Domestic Homicide Review (DHR) – Key Learning Points

What happened?

"Miriam" was a 26-year-old woman and mother of three children. She was killed by her ex-partner / father of the children in 2015. The relationship began when she was 14 and he was 50, and a key theme of the DHR was how professionals did not recognise how the relationship began, including potential child sexual exploitation, and the impact on the family dynamics.

Miriam's parents and grandfather died when she was a teenager and she experienced depression and trauma following her bereavement. She had unassessed learning disabilities. The relationship was volatile, and while there was little evidence of physical violence, the perpetrator was verbally abusive and undermined Miriam's parenting abilities, and she experienced low self-esteem. Miriam's often aggressive and abusive demeanour led professionals to consider her as the greater risk to the children and they were put on a child protection plan in 2013 due to poor parenting / supervision and domestic abuse. The family also received significant support from a children's centre and an organisation supporting parents with a learning disability, though there was little management oversight of the work and a lack of clarity on the outcomes needed from these interventions.

Miriam was murdered after the perpetrator found that she was in a new relationship. The perpetrator had also violently attacked Miriam's new partner a month before her murder. The perpetrator was convicted of her murder and sentenced to life imprisonment, with a minimum tariff of 21 years.

For a copy of the report contact domesticabuse_admin@sandwell.gov.uk

What were the main issues?

- **Working with a family with complex needs**
- **Family support and early help**
- **Coercive and controlling behaviour**
- **Child sexual exploitation**
- **Working with parents with learning disabilities**

What are the lessons to be learned?

- ***The early history of every family member needs to be sought and understood when working with a family with complex needs***
- ***An abuser will use tactics to undermine safeguarding by professionals to maintain his control***
- ***Abusers often use counter-allegations, including allegations of child abuse/neglect, to divert attention from their own abusive behaviour***
- ***Abusers are skilled in presenting a charming, calm and rational demeanour to professionals, which contrasts with the 'irrational, emotional responses' of their victim which the abuser will frequently both cause and highlight to professionals***
- ***A victim of coercive control may not recognise their abuse as domestic abuse or be able to name it – it is crucial to discover how their everyday life has changed since they met the abuser***
- ***It is possible that a vulnerable child or young person could be kept from CSE screening or enquiries***
- ***Without focus and a clear plan, support work can be extensive and well meaning, but ineffective***
- ***Learning disability can be recognised but not addressed in a family with diverse competing needs***

DHR report recommendations

All professionals need to develop an understanding of coercive and controlling behaviour and recognise and identify the dynamics of those behaviours as they manifest themselves, both within a personal relationship and the family. They need an ability to challenge those behaviours as they appear and respond appropriately.

To improve community safety, we should seek to raise awareness of the adverse impact of coercive control in relationships so that not only victims are better able to recognise they are experiencing this form of domestic abuse and seek help and support, but family and friends are better equipped to identify safe and effective pathways to provide that support.

As part of integrated professional practice, the agencies listed in the action plan for this recommendation should be able to demonstrate that consideration of possible coercive controlling behaviour has formed part of assessments, interventions and planning.

The DHR recommends to the Chairs of the 7 West Midlands Safeguarding Children Boards that work to raise awareness of CSE, violence and other exploitation of children under 18 should be undertaken with all abortion providers across the West Midlands.

Sandwell and West Birmingham CCG should ensure that contracts with Marie Stopes International for the provision of abortion services in Sandwell clearly define their safeguarding arrangements for children under 18 and vulnerable adults.

In the light of the findings of this DHR, the CCG should provide assurances to the Safer Sandwell Partnership that a specific, measurable and realistic action plan exists to rectify all existing shortcomings in safeguarding at MSI.