

# Lessons Learned Briefing

## Domestic Homicide Review - Victim H

This brief is based on the findings from a Domestic Homicide Review (DHR) undertaken by Safer Leeds. The purpose of a DHR is to learn lessons and improve future responses to domestic violence and abuse. We aim to demonstrate respect and compassion to victims and their families and to represent the victim's voice wherever possible in the review.

### What happened?

Victim H was a white British woman who died on her 38<sup>th</sup> birthday as a result of head injury inflicted by her 52 year old white British partner. He was convicted of her murder in December 2014. On the day of her death, Victim H had travelled to Leeds city centre and was seen leaving Leeds train station with the perpetrator. Police were called after receiving reports of a woman being assaulted on the Leeds-Liverpool canal towpath. She was admitted to hospital and died later that day. The perpetrator was sentenced to life imprisonment for Murder.

Victim H frequently changed addresses and often had no fixed abode. She presented as homeless regularly and suffered abuse in a number of relationships. She struggled with alcohol and drug addiction and engaged and disengaged with detoxification programmes over the years. At the time of her death, Victim H was estranged from all her family members. She had begun a relationship with the perpetrator and had moved to Leeds to live with him.

### What did the review tell us?

A critical issue in this review was the lack of multi agency oversight in the management of the perpetrator, especially given his known history of domestic violence and abuse.

### What can we do now?

The review highlighted that the perpetrator's risk to others was not managed effectively. His sustained history of violent offending against vulnerable women and his controlling and emotionally abusive behaviour should have involved multi-agency oversight which would have ensured key information and intelligence was shared about him. At one point, there was a reduction in his risk of harm level from 'high' to 'medium' which should not have happened. It was only two-weeks after his move into independent accommodation, before he had been visited at that address and before his response to independent living had been tested. There was no prior discussion between the offender manager and his supervisor, and there was no review of the risk assessment or risk management plan.

In addition, there was a missed opportunity to recognise that the perpetrator posed a serious threat to vulnerable women when the police were called to an incident. A search of police databases should have revealed the perpetrator's licence conditions but a combination of human error and information 'overload' meant the opportunity was lost.

The review also illustrated the way in which many victims of domestic violence use alcohol and drugs as a means of coping with difficult life events and experiences of abuse. Victim H found it particularly hard to beat her substance addictions as the only people she associated with were those in similar positions to her.

The full DHR report will be available after being quality assured by the Home Office and the DASH risk assessment and more information are available at: [www.leedsdomesticviolenceandabuse.co.uk](http://www.leedsdomesticviolenceandabuse.co.uk) or you can contact the DV team at Leeds City Council on 0113 3789682 or [dvteam@leeds.gov.uk](mailto:dvteam@leeds.gov.uk)

#### Domestic Violence Enquiry:

Services such as health visitors, social workers and midwives routinely ask women about domestic abuse. Consider if this approach is appropriate in your service area however it should only be introduced with staff training. Always ask directly and sensitively about domestic abuse if you have any concerns. Indicators of domestic violence could include injuries, low mood, self harm, substance misuse and depression.

#### Homelessness:

Be aware of the law regarding homelessness and help your service users to understand their rights regarding priority accommodation. Advocate for them if necessary and support them to disclose issues that might make them particularly vulnerable.

#### Working with Individuals who have Multiple Complex Needs:

People with complex needs may be unwilling or unable to access the services they need. Consider how your service can be flexible and creative to ensure your provision is as accessible as possible.

#### Recording Information:

Record all contact, professional or otherwise and maintain comprehensive records. It is especially important to record if you have asked about domestic violence, your response and any action agreed.

#### Managing Risk and Information Sharing:

Identifying the risk a service user poses is central to preventing them from harming others. A service user's history should be considered in full and background checks made before determining appropriate action plans for them. Service users should be regularly re-assessed to identify any changes to the risk they pose; with any such changes being recorded and shared with all agencies involved with the individual.