safe & sound

Dudley's Community Safety Partnership

Dudley DARDR15

Domestic abuse related death review of the death of Lisa.

Executive summary of Overview Report

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Commissioned by:

Dudley's Community Safety Partnership

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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 a 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.

Overview

1. 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 late 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.

2. Lisa was from Romani (Gypsy) heritage and at the time of her death 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 relationship aged 17 years. At the time of her death, Child 1 was living with Lisa’s sister.

[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).

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

4. 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.

5. 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 well-being, homelessness and concerns over her relationship with Child 1 and being a perpetrator of domestic abuse towards Child 1.

6. 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.

7. In mid to late 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. 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.

8. 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.

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

Conduct of review

10. The review comprises analysis of information compiled within an initial scoping document and Individual Management Reviews (IMRs). 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.

11. 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.

12. Each of the following organisations completed an IMR detailing their interactions with Lisa, Child 1 and Adam (where appropriate) for this review, with a timeline for the review of January 2022- May 2024 being agreed. However, material outside of this timeframe would also be considered where it provided cogent background information:

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

13. The core panel members were represented as below:

Organisation	**Role**
Independent Chair & Author	Independent Chair & Author
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

14. The review acknowledges and is grateful for the expert advice and insight regarding Romani (Gypsy) culture and the potential barriers faced by Lisa, which was kindly provided by the Traveller Movement[2].

Author of report

15. 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. The chair has significant experience in areas such as exploitation, coercion, abuse and domestic abuse, as well as safeguarding.

16. As a Senior 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. He has also completed

[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.

the on-line “conducting a domestic homicide review” training provided by the Home Office.

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

Family engagement

18. Family Engagement was sought with Lisa’s sisters and Child 1, with individually addressed letters being hand delivered to sister 1, sister 4 and Child 1.The Sisters initially indicated that they would want to engage with the review, but following some initial conversations with the Independent Chair, where sincere condolences were offered regarding their loss of Lisa, they then have not been able to be contacted further. It was clear from the engagement that the family were unaware that Lisa was in a housing facility, or that she had been in a relationship with another man.

19. As at the beginning of the report Lisa is described 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.

20. Towards the end of her life, Lisa’s sisters noted changes in her demeanour and felt she was scared and being controlled. In mid May 2024 they noted that Lisa had bruising to her face, but Lisa wouldn’t elaborate on how she had received the bruises.

Key dates

21. At the beginning of May 2022, 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.

22. 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 recent months. Adam was assessed as low risk and discharged back to the care of his GP and provided contact details for a Veterans Mental Health charity.

23. 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 been 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[3] (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.

24. 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.

25. 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.

26. 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. Following this incident Lisa no longer resided with her sister, and became effectivley homeless.

27. Throughout August 2023, Lisa was in contact with Children's Services on a number of occasions, seeking to understand why Child 1 could not be returned to her care, or why she was being excluded from conversations regarding Child 1's welfare.

28. 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.

29. Within the interview Lisa's risks and needs were assessed and it was recorded that she suffered from anxiety and osteoarthritis for which Lisa was prescribed medicines. It was recorded that Lisa had no issues with substance misuse.

[3] 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.

30. As a result Lisa moved into the housing facility. 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.

31. At the end of January 2024, 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.

32. 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".

33. 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,

34. 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.

35. Lisa's initial behaviour and engagement within the housing facility was good, but from March onwards it was noted that her behaviour had changed and that Lisa was involved in anti-social behaviour within the facility, much of it directed towards Adam.

36. In the second week of April 2024, 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.

37. 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.

38. At the beginning of May 2024, 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 in early 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.

39. On a particular day in mid- May 2024, a number of interactions occurred 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.

40. 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.

41. Lisa informed the support worker that she had been in a short term relationship with Adam, and that Adam had taken £2000 from her. Lisa also stated that she and Adam had taken Cocaine together a few days earlier in May. 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.

42. 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.

