01. MSCB Domestic Homicide Review

Middlesbrough Community Safety Partnership commissioned a DHR following the death of a female due to a domestic homicide incident.

02. The case

A mother was subjected to domestic abuse by her son for nine years, which began when he was an adolescent.

In December 2016, she died due to her injuries following a serious assault perpetrated by her adult son.

03. Background

- Long term abuse (assaults, damage to property, threats, financial abuse, taking money / pressure to pawn goods)
- Many times victim did not report domestic abuse or breaches of the restraining order.
- If she did, agencies / professionals did not always act upon them.
- Victim's life was severely affected by alcohol abuse.

04. Concerns

- Victim had contact with many services but her engagement was sporadic. No one service had holistic view of the issues affecting her.
- Victim declined support in relation to domestic abuse when it was offered. Following an appropriate referral to MARAC the single action taken was ineffective and engagement with victim was not achieved.
- Some of the features re: alcohol misuse camouflaged vulnerabilities and may have prevented services from regarding her as a victim.
- Domestic abuse took place over 9 years. During this period, victim's son was subject to prison, bail conditions, restraining order, suspended sentence orders and prison licence. Despite those measures he had continued to offend, breach the restraining order, and assault victim. From March 2016, because perpetrator released from prison and victim did not report any further issues, she became invisible to services until her murder in December 2016.
- Changes in the provision of substance misuse services meant records of victim's engagement with substance misuse services were incomplete.

05. Lessons to be learned

- People with multiple needs may find it difficult to engage with services. A coordinated case management approach may help support service users who for whatever reason engage in risky behaviours.
- A more assertive approach to supporting victims of DA who do not easily engage is required.
- People with long term substance misuse issues are vulnerable to a range of different abuses and may be unable to effectively protect themselves.
- Services had last tried to engage with victim in July 2015 and attempts could have been made to engage her in safety planning towards the end of her son's sentence in 2016.
- Commissioners should ensure that access to records is considered within the continuity arrangements when the provider of a service changes.
- It is important that all professionals recognise patterns of behaviour in a young person that may indicate APVA and the risk that young person presents to others. Agencies need to have pathways in place so that professionals can recognise and respond appropriately to APVA.

05. DHR report

Will be published November 2018 and can be found on Middlesbrough Council website / Community support and safety / Domestic abuse / Domestic Homicide Reviews

06. What we will do now

- Agree and implement recommendations via a multi-agency DHR action plan which will be monitored via Community Safety Partnership
- Revise DA Level 1 & 2 training programmes
- Embed learning from DHR through a series of briefings across children and adult services
- Raise awareness of Adolescent to Parent Violence and provide briefings to professionals working with families at risk
- Commissioning will review and manage access to records if a contract terminates.

Middlesbrough
moving forward