



Domestic Homicide Review

Executive Summary

Pseudonym of Deceased Person: Samantha
Month and Year of Death: September 2024

Independent Reviewer: Allison Sandiford
Report Completed – June 2026

Samantha is remembered as a vibrant, intelligent, and fiercely independent young woman who approached life with big dreams and a deeply compassionate heart. Possessing a brilliant mind and a natural curiosity about the world, she channelled her intellectual passions into the fields of science and psychology.

A true social butterfly, Samantha's real gift was her ability to connect with others. She brought warmth and energy into every room, easily striking up conversations with strangers and leaving a lasting, positive impression on everyone she met. While she was a highly respected voice in her industry - pouring her energy into her work - it was her radiant personality, her intellect, and her genuine love for connecting with people that truly defined her.

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The Review Process

1.1. To protect the identity of the individuals involved, the subject of this review (who was 36 years old at the time of her death), is referred to under the pseudonym of Samantha. Her estranged husband, (who at the time of Samantha's death was aged 34 years) is referred to under the pseudonym of Neil. Both individuals are White British.

1.2. At an inquest in February 2025, HM Coroner concluded that Samantha had died by suicide.

1.3. West Mercia Police conducted an investigation with regards to Samantha's death which, following a review of the evidence, concluded that there was insufficient evidence to provide a realistic prospect of conviction against Neil in relation to coercive behaviour.

1.4. It was agreed on the 1st of November 2024 by the members of the Domestic Homicide Review Screening group, that the case meets the criteria for a Domestic Homicide Review.

1.5. All agencies that potentially had contact with Samantha or Neil prior to the point of Samantha's death were contacted and asked to confirm whether they had involvement with them.

1.6. Eight of the fifteen agencies contacted confirmed contact and were asked to secure their files.

Contributors to the Review

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

- Shrewsbury and Telford Hospitals NHS Trust
- Primary Care
- West Midlands Ambulance Service
- Telford and Wrekin Council: Adult Social Care
- Telford and Wrekin Domestic Abuse Service
- Midlands Partnership University NHS Foundation Trust
- West Mercia Police

1.8. All agency report authors have confirmed their independence. None have been directly involved with either Samantha or Neil.

1.9. The following have contributed to this review by way of further communications.

- BUPA counsellor
- Samantha's Employer

The Review Panel Members

1.10. Membership of the domestic homicide review panel is;

- Allison Sandiford Independent Reviewer
- Lisa Jones Safeguarding Adults Board Manager
- Andrea Williams Domestic Abuse Services
- DI Catherine Taylor West Mercia Police
- Kathy George Shrewsbury and Telford Hospitals NHS Trust
- Tracy Holmes Adult Social Care
- Dr Ebenezer GP Practice
- Sarah Whenmouth Midlands Partnership University NHS Foundation Trust

1.11. The panel met on three occasions:

- 27th of January 2025
- 29th of April 2025
- 14th of July 2025

1.12. All panel members have confirmed their independence. None have been directly involved with either Samantha or Neil.

Author of the Overview Report

1.13. The report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with no links to the Safer Telford and Wrekin Partnership or any of its partner agencies.

1.14. Allison gained experience in domestic abuse and safeguarding both adults and children whilst working for a police service. Allison was part of a team responsible for the force's contribution to delivering Early Help, preventive support and problem-solving interventions for adults and children, in partnership with other key local and regional agencies. She represented the force at strategy meetings and protection conferences to assess risk and negotiate actions with other agencies to instate interventions to safeguard individuals' lives. She also gained experience in chairing meetings, conferences, and partnership initiatives such as daily management risk meetings and Multi-Agency Risk Assessment Conferences.

1.15. In 2019 Allison completed the SILP Lead Reviewer Course¹ and has since conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews, both independently and with SILP.

1.16. Allison has also completed the Home Office online learning with regard to conducting domestic homicide reviews and the AAFDA² domestic homicide review training.

1.17. Allison has a positive attitude to continuing professional development and regularly attends training and seminars.

Terms of Reference

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

- What did statutory agencies and other wider organisations know about Samantha's life, her lived experience, and the dynamics of her relationship with Neil?
- How did any mental health issues affect Samantha's relationship with Neil?
- How accessible and responsive were domestic abuse support services and how well known were these services to Samantha?
- Explore the effectiveness of the domestic abuse risk management plan?
- How well understood was the link between domestic abuse and the risk of suicide?
- What support was offered to Neil to manage his behaviour?
- Were there any barriers to Samantha accessing support?

¹ SILP is an approach to reviewing cases in the context of Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, Domestic Homicide Reviews and any other form of learning activity.

² Advocacy After Fatal Domestic Abuse (AAFDA) are a Centre of Excellence for Reviews after Fatal Domestic Abuse and for Expert and Specialist Advocacy and Peer Support.

- Could communication and information sharing within and between agencies have been improved during the scoping period. What opportunities existed for multi-agency referrals for vulnerability and/or risk management meetings?
- Were there missed opportunities to exercise professional curiosity?
- Identify areas of strong practice, both single and multi-agency.

2. Background Information (The Facts)

2.1. Samantha and Neil's relationship began early in 2021, and they were married after eight months.

2.2. Their relationship ended in July 2024. Neil moved out of the address.

2.3. On a day in September 2024, police were contacted by one of Samantha's friends who explained that she had not heard from Samantha for 48 hours and found this unusual having previously been in contact on a daily basis. Samantha's friend further detailed concerns regarding Samantha's recent mental health and said that Neil's stalking of Samantha had contributed to a recent decline. The allegations of stalking were, at that time, subject to an active police investigation.

2.4. The friend also said that Neil had contacted her earlier that day and had said that he had received an email from Samantha in the early hours of the morning, which had indicated that Samantha had taken, or was planning to take, her own life.

2.5. Officers forced entry into Samantha's address and found her deceased on the sofa. The evidence gathered indicated that Samantha had died by overdosing on prescription medication. Detectives deemed there to be no third-party involvement. Samantha had set a scheduled email to be sent to Neil at 04:00 hours. It was obvious upon attendance that Samantha had been deceased sometime before this email was sent.

