LEARNING FROM DOMESTIC HOMICIDE REVIEW: LUCIA

SAFER SHEFFIELD PARTNERSHIP

WHAT HAPPENED?

In July 2022, Lucia[1], a young black British woman who had arrived in the UK as a child with her mother fleeing conflict in the Congo, took her own life. Lucia had separated from her partner, Robert[1], the father of her pre-school child, around 10 months prior to her death.

Lucia had Non-Epileptic Attack Disorder, experiencing Dissociative Seizures which led to regular emergency department visits and contact with health services. Lucia also had an unusually high level of contacts with midwifery and obstetric services during her pregnancy.

There were several known domestic abuse related incidents during and after Lucia and Robert's relationship. One of these incidents, which included non-fatal strangulation and at which the child was present, resulted in a Multi-Agency Risk Assessment Conference (MARAC) referral. Robert was bailed with the condition not to contact Lucia for anything other than child contact arrangements. Lucia declined to provide a statement to support a prosecution, but an evidence led prosecution was sought by the Police resulting in a conviction of Battery.

Children's Social Care attempted to engage Lucia in a 'child in need' (S17 Children Act 1989) assessment. When consent was not forthcoming, a safety plan was agreed with Lucia. Lucia had brief contact with the Independent Domestic Abuse Service but did not engage beyond this. Lucia did disclose post-separation abuse to a professional the year prior to her death, including threats to kill, but this was not acted upon.

The IAPT service had contacts with both Lucia and Robert separately about mental health concerns. Robert talked to his GP and Improving Access to Psychological Therapy (IAPT) about relationship difficulties, alcohol and substance use, irritability and anger. He was signposted to MIND's anger management course.

Family and friends of Lucia were not wholly unaware that she was experiencing domestic abuse but were unaware of the full extent or impact of this.

WHAT DID IT TELL US?

The collective mental health issues presented by Lucia and her regular presentation at health services were a red flag for agencies, requiring a holistic and trauma informed response. There was a lack of professional curiosity in the accumulative impact of Lucia's experiences.

Despite organisational policy and guidance, routine enquiry was not undertaken when it should have been, missing multiple opportunities for disclosure.

Race, sex, disability and pregnancy may have increased Lucia's vulnerability to abuse and may also have acted as barriers to her ability to engage with services. Lucia's identity and experiences meant she was at particular risk of suicide.

Safeguarding concerns prompted timely referrals. However, while seeking consent is important, it should not be a barrier to responding to safeguarding concerns.

MARACs are most effective when all relevant agencies know about and are engaged with them, and when there is effective monitoring of subsequent action.

Post separation abuse, including this being facilitated through contact arrangements, is very real for many victims and must be at the forefront of agency assessments and responses.

The GP and IAPT held information about Robert's behaviour that required a more robust risk assessment. Anger management courses are an inappropriate intervention for perpetrators of domestic abuse.

There may have been missed opportunities to seek a higher-level criminal charge against Robert. Delays in the charging process do not engender the confidence of victims and their support with the process.

WHAT CAN WE DO NOW?

Routinely incorporate the risk of suicide into domestic abuse training and domestic abuse into suicide prevention training.	Review how the status of children as victims, as defined by the Domestic Abuse Act, is reflected in local strategy, guidance and training.	Engage with the commitments made by the Independent Commission into Racism and Racial Disparities in Sheffield (June 2022).	Raise awareness of the risk of domestic abuse and related suicide, and appropriate sources of support, amongst the general public and community organisations.	Develop plans to ensure that practice responses to non-fatal strangulation are aligned with current legislation, emerging guidance and evidence base.	Standardise domestic abuse training across statutory and voluntary agencies with guiding principles.

[1] Pseudonyms