Domestic Homicide Review - 'Jackie' - August 2022

1.What happened?

'Jackie' was in her mid 20's when she was killed in November 2019 by her partner, 'Adam'. They had been in an on/off relationship since Jackie was 16 years old, and had 2 young children who were previously subjects of child protection plans. 'Jackie' lived with poor mental health and although she often did not report abuse and hid 'Adam's' involvement in her life from professionals, she did make several reports to the police and he spent periods of time in prison. After 6 years of reporting domestic abuse including a significant pattern of coercive and controlling behaviour, Jackie was killed by her partner on a night out in the town centre.

2.Findings from the review

Jackie often retracted her reports of abuse and neither party engaged well with support services, Jackie expressed fear about losing her children if she did engage.
Between April 2013 and July 2019 there were 26 reports to the police on 3 occasions the crimes were filed without investigation.
The GP practice appears to have had little or no awareness of the impact of domestic abuse despite both attending with mental health concerns.

3.Good practice

Police pursued several evidence-based prosecutions which led to convictions and prison terms.
SWYPFT re-opening a referral after discharge to speed up care and support.
Domestic Abuse Hub partners showing persistence working together to assess the risk to the children and try and engage with the victim.

4. Recommendation summary

1. Examine the most effective and innovative ways of engaging with domestic abuse survivors
2. Tackle barriers to sustained survivor engagement with services.
3. Increase the availability of perpetrator programmes.
4. Review processes to identify and respond to chronic and repeat victims.
5. Review the quality of DASH risk assessments.
6. Review the process of closing crimes without investigation.
7. Consider a review process of DA Hub actions.
8. Review responses where DA is flagged on records.
9. Routine enquiry should take place in Single Point of Access for mental health services.
10. Extend and promote the DA Training
11. Improve understanding of mental health presentations in respect of domestic abuse
12. Ensure Domestic Abuse contracts include expectations around survivor engagement and clarity about how this is monitored.
13. Ensure the providers of domestic abuse services in Calderdale routinely ask for information about mental health, substance misuse and alcohol, and record as part of the organisational referral process.

5.Multi-agency Learning

1. Increase levels of staff awareness and understanding of domestic abuse risks
2. Support staff working with difficult to engage people to work tirelessly on building trusted relationships with victims (and perpetrators).
3. Be curious about domestic abuse when victims and perpetrators disclose poor mental health.
4. Look for innovative ways of engaging with victims and perpetrators in chronic and repeat cases.
5. There is a need for practitioners to understand domestic abuse from a perpetrator's perspective to prevent the abuse, rather than the focus being solely on the victim.

6.Resources

- Safeguard Guide Professional Curiosity and Challenge
- Calderdale Council: Domestic Abuse
- Safeguarding advice for professionals working with Domestic Abuse
- Safe Lives - Mental Health and Domestic Abuse