Sheffield Safer and Sustainable Communities Partnership October 2013

Learning from Domestic Homicide Review (DHR)

Adult C – Quality Assured by the Home Office July 2013

Domestic Homicide Reviews (DHRs) aim to improve practice and outcomes for people affected by domestic abuse. This learning sheet is designed to highlight the key areas of learning and practice in relation to the Adult C DHR. We hope you will reflect on your own practice in light of this information.

Summary of case

Adult C had no known contact with any specialist domestic abuse agencies or services before her death on the 18th May 2012. She was killed in an apparent "one off" incident by her adult son following a period of deteriorating mental health/psychosis.

Summary of process

A Domestic Homicide Review (DHR) was held in the city with an Independent Chair and Author, Brian Lawson. The Key findings were:

- **The incident which led to the death of Adult C is a one off**. Whilst there was evidence of a previous pattern of deteriorating mental health in Adult CS in the days before the fatal incident, there is no way that these emerging symptoms could have been predictive of a fatal risk to Adult C. There is no evidence of any previous incident involving Adult C and Adult CS. The history of explicit threat was from Adult CS to Adult CH [Adult C's husband / CS's father].

- Clearly, **more could be done to raise awareness** of both the issues surrounding and services to support victims **of domestic abuse where the abuser is a family member rather than an intimate partner**. This applies to both public and organisational awareness.

Lessons to be learnt

A number of lessons to be learnt were identified from the DHR into Adult C. These were:

- The need for domestic abuse awareness, early identification and risk assessment in Health and other Universal Services;

- The need for agencies to have specific domestic abuse policies;

- The need to enquire about / assess domestic abuse within the wider family where individuals are presenting with alcohol misuse and mental health issues;

- The need to develop pathways to support agencies across the city to address issues of domestic abuse;

- The role of operational deployment within the military and its impact on domestic abuse: a closer relationship between local mental health services and the military, including the local TA, would support serving personnel who have had these experiences successfully managing them on their return to the wider community;

- The need to sustain the development of practice and the implementation of recommendations through changes in commissioning and procurement processes, and changes to governance and partnership structures;

- The need to consider the timing and the process of engaging family members in the DHR in the context of a focus on particular issues or stresses in the family.

Recommendations

Key recommendations were as follows:

- The prompt use of the ACPO DASH risk assessment tool should be embedded into practice;

- A simple screening system should be developed for GPs to help them assess Domestic Abuse risk, and training delivered to GPs should include completion of ACPO/DASH when high risk issues are indicated;

- Agencies across the city [should] have in place up to date policies and procedures, and awareness and training for staff in relation to domestic abuse; including awareness that Domestic Abuse can affect non-intimate household members such as parents or siblings, and that local support services are available to people in these situations;

- Clinical supervision for Health staff is widely recognised as a beneficial activity that encourages reflection and supports best practice, and is recommended by the Nursing and Midwifery Council (NMC, 2008). Organisations [*as appropriate – single agency recommendation*] need to reinforce and remind staff of the availability and benefits of accessing regular clinical supervision;

- Social Workers need to give consideration to the role of wider family members within their assessments if they are frequent visitors to households even if they are not living at the address.

- Service providers should ensure all staff are aware of the need to recognise carers and offer carers assessments where appropriate.

- Providers should make the Dual Diagnosis protocols clear and accessible to staff. Individuals confirmed as reaching the threshold for “dual diagnosis” must have their care co-ordinated by the Mental Health Trust.

- The Domestic Abuse Strategic Board should support the principle of a whole household approach to assessments. The issues arising from this DHR should be shared with the group developing the family CAF and Building Successful Families;

- Domestic abuse pathway development work should be completed by September 2013;

- The Domestic Abuse Strategic Board should implement the joint commissioning arrangements proposed in the Domestic Abuse Strategic Review and consider its relationship with the new Health commissioning structures and strategic boards in relation to the maintenance of the effective delivery of domestic abuse support services;

- The Domestic Abuse Strategic Board [should] satisfy itself that the transfer of services from NHS Direct continues to progress smoothly in relation to the issues identified in this DHR;

- That the likely support needs of families and DHR subjects are assessed by future DHR panels when creating terms of reference for future DHRs;

- NHS Sheffield and future commissioners of NHS services should ensure any signposting directs contacts regarding a mental health crisis to appropriate emergency / urgent care services;

- The Domestic Abuse Strategic Board [should] express concern in relation to the National Contract for GPs not including any statutory responsibility in relation to the safeguarding of victims of domestic abuse, vulnerable adults and children;

- The local review of protocols in relation to dual diagnosis of substance misuse and mental health should address related issues of domestic abuse.