2.6. Prior to Samantha's death, there had been 18 domestic abuse incidents reported to the police wherein Samantha was recorded to be victim of abuse perpetrated by Neil.

2.7. After Samantha's death, a friend contacted the police, linking Samantha's death to the abuse perpetrated by Neil.

3. Summary Chronology

Background of Samantha and Neil prior to the scoping period

3.1. Samantha's friend (hereafter referred to under the pseudonym of Ivy) has described Samantha as a vibrant, intelligent, and independent young woman who had excelled in her work and had become a respected voice in her industry.

3.2. Samantha had been diagnosed with bi-polar, and during the scoping period of this review she was diagnosed with Attention Deficit Hyperactivity Disorder. There are incidents on record which evidence Samantha being in mental health crisis and having survived suicide attempts. Occasionally, concerns around

Samantha's mental health have resulted in her being detained under section 136³ of the Mental Health Act and she has also been detained under section 2⁴.

3.3. Notably case notes indicate that Samantha's mental health incidents are minimal in number prior to her relationship with Neil, in comparison to the recorded incidents following the start of the relationship.

3.4. Samantha has told professionals that it was during the preparation of their wedding that Neil started to control her behaviour and present as annoyed if she wasn't able to answer his telephone calls, or if she got dressed up or wore make-up. Samantha is recorded to have described that she became a 'shell of herself' and became isolated from friends.

3.5. Case notes evidence that Samantha revealed to a professional that a month after their wedding there was an argument, and Neil left a pub without her. Samantha is recorded to have said that she felt suicidal and had to be taken home by the police. Thereafter Neil became aggressive and damaged items in the house before attempting to strangle her with curtain tiebacks. Neil's mother, who was on the telephone at the time and heard the commotion, called the police. Samantha disclosed that she did not press charges because they had only been married for a month.

3.6. Samantha has reported debt in relation to Neil – she said that she obtained a loan to cover his debts and also that she owed £45,000 from the wedding. Ivy has informed this review that Samantha told her that she regularly covered the costs of their outings, holidays, and partying; creating an unequal financial dynamic, and that when Samantha was unable to afford something or if plans changed, Neil would become angry or agitated, often lashing out and making her feel guilty.

3.7. There are ten domestic abuse incidents recorded against Neil with previous partners and in 2013, Neil was convicted for common assaults relating to a domestic incident wherein he assaulted his ex-partner, her mother, and her niece. Additionally, case notes evidence that Neil has previously smashed property belonging to his mother.

3.8. Throughout Samantha and Neil's relationship there was regular police contact with a total of 18 recorded investigations. However, it must be remembered that domestic abuse is often unreported and therefore it is not possible to conclusively deduce the full extent of domestic abuse incidents between Samantha and Neil.

3.9. The police have a number of Vulnerable Adult concerns listed against Neil from incidents that have occurred over the years and relate to his mental health and thoughts of suicide. In 2017 Neil was given an initial diagnosis of possible bi-polar disorder, and he commenced medication. Neil reported that the medication stabilised his mental health and anger. However, this diagnosis was later queried when case notes state that his presentation was more in line with Emotionally Unstable Personality Disorder.

3.10. On occasions, Neil has been referred for mental health care co-ordination but has not been successfully engaged. However, a few months prior to the scoping period of this review, Neil was referred to the 'Managing Emotions' Group – with which he was engaged.

³ Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern. It is important to point out that a person is not under arrest when the decision is made to remove the person to a place of safety. The police power is to facilitate assessment of their health and wellbeing as well as the safety of other people around them.

⁴ Section 2 of the Mental Health Act allows for a person to be detained for up to 28 days for urgent assessment and treatment of a mental health disorder.

3.11. In relation to substance use, though it is not clear from records when Neil began to use alcohol and substances, it is known that he was already using them when he started his relationship with Samantha.

3.12. Samantha was a smoker and admitted to sometimes binge-drinking and using illicit drugs with Neil.

Chronology of Events

The review highlighted the following as key episodes in the case:

October 2023 – January 2024. Professional Response to Reported Incidents.

3.13. On a weekend commencing October the 14th 2023, Samantha reported to police that Neil was being abusive and would not leave. Neil accused Samantha of being intoxicated, using cocaine, and making threats. Officers attended and a medium-risk Domestic Abuse Risk Assessment was recorded, with Samantha noting Neil's increasing control.

3.14. The following day, a friend of Samantha reported to police that Samantha was experiencing suicidal thoughts and thereafter, Neil reported that Samantha had locked herself in the property. Samantha had self-harmed and was unable to cooperate with attending officers. An ambulance was called and when Samantha attempted to jump out of a window, officers restrained her.

3.15. Officers completed a further medium risk Domestic Abuse Risk Assessment and an adult risk assessment. (In relation to these and the aforementioned assessment, police referrals were processed to Mental Health, Adult Services, Children's Services⁵, and Op Encompass⁶.)

3.16. Samantha was taken to hospital for a mental health assessment where she was subsequently discharged. She declined the Crisis Team's services because she was seeking support with BUPA⁷.

3.17. Over the next 24 hours, Samantha's brother and her BUPA psychologist reached out to the crisis mental health team expressing concerns about Samantha. This led to Samantha's care coordinator (a trained healthcare professional who helps to manage a patient's condition and oversees a patient's treatment plan) contacting Samantha.

3.18. Around this time, Neil commenced the 'Managing Emotions' group where he said that he had separated from Samantha, was staying on a friend's couch and was drinking daily to manage his emotions. However, two weeks post the above incidents, Neil contacted Samantha's care coordinator on Samantha's behalf – which suggests that they were possibly back together. The care coordinator visited, and Samantha's medication was re-started with good effect.

3.19. In November, Neil reported suicidal thoughts to mental health services after heavy drug and alcohol use. A phone assessment ruled out a need for secondary mental health care, but Neil was referred to STARS for drug support (which he did not attend, though he joined a group session⁸ and saw psychology the next day).

