Safer Hull

Safer, Stronger, Resilient Communities

Domestic Homicide Review

Executive Summary

'Maria'

Died: July 2017

Tony Blockley
Independent Domestic Homicide Review Chair and Report Author
Johnston and Blockley Limited

1 Review Process

This summary outlines the process undertaken by the Hull Community Safety Partnership Domestic Homicide Review (DHR) panel in reviewing the death of 'Maria' who was resident in their area. 'Maria' and 'Steve' are pseudonym's used in this review.

Maria died as a result of a road collision; at the time she was in the company of Steve. The coroner determined that Maria had died as the result of a road traffic collision.

Maria's death was not immediately considered within the context of a Domestic Homicide Review, but following discussions with the Home Office, the Community Safety Partnership determined that her death came within the guidance for a Domestic Homicide Review. The Home Office was formally notified of the Community Safety Partnerships decision to commission a Domestic Homicide Review on the 10th October 2017.

Following the decision to hold a Domestic Homicide Review, all agencies that potentially had contact with Maria and/or Steve prior to the point of her death were contacted and asked to confirm whether they had involvement with them.

Eleven out of the 27 agencies contacted confirmed contact with Maria and/or Steve and were asked to secure their files.

2 Contributors to the review

The following agencies had information and were asked to give chronological accounts and analysis within an Individual Management Review (IMR) template of their contact with Maria and/or Steve during the scoping period:

- Humberside Police

- Hull Domestic Abuse Partnership, Domestic Abuse Support Service, Hull City Council
- Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Probation
- Hull City Council, Children Social Care
- RENEW - Representing Journey to Recovery, Provider of this commissioned service during the scope of this DHR.
- Preston Road Women's Centre
- Preston Road Women's Centre, Umbrella Housing Project
- City Health Care Partnership
- Hull and East Yorkshire Hospitals NHS Trust
- Pharmacy
- GP Practice

Other agencies were involved in the review and either did not hold / or had minimal information to inform the review.

- Hull City Council Housing Services
- National Probation Service Humberside
- Hull Clinical Commissioning Group
- Hull Women's Aid refuge and Children and Young people's Service – Independent Domestic Abuse Service
- Humber NHS Foundation Trust
- Safeguarding Adults, Hull City Council
- Primary Schools
- Hull City Council CIVICA
- Department for Work and Pensions
- Citizens Advice Bureau
- Yorkshire Ambulance Service
- Hull Churches Housing
- Hull City Council Anti-Social Behaviour and Early Help

- Children's Centre
- Together Women Project
- Humbercare

All the IMR authors were independent within their organisations. They were not involved in any of the contacts with Maria and/or Steve, nor did they supervise any staff that had been involved with them.

3 The Review Panel Members

Name	Organisation
Tony Blockley	Independent Chair and Overview Author
Vicki Paddison	Hull Community Safety Partnership
Dawn Clougher	Hull Domestic Abuse Partnership Support Service
Ria Toutountzi	Hull City Council Housing Services
Andy Lynch and Liz Robinson (Bates)	Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Probation
Judith Dent	Children's Social Care
Maria Woodmansey	ReNew
David Blain	NHS Hull Clinical Commissioning Group
Sally Dearlove	Hull Women's Aid - Independent Domestic Abuse Specialist agency
Alison Ashton and Ann Clarkson	Preston Road Women's Centre Preston Road Women's Centre Umbrella Housing
Danny Patrick and Nicholas Ram	Humberside Police

Christine Davidson	Hull and East Yorkshire Hospitals NHS Trust
Mags Shakesby	City Health Care Partnership

4 Author of the Overview Report

The author of the report, Tony Blockley is a senior lecturer at Derby University and is also completing a PhD in domestic violence and abuse, with a focus on risk identification and analysis. He is chair of the multi-agency child sexual exploitation strategic group within Derbyshire, the vice-chair of a domestic violence and sexual abuse services charity and the victims-lead on the advisory board for 'No Offence' CiC. Previously, he was responsible for a police department that included all aspects of public protection in Derbyshire. He devised and delivered training for specialist services that included safeguarding and multi-agency working.

Tony has no connection with Hull Community Safety Partnership, has never worked or been involved with any agencies included in the review.

