

Reviewing domestic homicides are a way to improve our local coordinated community response. Looking at the death of a person aged 16+ as a result of DVA, they aim to: understand what happened; identify where agency responses could be improved; learn lessons including how agencies work together; identify how to improve responses; and to prevent something similar happening to others in the future.

**Introduction:** The Safer Cornwall Partnership undertook a Domestic Homicide Review (DHR) to evaluate multi-agency responses to the death of a woman in her mid-20’s, who for the purposes of the review was known as Adult A, who was deemed to have taken her own life.

Adult A was mid-20s at the time of her death and had been living in Truro. From an early age Adult A had developed dependencies on drugs and alcohol and she was a frequent user of services. Adult A often presented to those services in crisis and, due to concerns raised with regards to her behaviour, a multi-agency package was put into place to support her. Adult A was also known to have been a victim of domestic abuse. On the18th November 2017, Adult A was deemed to have taken her own life.

**Key Issues Arising from the Review.**

**Evidence of Domestic Abuse in Adult A and Adult B’s relationship.**

Adult A had been the victim of domestic abuse in a number of relationships. All of the incidents had been assessed to an appropriate level and it was clear that those working in the main agencies had recognised the relevant risk factors and attempted engagement.

* 3 MARACs in 2017
* High level of violence, coercion and control and exploitation of vulnerability
* Relationships built around substance misuse
* Clear documented approach to safety planning and a co-ordinated approach across agencies
* Missed opportunities to fully assess disclosures of domestic abuse and signpost earlier
* Failure to engage with traditional service provision

**Alcohol and drug use**

Adult A would regularly use substances and the effect on her behaviour was self-evident to both professionals and her family. This included amphetamine, ecstasy, crack cocaine, heroin, ketamine, Subutex, and alcohol.

* Suspected encouragement of drug use to control adult A
* Clear evidence of effective intervention in relation to drug management, however, additional training specific to dealing with ‘crack users’ was identified as required.

**Training**

There would appear to be good understanding of domestic abuse amongst those professionals who were involved with Adult A. All of the staff that were involved with Adult A would appear to have been trained to the standards expected, and all were equipped to identify her safeguarding needs, although on occasions they had failed to fully explore the incidents or exploit the information that they were given. During the Review there were additional opportunities to improve training standards within a number of agencies, including CFT and GPs

**Adult A’s Mental Health**

When intoxicated Adult A would become incoherent, have a poor recollection of events and her capacity to make decisions was severely impaired. This made mental health examinations and assessments extremely problematic for practitioners. Professionals also found it difficult to identify whether the disclosures that she made in relation to abuse were real or imagined. In these circumstances, efforts were made by appropriate agencies to complete or repeat any assessments when Adult A was not intoxicated. She also had varied commitment to take medication. There has been nothing specifically identified by this review that would provide any rationale as to what lead Adult A to take her own life on that day.

**Self-Neglect**

Adult A did meet the definition of vulnerability used by statutory agencies[[1]](#footnote-1) and Adult Social Care had considered this as part of their assessment process.

* Numerous reports by family to services
* Obvious changes in appearance and demeanour
* Service shared information willingly
* The review identified additional awareness was required in relation to self-neglect and the self-neglect policy.

**Risk Management – Adult A**

There were significant high risks identified in Adult A’s life. These risks were known to professionals and identified in agency risk assessments. Although Adult A’s willingness to engage presented a significant challenge for all agencies in the management of her risk. The risks identified were managed on a multi-agency level and significantly via the MARAC process. There was also evidence that the safety plans that were initiated were discussed with family members when this was deemed to be appropriate. Escalation and joint care planning were identified as an area of learning, particularly between drug and alcohol and mental health services. The local high-risk behaviour policy was relatively new and there was evidence more awareness of this was needed and a clear lead should be identified as part of this policy.

**Information Sharing and Communication**

There is clear evidence of information sharing in this case, both internally within organisations and with other agencies. There was particular evidence of effective information sharing between Addaction, Health, Police and Housing. There were however, missed opportunities for sharing information with agencies. This included incidents involving the CFT, Primary Care and Addaction.

**Supervision and operational practice**

In the main there was effective supervision demonstrated by all agencies involved with Adult A and this was evidenced within IMR’s. There was evidence that records were reviewed, and that staff had supervisory input and support when making decisions. The Review did however identify that there were implications for the management and supervision around cases of substance misuse, self-neglect and consideration of capacity. The need for comprehensive recording practises and audits where complexities and capacity were an issue had been identified to improve quality assurance.

1. *Adult at Risk - An Adult at risk of abuse or neglect is defined as someone who has needs for care and support, who is experiencing, or at risk of, abuse or neglect and as a result of their care needs - is unable to protect themselves; Care Act (2014).* [↑](#footnote-ref-1)