

# **Domestic Homicide Review**

# 'Ann Marie'

This report is the property of the Safer Sefton Together Partnership.

# Learning identified

# Learning 1

#### Narrative

The victim in this case, was subjected to domestic abuse over an extensive period of time. The dynamics of this abuse was not recognised and therefore not responded to in that context. Whilst changes have been made in legislation, the knowledge around these need to be embedded into practice.

# Learning

Professionals' understanding of the dynamics of domestic abuse, and changes to legislation, will inform practice and aid identification on ongoing abuse and risk factors.

# **Learning 2**

#### **Narrative**

An individual's previous and current trauma can impact on agencies' ability to sustain engagement with them.

# Learning

Professionals understanding how trauma can impact on an individuals' engagement, will seek to inform practice, and prevent revictimisation.

# Learning 3

#### **Narrative**

Research identifies that there is an increased risk of suicide amongst parents who have either lost children or have limited contact with them, whether through care proceedings or other processes.

#### Learning

Professionals' understanding of these risks can improve engagement and identity opportunities for referrals and/or signposting for support.

#### **Panel Recommendations**

#### Recommendation

That all agencies that have contributed to this review, provide evidence to Sefton Domestic Abuse Partnership Board on how professionals are identifying cases of domestic abuse (in particular, coercive control), including cases of where domestic abuse and coercive control occur post separation. Furthermore, that agencies are using this knowledge to empower individuals to understand and recognise domestic abuse, which can then be used to gather evidence that would support further investigation in a multi-agency context.

That all agencies that have contributed to this review, provide Sefton Domestic Abuse Partnership Board with evidence as to professionals' knowledge, understanding, and response to trauma during contact and engagement with individuals.

That all agencies that have contributed to this review, should provide evidence to Sefton Domestic Abuse Partnership Board on how the learning on this case – around the indicators of increased risk of suicide, including where individuals no longer have contact and access with their children, and when this contact is 'controlled' due to the children living with and being cared for by the victim's perpetrator of abuse – has been disseminated and embedded into practice.

That Safer Sefton Together should share the learning from this review with CHAMPS Public Health collaborative<sup>1</sup>, to inform their ongoing work on suicide prevention.

That Safer Sefton Together should share the learning and recommendations from this review with other relevant partnerships.

<sup>&</sup>lt;sup>1</sup> https://champspublichealth.com/about-us/

The Champs Public Health Collaborative has developed a comprehensive and systematic approach to improving public health priorities by large scale action and working together as system leaders across Cheshire and Merseyside.