5 Terms of reference for the review

The review has:

- Invited responses from agencies or individuals identified through the process and requested Individual Management Reviews (IMR's) from each one that was involved with Maria, and/or Steve.

- Considered each agency's involvement with Maria and/or Steve between May 2015 to July 2017, subject to any information emerging that prompted a review of any earlier incidents or events that were relevant.

- Sought the involvement of Maria's family and friends and Steve, to provide a robust analysis of what happened

- Determined how matters concerning family, the public and media should be managed before, during and after the review and who should take responsibility for it

- Taken account of coroners or criminal proceedings (including disclosure issues) in terms of timing and contact with Maria's family and friends to ensure that relevant information could be shared without incurring significant delay in the review process or compromise to the judicial process

- Considered whether the review panel needed to obtain independent legal advice about any aspect of the review

- Ensured that the review process took account of lessons learned from research and previous domestic homicide reviews.

The review has addressed:

- Whether the incident in which Maria died was an isolated event or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence

- Whether there were any barriers experienced by Maria or family/friends/colleagues in reporting any abuse in Hull or elsewhere, including whether they knew how to report domestic abuse should they have wanted to

- Whether Maria had experienced abuse in previous relationships in the Hull area or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died

- If there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Maria that were missed

- Whether Steve had any previous history of abusive behaviour to an intimate partner, a relative or a co-habitee and whether this was known to any agencies

- If there were opportunities for agency intervention in relation to domestic abuse regarding Maria and Steve or to dependent children that were missed

- If there are any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the region

- Whether there are any equality and diversity issues that appear pertinent to Maria, Steve and any dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Review specific considerations:

The Terms of Reference recognised there were circumstances that required further in-depth analysis and sought to address the following key points:

1. Identify significant incidents and events and identify whether practitioners and agencies responded appropriately to these

2. Did practitioners and agencies involved follow appropriate interagency and multiagency procedures in response to the victim's needs

3. Establish whether single agency and interagency responses to concerns about

Maria and **Steve** needs and welfare, and the assessment of risk to himself and others were considered and appropriate.

4. Were the views of **Maria** and **Steve** appropriately taken into account to inform agency responses

5. Identify any areas where the working practices of agency involvement had a significant, positive or negative, impact on practice or the outcome

6. Identify any gaps in, and recommend any changes to, the policy, procedures and practice of the agency, and interagency working, with the aim of better safeguarding families and children where domestic violence is a feature in Hull

7. Establish whether there are lessons to be learned from the case about the way in which local practitioners and agencies carried out their responsibilities and duties and worked together to safeguard **Maria** and **Steve.**

6 Summary Chronology

The review has considered the impact of detailing all the circumstances surrounding the review into a publically available report, particularly relevant for Maria's son, whose wellbeing is paramount.

Having consulted with Maria's relative who has legal guardianship of Maria's son and considering the impact Maria's death has had on him, the Hull Community Safety Partnership and the independent chair do not consider it appropriate to relate all the circumstances surrounding Maria and her relationship within this document.

7 Key Issues Arising from the Review

The review has highlighted the complexities managing individuals with complex needs

and the impact that events have on them.

There were key points within Maria's life that increased her vulnerability and whilst all these points were managed according to legislative requirements and appropriately in their individual circumstances, their cumulative impact and effect on Maria may not have been fully recognised.

Maria was managed within the Multi-Agency Risk Assessment Conference (MARAC) process and as such risks were identified and appropriate strategies put into place to manage those individual risks.

There are some specific learning points for organisations however these were for isolated incidents and are not characteristic of any wider learning or organisational failings.

However, agencies should be aware of the need to view the risks towards an individual from a multi-agency viewpoint, especially when the individual's concerned have multiple complex needs so that a broader holistic view can therefore be developed.

8 Conclusions

There is no doubt this is a sad case and whilst Maria's death could not be attributed to the direct actions of Steve, it is clear from this review that their relationship was based on violence and abuse. That Steve utilised coercive and controlling behaviours towards Maria, that he created isolation, adding to that maneuvered Maria to a position whereby she was reliant on him.

Agencies were often in contact with both Maria and Steve at points of crisis, where they acted according to their policies and processes to support her and ensure the safety for her child.

