



Domestic Homicide Review Overview Report

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

Independent Reviewer: Allison Sandiford
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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1. Introduction

1.1. This report of a Domestic Homicide Review¹ examines agency responses and support given to Samantha, a resident of Telford, prior to the point of her death in September 2024.

1.2. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3. The circumstances that led to a review being undertaken in this case are that on a day in September 2024, police were contacted by a friend of Samantha's. The friend expressed concerns regarding a recent decline in Samantha's mental health. At the time, Samantha was actively supporting an ongoing police investigation related to stalking perpetrated by her estranged husband, hereafter referred to as Neil.

1.4. Police officers forced entry to Samantha's address and found Samantha deceased. The evidence gathered indicated that Samantha had died by suicide - overdosing on prescription medication.

1.5. The review will consider agencies contact/involvement with Samantha and Neil from October 2023 until September 2024, when Samantha died. This time period was established by the review panel members as it was deemed to offer sufficient analysis of Samantha's and Neil's history in order to understand learning for future practice.

1.6. In addition the report will include brief background information re any significant events and safeguarding issues prior to the scoping period if agencies consider that it would add value and learning to the review.

1.7. The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned from homicides where a person is killed or has died by suicide as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.8. It is not the purpose of this review to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation.

2. Timescales

2.1. This review began in January 2025 and concluded in September 2025.

¹ The purpose of the Domestic Homicide Review is to:

- a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
- d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.

2.2. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. This review has taken slightly longer than recommended timescales to accommodate conversations with Samantha's friend, employer and counsellor and to allow the panel adequate time to consider the analysis and learning.

3. Confidentiality

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

3.2. 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.

4. Terms of Reference

Methodology

4.1. Following presentations and discussions, 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. Allison Sandiford was secured as Independent Reviewer in January 2025.

4.2. Whilst applying the principles of proportionality, learning from good practice, and engagement with families, the Independent Reviewer has followed the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, as amended in December 2016.

4.3. Following the Independent Reviewer being in receipt of the agency screening reports, an initial scoping and first panel meeting was held on the 27th of January 2025, where agency representation, terms of reference, the scoping period and the project plan were agreed.

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

1. What did statutory agencies and other wider organisations know about Samantha's life, her lived experience, and the dynamics of her relationship with Neil?
2. How did any mental health issues affect Samantha's relationship with Neil?
3. How accessible and responsive were domestic abuse support services and how well known were these services to Samantha?
4. Explore the effectiveness of the domestic abuse risk management plan?
5. How well understood was the link between domestic abuse and the risk of suicide?
6. What support was offered to Neil to manage his behaviour?
7. Were there any barriers to Samantha accessing support?
8. 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?
9. Were there missed opportunities to exercise professional curiosity?
10. Identify areas of strong practice, both single and multi-agency.

4.5. Thereafter in March 2025, a virtual practitioner event was convened, bringing together key agencies - including the police, public protection, domestic abuse services, and various multi-agency representatives. Facilitated by the independent reviewer, the virtual session provided a collaborative forum where participants collectively worked through the chronology of the case, using the established lines of enquiry to review and analyse practice in real time. This event significantly contributed to the review by fostering a space for reflection; it allowed agencies to openly discuss whether actions could have been approached differently and to actively learn from one another's distinct organisational experiences. Ultimately, this event underscored the importance of multi-agency listening, resulting in positive, collaborative learning that directly shaped the findings and actionable insights of this review.

4.6. The panel met on two further dates to monitor the review process and contribute to the analysis and learning.

Involvement of Family, Friends, Colleagues, Neighbours and Wider Community

4.7. The Safer Telford and Wrekin Partnership and the Independent Reviewer would like to offer their condolences to the family and friends of Samantha.

4.8. The Partnership wrote to Samantha's mother, stepfather and close friend (hereafter referred to under the pseudonym Ivy) to inform them of the review and offer the opportunity to contribute to the process. The correspondence included a copy of the Home Office Domestic Homicide Review leaflet for family members and information in relation to the support available through AAFDA².

4.9. Samantha's mother and stepfather have not responded to the invitation³, and the Partnership, Independent Reviewer, and review panel, respect and understand their decision.

4.10. Ivy agreed to contribute to the review process and the Independent Reviewer subsequently shared and discussed the Key Lines of Enquiry with her, before speaking at length of Samantha and her lived experiences. Thereafter there was ongoing communication by means of email and on the 29th of April 2025, Ivy met the panel (virtually) and was introduced to members.

4.11. Ivy's comments are woven into the body of this report and the Partnership; the review panel and Independent Reviewer would like to thank her for her valuable engagement.

4.12. Safer Telford and Wrekin Partnership further wrote to Neil and invited him to contribute his experiences to the review. He has not responded to the contact and his decision is respected.

Contributors to the Review

4.13. 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

² Advocacy After Fatal Domestic Abuse (AAFDA) has over a decade of experience advocating for families after the homicide, suicide or unexplained death of their family member or friend, following domestic abuse.

³ The information was communicated by letter on two occasions.

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

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

- BUPA counsellor
- Samantha's Employer

The Review Panel Members

4.16. 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

4.17. The panel met on three occasions:

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

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

Author of the Overview Report

4.19. 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.

4.20. 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.

4.21. In 2019 Allison completed the SILP Lead Reviewer Course⁴ and has since conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews, both independently and with SILP.

⁴ 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.

4.22. Allison has also completed the Home Office online learning with regard to conducting domestic homicide reviews and the AAFDA⁵ domestic homicide review training.

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

Parallel Reviews

4.24. Police conducted a criminal 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.

4.25. A Coroner's Inquest concluded (in February 2025) that Samantha had died by suicide.

4.26. Cranstoun Telford and Wrekin Domestic Abuse Service⁶ completed an internal investigation in line with their internal incident investigation policy. The investigation has resulted in learning being implemented (which is detailed throughout the body of this report).

4.27. The Midlands Partnership University NHS Foundation Trust completed an After Action Review, led by the Patient Safety Team. Learning from the Trust's Domestic Abuse Lead involved in this review is outlined in paragraph 11.2.1 of this report.

Equality and Diversity

4.28. The Independent Reviewer has considered the nine protected characteristics under the Equality Act 2010 (age, disability⁷; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion⁸ or belief; sex; sexual orientation).

4.29. Samantha was a 36 year old White British female, and Neil⁹ is a White British male. Samantha and Neil were married at the time of Samantha's death, but the relationship had ended a few months earlier and Neil had moved out of the home they had shared.

4.30. Samantha and Neil did not have any children together, but Neil has two children from previous relationships. Samantha did not have any children.

4.31. Samantha died by suicide. After Samantha's death, a friend contacted the police, linking Samantha's death to domestic abuse perpetrated by Neil.

4.32. An estimated 4.4% of people aged 16 years and over (5.7% women and 3.2% men) experienced domestic abuse in the year ending March 2023¹⁰. This equates to an estimated 2.1 million adults. As in

⁵ 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.

⁶ Cranstoun deliver Telford and Wrekin domestic abuse service which is an integrated service for victims and children that delivers support throughout the Telford and Wrekin area.

⁷ Research confirms that disabled people experience disproportionately higher rates of domestic abuse and experience domestic abuse for longer periods of time. Samantha did not have a recorded disability.

⁸ Neither Samantha nor Neil are recorded to have followed any religion.

⁹ 34 years at the time of Samantha's death.

¹⁰ Data for Devon and Cornwall Police Force Area have not been included in the year ending March 2023 because of issues with their supply of data following the implementation of new force IT systems.

previous years, women were disproportionately represented among victims of domestic abuse-related crimes, with 73.5% of all victims being female in the last year¹¹.

4.33. Domestic abuse is about power and control and is always a choice on the part of the abuser. It can be physical, emotional, sexual, or financial or economic and can happen to anyone of any race, gender, sexual orientation, or religion. It is never the fault of the survivor/victim.

4.34. Typically, a perpetrator of domestic abuse will initially present themselves as charming. However, over time, they commence abusive behaviour aimed at diminishing the victim's self-confidence and independence. This pattern of behaviour often includes creating discord with the victim's friends and family, thereby fostering a dependency on the abuser.

4.35. Ultimately, the perpetrator instils a fear into their victim, which may manifest as apprehension of violence or humiliation.

4.36. This review has learned that Samantha described to friends and professionals circumstances which copied this pattern of behaviour; she described her independence waning around the time she married Neil and spoke of how Neil began to criticise her appearance and decisions. She also spoke of her fear of Neil humiliating her and confided in a friend that Neil had once sent some personal information to one of her employers in an act of revenge.

4.37. When/if a perpetrator's actions are questioned, they often justify their conduct with declarations of love, attributing their behaviour to uncontrollable jealousy, asserting it to be beyond their control. They claim that their actions are driven by an intense affection for the victim. If the victim reaches a breaking point, the abuser may offer rewards and promises of change.

4.38. Such abusive behaviour severely impacts a victim's well-being, potentially leading to sleep disturbances, erosion of self-esteem, mental health issues, and an overarching sense of helplessness. The victim is made to feel isolated, believing there is no recourse for help, that they will not be believed, and that the situation is their fault.

