Cheshire East Council

Working for a brighter future together

BRIEFING REPORT

Adults and Health Committee

Date of Meeting:	26 June 2023
Report Title:	Domestic Homicide Report - PAM
Report of:	Helen Charlesworth-May – Executive Director, Adults, Health and Integration
Report Reference No:	AH-/01/2023-24

1. Purpose of Report

1.1. The purpose of this briefing Report is to inform the Adults and Health Committee about the Domestic Homicide Review regarding "PAM". The Domestic Homicide Summary Report has been written by an Independent Author, John Doyle, and it is available as an Appendix to this Report. It has been approved by the Home Office and Pam's family and is now ready to be published on the Safer Cheshire East Website.

1.2. The Safer Cheshire East Partnership have a legal duty to commission and publish Domestic Homicide Reviews as set out in the Domestic Violence, Crime and Victims Act 2004. DHR's focus on the circumstances leading up to the murder of the victim, how agencies worked together and lessons to be learned. Cheshire East Council is committed to creating safe communities, where people can live free from abuse or harm. In this regard the DHR meets the strategic objectives of the Council.

2. Executive Summary

2.1. 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 was met to conduct a DHR.

2.2. PAM was 53 when she died. She had experienced childhood trauma and as an adult suffered from depression, anxiety, and suicidal thoughts. She was also alcohol dependent. She had 4 children, one of whom died shortly after birth. Her adult children have contributed to this DHR. She was known to many different services including MARAC (Multi Agency Risk Assessment

Conferencing). Her perpetrator was a Serial Domestic Abuse Perpetrator and had a diagnosis of Huntingdon's Disease. Pam's family say, "it is easy to see someone who is a drink 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."

2.3. The Scope of the Review covers the period 1st January 2017 – August 2019. The DHR panel met 6 times between 2020 and 2021 and all Agencies contributed fully by providing information and critical reflection and action plan.

2.4. The details of the DHR are not combined in this Briefing Report, as they are contained within the Domestic Homicide Report itself.

3. Background

3.1. The Home Office have recently published a Quantitative Analysis of Domestic Homicides Reviews which were published between October 2020 and September 2021. (To note 60% of the deaths occurred in 2018-2019) The key findings were based on 108 DHRs. Of the 113 victims, 15 appear to have died by suicide. The ages of victims ranged from 18 – 92 years with the oldest perpetrator being 88 years old. 77% of the victims were female and in 40% of the cases, children were living in the household.

3.2. The Home Office Analysis highlights familiar relationships with 68% of victims having been murdered by a partner or ex-partner. Additional vulnerabilities of both victims and perpetrators relate to mental ill-health, alcohol, and substance misuse. 55% of perpetrators were known to Agencies as Abusers (of those Agencies 7% were known to Childrens services and 4% to Adult Social Care). In 11% of cases the victims were carers. One victim received a Carers Assessment (nine had not).

3.3. In terms of geography,14 out of the 108 DHRs occurred in the Northwest of England. This was the second highest Region to conduct DHRs with the Southwest being the highest Region, having published 20 DHRs. To note that Cheshire East has, or is in the process of, completing 5 Domestic Homicides Reviews following deaths which have occurred since 2019. This number is unprecedented but also mirrors the numbers of Safeguarding Adult Reviews being completed by the Safeguarding Adults Board.

3.4. Cheshire East has an established Domestic Abuse and Sexual Violence Partnership and a Domestic Abuse Strategy. The Commissioned Service for working with victims of Domestic Abuse is My Cheshire Without Abuse (My CWA) and is highly regarded locally and nationally. Cheshire East is actively involved in the Violence Against Women and Girls Strategy with Cheshire Police developing local creative initiatives to help keep women and girls safe. Whilst Adult Social Care and Partners are highlighting the challenges faced by Carers who look after a relative with complex needs and how to reduce the incidents of abuse and neglect. The need to constantly raise awareness

about Abuse, Neglect and Exploitation supports a Prevention to Protection approach and needs to be embraced by all Officers.

3.5. Whilst PAM died in 2019, it should be noted that COVID and wider societal issues such as Housing, Employment, Access to Services and Social Isolation all have the potential to impact on instances of Abuse and Homicides.

4. Briefing Information

4.1. The key issues arising from PAM's DHR can be found in Section 5 of the Executive Summary. The themes include:

4.2. Pam's health, vulnerability, and engagement with services, whereby Pam would often contact a service during a period of crisis, but then miss appointments and disengage. The panel noted that she had been subject to domestic violence for over a decade by 2 separate perpetrators.

4.3. Assessment of Risk and Safeguarding. Whilst Pam's case had been heard at MARAC on several occasions, not all agencies had a complete picture of her history and risk. Sadly, Adult Social Care did not receive any Vulnerable Persons Assessments from the Police and therefore there was a missed opportunity to offer a Care Act Assessment or conduct a S42 Enquiry. Equally not all Agencies were aware of the historical risk factors associated with the perpetrator.

4.4. The offer of Refuge Accommodation. This was offered to Pam but was refused due to changes in circumstances or the available accommodation was too far away.

4.5. The health of the Perpetrator and his engagement with services. Homelessness was a key feature here, but it is noted in the DHR that Cheshire East Council, Stockport, and Manchester City Councils all attempted to resolve this but contacting and maintaining contact with him was difficult. Equally he did not engage with support provided by Cheshire and Wirral Partnership. The DHR did highlight a need for more awareness around Huntingdon's Disease and its impact on behaviour and capacity.

4.6. The Perpetrator was a Serial Domestic Abuse Perpetrator, with evidence of assaults against 3 other women. He failed to engage with the Integrated Domestic Abuse Team. The DHR points to missed opportunities by the Police to arrest him, and for Pam to be given the choice about providing a statement to support prosecution

4.7. Professional curiosity, Adverse Childhood Experiences, Information sharing were also noted in the findings.

4.8. Each of the Partner Agencies involved in the DHR have listed individual lessons learned and 9 recommendations were made. These can be found on page 30 of the Executive Summary. The Safer Cheshire East will be monitoring the Action Plan. It should be noted that due to the procedural and

quality assurance requirements set by the Home Office, there has been a significant gap in being able to publish the DHR locally. However, some of the actions have already been completed prior to publication. One such example is Adult Social Care now having access to CWPs case recording system and the Standing Operating Procedure for Adult Social Care supporting MARAC.

4.9. The DHR author concludes by saying "This was a tragic case resulting in the untimely death of Pam and leaving 4 children without their mother. The thoughts of the Panel are with these surviving children".

4.10. Equally it should be recognised the professionalism of those Officers who contributed to the Domestic Homicide Review.

5. Implications

5.1. Legal

5.1.1. The DHR has been conducted in line with relevant legislation. There are no further legal implications.

5.2. Finance

5.2.1. There are no specific financial implications. However, it should be noted that Cheshire East is conducting more Domestic Homicides and Safeguarding Adult Reviews which require commissioning, funding, and officer support. Attendance at DHR and SAR panel meetings is a timely but necessary commitment.

5.3. Human Resources

5.3.1. There are no specific HR implications for this Report. Nevertheless, it should be noted that the circumstances surrounding each DHR, and SAR are unique and traumatic. Officers are committed to the Learning Process, but elements can be emotionally draining and impactful.

Access to Information	
Contact Officer:	Sandra Murphy – Head of Adult Safeguarding Sandra.murphy@cheshireeast.gov.uk Tel 07825 145 464
Appendices:	Executive Summary DHR – Appendix 1 7 Minute Briefing – Appendix 2