43. On the following Monday, the Adult safeguarding referral regarding Lisa that had been sent by by the support worker on the Friday was reviewed and triaged by the MASH team. It has become clear that the referral had been 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.

44. In the afternoon on that Monday 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 after a short time 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.

Findings/conclusions

45. 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.

46. 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.

47. 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.

48. 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.

49. 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.

50. 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 49 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.

51. 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.

52. 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.

53. 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 52 above.

54. 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.

55. 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.

56. 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.

57. 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.

58. 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.

59. 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.

60. 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.

61. 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.

62. 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.

63. 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.

64. 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.

65. 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.

66. 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.

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

68. 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.

69. 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.

70. 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.

71. 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.

72. 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.

73. 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.

74. 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.

75. 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.

76. 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.

77. 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.

78. 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.

79. 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.

80. 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.

81. 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.

82. 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.

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

Recommendations and learning

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.

84. In Lisa's case, a DARA was not completed by Police officers, mainly because they were wrongly informed that Lisa had a learning difficulty and the mental capacity of a 13-year-old. This recommendation seeks to reinforce current Policy to complete DARA's on every occasion when an incident is considered a domestic abuse incident, and that mental capacity or learning disabilities or difficulties should not be a barrier to this.

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.

85. Recommendations 2 and 3 were made by Midland Heart following their internal review of events. These recommendations acknowledge that there is a need to improve knowledge of Domestic abuse, be familiar with the safeguarding and domestic abuse guidance, and for staff to have further training to ensure better decision making, escalation of issues and ensure record keeping is clear and accurate.

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.

86. This recommendation was made by Children's Services. It recognises that once the safeguarding plan for Child 1 had been agreed in line with the family arrangement, the voices of Child 1 and Sister 1 were heard, but Lisa's wasn't, and so seeks to ensure that all views are gained, even if that engagement may have its difficulties.

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.

87. This recommendation reflects the fact that Lisa was vulnerable when she was seeking temporary housing. Placing her in mixed accommodation was culturally inappropriate adding to her vulnerability. Her vulnerability meant she was exploited by other residents and abused by Adam. Once Lisa disclosed that she had been physically and sexually assaulted by another resident there was no consideration given to the ongoing risk Adam posed to Lisa and other female residents. Accommodation providers need to have in place robust systems to assess

vulnerability to ensure correct placement at the beginning, and be able to respond to situations when an individual might need to be moved to safeguard other residents.

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.

88. This recommendation is culturally specific, and recognises that due to mistrust of governmental services within the Romani (Gypsy) culture, that referrals to traditional services such as substance misuse services will almost never be taken up. Religion plays a significant part in Romani (Gypsy) culture, and therefore interactions with priests are likely to be a more effective way to divert individuals from substance misuse.

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.

89. This recommendation is made to seek to help agencies overcome cultural ignorance, and help individuals from diverse backgrounds navigate and understand the care/support system through the use of community advocates. In doing so, it will help agencies understand barriers to providing support, and encourage different and more inclusive avenues to providing support and safeguarding.

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.

90. It is vital that practitioners are open minded when working with individuals to try and help understand the root causes of the issues faced. Too often a lack of professional curiosity mean that it is only the symptoms that are addressed in a formulaic way that often do not help the individual.

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.

91. This recommendation is made in light of incidents of suicide following the victim being in an abusive relationship. Often these relationships are short term and intense and the perpetrator has moved on before the death of the victim, or before any official complaint has been made, which make evidential thresholds for criminal justice outcomes hard to reach. The question is asked as to how lawfully and with full regard to their human rights, can individuals be legitmately diverted from further perpertrator behaviour, and how any future partners could be safeguarded from domestic abuse.

92. This is an issue that goes beyond what happened to Lisa, and it is therefore felt appropriate that it is for the Home Office to provide guidance to CSPs and partners engaged in seeking to prevent domestic abuse/violence.

Dissemination

93. 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