4.39. This is a pattern that has been observed in Neil's behaviour towards Samantha. Samantha described to others how she blamed herself for Neil's behaviours when, a few days before she died, she told a friend that she was a *bad person* and she posted on Social Media that she had brought *stress and unhappiness* into Neil's life and that she had often dismissed his feelings and needs, prioritising her own.

4.40. Consequently, many people encountering domestic abuse experience mental health problems, substance misuse, depression, self-harm, eating disorders and suicidal ideation or suicide¹².

4.41. In 2006 the link between domestic abuse and suicide was brought to the attention of the public when the case of R v Dhaliwal (EWCA Crim 1139) came to the Court of Appeal. The Crown Prosecution Service attempted to bring manslaughter charges against an abusive husband who had subjected his wife to continuous psychological abuse prior to her suicide; but the case was unsuccessful. However, it was significant in drawing attention to the terrible consequences for individuals who are subject to domestic abuse.

¹¹ [Domestic abuse in England and Wales overview - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/domesticabuseinenglandandwalesoverview/2019-01-22)

¹² https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/Creating_hope_through_language_210_345_mm.pdf-3.pdf

4.42. After this case, Siddiqui and Patel produced the 'Safe and Sane Report' for Southall Black Sisters (2011), which found that across 409 women that had been subject to domestic abuse, 44% had contemplated suicide or self-harm, a further 18% had made attempts to do so, and eight women had lost their lives to suicide.

4.43. To further explore the links between domestic abuse and suicide, Aitken and Munro analysed 3,519 case files of clients who had interacted with REFUGE between April 2015 and March 2017. The clients had all completed psychological distress questionnaires, and it was found (using the questionnaires) that

- 18.9% of clients currently felt suicidal (or had recently),
- 18.3% had made plans to end their lives, and
- 3.1% had attempted to end their lives.

4.44. 2017 saw the first case of a successful verdict of manslaughter following suicide in domestic abuse¹³ wherein a male was jailed for ten years after admitting manslaughter, engaging in coercive or controlling behaviour and stalking of his ex-partner - who died by suicide following his sustained campaign of harassment.

4.45. Since this, the link between domestic abuse and suicide has been further confirmed in the fourth annual report from the national Domestic Homicide Project¹⁴ which works across England and Wales and was published in March 2025. The report shows that for the second year in a row, suspected suicides following domestic abuse have in reported cases have overtaken the number of homicides involving current or previous partners.

4.46. This link between domestic abuse and suicide is comprehensible because domestic abuse leaves a victim feeling isolated with nowhere to turn and no chance of ever escaping.

4.47. Suicide, for some like Samantha, may feel like their only way out.

4.48. Neil is known to use alcohol and drugs.

4.49. Neither alcohol nor drugs ever cause domestic abuse. Perpetrators can be violent and abusive when not under the influence of a substances, and many people who use alcohol or drugs, do not abuse their partner. Therefore alcohol/drug use should never be used to excuse violent or controlling behaviour. The perpetrator alone is responsible for their actions.

4.50. However, whilst substance use is never a cause of domestic abuse, it is known that alcohol and/or drugs can leave an individual more vulnerable to further abuse, (especially if it affects an individual's ability to access support). Furthermore, substance use may be adopted by a survivor as a coping strategy, or it can be deliberately used by the abuser as part of the abuse itself.

4.51. Samantha disclosed to professionals that on occasions, she would binge alcohol and sometimes she used drugs with Neil.

4.52. A specialist professional from Domestic Abuse Services assisted this Domestic Homicide Review panel to be reliably informed on issues relating to women experiencing domestic abuse and the support available.

4.53. Samantha had a diagnosis of bipolar disorder (and Neil had a possible diagnosis that was later queried when his presentation was deemed to be more in line with Emotionally Unstable Personality Disorder).

¹³ [Statement - publication of Domestic Homicide Review following the death of Justene Reece | Staffordshire Police](#)

¹⁴ [Domestic Homicide Project - VKPP Work](#)

4.54. Bipolar UK, a charity supporting people affected by bipolar, describes bipolar as a severe mental illness characterised by extreme mood swings and changes in energy levels. They state that someone with bipolar can have long or short periods of stability but can then go 'low' (into deep depression) or 'high' (experiencing hypomania, mania or psychosis)¹⁵.

4.55. Bipolar mood swings are significantly more intense than typical fluctuations in everyday emotions. For a clearer explanation of these mood extremes, Bipolar UK employs a Mood Scale¹⁶ where 0 represents the lowest point and 10 denotes the highest level.

4.56. People without bipolar have moods ranging from 4 (feeling down) to 6 (feeling happy). Bipolar individuals experience moods from 0 (deep depression and suicidal thoughts) to 10 (extreme manic high with psychosis and hallucinations), including mixed states with both depression and mania.

4.57. Bipolar disorder can significantly impact a person's close relationships as individuals may exhibit regrettable behaviours during both manic and depressive episodes. For example, according to Bipolar UK, individuals may spend family savings or have affairs that damage familial relationships. The charity further explains that people with bipolar disorder often blame themselves for their actions, experiencing self-stigma, guilt, and shame. These negative feelings, combined with low self-worth and traumatic experiences, can induce stress, making it challenging to maintain emotional stability. Many individuals find themselves trapped in a cycle of recurring issues, resulting in frequent hospital admissions.

4.58. However, a diagnosis can lead to effective treatment, support, and self-management, enabling individuals with bipolar disorder to live well and reach their full potential. Samantha had a diagnosis and engaged with professionals to manage the condition.

4.59. Additionally, during the scoping period of this review, Samantha was diagnosed with Attention Deficit Hyperactivity Disorder. According to the NHS website¹⁷ if you have Attention Deficit Hyperactivity Disorder, you may have trouble with things like concentrating and sitting still.

4.60. It has been reported by VeryWell Mind¹⁸ that people with Attention Deficit Hyperactivity Disorder can find themselves innately drawn to relationships with quick, intense beginnings. And whilst initial intensity in dating isn't always necessarily a bad thing, abusive relationships — where gaslighting¹⁹ and love bombing²⁰ take place — also often begin the same way. Consequently someone with Attention Deficit Hyperactivity Disorder may miss out on early signs that the other person is controlling and manipulative²¹.

4.61. Notably Samantha and Neil married only eight months after their relationship had begun. And it is reported in case notes that at the beginning of the relationship, Samantha's brother advised Samantha not to get involved, but Samantha is recorded to have said that she dismissed his warning.

Dissemination

¹⁵ [What is bipolar?](#)

¹⁶ [Bipolar UK Mood Scale](#)

¹⁷ [ADHD in adults - NHS](#)

¹⁸ VeryWell Mind is a medical and health website launched by About.com in 2017. The website provides factual, evidence-based information on mental health and psychology.

¹⁹ Gaslighting involves psychologically manipulating a victim to create self-doubt, with victims often questioning their own sanity. As with other types of abuse, it often develops gradually. And it can be subtle and difficult for the victim or others to detect.

²⁰ Love bombing is a form of psychological/emotional abuse that involves a person going above and beyond in an effort to manipulate a person into a relationship with them. It often involves some form of: Excessive flattery and praise; Over-communication of their feelings; unneeded/unwanted gifts and early, intense talks about a future together.

²¹ [The Connection Between ADHD and Toxic Relationships](#)

4.62. Once agreement for the final report has been given by the Home Office Quality Assurance Panel, the Overview Report and/or an Executive Summary of this Domestic Homicide Review will be available on the council website. The report(s) will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 1998.

4.63. The final report will be formally disseminated to

- Friends and Family²² (subject to their express wish to receive the document)
- The Domestic Abuse Commissioner (for national oversight and thematic learning)
- The local Police and Crime Commissioner (for regional strategic and policing oversight)
- The Home Office Quality Assurance Panel
- Telford Community Safety Partnership Board Members
- West Mercia Police
- Telford & Wrekin Council (Adult Social Care)
- NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB)
- The Participating GP Practice
- Telford and Wrekin Domestic Abuse Services (Cranstoun and West Mercia Women's Aid)

4.64. Upon publication, partner agencies will be made aware, and the action plan will be shared with all agencies involved.

4.65. The review has been assured by The Safer Telford and Wrekin Partnership that the learning will be disseminated by means of partnership training and developed guidance.

5. Background Information (The Facts)

5.1. Samantha and Neil's relationship ended in July 2024, and Neil moved out of the address (Samantha had resided there prior to their relationship).

5.2. 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.

5.3. 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.

5.4. Officers forced entry into Samantha's address and found her deceased. The evidence gathered indicated that Samantha had died by overdosing on prescription medication – police 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.

5.5. 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.

²² Explicit consideration will be given to dates to avoid for public release - ensuring that publication does not coincide with significant dates such as Samantha's birthday or the anniversary of her death. Furthermore, the report will be shared with her family and friends with the utmost sensitivity, and support will be offered.

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

6. Chronology

Background of Samantha and Neil prior to the scoping period

6.1. Ivy has described Samantha as a vibrant, intelligent, and independent young woman with big dreams and a heart full of compassion. Ivy said that Samantha had a deep love for science and psychology, a brilliant mind, and a natural curiosity about the world. She describes her as a true social butterfly with an incredible ability to connect with people; the kind of person who could strike up a conversation with a stranger.

