody else was present at the address. There were numerous empty prescribed medication packs near Lisa's body, suggestive of an overdose. The date the medication was prescribed was three days prior to Lisa's passing and three tablets were to be used daily. It is believed that Lisa took an overdose as it wouldn't be possible to finish the tablets within a three-day period. Lisa had previously disclosed to staff that she had been in a relationship with Adam and that he had sexually and physically abused her and he had financially exploited her.

1.18 The CSP were informed of Lisa's death a few days later in May 2024. A CSP core panel meeting was held on 18th June 2024 and determined that this case met the

criteria for a DARD review in accordance with Section 9 of Domestic Violence, Crime and Victims Act 2004. This was ratified by the chairs of the CSP.

1.19 The Home Office were informed of the intention to commission the DARD review.

1.2 Dissemination

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

- The Dudley Community Safety Partnership (Safe and Sound)
- The Office of the Coroner
- The Office of the Police and Crime Commissioner for West Midlands
- All agencies involved in the review
- Lisa's family (this is to be confirmed)
- The Office of the Domestic Abuse Commissioner
- The Office for Health Improvement and Disparities
- The Traveller Movement

1.3 Purpose

1.20 The purpose of the review is to:

i. establish the facts that led to Lisa's death in May 2024 and produce a comprehensive and balanced analysis of the information to inform organisational learning and influence change.

ii. establish what lessons can be learned from Lisa's suicide regarding the way in which local professionals and organisations work individually and together to safeguard individuals and/or family.

iii. identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

iv. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.

v. seek to help prevent domestic violence and abuse, deaths where domestic abuse or violence is a factor, and improve service responses for all domestic abuse victims and their children, by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

vi. identify potential gaps in service provision and/or potential barriers to accessing services.

vii. contribute to a better understanding of the nature of domestic violence and abuse.

viii. highlight good practice.

ix. The key reason for undertaking a review where a person has died through suicide following domestic abuse, is to enable lessons to be learned through professionals being able to understand what happened and most importantly, what needs to change to reduce the risk of similar tragedies happening in the future. The review is not an enquiry into how a victim of abuse died or who may be responsible.

1.3 Scope

1.30 The review primarily examines contact and involvement that services and agencies had with Lisa between January 2022-May 2024, with other relevant material outside of these dates to be used as cogent background information.

1.31 In order to meet its purpose the review also examines the contact and involvement that organisations had with Lisa's child, Child 1 and with Adam on the same basis as paragraph 1.30 above.

2. Terms of Reference

2.1 The terms of reference were agreed in consultation with the panel. After initial contact with the independent chair the family made the decision not to engage with the review, and as such did not contribute to the development of the terms of reference.

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ix. The key reason for undertaking a review where a person has died through suicide because of domestic abuse, is to enable lessons to be learned through professionals being able to understand what happened and most importantly, what needs to change to reduce the risk of similar tragedies happening in the future. The review is not an enquiry into how a victim of abuse died or who may be responsible.

2.2. The focus of the review.

i. This review will establish whether any agency, or agencies, identified potential and/or actual domestic abuse that may have been relevant to the death of Lisa, having due regard to policies, procedures, operating protocols, training provision, and working environments.

ii. Consider whether Lisa's interaction with services from 2022 onwards highlighted increased vulnerability and whether this presented opportunities for intervention/safeguarding, and whether any action taken was timely and robust.

iii. Consider Lisa's use of drugs (prescribed or otherwise) and alcohol, the causes and concerns related to their use and whether effective intervention or management strategies were considered and utilised for Lisa.

iv. Understand if Lisa had a learning issue or disability and whether this impacted subsequent interactions with Lisa. The review will consider the use of language, diagnosis and understanding when dealing with any potential issues.

v. Consider how services engage with individuals and whether differing backgrounds, lived experiences and potential bias may have impacted interactions between Lisa and relevant services. In considering this, factors such as professional curiosity, proactivity of engaging families from differing backgrounds, motivational interviewing and whether service provision is based on individual needs or is process driven are to be explored.

vi. Information sharing between agencies relating to Lisa.

3. Methodology

3.1 The overview report comprises analysis of information compiled within an initial scoping document and Individual Management Reviews (IMRs). Through the review panel meeting process, those agencies identified as having had significant contact with and involvement with Lisa were requested to provide additional information from that within the scoping document in the form of IMRs. These IMRs were prepared by representatives from the relevant organisations.

3.2 For the initial core panel all agencies were invited to provide an overview of their involvement with Lisa, Adam and Child 1 which was collated into an initial scoping document. From this document, where it was considered at the initial Review panel meeting that further details were required, the senior manager for an agency or service was commissioned to provide an IMR. The aim of the IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context in which practitioners were working, (culture, leadership, supervision, training etc), to see whether Lisa's death indicates that practice needs to change or be improved to support the highest standard of service delivery.
- Identify how and when those changes or improvements need to be delivered.
- Identify good practice within agencies.
- Provide an independent assessment of practice and service delivery by ensuring that the individual responsible for the IMR has not had involvement with anyone who is subject of the review. The IMR is signed off by a senior manager from that organisation before being submitted to the review panel.

3.3 Each of the following organisations completed an IMR detailing their interactions with Lisa, Child 1 and Adam (where appropriate) for this review:

- West Midlands Police
- Adult Social Care
- Children's Social Care
- Midland Heart
- Black Country NHS Healthcare Trust

4. Equality, Diversity, Inclusion

4.1 In compiling the overview report, the nine protected characteristics (see below) as prescribed within the Public Sector Equalities Act duties were considered, to assess if any were relevant to any aspect of the review. Also the review considered whether access to services or delivery of services were impacted upon by such issues:

a) **Age-** At the time of her death, Lisa was 51 years of age, Adam was 32. There is a 19-year age gap with Lisa being older which could lead to issues such as a power imbalance, and societal judgement. Also, a support workers assessment of Lisa having a mental age of 13 is relevant to risk and decision making by services in their contact with Lisa.
b) **Disability**-It is unclear whether Lisa had a learning difficulty or disability, and despite the possibility of Lisa having either a difficulty or disability being raised by practitioners, there was no formal diagnosis. Both Lisa and Adam disclosed issues related to mental health to practitioners. These areas are explored within the report.
c) **Gender Assignment**-This was not a consideration in this case.
d) **Marriage and Civil Partnership**-Lisa and Adam were not married or seemingly in a formal relationship at the time of Lisa's death. The evidence would suggest that they had been in a short-term intimate relationship in the months prior to Lisa's death.
e) **Race**- Lisa is from Romani (Gypsy) heritage. Cultural ignorance and potential bias, either conscious or unconscious are explored within the review and how they almost

certainly contributed to Lisa's increased vulnerability over the last 12-24 months of her life. Advice and insight regarding Romani (Gypsy) culture and potential barriers faced by Lisa was kindly provided by the Traveller Movement[2].

f) **Religion and Beliefs-** Lisa's Romani (Gypsy) heritage means that she had a strong Roman Catholic faith. Attitudes to issues such as relationships/sex outside of marriage, suicide and avenues of appropriate support for Lisa are considered as part of this review.

g) **Sex-** Sex is always a significant consideration in domestic homicide reviews, (DHRs). Analysis from the British crime survey[3] suggests that 74.1% of domestic abuse victims identified by police forces in the year ending March 2022 were female. Whilst this case does not involve a homicide, the victim Lisa was female, the alleged perpetrator of abuse, Adam, was male. Key findings from the 2021 analysis of Domestic Homicide Reviews shows that female intimate partner deaths where suicide was a factor, the proportion was 88% compared to 12% in men. Nationally men account for approximately 75% of all suicide deaths[4].

h) **Sexual Orientation**-This was not a consideration in this case.

i) Pregnancy and Maternity- Lisa did at one point indicate she was pregnant, with Adam being the Father. However, there is no medical corroboration regarding Lisa being pregnant.

3.2 A number of these characteristics are relevant to this review and have been assessed by the review panel. Evidence gathered during the course of this review process indicates that the characteristics of disability, race, religion and beliefs may have impacted how Lisa was able to access services, and that this would have contributed to and increased her already vulnerable state.

5.The Review Process

5.1 The review panel consisted of an Independent chair and senior representatives of the organisations that had relevant contact with Lisa, Adam and Child 1. The review panel members and IMR authors have not been immediate supervisors to any of the staff who had contact with Lisa, Adam or Child 1.

5.2 The panel members were:

Organisation	**Role**
Independent Chair & Author - Kevin Gee	Independent Chair & Author

[2] The Traveller Movement are a registered charity who aim to advocate and work with Romani (Gypsy), Roma, and Irish traveller people to tackle discrimination and promote equality.

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2022#sex

[4] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews-september-2021-

Dudley MBC Community safety Team, on behalf of Safe and Sound, Dudleys Community Safety Partnership	Community Safety Officer
West Midlands Police	Detective Sergeant
Children's Social Care	Acting Service Manager
Children's Social Care	Team Manager
The Dudley Group NHS Foundation Trust	Lead Nurse Safeguarding Children
Black Country Healthcare NHS Foundation Trust	Interim Associate Director of Safeguarding
Black Country Integrated Care Board-Dudley Place	Designated Nurse for Safeguarding Adults
CGL	CQC Registered Services Manager
West Midlands Ambulance Service	Safeguarding Coordinator
Black Country Women's Aid	Chief Executive Officer
Midland Heart	Head of Lettings and Tenancy Sustainment
Midland Heart	Quality and Safeguarding Officer
Housing strategy- Homeless Prevention and Response	Domestic Abuse Coordinator
Adult safeguarding	Team Manager
Adult Safeguarding	Head of Adult Safeguarding & Principal Social Worker
Dudley and Sandwell Probation Delivery Unit, West Midlands HM Prison and Probation Service	Deputy Head
The Dudley Group NHS Foundation Trust	Lead Nurse for Safeguarding Adults

5.3 The Independent chair of the review panel is a retired Senior manager from Law Enforcement, with a strong investigative background in threat areas such as Organised Immigration crime, Human Trafficking and child sexual abuse. As such he has significant experience in areas such as exploitation, coercion, abuse and domestic abuse, as well as safeguarding. As a strategic leader he has chaired Multi-agency stakeholder

meetings both Nationally and Internationally. He also led the National Crime Agency's (NCA) review team, providing independent second-line assurance in complex operational and thematic reviews for the NCA across all threat areas.

5.4 The Independent Chair has no association with any authority in Dudley and is completely independent of all of the agencies involved with this review.

5.5 The review panel met on the following occasions:

- **4th September 2024**- The panel discussed the initial scoping documents, areas to be included in the terms of reference (TOR) and to agree IMR requirements.
- **8th October 2024**- The final TOR was agreed, progress regarding IMRs discussed, and family engagement discussed.
- **12th December 2024**- discussion regarding content of finalised IMRs and where follow up questions were required
- **24th February 2025**- Panel considered the follow up answers for IMRs, discussion held regarding independent expert support relating to Lisa's cultural background, a discussion regarding initial findings/analysis, and discussions regarding Adam and an agreed position in relation to engagement with him.
- **28th April 2025**- consideration of draft report, findings and recommendations.

6. Family Engagement

6.1 The panel were united in the view that the family should be given an opportunity to engage with the review wherever possible.

6.2 Lisa had a number of siblings and a child. From the records held it could be seen that Lisa, at times, had a fractious relationship with one of her sisters, Sister 1 and also latterly her child, who had made allegations of domestic abuse by Lisa towards them. The child was at the time of Lisa's death living with Sister 1.

6.3 Records held did not provide much clarity in relation to Lisa's relationship with her other siblings. Also, as there was a concern that the family may not be aware of Lisa being in a relationship, or that it was abusive, therefore the panel were conscious about the effects of starting the engagement with the family by just sending a letter to family members and thereby potentially causing more trauma for the family.

6.4 Two of the sisters were living within social housing. It was therefore decided to engage with the housing officer who had knowledge of the family and a good working relationship with some of the sisters, in order to try and identify which family members to approach in the first instance and the best way to make the approach softer and more personable.

6.5 It was decided that the housing officer would arrange to meet with some of the siblings, hand deliver letters written by the chair (within these letters the chair introduced himself, offered condolences on behalf of himself and the CSP, explained briefly the review process and encouraged participation) and give a brief overview of why DARDR was being conducted. The letters were addressed to Sisters 1 and 4 as well as Child 1.

The family members were also provided with Home Office and AAFDA[5] information leaflets.

6.6 It was initially agreed at the meeting that the family would be willing to engage with the review and that Sister 2 would be the point of contact for the Independent chair.

6.7 Shortly after this the Independent chair was contacted by Sister 3. Sister 3, understandably, wanted to understand better the reasons for the review, and what it was seeking to achieve. The revelation that Lisa had potentially been in an abusive relationship with another man had added to the trauma of losing Lisa in the circumstances they had.

6.8 Within this telephone call Sister 3 was willing to provide some information about Lisa, the person she was and an insight into changes in Lisa's behaviour, especially in the last few months of her life.

6.9 Several days later the Independent chair was contacted by Sister 4. The conversation was very similar to that held with Sister 3, and it was clear that some of the details the family had now been made of aware of in relation to the circumstances leading up to Lisa's death, had caused more upset for the family. Sister 4 indicated that she would now be the families point of contact.

6.10 It was left that the Independent chair would contact Sister 4 in order to arrange a suitable date to come and speak in person with members of the family.

6.11 The chair made a number of attempts to contact Sister 4, and left answerphone messages. None of these calls were returned.

6.12 The Independent chair then attempted to contact Sister 3, but again all calls and answerphone messages were not returned.

6.13 The Independent chair then made the decision to contact Sister 2, who had been designated the original point of contact for the family. Sister 2 had not been at the original meeting with the housing officer, and it became clear from the conversation that she was unaware of some of the details the other sisters knew.

6.14 It was left for the Independent chair to contact Sister 2 to arrange a suitable time to visit the family. Again, on a couple of occasions phone calls were made to Sister 2, with answerphone messages left. None of these calls were returned and it was decided that any further attempts to contact the family would only have the effect of causing more distress, and hence no further attempts to call the family have been made. However, it is still the intention to provide the family with the opportunity to read the report, should they so wish, and take into account any views or concerns they may have.

6.15 Within the three phone calls to the sisters, the Independent chair was able to provide condolences regarding the loss of Lisa. These phone calls with the sisters did

[5] AAFDA---Advocacy After Fatal Domestic Abuse. A charitable organisation who provides specialist support to families affected by domestic homicide. They also provide support, training and resources to professional working in this field.

allow for some background about Lisa to be obtained and also to get a sense of the person she was.

6.16 The sisters described Lisa as a generous and kind hearted person, who always saw the good in people. Lisa liked to have “nice things” and always kept her home tidy and looked after her appearance. Lisa was described as a good cook and loved to cook at special events such as Christmas.

6.17 They spoke about the fact that Lisa’s parents had prevented her from going to what they described as a “special needs” school, and in effect home tutored Lisa, teaching her to read and write.

6.18 The sisters spoke about how Lisa loved and cherished her child, despite the fact the two of them could “clash”, as they described it. They said that Lisa was planning for Child 1’s birthday party in the June, and potentially looking to buy them a car as a present.

6.19 The sisters described how Lisa had struggled to cope with the death of her mother in 2020, and they were aware that she had been taking prescription medication to help and potentially had attended some grief counselling.

6.20 The sisters did not believe that Lisa would take her own life, and felt that she would have been coerced into doing it.

6.21 A change in Lisa’s behaviour was noted from around Christmas 2023. Lisa had dropped off the Christmas presents prior to the 25th December, but then didn’t turn up on Christmas day, which was considered very unusual, especially given her love of cooking at special events. When anyone tried to contact Lisa, she either didn’t answer calls or kept saying she was busy.

6.22 At Easter, Lisa did not drop off any Easter eggs for Child 1, which was out of character, and whenever they saw Lisa, her phone was always “pinging” after which she would make excuses and leave. Again this was unusual behaviour for Lisa. The sisters noted that Lisa also ignored phone calls from the sisters. One of the sisters reported receiving a text message from Lisa’s phone saying “Lisa doesn’t want to talk to you”.

6.23 They also noticed other changes in Lisa’s behaviour. She had changed her hairstyle to having shorter hair which had been coloured. The sisters state that Lisa had always had long hair, and disliked having her hair cut, and so having a shorter cut seemed unusual to them. Lisa was also increasing spending on herself in terms of appearance, spending more money on hair, make up and clothes. One of the sisters stated that they believed Lisa had also had some botox injections/treatment.

6.24 In May 2024, when the sisters saw Lisa, they state she was covered in bruises. When asked how she had got the bruises, Lisa wouldn’t elaborate or said that she had fallen over. Despite this they felt she seemed happy and enthusiastic for life, which included looking forward to Child 1’s birthday in June.

6.25 Lisa was due to meet with family members on 17th May 2024, the anniversary of her Mother’s birthday, in order to go to her grave, tend the grave and lay flowers.

However, Lisa did not attend, and was not answering her phone which they felt was highly unusual.

6.26 The family were unaware that Lisa was in a potential relationship. However, one of the sisters felt that she was scared and potentially being controlled. The family were also aware that £2000 had been removed Lisa's bank account.

6.27 The family only became aware that Lisa was resident at a housing facility following her death. They assumed that Lisa was staying with friends or another sister or family member. The family state if they had known, they would have taken Lisa away from the housing facility and ensured that Lisa live with one of them.

