SMBC Domestic Homicide Review 13

1 The case

Intimate partner homicide – Male aged 38 (adult 1), allegedly killed by his same sex partner, aged 37 years (Adult 2). Both were nationals from the same Eastern European country.
Review found numerous reported domestic abuse (DA) incidents between themselves, both as the perpetrator, and as the victim, alongside Anti-Social Behaviour (ASB) reports and additional complex needs, including mental health concerns for Adult 2.

Adult 2 was arrested for assault by police at the scene as he confessed to both police and paramedics that he pushed his partner to the floor before he proceeded to go into cardiac arrest. Adult 1 unfortunately died in hospital in the early hours of that morning. The charges against Adult 2 were upgraded to murder and he is awaiting trial for the offence.

2 Background

Adult 1 moved to the UK in or around 2012. Adult 2, who was also born in the same country, was under Walsall Mental Health Services. Adult 1 and 2 met whilst in Walsall around 2017 and moved to Solihull together in 2021 and would regularly argue late at night into the early hours of the morning. Many of their arguments occurred when the pair had been drinking alcohol. Both were known to have smoked cannabis on occasions and would take drugs.

There were nine reported DA incidents between them, with both listed as the victim and perpetrator. Eight of the DA incidents together with other reported ASB, hate crime and criminal allegations were attended to by police, the last DA incident being the homicide of Adult 1, in July 2022.

3 Key Findings

This DHR has identified that the complexities and domestic abuse in Adult 1 and 2's relationship was recognised by some of the agencies, but there was no effective agency safeguarding and agencies failed to work together. The concerns have been acknowledged and the review has received extensive and supportive information from agencies to ensure that lessons are learnt. Increasing reports of abuse, both towards each other and to others, particularly when intoxicated, coupled with reported mental health concerns, was predictable indicators of potential escalation.

4 Lessons to be learnt

Finding 1. Concerns raised for multi-agency working, referrals, professional meetings, sharing information, record keeping and communication.
Finding 2. Awareness needs to be raised of the Domestic Abuse Act 2021, Anti-Social Behaviour Guidance and CPS Evidence Led Victimless Prosecutions.
Finding 3. Identify the signs and symptoms of Coercive, Emotional and Manipulative Control also to be alert to Situational Violence and Identifying the suitability of the role of the carer.
Finding 4. Improvement of Supervision, Professional Curiosity and Risk Assessments.
Finding 5. A Review of WMP Domestic Abuse investigations.
Finding 6. Consideration of Mental Health and Mental Capacity Assessments for 'Best Interest' decisions.
Finding 7. Capturing the Voice, Culture, Diversity, LGBQT+, Sexual Orientation and Gender Bias and Hate Crime.
Finding 8. Awareness and Promotion of the SMBC ASC Triage Process of Safeguarding Referrals, existing safeguarding referral pathways and expectations to multi-agency partners.

5 DHR Report

It is anticipated that the hearing will be in March 2024.

6 What we will do now

An action plan is being drawn up ready to be signed off by partners.