minute briefing:

Domestic Homicide Review into the death of 'Mandy', 2022

Mandy's life

Mandy was 31 years old when she died and was the mother of two children who lived apart from her as a result of court proceedings.

Mandy had witnessed significant domestic abuse between her parents, growing up, and experienced other significant trauma. She had been using alcohol and substances as a coping mechanism since her teens.

In 2015 she entered into a relationship with a man, Mark, who was later to become her husband and the father of her second child. Mark had a history of domestic abuse towards previous partners, for which he had served a custodial sentence.

Agencies hold records of domestic abuse by Mark against Mandy from the start of their relationship which entailed verbal and physical abuse, controlling behaviours and threats of violence. Mark installed spyware on Mandy's mobile phone through which he stalked her.

Sadly Mandy died by suspected suicide following a verbal argument with her husband on a night out.

Purpose of the review

The review was commissioned by North East Lincolnshire Community Safety Partnership on receiving notification of the death of 'Mandy' 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

A referral was made to Children's Social Care when Mandy did not attend a number of her antenatal appointments.

After an initial child protection conference Mandy and Mark's unborn baby was placed on a child protection plan with a joint pre-birth plan between maternity services and Children's Social Care. Domestic abuse was recorded as one of the concerns.

During one incident Mandy denied that Mark had assaulted her. However the police took positive action in arresting Mark on the basis of statements from an independent witness, and later pursued an unsupported prosecution.

Following a MARAC meeting the police attempted to make a disclosure to Mandy about Mark's past offences.

An Independent Domestic Violence Advocate (IDVA) from Blue Door is now based back within the safeguarding team at NLaG offering support to victims of domestic abuse as well as assisting staff.

Key learning points

- When agencies are working with someone with suicidal ideation, it is vital that they continually revisit this with the person. Their risk may vary from one conversation to another meaning that the safeguards in place need to be continually reviewed.
- There were a number of agencies and workers involved with safeguarding Mandy. However, although this was necessary concerns have been raised by the review that Mandy may have found this overwhelming as she tried to leave her abusive relationship.
- More could have been done to review information holistically. Triangulating the statement made by Mandy in a mental health assessment with information already known (i.e. that she had previously discussed at MARAC) would have provided a more accurate picture of her situation.
- Further improvements could be made to sharing information between agencies. Mandy made a disclosure of assault in a health setting which was referred to MARAC but the police were not notified of the assault.
- In addition, emergency centre discharge plans should record where a patient is being discharged to following a presentation of disclosure of domestic abuse.

Next steps

- Briefings are being held to ensure hospital staff feel enabled to contact the police following a presentation or disclosure of domestic abuse. Staff now record discharge plans and where the patient is being discharged to following a disclosure.
- The NEL Suicide Prevention Strategy now includes domestic abuse as a priority.
- Clients supported by Women's Aid are given a key contact to build a trusted relationship with and feel less overwhelmed with receiving and maintaining contact with multiple agencies.

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