Domestic Homicide Review (DHR) 4 Key Findings and Recommendations concerning a victim referred to as Jean

BACKROUND Middlesbrough Community Safety Partnership (CSP) commissioned DHR-4 in February 2019 following the death of a 33 year old female in October 2018 due to a domestic homicide incident. The female will be referred to as Jean. The review examined agencies' contact and involvement with Jean and the perpetrator from 1 May 2018, until Jean's death in October 2018. Jean had history of two long term abusive relationships from age of thirteen. Her third known abusive relationship was with the perpetrator, who went on to murder her. The perpetrator was a violent abuser of women and other people. At the time he met Jean, two court orders were in place preventing him from contact with two separate women as a result of his abuse and he had convictions for violent offences. Jean had five children, at time of her death none of children were in her care.

THE PURPOSE OF A REVIEW To understand if agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. It is also considers if agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

WHAT WE LEARNT The collective response of agencies in Middlesbrough to the escalating risks faced by Jean from the perpetrator lacked urgency, coordination and in some cases agencies did not recognise changing risk factors, share information or follow their own procedures. Actions which may have reduced the risks were not taken. The identification and management of the risk in relation to the risks the perpetrator presented to Jean was inadequate and in this context, Jean did not receive the effective protection from a serial perpetrator of domestic abuse that she should have done.

The DHR was led by independent chair and author Ged McManus & David Hunter. The DHR panel was made up of specialist organisations and agencies from across Middlesbrough. The Review made 30 Middlesbrough Community Safety Partnership and Single agency recommendations;

What will Middlesbrough Community Safety Partnership (CSP) do?

- Increase understanding of interface between MARAC, MAPPA and MATAC
- Seek written assurance that staff dealing with anti-social behaviour understand it can mask DA or maybe underlying cause
- Seek written assurance that staff understand DA and responding effectively to victims and perpetrators of DA
- Seek written assurance from National Probation Service (NPS) and Durham and Tees Valley Community Rehabilitation Company (DTVCRC) that staff provided with training tools and skills to meet their agency standards re supervising victims and perpetrators and managers have processes, tools and skills to take remedial action if they are not met
- Seek written assurance from all agencies that they understand Domestic Violence Protection Notice (DVPN) and Domestic Violence Protection Order (DVPO) and how they can be obtained
- Agencies provide a written report to CSP re how they engage hard to reach victims of DA and work with trauma
- Alongside Durham CSP request from Durham police and NPS assurance that failure to share information is now resolved and processes are in place and both Home Office and Ministry of Justice are updated
- Review effectiveness and strengthen information provided to families, friends, employers and diverse communities regarding recognising DA and where to go to report
- Share Learning with Tees wide Adult Safeguarding Board (TSAB)

Alongside those above National Probation Service (NPS), Durham and Tees Valley community rehabilitation Company (DTVCRC) and Cleveland Police identified single agency actions

The Published DHR Overview report, Executive Summary and Action plan is available via the following link: https://www.middlesbrough.gov.uk/dhr

1) Domestic Abuse Response

- Between July and October seven incidents of domestic abuse were reported via witnesses and by Jean herself. They were not always responded to effectively
- MBC Neighbourhood team did not make connection 2 reports of anti- social behaviour could be Domestic Abuse
- A Claire's law application took 13 weeks to progress to Stage 1 which by this point further incidents had taken place and disclosure never made
- No communication between DTVCRC who supervised Jean and NPS who supervised Perpetrator in relation to incidents of DA or risk
- When police attended incidents they often interviewed Jean and perpetrator together during which Jean denied abuse and they took no further action. They removed perpetrator rather than considering DVPN or DVPO which would have given opportunity to support Jean without perpetrator influence.
- On one occasion Jean contacted Police to express concern for her safety and that the perpetrator was withholding her phone. Attempts to call back the following day were unsuccessful. Police called again 5 days later but perpetrator answered. This should have raised immediate concern for safety but did not until reviewed by supervisor in which police were dispatched.
- Jean was supervised by DTV CRC – missed initial appointment and no action taken for 40 days. Jean was never seen in person despite DTVCRC responsible officer being aware DA had been reported. This was deemed inadequate.
- Jean did reach out to agencies for help. Agencies did not always action her disclosures and overall agencies were unable to sustain effective engagement with Jean

2) Recognising Trauma and Barriers to Reporting Abuse

Domestic Abuse had longstanding effects to Jean mental and physical health, her relationships with friends and family, children, career and economic well-being.

Jean was distrustful of police, courts, probation and therefore did not always disclose. When she did the support was not always forthcoming. She was distanced from family and friends and was isolated due to her low mood, confidence and drug and alcohol misuse

No professional thought to refer Jean to Adult Social Care as a vulnerable person.

3) Managing Risk - Perpetrators

- NPS were responsible for supervising the perpetrator following his release on licence in 2017 to his hometown Durham. At the time he met Jean, he was on licence and had already abused two other victims in Durham and legal orders were in place preventing him from contacting them. He was 24 but already was a serial abuser of four women and had history of violent offences.
- NPS did not apply appropriate standards of supervision to the perpetrator. As a person who presented a high risk of serious harm to the public, he should have been seen at least once a week but went for long periods without supervision. His Offender Manager failed to recognise or deal with the risks that the perpetrator presented. Opportunities to sanction the perpetrator for missed appointments and poor behaviour were not taken. The potential to initiate a recall to prison or require the perpetrator to reside in Approved Premises when risks escalated were not considered. This was deemed inadequate
- Jean's case was referred to MARAC due to level of risk and from there to MATAC. However, MATAC which is specifically for perpetrators with history of domestic abuse was new and rejected the referral. No consideration was given to referring the perpetrator to MAPPA.
- Opportunities to intervene and manage the perpetrator's behaviour were not maximised by any agency. Greater coordination e.g. a referral to MAPPA for multi-agency management would have helped.

Learning Points

1. The interface between different processes such as MARAC, MAPPA and MATAC needs to be fully understood by professionals engaged in protecting victims from domestic abuse, otherwise the approach will be uncoordinated and victims left more vulnerable.
2. There is a need, for professionals in all agencies, to be alert to the fact that reported incidents/complaints, for example of noise nuisance, damage to property and other potential anti-social behaviour, could inadvertently mask domestic violence as a contributory factor and or risk.
3. There was staff in DTVCRC who did not comply with service standards, and a system that did not recognise that non-compliance, placed Jean at ongoing risk of domestic abuse from the perpetrator.
4. Agencies need to deploy the full range of tools available to them. By not considering DVPN and DVPO Jean was not supported as well as she should have been and the opportunity to use the breathing space provided by these tools was missed.
5. Responding rapidly to victims of domestic abuse when they ask for help is important for effective engagement. This may particularly be the case when a victim such as Jean has suffered extensive previous trauma. Agencies need to consider training for professionals to work in a trauma informed way
6. Failing to share critical information in relation to offenders who are assessed as presenting a high risk of serious harm to the public reduces agencies ability to manage the risks and increases the risk to victims.
7. The absence of clear guidance on what members of the public can do when they know or suspect that someone is a victim of domestic abuse, could contribute to the abuse enduring and/or placing the victim in greater danger
8. A failure to make an appropriate referral to Adult Social Care means that people do not have the opportunity to have their care needs assessed (Care act 2014) and Adult Social Care do not have the opportunity to provide appropriate services, advice and assistance.