Sheffield Safer and Sustainable Communities Partnership January 2014

Learning from Domestic Homicide Review (DHR)

Adult D

Domestic Homicide Reviews (DHRs) aim to improve practice and outcomes for people affected by domestic abuse. This learning sheet is designed to highlight the key areas of learning and practice in relation to the Adult D DHR. We hope you will reflect on your own practice in light of this information. This DHR has been approved for publication by the Home Office and can be found at: https://www.sheffieldfirst.com/the-partnership/safer-and-sustainable-communities/key-documents.html. The Home Office commended the report as 'open and very comprehensive. It also demonstrated a good understanding of domestic violence and a good level of professional curiosity. The author demonstrated a keenness to learn lessons from this case, and ensured the victim's experience resonated throughout the report.'

Summary of case

This Domestic Homicide Review (DHR) examined the response and support given by agencies to Adult D prior to her sudden unexpected death on 21st February 2013. The incident occurred during a planned handover of their child for contact, in a public place. Adult DX stabbed Adult D in view of the children and of members of the public. Their son aged 2, and Adult DX's daughter aged 10, were present; they were physically unharmed. Adult DX was convicted of the charge of murder of Adult D and sentenced to Imprisonment for Life with a minimum term of 28 years.

Review process

A Domestic Homicide Review (DHR) was held in the city with an Independent Chair and Author, Kate Mitchell. The Key findings were:

- This Review **identified a number of examples of good practice**, but also identified that **opportunities were missed**. Had opportunities been recognised and worked with while Adult D was in the relationship, she may have been provided with advice, guidance and support, and could have been helped to plan for her own safety at an earlier stage.
- Had **opportunities for speaking confidentially** with Adult D been taken earlier, there would have been information in relation to the domestic abuse, which could have assisted professionals not to be diverted by Adult DX's allegations, and a targeted response may have been provided more quickly after she did decide to leave the relationship.
- The Review has identified that after Adult D fled the home there were gaps in service responses, and finds that these were due not only to her **status as an A2 migrant**; and to the lack of knowledge and understanding of staff about her rights as an A2 migrant fleeing domestic violence; but most importantly, to deficits in the systems available to ensure she was provided with her rights in law and the resources for refuge, support and safety which would be provided to a UK national in similar circumstances.
- Adult D was a competent, resourceful and resilient woman who had no support and social network in the UK. Skilled and accurate guidance in relation to her rights to reside and to work could have enabled her to improve her own circumstances.
- Matters relating to contact were complex. However, the risks to Adult D and the children were not sufficiently considered in the contact and handover arrangements.
- It is recognised that **no one agency is responsible for these deficits**, that it is a systems issue arising from the status of A2 EEA nationals and the local interpretation of the very complex policy and legislation that relates to that status.
- There are a number of lessons to be learned and specific actions to be taken by agencies, which in the view of the author would help to prevent similar events in future. **It is not possible to say whether any or all of those lessons and actions, had they been applied in Adult D's situation, could have made her safe enough.** The benefit of hindsight may lead us to conclude that Adult DX

was very determined, and whilst Adult D could have been helped to be safer, however safe that was in the short term, her safety, in the face of that determination could never have been assured.

Lessons to be learnt

Children's Social Care:

- Practitioners need better awareness of the issues and stresses experienced by migrant families including those caused by isolation due to a lack of community, and often compounded by language difficulties. If agencies have contact with families for whom there have been reports of criminality or violence they should attract more attention and there needs to be a thorough assessment of their circumstances.
- It is clear that the heightened risk of violence at collection and handover of the young child was not given enough consideration. CYPFS has two family assessment centres that have now been made available to facilitate contact.
- Staff need to be proactive in gathering information to inform an assessment. Gathering information from other agencies and other areas, and maintaining the momentum when seeking information from other agencies, needs to be embedded in practice.

Adult Safeguarding:

- Consideration needs to be given to the application of the Human Rights Act, 1998, which guarantees the rights and freedoms enshrined in the European Convention for Human Rights, in the case of an A2 migrant fleeing domestic violence.

Housing:

- There is a need to formalise referral processes to outside agencies relevant to this case. There is also a need to clarify for staff the distinction between vulnerability, and Vulnerable Adult.

Education :

- Schools should record the reasons given by children for absences as this could give school staff an overview of a pattern of conflict in the family which might in turn lead to a referral for a multi-agency meeting.

Health services (including general practitioners, health visitors and hospitals):

- Clinical staff need to continue to improve their confidence in recognising and reporting domestic abuse. Domestic abuse should be considered at every contact if it has previously featured. When the service has information about domestic abuse, however historical that information may appear to be, it should be standard practice to follow that up and ensure the victim is seen one-to-one and given the opportunity to speak in a safe environment.
- GPs, health visitors, and all nursing staff need to be aware of the particular stresses of families with very sick children, with financial or other difficulties, and the potential link to domestic abuse. Information about other issues should trigger an inquiry.
- When one member of a household discloses domestic abuse, this should trigger a referral so that an inquiry can be made into the vulnerability of other people at the address.
- Practitioners in surgeries, clinics and hospitals should inquire confidentially into the reasons for delayed presentation of injury and record where this may be associated to domestic violence.
- Many newly qualified GPs initially work as locum GPs, so attention needs to be given to meeting their development needs in relation to domestic abuse.
- When a child is receiving care from the acute services information from other agencies about the families social situation and any concerns about domestic abuse need to be shared so all professionals are fully informed and can work together in the best interest of the child and their family.

Police Services:

- When a police officer needs to check on the background of a foreign national then, in addition to checking Guardian and the Police National Database (PND), the officer needs access to the ACPO Criminal Records Office (ACRO), Interpol Intelligence and UK Border Agency (UKBA).

- Domestic violence leaflets need to be available in a broader range of languages. In non-English speaking households, it is inappropriate to use children to interpret or to offer information on an incident.
- Following a domestic violence incident, welfare checks should be carried out on all parties including those not currently living at the address.
- The need to develop a protocol with courts to ensure previous convictions can be made available to family proceedings.
- Including information about MARAC for the Courts, will inform the Court that there is a serious domestic violence concern in a case and support judicial decision making.

HMCTS:

- There are shortfalls in information flows between parts of the criminal justice system (Police, Crown Prosecution Service and the Court).

Crown Prosecution Service:

- Prosecutors are very dependent on the quality of the evidence and other information supplied to them electronically and supplemented by their conversations with the officers seeking advice.

Victim Support:

- Consider the potential for confusion by a service user who is referred to Victim Support whilst already engaged with the IDVA.

Voluntary sector services:

- Review procedures to ensure staff are appropriately screening clients in to Adult Social Care, i.e. ensuring they fit the criteria for safeguarding.
- Where information about a risk concern has been passed to a statutory agency and there is no feedback about action in relation to that, the service should contact the agency for confirmation and where this is not believed to be appropriate, escalate the matter to managers.

All services:

- Better use could be made of interpreting services.

- There is a need for training in immigration issues and Human Rights Act assessments.

- MARAC representatives must ensure actions are communicated back into their agencies urgently and therefore, it should follow that actions would be implemented without delay. Staff should not wait for minutes before taking action.

- The Domestic Violence Strategy needs to set out how the partnership will ensure there is assistance for people fleeing domestic violence who are excluded from benefits and services, e.g. destitute service users.

- A question for Sheffield to consider is: what multi-agency response should there be to the issue of EEA migrants being excluded from benefits and services (in cases of domestic violence)? What is the national steer on exclusion from benefits and how will this impact on Sheffield?