⁵ In relation to Neil's children (who were not present)

⁶ Operation Encompass ensures that there is a simple telephone call or notification to a school's trained Designated Safeguarding Lead /Officer prior to the start of the next school day after an incident of police attended domestic abuse where there are children related to either of the adult parties involved.

⁷ Samantha had 13 weekly (with the exception of holidays) appointments with a clinical psychologist from BUPA starting from August 2023.

⁸ Neil continued to attend group sessions into February - when they completed and Neil was positively reviewed after he had reported that he was abstaining from 'heavy alcohol' and cocaine use, had secured a pay rise, and was attending the gym. Though early in the sessions (in December) Neil had self-harmed after drinking and using weed, during an episode of anger and frustration.

3.20. On Christmas Eve, police officers attended Samantha after she reported holding Neil at knife point and having suicidal thoughts. Officers established that the two had argued and after watching a recording of the incident (made by Neil), they concluded that Samantha had experienced a mental health episode. A Domestic Abuse Risk Assessment was recorded as medium risk.

3.21. In January 2024 Samantha had to be allocated a new care coordinator due to her previous worker leaving the service. The new care coordinator did not successfully engage Samantha for two months; Samantha cancelled appointments citing work commitments as the reason (Samantha had started a new job).

February 2024 – April 2024. Period of little professional intervention.

3.22. In February 2024, Samantha was diagnosed with Attention Deficit Hyperactivity Disorder and prescribed medication.

3.23. In March 2024 Samantha attended an appointment with the new care coordinator. During this appointment Samantha discussed how she was enjoying her new job, was happy with her medication for the Attention Deficit Hyperactivity Disorder and described Neil as being supportive. She showed good insight into her own mental health and said that Neil was addressing his.

3.24. The following month, a review of Samantha's mental health recorded that Samantha's mood was stable and that there were no concerns of psychotic symptoms.

May 2024 – September 2024. Samantha and Neil separate and Events Leading up to Samantha's Suicide.

3.25. On the 23rd of May 2024, the ambulance service was called for Samantha due to thoughts of self-harm during a mental health episode. As ambulances were delayed, the clinical validation team phoned Samantha and conversed with both Samantha and Neil, who both reported the crisis had passed. Samantha agreed to contact the community mental health team; thus no ambulance was dispatched, and no face-to-face assessment occurred.

3.26. In June, Samantha missed her next scheduled appointment with her care coordinator. In line with procedure, a standard 'opt-in' letter was sent.

3.27. At the beginning of July 2024, Samantha presented to hospital physically unwell. She was admitted for three days.

3.28. Neil left Samantha's address on the 13th of July 2024. Two days later, Samantha contacted the West Mercia Women's Aid Helpline stating she had recently separated from her partner of three years. She reported that Neil had been unfaithful, emotionally abusive, had issues with alcohol and cocaine, and was financially controlling. Samantha also mentioned that Neil had neglected her cat while she was in hospital. Samantha said that there had been no contact attempts from Neil since he had left and there were no signs of stalking. Samantha was referred to Cranstoun Telford and Wrekin Domestic Abuse Service for ongoing support.

3.29. Five days later Samantha requested an update in relation to the referral. She said that she was feeling positive and proactive and wanted to deal with the situation. The worker emailed Cranstoun Telford and

Wrekin Domestic Abuse Service requesting an update and sent Samantha some supporting information⁹. And the following day a Cranstoun key worker sent Samantha an introductory email.

3.30. A week later, Samantha contacted the police and disclosed the domestic abuse, outlining coercive and controlling behaviours, threats to kill, and recent unwanted contact to officers. She also disclosed that Neil had previously tried to strangle her. A medium risk Domestic Abuse Risk Assessment was recorded.

3.31. The following week, during a phone call with her care coordinator, Samantha described herself as well and said that the marriage was over and that she was being firm in relation to asking Neil for financial support.

3.32. On the 5th of August 2024, police created a Domestic Abuse Risk Management Plan¹⁰ to support Samantha and two days later Samantha texted Cranstoun Telford and Wrekin Domestic Abuse Service to arrange her appointment, which was then scheduled for the following day. During this scheduled telephone¹¹ appointment, a Domestic Abuse Stalking Harassment risk assessment was completed which scored High Risk and Samantha's safety plan was reviewed. A referral to the Multi-Agency Risk Assessment Conference¹² was agreed and Samantha said she would check with her landlord whether she was allowed a ring doorbell¹³.

3.33. On the 10th of August 2024, police attended Samantha after she had been found lying on the ground. Samantha said she had drunk alcohol after a conversation with Neil had left her "spiralling". She said she was upset as Neil hadn't been arrested yet.

3.34. An ambulance crew attended and reported Samantha to be calm with ordered thoughts. Before leaving Samantha, the crew contacted the crisis team who subsequently telephoned Samantha, but Samantha was difficult to hear (Samantha said it was because she had been shouting all night) and the call had to be terminated. The crisis team and the care coordinator made further attempts to contact Samantha, but no calls were answered, even after Samantha had sent a text message asking for the care coordinator to call.

3.35. Neil was arrested the following day and the police updated Samantha explaining that Neil had bail conditions not to enter her street or to contact her. However within 24 hours, Neil had sent a penny to Samantha's bank account referenced 'readyouremails' and consultation with Samantha's emails evidenced that he had sent her a lengthy message. There is nothing to evidence that Samantha reported this to the police.

3.36. On the 19th of August, Samantha saw her care coordinator face-to-face¹⁴. It is recorded that Samantha said that Neil had moved out but that he had been 'gaslighting' her and making threats to kill her. Samantha disclosed that she didn't feel safe leaving the flat and the practitioner encouraged Samantha to call the police if she felt threatened. Samantha said that her employer¹⁵ was being supportive and had offered counselling, occupational health and financial support, and that she was also working with a domestic abuse charity who had referred her to Multi-Agency Risk Assessment Conference. Additionally Samantha said that she had

⁹ In relation to: Setting healthy boundaries, What is coercive control, Post separation power and control, Survivors Handbook, Red flags for abusive relationships, The 7 stages of grief after the end of a relationship, Who are the abusers and who is responsible for the abuse, and Information re accessing legal advice.