6.28 When family members attended the housing facility following her death, they were shocked at how little Lisa had in her room, given her love of nice things. They also found a fragment of a letter, which on one side stated words to the effect of "he" had been cheating on her and avoiding her. On the other side was an apparent reply stating words to the effect that " His father had had a stroke, he had no phone and he loved her".

6.29 When the family members were at the housing facility, some residents had indicated that Lisa had been in a relationship with a male who was a potential drug dealer. The family were led to believe that the individual had been released to the housing facility from prison and was on a monitoring tag.

6.30 It is apparent that the person identified to the family is not the individual that Lisa was in a relationship with, and it is unclear why this individual was pointed out. However, the fact that the housing facility potentially houses individuals released from prison has added to the families distress. They have questioned the validity of mixing individuals released from prison with potentially vulnerable females.

7. Background information.

7.1 Lisa is of Romani (Gypsy) heritage and was born in 1973. Lisa is part of a large family, and has a number of sisters and one brother.

7.2 There is little known to the review regarding Lisa's academic history, other than information provided by the family. This indicates that Lisa was due to attend what they describe as a "special needs" school. Lisa's parents refused to allow her to attend this school and home tutored Lisa, teaching her to read and write.

7.3 From a medical perspective, records show a GP assessment with Lisa in 2012[6] where she details a history of anxiety and some bullying in a past relationship. This was also the first time a potential learning difficulty was considered, as the GP had difficulty in gaining an accurate history.

7.4 In 2017 there are a number of interactions between the GP and Lisa. In these interactions Lisa was treated for low mood and anxiety. There was also a concern regarding Lisa potentially becoming addicted to Codeine which had been prescribed for

[6] GP electronic records only go back to 2011, so information prior to this has not been considered as part of this review.

a musculoskeletal condition (Osteoarthritis). Further to this there was a concern that Lisa did not appear to understand the logic of addiction, but recognised that she may have some dependency.

7.5 Due to concerns about Lisa being potentially addicted to the prescription drugs ,the GP placed Lisa on a weekly prescription to manage the amount of drugs within her posession.

7.6 Throughout this period Lisa also reporting consistently experiencing panic attacks, and as such she was referred to a primary mental health practitioner. It is reported Lisa made the decision not take up the referral and did not attend any scheduled appointments.

7.7 In 2018 Lisa was referred to substance misuse services and the records suggest that she found the input from service useful, but there is no communication from the substance misuse services on any potential treatment plan. Lisa's prescription of Diazepam was reduced in this period.

7.8 From 2022 onwards there are further interactions with the GP which are explored in more detail in the narrative chronology in section 6.

7.9 Prior to 2022 Lisa has a small footprint with the Police. In 2004 Lisa was charged with harassment x2 whereby she harassed the mother of her ex-partner (no further details) with abusive calls and notes. Lisa received a 12-month conditional discharge for these offences.

7.10 Lisa and Child 1 were known, intermittently, to Children's Social Care between 2008 and 2023.

7.11 In 2008 a referral was received detailing a concern that Lisa had been providing Child 1 with medication to make them drowsy. A Children and Young Persons Initial Assessment (CYPA) details that Lisa was spoken to and admitted to giving Child 1 flu medication, but stopped using it when it made Child 1 drowsy. It is recorded at this time that Child 1 had no contact with their birth father, that Lisa was a single parent and in receipt of benefits as she was unemployed. As part of the CYPA, a home visit was undertaken and lateral checks were made with health and education, and as there were no identified concerns, there was no further action taken by Children's Social Care at this stage.

7.12 The next contact with Children's Social Care was in 2018 where concerns were raised regarding Child 1's attendance record at school. The contact states that Lisa was displaying erratic behaviours, alleging that Child 1 was being bullied, that Lisa was purchasing lavish gifts for Child 1 and sending texts to Child 1's peers offering them money to be Child 1's friend.

7.13 The contact also indicates that Child 1 had been referred by the GP regarding potential self-harming behaviour. The contact also makes reference that Lisa is "alleged to have some learning needs".

7.14 Child 1 is recorded on the school system as “Traveller/Catholic of Gypsy Roma background”. Following a meeting with the school, Lisa informed them that she was under pressure by her family to visit her sick mother every day. Early help support was offered. This was declined by Lisa, and the school agreed to monitor and work with Lisa. The notes also indicate Lisa was referred to a Traveller service, but with very little context as to why.

7.15 In 2020, West Midlands Ambulance Service (WMAS) reported concerns relating to Lisa. These concerns were regarding poor mental health, and Lisa not looking after herself. Lisa had stopped taking her prescribed medication, citing grief for her mother, who had died that year. Lisa refused support from WMAS. Children’s Social Care as part of the referral, initiated checks with Child 1’s school, where poor school attendance was noted and that Child 1 was displaying some “tics”. However, no safeguarding concerns were raised at this time.

7.16 Also in 2020 WMAS were called to assess Child 1 following a 999-call, citing discomfort in the throat after eating at a restaurant. All the checks conducted were normal and Child 1 was left in the care of Lisa. It is recorded that the crew provided advice regarding eating disorders and encouraged Lisa and Child 1 to speak with their GP.

7.17 In relation to Adam, there is little recorded on the systems within this Community Safety Partnership.

7.18 Adam does not appear to be known to the Police, and his contact with services in this area began around 2022. These contacts are explored in more detail in section 6- Narrative chronology.

7.19 What is known about Adam, largely comes about from his interactions with the mental health services. Adam stated that he had previously been in the Armed Forces and was discharged in 2018 after having failed a drug test. He also indicated that his time in the Army had left him traumatised.

7.20 Adam had been in a long-term relationship prior to 2022, and he and his partner were parents to a child who was approximately 2 years of age in 2022.

7.21 Adam also stated to practitioners that he had been misusing drugs (Cocaine) and alcohol from 2018 onwards.

8. Narrative Chronology

8.1 Whilst there had been interactions between Lisa and various services prior to 2022, they were infrequent and relatively low level. After 2022 the interactions became more frequent and acute, being perhaps indicative that Lisa's was struggling to cope with life as well as she had previously.

1ST January 2022- 31st December 2022

8.2 In February 2022, Child 1 was reported by their school as "missing". The exploitation hub completed a return home interview, where Child 1 stated they had suffered an anxiety attack on the way to school and had returned home. It was agreed that the school's designated safeguarding lead would monitor Child 1 in school. Child 1 was also referred to the WHAT centre[7], although Lisa indicated that Child 1 was in contact with a private counselling service. This incident met the level 3 targeted early help threshold, but Lisa and Child 1 declined early help intervention.

8.3 At the beginning of May, Adam attended Russell's' Hall Hospital and presented in Mental Health crisis. Adam disclosed that he had a long-term partner and young child, whom he lived at home with. Adam also stated that there were issues in his relationship and reported a lack of trust and having paranoid thoughts regarding his partner. Adam stated he studied the door camera footage and was convinced his partner had deleted footage from it.

8.4 Adam reported an inability to trust others as a result of his mother lying and cheating throughout his childhood. He also stated that he was in the Armed Forces and that the experiences from his service could haunt him. Adam admitted to using Cocaine for the previous four years and drinking excessively, although he stated he had stopped drinking in the last 4 months. Adam indicated he had been suspended from his job the day before, but as long as he didn't lose his job, his family would be financially fine. Adam was assessed as low risk and discharged back to the care of his GP. Adam was prescribed 5 days' supply of Promethazine and provided contact details for a Veterans Mental Health charity.

8.5 On 17th May 2022, a safeguarding referral was received by MASH in relation to Lisa. The referral was from the hospital and there was a concern regarding self-neglect for Lisa. The hospital required Lisa to attend urgently to receive a blood transfusion. After several attempts to contact Lisa, she was advised by telephone that she needed to attend the hospital, and that the GP would call Lisa with the arrangements. Further attempts to contact Lisa by telephone were unsuccessful. The GP attended Lisa's home address but was unable to contact Lisa.

8.6 West Midlands Police (WMP) were contacted to conduct a health and welfare check. Officers attended Lisa's address and following the conversation, Lisa packed a bag and went to the hospital. The hospital confirmed that Lisa had received treatment. The

[7] The WHAT centre is a young person's advice, information and counselling service, supporting young people with mental health and wellbeing.

safeguarding incident was therefore closed, and WMP recorded the incident as a vulnerable adult non-crime (VANC).

8.7 In November 2022, Lisa's GP made a referral to the Mental Health Assessment Team (MHAS) over concerns that Lisa was potentially overusing her medication and had a possible addiction. It was noted that Lisa had been trying to manage stress and anxiety for a number of years and as a result she had prescribed a number of different anti-depressants. The notes indicate Lisa's compliance with the antidepressant medication was poor, particularly Diazepam, where Lisa would take more than the recommended doses and request prescriptions early. The notes also indicate that Lisa was known to use above the British National Formulary[8] (BNF) limits of Zopiclone, which was prescribed to aid sleep and provide pain relief. The referral also made reference to the possibility that Lisa had a mild learning disability which had gone unnoticed. Following a referral meeting with the GP, Lisa was offered a routine MHAS assessment, with the appointment being scheduled for the end of January 2023.

8.8 The GP notes for this meeting refer to the fact that Lisa had moved in with her sister and that she did not get on with her sister.

8.9 In November WMAS service made a referral to Children's Social Care, after they attended a local shopping centre and found Child 1 drunk and collapsed. Child 1 was accompanied by a group of friends. Lisa was supportive of Child 1, and discussed the consequences of drinking alcohol with Child 1. Lisa also raised concerns with Child 1's Head of year regarding Child 1's peer friendship group being a bad influence.

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8.10 In January 2023, Lisa did not attend the MHAS assessment with the consultant psychiatrist. As a result a "did not attend" discharge letter was sent to Lisa's GP which advised that Lisa could be re-referred back.

8.11 In March 2023, WMP were initially contacted by Lisa, reporting that she had been involved in a fight with Sister 1 who would not let Lisa talk to Child 1. On attendance at the address, Lisa was not present and officers spoke with Sister 1. Sister 1 detailed that there had been an argument between her, Lisa and Child 1. Lisa had attempted to "forcibly drag" Child 1 out of the house. Sister 1 had intervened and been punched in the face by Lisa, who had then left.

8.12 Sister 1 also informed the attending officers that Lisa and Child 1 had been evicted from their previous home due to Lisa having a drug habit and misusing alcohol. Sister 1 had agreed that both Lisa and Child 1 could live with her, but there had been issues between Sister 1 and Lisa since.

[8] British National Formulary (BNF) guidelines aim to provide prescribers, pharmacists and other healthcare professionals with sound up to date information about the use of medicines. The BNF includes key information on the selection, prescribing, dispensing and administration of medicines.

8.13 Child 1 was also spoken to by Police, and told Police that Lisa had been physically and emotionally abusing Child 1 for as long as they could remember. Child 1 stated that they did not feel safe with Lisa and wanted to reside with Sister 1. A safety plan was implemented whereby any contact between Lisa and Child 1 was to be supervised by another adult.

8.14 Neither Sister 1, nor Child 1 wanted to make a formal complaint, with Child 1 stating that they felt Lisa was not very well and needed help. As a result the incident was recorded as a Domestic Abuse-non crime (DANC), with a Domestic Abuse risk assessment (DARA) being completed and a Multi-agency referral being submitted.

8.15 WMP officers were able to locate Lisa, who confirmed that she had been evicted from her long term rented home of 17 years, and so had moved in with Sister 1. Lisa denied the offences, but did agree that Child 1 could stay with Sister 1 until Lisa had secured accommodation. Lisa was given advice regarding physical chastisement and appropriate conduct. Lisa was also advised to contact Children's Services if she felt she needed support in those areas.

8.16 Later that day, WMP were called to the home address of one of Lisa's other sisters, Sister 2. Lisa had blood around her mouth and bruising to her cheek/eye area. Lisa stated that she had been organising her belongings in a caravan on Sister 1s driveway when she was challenged by an individual regarding Lisa taking drugs. Lisa then stated she had been punched by the assailant and potentially hit with either a frying pan or ornament. Sister 1 had intervened pulling the assailant away. Lisa informed officers that she did not wish to make a complaint, stating she was "a nice person" and didn't want to get them in trouble.

8.17 Officers record Lisa presenting as erratic, and that she had sleepy or droopy eyes, which she frequently closed for short periods of time when speaking or listening to the officers. As the officers were obtaining final details of the incident, Lisa stormed out of the house.

8.18 Officers arrested the assailant and then contacted Sister 1 as there was potentially CCTV footage that covered the events. Sister 1 informed officers that Lisa had been antagonising the assailant and that there had been an argument and not a fight. As there was no complaint forthcoming and not enough evidence to support a victimless prosecution the assailant was released with no further action.

8.19 In June, following a Child and Young Person Assessment, it was recorded that Child 1 required further support regarding school attendance and emotional wellbeing. It was recorded that Child 1 was living with Sister 1. The assessment records that Child 1 reaffirmed that they had faced a number of significant difficulties whilst in the care of Lisa. Consent for a level 3 referral to Early Help was gained and planning was completed to seek to enure Child 1 was safeguarded from any risky adults and their behaviours when out in the community.

8.20 It is recorded that the assessment completed in June clearly sought the views of Child 1 and Sister 1. It also reports that attempts were made by the social worker to engage with Lisa, but that these were unsuccessful.

8.21 Children's Services also record a referral from a GP regarding Child 1 in July 2023. Here, Child 1 disclosed to being the victim of physical and emotional abuse by Lisa. It is reported that Lisa turned up to this meeting, but Child 1 refused to see Lisa, or have her present in the meeting, citing that they, Child 1, were only able to see Lisa in a public domain. The referral reports that Lisa was reported to have an addiction, and that Child 1 remained living with Sister 1.

8.22 Also in July, a referrral was received from the housing team to Children's Services regarding Lisa. The referral stated that Lisa was reported to have been sofa surfing due to having been evicted from her home in January 2023. It also reports that Lisa and Child 1 had been sleeping rough in tents.

8.23 The referral states that Lisa presented as being "very chaotic", that she was unable to remember why she had been evicted, and that Lisa appeared to be suffering from trauma. Lisa had stated that she was grieving for her mother who had passed away three years previously, and that Child 1 no longer speaks with her. No outcomes are recorded on any of the systems regarding this referral.

8.24 Throughout the month of August there were a number of contacts from Lisa to Children's Services. In these calls, Lisa was actively trying to understand why Child 1 could not live with her and is asking for Child 1 to be returned to her care.

8.25 In the first referral, Lisa stated that Sister 1 was preventing her from seeing Child 1, and that she was concerned for Child 1's safety. In the call, Lisa confirmed that she was evicted from her home in January 2023, and that she and Child 1 had moved in with Sister 1. Lisa confirmed that the housing team were aware of her sofa surfing, and that she was going to a residential setting until she could get rehoused. Lisa confirmed that she was only able to contact Child 1 via phone or text. Lisa also complained that people are making false allegations about her being on drugs and that she had been excluded from conversations regarding Child 1 and their welfare, with those conversations now being conducted between Childrens Services and Sister 1.

8.26 On the same day, a concern was raised by Child 1's place of education, whereby they reported an argument occuring between Lisa and Sister 1. Sister 1 no longer wanted Child 1 to stay with her, due to alleging that Lisa was defrauding an elderly male with dementia out of thousands of pounds. Child 1 was given £600 of this money and did not care that origin of the money was not legitimate. Sister 1 alleged that Lisa would bribe Child 1 in order to have contact, and that Lisa's illegal and unsafe behaviours were having a detrimental effect on Child 1's development.

8.27 The following day, Lisa again contacted Children's Services requesting that Child 1 be allowed to live with her. Lisa confirmed in this call that she "gives Child 1 money and

buys them clothes". Lisa again stated that she hadn't been on drugs or drinking, before then cutting the call off.

8.28 A few days later, a further call was received from Lisa, who was described as being very distressed. In this call Lisa requested to speak with senior managers. Lisa specifically asked why Child 1 couldn't live with her, and why Lisa had not been informed of the decision. In this call Lisa also referred to the fact that Sister 1 had "thrown her out" and that Sister 1 was a bully. It was explained that Child 1 was on an Early Help allocation list for a support worker, and it was agreed that a senior manager would call Lisa. It is not clear if Lisa was contacted by a senior manager as promised.

8.29 Four days later, Lisa called again. In this call Lisa gave consent for Child 1 to receive the correct support, but reiterated that she did not feel that Child 1 was safe living with Sister 1, citing Sister 1 as not being a good role model and that the child was at risk of harm. Lisa was advised to contact Social Services, the Police or NSPCC if she felt Child 1 was at risk of harm. Lisa refused, but again wanted to know why she was unable to see Child 1.

8.30 In early September WMP officers attended the address of Sister 1, following a telephone call, stating that Sister 1 was getting aggressive with a young child. On arrival the officers were able to establish that no incident had taken place, and that an allocated Early Help Practitioner had been present at the address until a few minutes before their arrival. It became apparent that the telephone call had been made a long way away from the incident, and it was suspected that the call had been made by Lisa. Officers completed a DARA risk assessment and despite the call being suspected of being false and malicious, with the associated paperwork for a Domestic Abuse incident being completed, and the incident being recorded as a DANC.