6.2. Ivy described Samantha as having excelled in her work and having become a respected voice in the industry. In reflection of both Samantha's talent and passion, Samantha achieved a great deal; she is featured in a published book, and she contributed to other industry publications. Ivy told this review that Samantha loved what she did and poured her energy into it.

6.3. As mentioned, 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 136²³ of the Mental Health Act and she has also been detained under section 2²⁴.

6.4. 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.

6.5. Samantha and Neil started their relationship in 2021 and married after eight months. Samantha has told professionals that it was during the preparation of the 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.

6.6. 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.

6.7. Samantha has reported debt in relation to Neil – she said that she obtained a loan to cover his debts and also that she owed a considerable sum of money 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.

²³ 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.

²⁴ 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.

6.8. 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.

6.9. 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.

6.10. 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.

6.11. 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.

6.12. 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.

6.13. Samantha was a smoker and admitted to sometimes binge drinking and having used 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.

6.14. 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.

6.15. 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.

6.16. Officers completed a further medium risk Domestic Abuse Risk Assessment and recorded, in an adult risk assessment, that the flat was messy and Samantha had consumed vodka. (In relation to these and the aforementioned assessment, police referrals were processed to Mental Health, Adult Services, Children's Services²⁵, and Op Encompass²⁶.)

²⁵ In relation to Neil's children (who were not present)

²⁶ 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.

6.17. 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 BUPA²⁷. Over the next 24 hours, Samantha's brother and her BUPA psychologist both reached out to the crisis mental health team expressing concerns about Samantha. This led to Samantha's care coordinator contacting Samantha. A care coordinator is a trained healthcare professional who helps to manage a patient's condition and will oversee a patient's treatment plan.

6.18. 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 described Samantha's flat as being unclean and Samantha presenting unkempt - Samantha's medication was re-started with good effect.

6.19. 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 session²⁸ and saw psychology the next day).

6.20. 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.

6.21. 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.

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

6.23. 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.

6.24. 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.

6.25. 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

²⁷ Samantha had 13 weekly (with the exception of holidays) appointments with a clinical psychologist from BUPA starting from August 2023.

²⁸ 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.

contact the community mental health team; thus no ambulance was dispatched, and no face-to-face assessment occurred.

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

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

6.28. 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.

6.29. 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 information²⁹. And the following day a Cranstoun key worker sent Samantha an introductory email.

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

6.31. The following week, during a phone call with her care coordinator, Samantha described herself as well and happy and said that she was being more '*boundaried*' with Neil. She said that their marriage was over, and she was being firm in relation to asking him for financial support.

6.32. On the 5th of August 2024, police created a Domestic Abuse Risk Management Plan³⁰ 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 telephone³¹ 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 Conference³² was agreed and Samantha said she would check with her landlord whether she was allowed a ring doorbell³³.

6.33. 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.

²⁹ 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.

³⁰ The core objective of a police Domestic Abuse Risk Management Plan is to plan how the police can safeguard and support the victim of reported abuse.

³¹ All contact between this service and Samantha was conducted by telephone.

³² 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

³³ 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.

6.34. 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.

6.35. 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.

6.36. On the 19th of August, Samantha saw her care coordinator face-to-face³⁴. 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 employer³⁵ 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 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.

6.37. 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.)

6.38. 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.

6.39. 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.

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

6.41. 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.)

6.42. 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

³⁴ The contact was only for 15 minutes as Samantha had attended late.

³⁵ Around this time Samantha had begun in-house counselling at work.

contacted her stating that she had written it a few days earlier when feeling low, but the crisis team were on their way now.

6.43. 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.

7. Overview

7.1. In summary, during the scoping period of this review, several teams within the Midlands Partnership University NHS Foundation Trust provided mental health services to Samantha and through assessment and consultation learned of the affect her relationship with Neil had upon her mental health.

7.2. Mental health services also knew of Neil's mental ill health and substance use – though the two individuals were not linked on the system.

7.3. The police were aware of both Samantha and Neil as they had responded to them as a couple several times in times of crisis. Their database evidenced previous domestic abuse perpetrated by Neil and towards the end of the scoping period, police commenced a new investigation into domestic abuse reported by Samantha perpetrated by Neil.

7.4. The domestic abuse situation was also known to Cranstoun Telford and Wrekin Domestic Abuse Service after Samantha reached out to them and engaged with assessments, disclosing much information.

7.5. As such Samantha's vulnerabilities and relationship were known to many professionals.

8. Analysis

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

8.1. At the beginning of the scoping period of this review, Samantha had been married to Neil for two years, and they had lived together in the flat which had been Samantha's home before their relationship had begun.

8.2. Samantha had a diagnosis of bipolar and lived with mental ill health, but she was engaging with mental health professionals including a BUPA clinical psychologist.

8.3. The police were called to Samantha and Neil on multiple occasions during the scoping period and as such, were aware of their relationship. 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.

8.4. 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 assessment³⁶ but it has

- less questions

³⁶ The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was endorsed by National Policing leads in 2009 to support and improve professional responses to a domestic situation by employing a proactive response which asked direct questions to assess risk.

- more prompts to help officers to probe into what might be happening, and
- an increased focus on coercive and controlling behaviour.

8.5. 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.

8.6. Like the Domestic Abuse, Stalking and Harassment and Honour-based violence risk assessment, a Domestic Abuse Risk Assessment should be completed for every domestic abuse and stalking and harassment incident attended, and police completed the assessment 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.

8.7. 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.

8.8. 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.

8.9. Given the potential divergence of how domestic abuse risks are responded to, the practice of risk assessing cases was discussed amongst the professionals in attendance at the practitioner event held within this review, and it was debated whether the grading process is somewhat subjective - with individual officers potentially identifying different thresholds of medium and high risks.

8.10. The panel member representing the police subsequently assured this review that whilst risk assessment is subjective, it is evidence led with the use of the Domestic Abuse Risk Assessment tool and also subject to scrutiny by a police sergeant; and further reviewed by the Harm Assessment Unit. This provides a level of uniformity. Additionally whilst it is correct that high risk referrals are automatically referred to the Domestic Abuse Risk officers via a spreadsheet (for contact, a risk management plan, and a referral to Multi-Agency Risk Assessment Conference), medium risk referrals also feature in this spreadsheet and in Telford, are subject to scrutiny by the domestic abuse risk officers. The officers then assess the level of offence and the previous history, in order to decide whether the victim requires; contact; a referral to Multi-Agency Risk Assessment Conference; agency support (such as domestic violence assist, freedom programme), and/or a risk management plan.

8.11. Notably medium/low risk 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).

8.12. Nevertheless, any declination must be considered within context. The query *do you consent to being referred to domestic abuse support services* is a big question to ask at such an emotive time when cognitive

decision making could be affected by adrenalin, mental health crisis, and drug or alcohol consumption. Individuals may decline because in their minds the relationship has now ended or conversely because they don't want it to end. Furthermore, some individuals may want their abusive partner to get the help and support, particularly if the survivor deems the relationship problems to stem from their partner's substance use or mental health.

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?

8.13. 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.

8.14. Clare's Law is a Domestic Violence Disclosure Scheme that was implemented in 2014 across all police forces in England and Wales to allow an individual to check whether their partner has a violent past. The scheme 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.

8.15. The scheme has two elements: the "Right to Ask" and the "Right to Know". Under the scheme an individual or relevant third party (for example, a friend, family member or concerned professional) can ask the police to check whether a person's current or ex-partner has a violent or abusive past. This is the "Right to Ask". If records show that an individual may be at risk of domestic abuse from a partner or ex-partner, the police will consider disclosing the information to the individual at risk.

8.16. The "Right to Know" enables the police to make a disclosure on their own initiative if they receive information about the violent or abusive behaviour of a person that may impact on the safety of that person's current or ex-partner. This could be information arising from an incident or criminal investigation.

8.17. 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.

8.18. Consequently had a disclosure been given to Samantha (under either the Right to Ask or the Right to Know element) she could have been advised of the range of orders available to her should she require support. For example, Non-Molestation Orders, Restraining Orders, Domestic Abuse Protection Orders and Stalking Protection Orders which were introduced in 2020 and provide an additional tool for managing the risk posed by perpetrators by enabling courts to impose a range of conditions.

8.19. 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.

8.20. This review has been informed that the Safer Telford and Wrekin Partnership has a 7 minute briefing³⁷ which is regularly circulated in newsletters to raise awareness of Clare's Law among professionals. And that West Mercia Police Comms team are also exploring the creation of a Clare's Law awareness video to be used for members of the public. Furthermore The current Domestic Abuse leaflet³⁸ (which is being revised) has a section highlighting Clare's Law along with details on how to go about making an application.

8.21. Additionally West Mercia Police have explored ways to provide disclosures to support where attendance at the police station is not possible, for example, virtual meetings and disclosures via Cranstoun.

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?

8.22. Later in the scoping period, Samantha bravely self-referred to domestic abuse support services after Ivy told her about Women's Aid, and within days Samantha also contacted the police to report the abuse. The police response included an investigation and a Domestic Abuse Risk Management Plan - which is considered in detail later in this report.

