Domestic Homicide Review Learning Event ‘Karen’

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MANCHESTER SAFEGUARDING ADULTS BOARD

Domestic Homicide Reviews:

- Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on the 13th of April 2011.
- The Act exerts a statutory responsibility on Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review when a case meets the criteria set in the guidance.

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Purpose of a Domestic Homicide Review :

- Establish what lessons are to be learned about how local professionals and organisations work individually and together to safeguard victims.
- Clearly identify those lessons, how they will be acted upon, timescales for completion, and what is expected to change as a result.
- Apply these lessons to service responses, including any changes to policies and procedures that may be appropriate.
- Prevent further domestic homicides and improve service responses for all Domestic Violence and Abuse (DVA) victims and their children, through improved intra and inter-agency working.

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A Domestic Homicide Review is not:

An enquiry into:

- how the victim died;

  or

- which agency or individual professionals were culpable.

Background:

- In March 2016 Karen tragically died from injuries sustained as a result of her brother pouring petrol over her which he then set alight.
- Her brother, John, was charged and convicted of her murder.
- There was no previous history of John being violent towards Karen, albeit he had convictions for other offences and had previously ‘stalked’ a female not known to him.
- There was also evidence of aggression and controlling behaviour in previous relationships.
- Both Karen and John had enduring mental health conditions, managed differently by themselves and services.

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Think about ……..

- What are your impressions so far?
- Have things changed?
- How is your practice influenced?
- How does the ‘system’ support the implementation of your work?

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Key Findings:

- Clinical guidance in respect of appropriate management of Paranoid Schizophrenia was not adhered to.
- Missed opportunities to assess and refer Karen and John in respect of excessive alcohol use.
- Despite John's difficulty maintaining engagement with mental health services, he was allowed to drift from them over a number of years.
- Restrictive and complex communication channels between public services meant that key information was not shared and therefore not included in support/management plans.

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Conclusions and recommendations

- Evidence that Karen's mental health condition was managed well in the community.
- Opportunities were missed to support Karen and John in relation to excessive alcohol consumption.
- Evidence of clinical guidance not adhered to in the management of enduring mental health conditions.
- John was allowed to drift away from services seemingly unchallenged.
- Restrictive information sharing practices made communication between agencies difficult.

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Key learning points

- Management of severe and enduring mental health conditions to be in accordance with clinical practice guidance, including family support and psychosocial support.
- Agencies to consider their roles and practice in relation to the management of service users who are ‘difficult to engage’.
- Ensure multi-agency systems for sharing information about risk of harm / self harm are in place, particularly between health and justice agencies.

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For Discussion

- What are your impressions of the findings?
- Have things changed?
- How is your practice influenced?
- How does the ‘system’ support the implementation of your work?

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Feedback and Impact Evaluation

It is important that all trainees complete:-

- On-line feedback
- Action Plans
- Impact Evaluation Questionnaire will be need to be completed online in 3 months after attending this course to attain the training certificate.

Thank You

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