¹⁰ The core objective of a police Domestic Abuse Risk Management Plan is to plan how the police can safeguard and support the victim.

¹¹ All contact between this service and Samantha was conducted by telephone.

¹² A Multi-Agency Risk Assessment Conference (Multi-Agency Risk Assessment Conference) is a non-statutory process that brings together statutory and voluntary agencies to jointly support adult and child victims of domestic abuse who are at a high risk of serious harm or homicide, and to disrupt and divert the behaviour of the perpetrator

¹³ It is an example of positive practice that Cranstoun Telford and Wrekin Domestic Abuse Service followed up this contact the next day (which was a Friday) by means of a check in call and planned a further call for after the weekend on the Monday.

¹⁴ The contact was only for 15 minutes as Samantha had attended late.

¹⁵ Around this time Samantha had begun in-house counselling at work.

stopped taking her mental health medication as she felt that she no longer needed it. The practitioner recorded that this would be shared with the responsible clinician with whom Samantha had an imminent appointment. Plans were also made to see Samantha in eight weeks.

3.37. The following week, Samantha responded to a missed call from Cranstoun Telford and Wrekin Domestic Abuse Service (by text) citing that she was busy at work and she arranged her next appointment for the following week. (Though further contact was also had two days later when Cranstoun Telford and Wrekin Domestic Abuse Service contacted Samantha to discuss security items for her property, i.e., a ring doorbell.)

3.38. On the 21st of August 2024 Samantha saw the mental health consultant and disclosed that she had stopped her medication. Samantha said that she was filing for divorce, and she discussed how she had binged on alcohol a few weeks earlier (which had led to erratic behaviour) but hadn't used alcohol since.

3.39. Soon after this Samantha told Ivy that she had joined a dating app and met a man. However she soon found out that he had an issue around alcohol use and ended the relationship.

3.40. On the 31st of August 2024 Samantha reached out to Ivy saying that she wasn't coping well. Before Ivy could respond, Samantha attended a festival with another friend.

3.41. On the 2nd of September 2024 Neil contacted the police wishing to make a formal complaint against Samantha. He said that despite his bail conditions not to contact her, Samantha had been calling him, trying to add him on social media, emailing him and getting her friends to message him on her behalf. Officers visited Neil and obtained a statement and evidence of the contact. A Domestic Abuse Risk Assessment was recorded as medium risk. (This investigation was subsequently filed after Samantha's death.)

3.42. Around this time Samantha began a rhetoric expression of self-blame. She resigned from her job and posted a public apology to Neil on Social Media, taking the blame for their marriage breakdown. The day after, Samantha wrote suicide emails to loved ones. As soon as the email landed in Ivy's inbox, Samantha contacted her stating that she had written it a few days earlier when feeling low, but the crisis team were on their way now.

3.43. Two days before Samantha sadly died by suicide, an officer from the Safer Neighbourhood Team tried calling Samantha and visited the address - but got no reply. Friends also report that they were unable to contact Samantha after this day.

4. Key Issues Arising from the Review

What did statutory agencies and other wider organisations know about Samantha's life, her lived experience, and the dynamics of her relationship with Neil?

4.1. The police were called to Samantha and Neil on multiple occasions during the scoping period and as such, were aware of their relationship. And owing to the fact that officers attended incidents wherein poor mental health was evident and discussed, and in which alcohol and drugs factored, Samantha's vulnerabilities were also known to them.

4.2. Police officers completed a Domestic Abuse Risk Assessment¹⁶ with Samantha on five occasions during the scoping period, grading all the assessments to be medium risk. The details were then forwarded to the police Harm Assessment Unit for further assessment and for consideration of further support.

4.3. This review has been informed that in West Mercia, whilst a medium risk assessment does not preclude a referral to domestic abuse services, unless it is a repeat Multi-Agency Risk Assessment Conference case, a medium Domestic Abuse Risk Assessment is not automatically forwarded to domestic abuse support services - whereas a high risk assessment is referred with or without consent.

4.4. As such, whilst the Harm Assessment Unit forwarded information in relation to Samantha (and Neil) to mental health and adult services, none was sent to domestic abuse support services, and (with the exception of around August 2024 whereby Samantha had already reached out to domestic abuse services) this resulted in missed opportunities to explore the incidents further with Samantha and to confirm whether Samantha understood what constituted domestic abuse and knew where she could seek support.

4.5. Notably medium/low risk assessments can still be referred to the Victim Advice Line and domestic abuse agencies (with consent), and in addition, the officer who attends the preliminary incident is expected to discuss/signpost to domestic abuse support services and obtain consent for referral where possible whilst in attendance. Therefore, whilst it is not evidenced within the documentation, it is possible that attending police officers did offer to refer Samantha - but that she declined (and that this wasn't always recorded).

Learning 1: Individuals whose circumstances are graded Standard/Medium risk in a Domestic Abuse Risk Assessment, could be at risk of losing a domestic abuse support offer.

Question 1: How can West Mercia Police and Cranstoun Domestic Abuse Services work together to identify how they can ensure that individuals whose circumstances are graded Standard/Medium risk in a Domestic Abuse Risk Assessment, are not at risk of losing a domestic abuse support offer - and thereafter assure the Safer Telford and Wrekin Partnership of the outcome/action plan?

4.6. As mentioned, Neil had a history of domestic abuse dating from before he started a relationship with Samantha but whilst it is evident from some conversations Samantha had with professionals that she knew of some of this abusive behaviour; records suggest that Neil's abusive past wasn't ever disclosed to Samantha before or during the scoping period of this review.

4.7. Clare's Law is a Domestic Violence Disclosure Scheme that enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending. The guidance on the scheme is clear that all disclosures must be accompanied by a robust safety plan, tailored to the needs of the victim or potential victim and based on all relevant information available. Consequently had a disclosure been given to Samantha she could have been advised of the range of orders available to her should she require support.

