DOMESTIC HOMICIDE REVIEW – QDCNH/18

LEARNING BRIEF

ONE CALL CHANGES LIVES

THE REVIEW

The Safer Derbyshire Community Safety Partnership have conducted a Domestic Homicide Review (DHR) to learn lessons regarding the sad death of Ruth, a resident of Derbyshire at the time of her death in late 2018.

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 abuse. The DHR was completed by an independent panel of senior representatives of all the agencies and organisations who had contact with Ruth and the Perpetrator. Chaired by an independent reviewer, the panel and chair worked together to examine and analyse service involvement and identify learning in order to improve practice.

Views of Ruth's family were obtained and are included in the final overview report. Ruth was described by her family as a beautiful person, she is missed every day by all who knew her but especially her immediate family and her five children.

BACKGROUND

At the time of her murder Ruth lived with her partner (the Perpetrator) and their three young children in Derbyshire. Ruth's eldest two children resided with their father in a different part of the country. In late 2018 the ambulance service attended the home of Ruth and the Perpetrator. Ruth was found deceased with multiple injuries. The Perpetrator was present and suggested Ruth had fallen downstairs.

The Perpetrator was arrested later the same day and subsequently charged with murder. He was convicted after pleading not guilty, in 2019. The couple had been in a relationship for around 4 years. Ruth had a known history of being a victim of domestic abuse with two previous partners and information obtained in the review suggests abuse was ongoing by the Perpetrator to Ruth, prior to her death.

Children's services were involved at different points in Ruth's life, with the majority of referrals to children's services being from the police in response to domestic abuse incidents. Ruth had some mental health challenges throughout much of her adult life and had been supported by services within Derbyshire. Ruth had regular contact with health services during her pregnancies and spoke of some non-recent abuse in her life, although did not disclose the domestic abuse that she was suffering at the time.

FINDINGS

Domestic abuse incidents were suspected of occurring throughout Ruth's relationship with the Perpetrator but few were formally reported to the Police. Of the concerning incidents coming to the attention of services, three were during pregnancy, however risks to mother and the unborn child were not fully considered or assessed. Attempts were not consistently made by those seeing Ruth, to sensitively enquire into her experience of domestic abuse, or to create safe space for abuse to be disclosed. Opportunities were not taken to coordinate multi-agency information and to formulate an effective safety plan.

Ruth suffered domestic abuse in two other significant relationships, her two older children were born at this time. Her parenting capacity with the eldest two children was sometimes affected by the abuse and other risk factors in her life. The harm to Ruth's children was not fully identified and assessed as the focus of agencies was on the lifestyle of Ruth and her abusive partner(s).

Support for Ruth was attempted by specialist domestic abuse workers, housing support officers and mental health professionals within the community and in acute settings. Her engagement was affected due to the cumulative challenges in her life and because of the suspected control she was under from the perpetrators of domestic abuse. Reports of abuse and requests for help were responded to but mostly in isolation without taking into account patterns of behaviour and historical information.

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LEARNING FROM THE CASE

A DHR WILL ALWAYS PROVIDE AN OPPORTUNITY FOR AREAS OF DEVELOPMENT TO BE IDENTIFIED FOR SERVICES INVOLVED.

LEARNING RELATED TO PREGNANCY

"Routine enquiry" to sensitively ask pregnant women about any experience of domestic abuse should take place at all opportunities by health partners. All professionals/practitioners should provide a safe space and encouragement to women to enable them to disclose abuse should they feel able.

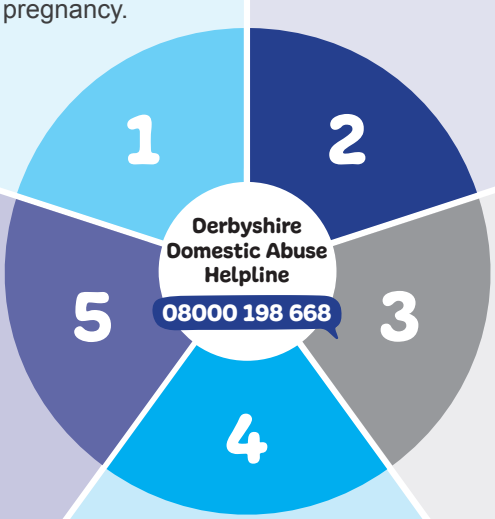
Assurance is required that pre-birth assessments are being completed when necessary as per the updated local pre-birth protocol to improve outcomes for pregnant women, unborn children and their wider families. The Derby and Derbyshire Childrens Safeguarding Partnerships Pre-Birth Protocol can be **found here.**

All domestic abuse related multi-agency and single agency training should include information regarding additional risks of domestic abuse associated with pregnancy.

LEARNING RELATED TO HISTORY AND CUMULATIVE HARM

All relevant safeguarding children and safeguarding adults' policies and practice guidance require review to ensure they reflect the need for practitioners to be alert to long term patterns of abuse and cumulative risk factors and warning signs. A shared multi-agency understanding will then be developed of risks within past/current relationships and within families to help improve the collective response.

The Multi-Agency Risk Assessment Conference (MARAC) referral criteria should be updated as necessary and widely circulated to help professionals consider the specific circumstances and risk factors of individual victims in order that they may benefit from their case being discussed at MARAC.



NEXT STEPS

All agencies and professionals are encouraged to reflect on the findings and learning themes regarding what happened to Ruth 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.

LEARNING RELATED TO MENTAL HEALTH SERVICES

All mental health services including crisis teams, community and hospital services, across delivery areas and health trusts, must aspire to collaborate with other relevant organisations to enable seamless continuity of care focussed on the needs of individuals - particularly during transfer of care, and when closure of cases is proposed, and especially when non engagement is a reason for closure.

LEARNING RELATED TO CHILDREN

All agencies and organisations must demonstrate their focus regarding the impact of domestic abuse and its cumulative harm on children. Continued commitment is a necessity to identify children living in abusive households as victims in their own right, to listen to their voices and to enable them to receive effective support.

Derbyshire Domestic Abuse Helpline

08000 198 668

All requests for information please email: **community.safety@derbyshire.gov.uk**
Details of Derbyshire DA Helpline

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

DERBYSHIRE County Council