Nottingham Crime & Drugs Partnership
www.nottinghamcdp.com

A domestic homicide review into the death of Adult A

EXECUTIVE SUMMARY

A report for the Nottingham Crime and Drugs Partnership

2012

Executive Summary

The review process

This summary outlines the process undertaken by the Nottingham Crime and Drugs partnership Domestic Homicide Review Panel in reviewing the murder of Adult A. Adult A's husband, Adult B, pleaded guilty to the manslaughter of adult A, on the grounds of diminished responsibility and was sentenced to 4 years imprisonment.

The process began with an initial meeting on 23rd February 2012 of all agencies that potentially had contact with Adult A prior to the point of death.

Agencies participating in this Review and commissioned to prepare Individual Management Reviews were:

- *Women's Aid Integrated Services*
- *Nottingham City Council Children's Services*
- *Police Regional Review Team*
- *Nottinghamshire Probation*
- *Clinical Commissioning Group (CCG) NHS*
- *Nottingham CityCare Partnership*
- *Nottinghamshire Healthcare NHS Trust*
- *East Midlands Ambulance Service*
- *Nottingham University Hospitals NHS Trust*

Agencies were asked to give chronological accounts of their contact with the victim prior to her death. Each agency's report was asked to consider whether internal procedures were followed; and draw conclusions and recommendations.

The Domestic Homicide Review examined a 27 year history of a family severely affected by violence in the home. During the 27 year period, there were 22 occasions where domestic abuse was either reported or an incident occurred that, with today's knowledge and learning, would be recognisable as being a consequence of domestic abuse. Adult A suffered injuries on 5 separate occasions which were either reported or could be fairly attributed to being caused by Adult B. Similarly, adult B also suffered injuries which were either reported or could fairly be attributed to being caused by adult A.

The DHR panel, after thorough consideration, believes that under the circumstances, agency intervention would not have prevented the victim's death, given the information that has come to light through the Review.

Key issues arising from the review

A number of themes have arisen from the overview of this case. These are:

- *Record keeping*

- *A whole family approach to interventions*
- *Information exchange*
- *The perpetrator survivor*
- *Child survivors of domestic abuse*

Record Keeping

The records show that both adults presented with injuries for which no explanation was recorded. Professionals involved in recording and treating injuries should, as a matter of routine, record any explanation given or record that no explanation was offered.

Whole Family Approach

The facts of this case as reported by each individual agency show that issues were responded to in accordance with the policies and procedures relevant at the time. However, each presentation was dealt with in isolation of the wider family context, history and records.

A Whole Family Approach in this context is identified as an awareness of a multi generational dimension to domestic abuse. This concept was outlined in the Think Family Approach published in 2009 by the Department of Children, Schools and Families.

Adult safeguard practices are key to early intervention and prevention strategies. Therefore all agencies who become aware of vulnerability to abuse should take appropriate steps to ensure that information is available to other agencies who are engaged with the provision of treatments or services to that vulnerable person as a matter of routine.

All agencies have demonstrated a commitment to learning the lessons from this case. The challenge now is to look beyond the presenting victim or perpetrator and see the affected family.

Information Exchange

There are still significant doubts among agencies about what information they can share with whom to enable early intervention, prevention and when necessary enforcement to take place.

The capacity to share information may also be affected by narrow commissioning objectives at a regional or national level. The EMAS are commissioned to collate information regarding households not individuals. Therefore the identification of vulnerable people will only be effective if the person remains static in an address. This is in contrast with patient held data and police records which place primacy in the nominal and not necessarily on the address.A common system of managing both address data and people related data would be more effective.

There is scope for GP practices to flag vulnerable people to their colleagues in such a way that where risk is obvious the other affected family members are considered a priority as well.

The Multi-agency Case Conference (MARAC) could also ensure that the relationship that GP's have with their patients and responsibility to reduce harm to their patients can be an effective route for a preventative, protective approach.

Perpetrator – Survivor

"Co-combatants" is a phrase used in records about adult A and adult B's relationship. They were in fact both survivors and perpetrators of domestic abuse, until adult A was murdered by adult B. Agencies are careful and sensitive in such cases although the records do show that what little interventions were available in the early years were geared towards the female survivor. In this instance consideration of support and referral to male survivor groups and services were an obvious choice, however no record of them being considered has been evident.

The screening of male victims[1] or as the case may be same sex couples, should be available through trained and appropriate staff.

Child Survivors

In 1989 when the Children Act came into force the children of this family would have been 11 & 12 years of age and consideration must be given to the apparent lack of a safeguarding referrals being made to Social Services. In addition, grandchildren were in contact with adult A & adult B and potentially exposed to a violent and abusive household.

<u>Recommendations</u>

The Review endorses the recommendations of the IMRs. In addition, the Review makes the following recommendations:

Record Keeping.

Agencies should ensure that operational procedures reflect the requirement for staff dealing with domestic abuse to enquire into the circumstances of each injury presented and that the explanation offered or otherwise is noted clearly. The procedures should include narrative on when to refer the injury to other agencies and how to achieve that referral, including reference to record keeping and the responsibility of supervisors, where appropriate, to ensure

compliance. Agencies will ensure that training is delivered to ensure compliance with operational procedures.

Whole Family Approach.

Agencies should ensure that operational procedures reflect the requirement for staff dealing with domestic abuse victims to enquire into the full extent of domestic abuse history as new cases are presented, especially where a period of over 12 months has elapsed since they last came to notice of that agency. The procedures should include narrative to guide staff to routinely enquire beyond the extent of the presenting patient/victim and their condition, including looking to establish whether children or other family members are at risk. The procedures, where appropriate, should include reference to record keeping and the responsibility of supervisors to ensure compliance. Agencies will ensure that training is delivered so that operational procedures are complied with.

Information Exchange

Key contact agencies should review how they refer vulnerable people who are subject of domestic abuse to other organisations more routinely to assist in reducing the risk to the survivor.

It is recommended that EMAS work with their commissioners to re-consider the extent to which the service is reliant upon address data. The identification of vulnerable adults is essential for GP's to contact other agencies.

Perpetrator – Survivor

Operational procedures and staff training should focus on how to respond to cases of enduring domestic abuse cases and establishing what can be done to manage when adults present as both the victim and perpetrator. A piece of work to look at the multi-agency management of enduring domestic abuse cases should be established.

Commissioning

Commissioners should ensure that an agency wide interdependency map is developed to show how services relate to each other with regard to domestic abuse. The role of commissioners can be further enhanced if they were aware of how other services are dependent upon each other and therefore avoid limiting the process to a single agency perspective.

Commissioners should ensure that agencies commissioned to deliver services to male victims are more prominent in campaigns to ensure that male victims feel they have somewhere to go for help and support.