8.31 In mid September, Lisa had an initial interview with housing facility staff, following the referral by the Homeless and Housing advice team, to assess if the housing facility was appropriate accommodation. After being accepted, Lisa signed a tenancy agreement. Within the interview Lisa's risks and needs were recorded and Lisa stated the following; Lisa had anxiety and was prescribed Diazepam, she had no issues with alcohol or non prescribed subtances, had Osteoarthritis in her knees for which Lisa was prescribed Diacodeine and was able to manage this independently, had a debt with DWP due to an advance loan paid, and left her last address after the owner wanted to sell it and left with no rent arrears. Lisa also stated she had no issues with relationships.

8.32 Adam also moved into the housing facility on the same day. Adam and Lisa were allocated rooms that were next to each other within the facility.

8.33 Between September and mid December, Lisa attended scheduled support sessions where support was provided to help Lisa make housing bids for permanent accommodation, as well as check on how she was settling into the facility. In these sessions Lisa highlighted that she had depression following the passing of her mother and worries about not living with Child 1. Lisa also stated she only felt low following

family disputes. No issues regarding substance misuse were raised and Lisa indicated that there were no previous or current thoughts regarding self harm. Lisa appeared to be integrating with other residents and there were no issues in paying her rent.

8.34 After the November support session, it was agreed to meet on a weekly basis in order to help Lisa bid on available properties on the housing register.

8.35 In mid-December the Housing application team contacted the Early Help Targetted team to inform them that Lisa had added Child 1 to her housing application. Due to the fact that Child 1 had informed their allocated Early Help Practitioner that they had stopped contact with Lisa, and were not sure if they wanted to see her again, it was advised that Lisa should be offered a 1 bedroom property.

8.36 In a further support session just after Christmas, the support worker identified that there appeared to be other issues going on with Lisa. Lisa did not stay in order to review her needs and risks assessment, indicating that she had other appointments. Lisa did not return in the afternoon as promised to complete the assessment, and so it is unclear what the issues were.

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8.37 In early January Lisa attended her scheduled support session. At this session, Lisa raised concerns about attending the breakfast club and socialising with other residents, because of drug issues, and being asked for drug money by other residents. Lisa was advised to say no to anyone asking for money. A conversation was also held regarding referring Lisa to “Aspire” an external mental health support agency. Lisa declined the support, citing her Gypsy background as the reason.

8.38 In mid-January the Team Around the Family (TAF) had a meeting with Child 1’s educational establishment, due to their poor attendance. Child 1 was reported as struggling to wake and Sister 1 was struggling to get Child 1 up in the morning. The decision was made for the educational establishment to continue to support and review Child 1.

8.39 At the end of January, the housing facility night staff member recorded that he was required to assist Lisa to enter her corridor and room, as Lisa had left her fob within the flat. It was noted that Adam was observed sat in the doorway of Lisa’s flat, and appeared intoxicated and looking paranoid. This is the first recorded contact between Lisa and Adam.

8.40 The next day, Adam attended Russell’s Hall Hospital emergency department and was referred to the Mental Health Liaison team. During his assessment Adam reported issues with alcohol and Cocaine use. Adam stated that he had been abstinent but had relapsed the previous evening and called the Ambulance after experiencing paranoid thoughts. WMAS record an Ambulance was sent to assess after a 999 call had been made. Adam informed the crew he believed he was suffering with drug induced

psychosis and paranoid schizophrenia. Adam told the crew that he “felt everyone he sees in his day to day life, he knows and that every women’s face he sees, they all look like his ex”.

8.41 Adam reported that he had lost his job, partner and child, and had not been in employment for a year. He stated he had been discharged from the Armed Forces in 2018 after failing a drugs test. Adam indicated he was experiencing financial difficulties but had a payment plan in place to service his debts. Adam also indicated he had not had any contact with his child for a year due to not responding to court mediation letters from his ex-partner,

8.42 Following this assessment Adam was referred to the Primary Care Mental Health team. Attempts by the Primary Care Mental Health team to contact Adam were unsuccessful and as such he was sent a 7 day opt in letter in early February, and then a discharge letter a week later.

8.43 In early February Lisa’s family were closed to Children’s Social care due to Child 1s age. It was agreed that the educational establishment and Street team were to remain involved in supporting Child 1.

8.44 In mid-February Lisa attended her support session at the housing facility. It was noted that Lisa sounded depressed, which Lisa indicated was because of a broken tooth crown, but also because Child 1 was not speaking to her. Lisa went onto say that nothing could be done regarding that as that was how it was in the Romani (Gypsy) community. It was also noted that Lisa had missed a rent payment.

8.45 The support worker offered to support Lisa to contact the CRISIS Mental Health team. However, Lisa refused stating that she was managing at that time.

8.46 In late February, the night staff member at the housing facility recorded that Adam approached the reception desk, stating that he had been physically assaulted and was meeting a friend who owed him money so he could pay off his debts. Adam was recorded as leaving the facility and returning 15 minutes later with visible injuries on his face. Adam stated he did not wish to speak about the injuries, and there are no actions or decisions recorded following this interaction. This is potentially indicative of Adam having money issues.

8.47 In the support session towards the end of February, Lisa stated she was feeling mentally better, and had made an appointment with a dentist to fix her tooth. It was noted that her rent arrears had almost been cleared.

8.48 In the support session a week later, it is recorded that Lisa was feeling low and depressed. It was suggested that Lisa speak with her GP, but Lisa stated that her mood fluctuated and didn’t need to see a Doctor.

8.49 In early March, the support session with Lisa focused on friendships with other customers. It is specifically recorded that Lisa did not mention Adam when speaking of friendships, and there is no context provided as to why it was significant that Lisa did not mention Adam.

8.50 It was also recorded at this session that Lisa's rent arrears were increasing. It was established that Lisa had made no rent payments since mid to late February 2024. There is an indication that Lisa was potentially lending money to other residents, but it was not fully understood what else Lisa was spending her money on. A decision was made to send Lisa a warning letter regarding her rent arrears.

8.51 Within the support session a week later, Lisa confirmed that she had been successful in one of her housing bids. Lisa's rent arrears were also discussed and an action plan was agreed for Lisa regarding reducing her rent arrears.

8.52 In mid-March, it was recorded in the handover from the nightstaff at the housing facility, that Lisa had informed the night concierge that Adam was suicidal. The night concierge checked on Adam, who denied he was suicidal, stating he was resting. Adam added that he did not know why Lisa would say this to staff.

8.53 The following day at a scheduled support session, it was noted by the support worker that Lisa appeared to have many issues troubling her, although there is no clarification as to what these issues were. It was also noted that Lisa did not have the relevant identification to send to the housing association for rehousing. Lisa was advised that she needed to act fast so as not to lose out on the property and it was agreed that she would collect bank statements following a dentist appointment.

8.54 The next scheduled support session occurred in early April. At this session Lisa disclosed that she had been headbutted by another resident and it is recorded that Lisa had visible injuries on her face. Lisa also disclosed that she had been called a "slut" by two other residents. Lisa also disclosed that residents had borrowed money from her and as a result Lisa could now not pay her rent.

8.55 Lisa indicated that she did not want to take any further action on these disclosures, and so was provided advice from the support worker regarding her moving goals and to maintain personal boundaries with other residents. It was also recorded that Lisa expressed embarrassment when discussions were held regarding her saving money in order to move on.

8.56 That same morning Lisa attended the breakfast club, and a Life skills worker had a conversation with Lisa regarding the headbutting incident, and asked whether Lisa wanted to report the incident to Police or senior managers. Again Lisa declined, stating that she would be moving out soon.

8.57 A week later a Senior support worker recorded that they had a conversation with Lisa about the headbutting incident. Again, Lisa indicated that she did not want any

action taken and stated that she had reconciled with the individual who had assaulted her. Lisa was also spoken to about causing anti-social behaviour in the scheme at 3 am earlier that day. A decision was made to send Lisa a letter regarding the anti-social behaviour.

8.58 The next day the 11th April, Lisa approached a support worker requesting a support session. In this session Lisa disclosed that she had been both physically and sexually abused by Adam and financially exploited. Lisa stated that she had been in an on/off relationship with Adam and that during this time Adam had given her Cocaine and borrowed £2000 from her. It is recorded that Lisa indicated there was a payment plan in place for Adam to pay her back. Lisa was recorded as being distraught.

8.59 The support worker also reported that Lisa disclosed that she was feeling broken and had lost confidence in moving house. The support worker recorded that they spoke to Lisa about her being in rent arrears, which would need to be paid prior to Lisa moving on. The support worker also stated to Lisa that “staff do not get involved in personal issues” and advised Lisa to make a report to the Police.

8.60 The support worker did not raise Lisa’s serious disclosure as a statutory safeguarding or domestic abuse concern. There is no record of the support worker seeking the advice or support of the management team in order to put in place support for Lisa. It is also recorded that Lisa expressly declined Police involvement.

8.61 It is recorded that the support worker made attempts to engage with Adam following this disclosure, but due to Adam working multiple jobs, and potentially being evasive, they were unable to speak to him until the end of April.

8.62 In mid to late April, Adam approached the night staff concierge for the housing facility and reported that Lisa had been knocking on his door and shouting and swearing at his window from outside of the facility.

8.63 The next day, Lisa was spoken to by a senior support worker and given an verbal warning regarding her anti-social behaviour from the night before.

8.64 The following week, it was noted by the support worker, that Lisa had postponed support sessions, stating that she wanted to be with friends. It was noted by the support worker that Lisa had many issues and kept diverting questions that were being asked.

8.65 The support worker also went on to talk about Lisa’s rent arrears. Lisa indicated that she had paid the deposit for her house move and so was unable to pay her rent for the next week. Lisa also reported being upset regarding the passing of a resident at the housing facility. Lisa disclosed that she had bought 6 red pills from this resident and had taken one of the pills. The support worker advised that the longer Lisa stayed at the facility, the longer she would encounter problems. The session concluded with Lisa stating that she would pay her arrears and move on.

8.66 At the end of April, West Mercia Police received a Domestic Violence Disclosure scheme request from a female, who stated that she had been forming a relationship with Adam from the beginning of April, and wanted to know if anything adverse was known about him. The female was further contacted a week later and stated she had decided to end the relationship due to her and Adam working together. No disclosures were provided to the female.

8.67 At the end of April, Adam again approached the night concierge staff and reported Lisa for harrassing him and having been at his door. When staff attended Lisa was not present.

8.68 That same day, Adam was spoken to in a support session. Within this session Adam disclosed that he was forming a relationship and because it was in its early stages, he did not want people to know about it. He also stated he had made incorrect decisions on past friendships,but would not provide specific details. It is not recorded whether Adam asked about being in a relationship with Lisa, or about the serious disclosures Lisa had made earlier in April.

8.69 At the start of May, the anti social behaviour concerns regarding Lisa were discussed as part of the handover from the night team. At this meeting the serious disclosures made by Lisa on 11th April were highlighted after the senior support worker reviewed Lisa's notes. The senior support worker then completed an on line report to WMP logging the disclosures made by Lisa, with the exception of the sexual assault. Later that day it was recorded that Lisa informed a support worker that she did not wish to make a complaint to Police, and that she had agreed a payment plan with Adam.

8.70 WMP record that the report detailed that Lisa had made an allegation that Adam had taken money from her bank account using her card without permission, and that Adam had threatened and used violence against Lisa.

8.71 Over the first week in May, WMP made several attempts to contact both the reporting support worker and Lisa. On the 6th May an officer attended the housing facility but staff were unable to locate Lisa. The staff the Police officer spoke to were recorded as being unaware of the allegation made by Lisa, and were unaware of any relationship between Lisa and Adam. They also stated that Lisa was homeless and a drug user.

8.72 Lisa is recorded as having approached the reception desk on 6th May, where she again stated that she had obtained pills from the resident that had passed away, that she was sad about the passing of the resident and that she did not cope well with death. Support was offered to Lisa in contacting bereavement services, which she declined.

8.73 Two days later, WMP officers spoke with the support worker, who updated them that Lisa had informed the support worker that she did not want to pursue a complaint and that Adam had taken money from her account with her permission, on the basis that he paid her back. Lisa confirmed Adam had paid some money back, but that she was fed up and now wanted all her money back.

8.74 Lisa was spoken to in the presence of her support worker, where she confirmed she did not wish to make a complaint. Lisa stated to Police that Adam had not threatened or assaulted her and that she did not feel harrassed. Lisa stated to the officer that she “isn’t a grass” and that she wanted to leave the housing facility. Lisa was advised to change the pin on her bank card or get a new card.

8.75 Due to the information provided to Police, the incident was recorded as a Vulnerable adult non crime (VANC), as it was considered Lisa was vulnerable and had the potential to be “used” by other residents.The incident was therefore considered a civil matter between Lisa and Adam. It was not recorded as a domestic incident due to the information provided to Police whereby Lisa stated she was not in a relationship with Adam, and staff stating they were not aware of any relationship.

8.76 Later that day, a support worker recorded that Lisa approached reception to report that two residents had taken her bank card, were using it and would not return it. The support worker helped Lisa to cancel the card, but again advised Lisa that staff do not get involved in customers affairs.

8.77 The following day, the senior support worker directed that a support worker would complete an incident report and make a report to Police regarding the incident. The support worker met with Lisa, who stated that she was fearful to make the report to Police due to potential reprisals from the residents. It is recorded that a report was made to Police and that the support worker made a call to housing association to extend the time for Lisa to pay her deposit, as Lisa feared she would not be able to pay.

8.78 Four days later, Lisa approached the reception desk and stated that she had received a call from the Police, and did not want to press charges for fear of being bullied by the residents that had taken her card. In the information supplied to the review, this incident is not recorded by the Police.

8.79 At the end of the next week in May, in the handover from the night staff at the housing facility, it is recorded that a complaint had been made by a resident regarding Lisa pulling the window to their apartment open during the night, and on inspection it could be seen the wire lock had broken off. Lisa told the night staff member that she had left her mobile phone in the apartment. Throughout this interaction it is recorded that Lisa was continually laughing. The night staff concierge recorded that another resident had returned Lisa’s mobile phone.

8.80 During that day, a number of ineractions occured with Lisa within the housing facility. In the first of these, a support worker noted that Lisa walked through reception and informed them that Lisa was going to the doctors. When Lisa was asked why, Lisa reportedly replied she did not know why. It was reported that Lisa appeared calm and was speaking clearly.

8.81 Later that day, a support worker noticed that whilst in reception, Lisa had a bruised eye. When Lisa was asked how she received it, Lisa stated she did not know. The support worker then spoke with Lisa in a meeting room. In this conversation Lisa restated the serious disclosure that she had been raped by Adam, who had grabbed her by the throat and pulled her hair. Lisa indicated that the incident had occurred sometime around February/March that year.

8.82 Lisa informed the support worker that she had been in a short term relationship with Adam, that Adam had taken £2000 from her. Lisa also stated that she and Adam had taken Cocaine together 4 days earlier. The support worker noted that Lisa appeared confused and disorientated and potentially “under the influence”. Lisa was recorded as bumping into walls when walking, so the support worker accompanied Lisa back to her apartment.

8.83 The support worker completed an incident report and raised a local authority safeguarding concern, and made an online report to WMP, reporting the rape and assault.

8.84 WMP received the online report at 1916 hours. The incident was graded as a P2 response. At 2221 hours a Sergeant reviewed the log and requested attendance as soon as possible due to Lisa and Adam living within the same accommodation. Officers were allocated to attend at 2251 hours, but then diverted to a higher priority P1 response incident.

8.85 Throughout the overnight period and throughout the next morning regular reviews were conducted by Sergeants and Inspectors, as WMP were unable to attend due to a number of higher graded priority incidents, which meant that demand had outstripped the resources WMP had available. A crime report was raised at 0816 hours the day after revcieving the report, which was reviewed by a Sergeant on the Adult complex crime unit. The Sergeant noted that no primary investigation had been conducted, and a further review would be conducted following the primary investigation.

8.86 Later that day at 1345 hours it was recorded that an officer was working on the investigation from the office and had been unable to make contact with the phone number provided. At 1512 hours officers were allocated and attended the Housing facility to speak with Lisa.

8.87 In the conversation with officers, Lisa denied making an allegation of rape, or any comments suggesting she had been raped. Lisa did confirm that Adam had assaulted her at some point between January and March that year, whereby Adam had pulled her hair and placed a hand around Lisa’s throat.

8.88 Lisa was adamant that she did not wish to make a formal complaint and officers recorded the incident as a common assault. Officers noted that the support worker had informed them that Lisa had made the allegation, when it was likely that she was under the influence the day before and that Lisa was known for drug and alcohol misuse. The

support worker also informed officers that Lisa suffered with undiagnosed learning needs and had the mental age of that of a 13 year old. The support worker did confirm that Lisa and Adam had been in short term relationship.

8.89 Officers noted that Lisa was able to understand their questions, but not able to provide any circumstances regarding the assault. A DARA risk assessment was not completed by the officers due to Lisa's apparent mental age. Officers also reported that Lisa had a bruised left eye, but when asked how the bruising occurred, Lisa stated that she had walked into a window and then stated she had fallen into a tree.

8.90 As both Lisa and Adam lived in the same facility and adjacent to each other, officers raised safeguarding concerns with the support worker, making a suggestion of moving either Adam or Lisa to another room within the facility. The support worker recorded that they would speak with managers on Monday regarding this suggestion (This being a Saturday). There is no evidence to suggest that the "out of hours" manager was contacted in this regard.