¹⁶ The Domestic Abuse Risk Assessment is a tool that has been developed to be used by first responding police officers to support them in identifying domestic abuse. It has been designed to work alongside the Domestic Abuse, Stalking and Harassment and Honour-based violence risk assessment but it has: less questions; more prompts to help officers to probe into what might be happening; and an increased focus on coercive and controlling behaviour. The Domestic Abuse Risk Assessment does not replace the Domestic Abuse, Stalking and Harassment and Honour-based violence risk assessment. It is a primary assessment only to be used by first responders and can be complemented with further assessment by secondary specialist teams within the police or other organisations.

4.8. There were many opportunities for either, professionals who were working with Samantha to approach the police and request disclosure, or for officers to choose to disclose. Why disclosure was overlooked was discussed with professionals during the practitioner event, but ultimately it remained unknown.

Learning 2: There were missed opportunities to utilise Clare's Law to ensure that Samantha was fully aware of Neil's domestic history and to discuss a robust safety plan.

Question 2: How can the Safer Telford and Wrekin Partnership, and partner agencies, develop and continue their promotion of Clare's Law to professionals from all agencies and how can application of the law be thereafter audited?

4.9. Throughout the scoping period of this review, mental health professionals discussed Samantha and Neil's relationship with Samantha and explored: the cycle of abusive behaviours, relationship boundaries and the benefits of the relationship ending. Records evidence that Samantha's voice was heard and that the professional response to Samantha's decisions about her relationship was non-judgmental. However, whilst this is an example of positive practice, it is notable that no referrals were made to domestic abuse services.

4.10. This has been explored within discussions with professionals engaging with this review, and it has been established that many of Samantha's disclosures to mental health professionals were in relation to Neil having affairs. This was not construed to be domestic abuse. However, had more professional curiosity been had into the information contained in Samantha's historic interactions with mental health services, it could have been viewed holistically and recognised as potential coercive control and abuse.

Learning 3: Improved professional curiosity to establish the abuse Samantha was experiencing would have supported better identification of risks and supports required.

4.11. Professional curiosity within all agencies/organisations is discussed further later in this report.

How did any mental health issues affect Samantha's relationship with Neil?

4.12. Samantha had a history of mental ill health and had self-reported traumatic experiences as a child; both of which would have left her susceptible to trauma bonding.

4.13. Trauma bonding refers to the attachment a victim feels towards their abuser. It forms when incidents of abuse are intermixed with occasional positive interactions. The victim becomes used to the fluctuations between the distress caused by abuse and the relief experienced during good times. The positive moments are sufficient to establish a strong bond in the victim, making it challenging for them to leave the situation.

4.14. In trauma-bonded relationships, a cycle of positive and negative behaviours reinforce the relationship. For example, Samantha reported that Neil's initial kindness made her overlook her brother's warnings about the relationship. This early kindness likely kept Samantha attached even when Neil's behaviour changed, as she hoped for a return to the earlier positive interactions.

4.15. Samantha reported to professionals that the changes in behaviour began around the time they were getting married. From this time Neil's patterns of abusive behaviour, followed by compensations, began. An example of this is recorded when Samantha referred to Neil as being 'supportive' during one of their 'better' periods.

4.16. Samantha's trauma bond with Neil is evident in her behaviour after abuse or crises. Hospital records show Samantha frequently sought comfort from Neil, reinforcing the bond as her mental health and self-

confidence likely declined. And Samantha's BUPA psychologist has described how mental health crisis would be alleviated by Neil returning to the relationship.

4.17. Addressing trauma bonding necessitates a thorough intervention that encompasses educating victims and survivors of abuse on the formation and maintenance of the bonds – helping them to understand their own emotions and feelings towards their abuser, as well as setting objectives to assist them in developing a safety plan.

Learning 4: Professionals need to support domestic abuse victims and survivors to recognise the signs of trauma bonding and understand what is happening and why.

Question 3: How can the Safer Telford and Wrekin Partnership and partner agencies continue to strengthen awareness of trauma bonding to domestic abuse victims and survivors?

4.18. The complex interaction between Samantha's mood and the abuse she was experiencing has been recognised by Midlands Partnership University NHS Foundation Trust when reflecting upon their contacts with Samantha. However, documentation does not evidence any domestic abuse routine enquiry being had by professionals at the time, nor of any domestic abuse, stalking, harassment and honour-based abuse risk assessment being completed with Samantha.

4.19. Why the effect of the relationship upon Samantha's mental health wasn't recognised as an indicator of domestic abuse at the time is deemed to be because the contacts were not viewed through a domestic abuse lens. Instead conversations were naturally framed around Samantha's mental health - because this is what Midlands Partnership University NHS Foundation Trust staff were working with Samantha to manage.

4.20. This implies a potential gap in the knowledge of mental healthcare professionals concerning domestic abuse that must be addressed, as it could negatively affect professionals' confidence in addressing domestic abuse issues and consequently constitute an obstacle for survivors seeking support.

Learning 5: There is a knowledge gap within mental healthcare concerning domestic abuse which must be addressed with specialist training to support professionals to identify the patients who are experiencing domestic abuse and refer them to specialist domestic abuse support.

4.21. This review has been assured that this learning has been addressed; the team has received a learning/supervision session concerning domestic abuse and Multi-Agency Risk Assessment Conference processes and learning has been had in relation to discussing cases with the Safeguarding Named Professionals when they are unclear about thresholds or consent.

4.22. Additionally, in March 2024 Midlands Partnership University NHS Foundation Trust hosted a week-long Domestic Abuse event with guest speakers from Shropshire Integrated Care Board, Women's Aid, GALOP¹⁷, Mankind, Karma Nirvana and the Domestic Abuse Commissioner. All staff were invited to the five events intended to increase staff knowledge and confidence in support services available to anyone experiencing domestic abuse. And Cranstoun and West Mercia Women's Aid delivered a 'Lunch and Learn' to which all Midlands Partnership University NHS Foundation Trust staff working in the Telford area were invited.

How accessible and responsive were domestic abuse support services and how well known were these services to Samantha?

¹⁷ Galop is the UK's LGBT+ anti-abuse charity.

4.23. This review has learned that Samantha self-referred to domestic abuse services after Ivy researched how to get support and passed the information to her.

4.24. This would suggest that Samantha either did not know where to turn for support or did not recall any information she had previously been given or seen.

