7 minute briefing:

Domestic Homicide Review into the death of ‘Suzanne’, 2020

Suzanne’s life

Suzanne had been in an ‘on and off’ relationship with her partner since she was 16 years old. They had young children together who lived at home with them. It is clear to this review that at the time of her death, Suzanne felt under immense pressure from her home circumstances, exacerbated by the country having moved into the most severe Covid lockdown regulations (lockdown one). A few days before she took her life Suzanne had spoken with her GP, describing suicidal thoughts and disclosing that her partner was prone to becoming verbally abusive after consuming alcohol. The GP made an urgent referral to mental health services, prescribed medication and provided her with details of specialist domestic abuse services. The mental health trust conducted an access assessment the same day. Due to temporary Covid 19 adjustments to service provision, this was completed by telephone rather than face to face. Suzanne was assessed as not being immediately suicidal and was talked through coping strategies. There was the intention of a further call the following day but no evidence on the patient record that this took place. Sadly, Suzanne ended her life before any further contact was made.

Purpose of the review

The review was commissioned by North East Lincolnshire Community Safety Partnership on receiving notification of the death of Suzanne in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

The Community Safety Partnership has a legal duty to conduct a multi-agency review to understand where public services may improve their responses to similar situations in the future. The review does not consider who is to blame but seeks to support the prevention of similar incidents from happening in the future.

Good practice identified

The GP not only referred Suzanne urgently to mental health service, but also followed up this electronic referral with a telephone call and provided Suzanne with details of support agencies.

Following the GP’s referral, the single point of access practitioner contacted Suzanne by telephone within one hour.

Earlier in Suzanne’s life, when she was pregnant, Suzanne was referred to the Perinatal mental health Midwife and consented to this.

During the interactions with Suzanne, she was asked twice by the health visitor if she was experiencing domestic abuse.

The unintended consequences of the first Covid-19 lockdown have been considered by all organisations involved; they have reflected upon the practices that were put into place at the time and all have made changes to better respond to such cases in the future.

Key learning points

- Suzanne did not recognise herself as a victim of abuse because her partner was not violent towards her. Her family were also of the view that abuse meant 'physical abuse'.
- Suzanne always minimised her partner's behaviour and placed the onus upon herself to cope better.
- Staff within some services are unaware of the wider aspects of domestic abuse including controlling behaviour and verbal abuse. Professionals need to try to understand the factors affecting people's anxiety for what they are – to look for the cause and not just the symptom.
- The severity of the pressures building in Suzanne's home and the risk of her harming herself were not recognised. The advice given to her was not cognisant of the circumstances at home, particularly given the acute and intensive period of time when lockdown rules were at their tightest.
- The Covid-19 regulations during lockdown one of the pandemic unintentionally contributed to the pressures on Suzanne. She was unable to have a face-to-face mental health assessment which may have provided the opportunity to discuss issues in a more conversational manner with time and space away from the pressures of her home circumstances. In addition, she was required to spend almost all of her day at home, in the very circumstances that were causing the pressures.

Next steps

- Domestic abuse has become a routine enquiry at midwife appointments, postnatal checks, and Families First appointments, to introduce earlier opportunities for identification and support. If the enquiry cannot be made (for example, if the partner is present) the reason is documented.
- All staff at GP surgeries have attended domestic abuse training, including coercion and control.
- Learning from this DHR has been disseminated to all organisations involved in the review. Healthcare professionals have been offered safeguarding supervision around this case with particular focus on the possible health indicators of domestic abuse.
- Families First Locality Family Hub Practitioners have received Signs of Safety refresher training to ensure they confidently gain a better picture of the issues that families face. The scaling questions within Signs of Safety have also been reviewed.
- Practitioners are challenged through supervision if actions or recommendations are not completed. Conversely, practitioners are provided with a safe space for raising concerns about the support they themselves receive to undertake their role.
- The North East Lincolnshire Suicide Prevention Strategy includes domestic abuse as a priority area of focus. This uses real time surveillance to reduce the risk of suicide in key high-risk groups and tailor approaches to improve mental health in specific groups.
- North East Lincolnshire Community Safety Partnership is undertaking a campaign of awareness raising within our communities focussing on coercive and controlling behaviours as a form of domestic abuse.

The full action plan for this review, and a copy of the quality assurance letter from the Home Office can be found at:

https://www.safernel.co.uk/crime-and-staying-safe/domestic-homicide-review/

NORTH EAST LINCOLNSHIRE
Community Safety Partnership