8.91 The incident was reviewed by a supervising officer within WMP. It was noted that Adam did not have a Police record. The supervisor provided the following rationale for not pursuing the allegation of rape:

With the offence of rape, it is the prosecution's responsibility to:
1) Evidence that sexual intercourse occurred
2) Show that consent was not present or removed

With the victim not willing to provide an evidential account of the circumstances of the reported rape then we are incapable of reaching the required evidential standard to

1) Justify interviewing the suspect
2) Approaching CPS as the threshold test in incapable of being met.

Based on these factors I do not believe that it is proportionate to continue with any form of investigation as it is not possible to reach a level to gain a prosecution whilst not having the victim's support. Therefore, this report shall be filed pending the Victim coming forward.

8.92 Later on the that day, a support worker recorded that Lisa indicated that she had lied to the Police, and that in fact Adam had assaulted her on two days earlier when she went to his flat to ask for her money back. Lisa also disclosed that she had been pregnant but had undergone an abortion. Lisa stated that Adam had been the father. There are no records available to the review to confirm, or otherwise, that Lisa had been pregnant.

8.93 Within this conversation, Lisa also further admitted to taking Cocaine supplied by another resident within the facility. Lisa also stated that she was afraid to speak to the

Police, and was hesitant when encouraged to update the Police. It was left for Lisa to consider whether she wanted to update the Police.

8.94 On that day in May, Adam also had several interactions with staff at the housing facility. It is recorded that he came to the reception and asked staff to speak with Lisa, although it is not recorded what Adam wanted staff to speak to Lisa about.

8.95 Adam also sent a text to his support worker stating that he was being harrassed by Lisa, stating she was banging on his door and sending him letters. Adam was encouraged to log his concerns with the Police.

8.96 Adam also met with his support worker and produced a pile of letters which he stated had been sent by Lisa. Again he was encouraged to liaise with the Police on the matter.

8.97 Adam also spoke with the accommodation officer at the housing facility and provided a 28 day notice to vacate his property. Adam indicated that he would be moving into private rented accommodation.

8.98 Records from the housing facility indicate that Lisa was not seen by staff on the day after the police attendance.

8.99 On The Monday the Adult safeguarding referral regarding Lisa that had been sent by the support worker on the Friday was reviewed and triaged by the MASH team. It has become clear that the referral was sent after the MASH teams normal business hours on the Friday. There was no follow up with the Emergency duty team, as directed by the automated e mail response, and so the referral was not seen until the Monday.

8.100 The referral to MASH stated the following:

"Customer is acting really out of character and we believe she is under some influence. She has a black eye and swollen lip. She informed staff around about February she was sexually assaulted by another customer. She has been financially abused by the customer. She is quite depressed
Depressed, financially abused, possibly sexually abused according to her and possibly physically abused although she is so confused she does not know
Other customers within the service are taking advantage. They are befriending and taking advantage.
For Lisa to have some support a social worker or women's aid help. She is from the traveller community and says she is scared if they find out she is being abuse"

8.101 Also provided with the referral was a photograph of Lisa's injuries. The MASH team had 23 other referrals that day and due to the information presented to MASH, particularly that the offences occurred months previously, the referral was not flagged as urgent. It was sent to the duty officer to make contact with Lisa to obtain more details

and understand her care and support needs, and what support services were already involved. The duty officer attempted to contact Lisa at 1438 hours and a voicemail was left. The referral remained open pending a call back from Lisa, but was closed once notification of Lisa's death was received.

8.102 Later that day, a 999 call was made to WMAS reporting that Lisa was in cardiac arrest. An ambulance was sent to assess. The ambulance crew were told that Lisa had not been seen for three days, so a support worker entered her property and found Lisa unresponsive. The crew found Lisa to be in cardiac arrest and a shortwhile after recognition of life extinct was confirmed, and Police attendance was requested. The ambulance crew observed some empty medication packets on Lisa's bed side table.

8.103 WMP received the request to attend the housing facility at 1415 hours that afternoon in response to a sudden death. Officers attending recorded that staff had gained entry to Lisa's apartment using a master fob. Lisa's fob was found within the apartment. It was noted that there were empty packets of prescription medication including Zopiclone- 28 tablets, with the instructions stating "to be taken once per night". The most recent medication had been prescribed to Lisa on 17th May and all tablets had seemingly been taken.

8.104 Housing facility staff informed Police that Lisa was known to take Class A drugs, however, officers noted no signs of illegal drug use. There were no other visible injuries, other than the bruising to Lisa's face that had been noted on the 18th May.

8.105 CCTV was reviewed and showed Police officers attending Lisa's room between 1426 and 1436 hours two days prior to her passing. At 1436 hours Lisa was seen to leave her room and go to reception, before returning at 1444 hours. On her way back she was seen to kick Adam's door. At 1734 hours Lisa was seen to leave her room and put a note under Adams door before returning to her room. The last time Lisa used her fob was at 2126 hours on that day and CCTV matched the fob usage.

8.106 The WMP Force Incident manager was informed and noted that pending a coroners verdict the death appeared to be an unfortunate accidental or intentional overdose of tablets.

8.107 The day after Lisa's passing, Adam left the housing facility with his belongings and has not returned. The housing facility made contact with Adam on three occassions over a period of ten days where he confirmed he would be returning to the scheme to collect any outstanding belongings, but not returning to stay.

8.108 The day after Lisa's death, WMP reviewed the assault report regarding Lisa. A THRIVE+ risk assessment was conducted. It recorded that Lisa would not support any Police action, and that Lisa had a lack of confidence in the Police. It was decided that the report would be filed and Lisa was sent signposting information for support services and a text confirming the decision.

8.109 Later on that day, it was recorded that a support worker had called Police on the last day Lisa was seen alive to relay the information that Lisa had disclosed that Adam had assaulted her and caused her bruised eye. By the time the update had been fully logged, Lisa had passed away.

9. Findings and Analysis

9.1 When looking at suicide following potential domestic abuse I have considered the following research:

Eight Stages towards suicide following Domestic abuse

9.2 Research into domestic abuse was conducted by Professor Jane Monkton Smith et al in 2022[9]. This research describes eight stages that show a potential and incremental escalation in risk towards suicide in victims of domestic abuse:

Stage one- A history of domestic abuse, either in the perpetrator or victim's history.

9.3 In the case of Lisa, there is an indication following a GP assessment where she details a history of anxiety and some bullying in a past relationship. Lisa is also known to Children's Services and Police with regard to domestic abuse towards Child 1.

9.4 With Adam, whilst there is nothing specifically recorded within Police or local CSP records regarding domestic abuse, he does, when presenting in mental health crisis provide potentially cogent insights. He describes having trust issues a result of his mother lying and cheating throughout his childhood. Adam spoke about his previous relationship breaking down, and although with no definitive information as to why, Adam does highlight controlling behaviours and paranoia. Adam described issues in his relationship and reported a lack of trust and having paranoid thoughts regarding his partner. Adam stated he studied the door camera footage and was convinced his partner had deleted footage from it.

Stage two- A controlling relationship that develops quickly, often involving early co-habitation and/or pregnancy.

9.5 From the information known to the review, it can be seen that Lisa and Adam formed a short, yet intense relationship in the time they were at the housing facility, and whilst the exact dates of the relationship are unknown, from the timeline gathered the relationship seems to have occurred sometime between December 2023 and April 2024.

9.6 Whilst there is no evidence of co-habitation, Lisa and Adam were in apartments next door to each other, meaning they were in close proximity to each other.

[9] Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing and intimate partner homicide. Monckton-Smith et al, 2022.

9.7 In one of her disclosures to support workers in and around mid May, Lisa states that she had been pregnant and had an abortion. Lisa stated that Adam was the father.

Stage three- In all of the cases that this research looked at, the relationship was dominated by control and abuse, often from a very early point within that relationship.

9.8 Lisa makes several disclosures regarding abusive behaviour from Adam. Lisa reported that she was subjected to rape by Adam, and that he physically assaulted her during the act. From 4 days prior to her death, Lisa had bruising to the face which she disclosed was caused by Adam punching her in the face.

9.9 Lisa also reported financial exploitation, whereby Adam had taken £2000 from her. Although Lisa indicated that she gave Adam permission to take money from her account, it is clear that Lisa became agitated when Adam did not return the money as promised.

9.10 Adam also displays potential gaslighting behaviour when Lisa had informed the night concierge that Adam was suicidal. The night concierge checked on Adam who denied he was suicidal, stating he was resting. Adam added that he did not know why Lisa would say this to staff. This would have had the effect of undermining Lisa and making her look silly and/or dramatic to housing facility staff.

9.11 Adam also displayed behaviours of collusion and portraying himself as the victim. Adam made several complaints regarding Lisa's behaviour, and on most occasions, it is to the night concierge(s), who are less likely to question the reasons for the behaviour. It also potentially helps create an impression of Lisa acting irrationally towards him, and therefore being the victim of Lisa's apparent anti-social behaviour.

9.12 Adam also complained to his support worker about being harassed by Lisa. Adam showed the number of letters that Lisa had written to him as evidence of her harassing behaviour. There is nothing recorded that indicates the reason Lisa is sending him the letters is because of the money he has taken from her, and potentially the rape and physical abuse.

Stage four- In 83% of the cases, the victim disclosed abuse, not always to services, but to family members. Other research, (Vasiliauskaite and Gaffner 2020)[10], found that shame and secrecy were influential in preventing disclosure by victims but also fears of retaliation and fears of not being believed were key issues. Monckton-Smith et al go on to describe disclosure as an escalation in risk, not the beginning of risk progression. They observed that control and abuse may already be at a high level of risk at the point of first disclosure.

9.13 In Lisa's case her Romani (Gypsy) heritage is particularly relevant, especially with regards to reporting to Police, community attitudes to domestic violence and in this case the fact that Lisa was resident in a mixed gender facility.

[10] Eight Forms of Abuse: The Validation and Reliability of Two Multidimensional Instruments of Intimate Partner Violence--- Vasiliauskaite and Gaffner 2020.

9.14 From information kindly provided to the review from the Traveller Movement, the fact that Lisa had been homeless and then gone to a mixed-gendered housing facility would be seen as shameful, which could lead to Lisa becoming an outcast from her community.

9.15 A female from a Romani (Gypsy) background is not allowed to be in the proximity of men she is not married to or who is a family member. Therefore, being in this situation would also be a potential source of shame.

9.16 Sex outside of marriage for a Romani (Gypsy) female is not acceptable within the community. Therefore, it is feasible Lisa would have blamed herself for the rape, potentially adding to the shame she may have already felt.

9.17 The Community attitudes to rape in this scenario, would be an assumption that the woman was making it up to cover up the shame of sleeping with another man. The community perception would be that “she was up to no good with him” and should not have put herself in the situation.

9.18 This therefore means that due to these community perceptions, Lisa would not have been able to confide in friends or family. To make an allegation of rape is an immense thing for Lisa to do, and therefore perhaps indicative of the risk she perceived at the time. For this reason, it is also unlikely that Lisa would have made the disclosure without being under the influence of either alcohol or drugs. It is also probably one of the reasons Lisa denied making the allegation once she was more sober.

Stage five- Help seeking was present in more than 80% of the cases this research looked at, it came after the first disclosure. They quote previous studies that found that victims do not report abuse or seek help where they believe that the service would not be useful, or they might not be believed. Monckton-Smith et al describe active help seeking as potentially being seen by the perpetrator as challenging their control and can provoke consequences for the victim.

This research also noted that although calls to the police were made in 78% of the cases they looked at, the police intervention did not, in any of the cases, halt the abuse of the stalking, this included cases where the perpetrator was arrested, charged and released on conditional bail and where the perpetrator was in prison. They also noted that the lack of consistency, especially in risk considerations across agencies, was described by families of the deceased, to actually encourage the perpetrator.

9.19 For Lisa, her only source of seeking help was with the support workers. This is due to the Romani (Gypsy) community attitudes to domestic abuse and rape as described in Paragraphs 8.16 and 8.17. From her initial risks and needs assessments at the housing facility, Lisa made it clear that she did not want family or friends to know she was there. Without this community/family support network there were few places Lisa could seek help.

9.20 Another issue for Lisa in seeking help was that the perpetrator lived within the same housing facility, and in the next door apartment. Lisa, on a few occasions, had stated to the support workers that she did not want to talk to Police for fear of reprisals.

9.21 The fact that Police would have to attend the housing facility, would mean that Lisa would be aware that other residents will have noted the presence of the Police. In Lisa's mind this could well have heightened the perceived risk against her.

9.22 Lisa's background also meant that she would never seek to speak with the Police or make a complaint to the Police. To do so would be seen as "grassing up" and could lead to being ostracised from the community. The Romani (Gypsy) community have no trust or confidence in the Police and would not advocate going to the Police to resolve problems.

9.23 When Lisa made the original disclosure regarding sexual and physical assault and financial exploitation by Adam, the staff at the facility took just under a month to speak with Adam. Even when they did, the allegations were seemingly not specifically addressed. In the meantime, Adam had complained about anti-social behaviour from Lisa, for which Lisa had been admonished by staff almost immediately.

9.24 This would have had a potential effect that Lisa felt she had not been taken seriously, and that staff were potentially taking Adam's side. The anti-social behaviour towards Adam was a direct result of the disclosures she had made, and trying to get her money back. To be admonished for that behaviour, would potentially lead to a lack of trust in the support workers, which can be seen towards the end of April and in May where Lisa consistently stated that she "just wants to get out of the facility."

9.25 Adam, by portraying himself as a victim of Lisa's behaviour, and seeing staff act on his complaints, would potentially feel empowered and in control of the situation. In this way, the responses by staff within the housing facility would potentially encourage Adam as described within the research.

Stage 6- In a high percentage of cases, suicidal ideation was identified, this tended to coincide with the victim feeling trapped and in a hopeless situation. It was also noted that there were cases where the perpetrator actively encouraged the victim to end their life. Monckton-Smith et al also noted previous research that found that children were a protective factor in suicidality and the primary reason why victims didn't act on such thoughts. Monckton-Smith et al also observed that the thought of having lost the children would create a feeling of entrapment and hopelessness.

9.26 There is no identified moment where Lisa stated that she was considering taking her life. Part of this may have had something to do with her religious beliefs, whereby suicide is considered against God's will, and even to mention thoughts of suicide would be considered blasphemous.

9.27 However, at the end of April and beginning of May, there is a potential that Lisa was seeking help and alluding to having dark thoughts. On two occasions Lisa stated that she was upset about the death of a resident, and that she did not cope with death well. Lisa also stated she had obtained 6 red pills from that resident and had taken one. Whilst it is not known what these pills were, it is apparent that Lisa had taken Pregabalin prior to her death. Pregabalin is known by the street name as "Buds" or "Budweisers" due to the fact the pills are red or red and white in colour.

9.28 Lisa was offered support in contacting bereavement services This she declined, which is potentially because she was using the death of the resident to try and articulate her thoughts about suicide, but did not know how to, without compromising her religious beliefs.

9.29 When Lisa came to the housing facility, it was with a clear objective to secure independent housing so that she and her Child could live together. From the point that Lisa initially agreed that Child 1 was allowed to stay in Sister 1's care, it can be seen that Lisa fought tooth and nail to get Child 1 back into her care.

9.30 Within the Romani (Gypsy) culture, to have a child removed by social services, or to be seen as a bad mother, will illicit feelings of shame. It could also lead to the community turning against her. Whilst it is noted that Child 1 stayed with Sister 1 under a family arrangement, and was not formally removed from Lisa's care by Children's Social Care, it would appear that Lisa would have interpreted this as Child 1 being removed from her care, and a potential reflection on her ability to be seen as a good mother.

9.31 At one point, Lisa states to a support worker that she was upset because her Child was not speaking with her, and "nothing could be done because that's how it is in the travelling community." It is possible that by this point that Lisa had been warned off seeing Child 1 by the family/community. Being seen as a bad mother and not being able to get Child 1 back into her care would be potentially devastating for Lisa.

9.32 The other factors that would have increased Lisa's vulnerability, such as having been homeless, living in a mixed gendered housing facility, and her socialisation within her community regarding domestic abuse/rape i.e. having brought it upon herself and potential exclusion from her community, would have potentially left Lisa feeling trapped and in a hopeless situation. If Lisa perceived that there was no chance of living with Child 1 again, then Lisa would have lost that protective factor.

Stage 7-In just under half of the cases looked at, the relationship between victim and perpetrator had ended but the contact, control and stalking persisted. Perpetrators seemed oblivious to the deteriorating mental health of the victim, some actively encouraged suicide. In most of the cases considered, the victim had said that they were trapped in a situation from which they felt there was no escape.

9.33 In this case, it is likely that by the end of March the relationship between Lisa and Adam was over. Adam disclosed to support workers at the end of April that he is in a new relationship but did not want to disclose details as it was "early days."

9.34 In late April 2024, West Mercia Police received a Domestic Violence Disclosure scheme request from a female, who stated that she had been forming a relationship with Adam from the beginning of April, and wanted to know if anything adverse was known about him. The female cited that Adam suffered from paranoid schizophrenia and had trauma from being in the Armed Forces. This is indicative that Adam had moved on from Lisa.

9.35 However, due to Adam taking the £2000 from Lisa's account, she was still in contact with him in order to get her money back. This would also allow Adam to maintain some element of control over Lisa.

9.36 Lisa's behaviour and mood changed significantly from the March until her death. Lisa increasingly presented as angry and resentful. Also, in conversations with support workers, Lisa talked about low moods and anxiety and adverse interactions with other residents. Lisa admitted to drug taking and was observed on a couple of occassions to be under the influence. There is nothing known to the review that indicates any empathy or sympathy from Adam towards Lisa. There are no recorded incidents where he has indicated to support workers or staff that he is concerned for Lisa or her welfare.