Learning 6: Services and organisations must continue to work to enhance awareness of domestic abuse and promote support services within our communities.

4.25. Publications such as leaflets and posters are effective tools to address this learning and another Domestic Homicide Review (Sarah) commissioned by Telford has also highlighted this as learning and recommended a review of the content and distribution of domestic abuse literature. The circumstances within this review should be considered alongside DHR Sarah when developing the action plan.

Explore the effectiveness of the Domestic Abuse Risk Management Plan.

4.26. This review learned that the core objective of a police Domestic Abuse Risk Management Plan is to plan how the police can safeguard and support a victim of reported abuse. It is not a multi-agency plan – other multi-agency processes exist for that.

4.27. It is an example of good practice that Samantha was subject to a risk management plan as they are mostly used in high-risk domestic abuse cases. One was used for Samantha because, whilst her risk had been deemed as medium, there was an increase of medium risk incidents over a period of time.

How well understood was the link between domestic abuse and the risk of suicide?

4.28. The fourth annual report from the national Domestic Homicide Project shows that for the second year in a row, suspected suicides following domestic abuse have overtaken the number of homicides involving current or previous partners. This data highlights the need to explore domestic abuse with individuals at risk of suicide.

Learning 7: Professionals should explore domestic abuse when attending to individuals at risk of self-harm or suicide.

4.29. Cranstoun Telford and Wrekin Domestic Abuse Service has informed the review that Samantha's caseworker recognised the link between domestic abuse and suicide risk in Samantha's case, but no formal mental health or safeguarding referrals were made. The reason cannot be confirmed because the practitioner involved in this case no longer works for the service, but since this Domestic Homicide Review was commissioned, the service has now scheduled Suicide Prevention in the Context of Domestic Abuse training by Grassroots Suicide Prevention for all staff, and refresher training by SafeLives on the domestic abuse, stalking, harassment and honour-based abuse risk assessment.

4.30. The Midlands Partnership NHS Foundation Trust has informed this review that suicide, and situations that are precursors, are very well understood by mental health staff and that Samantha's risk of suicide was acknowledged in her risk assessment - which stated that there were risky behaviours, and suicide attempts, reactive to altercations with Neil.

4.31. The Shrewsbury and Telford Hospitals NHS Trust has informed this review that the link between domestic abuse and the risk of suicide is something that they have already picked up on, and it has been

included in their medical training for doctors for the last year – especially those who work in the Emergency Department.

4.32. BUPA assured this review of good safeguarding training and support for their professionals but agreed that the link between suicide and domestic abuse is something that could, and will, be strengthened.

4.33. This review has been assured that the link between domestic abuse and the risk of suicide is a current priority for the Partnership and partner agencies. However the review would still pose the following question:

Question 4: In what ways can the Safer Telford and Wrekin Partnership provide assurance to the Domestic Homicide Review and Safeguarding Adults Review panels that they have robust mechanisms in place to monitor review referrals which will determine if professionals are not consistently recognising the connection between domestic abuse and suicide in the future. And can Safer Telford and Wrekin Partnership confirm to the panels that consideration will be given to commissioning a thematic review when/if appropriate?

What support was offered to Neil to manage his behaviour?

4.34. There was a missed opportunity to consider a referral for support for Neil as perpetrator when he was arrested towards the latter end of the scoping period. This was particularly crucial because officers knew that Neil and Samantha had separated and research evidences that the end of a relationship is the most dangerous time. Approximately 75% of all domestic violence homicides occur when the victim is attempting to leave, or after ending the relationship¹⁸, and stalking increases the risk of intimate partner homicide by three times¹⁹.

Learning 8: There were missed opportunities for the police to refer Neil to support services in relation to his abusive behaviours as they became known.

Question 5: There is a need for West Mercia police to review how the support available to perpetrators of domestic abuse is relayed to their officers and how it is embedded into their guidelines. And to thereafter assure the Safer Telford and Wrekin Partnership of improvement.

Were there any barriers to Samantha accessing support?

4.35. In July 2024 Samantha bravely self-referred to support services and soon disclosed the abuse to the police.

4.36. Whilst good practice was demonstrated by officers taking positive action and arresting Neil after Samantha had disclosed the abuse, there was a delay of three weeks before the arrest. Similarly there was a delay of three weeks between Samantha contacting West Mercia's Women's Aid helpline and Cranstoun Telford and Wrekin Domestic Abuse Service engaging her.

4.37. In relation to the police delay, the officer in the case no longer works for West Mercia Police and therefore the exact reason cannot be ascertained. However the panel are informed that with the risk being graded as medium, factors can impact arrest timings such as resourcing issues; conflicting high risk incidents to attend; and the availability of the suspect. The domestic abuse support delay has been established to be partly in relation to how contact was first attempted with Samantha.

¹⁸ ["Why Don't You Just Leave?"](#)

¹⁹ Spencer, C.M. & Stith, S.M. (2018). Risk Factors for Male Perpetration and Female Victimization of Intimate Partner Homicide: A Meta Analysis. Trauma, Violence, & Abuse, 21(3): 527-540.

4.38. Samantha spoke of these delays with Ivy, citing her frustrations and there is evidence of the situation escalating for Samantha during this waiting period:

- A few days after she had initially reported the abuse to the police, Neil entered her flat and brandished knives - he suspected that she was starting a relationship with someone new.
- Hereafter Samantha reported that she thought that Neil had now involved third parties and had asked them to watch her and send her messages.
- Samantha's uneasiness is evidenced by the messages that she sent the 'Officer In the Case' in relation to 'suspicious' things that were happening. There wasn't ever proof that Neil was behind them – but the incidents clearly worried Samantha and caused her stress.

4.39. Disclosure was the beginning of Samantha's difficult journey; and from that time she was vulnerable and needed support to manage any retaliation.

4.40. The positive and empowered mindset Samantha had been building, was dismantled with time. She died less than two months after she had first sought support.

4.41. This demonstrates the need to act quickly when a survivor of abuse gains the ability to disclose, support prosecution and engage with support services.