8.23. During one police attendance early in the scoping period of this review, officers recorded that Samantha's flat was messy. On this occasion the Harm Assessment Unit shared the report – which cited emotional concerns and advised that Samantha had been taken to hospital for consideration of a Mental Health Act Assessment, with Adult Social Care.

8.24. Adult Social Care has advised that no care and support needs were identified for Samantha, and the report was consequently sent to the Mental Health Access Team before being closed to Adult Social Care with no further action. This was positive practice because adult safeguarding responsibility is broader than just those situations that can progress to a safeguarding enquiry; there is a shared responsibility across organisations to address risks to wellbeing and safety, whether through safeguarding responses or through alternative support pathways.

8.25. Adult Social Care has informed this review that during the scoping period, the only information they received in relation to Samantha was via the aforementioned police Harm Assessment Unit and in relation to Mental Health Act Assessment. However it is recorded that Samantha could never truly open up to professionals in the Mental Health Act Assessments and at times told the assessing team they could have five minutes. Nevertheless information was gained in relation to how Samantha and Neil would argue - often when both had been using alcohol, and how events would escalate. The mental health team has said that Samantha denied any physical abuse, and would make excuses for Neil, advising that he just needed support in managing his temper³⁹.

8.26. Furthermore Adult Social Care has identified that whilst both Samantha and Neil were known to them and had records within their database system, Samantha and Neil had not been linked on their system. This is despite Adult Social Care completing two Mental Health Act Assessments with Samantha during the scoping period and the assessments including discussions around her relationship/marriage with Neil.

³⁷ [7 Minute Briefing - Clare's Law - Telford and Wrekin Safeguarding Partnership](#)

³⁸ [Domestic Abuse Help Leaflet 2022 - Telford and Wrekin Safeguarding Partnership](#)

³⁹ Additionally, prior to the scoping timescales of this review, it is recorded that during a conversation between Samantha and a Safeguarding Social Worker, Samantha denied domestic abuse and minimised previous events.

8.27. Adult Social Care has recognised that the practice of linking connected persons' records requires improvement and has assured this review that their professionals will be reminded of this practice requirement via their monthly briefings.

8.28. Similarly Midlands Partnership University NHS Foundation Trust, who provided mental health services to Samantha and Neil has advised that the couple were not linked within their systems either but conversely their practice does not allow practitioners to look at another's file unless there is a *significant* reason under safeguarding.

8.29. Samantha was already known to Midlands Partnership University NHS Foundation Trust prior to the scoping period of this review as she:

- had already been assessed by the mental health crisis team,
- had been detained under section 2 of the Mental Health Act 1983⁴⁰ twelve months earlier (she had survived a suicide attempt at a time when Neil had been subject to bail conditions in relation to domestic abuse perpetrated against her, and Samantha had also discussed that she was in a large amount of debt as a result of paying for their wedding), and,
- she had been allocated a care coordinator⁴¹ six months prior.

As mentioned, a care coordinator is a trained healthcare professional who helps to manage a patient's condition and will oversee a patient's treatment plan. In Samantha's case, the care coordinator was a mental health nurse. The nurse would monitor and coordinate Samantha's treatment plans and support her to access any other support she needed.

8.30. Partway through the scoping period, Samantha had to be allocated a new care coordinator and the relationship with this worker did not commence for several months as Samantha cancelled appointments citing work commitments to blame. When they did meet, Samantha presented well.

8.31. Throughout the scoping period, 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.

8.32. 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.

8.33. Additionally Samantha did disclose potential financial abuse within the scoping period - when she described obtaining loans for Neil and his lack of responsibility for debt accrued in relation to their wedding.

8.34. Financial abuse is a form of domestic abuse that involves the control of a partner or ex-partner's money and finances, and it is a legally recognised form of domestic abuse. It can include a variety of things, like controlling and preventing your access to money, forcing you to get loans you don't want or preventing you from getting a job. Though professionals evidenced a good understanding of financial abuse, further exploration of this type of abuse was missed in Samantha's case.

⁴⁰ Section 2 provides for someone to be detained in hospital under a legal framework for an assessment and treatment of their mental disorder. It allows inpatient hospital detention for 28 days.

⁴¹ The role of care coordinator is now known as Key Worker.

8.35. Professional curiosity could have supported a better understanding of Samantha's circumstances, and the details of the financial pressure Neil was putting on her. For example, Ivy has informed this review that Samantha had disclosed situations to her whereby Neil used guilt, threats, and emotional abuse to manipulate Samantha's financial decisions, and she has described how if Samantha was unable to afford something, Neil would become angry or agitated, making her feel guilty.

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

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

8.37. In August 2024, Samantha did clearly disclose domestic abuse to Midlands Partnership University NHS Foundation Trust when she described threats to kill her and not feeling safe. On this occasion, the mental health professional advised Samantha about contacting the police but did not take any further action because Samantha had already assured that she was working with domestic abuse agencies and was to become subject to Multi-Agency Risk Assessment Conference. Nonetheless, it could have been beneficial for this information to have been verified and shared with other involved practitioners.

8.38. In relation to Midlands Partnership University NHS Foundation Trust and their identification and response to domestic abuse, this review has been assured that since 2023, all mental health teams provided by the Midlands Partnership University NHS Foundation Trust have assigned Named Safeguarding Practitioners⁴² to their teams. This Safeguarding Practitioner is a member of the Corporate Safeguarding Service who provides a service to all adult mental health teams, as a point of contact for all safeguarding concerns. Proactively, they offer regular safeguarding supervision to operational teams, and 1:1 case supervision where practitioners have concerns. They also provide reporting, audit and assurance, representation at Domestic Homicide Review/Safeguarding Adult Review training events such as Lunch and Learns, and targeted training. All mental health practitioners are aware that the Named Safeguarding Practitioner is a resource for safeguarding, domestic abuse and Prevent, and that they are accessible via Teams/email/phone as required.

8.39. Additionally Midlands Partnership University NHS Foundation Trust has developed the role of Domestic Abuse Lead for the Trust. This role provides a lead on the Trusts' response to domestic abuse⁴³.

8.40. Both of these developed roles should provide Midlands Partnership University NHS Foundation Trust staff with increased learning, and confidence, in spotting, referring and protecting against domestic abuse.

8.41. Samantha presented at hospital with physical health needs during the scoping period of this review and the Review Panel has been assured that domestic abuse is always considered and recorded by staff within the Emergency Department. This is evidenced by the fact that Emergency Department staff are recorded to be the highest referrers into Multi-Agency Risk Assessment Conference/Safeguarding processes. However Samantha didn't ever present with injuries that might have suggested physical abuse and in the absence of immediate concerns, no domestic abuse enquiry is recorded.

⁴² Named Safeguarding Practitioners hold a Social Work degree, MA in Safeguarding Law, Policy and Practice and have specialist subject knowledge around safeguarding adults and children.

⁴³ Leading on becoming a White ribbon accredited Trust, representation on Staffordshire, Stoke, Telford and Shropshire Domestic Abuse Local Partnership forums and operational forums, providing training and information events across the Trust, keeping the Trust's SharePoint and Learning Platform domestic abuse information up to date, representation at some Domestic Homicide Reviews where possible, developing the Trust's Domestic Abuse policy for patients and staff.

8.42. Nevertheless following on from this case and recent Safeguarding Adults Reviews, the Trust has further strengthened their practice around domestic abuse by ensuring that the bariatric team, who engaged Samantha during the scoping period, have received additional training in respect of understanding and considering domestic abuse when they meet with patients in clinic. This is because it has been identified that they are often uniquely placed to explore such considerations with people who may not have contact with other Trust services.

8.43. Samantha registered with the GP Practice in April 2022 (when she moved into the Practice's area). Upon registration a routine summary care record review was conducted, and her previous medical history, including mental health conditions, was documented. No safeguarding concerns were highlighted in Samantha's transferred records.

8.44. In relation to Samantha's consultations with her General Practitioner, Samantha's presentation did not ever cause concerns, and she did not ever disclose any domestic abuse. As such, no routine domestic abuse enquiry is recorded.

8.45. However this review has been informed that had the GP Practice been aware of Samantha's disclosures when she raised them to other agencies, the Practice could have optimised any further opportunities to enquire about domestic abuse within routine appointments.

8.46. In summary, the GP Practice's knowledge of Samantha's lived experience was limited to information received from secondary care providers and the GP Practice has said that the correspondence received from Midlands Partnership NHS Foundation Trust did not link to domestic abuse. In the absence of formal safeguarding disclosures or risk assessments being shared, the Practice did not know of any domestic abuse related risks within Samantha's relationship with Neil.

8.47. Since June 2023, the Telford and Wrekin Domestic Abuse Service has been provided in partnership between Cranstoun and West Mercia Women's Aid. Cranstoun serves as the lead provider, while Women's Aid operates as a single point of contact.

8.48. To explain the framework, West Mercia Women's Aid works under a separate contract specifically focusing on high-risk cases, and Cranstoun supports clients classified as standard and medium risk.