9.37 In fact the evidence indicates that he does not indicate any closeness to Lisa, and when he did engage with staff regarding Lisa, it was to complain about her behaviour towards him, or gaslight her.

9.38 There is also evidence of abuse towards Lisa up to a few days before her death, whereby Lisa had a briused eye and informed a support worker that Adam had punched her in the face after she had knocked on his door to get her money back. Lisa had been trying to get the money back since at least April, and possibly feared she would never get the money back, leaving her feeling trapped.

9.39 In last few days of Lisa's life, Adam portrayed himself as the victim of Lisa's behaviour. He texted his support worker to complain of being continually harrassed by Lisa, he approached the reception desk to ask that staff speak with Lisa, and in a meeting with his support worker produced a pile of letters received from Lisa to evidence her behaviour towards him. Potentially, this was Adam trying to control the narrative, in response to the fact Lisa had a visible injury and that the Police had attended the housing facility to see Lisa. Therefore, fearing possibly being arrested, wanted to set the impression of Lisa behaving badly towards him.

Stage 8- The suicide.

9.40 In late May 2024 Lisa was found in her room unresponsive, with a number of empty packets of prescription pills at her bedside. WMAS pronounced recognition of life extinct at 1411 hours that day.

9.41 When looking at the key lines of enquiry from the Terms of reference the following can found:

Establish whether any agency, or agencies, identified potential and/or actual domestic abuse that may have been relevant to the death of Lisa, having due regard to policies, procedures, operating protocols, training provision, and working environments.

9.42 Children's Services identified that Lisa had potentially been the perpetrator of domestic abuse towards her child, Child 1.

9.43 There were numerous referrals to Children's Social Care from WMAS, Police and education. Concerns were raised regarding Lisa's parenting abilities, her mental health,

substance misuse and housing issues. Child 1 also disclosed being the victim of historical emotional and physical abuse.

9.44 Lisa became homeless in 2023 and moved in with Sister 1. Following an altercation involving Child 1, Lisa and Sister 1, Child 1 disclosed that they had been subject to abuse from Lisa. Child 1 indicated that they did not feel safe with Lisa and wanted to live with Sister 1.

9.45 Children's Social Care agreed to a safeguarding plan for Child 1, meaning it was agreed, that in accordance with the family arrangement, Child 1 would continue to stay with Sister 1.

9.46 From this point on, Lisa found herself not included in many of the conversations relating to Child 1 and their welfare. It can be seen that Lisa, after this, had one objective and that was to get suitable accommodation, so she and Child 1 could live together.

9.47 Although Children's Social Care acted within their policies and procedures, and the overriding aim was to ensure that Child 1 was safeguarded, there is an acknowledgement that while Child 1 and Sister 1's voices were heard, Lisa's was not.

9.48 There was also a potential misunderstanding of how the perception of having Children's Social Services involvement would impact on a person from Romani (Gypsy) heritage, and their standing in the community. The agreement for Child 1 to stay with Sister 1 would have added to Lisa's anxiety and vulnerability, and the desire and desperation to get to a position where she had Child 1 back in her care, would have influenced Lisa's decision making thereafter.

9.49 So, whilst this recognition of domestic abuse is not in regard to abuse Lisa suffered, it is relevant to the events that occurred thereafter and Lisa's increased vulnerability.

9.50 From a Healthcare perspective there are no direct interactions held with Lisa that indicated that she was experiencing domestic abuse. However, the Primary Care Mental Health team legacy notes indicate Lisa had been bullied in a previous relationship prior to 2012.

9.51 Given Lisa's mental health difficulties and misuse of substances (prescription medication) it could have been perceived that Lisa could be vulnerable to abuse. However, given the information held from the contact with Lisa, it is considered there were no missed opportunities identified to highlight domestic abuse or safeguard Lisa.

9.52 Adult Social Care had two referrals regarding Lisa. The first, in 2022, was related to Lisa's medical welfare and the urgent need for her to have a blood transfusion. Nothing within that referral would lead to any perception of current or historic domestic abuse.

9.53 The second referral occurred on Friday in mid-May 2024. When triaged, considerations regarding potential domestic abuse were present, with a view to obtain more information from Lisa. However, the referral had been sent outside of normal office hours on a Friday. Therefore, by the time it was triaged on the Monday, and attempts were made to contact Lisa, she had passed away.

9.54 There is a MASH emergency duty team that cover out of hours and weekends. The automated e mail response to an online MASH referral does provide details of the core hours and details of how to contact the emergency duty team outside of core hours. This was not done by the support worker for the Housing facility.

9.55 The referral to Adult Social Care identified Lisa to be the victim of sexual assault, financial and physical abuse. However, the context of being in a relationship was not given and the details of a potential source of risk were not provided by the referrer. Domestic abuse was therefore not explicitly considered as an immediate key line of enquiry by Adult Social Care. However, as the referral highlighted services such as Women's Aid, it was planned to discuss this with Lisa when contact was attempted on the Monday.

9.56 Following internal review, it was identified that Adult Social Care staff followed internal processes to triage the safeguarding concerns effectively and within expected timescales, with the information available to them at the time.

9.57 WMP had several contacts with Lisa and her family members post 2022. The first incident just after Mid-May 2022 was a concern for welfare incident. Lisa required an urgent blood transfusion, and when she could not be contacted, WMP were called to help assist in locating Lisa, ensuring no harm had come to her due to her condition, and to seek to ensure Lisa attended hospital. Nothing within this referral was suggestive of domestic abuse, and all actions were conducted appropriately and in accordance with operating procedures and recorded as a Vulnerable adult- Non crime.

9.58 On 11th March 2023 WMP were called to an incident involving Lisa, Child 1 and Sister 1. Domestic abuse was identified, with Child 1 stating that Lisa was the perpetrator of physical and emotional abuse towards her.

9.59 There was also a report of assault from Lisa towards Sister 1, following an altercation where Lisa tried to remove Child 1 from Sister1's home. Officers attending were informed that Lisa and Child 1 had been homeless and been taken in by Sister 1. Information provided to officers also indicated that Lisa had alcohol/drug misuse issues.

9.60 As no complaints were forthcoming, no arrests were made. Officers completed a Domestic Abuse Risk Assessment (DARA) and Multi Agency Referral Form (MARF). Lisa was spoken to regarding her behaviour and provided advice re physical chastisement. The assault on Sister 1 was recorded as common assault and filed.

9.61 Child 1 was safeguarded, in that as Child 1 stated they did not feel safe in Lisa's care it was agreed that they would continue to live with Sister 1.

9.62 Later that day officers attended another incident involving Lisa, where she had been the victim of an alleged assault. Lisa had visible injuries, but when speaking to officers, did appear to be under the influence of either drink or drugs. The alleged assailant had hit Lisa with either an ornament or frying pan, and information suggested that the assault happened because Lisa was taking drugs. The assailant had been pulled off Lisa by Sister 1.

9.63 Police arrested the identified assailant and made immediate post incident investigations. Lisa did not wish to make a complaint and when Police approached Sister

1 to view CCTV, they were advised by Sister 1 that Lisa had been antagonising the assailant, and that the incident was an argument not a fight.

9.64 There was no complaint from Lisa and a lack of evidence as to what exactly had happened, meaning there was not enough information available to support officers to consider a victimless prosecution. A decision was therefore made to release the assailant with no further action.

9.65 WMP review of the incident indicate that actions taken for both events were timely and appropriate. Whilst Lisa was advised to contact Children's Services and a DARA and MARF were submitted, there is no indication that Lisa was offered referrals that could have been appropriate to the circumstances, for example Housing services or drug/alcohol misuse services.

9.66 The incident in early September 2023, whereby Police attended in response to an allegation that Sister 1 was mistreating a child, was recorded as a domestic incident non-crime, as no offences were disclosed, but the parties involved were related. It was suspected that the report was in fact false and malicious, and it was further suspected that Lisa had made the telephone call. Officers recorded the incident as Domestic abuse no crime (DANC) for reference in case of further incidents, and reflected the fact that Child 1 had informed officers of being the victim of historic emotional and physical abuse from Lisa towards them.

9.67 WMP officers also attended the housing facility on two separate occasions in regard to Lisa.

9.68 The first incident was in early May 2024, and officers were informed that Lisa had alleged that her bank card had been stolen by Adam, and that Adam had threatened and used violence towards Lisa. Crucially this referral did not reference the allegation of sexual assault that Lisa had detailed to support workers in April 2024.

9.69 There were delays in officers getting to speak with Lisa, mainly due to not being able to contact the original support worker who had made the referral. When officers did speak with Lisa it was in the presence of a support worker, but not the support worker who had made the referral to Police.

9.70 When speaking with officers, Lisa denied that Adam had threatened or assaulted her and that she did not wish to make a complaint against Adam regarding the missing money, but instead wanted to deal with it herself. Prior to attending, when officers were trying to get hold of Lisa to make an appointment, they were provided information from the support workers they spoke to, indicating Lisa was homeless and a drug user. Support workers also informed Police that Lisa and Adam were not in a relationship.

9.71 As no offences were disclosed by Lisa, the incident was considered to be a civil matter between Lisa and Adam. With Lisa not confirming to officers that she was in a relationship with Adam, and support workers stating that Lisa and Adam were not in a relationship, domestic abuse was not considered or recorded, and a DARA was not completed.

9.72 Officers did recognise that Lisa was vulnerable due to the potential she could be "used" by others and recorded the incident as a VANC. They provided advice to Lisa regarding changing the PIN on her bank card and getting a new card. The support workers were requested to ensure safeguarding for Lisa was in place within the facility, although it is not recorded what was specifically requested to be put in place to safeguard Lisa.

9.73 A WMP internal review indicates that a point of good practice was the fact that Lisa was seen in the presence of a support worker. However, it may be that there was a reliance on information provided by support workers, especially in relation to whether Lisa and Adam were in a relationship, which meant that the consideration of this being a domestic incident was missed.

9.74 On the Friday in Mid- May 2024, WMP received a report relating to rape and assault, with Lisa being the victim. The incident was reported at 1916 hours that evening. Lisa was not spoken to by officers until after 1500 hours the next day. It is accepted by WMP that this did not meet the response times required for an incident of this type, and not acceptable for a potential victim of rape to wait this long. The delays in responding are fully documented, with the offence against Lisa being prioritised as a P2 response. However, on that evening the number of higher priority P1 incidents that occurred, outstripped the resources available, and so no officers were available to attend until the next day.

9.75 There is supervisory oversight of the incident and the reasons for the delay are well documented by supervisory officers. In June 2024 WMP response grading was changed to four incident grades:

1. **Emergency** – *attend as soon as possible and within 15 minutes*
2. **Priority** - *attend as soon as possible and within 60 minutes*
3. **Scheduled** – *attend at a time convenient with the victim but within 3 days*
4. **Contact Resolution** – *for incidents that do not need physical attendance including all logs managed within Force Contact.*

The new incident grades were phased in to:

- *simplify things*
- *align WMP with other forces*
- *help WMP better identify threat, harm and risk*
- *improve service.*

9.76 Whilst this change in priority gradings was not solely as a result of the response to the incident relating to Lisa, it will have played a part in providing evidence as to why a change was needed.

9.77 Lisa denied the offence of rape to the officers attending, and was adamant no such offence had taken place. Lisa did confirm that Adam had assaulted her, but it had been between January and March time. Lisa stated that no injuries were caused. Officers established that there were no known witnesses, and other evidential avenues such as

CCTV were unlikely to be in place. Lisa was also adamant that she did not want to make a complaint of assault. Lisa would also not disclose how she received the injuries to her eye that were visible to attending officers.

9.78 Whilst it is an option for officers to arrest a potential offender of domestic assault even where a complaint is not forthcoming from the victim, there is a need to be able to build a cogent and credible case. In terms of the rape, the fact that the information the officers had was that the offence occurred sometime between January and March, meant there was no ability to recover forensic evidence. Similarly, without other corroborating evidence regarding the assault, the officers could not meet the threshold for offences to be charged by CPS.

9.79 Officers did identify the incident as a domestic incident and did set out to complete a DARA assessment. However, due to the support worker informing them that Lisa had the mental age of a 13-year-old, the officers did not ask Lisa the questions.

9.80 The officers did not record that there were any difficulties in communicating with Lisa, or that she had an inability to understand or answer questions. Notwithstanding that questions could have been asked in an age-appropriate way, and the DARA should have been completed.

Recommendation 1

To reiterate current Policy and procedure whereby Police officers attending incidents that are considered to be a domestic abuse incident to complete a Domestic abuse Risk assessment (DARA) on every occasion.

If the potential victim is a child or has potential learning difficulties or disability, the questions should be asked in an age-appropriate way.

Ensuring the presence of an appropriate adult, or intermediary or advocate to be considered to help aid and facilitate communication and understanding where appropriate.

9.81 Recognising Lisa's vulnerability, and the fact Lisa and Adam resided in the same facility and adjacent to each other, officers made safeguarding recommendations to the support worker for Adam and Lisa to be moved to different rooms within the facility. There should also have been consideration given to whether Adam's reported behaviour represented a potential risk to other females within the facility.

9.82 The incident was recorded as a common assault and prior to the incident being filed a THRIVE + risk assessment was carried out. By the time the information was received that Lisa had admitted to the support worker that Adam had punched her on 16th May, causing bruising to her eye, Lisa had already passed away, and so no follow up enquiries were possible

9.83 For staff within the housing facility there were several interactions that could have been indicative of domestic abuse against Lisa.

9.84 The most significant of these was in the first week or so of April 2024 when Lisa disclosed to a support worker that she had been in an on/off relationship with Adam. Lisa disclosed that Adam had sexually and physically assaulted her, and that Adam had taken £2000 from Lisa, and she was now struggling to get the money back.

9.85 Lisa was advised to contact the Police, which she declined. Attempts were made by staff to engage with Adam, but he was not spoken to until the end April, and even then, the specific details within Lisa's serious disclosure were not discussed.

9.86 An internal review regarding the initial disclosure by Midland Heart have identified that this incident should have been raised as a safeguarding concern by the support worker. In not doing so, this meant that the incident was not recorded in line with the Midland Heart Safeguarding Policy. The internal review also identifies that this significant disclosure was not considered as domestic abuse, despite Lisa indicating that she was in a relationship (however short) with Adam.

9.87 Whilst support was offered to Lisa to report it to Police, which Lisa declined, no other options were seemingly considered in terms of a Multi-agency safeguarding referral or any safeguarding within the facility. The risk posed by this situation is seemingly not recognised, in that, there is a male within a mixed gendered housing facility containing other vulnerable females, who is accused of sexual and physical assault against a woman. This male, Adam, lived immediately next door to the female who had disclosed the assault. This individual is also reported to be taking Class A drugs. With all these factors it is surprising that there was no immediate escalation to senior managers.

9.88 Lisa's disclosure only came to the attention of managers following a report of anti-social behaviour by Lisa, where she was banging on Adam's door mid to late April. In seeking to deal with Lisa for her behaviour, the disclosure came to light to senior managers. This resulted in a referral to WMP; however, the referral only relates to financial exploitation and physical assault. The reason given for not highlighting the sexual assault was because Lisa had informed the social worker in April that she did not want to report it to Police.

9.89 When Police attended, support staff informed officers that there was no relationship between Lisa and Adam, and so when Lisa did not wish to pursue complaints against Adam, the incident was considered as a civil matter, and not a result of potential domestic abuse. This means the incident was recorded as a VANC by Police, but not a domestic incident.

9.90 It is only later in May, when Lisa reaffirmed her original disclosure of rape, physical assault and financial exploitation was the Midland Heart Safeguarding Policy followed. Referrals were made to the Police, and a Multi-agency safeguarding referral was made.

9.91 In parallel to this, Adam made a number of complaints regarding Lisa's behaviour. These were treated in isolation from the information supplied by Lisa early to mid-April and mid-May and meant that Lisa was admonished for her behaviour towards Adam and others. These interactions would help to support the fact that Lisa and Adam had been, or where in some sort of relationship. These interactions were seemingly not married up and as a result the significance of Lisa's hostility towards Adam was potentially not recognised.

9.92 The fact that Adam's complaints against Lisa were dealt with, and Lisa admonished, but nothing being done about Lisa's serious disclosures regarding Adam, it can be seen this would have the potential to cause resentment and anger from Lisa towards both Adam, other residents and staff, and lead to mistrust. The fact that Lisa repeatedly stated that all she wanted to do is get out of the facility after her disclosure in April is indicative of this.

9.93 It is important to understand perhaps the working environment within the housing facility. There are 58 apartments and residents are referred to the facility in order to support them into moving to independent living. This invariably means that they have been homeless at some point and have potentially had trauma within their lives. The support workers are primarily there to support individuals transition into independent living. Support provided aims to help residents sustain their accommodation and develop independent living skills, enabling them to transition into appropriate housing within the wider community. The support workers therefore promote independence and will respect individuals' rights to make their own decisions and privacy in how much information is being shared.

9.94 Whilst staff encourage residents to share information and work on building a relationship of trust, Midland Heart relies on residents to provide disclosure around these issues voluntarily, to enable them to signpost the residents for any additional help.

9.95 The internal review of events post Lisa's death led to the following recommendations from Midland Heart:

Recommendation 2

To increase awareness of domestic abuse for staff within the service, including ensuring training with partners such as women's aid, and the Dudley safeguarding team.

