

Minute Briefing – PAM

2

Appendix 2

Background:

A referral was made to SCEP in 2019 following the death of Pam who was unlawfully killed by her boyfriend in August 2019. The Partnership agreed that the criteria for a Domestic Homicide Review were met.

Pam was 53 when she died. She had experienced childhood trauma and as an adult suffered from anxiety, depression and suicidal thoughts. She was also Alcohol dependent.

Pam had 5 children, one sadly died shortly after birth. Her adult children contributed to the DHR

Pam was known to many different services and MARAC

"It is easy to see someone who is a drinker and assume they are trouble, but my mum was not just a drinker, she was kind, loving, funny and a caring mum to us all"

Her perpetrator was a Serial Domestic Abuse Perpetrator and had a diagnosis of Huntingdon's Disease. He was sentenced to an Indefinite Hospital Order in April 2020

Resources and further information: Cheshire East Domestic Abuse Hub: Tel: 0300 123 5101 or cedah@cheshireast.gov.uk

Huntingdon's Disease Association: Helpline 0151 331 5444 Change, Grow, Live:

Eastcheshire.info@cgl.org.uk

7

6

5

St. Mary's Sexual Assault Referral Centre: 0161 276 6515 Rape and Sexual Abuse Support Centre: 0330 363 0063

Implementing change:

Discuss the themes with your team or service and consider how they may affect your practice. Determine what you or your team could do to act on these and implement any necessary changes.

Practice implications:

When anyone discloses Domestic Abuse, it is essential to listen and believe them and promote safety and wellbeing. When there is a concern for a person's safety, it may be necessary to override consent.

Information sharing and accurate record keeping is essential.

AL-

The Purpose of a Domestic Homicide Review:

Establish the facts that led to the death and whether there are any lessons to be learned from the case about how local professionals and agencies worked together to safeguard Pam

- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Prevent domestic abuse and carer related deaths and improve service responses where these issues are identified and responded to at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse

3

2

• Ensure that the experiences of Pam and her family are heard regarding their lived experiences and the impact of Domestic Abuse

Key Emerging themes:

Gender: Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women. Pam's case was heard at MARAC on 5 occasions between 2018/19

Assessing Risk and Safeguarding: It was noted that a significant number of VPAs had been submitted but not all agencies received them. This led to missed opportunities for information sharing including previous incidents of abuse, liaison and assessments under the Care Act

Health Vulnerabilities and Complex Needs: At least 20% of high-risk victims of abuse report using drugs and/or alcohol. Pam was more vulnerable to abuse due to complex health needs. She had a good relationship with her GP and IDVA. There was a pattern of accessing services at crisis points but would disengage leading to case closure. Care Act eligibility includes "substance misuse and brain injury".

Previous criminality of the perpetrator: Pam's perpetrator did not engage with services including harm reduction schemes. The review highlighted limitations of the wider criminal justice systems in holding perpetrators to account.

Housing Provision: Offers of refuge were declined due to distance and accessibility. The perpetrator

Recommendations:

It should be noted that some actions have been put into place since the incident and the DHR publication.

The DHR made the following recommendations:

- Vulnerable Person's Assessments (VPA's) should be clear and a robust pathway to be established
- Multi Agency Professionals Meetings/Full MARAC meetings to be held for High Risk/Complex cases
- Promote Behaviour Change Programmes for Perpetrators
- Mental Capacity Assessments to be completed to evidence decision making
- Risk Indicator Checklists to be completed including Honour Based Abuse and Stalking
- The DA Partnership to collate and measure successful prosecutions
- Multi Agency Training regarding Domestic Abuse, Adult Safeguarding/VPAs and to create opportunities to understand roles and responsibilities

SAFER Cheshire East Partnership

4

4

1

7

5

6