8.49. In July 2024 Samantha contacted the Women's Aid Helpline for support and because she was classed as medium risk, she was thereafter referred into Cranstoun.

8.50. The domestic abuse support offer is detailed later in this report, but the service used the domestic abuse, stalking, harassment and honour-based abuse risk assessment to understand Samantha's lived experience and ensure that their support was tailored to her needs.

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

8.51. Samantha lived with mental health illness before she commenced an intimate relationship with Neil but police records evidence an increase of callouts to Samantha in mental health crisis during her relationship with Neil. This suggests a deterioration.

8.52. Additionally, the Midlands Partnership University NHS Foundation Trust has reflected that there is a clear cycle in Samantha's case notes in that when the relationship was either in the 'romance phase', or had

ended, Samantha experienced better mental health, but at the times the relationship was most volatile; Samantha's mental health was poor. This was also recognised by Samantha's BUPA clinical psychologist.

8.53. It is crucial to highlight that mental ill health is not a cause of domestic abuse. However, it can be a risk factor for victimisation⁴⁴ and can lead to an increased risk of being a victim of domestic abuse⁴⁵. Moreover, in 2021, Women's Aid reviewed the literature in relation to mental health and domestic abuse⁴⁶ and highlighted how research evidences that some perpetrators target women who are already experiencing mental health problems. This means that women with pre-existing mental ill health (like Samantha) are more likely to experience domestic abuse and sexual violence⁴⁷.

8.54. The relationship between domestic abuse and mental health is complex, with varying effects on individuals. Domestic abuse can lead to significant psychological and emotional repercussions for those who endure it - even if there isn't a history of mental ill health. Victims of any type of abuse may experience lowered self-esteem, loss of identity, anxiety, depression, post-traumatic stress disorder, disordered eating, among other issues. Statistics from Refuge⁴⁸ indicate that women who suffer from domestic abuse are twice as likely to develop depression.

8.55. Samantha's situation shows how serious the consequences can be and evidences how crucial it is to highlight the severe effect of domestic abuse on mental health.

8.56. 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. 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.

8.57. 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.

8.58. 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.

8.59. 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.

8.60. 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

⁴⁴ [Domestic Abuse: statutory guidance \(accessible version\) - GOV.UK](#)

⁴⁵ Bacchus, L., Ranganathan, M., Watts, C., Devries, K., 2018. [Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies.](#)

⁴⁶ [FINAL-WA-literature-review.pdf](#)

⁴⁷ Howard et al., 2010; Khalifeh et al., 2015; Pettitt et al., 2013; Stay Safe East, 2021a; Women's Mental Health Taskforce, 2018

⁴⁸ [Facts and Statistics - Refuge](#)

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?

8.61. In response to this learning, Safer Telford and Wrekin Partnership has contacted the team that organises the White Ribbon Day⁴⁹ event (November 2025) and they have agreed to help to raise awareness around trauma bonds with members of the public / domestic abuse survivors.

8.62. 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.

8.63. 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.

8.64. 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.

8.65. This review has been assured that this learning has been addressed. Alongside the developed roles described at paragraphs 8.38 and 8.39, 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.

8.66. 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, GALOP⁵⁰, 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.

⁴⁹ White Ribbon Day is an international campaign that calls on individuals, communities, and organizations to take a stand against violence targeting women and girls. The white ribbon itself is a symbol of men's commitment to ending violence against women, with men pledging to be part of the solution to this pervasive problem.

⁵⁰ Galop is the UK's LGBT+ anti-abuse charity.

8.67. Samantha's BUPA clinical psychologist has informed this review that they too noticed a direct correlation between Samantha's mental health and Neil's behaviours. For example, early within their intervention with Samantha she disclosed that she had smashed up her flat and self-harmed after Neil had gone to stay with a female with whom he had been having an affair. On this occasion, because the psychologist was very concerned for how Samantha would manage her mental health whilst in this situation, they gained her permission to liaise with the crisis team. This was positive practice that proved crucial, as the team said that they had been about to discharge Samantha but would now not do so.

8.68. It was discussed how around this time; it was unlikely that Samantha would have accepted a referral to domestic abuse services as the affair was not being equated to domestic abuse. However, it was agreed that given that there was a suggestion of abusive behaviour, domestic abuse services could have been detailed to Samantha in anticipation of any future need and/or any 'window of opportunity' wherein Samantha may have felt ready and able to discuss the situation.

8.69. However it was positive practice that in recognition of Samantha's vulnerabilities, her BUPA clinical psychologist sought Samantha's permission to contact her brother if concerns arose, and in particular, to alert her brother in the event of Samantha not attending an appointment and/or becoming uncontactable.

8.70. Cranstoun Telford and Wrekin Domestic Abuse Service have informed this review that Samantha's mental health was discussed during their assessments, and the significant role it played in relation to Samantha's vulnerabilities and dependencies on Neil was recognised.

8.71. This was particularly regarding Neil's coercive controlling behaviours in relation to Samantha's medication and wellbeing, as Samantha disclosed that after her diagnosis of Attention Deficit Hyperactivity Disorder, she believed she had been misdiagnosed with bipolar disorder - yet Neil had forced her to take bipolar medication.

8.72. Cranstoun Telford and Wrekin Domestic Abuse Service note that this suggests a clear pattern of coercion, where Neil exerted control over her mental health treatment and medical decisions, limiting her autonomy and reinforcing her dependency on him.

8.73. During the assessment Cranstoun Telford and Wrekin Domestic Abuse Service learned that Samantha had an appointment scheduled within the next couple of weeks with her community psychiatric nurse. This implied that Samantha was already engaged in mental health support, and this is thought to be why no mental health referrals were made (though this cannot be confirmed as the worker is no longer with the service).

8.74. However, positive practice could have seen domestic abuse support services contacting mental health services to share information and this review has been assured that this has already been recognised and addressed within the service's internal investigation.

8.75. A further effect of Samantha's mental health which could have affected her vulnerability, was the limitations it may have potentially put on her ability to maintain her support of the police prosecution and the separation of the relationship. This is discussed later in the report when considering the barriers to support.

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

8.76. 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.

8.77. This would suggest that even though this review has been assured that

- Domestic abuse support services are publicised in posters and leaflets around the Shrewsbury and Telford Hospitals NHS Trust hospitals, across the Midlands Partnership University NHS Foundation Trust buildings and within the GP Practice,
- all front facing Shrewsbury and Telford Hospitals NHS Trust hospital staff receive face to face safeguarding and Domestic Abuse specific training on a three yearly basis and the Trust has a domestic abuse referral pathway readily available on the Intranet for all staff to access, and that
- Shrewsbury and Telford Hospitals NHS Trust hospitals make staff aware of the BrightSky App⁵¹ so that they can share with patients as an additional resource if they do not wish to report or have a referral into services,

prior to this conversation with Ivy, 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.

8.78. 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.

8.79. However, the onus of seeking support should never have been on Samantha and the fact that Samantha sought support from domestic abuse services only after her friend had signpost her to the service, highlights the crucial need for professionals from all agencies to know where to signpost and how to refer.

8.80. In relation to this, Cranstoun Telford and Wrekin Domestic Abuse Service has informed this review that they are happy to go into any service and talk about their offer and referral process.

8.81. Positive practice in relation to identifying domestic abuse support for Samantha has been recognised by this review in terms of the support offered through her employer – though Samantha had already contacted services by the time she disclosed her circumstances to work.

8.82. In July 2024, Samantha approached the Human Resource department where she worked and confided her circumstances and marriage break up. She talked about Neil having affairs and described herself as his 'cash cow'.

8.83. In the first instance, Samantha was referred to the company's occupational health for support, Neil was removed from her emergency contact list, his email address was blocked from the firm systems so he couldn't contact her in work (this was at Samantha's request), and Samantha began in-house counselling sessions. Additionally, in line with the company's domestic abuse policy, Samantha was offered things such as emergency money, support changing any bank details, sign post to various helplines and resources and she was also made aware of domestic abuse champions within the organisation who she (or anyone supporting her) could reach out to for additional support.

⁵¹ The Bright Sky app is free to use and can help individuals to spot the signs of abuse, know how to respond, and find a safe route to support.

8.84. The company representative confirmed that domestic abuse training is provided for staff in certain roles, enabling them to understand the organisation's support offer for domestic abuse. However, they noted that upon reflection, this training could be expanded to other staff members, increased in frequency and could benefit from including additional information on topics such as the definition of domestic abuse.

8.85. As mentioned, Samantha contacted the Women's Aid Helpline for support and Ivy has told this review that Samantha said that she felt validated by her communications with the charity because she felt that professionals were taking her situation seriously. Ivy believes it was this that gave Samantha the confidence to proceed further and contact the police.

8.86. Women's Aid referred Samantha into Cranstoun Telford and Wrekin Domestic Abuse Service (because she was deemed medium risk).

8.87. Standard practice would have seen Cranstoun Telford and Wrekin Domestic Abuse Service promptly send Samantha a text, followed by a call, to make the initial contact and establish with Samantha how she would like to be contacted moving forward with their support.