Staff are also required to re-read the safeguarding and domestic abuse guidance (June 2024) and sign to show this is completed.

Recommendation 3

Further training to be conducted with staff to ensure understanding roles and responsibilities within case management, escalation to senior managers for case support and the importance of clear and accurate record keeping with clear and appropriate rationale for actions taken.

9.96 With regard to Adam, on the two occasions he presented to the mental health team in crisis, he potentially highlighted aspects of perpetrator behaviour, including paranoia, admitting to not trusting his partner, watching door camera footage and believing his

partner had deleted footage, trust issues, potential Post Traumatic Stress Disorder and misuse of alcohol and drugs which could enhance and amplify these issues.

9.97 Whilst it accepted that without the context of specific examples of domestic abuse being highlighted, that consideration to referring Adam to intervention programmes is an unlikely scenario, but discussion was held with the panel as to whether this could be considered going forward. It was considered that the focus of these assessments is to seek to help the individual out of crisis, and that the onward referral is likely not appropriate in the circumstances. The concern was that it could lead to harm for the individual and/or staff if the signs are misinterpreted. Significantly more training would be required, without any guarantee of ensuring an accurate interpretation of what is or is not perpetrator behaviour.

Consider whether Lisa's interaction with services from 2022 onwards highlighted increased vulnerability and whether this presented opportunities for intervention/safeguarding, and whether any action taken was timely and robust.

9.98 From all the information available to the review, it is clear that Lisa was a vulnerable individual prior to 2022, having been on prescribed medication for anxiety and depression for some time. It is also recorded that the death of Lisa's mother in 2020 had a profound effect on her. However, from 2022 onwards, Lisa's interactions with services increased exponentially and is perhaps indicative of an increase in her vulnerability.

9.99 Lisa's interactions with her GP in late 2022 indicate increased concern and vulnerability. Lisa's GP made a referral to the Mental Health Assessment team (MHAS) over concerns that Lisa was potentially overusing her medication and had a possible addiction. It is noted that Lisa was taking a higher dose of medicine than she was prescribed. Lisa had already been placed on a weekly prescription programme due to previous concerns regarding her use of prescription medicine.

9.100 Previously in 2017, Lisa had been referred to substance misuse services due to a potential addiction to her prescription medication, and potentially this latest instance of Lisa overusing her medication provided another opportunity to seek to refer Lisa for more support. From the information provided it is unclear why that did not occur, notwithstanding the GP did refer Lisa to the MHAS for this issue.

9.101 With regard to Child 1, Lisa had been involved with Children's Services intermittently over a number of years. Concerns had been raised regarding her parenting style, and Child 1's attendance at school.

9.102 In March 2023, following a domestic incident between Lisa, Child 1 and Sister 1, Child 1 made a disclosure of emotional and physical abuse by Lisa towards them over a long period of time. Child 1 stated they did not feel safe in Lisa's care.

9.103 This incident also highlighted that Lisa and Child 1 had been evicted from their home and had moved in with Sister 1. Both Child 1 and Sister 1 indicated that Lisa was not coping well and was abusing substances. Sister 1 indicated that Lisa had been evicted due to her dependence on drugs and alcohol. This is something Lisa denied.

9.104 Police attending the incident and a later incident the same day noted that Lisa appeared erratic in her behaviour, and that she had sleepy or droopy eyes which she frequently closed for short periods of time when speaking or listening to the officers.

9.105 Following this incident a safeguarding plan for Child 1 was put in place, following a family agreement that Child 1 could stay with sister 1. From this point on Lisa's voice in regard to Child 1's welfare became less prominent.

9.106 Children's Services acknowledge that between March 2023 and February 2024 Lisa's levels of anxiety increased, due to the fact she did not have contact with Child 1 or have Child 1 in her care. It is clear that Lisa was seeking to do everything in her power to get Child 1 back into her care.

9.107 Children's Services also acknowledge that it is recorded that Lisa was nervous about any services or agency involvement, but no narrative as to why. This shows a lack of understanding of Lisa's Romani (Gypsy) background, where there is an inherent mistrust of services and agencies. Not only that, one of the biggest fears within the Romani (Gypsy) community is having a child taken away by social services, as this would indicate the individual was a bad parent.

9.108 Therefore, whilst the safeguarding of Child 1 was the overriding factor in Children's Services considerations, these actions would also have had a potentially very damaging effect on Lisa, especially perceptions of her being a bad mother, which within the Romani (Gypsy) community can be a source of shame and lead to being shunned within the community. This would have added significantly to Lisa's vulnerability and anxiety.

Recommendation 4

To ensure that the views of all individuals are gained as part of an assessment and clearly recorded. Where individuals may not be engaging, to consider the different approaches to encouraging engagement.

9.109 Another factor that potentially added to Lisa's vulnerability was the fact that she had become homeless.

9.110 In order to try and get to a position whereby Lisa could get Child 1 back into her care, she needed to be in independent accommodation. This meant engaging with Housing services.

9.111 Lisa was referred to Midland Heart and was placed in a mixed gendered housing facility. Whilst this is in line with the policies and procedures, it would have potentially had a detrimental effect on Lisa in a number of ways.

9.112 The first being that homelessness, and then having to go into supported housing, would be seen as shameful within Lisa's community. It is likely this is the reason that Lisa did not want any of her family to know that she was in the facility. In the engagement with the family, they state that if they knew where Lisa was staying, they would have come and removed her from the facility.

9.113 The second major consideration, is that being in a mixed gender accommodation would be considered taboo, as females from the Romani (Gypsy) community are not allowed to be in the proximity of a man she is not married to or is not from her family. This therefore would have increased Lisa's anxiety and potential feelings of shame.

9.114 This means that by the time Lisa moved into the housing facility she would have been highly anxious and vulnerable, albeit Lisa provided an initial outward appearance of being independent.

9.115 If these cultural issues were known or acknowledged there may have been a different approach, with at the very least all female accommodation being a strong consideration.

9.116 Within the housing facility, it is noted that Lisa was initially highly motivated to find a property, but from March onwards there was a step change in her behaviour, where the following was noted:

- Changes in mood during support sessions.
- Altercations with other residents.
- Causing disruption, nuisance, and anti-social behaviour.
- Falling into rent arrears.
- Appearing under the influence on a number of occasions.

9.117 However, when looking at the information more closely, it can be seen that Lisa started to highlight issues regarding being uncomfortable with other residents, concerns regarding drug taking within the facility, and potentially being financially exploited from as early as January 2024. This financial exploitation impacted on Lisa's ability to pay rent, and therefore have impacted her ability to move out of the accommodation to somewhere where she may have been safer. Some of this change in mood coincided with Lisa's perception that, as Child 1 did not want to speak with Lisa, that she was only being offered a 1-bedroom property.

9.118 Lisa's disclosure of sexual assault, physical assault, and financial exploitation in April 2024, represents a key moment when an appropriate intervention/safeguarding should have occurred. The support worker offered to support Lisa in reporting it to the Police, however Lisa did not want to do this.

9.119 As per Paragraphs 9.86 and 9.87 this incident was not raised as a safeguarding incident. Senior managers were not informed about the potential risks to Lisa, but also potentially to other residents. The record keeping was poor, and case notes were not updated as they should have been. Lisa was told following her disclosure that support workers "do not get involved personal issues" and then the conversation was concluded with a reminder that Lisa was in rent arrears.

9.120 Clarification has been sought regarding the comment about not being involved in personal affairs. The support worker has clarified that their reference to "personal issues" was not intended to dismiss the seriousness of the disclosure, but rather to acknowledge the limitations of the professional scope of their role. However, this comment would have potentially had a very damaging impact on Lisa and her perception

of being believed. To finish the conversation by speaking about rent arrears would have had a similar effect.

9.121 This is a significant moment where an intervention and safeguarding should have been implemented. Beyond the Police, there were other avenues to be explored, not least safeguarding within the facility. This represents a missed opportunity.

9.122 There was no perceived urgency to speak with Adam, the alleged perpetrator, whose records indicate that he was generally evasive in engaging with support workers. The delay in speaking with Adam would potentially reinforce and confirm to Lisa that she had not been believed, possibly due to her cultural background. Lisa's behaviour became angry and more resentful, and the fact that she was dealt with promptly for banging on Adams' door, would potentially reinforce a sense of injustice and the view she had not been taken seriously.

9.123 Early May represents another key point where an intervention/safeguarding could have occurred. Following the incidents of anti-social behaviour from Lisa towards Adam, Lisa's disclosure from April becomes known to senior managers and a referral is made to Police.

9.124 Crucially the referral does not make mention of the sexual assault, on the basis that Lisa had indicated she did not want to make a complaint to Police when she made the initial disclosure.

9.125 Due to not being able to contact the referrer of the report and difficulty in getting Lisa to be available to meet the officers, it meant that the information provided to officers left them with a view that Lisa and Adam had not been in a relationship and that this was a civil dispute between two residents, and not a potential domestic abuse incident.

9.126 Had officers known more about the full disclosure it could have led to a different approach. Whilst it is unlikely that Lisa would have supported a prosecution, it may have led to a more coordinated multi-agency approach to intervene and support Lisa. Again, this is a missed opportunity.

9.127 Officers did make representations to staff that Lisa should be safeguarded, but beyond cancelling and re-ordering her bank card and changing her PIN number, it is not articulated what these safeguarding considerations were.

9.128 In early May, there is the potential that staff missed Lisa starting to signal a potential suicidal ideation. On two occasions Lisa approached the reception desk following the death of a resident and stated that a) she did not cope with death well and b) that she had bought 6 red pills from the resident. This may have been a cry for help, but given the working environment within the housing facility it is easy to understand that the significance of these interactions would not have been noticed.

9.129 In and around mid-May, Lisa reaffirms the disclosure she made in April. Lisa's behaviour by this time has deteriorated significantly, whereby Lisa seemed to be struggling to cope. On this occasion the Police were called, and a Multi-agency safeguarding referral was made. Domestic abuse is considered and within the safeguarding referral consideration for services such as Women's Aid are articulated. This represents what the response should have initially been in April.

9.130 Whilst it was appropriate that the referrals were made, the timings of them created an issue. The referral to MASH was sent on Friday evening outside of normal office hours. Therefore, the referral is only received and reviewed by the MASH team on the Monday. By the time it was actioned, Lisa had passed away.

9.131 The online referral to MASH does have an automated out-of-hour response, which directs urgent referrals to the emergency duty team (EDT), who are on call over the weekend. This team were not contacted. It is not clear how this referral would have been prioritised in relation to other referrals received by the EDT over the weekend, but it is likely that there would have been some attempt to contact Lisa. Whether this would have diverted Lisa from taking her life cannot be ascertained, but it could be a potentially missed opportunity.

9.132 Police attended the housing facility on the Saturday in mid-May, and Lisa was clear that she did not want to support any formal action against Adam. Lisa denied the rape allegation, but did acknowledge she had previously been assaulted by Adam. With Police unable to meet evidential thresholds as a result, the referral was recorded as a common assault, and officers made a safeguarding suggestion for Lisa and Adam to be moved apart.

9.133 The support worker did not act on this advice; however, a review has indicated that there were no spare apartments within the facility, so the suggestion would have been difficult to achieve. It is unclear, if, given Lisa's emotional state at this time, if this action would have had any effect. It potentially should have been considered as far back as April, when Lisa first disclosed the sexual and physical assault.

Recommendation 5

Agencies must reform their policies and systems to embed rigorous risk assessments for all vulnerable individuals, ensuring placement decisions—especially in mixed accommodation—actively prevent exploitation. Equally, robust protocols for relocating residents whose behaviour poses a significant threat are essential to safeguard and protect all residents, driving meaningful change across the accommodation system.

9.134 Records indicate that Lisa was not seen at all on the Sunday, and no welfare checks were conducted. The housing facility has a "3 day not seen" procedure regarding the welfare of residents, and whilst a welfare check on the Sunday would have been outside of this procedure, given Lisa's emotional state it would not have been unreasonable to have considered doing so, if staffing or other incidents allowed.

Consider Lisa's use of drugs (prescribed or otherwise) and alcohol, the causes and concerns related to their use and whether effective intervention or management strategies were considered and utilised for Lisa.

9.135 In terms of prescribed medication, Lisa had a long history of anxiety and depression and had been prescribed anti-depressants to help manage the condition.

9.136 Lisa also had a Musculo-skeletal condition and was prescribed Codeine and Zopiclone to help manage the pain and allow Lisa to sleep.

9.137 Between 2017 and 2018 there were concerns regarding Lisa having developed an addiction to Codeine. It was noted by the GP that Lisa did not understand the logic of addiction, and in order to try to manage the situation Lisa was placed on a weekly prescription routine. This would help prevent the number of pills Lisa could have at any time.

9.138 In 2018 Lisa was referred to a substance misuse service, and records show that Lisa found the input from the service useful. However, there is no communication from the service regarding a treatment plan for Lisa.

9.139 In 2022 Lisa was referred to the MHAS over concerns about her use of prescription medication. An appointment was made for Lisa to attend the MHAS service in January 2023. Lisa did not attend the appointment and was discharged back to the care of her GP.

9.140 Outside of the medical notes, there is evidence to suggest that on occasions Lisa was either under the influence of drugs or alcohol.

9.141 Police on attendance at an incident on 11th March, where Lisa had been assaulted, record that Lisa did appear to be under the influence of either drink or drugs. The altercation that had led to Lisa being was assaulted was reported to have been because someone had challenged Lisa about taking drugs.

9.142 Sister 1, who Lisa had been living with following her eviction, indicated to Police that Lisa had been evicted due to issues with alcohol and drugs, something Lisa disputed.

9.143 Also On 11th March Child 1 disclosed that they had been the victim of emotional and physical abuse from Lisa. Child 1 indicated that Lisa's mental health had declined. In response Children's Social Care had undertaken agency checks and established that Lisa was known to Mental health services between November 2020 and January 2023.

9.144 Children's Services acknowledge that consideration should have been given to whether an Adult safeguarding referral should have been made, given the concerns raised about Lisa at this time.

9.145 Within the housing facility Lisa admitted to support workers that she and Adam had taken Cocaine.

9.146 Also, as 2024 progresses, there are occasions whereby Lisa was reported to be under the influence by support workers. However, on the information provided, other than Lisa's admissions, it is only on two days on the lead up to her death in May when it is specifically recorded that Lisa appears intoxicated, or under the influence of drugs or alcohol. Indeed, a risk assessment and support plan review completed with Lisa at the end of April 2024, confirmed that Lisa did not identify as having any needs around substances or alcohol use.

9.147 Yet, despite this on each occasion referrals were made to the Police on Lisa's behalf, it is recorded that Lisa was a drug user, that Lisa had taken drugs with Adam and was often under the influence of drugs.

9.148 On the occasions Police officers spoke with Lisa within the facility, they do not record that Lisa appeared to be under the influence of alcohol or drugs. When attending the report of sudden death regarding Lisa, housing facility staff informed Police that Lisa was known to take Class A drugs, however officers noted no signs of illegal drug use.

9.149 The information regarding Lisa being under the influence when making the disclosure was also communicated in the adult safeguarding referral in order to provide some cogent background to assist those triaging the information.

9.150 Given the information provided to them, WMP acknowledge consideration could have been given to seeking to refer Lisa to substance misuse services.

9.151 Staff within the housing facility did signpost Lisa to external services relating to support for her mental health, including the Crisis Team, the Samaritans, Cruse Bereavement Support, and Aspire mental health support services, but on each occasion, Lisa declined, citing the complexities of her cultural background as the reason for doing so.

9.152 Consultation with the Traveller Movement indicate that it is highly unlikely that Lisa would ever engage with these services. Within the community there is a significant distrust of these services, and the confidentiality of the information provided. It is felt that any information provided would be shared and used against individuals from the community to justify, for example, taking Romani (Gypsy) children into care.

9.153 One avenue that could/should have been considered by any of the agencies that were involved with Lisa, was to engage with Lisa's priest/pastor, or a Roman Catholic priest/pastor. Religion is an extremely important part of Romani (Gypsy) background and culture, and colloquially it is reported that religion will have a greater effect in diverting a person from a Romani (Gypsy) background away from substance misuse, than any of the traditional services provided.

Recommendation 6

For individuals from a Romani (Gypsy) background, consider the use of a Roman Catholic priest or pastor as an avenue to help individuals deal with substance misuse, over and above traditional services, due to the importance of religion within the community.

Understand if Lisa had a learning issue or disability and whether this impacted subsequent interactions with Lisa. The review will consider the use of language, diagnosis and understanding when dealing with any potential issues.

9.154 Information obtained from Family members indicate that Lisa was scheduled to attend what they describe as a "special school" as a young child. This was not considered acceptable by Lisa's parents, who did not allow her to attend. They then undertook to home school Lisa, teaching her how to read and write.

9.155 It is therefore unlikely that Lisa would have spent much time, if any, within formal state education.

9.156 Notes from the Healthcare trust indicate that the practice had not referred Lisa to the Learning Disability Service as there is no evidence in the records to suggest that Lisa had a Learning disability (e.g. no global development delay, did not attend a special school or no Education Health or Care Plan).

9.157 Healthcare trust records indicate three occasions when clinicians identified the possibility of a mild learning difficulty. These were in 2012, 2017 and 2022.

9.158 In 2017 Lisa was referred to the primary mental health practitioner, but declined to attend the appointments. This referral was centred more on Lisa's mood and anxiety and the potential addiction to prescribed drugs.

