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Safeguarding & Protection

Learning from a Domestic Homicide Review

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Background and context

****THIS REVIEW REMAINS ON GOING AND THE FINAL REPORT IS NOT IN THE PUBLIC DOMAIN – NO SPECIFIC DETAILS WILL BE INCLUDED****

- 31-year-old lady with history of mental health problems admitted to an out of area acute ward
- Under the care of home treatment services prior to admission
- No local beds available
- Informal admission
- History of living with an abusive partner (physical and mental abuse)
- Son living with her parents, not in local area
- Few protective factors in home life

Why DHR for suicide?

The Standing Together Domestic Homicide Review process guidance states:

The 2016 Guidance (para 18) specifically notes that 'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.

Admission

- Informal admission May 2021 – no MHA prior to admission
- No bed available in local NHS trust
- Out of area placement
- Seven day admission
- Risk assessment on admission
  - Suicide – medium
  - Deliberate self-harm – high
  - Vulnerability from self-reported domestic abuse – medium
  - Overall risk - **HIGH**
- Risk assessment at discharge
  - Suicide – medium
  - Deliberate self-harm – high
  - Vulnerability from self-reported domestic abuse – medium
  - Overall risk - **LOW**

Risk assessments

- Risk assessment on admission
  - Suicide – medium
  - Deliberate self-harm – high
  - Vulnerability from self-reported domestic abuse – medium
  - Overall risk - **HIGH**
- Risk assessment at discharge (only 7 days later)
  - Suicide – medium
  - Deliberate self-harm – high
  - Vulnerability from self-reported domestic abuse – medium
  - Overall risk - **LOW**
- "Crisis team are aware of her intention to return home where the partner resides. Staff have also spoken to her regarding return home, she reports feeling safe and happy to go home and has the capacity to make this decision."

Discharge

- Patient requested discharge seven days after admission
- Patient reported being in contact with partner and son (staying with patient's parents)
- Denied suicidal thoughts, or thoughts of self-harm
- Liaison with community team – however, this was not with the home treatment department of the community team
- No formal discharge planning meeting involving patient, CRHT, partner, family or ward doctor
- Plan for CRHT to make contact within 48 hours of discharge
- Patient found hanging at home by partner two days after discharge. Police and ambulance arrived, and she was pronounced deceased at the scene

Learning outcomes

- Challenges
  - Legal framework – patient was informal and not liable to be detained
  - Understanding of out of area team processes
  - Establishing family networks
  - Short admission
- Communication
- Joined up working between agencies
- Lack of joined up discharge planning
- Follow up plans

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Thank you

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