8.88. This review has been informed that this process was not followed on this occasion; instead, initial contact was attempted by email and again by text (ten days later) – to which Samantha responded after nine days. The practitioner involved in this case no longer works for the service, thus the reasons for the deviation from practice cannot now be ascertained.

8.89. However once Samantha had been engaged, Cranstoun Telford and Wrekin Domestic Abuse Service completed a domestic abuse, stalking, harassment and honour-based abuse risk assessment and needs assessment with Samantha.

8.90. The assessments reviewed Samantha's safety plan, housing, domestic abuse incidents, mental health and wellbeing, and financial situation. The domestic abuse, stalking, harassment and honour-based abuse risk assessment, which was graded high risk, obtained detailed comments in relation to some of the incidents that had occurred and established that Samantha was very frightened.

8.91. Samantha explained that Neil was due to be arrested for threats to kill but disclosed that she was worried Neil might turn up at her door and also said that Neil had asked third parties to intimidate her. She also made Cranstoun Telford and Wrekin Domestic Abuse Service aware that there was a police risk management plan and that police welfare visits were part of the management strategy. And she also informed that a GAZ warning had been placed on her property which would ensure that any emergency calls from the property would be prioritised.

8.92. Following the assessments, it was agreed that Samantha would be referred to Multi-Agency Risk Assessment Conference and that Samantha would check with her landlord whether she was allowed a Ring doorbell.

8.93. Cranstoun Telford and Wrekin Domestic Abuse Service maintained regular contact with Samantha. There was a check-in call the following day, and a further call attempted after the weekend - to which Samantha later responded via text to say that she was busy at work and rearranged for the following week. However this appointment was not recorded in the case management system, resulting in a missed opportunity to follow-up - and consequently since this, some of the team have been on Respect Report Writing Essentials training; to improve the accurate recording of case notes.

8.94. It has also transpired that the referral to Multi-Agency Risk Assessment Conference was not made. This forfeited a joined up multi-agency support plan for Samantha and is discussed in more detail later in this report. Samantha remained unaware this referral had not been made.

Explore the effectiveness of the Domestic Abuse Risk Management Plan.

8.95. Prior to Cranstoun Telford and Wrekin Domestic Abuse Service commencing their work with Samantha, Samantha had contacted the police to report the domestic abuse and to disclose her concern that Neil may turn up at the address. The following day officers had taken statements which outlined various coercive and controlling behaviour during their relationship, as well as incidents whereby Neil had tried to strangle Samantha, threatened to kill her and recent unwanted contact. Officers recorded a medium risk Domestic Abuse Risk Assessment and Samantha said she was willing to support a prosecution⁵².

8.96. Following this a Domestic Abuse Risk Management Plan was created. It is recorded on the plan that the perception of risk was escalating as Samantha had reported that the attacks from Neil had got worse and were happening more frequently. The plan noted that other risk factors such as alcohol and drug abuse, controlling/jealous behaviour and the past use of weapons, caused a credible threat of harm – though notably nothing is documented in relation to mental health.

8.97. Risk management plans are mostly used in high-risk domestic abuse cases but can be used if there is an increase of medium risk incidents over a period of time. It was therefore good practice to subject Samantha to one at this time - when her risk had been deemed as medium.

8.98. Furthermore, this review has been informed that domestic abuse risk officers had previously discussed a plan with Samantha prior to the scoping period of this review - in January 2023, but Samantha had declined stating that she didn't feel a plan was necessary. It is positive practice that at that time, regardless of this decision, officers had continued to monitor the situation and given Samantha the appropriate domestic abuse support and information.

8.99. The plan was reviewed by a domestic abuse risk officer who contacted Samantha to offer advice and support. (A warning marker had already been placed on Samantha's address.)

8.100. The plan was then allocated to an officer from the safer neighbourhood team for visits to Samantha at least once every two weeks. On the same day a police community support officer contacted Samantha and introduced herself and discussed how officers from the Safer Neighbourhood Team would visit.

8.101. The following day the officer and community support officer visited Samantha. It is recorded that Samantha said that she was well and hadn't had any problems, other than Neil trying to contact her on social media, which she said she had informed the investigating officer of already. Samantha was provided with contact details and offered suitable advice on crime prevention. She confirmed that she was happy for further visits, but when officers next visited two weeks later, Samantha couldn't come to the door as she was on a work call on her laptop. However she did confirm that she was okay.

8.102. At the next visit, 17 day later, officers were unable to get a reply to Samantha's door. This was two days before Samantha was found deceased.

⁵² Neil was arrested for Threats to Kill, Stalking and Criminal Damage five days after the Risk Management Plan had been created. He denied the offence and was bailed with conditions not to go to Samantha's address or contact her in anyway.

8.103. Medium risk plans require at least one visit every 14 days. These can be more frequent if it is considered necessary. The expectation under the plan is for the allocated officers (or those tasked to visit) to ensure that all relevant safeguarding is put in place/signposted to the victim and where relevant, the 'Officer In the Case' is spoken to in relation to any updates or any live matters.

8.104. Any officer can update the Risk Management Plan. Therefore the 'Officer In the Case' (i.e., the officer in charge of the investigation) is able to add further information surrounding the investigation and contact with Samantha - but it must be remembered that the Risk Management Plan is separate to the investigation and victim updates relating to the investigation are recorded on the crime and investigative updates (not the Risk Management Plan).

8.105. Risk Management Plans are designed with the core objective being to safeguard a victim/vulnerable person. Hence it is the persons tasked to develop and execute this safeguarding plan, who are required to provide updates on the plan as to when tasks are completed and/or the victim is contacted. Normally this would be Domestic Abuse Risk officer or a member of the safer neighbourhood team; not the Officer In the Case⁵³.

8.106. As such any key updates that may impact on risk would be added to the Risk Management Plan - such as - arrest/bail conditions or further offences. Likewise any reports from Samantha during a safeguarding visit would be expected to be recorded and reported back to the 'Officer In the Case'. Routine investigation updates/victim contacts would not be added as this would duplicate information and make the Risk Management Plan unwieldy and lacking focus

8.107. This review has learned that Samantha often contacted the 'Officer In the Case' to update her of concerns and/or incidents. And Ivy has said that Samantha had expressed how she appreciated having a police officer contact who she could message directly. However as per above, these contacts were not necessarily input onto the Risk Management Plan.

8.108. This review has learned that other agencies are not made aware of a police Risk Management Plan or invited to contribute because that is not its purpose. And, in the absence of a formal multi-agency process such as that used within Multi-Agency Risk Assessment Conference, sharing a Risk Management Plan multi-agency would be very difficult to manage and cause a significant capacity issue across all agencies. However the police report that in general, partner agencies, upon learning of a domestic abuse risk officers involvement, are very good at touching base with them.

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

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

8.110. A Lancet study⁵⁴ in 2022 revealed that 49.7% of all suicide attempts in the United Kingdom are linked to domestic abuse.

8.111. Additionally, the aforementioned 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.

⁵³ Though it is expected that there would be a two-way dialogue between the investigation and the Risk Management Plan where needed

⁵⁴ [Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - The Lancet Psychiatry](#)

8.112. 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.

8.113. 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 that opportunities were missed in responding to this risk appropriately:

8.114. The domestic abuse, stalking, harassment and honour-based abuse risk identification checklist that was completed, identified that whilst Samantha said she was not having active suicidal thoughts at the time, suicidality was a historical issue. Additional Samantha disclosed previous hospitalisation and sectioning during the assessment and importantly, she did describe feeling very depressed and struggling with the stress of the ongoing abuse and financial burden.

8.115. Despite this, no formal mental health or safeguarding referrals were made by the domestic abuse service, and the reason cannot be confirmed because, as already mentioned, the practitioner involved in this case no longer works for the service. However it has been deemed that referrals were likely not made because Cranstoun Telford and Wrekin Domestic Abuse Service were aware that Samantha was already receiving mental health support and had a scheduled appointment with her community psychiatric nurse.

8.116. This review has learned that the Cranstoun Telford and Wrekin Domestic Abuse Service team had already completed the Papyrus Applied Suicide Intervention Skills Training, 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.

8.117. 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 all the practitioners who worked with Samantha had undertaken significant training in managing risks of and around suicide as part of their qualification and continued professional development.

8.118. Samantha's risk of suicide was acknowledged in her risk assessment which stated that there were risky behaviours and suicide attempts, which were reactive to altercations with Neil.

8.119. Safety planning (that was put in place to manage this risk) details how the Crisis and Home Treatment Team would make contact with Samantha for ongoing assessment, and assessments that had been completed in hospital, would be directly shared with Samantha's care coordinator and doctor – rather than relying on staff to access Samantha's records for them.

8.120. Overall professionals had no concerns about Samantha's capacity or ability to follow the safety plan but her impulsiveness when using alcohol was acknowledged (as this was often a feature during 'crisis' episodes) and safety planning in relation to this included:

- ensuring Samantha had enough medication at home,
- arranging for the community team to complete follow-up blood tests,
- Samantha staying with a friend,
- ensuring Samantha had no plans to get in touch with Neil, and on safety planning whereby it had been acknowledged that Samantha could not keep herself safe at that time,

- admittance into hospital.