9.159 In 2022 Lisa was further referred to MHAS, again predominently regarding medication overuse and possible addiction. This referral did also reference Lisa potentially having a mild learning difficulty.

9.160 Lisa did not attend the MHAS assessment and was referred back to the care of her GP. Therefore any potential learning difficulty that Lisa may or may not have had remained undiagnosed.

9.161 The Clinicians within the Doctors surgery, having identified that Lisa may have had a learning difficulty, ensured that reasonable adjustments were in place, such as ensuring extra time given during the consultations, consultations taking place face to face, rather than via phone and regular follow ups were arranged

9.162 Children's Social Care recorded that there had been an assumption made by Child 1's school on 5th October 2018, that alluded to Lisa having had some learning needs in response to the behaviours that she displayed, which were described as being 'chaotic'. However, nothing else is recorded as a concern in interactions with Lisa, and therefore would not have impacted how staff engaged with Lisa.

9.163 The housing facility internal review indicates that there were no learning issues or disability identified throughout risk and needs assessments undertaken with Lisa. Similarly, the review of interactions with Lisa did not indicate any learning issues. However, it was noted that Lisa's communication style could be characterised as simplistic, which potentially may have been because of incomplete schooling.

9.164 Lisa was, however, able to progress housing applications and seemingly understand what was required of her.

9.165 When Police attended the housing facility in mid-May, in response to the referral regarding Lisa being sexually, physically, and financially abused, they were informed by the support worker that Lisa had the mental age of a 13-year-old, although there was no formal diagnosis.

9.166 The housing facilities internal review has been able to clarify with the support worker, that this assessment of Lisa's mental age was based on their professional observations during the interactions they had, and was not derived from any formal evaluation, or direct discussion with Lisa regarding her cognitive abilities or learning challenges. It is apparent that the support worker in making this assessment, did not question or raise with managers whether it was suitable for Lisa to be within a facility designed to support independence, or that this was a factor that would make Lisa's vulnerable, especially in regard to interactions with other residents.

9.167 This information had the effect of changing the way officers dealt with part of the incident. As a result, officers did not complete the DARA based on the potential mental capacity of Lisa. Irrespective of this information, officers should have completed the DARA through the use of age-appropriate questions, if required.

9.168 It is also noted that officers did not indicate within their reports, following the interaction with Lisa, that there were any difficulties in communication, any concerns with her understanding or how she presented. Earlier reports, where officers spoke to Lisa, following the altercation at her sisters, made no mention of any learning difficulties or barriers to communication.

9.169 Whilst it is accepted that most of the individuals within this review that had interactions with Lisa are not medical professionals, it would have been helpful for them to describe in reports how Lisa interacted with them, including if there were no issues in communicating with Lisa.

Consider how services engage with individuals and whether differing backgrounds, lived experiences and potential bias may have impacted interactions between Lisa and relevant services. In considering this, factors such as professional curiosity, proactivity of engaging families from differing backgrounds, motivational interviewing and whether service provision is based on individual needs or is process driven are to be explored.

9.170 As already described, Lisa's heritage is Romani (Gypsy), which means that Lisa's socialisation would have been within a community rich in culture and tradition. Much of this tradition and culture is not integrated with mainstream society.

9.171 People of Romani (Gypsy) heritage are not keen to mix outside of their community, which can lead to a lack of mainstream cultural competency and be exhibited in confusion in some social settings.

9.172 Some of the cultural norms within Lisa's community will mean that there will be barriers to accessing support, and it can be seen from several interactions with services, that Lisa does not engage with onward referrals or offers to access support. In some cases, Lisa specifically cites her heritage as a reason why she would not accept the support.

9.173 One of the biggest barriers to accessing support is a misunderstanding that the information provided is confidential. The perception within the community is that any information can be used and twisted in a negative way by agencies. In particular, it is feared that the information could be fed back to Social Services and used to take children away and into care.

9.174 It is apparent that in the most part, the services that interacted with Lisa followed their policies and procedures, and where they identified that Lisa may need support, offered routes to access that support. When Lisa did not attend referrals or declined the support, there was no follow up to understand why, and whether there was a different avenue to access support.

9.175 Children's Services note within their records that Lisa was nervous regarding accessing services and states:

It was documented that Lisa was very nervous about any services involvement however there does not appear to be any detailed recorded information from Adult Care Services, Adult Mental Health, Substance Misuse Team, Housing or Police in regard to why this was, what had happened and how this could be resolved.

9.176 There does not appear to be a recognition within this statement that exploration of Lisa's culture and heritage may provide part of the answer and a potential avenue to seek resolutions.

9.177 The interactions also had the inadvertent effect of increasing Lisa's vulnerability, and the standardised responses would also inhibit any potential safeguarding in the following ways:

- The safeguarding plan agreed in relation to Child 1 in effect meant that Lisa did not have her child in her care. It is likely that this meant within Lisa's community she was not seen as a good mother, which could illicit feelings of shame. It could also mean a community turning against Lisa.

- In relation to children from the community, often they can be bullied at school. Therefore, parents will, in an effort to stop them from being bullied, buy children lavish gifts. This was a basis of a referral from the school to Children's services in relation to Lisa and Child 1, with Lisa's parenting style being questioned.

- There is a strong desire to be seen to be doing well and essentially keeping up with the "Joneses" within the community. If children are not in expensive designer clothing, then it is perceived within the community that they are being mistreated.

- This means often appearances are prioritised over bills, with designer clothes etc being bought at the expense of food and other household commitments. It can be seen that often Lisa would spend money on other "things" rather than her rent within the housing facility. Family members also report that at this time they noticed that Lisa was spending more money on her appearance, including expensive clothes and haircuts.

- Being homeless could be seen as shameful. Lisa's interaction with housing services and then being placed in a housing facility could also be seen as shameful.

- Lisa being placed in a mixed gender facility would be considered taboo, as Romani (Gypsy) females are not allowed to be in the proximity of a man she is not married to, or part of the family. Also, a married female from this community is not allowed to be friends with another man. This is heavily policed within the community. Therefore, being placed in a mixed gender facility could lead to feelings of shame for Lisa

- Mental Health issues are a taboo subject, and there is a lack of understanding regarding mental health within the community. Often addiction and mental health come hand in hand, therefore potentially Lisa would have grown up with a normalised view of mental health and not speaking about it. As such Lisa wouldn't necessarily recognise mental health as an issue, albeit it can be seen that in interactions with her GP there were occasions when Lisa was very open regarding her mental health.

- There is huge mistrust of the police, and individuals from a Romani (Gypsy) background would **never** go to the Police to sort out issues and make a formal complaint. It is often seen as putting them in harm's way. Any reporting to the Police would be seen as "grassing up" and could lead to being ostracised from the community. Therefore, encouraging Lisa to report her disclosures to the Police was never going to be something that Lisa did, and so not a proceedable way to safeguard and protect her.

- Sex outside of marriage for Romani (Gypsy) female is not acceptable, therefore there is the potential that Lisa would have blamed herself for the rape. In terms of rape, often the community assumption is that the woman is making it up to cover up the shame of sleeping with another man. The perception will be "she has been up to no good with him" and shouldn't have put herself in that situation!

- Therefore, it would have been a massive undertaking for a Lisa to make an allegation of rape, and Lisa probably would never have made the disclosure without being under the influence of either alcohol or drugs due to the factors described above. Once she had sobered up, again because of the above factors, Lisa would deny the disclosure, which is what happened prior to her death in May.

9.178 By not recognising or being aware of all, or some of the above, the agencies involved with Lisa demonstrated cultural ignorance and continued with a one size fits all approach to the issues, concerns and problems that presented themselves in Lisa and Child 1's life.

9.179 It has been suggested that one way that could have helped to alleviate this, was that in recognising Lisa's background and heritage, agencies could have considered the use/support of an advocate from the community. This advocate would be able to help, in this case Lisa, but also the agencies, navigate, understand, and maneuver through the care/support system and provide advice on suitable support and safeguarding avenues. This individual would have been able to help explain processes, procedures, and

confidentiality to Lisa, which could have led to better engagement. Often these advocates are members from the community, or can be priests/pastors (see **recommendation 5**)

Recommendation 7

For individuals from a diverse background, consider the use of advocates from that community, to help overcome cultural ignorance and ensure suitable support to help individuals and agencies navigate, understand and maneuver through the care/support system and provide advice on suitable support and safeguarding avenues.

9.180 In the IMRs received from the nominated agencies, in the most part all accept that there were potential opportunities to show more professional curiosity to help understand backgrounds, illicit more information and understand potential barriers and opportunities to provide a tailored response.

9.181 It is also accepted that the working environments for many of these professionals, particularly in relation to workload and competing demands, make professional curiosity a challenging thing to pursue. In many cases it is also conditional on the individuals they deal with being willing to engage and share information. It can be seen that it is unlikely that Lisa would have wanted to share too much information with professionals due to her socialisation.

9.182 However, it is important that professionals do seek to display professional curiosity to try and ensure tailored and suitable outcomes. Otherwise, as can be seen within these circumstances' services ending up treating the symptoms with a one size fits all approach, and not necessarily treating the causes. In doing so, they can also inadvertently add to an individual's vulnerability.

Recommendation 8

Practitioners need to display professional curiosity when working with individuals and families, to ensure that the views of all individuals are gained as part of an assessment and clearly recorded.

9.183 In relation to the potential of unconscious or conscious bias being a factor in the interactions with Lisa, all agencies that responded feel that this was not a factor relating to their staff.

9.184 However, from the chronology supplied by the agencies, there do appear to be incidents where Lisa was potentially treated in a less equitable manner.

9.185 One of the key dates is in April when Lisa made her initial disclosure of sexual and physical assault and financial exploitation. As reported in paragraphs 9.86, 9.87, 9.119 and 9.120, the incident was not raised as a safeguarding concern. The incident was not recorded correctly, senior managers were not alerted to the risk, and internal

safeguarding was not considered. Once Lisa had indicated that she did not want Police involvement, there was no further exploration of how to support her.

9.186 Within the conversation Lisa was told that support workers do not “get involved in residents personal affairs” and the conversation was concluded by reminding Lisa she was in rent arrears.

9.187 It is accepted that the comment re “personal affairs” has been clarified as the support worker acknowledging the limitations of the professional scope of their role and not seeking to diminish the seriousness of Lisa’s disclosure, however, it is probably the exact effect it would have had in Lisa’s eyes.

9.188 Lisa’s behaviour after this point deteriorates, and Lisa becomes angry and resentful and seeks to get her money back from Adam. This translates to behaviour that is regarded as anti-social.

9.189 Whilst it takes almost a month to speak to Adam regarding Lisa’s serious disclosures regarding him, Lisa’s anti-social behaviour is addressed almost immediately following Adam making complaints. There is no evidence that shows that consideration was given as to whether Adam posed a significant risk to other vulnerable females within the facility and whether steps to safeguard them needed to be considered.

9.190 When Police are called in early May, following senior managers becoming aware of Lisa’s disclosure, the information provided by support workers to Police is not entirely accurate and potentially undermines Lisa as a complainant and witness. The support workers state that Lisa was homeless and a drug user, and that there was no relationship between Lisa and Adam. This information is in part why officers do not consider the incident as a domestic incident.

9.191 Whilst it is accepted Lisa could have sought to correct the information with officers, it is unlikely that she would want to, given that Lisa would not seek to involve Police, and so would not do anything to prolong the meeting with them.

9.192 When Police were informed of Lisa’s reaffirmation of the disclosure of sexual and physical assault and financial exploitation, the support workers inform Police officers attending that Lisa is known for drug and alcohol misuse and that she had a mental age of a 13-year-old. Again, this information would have the effect of undermining Lisa as a complainant and witness, and it meant that officers did not complete the DARA risk assessment as they should have.

9.193 Lisa had also informed support workers regarding her fear of reprisals from residents if she spoke to Police. These concerns were not conveyed to Police officers.

9.194 When officers attended following the report of Lisa being unresponsive towards the end of May, support workers informed them that Lisa was known for being a class A drug user. Officers noted that there is no sign of any class A drug misuse in Lisa’s room.

9.195 Other than Lisa’s own admissions of taking Cocaine with Adam on two occasions, and it being observed that Lisa appeared intoxicated, or under the influence of drugs or alcohol in two separate days preceding her passing in May, there are no other instances recorded where Lisa had taken drugs or alcohol. Lisa’s last risk assessment at the end

of April indicated no issues with alcohol or substance misuse, which is odds with the information provided to Police.

9.196 By contrast, Adam made several complaints about Lisa's behaviour towards him. He presented himself as the victim and on each occasion, each complaint appears to be dealt with more sympathetically and promptly than those made by Lisa. Even when presenting the letters to his support worker in late May, which Lisa had sent him relating to the money he had taken from Lisa, Adam was encouraged to liaise with Police regarding the matter. This was in and around the time Lisa had disclosed that Adam had raped her and punched her to the face.

9.197 It does therefore appear that some sort of negative bias may have been present regarding Lisa, and in part it may be due to Adam seeking to manipulate staff within the housing facility by presenting Lisa in a certain i.e. antisocial, aggressive etc.

Information sharing between agencies relating to Lisa.

9.198 It is clear from the information supplied, that the agencies that came into contact with Lisa, all held information that would give indications of the stressors in her life, an insight into her vulnerability at various points in her life, and perhaps information that would show a step change in her need for support.

9.199 In the most part, the majority of this information remained with the agency where it originated. It is only when agencies have needed to, have they shared relevant information.

9.200 This can be seen in instances where welfare was a concern, for example adult MASH sharing information with Police to locate Lisa when she required an urgent blood transfusion.

9.201 Similarly, where there have been concerns regarding Child 1, agencies such as Education, WMAS and Police have made relevant referrals to Children's Services either through the use of CYPA or MARF processes.

9.202 It is clear that before 2022 Lisa's life seemed to be mostly in control, but the death of her mother in 2020 seemed to lead to increased vulnerability and Lisa being less well equipped to cope.

9.203 The events of early April 2024 when Lisa made her initial disclosure of sexual and physical assault and financial exploitation against Adam, represents a significant missed opportunity to safeguard and support Lisa. This disclosure should have resulted in an adult safeguarding referral if policies and procedures had been correctly followed. Given Lisa's history to that point, and her increased vulnerability, consideration could then have been given to holding a Multi-agency strategy meeting.

9.204 From 2022 Lisa's engagement with services increased exponentially. A number of the services have reflected on the events and have raised the question, whether, given that Lisa was a vulnerable adult having a footprint across many agencies, that consideration should have been given to holding a Multi-agency strategy meeting earlier. This meeting could have assessed the increased vulnerability, and notable change in

circumstances regarding Lisa. This in turn could have led to a more coordinated approach to supporting Lisa and Child 1.

9.205 Other than the point above, the information sharing appears to have been appropriate and proportionate.

Other issues arising

9.206 One of the issues that seems to be relevant to a death related to domestic abuse where victim has not died due to homicide, is in relation to the perpetrator.

9.207 In a more traditional Domestic Homicide type incident, invariably the perpetrator is arrested and faces a criminal justice outcome. Therefore, they have the potential to have interventions to address issues such as mental health and their perpetrator behaviour as part of their rehabilitation.

9.208 In some deaths, and in this particular scenario, the relationship between the victim and perpetrator are short term and intense, and by the time the victim makes the decision to end their life, the perpetrator has moved on. Often there is not enough corroborating evidence to ensure a criminal justice resolution. This means the perpetrator is free to move onto another relationship and continue the cycle of abuse.

9.209 In this case, Adam left the housing facility the day after Lisa's death to move into private rented accommodation. Whilst there was some evidence of him committing sexual and physical violence, Lisa did not make a formal complaint. Due to the time elapsed from when the sexual assault occurred there was little or no prospect of corroborative evidence, meaning a criminal justice outcome in relation to Adam was not viable.

9.210 Aside from Lisa's disclosures naming Adam as the person who committed sexual and physical violence towards her, there are other indications of Adam displaying perpetrator behaviour.

9.211 In conversations with Mental health professionals, when he presented in mental health crisis, Adam describes having trust issues a result of his mother lying and cheating throughout his childhood. Adam speaks about his previous relationship breaking down, and although with no definitive information as to why, Adam also highlights controlling behaviours and paranoia. Adam describes issues in his previous relationship and reported a lack of trust and having paranoid thoughts regarding his partner, where he stated he studied the door camera footage and was convinced his partner had deleted footage from it.

9.212 Adam describes himself as having paranoid schizophrenia and PTSD from his time in the Armed Forces and having a history of drug and alcohol misuse.

9.213 In the housing facility Adam displayed gaslighting behaviour in regard to Lisa, as well as financial control regarding the £2000 he took from her. In regard to staff at the facility Adam showed potential behaviours such as collusion with staff, and manipulation of staff by presenting himself as a victim of Lisa's "antisocial" behaviour.

9.214 Adam seemingly moved on very quickly from Lisa and appeared to be forming a relationship with a female with whom he was working. This female made a Domestic Violence Disclosure scheme request, as she was concerned regarding Adam suffering from paranoid schizophrenia.

9.215 Whilst it is accepted that Adam seemingly has trauma within his background, the concern for the panel was that he could potentially repeat the behaviours displayed towards Lisa, with another female.

9.216 The question was raised as to how Adam could lawfully and with full regard to his human rights, be legitmately diverted from further perpertrator behaviour, and how any future female partners could be safeguarded from domestic abuse. It was felt that this is a wider consideration than the CSP, and is something for the Home office to provide guidance on.