Learning 9: Delay to support from services can affect a survivor's ability to maintain separation/disclosure/prosecution. It is therefore crucial that professionals respond in a timely manner to survivors of domestic abuse and seek to address the impact.

4.42. The timelapses in Samantha's case have been discussed and as previously mentioned, professionals have recognised that the delays to Neil's arrest, though certainly not ideal, may have been unavoidable.

4.43. Furthermore Cranstoun Telford and Wrekin Domestic Abuse Service have already audited their response times and have established that the delays in relation to responding to Samantha were 'human error' - and the individual no longer works for the service.

Could communication and information sharing within and between agencies have been improved during the scoping period. What opportunities existed for multi-agency referrals for vulnerability and/or risk management meetings?

4.44. There was a missed opportunity for multi-agency work after Samantha had disclosed the abuse and sought support when it had been agreed that Samantha would be referred to Multi-Agency Risk Assessment Conference. But, for reasons that cannot be ascertained (as the practitioner involved in this case no longer works for Telford and Wrekin Domestic Abuse Service) the referral was not made in line with expected practice.

4.45. In the absence of the Multi-Agency Risk Assessment Conference referral, there was no formal multi-agency risk management strategy in place, and opportunities to explore additional protective measures, such as emergency housing options, financial support interventions, and mental health safeguarding referrals, were missed.

4.46. Cranstoun Telford and Wrekin Domestic Abuse Service has assured this review that since this case, a Multi-Agency Risk Assessment Conference Masterclass has been delivered to all outreach staff, reinforcing when and how to refer high-risk cases. Additionally, all staff have now completed specialist training on Multi-

Agency Risk Assessment Conference processes and multi-agency working, ensuring that high-risk victims are escalated appropriately, and no similar cases are missed in the future.

Were there missed opportunities to exercise professional curiosity?

4.47. Opportunities wherein professionals could have shown increased curiosity were discussed during the learning event and some have been highlighted within the full Overview report - but given that:

- professionals at the practitioner learning event were all able to inform what professional curiosity means,
- agencies were able to assure that professional curiosity is always incorporated into their mandatory safeguarding training programmes, and
- professional guides to professional curiosity, including a seven-minute briefing²⁰ are available to professionals on the Telford and Wrekin Safeguarding Partnership website²¹;

the question that this review must ask is - though it is an essential component of safeguarding procedures, and its application is rooted in safeguarding adult policies and the Care Act 2014, why is being professionally curious still not always embedded into practice - as is evidenced in this review.

Learning 10: To gain an effective understanding of Samantha's circumstances, professionals needed to be 'curious' by asking questions and verifying information from alternative sources such as historic case notes and partner agencies, as required.

Question 6: How can agencies evidence to Safer Telford and Wrekin Partnership that that they are prompting and encouraging their professionals to be professionally curious, and how can Telford and Wrekin Community Safety Partnership gain an improved understanding of how to support agencies with this practice.

5. Conclusions

5.1. Agencies who were aware of Samantha's relationship recognised the direct affect that Neil's behaviours had upon Samantha's mental health, and the link to her suicidal ideations.

5.2. Police officers attending incidents completed Domestic Abuse Risk Assessment with Samantha (grading the risk to be medium) and ensured that she received immediate attention for any mental health crisis as appropriate. Thereafter the police Harm Assessment Unit forwarded information in relation to Samantha (and Neil) to mental health services and Adult Social Care as appropriate but in the absence of Samantha's consent, no referrals into domestic abuse support services were able to be made (until August 2024, by which time Samantha had already self-referred).

5.3. Mental health professionals (including BUPA) developed safety plans to support Samantha in mental health crisis and discussed the affect the relationship had upon her mental health; but Neil's abusive behaviours were not considered as a separate risk. This resulted in domestic abuse support being overlooked and domestic abuse support services remained unaware of Samantha's circumstances until she self-referred.

5.4. In addition to Samantha not being referred to domestic abuse services, a disclosure of Neil's domestic history was not ever given to Samantha under Clare's Law. Such disclosure could have resulted in more timely domestic abuse intervention with Samantha, as alongside ensuring that Samantha knew the risk Neil posed,

²⁰ [Professional curiosity - Telford and Wrekin Safeguarding Partnership](#)

²¹ Data analysis evidence that there have only been 148 hits across the resources between the 1st of January 2025 and the 15th of May 2025.

the disclosure would have included an explanation of the available support and orders Samantha could access when she was ready.

5.5. After Samantha had bravely reached out for domestic abuse support and disclosed the abuse to the police, there were unfortunate delays to both her support offer and Neil's arrest. Furthermore when Neil was arrested, he was not offered any perpetrator support which would have aimed to help him to recognise and address his own behaviours.

5.6. Neil persisted in contacting Samantha, undermining the progress she had made in her mental wellbeing. Over a brief period, her mental health declined; she contacted Neil, experienced a loss of self-worth, internalised blame for the abuse, and ultimately took her own life.

5.7. No agency had supported Samantha to understand trauma bond or to recognise that it would not be uncommon for her to feel an ongoing attachment towards Neil, despite his abuse.

6. Lessons to be Learnt and Recommendations²².

6.1. The lessons learned from this Domestic Homicide Review commissioned by Telford Community Safety Partnership are highlighted in bold text throughout this report, but for reference, are repeated here alongside the relevant question if the learning has not been already addressed:

²² By way of questions.