8.121. Professionals involved with this review did identify one area of practice which could be strengthened when they learned that when Samantha did not attend a couple of her appointment with the second care coordinator during the scoping period, and a standard 'opt-in' letter was sent to her. This was in line with procedure but professionals at the practitioner event agreed that given that amongst other factors⁵⁵, the dynamics of Samantha's relationship and how it directly linked to her mental health was known; robust contact could have been made to check all was well.

8.122. In relation to suicide training, suicide prevention has been high on the agenda for the Midlands Partnership University NHS Foundation trust and following the suicide prevention plan re-launch from Shropshire Public Health in October 2023, the work has been shared with the teams. This included the Shropshire Community Safety Partnership resource concerning domestic abuse and suicide⁵⁶ (which was shared by Teams and is also hosted within the Midlands Partnership University NHS Foundation Trust Safeguarding Teams Site and Learning Platform resources).

8.123. Furthermore the Midlands Partnership University NHS Foundation Trust hosted a wide variety of Lunch and Learn events and in March 2023, Jane Monckton Smith provided a Lunch and Learn (which was available and offered to all staff) concerning the Domestic Homicide Timeline. This included death by suicide.

8.124. 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.

8.125. Medics are now prompted to explore domestic abuse with any patients (male or female) admitted for self-harm and the Trust has identified learning around the importance of considering whether acute mental health crisis may also be linked to domestic abuse.

8.126. Importantly staff are being reminded to not allow diagnostic overshadowing to stop active curiosity - especially when partners/family are present and providing a history.

8.127. All of this will also be incorporated within the Trust mandatory domestic abuse training for nursing and frontline Allied Health Professionals (which is refreshed 3 yearly).

8.128. 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.

8.129. This review has learned that whilst police officers receive training in relation to

- their power under the Mental Health Act,
- seeking medical advice in any case where immediate risk of self-harm and/or suicide is identified, and
- domestic abuse

there is no specific training into the link between domestic abuse and suicide.

8.130. However, on the incidents within the scope of this review police officers responding to reports concerning the welfare of Samantha and discovering that prior to thoughts of suicide or self-harm, an argument had taken place between Samantha and Neil, evidenced good practice and professional curiosity

⁵⁵ Samantha had been treated for a number of years for bipolar and had a new diagnosis of Attention Deficit Hyperactivity Disorder.

⁵⁶ <https://www.shropshiresafeguardingcommunitypartnership.co.uk/media/tcwkgpnb/domestic-abuse-and-suicide-learning-briefing.pdf>

by submitting a Domestic Abuse Risk Assessment (although on occasions both parties refused to answer) before Samantha was taken for Mental Health Assessment.

8.131. Nevertheless, this review is assured to learn

- of a current project, known as the Domestic Abuse Suicide Screening Tool (DASST) project which is being conducted by the University of Birmingham and is aiming to develop an evidence-based suicide Screening Tool to assist frontline workers in the police and health services to identify domestic abuse victims at heightened risk of suicide, and to facilitate early intervention and suicide prevention.
- And that the West Mercia referral/case pathway is under development with a decision having been made to conduct a trial within Telford and Wrekin. The police pilot is estimated to take place in Autumn 2025.

8.132. Additionally the Safer Telford and Wrekin Safeguarding Partnership has held a series of online seminars explaining the Domestic Homicide Review process to practitioners and also reinforcing the increase in suicide related Domestic Homicide Reviews. A further session has been held focussing on suicide prevention and the various links to it (including domestic abuse). This was attended by 77 professionals and was recorded for ongoing use on the Partnership website.

8.133. In summary 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?

8.134. Cranstoun Telford and Wrekin Domestic Abuse Service operate a whole-family approach to domestic abuse, operating a behaviour change programme called 'Men and Masculinities'.

8.135. In order to support Neil to change his harmful behaviour in relationships (and therefore safeguard Samantha), Neil could have been signpost or referred to domestic abuse services for consideration of this programme based upon the information provided in the Domestic Abuse Risk Assessments. However the service has informed this review that they had no direct involvement with Neil and did not receive or process any referrals for perpetrator support in this case.

8.136. This review has learned that on an occasion prior to the scoping period; police officers had considered referring Neil to the Richmond Fellowship Programme - which is an intervention for perpetrators of domestic abuse. It includes a programme of change and holds perpetrators to account for their behaviours. It is not recorded whether Neil consented or not – but it is recorded that Neil had said he was seeking support for his behaviour and domestic abuse through his Human Resources Department at work.

8.137. However there was a missed opportunity to consider a referral for support for Neil as a perpetrator when he was arrested towards the latter end of this 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 relationship⁵⁷, and stalking increases the risk of intimate partner homicide by three times⁵⁸.

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.

8.138. It is important to mention that this review has learned of a positive step forward to supporting changing offenders' behaviours. A three-session educational intervention is to be introduced which will be called Cranstoun Domestic Abuse Interventions and Resolutions (C-DAIR). Whilst this review recognises that this intervention would not have been appropriate for Neil because it is to be aimed towards first time offenders who are at a standard risk level (and will be treated like a police conditional caution), it is important to ensure that professionals are aware of its existence to support improvement to future practice. There will be a process to be followed in terms of eligibility criteria which will need to be effectively shared.

8.139. Mental health staff working to support Neil during the scope of this review have informed that they are aware of the Cranstoun offer of perpetrator services in the area as Cranstoun provided a Lunch and Learn to all Telford staff in March 2024 where this was discussed. And to support raising further awareness, there are plans in place for the 'Men and Masculinities' group to be invited to the 2025 domestic abuse event provided by Midlands Partnership University NHS Foundation Trust.

8.140. However because Neil didn't ever express any feelings of wanting to harm Samantha either physically or emotionally, he wasn't ever identified as a perpetrator of domestic abuse by mental health staff. In fact, to the contrary some of his interactions with mental health professionals portrayed him to be a protective factor and a support to Samantha in relation to her mental health. For example, Neil called Samantha's care coordinator on one occasion to advise that Samantha had asked him to inform staff that she was "delusional" and feeling very unwell.

8.141. Therefore no referrals to perpetrators services were made. Though at the beginning of the scoping period of this review, Neil was attending, and engaging with, the 'Managing Emotions' group⁵⁹ - a group which works to support individuals to regulate their emotions at times of heightened emotion. It is not a domestic abuse perpetrator course, and this review has learned that Neil's contact with this service was in relation to his use of drugs and alcohol as a maladaptive coping mechanism.

Were there any barriers to Samantha accessing support?

8.142. Samantha's identity as a capable, intelligent, and articulate woman with a dynamic career is evident in all agency case notes. Professionals engaging with this review have discussed how this, combined with Samantha's demonstrated ability to call the police in order to protect herself when required, may have subconsciously affected professionals' practice. That is, it may have resulted in some professional's assuming

⁵⁷ ["Why Don't You Just Leave?"](#)

⁵⁸ 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.

⁵⁹ Neil is recorded to have engaged well with the group sessions and his interactions with staff following the sessions was positive.

that Samantha would recognise abuse and disclose it if it was happening, and for those professionals who knew of the arguments and toxicity of the relationship, i.e., the police – it may have resulted in officers discounting the option to override any non-consensual referrals to support services.

8.143. However, many individuals from all areas of life, have limited or no understanding of abusive relationships and Samantha may have not recognised that she was in a domestic abusive relationship, or have identified the trauma bond previously described. This is supported by Samantha's messages to Ivy, which indicate that (in line with the symptoms of bipolar as described in section 4) she often blamed herself for Neil's behaviours, and also within a conversation Samantha had with her care coordinator during which she described how she was being more 'boundaried' with Neil, asking for more financial support. This potentially indicates that Samantha felt that it was her behaviour/approach to Neil that affected his actions/response. Her words suggest that she felt responsible for the way Neil behaved towards her.

8.144. Additionally some of Samantha's messages to Ivy evidence that Samantha was scared to seek support as Neil had threatened to tell her employers that she had used drugs with him if she told anyone about his behaviours.

8.145. This self-blame and fear, alongside with Samantha potentially not recognising the abuse, would have affected Samantha's ability to disclose the situation and seek domestic abuse support.

8.146. In July 2024 Samantha bravely self-referred to support services and soon disclosed the abuse to the police. It is important to remember here how difficult it is for victims to speak up about abuse and get support, and it is unlikely that Samantha would have been able to disclose the full extent of the abuse in one statement.

8.147. 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. 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.

8.148. Samantha spoke of these delays with Ivy, citing her frustrations.

8.149. There is evidence of the situation escalating for Samantha during this waiting period as 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.

8.150. Hereafter Samantha reported that she thought that Neil had now involved third parties and asked them to watch her and send her messages.

8.151. 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.

8.152. Disclosing abuse always puts survivors in a dangerous position - and this, combined with a fear of not being believed, or of there being insufficient evidence to prosecute, makes it is extremely hard for any individual to continue to support an ongoing police investigation into domestic abuse. And, as mentioned earlier, Samantha had an additional barrier in that stress could impact a deterioration to her mental health, and her bipolar could trigger her to self-blame and to have low self-worth.

