

Dudley DARDR15 Learning Brief

Who should read this?

Any practitioner or manager within the borough who works with adults, including those providing temporary housing/accommodation. It will also be of interest to individuals that work with children, young people and their families due to the impacts of decisions made, where the impacts of cultural background are not fully considered.

Background information

This Domestic Abuse Related Death Review (DARDR) was commissioned by Safe and Sound Dudley Community Safety Partnership (CSP) in response to the death of Lisa. Lisa's death would appear to be as the result of an overdose. Lisa was from Romani (Gypsy) heritage and at the time of her death was 51 years of age. She had seemingly been involved in a short-term, intense relationship with Adam, who was 32 years of age, whom she had met when both were residents of a local housing facility. Lisa had one child, Child 1, from a previous relationship aged 17 years. At the time of her death, Child 1 was living with Lisa's sister.

In mid to late May 2024, staff at the housing facility, where Lisa was resident, were unable to contact Lisa which raised their concerns. Staff entered her room; where they found her lying in bed, unresponsive. West Midlands Ambulance Service (WMAS) attended and pronounced life extinct. Police arrived a short while later. Nobody else was present at the address. There were numerous empty prescribed medication packs near Lisa's body, suggestive of an overdose. Lisa had previously disclosed to staff that she had been in a relationship with Adam and that he had abused her sexually and physically and had financially exploited her.

Key Areas of Learning Identified

Mental capacity, learning difficulties or learning disabilities should not be a barrier that prevents professionals in adequately assessing risk.

In Lisa's case, a Domestic Abuse Risk Assessment (DARA) was not completed by Police officers, mainly because they were wrongly informed that Lisa had a learning difficulty and the mental capacity of a 13-year-old. Mental capacity or learning disabilities or difficulties should not be a barrier to assessing risk, with questions being able to be asked in age appropriate ways or with the support of appropriate adults, intermediaries or advocates.

Cultural ignorance contributed to responses that increased vulnerability, inhibited engagement and led to missed opportunities.

Due to mistrust of governmental services within the Romani (Gypsy) culture, it is likely that referrals to traditional services such as substance misuse services, psychological therapies, and Police will almost never be taken up. Religion plays a significant part in Romani (Gypsy) culture, and therefore interactions with priests are likely to be a more effective way to divert individuals from substance misuse, as an example. To help agencies overcome cultural ignorance, and help individuals from diverse backgrounds navigate and understand the care/support system the use of community advocates should be considered. In doing so, it will help agencies understand barriers to providing support, and encourage different and more inclusive avenues to providing support and safeguarding.

In formulating a safeguarding plan for Child 1 that had been agreed in line with the family arrangement, the voices of Child 1 and Sister 1 were heard, and cultural sensitivities were not considered especially in regard to Lisa being seen to be a poor mother within her community. This plus Lisa's voice not being heard, adding to her increased vulnerability. All views need to be gained, even if that engagement may have its difficulties.

A lack of understanding of risk and vulnerability can lead to placing victims in harm's way.

Lisa was vulnerable when she was seeking temporary housing. Placing her in mixed gender accommodation was culturally inappropriate, adding to her vulnerability. Lisa's vulnerability meant she was exploited by other residents and abused by Adam. Once Lisa disclosed that she had been physically and sexually assaulted by Adam, there was no consideration given to the ongoing risk Adam posed to Lisa and other female residents. Accommodation providers need to have in place robust systems to assess vulnerability to ensure correct placement at the beginning and be able to respond to situations when an individual might need to be moved to safeguard other residents.

A better understanding of Domestic abuse, policies and procedures especially in regard to escalating issues, coupled with accurate and robust record keeping will lead to better outcomes.

Agencies acknowledged that there is a need to improve knowledge of Domestic abuse, be familiar with their safeguarding and domestic abuse guidance, and for staff to have further training to ensure better decision making, escalation of issues and ensure record keeping is clear and accurate. This will ensure transparency and accountability and support for professionals in dealing with challenging circumstances, and escalating them as appropriate.

Perpetrator accountability can be limited when victims die in circumstances other than homicide.

In incidents where victims die other than by homicide following being in an abusive relationship, it can be a feature that these relationships are short term and intense and that the perpetrator has moved on before the death of the victim, or before any official complaint has been made. This can make evidential thresholds for criminal justice outcomes hard to reach. The question is asked as to how lawfully and with full

regard to their human rights, can individuals be legitimately diverted from further perpetrator behaviour, and how any future partners could be safeguarded from domestic abuse.

This is an issue that goes beyond what happened to Lisa, and it is therefore felt appropriate that it is for the Home Office to provide guidance to CSPs and partners engaged in seeking to prevent domestic abuse/violence.

Overview Recommendations for Safe and Sound, Dudley's Community Safety Partnership

Recommendation 1:

To reiterate current Policy and procedure whereby Police officers attending incidents that are considered to be a domestic abuse incident to complete a Domestic abuse Risk assessment (DARA) on every occasion.

If the potential victim is a child or has potential learning difficulties or disability, the questions should be asked in an age-appropriate way.

Ensuring the presence of an appropriate adult, or intermediary or advocate to be considered to help aid and facilitate communication and understanding where appropriate.

Recommendation 2:

To increase awareness of domestic abuse for staff within the service, including ensuring training with partners such as women's aid, and the Dudley safeguarding team.

Staff are also required to re-read the safeguarding and domestic abuse guidance (June 2024) and sign to show this is completed.

Recommendation 3:

Further training to be conducted with staff to ensure understanding roles and responsibilities within case management, escalation to senior managers for case support and the importance of clear and accurate record keeping with clear and appropriate rationale for actions taken.

Recommendation 4:

To ensure that the views of all individuals are gained as part of an assessment and clearly recorded. Where individuals may not be engaging, to consider the different approaches to encouraging engagement.

Recommendation 5:

Agencies must reform their policies and systems to embed rigorous risk assessments for all vulnerable individuals, ensuring placement decisions—especially in mixed accommodation—actively prevent exploitation. Equally, robust protocols for relocating residents whose behaviour poses a significant threat are essential to safeguard and protect all residents, driving meaningful change across the accommodation system.

Recommendation 6:

For individuals from a Romani (Gypsy) background, consider the use of a Roman Catholic priest or pastor as an avenue to help individuals deal with substance misuse, over and above traditional services, due to the importance of religion within the community.

Recommendation 7:

For individuals from a diverse background, consider the use of advocates from that community, to help overcome cultural ignorance and ensure suitable support to help individuals and agencies navigate, understand and maneuver through the care/support system and provide advice on suitable support and safeguarding avenues.

Recommendation 8:

Practitioners need to display professional curiosity when working with individuals and families, to ensure that the views of all individuals are gained as part of an assessment and clearly recorded.

Recommendation 9:

The Home Office to provide guidance to Community Safety Partnerships (CSPs) on lawful and ECHR-compliant methods for managing perpetrators of domestic abuse who cannot be addressed through criminal justice outcomes, with funding to enable delivery of this work attached. These guidelines should aim to encourage diversion interventions to address perpetrator behaviour and prevent the recurrence of domestic abuse.

More information

To access the full report and Executive Summary, including individual agency recommendations please visit: <https://www.dudleysafeandsound.org/dudley-dhrs>

For more information in respect of Domestic Abuse please visit our helphub: <https://www.dudleysafeandsound.org/help-hub>