LEARNING BRIEF-JDCNH/16

The Review

The Safer Derbyshire Community Safety Partnership have conducted a Domestic Homicide Review (DHR) to learn lessons regarding the sad death of Lucy, a resident of Derbyshire who died in 2016.

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. The DHR was completed by a panel of senior representatives of all agencies who knew the victim and perpetrator, chaired by an independent reviewer. The panel worked together to examine and analyse service involvement. Views of Lucy's family were requested and are included in the final overview report.

Background

Lucy was a mother living with her children in Derbyshire. She had been a victim of sustained domestic abuse from a previous partner and services had become involved to support the family. Lucy regularly had alcohol dependency and some mental health issues, which sometimes impacted on her ability to prioritise the needs of the children and made her additionally vulnerable.

A casual relationship between Lucy and the perpetrator John commenced about nine months before the fatal incident. John had previous convictions for violent offences, including domestic abuse to a previous partner. He also had mental health issues, reporting some suicidal thoughts, and was alcohol dependent.

The relationship between Lucy and John (in his true identity) was not known to any professionals who were involved with either individual, or involved with Lucy's family leading to the time of her death. Only Lucy's children, her mother and some close family and friends had knowledge of Lucy and John being a couple.

When a professional met John at Lucy's home in the months leading to her death he was evasive and aggressive about his identity. Lucy subsequently provided a false name for John to professionals meaning his true identity and violent history remained hidden to those trying to support the family. As a consequence risks to Lucy and the children could not be fully assessed, and a safety plan could not be devised.

Lucy was described as depressed and drinking heavily in her final weeks. John was known to be having suicidal thoughts; he attended his GP but failed to engage with treatment offered.

On the day of her death, Lucy requested a GP appointment but failed to attend. Over the following hours she was fatally harmed by John at her home; he then left the property after starting a fire. The fire service attended and discovered Lucy's body. John was arrested soon after.

*** Names have been changed in consultation with the victim's family.**

Findings

Individual agencies had chronological written records of historical information about domestic abuse and other concerns, relating to the victim Lucy, her family, and the perpetrator John. Therefore opportunities were available for assessment and subsequent decision making, albeit the pair could never be assessed jointly as their relationship remained hidden to professionals.

Child and family assessments were not as holistic as they could have been. There was limited consideration of the impact of the historic domestic abuse from the previous partner of Lucy. Survivors of domestic abuse can be vulnerable to future relationships where domestic abuse reoccurs, and awareness of this possibility is key to good practice and risk assessment. In addition, there is research evidence that relationships where drug or alcohol use combined with poor mental health and domestic abuse can be particularly harmful; this is known as the 'toxic trio'. These additional concerns appear not to have been strongly considered.

Professional curiosity of family circumstances and relationships should form part of any good assessment and this did not routinely happen when Lucy and John attended separately for health appointments.

Lucy and John sought to deceive professionals about John's identity and it is a priority for all professionals to be alert to this possibility and rigorously explore the identity of new visitors or relationships in the families with whom they are working. The need to respond robustly to 'hidden men', in particular who may wish to remain under the radar of professionals, and who may pose a risk to a family has been a key learning point from other reviews and is a finding in this case.

The Derbyshire Domestic Abuse Support Line:

08000 198 668

IN AN EMERGENCY CALL 999

Lessons to be learnt

A DHR will always provide an opportunity for areas of development to be identified for services involved.

Learning for Children's Services

Learning for Children's Services includes increased awareness of risks from 'hidden men' and of the 'toxic trio', conducting holistic assessments of all concerns both past and current for adults and children. Timely supervision which includes discussion of all risks, and seeing and speaking to children to obtain a window on their experiences and the experience of others in their family.

Learning for health professionals

Learning for health professionals includes the need to have more professional curiosity about personal circumstances of patients especially where domestic abuse is known to be/or has been a factor.
Follow up on non-attendance of health appointments when suicide is a clear risk factor needs to be robust.

Next steps

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All agencies and professionals are encouraged to reflect on the findings and learning themes, and discuss the implications for their service and future practice.
The full overview report is available to professionals where it is identified that specific teams will benefit from further scrutiny of the circumstances and findings of the DHR.

All professionals

All professionals, statutory and non-statutory should have a better understanding of victims living with controlling and coercive behavior, including how to respond more sensitively and effectively. Every contact by any professional with individuals or families known to have been in some way involved with domestic abuse is a potential opportunity for assessment of need or risk, or both.

Positive practice

All professionals worked hard to support Lucy and her family but some practice was identified as particularly noteworthy. Examples included timely response and follow up by some primary care services, perseverance by out of hours call handlers to speak with patients, and engagement by partners in multi-agency child protection processes.

All requests for information please email:
community.safety@derbyshire.gov.uk

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