LEARNING FROM DOMESTIC HOMICIDE REVIEW - LEAH

SHEFFIELD SAFER AND SUSTAINABLE COMMUNITIES PARTNERSHIP

WHAT HAPPENED?

In summer 2020 Leah, a mother and a victim of domestic abuse, died by suicide following an overdose of prescription drugs and alcohol. Her partner AP had breached a 14-day Domestic Abuse Violence Protection Order (DVPO) and was with Leah leading up to her death.

Leah had been assaulted as a young person and abused by previous partners; she had made suicide attempts and had problematic alcohol use. As a victim of controlling behaviour, she would minimise the abuse and struggled to engage with support including IDVAs and criminal justice processes.

AP was Leah's on/off partner for 2 years and was not the father of her children. As a child he experienced domestic abuse and became a Looked After Child. He struggled with alcohol, drug use and poor mental health. He had a criminal history and was supervised by Probation.

Leah and AP's relationship was violent and volatile from the start. AP was coercive and controlling, using physical, psychological, sexual and emotional abuse. Incidents often included alcohol. The children were sometimes present. There were 12 police investigations as the abuse escalated. He threatened suicide, breached orders and caused damage to Leah's mum's property. He attacked Leah at an airport and was found guilty of battery. Incidents were assessed as standard or medium risk. He attacked his mother and sister in a high-risk incident, but the MARAC referral did not include Leah, although she was present.

Six weeks before her death, Leah retaliated in self-defence and was heard at MARAC as a perpetrator. Children's social care started an assessment and a week before her death she told the police she feared for her life.

WHAT DID WE LEARN?

Agencies failed to identify and address the risk of suicide as a possible outcome of the domestic abuse she was experiencing – it was thought her children were a protective factor.

Leah lived in fear of AP. Coercive and controlling behaviour was not recognised. He would "control her" by threatening to kill himself if she left him.

Agencies focused on AP's mental health and self-harm and didn't identify him as a perpetrator. A trauma informed approach was required to better understand Leah and AP in the context of their life histories and experience. This may have changed practitioner's attitudes towards them, built trust and engagement in support.

The police missed opportunities to fully understand Leah's risk and refer to MARAC. The police did not use previous incidents (5 in a five-month period) to inform the risk assessment process. Holding perpetrators to account disrupts abusive relationships. AP was not breached for failing to comply with his probation order or bail.

Safeguarding children's referrals were not completed following all domestic abuse incidents e.g. when her children were not present at the incidents.

Professionals did not use a trauma informed approach or professional curiosity with Leah. Therefore, they did not always understand the risk to her and why she distrusted children's agencies.

Recording spellings of names correctly is essential to help find individuals on systems when safeguarding checks are undertaken.

As in previous Sheffield reviews, where there are substance misuse issues and poor mental health it is important to ask about domestic abuse.

Had Leah's act of self-defence / violent resistance being identified as such, then a trauma-informed approach could have been used, a safety plan agreed, and her needs considered.

WHAT CAN WE DO NOW?

Use a trauma informed approach with complex cases of domestic abuse.	DASH risk assess all victims, consider their children and refer to social care.	Check the correct spellings of names.	Consider if it is self defence / violent resistance when women apparently perpetrate domestic abuse	Report and act on breaches of orders such as Domestic Violence Protection Orders.