South Worcestershire Community Safety Partnership

Learning Briefing - “Miss A”

The South Worcestershire Community Safety Partnership undertook a Domestic Homicide Review (DHR) into the death of a woman aged 28, who for the purposes of the review was known as Miss A. Miss A was killed by her ex-partner, known as Mr N for the purpose of the report.

Overview

Miss A and Mr N were in a relationship for around 12 months during which time Mr N lived with Miss A and her daughter on a casual on/off basis. Mr N ended the relationship after a year citing his mental health issues as a factor in the break-up.

Two months after the separation Mr N went to Miss A’s home where he murdered Miss A and attempted to murder Miss A’s daughter.

Mr N had experienced poor mental health for around seven years prior to the murder. It was subsequently reported that Mr N killed Miss A as a result of his untreated schizophrenia, which was diagnosed following his arrest.

In the four months prior to the murder, Mr N had had contact with police, his GP, mental health services and the local hospital. Miss A had no contact with any agency.

Learning Arising from the Review

Risk Assessment

Two risk assessments were carried out in respect of Mr N. The first identified low risk and the second identified no risk to others despite a history of violence to other family members, damage to property, suicidal ideation and delusional beliefs.

The review identified that the risk posed by Mr N to others was not fully considered, it was unclear to what extent the information that was shared by his family was considered when undertaking assessments and assessing risk to others. The recent separation from Miss A was also not considered.

There were missed opportunities to explore risk which might have led to the sharing of information with other agencies.

Professionals undertaking risk assessments need to consider past history and previously completed risk assessments, as opposed to undertaking risk assessments in isolation, and in response to individual incidents.

Multi-agency Working

Mr N had experienced poor mental health for at least seven years. His mental health had deteriorated over the previous 18 months, with a sharp decline four months prior to the homicide.

The review found that professionals need a greater understanding of partner agencies, referral pathways and terminology used, to ensure the requested support and response is secured.

The review has also identified the need for greater professional curiosity and triangulation of information, utilising those involved with the individual: both family and friends, and professionals. There were occasions when self-reports by Mr N were taken at face value which meant that responding agencies did not appreciate the full context of the situation and the extent of Mr N’s mental health, this meant that onward referrals/notifications to other agencies were not made.

In addition, there were no multi-agency/multi-disciplinary meetings undertaken which would have provided a forum for concerns and risks to be shared and managed.

Support for Carers

Mr N's mother was an informal carer to Mr N. There were opportunities for the agencies involved to consider and make a referral for Carer's Assessment but no referrals were made. Whilst Mr N's mother would have been considered a protective factor in the context of his mental health, her own needs were not considered. A Carers Assessment would have highlighted his mother's own need for support and may have elicited further information, including indicators of domestic abuse and risk. Receiving support in her own right may have empowered her to support Mr N further.

Friends and family who provide informal support to people experiencing poor mental health should be provided with timely information which includes details of their rights, such as their right to a carers assessment and their right to request an assessment for the cared for person under the Care Act 2014.

Carers should be recognised as a vital source of information. They are the experts of their own experience, and of those that they provide care and support to. Carers should be included in assessments of need and risk, regarding the cared for person, wherever possible.

Furthermore, carers should be provided with general mental health advice and guidance about the person they support. Where they would also be considered the Nearest Relative they should be informed of their rights and responsibilities, for example, their right to apply for detention under the

Access to Services

Miss A's voice was absent in the review due to the absence of family and friends to provide an insight into her life and who she was as a person. Furthermore, Miss A and her daughter had minimal involvement with services, with no involvement during the scoping period. It was therefore important to explore and understand the potential barriers Miss A may have experienced in relation to accessing services and disclosing domestic abuse.

Barriers to seeking domestic abuse support and disclosure can include: **emotional factors** such as fear, embarrassment, shame and self-blame; factors relating to **negative past experiences** and a **lack of trust** in professionals; fear that nothing will be done or that it might make the abuse worse; **physical factors** such as the perpetrator's presence, controlling behaviour and manipulation of others including professionals; and **organisational factors** such as the appropriateness of the setting and time for disclosure.

Barriers to disclosure and access to services may be further compounded by protected characteristics, for example, cultural barriers relating to ethnicity, physical barriers relating to disability and so on. Miss A was a 28 year old female of dual British and Asian heritage. The review was unable to ascertain, and cannot assume, if and how Miss A's age, gender and ethnicity affected her access to services or disclosure. However, it is important nonetheless for professionals to be aware of potential barriers and how protected characteristics and intersectionality of can exacerbate these barriers.

Recommendations

- Increase carer awareness for frontline practitioners which includes identification of carers, ensuring that carers are aware of their right to an assessment and the services that carers can be signposted to for further information and support.
- Increase awareness with carers, who would also be the Nearest Relative under the Mental Health Act 1983, of their rights and responsibilities as the Nearest Relative.
- Improve competence in risk assessment undertaken by frontline practitioners which includes the use of professional curiosity and consideration of the risk to others.

Primary Care GP Services, Herefordshire and Worcestershire CCG

- To share learning from this review with the relevant GP surgery.
- For all clinical staff to be aware of the agreed referral pathway for those patients requiring mental health services.
- For all staff to understand the need to consider risks to others (adults and children) where concerns are raised and understand the requirement for discussions/referrals to other agencies.

Herefordshire and Worcestershire Health and Care NHS Trust

- Ensure GPs are aware of The Trust's Mental Health Services and how to access advice and guidance through the production of a referral pathway and guidance.
- Ensure GPs understand the referral criteria for Worcestershire Healthy Minds (WHM) by producing clear documentation and guidance which will lead to an increase in accepted referrals.
- For the Integrated Safeguarding Committee to consider what additional measures can be taken to extend the consideration of domestic abuse risks when the victim and perpetrator do not live together.
- Further training and education to be rolled out to all mental health staff in assessing patient risk towards others and exploring intensity and frequency of thoughts, asking the question of past behaviour as an indicator for future behaviour. The requirements to complete GRIST risk assessment accurately and in detail.
- That the digital clinical reference group considers if the project to review the content of standard letters should include a review of the letters to patients who are not accepted by mental health services after referral from General Practitioners

West Mercia Police

- West Mercia Police to review current attachment programme to expand and include opportunities for new recruits and CPD training for existing staff / officers for role experience within vulnerability teams and HAUs to enhance understanding of referral requirements and agency requirements.