Lessons Learned Briefing
Domestic Homicide Review
Victim B – 'Rosie' - Deceased 08/2019

This brief aims to help professionals improve future responses to domestic abuse, based on the learnings from a Domestic Homicide Review (DHR) undertaken by the Wakefield Community Safety Partnership. We aim to represent the victim's voice and be respectful and compassionate towards them and their families.

What happened?

Victim B was a 30-year-old white British woman who lived with her 6-year-old child (of a previous partner).

Her child was not present at the time of the incident and was staying with family.

The perpetrator is a 32-year-old white British male (with 2 young children to a previous partner).

The victim and perpetrator did not live together but were in an intimate partner relationship spanning over approximately 6 months. Throughout their relationship there were signs of coercive control although there had been no reports to the police or any other agencies.

Neither parties had a known history of domestic abuse.

Following a night out they returned to victim B's home address. Shortly after the perpetrator requested support from a neighbour stating Victim B had fallen down the stairs.

Emergency services were called, and victim B was admitted to hospital suffering severe head trauma. She later died in hospital from these injuries.

Subsequently police were notified by the Hospital and the perpetrator was arrested.

The perpetrator was charged with Murder but was convicted of Manslaughter and is currently serving a prison sentence.

What did the review tell us?

The review did not identify any opportunities when any individual or service could have predicted the circumstances of victim B's death.

Contact between statutory agencies for victim B and the perpetrator had been very limited.

They had not been engaged with any services or agencies in relation to domestic abuse matters. Contacts with agencies had been largely routine general health concerns.

Victim B and the perpetrator in essence were unknown to services. However, there was some key issues arising from the review:

- Domestic Homicides can occur without any reports of domestic abuse being made to agencies.

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What did the review tell us? (Continued)

- The relationship was short, but it appeared that almost from the start, the relationship was characterised by incidents of coercive and controlling behaviour. At the beginning of a relationship coercive and controlling behaviour can be misunderstood for someone who is showing a form of 'love, care and attention'.
- Coercive and controlling behaviour can be so subtle that this may not be recognised as abuse by victims, family and friends.
- Lack of awareness of coercive and controlling behaviour. Victim and perpetrator did access routine health appointments, giving an opportunity to ask the question about domestic abuse/personal relationships.

How can we improve?

Training

Professionals to be aware and understand signs of domestic abuse. Specifically, coercive and controlling behaviours.

Professionals to attend domestic abuse training to enable them to understand the complexities of domestic abuse and coercive control.

Professional Curiosity

When working or supporting individuals and families use your professional curiosity to understand the wider picture.

The Role of Health Professionals

Encourage and embed targeted and routine enquiries across all health settings.

The full DHR Report has been approved by the Home Office in 2021. For further information visit wakefield.gov.uk/DHR or email DHR@wakefield.gov.uk.