8.153. Disclosing Neil's abuse did not end for Samantha when she picked up the phone to support services and to the police. She would have likely then been

- asked to give evidence against her husband in court (causing further stress to her mental health and risking her personal life being exposed to the public domain),
- potentially worried about how she was able to protect herself if he entered her flat again, and
- worried about retaliation as it is known from Samantha's conversations with Ivy that Neil had historically made threats to tell her employer that she had used drugs if she disclosed the abuse.

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

8.155. Ivy has informed this review that whilst investigations were ongoing, Neil was able to maintain a hold over Samantha. For example, he sent various messages prior to his arrest, and he sent a penny to her bank account less than 24 hours after receiving bail conditions. The bank reference was 'readyouremails' and when Samantha consulted her emails, Neil had sent her a lengthy message asking her to *stop being so horrible*. During the email he referred to *reporting Samantha for things*. Samantha thought this to be in relation to him telling her landlord that she had a cat when she wasn't allowed.

8.156. In reviewing the barriers and anxieties Samantha faced, the review has considered whether Samantha's cat had come to physical harm. While the review has found no evidence or agency records suggesting that the cat was subject to direct physical violence, the timeline highlights how the cat was leveraged by Neil as a mechanism for emotional abuse and psychological control. Early in the timeline, during July 2024, Samantha reported to the West Mercia Women's Aid Helpline that Neil had neglected her cat while she was in hospital - a recognised tactic used to inflict distress on a victim. Then later, as just mentioned, Neil shifted to weaponising the cat by threatening to inform her landlord of a tenancy breach. This malicious threat caused Samantha distress, ultimately forcing her to begin the heartbreaking process of trying to rehome it. The review notes that while physical harm to the animal was not substantiated, the targeting of Samantha's pet constituted a significant barrier to her wellbeing and compounded her feelings of isolation and self-blame.

8.157. No one but Samantha can truly understand what led her to contacting Neil just prior to her death, but when she did, Neil reported her to the police. The police did not inform Samantha of this, but it is possible that Neil or someone else did and consideration must be given to how this might have impacted Samantha. The potential psychological implications are twofold. Had she become aware of the allegation, the prospect of a formal police investigation would likely have exacerbated her distress, compounding her existing self-blame and deepening her feelings of despair during an active mental health crisis. Conversely, even if she remained unaware, the act of making a formal counter-allegation demonstrates how systemic processes can be leveraged by an abuser to shift culpability and conceptually isolate a victim, whether or not the victim is consciously aware of the official report.

8.158. A message appeared on Samantha's social media, one week before she died by suicide which examples how Samantha had now started to doubt the abuse and revert to blaming herself - *I want to take this moment to offer a sincere apology for the pain and turmoil I have caused during my marriage to Neil. In reflecting on our time together, I've come to understand that my actions were often driven by selfishness and a need for*

control, which hurt him in ways I never fully acknowledged. I recognise now that my behaviour was extremely toxic, and I deeply regret the stress and unhappiness I brought into his life. I was consumed by my own insecurities and fears, which lead me to act in ways that were unfair to him. I often dismissed his feelings and needs, prioritising my own desires above everything else, and for that, I am truly sorry. Thank you, Neil, for all of the patience, love and kindness you have shown me, even when I didn't deserve it. I wish you nothing but happiness and healing as you move forward. You only deserve the best. Peace Out.

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

8.160. 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.

8.161. 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.

8.162. 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?

8.163. There was a missed opportunity for multi-agency work after Samantha had disclosed the abuse and sought support: 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.

8.164. This referral was necessary due to Samantha's disclosure of several significant high-risk factors, including threats to life, coercive control, stalking through third parties, financial abuse, and previous incidents involving attempted strangulation. And as previously noted, the safety planning conducted by the police alone would not have facilitated a multi-agency response or a coordinated safeguarding strategy capable of addressing both Samantha's physical safety and emotional wellbeing. A collaborative approach - which involved police, housing, health, and specialist domestic abuse services, was needed to effectively mitigate these risks.

8.165. 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.

8.166. A multi-agency approach would have led to more proactive interventions. For example, Samantha's General Practitioner has highlighted to this review that the Practice wasn't ever informed of the domestic

abuse (though it would have been had the Multi-Agency Risk Assessment Conference convened) and that had the Practice been informed, it could have triggered a safeguarding discussion within primary care. This could have potentially led to further enquiry or additional support being offered to Samantha during her physical health appointments.

8.167. Such additional supports were necessary to reduce the burden on Samantha to navigate safety planning independently - because, whilst Samantha was clearly a capable and independent lady, freely engaging with services, she was managing multiple crises simultaneously: work commitments, financial strain, and ongoing stalking - and this may have affected her ability to consistently seek support.

8.168. Samantha did not ever know that this referral hadn't been made, and she referred to the Multi-Agency Risk Assessment Conference risk assessment in her communications with Ivy – stating that this was particularly validating for her. Ivy told this review that Samantha had described the moment she learned that Neil had been scored 68 out of 100 as a moment of realisation and recognition. She had said that it made her feel seen and believed.

8.169. 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?

8.170. Due to the established link between domestic abuse and suicide it is important for professionals from all agencies to apply professional curiosity when working with individuals like Samantha who may be at risk.

8.171. Opportunities wherein professionals could have shown increased curiosity were discussed during the learning event and some have been highlighted within this 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 briefing⁶⁰ are available to professionals on the Telford and Wrekin Safeguarding Partnership website⁶¹;

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.

⁶⁰ [Professional curiosity - Telford and Wrekin Safeguarding Partnership](#)

⁶¹ 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.

8.172. Telford and Wrekin Domestic Abuse Service has shared that to support their professionals they have introduced additional case oversight procedures, including more frequent team case reviews and reflective practice sessions and they added that supervisors are providing closer oversight of risk assessments in order to support improvement of their practice in relation to professional curiosity - particularly wherein decisions around Multi-Agency Risk Assessment Conference referrals and safeguarding escalations are to be made.

8.173. Telford and Wrekin Domestic Abuse Service also acknowledged to this review that the barriers professionals face in relation to professional curiosity in their service have been found to include high caseloads, time pressures, and the challenge of balancing survivor-led approaches with proactive safeguarding interventions. To address this, they have encouraged a culture of reflective practice, where caseworkers are supported to ask difficult questions, challenge their own assumptions, and escalate concerns where necessary. The team hold regular reflective practice sessions where the case workers are asked to discuss the following questions in regards to cases: "What do I need to learn more about?", "What went well?", "What went poorly?", "How can I improve in the future?", "Why did I feel the way I did?", "What did I learn?", "What was easy?", "I wonder what would happen if...". This is a way for management to understand what pressures the team feel and put practices in place to support them.

8.174. This review would agree that such case oversight, sessions with supervision, and reflective practices are key to fostering a professional curious culture.

9. Positive Practice.

9.1. Professional discussion during this review has highlighted many examples of positive practice⁶² from professionals involved. Examples are included within the body of the report but additionally:

9.1.1. It was positive practice that following incidents; referrals were made to children's services and Operation Compass⁶³ in relation to Neil's children. The children were not present at incidents and didn't live with Neil, but referrals were nevertheless necessary in order to allow those working with the children to effectively safeguard.

9.1.2. West Mercia Police demonstrated continued assessment of the relationship between Samantha and Neil through the use of a Risk Management Plan even though Samantha's risk had been graded medium.

9.1.3. There is evidence of excellent communication between Samantha's care coordinator and Consultant.

9.1.4. Samantha would regularly text message her care coordinator and appointments were often moved due to facilitate the demands of Samantha's work.

9.1.5. The domestic abuse, stalking, harassment and honour-based abuse risk identification checklist assessment conducted by Cranstoun Domestic Abuse Support Services effectively captured Samantha's voice, concerns, and lived experience. The assessment not only identified high-risk factors but provided Samantha with the opportunity to express in detail the coercion, intimidation, and escalating abuse she was experiencing. Her disclosures around Neil's financial control, forced medication, stalking via third parties, and physical assaults were recorded comprehensively, ensuring a clear and nuanced understanding of the risks she faced. This survivor-centred approach aligned with best practice in trauma-informed work, ensuring that Samantha was actively involved in the risk assessment and safety planning process rather than simply being a subject of assessment.

9.1.6. Ivy has informed that having a direct contact in the police made it more accessible for Samantha to report and update on the situation.

⁶² Positive practice in this report includes both expected practice and what is done beyond what is expected.

⁶³ Operation Encompass is a police and education early information safeguarding partnership enabling schools to offer immediate support to children experiencing domestic abuse. Operation Encompass ensures that there is a simple telephone call or notification to a school's trained Designated Safeguarding Lead /Officer (known as key Adult) 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.

9.1.7. Samantha was quickly updated when bail conditions were imposed.

9.1.8. Samantha's employer provided in-house therapy quickly and implemented safeguarding.

10. Conclusions

10.1. 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.

10.2. 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).

10.3. 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.

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

10.5. After Samantha 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.

10.6. 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.

10.7. 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.

11. Lessons to be Learnt and Recommendations⁶⁴.

11.1. 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:

⁶⁴ 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 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.

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

11.2.1. 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.

11.2.2. 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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11.2.3. 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.

11.2.4. 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	