Safer Hull

Safer, Stronger, Resilient Communities

Domestic Homicide Review

Executive Summary

'Marcia'

Died: September 2017

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

Section	Content	Page
1	Review Process	3
2	Contributors to the review	4
3	The Review Panel Members	5
4	Author of the Overview Report	6
5	Terms of reference for the review	6
6	Summary Chronology	9
7	Key Issues Arising from the Review	10
8	Conclusion	11
9	Lessons to be Learned	12
10	Recommendations from the review	12

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 'Marcia' who was resident in their area. 'Marcia' and 'Stephan' are pseudonym's used in this review.

Hull Community Safety Partnership was notified of Marcia's death on 28th September 2017. The Home Office was formally notified of the decision to hold a Domestic Homicide Review on 2nd October 2017.

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

Nine out of the 16 agencies contacted confirmed contact with Marcia and/or Stephan 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 Marcia and/or Stephan during the scoping period from 1st May 2011 to the date of her death, believed to be 24th September 2017.

- Humberside Police
- GP Practice
- Hull City Health Care Partnership
- Hull and East Yorkshire Hospitals NHS Trust
- Hull City Council Children's Social Care

- Hull City Council Housing
- Hull Domestic Abuse Partnership Domestic Abuse Support Service
- Blue Door Domestic Abuse Independent Sexual Violence Advocate (ISVA) Service
- Hull Women's Aid

Other agencies were involved in the review but either did not hold, or had limited information to share.

- NHS Hull Clinical Commissioning Group
- Yorkshire Ambulance Service
- Hull Safeguarding Adults Team
- Hull Children Centre - including Employment advisor involvement
- Anti-Social Behaviour Team, including Priority Families team
- Early Help
- Primary School

All the IMR authors were independent within their organisations. They were not involved in any of the contacts with Marcia and/or Stephan, 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	Community safety Partnership
Danny Patrick / Paul Welton	Humberside Police
David Blain	NHS Hull Clinical Commissioning Group (GP Practice)
Michelle Blenkin	Hull City Health Care Partnership
Michelle Priest	Hull Children and family service

Ria Toutountzi	Hull City Council Housing
Michelle Donnelly / Sally Dearlove	Hull Women's Aid
Dawn Clougher	Hull Domestic Abuse Partnership Domestic Abuse Support Service
Sandra Park	Hull and East Yorkshire Hospitals NHS Trust
Steph Price / Debbie Winning	Blue Door ISVA Service
Alison Ashton	Preston Road Women's Centre (Independent Domestic Abuse Agency)

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 Marcia, and/or Stephan

- Considered each agency's involvement with Marcia and/or Stephan between May 2011 to September 2017, subject to any information emerging that prompted a review of any earlier incidents or events that were relevant

- Sought the involvement of Marcia's family and friends and Stephan, 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 Marcia'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 Marcia 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 Marcia 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 Marcia 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 Marcia that were missed

- Whether Stephan 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 Marcia and Stephan 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 Marcia, Stephan 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 **Marcia** and **Stephan** needs and welfare, and the assessment of risk to himself and others were considered and appropriate

4. Were the views of **Marcia** and **Stephan** 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 **Marcia** and **Stephan.**

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 Marcia's children whose wellbeing is paramount.

Both children are subject to S31 Care Orders and as such Hull Children's Social Care are responsible for their protection and care. It is clear if the report and the details were published it would cause further trauma to the severe trauma, they have already suffered.

Children's Social Care, the Hull Community Safety Partnership and the independent chair do not consider appropriate to relate all the circumstances surrounding Marcia and her relationship within this document.

7 Key Issues Arising from the Review

The review identified that there is a need for greater understanding of culture for agencies, who should be able to identify and differentiate between cultures and adapt their response accordingly. It is also important for agencies to understand the impact coercive and controlling behavior and the associated risks. The ability to take a holistic view is important and allows professionals to understand and respond to needs accordingly.

8 Conclusions

This is a very sad case of an individual who despite living within an abusive and violent relationship had worked hard to provide independence for herself and her children.

9 Lessons to be Learned

There are some general lessons for all agencies that focus on culture, family and coercive and controlling behaviour. It is important that agencies look at cases in the context they occur and not defer to traditional roles and value.