	Learning	Has this learning been addressed?		Question to address outstanding learning
1	Individuals whose circumstances are graded Standard/Medium risk in a Domestic Abuse Risk Assessment, could be at risk of losing a domestic abuse support offer.		1	How can West Mercia Police and Cranstoun Domestic Abuse Services work together to identify how they can ensure that individuals whose circumstances are graded Standard/Medium risk in a Domestic Abuse Risk Assessment, are not at risk of losing a domestic abuse support offer - and thereafter assure the Safer Telford and Wrekin Partnership of the outcome/action plan?
2	There were missed opportunities to utilise Clare's Law to ensure that Samantha was fully aware of Neil's domestic history and to discuss a robust safety plan.		2	How can the Safer Telford and Wrekin Partnership, and partner agencies, develop and continue their promotion of Clare's Law to professionals from all agencies and how can application of the law be thereafter audited?
3	Improved professional curiosity to establish the abuse Samantha was experiencing would have supported better identification of risk and supports required.	Refer to learning 10.		
4	Professionals need to support domestic abuse victims and survivors to recognise the signs of trauma bonding and understand what is happening and why.	Safer Telford and Wrekin Partnership has contacted the team that organises the White Ribbon Day event (November 2025) and they have agreed to help to raise awareness around trauma bonds with members of the public / domestic abuse victims and survivors.	3	How can the Safer Telford and Wrekin Partnership and partner agencies continue to strengthen awareness of trauma bonding to domestic abuse victims and survivors?
5	There is a knowledge gap within mental healthcare concerning domestic abuse which must be addressed with specialist training to support professionals to identify the patients who are experiencing domestic abuse and refer them to specialist domestic abuse support.	The team has received learning/supervision session concerning domestic abuse and Multi-Agency Risk Assessment Conference processes		
6	Services and organisations must continue to work to enhance awareness of domestic abuse and promote support services within our communities.	DHR PS has also highlighted this as learning and recommended a review of the content and distribution of domestic abuse literature.		
7	Professionals should explore domestic abuse when attending to individuals at risk of self-harm or suicide.	Work/training has been undertaken by agencies to address this learning.	4	In what ways can the Safer Telford and Wrekin Partnership provide assurance to the Domestic Homicide Review and Safeguarding Adults Review panels that they

				have robust mechanisms in place to monitor review referrals which will determine if professionals are not consistently recognising the connection between domestic abuse and suicide in the future. And can Safer Telford and Wrekin Partnership confirm to the panels that consideration will be given to commissioning a thematic review when/if appropriate?
8	There were missed opportunities for the police to refer Neil to support services in relation to his abusive behaviours as they became known.		5	There is a need for West Mercia police to review how the support available to perpetrators of domestic abuse is relayed to their officers and how it is embedded into their guidelines. And to thereafter assure the Safer Telford and Wrekin Partnership of improvement.
9	Delay to support from services can affect a survivor's ability to maintain separation/disclosure/prosecution. It is therefore crucial that professionals respond in a timely manner to survivors of domestic abuse and seek to address the impact.	The timelapses in Samantha's case have been discussed and professionals have recognised that the delays to Neil's arrest were unavoidable; police must gather evidence and need resources to arrest. Furthermore the delays to Cranstoun responding to Samantha have been identified as 'human error'.		
10	To gain an effective understanding of Samantha's circumstances, professionals needed to be 'curious' by asking questions and verifying information from alternative sources such as historic case notes and partner agencies, as required.		6	How can agencies evidence to Safer Telford and Wrekin Partnership that that they are prompting and encouraging their professionals to be professionally curious, and how can Telford and Wrekin Community Safety Partnership gain an improved understanding of how to support agencies with this practice.

6.2. In addition agencies have self-identified the following single agency recommendations during the process of this review:

6.2.1. Midlands Partnership University NHS Foundation Trust

Recommendation	Detailed actions	Timescales	Desired Outcome	Audit
Telford Community Mental Health Team to have dedicated Safeguarding Supervision around Domestic Abuse and the Multi-Agency Risk Assessment Conference process	Team were encouraged to attend targeted supervision/learning session.	Completed December 2024	Team up skilled in why recognition and early intervention in domestic abuse is necessary.	Referral data into Multi-Agency Risk Assessment Conference/ Safeguarding Practitioner
Learning Session for staff around Perpetrator Programmes	Men and Masculinities to be invited to provide Lunch and Learn event during a planned Domestic Abuse Week provided by Midlands Partnership University NHS Foundation Trust Safeguarding	TBC – Dates currently being considered for this.	Staff knowledge increased in the use of perpetrator programmes	Referral data in to programmes.

6.2.2. GP Practice

Recommendation	Detailed actions	Timescales	Desired Outcome	Audit
Increase flagging pathways	To have low threshold for flagging letters and discussing at weekly safeguarding meeting	Already completed		Weekly safeguarding meetings already show increased level of discussions/flagging
Improve safeguarding communication	An in house flagging system to look into 'soft concerns' which may be comments in a clinic letter that warrant further investigation	Already completed	Better-informed risk assessments	Weekly safeguarding meetings already show increased level of discussions/early flagging without having to reach the threshold for safeguarding but would identify risk factors.
Enhance Domestic Abuse Training	Arrange training session with Safeguarding Lead	In progress	Improved clinician confidence in Domestic Abuse identification	Microsoft Teams Based Domestic Awareness training has now started with first session on 3/9/25 facilitated by Voices Social Enterprise (Tracey Secker)

Improve flagging and coding	Implement structured safeguarding reviews for hospital correspondence	Already completed	Increased Domestic Abuse awareness and proactive enquiry	Weekly safeguarding meetings and updated pathways already show increased level of discussions/flagging/coding
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6.2.3. Domestic Abuse Services

Recommendation	Detailed actions	Timescales	Desired Outcome	Audit
Staff to implement knowledge gained from training regarding the link between domestic abuse and suicide within their practice	Staff undertake training outlining the link between domestic abuse and suicide.	Completed April 2025	Better of understanding of the link between domestic abuse and suicide.	This will be reviewed in monthly case management, and three-monthly audits. Reflective practice sessions, and clinical supervision.
Staff to implement knowledge gained from training on the threshold for Multi-Agency Risk Assessment Conference referral into their practice.	Staff undertake training creating a clear understanding of the threshold for a referral to Multi-Agency Risk Assessment Conference.	Completed April 2025	A clear understanding of the threshold for a referral to Multi-Agency Risk Assessment Conference.	This will be reviewed in monthly case management, and three-monthly audits. Reflective practice sessions.

6.2.4. Shrewsbury and Telford Hospital NHS Trust

Recommendation	Detailed actions	Timescales	Desired Outcome	Audit
Scoping outcome learning to be shared with Bariatric team	Face to face training session for the team	Completed January 2025	Improved awareness and appreciative inquiry	