LEARNING FROM DOMESTIC HOMICIDE REVIEW

Kirsten – ADULT V DHR SAFER SHEFFIELD PARTNERSHIP

DATE October 2021

WHAT HAPPENED?

Kirsten moved to Sheffield in early 2019 with partner Jake. She died aged 33, from a fatal overdose in October 2021, having reached a point when she felt she could no longer go on due to the cumulative impact on of the controlling and coercive domestic abuse she was subjected to by Jake over many years from when she was a teenager. There is evidence the abuse included non-fatal strangulation.

Kirsten and Jake had three children who were removed and placed for adoption before they arrived in Sheffield. The couple were homeless when they first arrived in Sheffield but were later rehoused by the Council.

Kirsten and Jake both struggled with mental health and substance misuse issues. Jake was a spice (psychoactive drug) user and they both used cannabis and other substances. Jake was registered on the special allocation scheme for violent patients. Kirsten disclosed to her GP previous domestic abuse, self-harm and overdoses. She was referred for mental health support but did not attend.

Several domestic abuse incidents were reported by neighbours and third parties to the Police, to housing and later by Kirsten herself. These resulted in three referrals to the Multi Agency Risk Assessment Conference (MARAC) as Kirsten was at high risk of serious harm or homicide, however information was not shared about the length of the relationship, so the extent of coercive control was not realised. Reports by neighbours of screaming were treated as noise nuisance and anti-social behaviour by housing. A Domestic Violence Protection Order, then a Restraining Order were granted. In June 2021 Kirsten reported to the Police that Jake had pinned her to the floor and strangled her. Jake was remanded to prison.

However, the domestic abuse continued, including harassment from prison.

Jake took two overdoses in 2021 and had ongoing suicidal thoughts. He and Kirsten told agencies she was his carer. In August 21 Kirsten attempted suicide via an overdose – she told her friend that she had 'had enough'. Jake was convicted for the June assault but was allowed to live with a friend on the same road as Kirsten. He breached the restraining order soon after. He was prosecuted and received a suspended sentence. Kirsten reported constant harassment to the police. At this point a Domestic Abuse Worker completed an assessment with Kirsten, referred her for mental health support and debt advice and discussed group work and counselling. Sadly Kirsten took her own life a few days later.

WHAT DID IT TELL US?

Nobody had enough understanding of the narrative of Kirsten and Jake's relationship. The lack of professional curiosity about the long history and the focus on incidents, rather than understanding it as the pattern of coercive control, is significant learning along with the absence of coordination and consistency in response.

It was not explored with Kirsten whether her substance misuse was a means of coping with the domestic abuse. Covid also had a major impact on services, how they worked together and were able to give support to Jake and Kirsten.

Kirsten's role as Jake's carer contributed to the domestic abuse not being considered well enough.

WHAT CAN WE DO NOW?				
Encourage professional curiosity and to purposefully question when there are concerns.	Review MARAC and consider how historical information about the relationship can be shared so that the impact of coercive control is understood.	Ensure referrals made to the Carer's Centre and Carer's assessments are undertaken. Consider the appropriateness of informal carers to fulfil this role if any element of the Trilogy of Risk is present.	Provide training to staff on Domestic Abuse and MARAC. Make MARAC warnings explicit on systems where possible.	Raise awareness of attempted suicide as a potential indicator of domestic abuse.