Agencies can be solely focused on events on an incident by incident basis and not take a more holistic view of the events to enable a greater understanding of the broader implications of the impact. This is understandable on the basis they are managing a

specific incident, however there is a point of learning going forward in that services need to consider the full history and impact of patterns of abusive and coercive and behaviour over time.

10 Recommendations from the review

That culture should be recognised as a significant factor within the risk assessment process, that research should be utilised to ensure that professionals are aware of the impact and that due regard and assessment is made on the impact of such belief.

That agencies should not be solely focused on events on an incident by incident basis and take a more holistic view of the events to enable a greater understanding of the broader implications of the impact. This is learning for all agencies.

Hull Domestic Abuse Partnership Domestic Abuse Support Service

Within the next 4 months training audit to be completed to identify who has completed the Hull City Council Training - Becoming Culturally Competent. All staff to have attended this training in the next 4 months.

Within the next 4 months training audit to be completed to identify who has completed the Hull City Council Training - Forced Marriage, Honour Based Violence and Female Genital Mutilation training delivered by Hull Safeguarding Children Board. All staff to have attended this training in the next 4 months.

Increased joint working with Blue Door ISVA service by inviting the service to attend a DAP Support Service team meeting every 3 months.

By December 2018 the DAP Support service to discuss in reflective practice their role as Independent Advocates and their responsibility to professionally challenge.

The Community Safety Partnership to increase awareness in the city of the impact of domestic abuse on victims from BMER communities and to explore cultural norms and expectations.

Additional information and advice regarding what constitutes a repeat MARAC's to be provided to all agencies. This includes all agencies responsibilities to refer in to MARAC wherever appropriate

City Health Care Partnership

All health practitioners working within the 0-19 team, employed by CHCP CIC, should access the DASH Training.

All health practitioners working within the 0-19 team, employed by CHCP CIC, should ask Routine Enquiry, when possible.

If health practitioners are unable to ask Routine Enquiry at a core contact, health practitioners should consider opportunities outside of routine contacts, for instance Child Health Clinic/ appointments outside the home, so Routine Enquiry may be asked.

Humberside Police

Further multi agency training re Honour Based Coercion. While most agencies have trained staff around Honour Based Violence, in this case the honour of the family is preventing the victim from taking appropriate action against the perpetrator. This is subtler than Honour based violence and requires further training.

Within any investigation into a criminal offence of the nature dealt with here the following is required;

1. Agreement re victim updates

2. Safeguarding plan
3. Investigation Plan
4. Suspect updates

This needs to be considered from the initial reporting of a crime.

Further training required for hub staff to recognise and correctly risk assess calls to the hub. Where both victim and perpetrator are in a premise and victim has ended a call because the offender is approaching her there must be immediate deployment.

Hull and East Yorkshire NHS Trust

To develop a Domestic Abuse Strategy for the Trust

To improve risk identification, information sharing and communication in relation to Domestic Abuse.

Children's Social Care

There should be awareness raising and training made available to staff regarding greater understanding of different cultures and in particular domestic abuse in these cultures and the impact of an arranged marriages. Such information can then inform the approach and intervention with the victim and their family.

In managing risk with families there should be a Social Care Assessment in place. This will outline the concerns and risks, whether parents understand the seriousness of concerns and risks, what they are expected to do, and the consequences of not following a plan. The focus must be on the child's lived experience and should always consider their individual needs. When there is a clear assessment of risk and a safety and support plan is in place for the perpetrator to stay away from the home there needs to be a clearly articulated contingency plan and multi-agency action taken

when this is not complied with to support victims and children.

To ensure all decision making is clearly documented on the child's file so management oversight is clear alongside the rationale for actions

Blue Door

To ensure that ISVA is represented at MARAC and able to present the views of the victim in relation to sexual abuse/violence

To ensure that joint working is effective with Humberside Police for the benefits of the ISVA role working alongside the specialist unit within the police

To ensure that in a case where an ISVA is involved and a retraction statement is being considered, they be notified and support the individual concerned for best outcomes for all

To increase joint working with the DAP Support Service.

Hull Women's Aid

To Inform and update EHASH on all Police DASH referrals involving children

GP Practice

Within 6 months, review and update governance processes around practice safeguarding meetings.

Within 12 months, safeguarding leads at the practice to attend and complete DASH training.

Within 6 months, the practice will review and update safeguarding policies to include domestic abuse/violence.

Within 6 months, all practice staff to attend and complete domestic abuse/violence training.