Domestic Homicide Review (DHR) 3 Key Learning and Recommendations

BACKGROUND Middlesbrough Community Safety Partnership (CSP) commissioned DHR-3 in September 2018 following the death of a woman due to a domestic homicide incident. The woman will be referred to as Kathie. She was murdered by a man who had been an intimate partner and from whom she was seeking to end the relationship. In the years immediately preceding her death, she had struggled with alcoholism but had taken steps to address this and was on a recovery journey with local Alcohol Services. She had become close friends with the man who murdered her whilst they were both in the same residential rehabilitation centre. After they both left the centre, they formed an intimate relationship. Kathie was found dead in his flat and he was arrested for her murder. He pleaded not guilty to that murder but after a trial was convicted and sentenced to a term of life imprisonment.

This review has been cognisant of other safeguarding/learning Reviews undertaken in the local area particularly the 'Lessons Learned Review concerning Adult C1'. This review has identified several similar areas of learning – particularly relating to domestic abuse and alcohol abuse – and it urges the local partnerships to ensure that this report is considered when progressing the learning across this and other previous reviews.

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 also considers if agencies have sufficient and robust procedures and protocols in place, and that they were understood and adhered to by their employees.

KEY ISSUES ARISING FROM REVIEW

- Multi-agency meetings that were held prior to the perpetrator's placement in residential rehab were not effective in sharing sufficient information to properly identify the risk that he posed of developing unhealthy relationships within that setting.
- The Review considered the issue of mixed gender residential rehabilitation and did not conclude that it is inappropriate per-se. However, much more must be done to ensure that predatory perpetrators such as this are recognised for the danger that they present.
- At the time of Kathie's murder there were delays in both the timeliness of the MARAC process and a process to consider Clare's Law disclosures.

The DHR was led by independent chair and author Gary Goose MBE and Christine Graham Report Writer. The DHR panel was made up of specialist organisations and agencies from across Middlesbrough. The Review made 2 Middlesbrough Community Safety Partnership recommendations, 1 MARAC and 22 Single agency recommendations.

What were the identified recommendations for Middlesbrough Community Safety Partnership?

- That Middlesbrough Community Safety Partnership reviews the implementation of the Integrated Commissioning Model to assure itself that the issues identified in the way in which Kathie was dealt with have been eradicated.
- That Middlesbrough Community Safety Partnership seeks assurance regarding the implementation of MEAM approach in Middlesbrough and if it has driven system change and improved outcomes for vulnerable women.

Alongside those above MARAC, Adult social Care, Integrated Health Board, Cleveland Police, GP surgeries. Durham and Tees Valley CRC (now part of Teesside Probation Service)

Middlesbrough Recovery Together, Foundations and Recovery Connections all had single agency recommendations

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

LESSONS LEARNED Below summarises the main learning points identified within the report.

Cleveland Police

- Review of effectiveness of MARAC and MATAC in managing risk
- Officers who are investigating domestic abuse cases should monitor their ongoing cases so that they can identify any new relationships that victims/perpetrators may enter so that early safeguarding referrals can be made.
- Referring victims to specialist services may lead to them feeling able to support a police investigation.

Durham and Tees Valley Community Rehabilitation Company

- A lack of response to concerns relating to risk of harm, specifically in relation to domestic abuse and that information and assessments were not reviewed contextually.
- Assessments were not updated after significant events.
- Record-keeping was not, at times, contemporaneous.
- Multi-agency working was not always co-ordinated and holistic in nature.
- Unconscious bias and overfamiliarity led to a lack of focus.

GP surgeries

- Patient records would benefit from more information being recorded, such as details of family, partners, and children.
- Patient records would be improved by a record of any discussions about alcohol misuse being recorded, along with any subsequent referrals and risk assessments.
- Those surgeries would benefit from the development of a Domestic Abuse Policy and staff training in relation to domestic abuse.

MARAC

- That, as the first point of contact for many patients, MARAC information needs to be shared with GP practices so that potential risks can be flagged.

Middlesbrough Recovery Together

- Evidence of considerations of risk and vulnerability should form part of the services documentation to ensure that both aspects are properly considered and continually reviewed considering emerging information.

Recovery Connections

- There is a need to review some of the policies and procedures of the organisation considering the findings of this review.

Adult Social Care

- There needs to be more ownership of cases, with a named person having a level of oversight of the case and ensuring that it is progressing appropriately.

Homeless Service

- Homeless Service needs to proactively engage with the domestic abuse agenda, ensuring that they are engaged in the processes and staff are confident with their understanding of domestic abuse.