minute briefing:

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

Emma's life

Emma was 35 years old when she died and was the mother to several children. Emma had experienced a number of traumatic childhood events and sadly found herself in multiple relationships where violent men abused her until she could take no more.

As a consequence Emma suffered with poor mental health, which worsened when all but two of her children were taken into care, with the remaining two children living with their father. The day before her death Emma attended the contact centre with a view to seeing one of her children in person, but this was not possible. Sadly, Emma ended her life the following day.

Purpose of the review

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

During a pregnancy booking in meeting Emma informed the midwife that she had a social worker as she had fled domestic abuse and had lived in the Refuge. She said she was now in a new relationship and, when asked about domestic abuse, said there were no concerns. The midwife then contacted Emma's social worker and advised NLAG's Named Safeguarding Midwife of the pregnancy.

The family file was completed after antenatal appointments. It is recorded that the family file and medical records were reviewed on several occasions and no new concerns were raised.

The review identified some positive dialogue between the GP and health visitors in relation to Emma's wellbeing.

Key learning points

- Professionals did not recognise the link between domestic abuse, physical and sexual harm. There was no understanding of how domestic abuse had rendered Emma's parenting ineffective. The subsequent separation of Emma from her children had a huge impact on her mental wellbeing.
- There is a need for vulnerable adults to be clearly identified on health systems. Processes are needed to identify and register patients under the care of Women's Aid.
- Actions arising from multi-agency meetings should be routinely recorded in family files.
- Notifications to GP practices of overdoses and suicide attempts should be reviewed by a clinician.
- Opportunities for speaking to victims about domestic abuse and maternal wellbeing should be maximised, through Early Pregnancy Unit appointments, and antenatal and postnatal visits.
- There is a lack of understanding amongst police officers of Clare's Law and when and how it can be used. This allowed Emma to enter into further relationships with abusive men.

Next steps

- Training and awareness continues on the Domestic Violence Disclosure Scheme ('Clare's Law') to ensure professionals are aware of the opportunity and responsibility to make referrals to the police for a Right to Know disclosure.
- Police officers have a full overview of the domestic situation prior to attending an incident so that a full risk assessment can be made, and are able to speak to a specialist officer for advice and support.
- The national guidance 'Vulnerabilities: applying All Our Health' is being embedded into GP practices through discussion and training to increase awareness of the impact of vulnerabilities and how to safeguard patients.
- Briefings are ongoing to ensure primary care has understands the importance of enquiring about maternal health in post-natal reviews in relation to safeguarding the mother.
- Information pathways are being improved between primary care and child protection conferences.
- Processes have been strengthened to ensure women in refuge have access to primary health care and that PO Box addresses are used on records.
- Professional curiosity is being supported through practice guidance and assessment tools and appropriate training.
- Parental history is being considered when completing child assessments which takes into account parental ACEs to allow for better understanding of family complexities.
- Routine questioning about domestic abuse is being extended to the Early Pregnancy Unit, and midwives attending any multi-agency meeting record actions in family files.
- Processes are being developed to ensure all overdoses and suicide attempts are reviewed by a clinician in primary care as standard.

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-stay

NORTH EAST LINCOLNSHIRE
Community Safety Partnership