Recommendation 9

The Home Office to provide guidance to Community Safety Partnerships (CSPs) on lawful and ECHR-compliant methods for managing perpetrators of domestic abuse who cannot be addressed through criminal justice outcomes, with funding to enable delivery of this work attached. These guidelines should aim to encourage diversion interventions to address perpetrator behaviour and prevent the recurrence of domestic abuse.

10 Conclusions

10.1 Lisa had a long history of anxiety and depression (predating the agreed timeline for the review) and was prescribed medication to manage this. Lisa also suffered from Osteoarthritis for which she was prescribed Codeine.

10.2 On a number of occasions there were concerns regarding Lisa’s compliance in the use of her prescribed medicine. Lisa had previously overused the medication and had expressed concerns/fears of becoming addicted to them.

10.3 Due to these concerns Lisa was put onto a weekly prescription by the GP to manage fears over abuse of prescription drugs. Lisa was appropriately referred to a substance misuse programme in 2018, which she reportedly found useful and the MHAS in 2022. Lisa did not attend the MHAS appointment.

10.4 The passing of Lisa's mother in August 2020 significantly exacerbated her anxiety and depression. This information was communicated to several agencies with whom Lisa interacted. Of particular note, mid-May is a significant time in Lisa’s life as it coincides with the date of her mother’s birthday. Within the Romani (Gypsy) community, the customs surrounding death and mourning are taken very seriously. Visiting graves on special anniversaries to maintain them holds great cultural significance. Failure to

observe these traditions or follow the grieving processes can bring about feelings of shame and, in Lisa's case, may have increased her vulnerability.

10.5 From 2022 onwards Lisa appeared to be struggling to cope with everyday life. This included becoming homeless, her and her child moving in with her sister, the Domestic Abuse allegations relating to Lisa towards her Child, Lisa falling out with Sister 1, and Child 1 not wanting to stay with Lisa but with Sister 1 instead. Being homeless and not being able to look after her child would be a great source of shame within the Romani (Gipsy) culture. Therefore, having to allow Child 1 to stay with Sister 1 could be perceived that Lisa was a "bad mother". This would add to Lisa's anxiety and vulnerability.

10.6 History with Children's Social Services indicated potential domestic abuse or neglect from Lisa towards Child 1. Consequently, the agreed safeguarding plan was that Child 1 be cared for by Sister 1 in line with a family arrangement. It is acknowledged by Children's Social Care (CSC) that after this, Lisa was excluded from key discussions regarding Child 1's welfare. This significantly heightened Lisa's anxiety and vulnerability. As mentioned in paragraph 9.5 above, not being able to care for her child would be a source of shame within Lisa's cultural background. There is significant distrust of governmental services within Lisa's community, particularly regarding Social Services. The perception is that information provided can be misinterpreted and used against individuals, leading to children being removed and placed into care. Therefore, Romani Gypsies are generally reluctant to engage with agencies or provide information. For Lisa, effectively not having her child in her care would have been catastrophic, as she would be seen as a poor mother within her community and potentially faced ostracism.

10.7 It is clear that following the agreed safeguarding plan, Lisa had only one goal in mind which is to be in a position to have Child 1 returned to her care.

10.8 By the time Lisa was placed within the housing facility by Housing services, she was in a vulnerable state. The placement in mixed-gender accommodation was culturally inappropriate for a Romani (Gypsy) female. Additionally, being in sheltered accommodation was not considered acceptable within her culture. The appropriateness of having Lisa in a facility designed to support independence when there were concerns regarding her having a mental age of 13 meant that the experience of being within the facility would have increased Lisa's anxiety and vulnerability.

10.9 Upon arriving at the housing facility, Lisa aimed to secure her own accommodation so she and Child 1 could live together. Lisa chose not to disclose her location to her family due to the reasons mentioned in paragraph 9.8 above.

10.10 Lisa's initial behaviour at housing facility was considered good, however from January 2024 onwards Lisa started to state she was having issues with rent and money, telling support workers consistently money was being taken by other residents, which potentially highlighted her vulnerability.

10.11 It is evident that Lisa engaged in a brief but intense relationship with Adam while at the housing facility. Relationships with individuals outside of the Romani (Gypsy) community are not culturally accepted, which may have caused feelings of shame for Lisa. Consequently, her family, in particular, were unaware of this relationship.

10.12 From March 2024 onwards, it can be observed that Lisa's behaviour changed notably. Lisa exhibited signs of anger and resentment and engaged in antisocial behaviour within the facility, with most incidents directed towards Adam.

10.13 In April 2024, Lisa made an allegation of sexual assault, physical assault, and financial exploitation against Adam. The response to this disclosure was poor and outside of the policies and procedures of the housing facility. Lisa was advised to go to the Police. Lisa did not want Police involved, which is in line with her cultural background, whereby a Romani (Gypsy) person will never go to the Police for help due to significant mistrust of the Police within Lisa's community. Lisa was informed that "staff do not get involved in personal issues", which although clarified by the support worker as not intending to diminish the seriousness of the disclosure, it would have done just that.

10.14 There was an insufficient understanding of Lisa's cultural background in the suggestion to report the matter to the Police. No adult safeguarding referral was made to MASH, and no protective measures were established at the housing facility to support and safeguard Lisa. Additionally, there seems to have been a lack of professional curiosity regarding the relationship between Lisa and Adam. The disclosure was not adequately recorded nor escalated to senior management, indicating a significant missed opportunity.

10.15 Following Lisa's disclosure, it took a month to address the allegation with Adam, which was an excessive delay. It has been reported that there were ongoing issues concerning Adam's lack of engagement and limited attendance at the Service. It also suggests that no consideration was given to the possibility that Adam and his highly inappropriate behaviour posed a potential risk to other vulnerable females within the facility. Meanwhile, Lisa was reprimanded for anti-social behaviour, including banging on Adam's door, sending him letters, and falling behind on her rent.

10.16 The optics from Lisa's point of view would likely be that she was not believed or taken seriously, and that Adam was being treated more favourably than she was. This would have an impact on Lisa's ability to trust staff at housing facility and lead to more anxiety, anger, resentment and potentially reinforce cultural views that every authority figure was against her because of her background.

10.17 In early May, Lisa's disclosure made in April was reviewed by a senior manager and Police called, but only for the physical assault and financial exploitation and not the sexual assault, as Lisa had stated she did not want Police involved.

10.18 Information provided to the Police by support workers indicated that Lisa had a history of drug use and that she and Adam were not in a relationship. Therefore, the Police did not classify the incident as a domestic assault. When Lisa did not file any complaints, the incident is treated as a civil dispute. The attending officers record the incident as a Vulnerable Adult - Non-Crime due to Lisa's recognised vulnerability.

10.19 There appears to be a disconnect and lack of joining the dots between the information regarding Lisa reporting financial exploitation since January, the serious allegations in April, and the change in Lisa's behaviour. No safeguarding actions were

taken, and no adult safeguarding referral was made. This indicates a missed opportunity to support Lisa.

10.20 In May 2024 on the anniversary of Lisa's dead Mothers Birthday, Lisa repeated the allegation re sexual assault, physical assault and financial exploitation. Lisa had physical injuries and was potentially under the influence of drink or drugs. This time both Police are informed, and a MASH adult safeguarding referral was made, albeit it was sent outside of normal working hours and not followed up with the out of hours emergency duty team.

10.21 The Police did not attend until the Saturday having been informed on the Friday, which is acknowledged to be beyond West Midlands Police's key performance targets. Upon arrival, officers were informed by support workers that Lisa was frequently under the influence [of alcohol or drugs] and that she had an undiagnosed learning disability with the mental capacity of a 13-year-old. However, there is no record within the housing facility's documentation indicating that Lisa had a learning disability or a mental capacity equivalent to that of a 13-year-old. The information provided negatively impacted the officers' responses, resulting in a Domestic Abuse Risk Assessment (DARA) not being completed. Additionally, Lisa was insistent that she did not wish to file a complaint.

10.22, The Police officers recommended implementing safeguarding measures for Lisa, specifically relocating her being moved to a different room away from Adam. Despite the history of allegations, Lisa's vulnerability, her deteriorating demeanour, and her reported fear of reprisals, the support worker decided to wait until after the weekend. It is noted however, that at that time, there were no available apartments within the facility where Lisa could be moved to. The fact that Adam could also pose a risk to other vulnerable females in the facility was also not seemingly considered.

10.23 The events of mid- May represent another missed opportunity to properly support and safeguard Lisa.

10.24 On the Friday evening, the MASH referral was sent outside of normal working hours and was not followed up by the referrer to the emergency duty team in accordance with the automated e mail response. Had it been followed up, a response might well have been initiated over the weekend, enabling safeguarding professionals to contact Lisa in the days preceding her death. This could therefore represent another potential missed opportunity.

10.25 Adam's history and behaviour provide several indications of potential perpetrator behavioural traits. There is evidence of trauma within his background, and in conversations with medical professionals, Adam indicated he suffered from trust issues and paranoia, and displayed controlling behaviours by monitoring doorbell camera footage of his ex-partner. Adam appeared to be consistently in financial difficulty, potentially due to substance and alcohol misuse. He demonstrated gaslighting behaviour towards Lisa; when she expressed concern that he may be attempting to commit suicide, Adam informed the attending staff that he was merely sleeping. Adam also portrayed himself as a victim of Lisa's behaviour, but mainly complained to the night concierge about her conduct, suggesting attempts at collusion and potential manipulative behaviour towards staff at the housing facility. Additionally, a potential new

partner of Adam made a Domestic Violence Disclosure scheme request due to concerns related to Adam's paranoid schizophrenia.

10.26 When questioned about his relationships, Adam provided minimal detail. In light of the complaint made by Lisa, there was a noticeable lack of inquiry regarding Adam's description of being in a new relationship. Consequently, until a few weeks prior to Lisa's death, it remained unclear whether Adam and Lisa had been in a relationship, as asserted by Lisa. This ambiguity negatively impacted responses to Lisa's disclosures.

10.27 Cultural ignorance was a factor in increasing and adding to Lisa's vulnerability and anxiety. Whilst agencies acted in good faith and in the main part within their policies and procedures, Lisa's background and heritage do not seem to have been considered. Therefore, the impacts of things such as the safeguarding plan whereby it was agreed Child 1 would stay with Sister 1, or being placed in a housing facility in the first instance, and that the housing facility was mixed gendered, were not seemingly considered. Although it is clear that Lisa was referred to many support services, in response to some of the issues she had, it was not considered that due to her heritage and cultural norms that she would almost certainly never engage with these services.

10.28 Additionally, the failure to recognise that Lisa would not seek assistance from the Police for any criminal activities conducted against her, indicates that no consideration was given to alternative methods of providing support and protection to Lisa following her disclosures of sexual and physical assault.

10.29 The consideration of engaging a community advocate or a clergy member such as a priest or pastor was overlooked. Such support could have been beneficial in assisting Lisa to understand her situation and that of Child 1 within the care system, and it might have also aided in addressing potential substance misuse issues.

10.30 Due to a lack of cultural awareness, Lisa experienced systematic failures by the agencies she interacted with. This likely contributed to heightened anxiety and vulnerability, particularly in the final year of her life.

10.31 There is also evidence that Lisa suffered from treatment that was less equitable than that of Adam. When Lisa made the initial disclosure regarding sexual and physical assault, it was not recorded properly, nor was it escalated in line with policies and procedures. When Police did attend in response to Lisa's disclosures, they were provided information that Lisa was a known drug user, had a mental age of a 13 years old, and that there was no relationship between Lisa and Adam, all of which had the effect of negatively shaping the Police response.

10.32 On the other hand, in regard to Adam, it took a month to speak to him regarding these serious allegations. Yet, when Adam made complaints regarding Lisa's behaviour towards him, they were addressed with Lisa within days. When Adam produced letters sent by Lisa as evidence of him being harassed there was support offered for him to contact the Police. This is despite the fact the letters were in regard to the £2000 Adam had taken from Lisa, and his financial exploitation of her.

10.33 Whether this unequal treatment is as the result of a conscious or unconscious bias towards Lisa, or support workers just not dealing with the situation very well, or the fact

that Adam was seeking to manipulate staff into believing that he was the victim of erratic and irrational behaviour from Lisa, or a combination of some or all of these factors, is unclear. Whatever the reason, it is clear Lisa was treated in a less equal way, which would have resulted in increased vulnerability and potentially being trapped in a situation, from which Lisa felt there was no escape.

10.34 The working environments significantly influenced how agencies responded to Lisa. For instance, the Adult Safeguarding MASH team had approximately 40 referrals in addition to Lisa's referral in May. To effectively triage and prioritise risks, they rely heavily on the initial information provided. In relation to Children's Social Care, the primary concern was the safety and safeguarding of Child 1, with decisions regarding that taking precedence over other factors such as community or individual perceptions. Police officers responding to Lisa's referrals also faced pressures to attend to other incidents. In mid- May, officers were delayed in attending to Lisa due to other higher priority incidents. Their response was also partly dependent on the information available to them and the wishes of the complainant. Accommodation providers faced challenges due to the volume of residents (over 50) at the facility, many of whom have experienced chaotic or traumatic situations, leading to significant demands on support workers' time and emotional resources. Support workers are not trained counsellors but are there to assist adults with the capacity to transition to independent living, again relying on the information provided to them to perform their duties.

10.35 Given the competing demands and intricate histories of the individuals served by these services, then often Agencies end up addressing the symptoms rather than root causes. This is apparent in their responses to Lisa.

10.36 There was no obvious suicidal ideation shown by Lisa, which may have been down to her religious beliefs where suicide is considered blasphemous. However, it is possible that in early May, Lisa gave an inclination regarding her thoughts and vulnerability when telling support workers that she did not deal with death well. This was following the death of another resident. Lisa also indicated that she had obtained 6 red pills from the resident before they died. It is possible that these pills were Pregabalin, which was present in Lisa's system on her death. It is possible that this was a possible cry for help from Lisa.

10.37 It is clear that Lisa had a long history of anxiety and vulnerability. The death of Lisa's mother in 2020 significantly added to this, to the point that from 2022 onwards Lisa appeared to be struggling to cope with everyday life. This brought her evermore into contact with various services. These interactions, in part due to cultural ignorance of her background, added to her vulnerability and anxiety. Lisa then formed a short-term relationship with Adam, and from the information available it is clear that within this relationship Lisa suffered domestic abuse, including sexual and physical assaults.

10.38 Ultimately it would appear that all of these factors combined leading Lisa to making the tragic and sad choice to end her life. This review is of the opinion that domestic abuse was one of the factors in her decision. Through examining the circumstances, there are areas where Lisa was dealt with appropriately by services, but also areas where she was failed, with there being missed opportunities to safeguard and

support her. This review makes nine recommendations with a view to help learn lessons and improve responses going forward.

Appendix 1 Table of recommendations

No.	Recommendation.	Theme.	Agency.
1.	To reiterate current Policy and procedure whereby Police officers attending incidents that are considered to be a domestic abuse incident to complete a Domestic abuse Risk assessment (DARA) on every occasion. If the potential victim is a child or has potential learning difficulties or disability, the questions should be asked in an age-appropriate way. Ensuring the presence of an appropriate adult, or intermediary or advocate to be considered to help aid and facilitate communication and understanding where appropriate.	Engagement and professional curiosity.	WMP
2.	To increase awareness of domestic abuse for staff within the service, including ensuring training with partners such as women's aid, and the Dudley safeguarding team. Staff are also required to re-read the safeguarding and domestic abuse guidance (June 2024) and sign to show this is completed.	Identifying and referring domestic abuse/Training	MH
3.	Further training to be conducted with staff to ensure understanding roles and responsibilities within case management, escalation to senior managers for case support and the importance of clear and accurate record keeping with clear and appropriate rationale for actions taken.	Identifying and referring domestic abuse/Training	MH.
4.	To ensure that the views of all individuals are gained as part of an assessment and clearly recorded. Where individuals may not be engaging, to consider the different approaches to encouraging engagement.	Engagement and professional curiosity.	CSC
5.	Agencies must reform their policies and systems to embed rigorous risk assessments for all vulnerable individuals, ensuring placement decisions—especially in mixed accommodation—actively prevent exploitation. Equally, robust protocols for relocating residents whose behaviour poses a significant threat are essential to safeguard and protect all residents, driving meaningful change across the accommodation system.		MH, Housing services, accommodation providers
6.	For individuals from a Romani (Gypsy) background, consider the use of a Roman Catholic priest or pastor as an avenue to help individuals deal with substance misuse, over and above traditional services, due to the importance of religion within the community.	Cultural awareness	All
7.	For individuals from a diverse background, consider the use of advocates from that community, to help overcome	Cultural awareness	All

	cultural ignorance and ensure suitable support to help individuals and agencies navigate, understand and maneuver through the care/support system and provide advice on suitable support and safeguarding avenues.		
8.	Practitioners need to display professional curiosity when working with individuals and families, to ensure that the views of all individuals are gained as part of an assessment and clearly recorded.	Engagement and professional curiosity.	All
9.	The Home Office to provide guidance to Community Safety Partnerships (CSPs) on lawful and ECHR-compliant methods for managing perpetrators of domestic abuse who cannot be addressed through criminal justice outcomes, with funding to enable delivery of this work attached. These guidelines should aim to encourage diversion interventions to address perpetrator behaviour and prevent the recurrence of domestic abuse.	Policy and guidance/ Governance systems	Home office