Sadly, this could have increased her isolation and in turn have influenced her into returning to a relationship with Steve.

There is nothing in the review that indicates any failings by any agency, but it does highlight the complexity of relationships, particularly for vulnerable people; accordingly, all agencies should be mindful of the consequential impact of their individual and cumulative actions and how to mitigate such impact.

9 Lessons to be Learned

The key lesson from this review is the consequential impact of actions towards individuals and whilst in the first instance they may seem appropriate, the cumulative effect can increase the impact on the individual. On occasions the isolation created could be a continued barrier for the victim to move ahead with their life and provide further opportunity for the perpetrator to retain control and so continue with the cycle of abuse.

It is important that a holistic approach is considered, particularly with individuals who have multiple complex needs, thereby providing opportunities for agencies to identify suitable strategies of support.

10 Recommendations from the review

Hull Domestic Abuse Partnership Support Service

By November 2018 training to be delivered to DAP Support Workers to increase awareness of the impact of domestic abuse on victims from BMER communities and to explore cultural norms and expectations.

In June 2018, training audit to be completed to ensure all DAP Support Service

Support Workers have completed substance misuse training.

Humberside Police

Further training input about the use of F125's. There is evidence to suggest that officers are still unsure as to when to submit a form.

Further training around risk assessing Domestic incidents. Officers who attend incidents are still looking at incidents in their single form and not holistically.

Further training around what constitutes a vulnerable adult and what is vulnerability.

Preston Road Women's Centre

Continue to work towards finding further information and or training around the benefit entitlement for EEA nationals to prevent any future women in similar circumstances falling into arrears/debt.

Housing officers to make it clear to women in similar circumstances that they can refer them to a different agency for domestic abuse support as that may make the woman feel less beholden to the organisation they are in arrears with.

Preston Road Women's Centre Umbrella Housing

Continue to work towards finding further information and or training around the benefit entitlement for EEA nationals to prevent any future women in similar circumstances falling into arrears/debt.

Housing officers to make it clear to women in similar circumstances that they can refer them to a different agency for domestic abuse support as that may make the

woman feel less beholden to the organisation they are in arrears with.

Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company Probation

Risk assessments need to be completed taking into account all available information to ensure the assessment is as comprehensive and current as is possible.

Consideration needs to be given to the imposition of additional license conditions in all cases that are subject to other Orders such as Restraining Orders in order to reinforce those conditions and further protect the victim.

In cases that are subject to additional Orders such as Restraining Orders, sentence plan objectives should be set to further encourage compliance with those identified conditions / prohibitions.

Supervising officers need to ensure that all additional requested license conditions are applied to the actual release license; and take prompt action in those cases where conditions are missing. This will ensure that ensure that prompt enforcement action can be taken in cases of non-compliance.

Hull and East Yorkshire Hospital Trust

The Trust is implementing a three-year 'Routine Enquiry' systematic roll out programme to areas not currently implementing 'Routine Enquiry'. This will be completed in or before 2021/2022

Within 3 months of the onset of this enquiry, awareness training will be delivered to key staff in the DSU departments at HRI and CHH. This has been completed

At the earliest opportunity the outcomes of this report will be shared with the

Safeguarding Committee and members will cascade outcomes to key staff in the clinical areas.

Children's Social Care

That training on CSC Assessments should be reviewed to ensure that it emphasises the need to capture parents/carers' background histories and their own experiences of being parented, to be underpinned by comprehensive genograms. By July 2018

For there to be awareness raising/ training made available to social workers regarding different Eastern European countries and their cultures and/or access to such expertise to inform assessments and interventions. By September 2018.

When parents who require interpreters in formal meetings, also attend core groups, interpreters should also be provided in these meetings unless the parent/s are very clear that they can understand multiple speakers and do not want an interpreter to attend. This needs to be incorporated into training and procedures. By September 2018.

GP Practice

Within 12 months, the practice will review and update the domestic abuse policy and guidance, this will include roles and responsibilities of the Domestic Abuse/Violence lead.

Within 12 months, the practice will provide domestic abuse training for all staff.

Within 6 months, the practice will appoint a designated person who is trained in the use of a Domestic Violence Risk Assessment tool such as the DASH.