7 Point Briefing

Mary

POINTS TO CONSIDER

- Reflect on the findings and discuss the implications for your practice.
- Outline the steps you and your team will take to improve practice in line with the recommendations.

Further reading

- https://www.vkpp.org.uk/news/report-reveals-scale-of-**domestic-homicide-and-suicides-by-victims-of-domestic-abuse/**
- A study of ACE – Psychology today, journal of Psychological and Cognitive Sciences.
- Jane Monckton-Smith (2019) Homicide Timeline.

BACKGROUND

Mary (50 years) and the perpetrator (Simon) were father and daughter. Mary was an only child and after her mother died there was no one else in the family.

Mary suffered from mental health issues at times severe and was also diagnosed with ADHD in adulthood. Mary died from taking a deliberate overdose and she was not sure if she would survive or not.

Mary's suffered adverse childhood experiences due to life with her father and this trauma continued into adulthood.

SAFEGUARDING CONCERNS

The review found that the Perpetrator (father-Simon) was extremely coercive and controlling of the victim (daughter-Mary). This behaviour towards her commenced in childhood and again in adulthood until her death. Numerous professionals from a number of agencies were told about this and also her taking overdoses and suicide ideation.

The review focussed on the following areas.

• Familial domestic abuse.
• Coercive controlling behaviour.
• Mental Health issues stemming from Domestic Abuse.
• Medication overdose and suicide ideation.

WHAT TO DO

- Always respond to the voice and actions of the client.
- Share important safeguarding information and improve communication between staff and agencies.
- Identify risk and act on it in a multi-agency -holistic way.
- Always think of coercive-controlling behaviour in cases of familial relationships such as Mary had with her father.

WHY WAS THE REVIEW CARRIED OUT?

The Safer Lincolnshire Partnership carried out a statutory **Domestic Homicide Review** to identify learning for agencies and practitioners working in areas involved in this case.

WHAT NEEDS TO CHANGE

- Ensuring that is a lead professional in cases where DA and mental health coalesce.
- Ensuring that professionals to not dismiss a victims account because of their behaviours due to their mental health condition.
- Professionals to take account of a clients. vulnerabilities when they are in a familial coercive controlling relationship.
- Better knowledge of the impact of hoarding across all professionals.
- Improvements to Information sharing between providers of adult services and other voluntary sector or other statutory services in cases of familial DA.
- Ensure knowledge of non-fatal strangulation and its consequences of risk to the victim are well known. across all professional agencies.

FINDINGS & RECOMMENDATIONS

- There was no lead professional or joined up multi-agency working.
- Partnership understanding of familial DA and coercive controlling behaviour, including economic abuse.
- Partnership understanding of the risks associated with deliberate overdoses and suicide ideation.
- Ensuring that a carers assessment is considered when it is apparent that a vulnerable person takes on a carers role.
- Ensure that there is a better understanding of ACE's and trauma that impacts on a victims mental health and their exposure to DA by the same perpetrator from childhood.
- Consider commissioning a familial perpetrator programme for cases similar to Mary's.