BCSSP – 7 Minute Briefing

Domestic Homicide Review (DHR) Adult 'A'

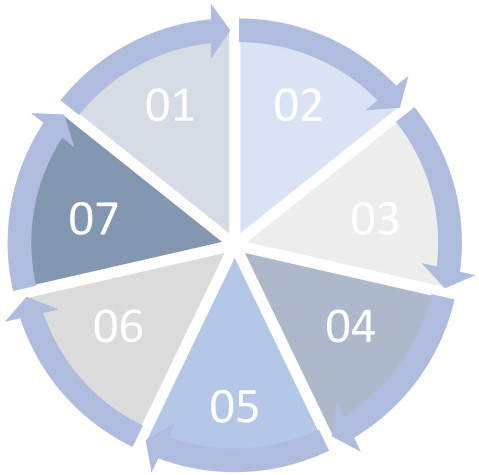
Bath & North East Somerset
Community Safety & Safeguarding Partnership

01. Rationale for a DHR: DHRs enable lessons to be learned from homicides where a person is killed (or has died by suicide) as a result of domestic violence and abuse. On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. Six agencies submitted Independent Management Reviews and chronologies and three agencies submitted chronologies only due to the brevity of their involvement.

02. What happened? Adult 'A' was admitted to hospital in December 2017 with a head injury. They informed staff they thought they had slipped and fallen at home. Three days later, police were informed about the incident by family members, who believed the injuries to be caused by Adult 'B'. Adult 'A' maintained that Adult 'B' was not responsible for the injuries, Adult 'B' had made admissions to assaulting Adult 'A'. Adult 'B' was arrested on suspicion of Grievous Bodily Harm and during police interview admitted throwing a number of items at Adult 'A', causing a head injury. Adult 'A' remained in hospital and was expected to survive, despite the serious injuries, but their condition rapidly deteriorated and they died 14 days following admission. Police took the information to the Crown Prosecution Service which authorised a charge for manslaughter (gross negligence).

07. Recommendations:

- Community Safety and Safeguarding Partnership to incorporate the above learning into ongoing and planned awareness raising communications.
- All organisations on the Community Safety and Safeguarding Partnership to review the findings of this and other Domestic Homicide Reviews and incorporate into safeguarding/domestic abuse training, with emphasis on awareness of older people and domestic abuse.



03. Learning Point 1: *Awareness of Domestic Abuse in Families.* Domestic abuse is commonly seen as something that happens from one intimate partner to another, not as happening in families. While professional knowledge has improved, it was felt that awareness and understanding could be improved. This could also be improved amongst families and communities. Individuals and families should be informed that any kind of violence or abuse from a family member is something for which they can seek support from agencies.

04. Learning Point 2: *Domestic Abuse & Adult Safeguarding.* There is a crossover between adult safeguarding and domestic abuse as many cases will fall into both categories in relation to procedures and pathways. While recognising that many do not recognise the term 'domestic abuse' as relevant to their situation, it is good practice to have this discussion with them. It is essential that professionals recognise the overlap and ensure that both pathways are discussed with individuals and multi-agency discussions and action plans are developed to ensure individuals receive relevant support for their circumstance.

05. Learning Point 3: *Multi-Agency Risk Assessment Conference (MARAC).* The MARAC and Adult Safeguarding should be more closely aligned. This is also the response to another local review and discussions have started in relation to this. It was noted that for non-high-risk cases, referrals can be made into the Multi-Agency Safeguarding Hub (MASH). Southside domestic abuse service are now linked with this process.

06. Learning Point 4: *Opportunities to disclose in brief or outpatient appointments.* It is essential for all professionals to demonstrate professional curiosity and to know how to ask individuals about their personal, family and social circumstances in a sensitive way, even in brief appointments and over time when someone is in contact with a service for a long period. All professionals must be aware that domestic abuse can occur in families and involve older people.