01 Background:

This Domestic Homicide Review (DHR) concerns a 23 year old woman who died. Olivia had cerebral palsy and lived an active and purposeful life. Mario was Olivia's boyfriend. They had known each other for some time although only lived together for a short period. Mario had suffered from mental health problems for a long time and was diagnosed with paranoid schizophrenia. Mario killed Olivia in the home they had shared following a series of events in autumn 2016 during which his behaviour became more irrational and he disengaged completely from mental health agencies.

This document has been published as part of the Rochdale Borough Community Safety Partnership's DHR learning. The full DHR will be published on Rochdale Council website later in 2019.

Why it matters: 02

A Domestic Homicide Review (DHR) takes place when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

The purpose of the review is to:

- Establish whether there are any lessons to be learnt from the case and from the way in which local professionals and organisations worked together.
- Identify what is expected to change as a result of the learning
- Try to prevent similar incidents.

Learning: 03

1. GPs need to undertake more probing and consider wider issues when they receive important information that might indicate that a patient is at increased risk of domestic abuse.

2. Professionals need to recognise the factors that may increase the risk of harm from domestic abuse. They need to be able to assess that risk using a recognised model and provide appropriate referrals to agencies that can help respond to that risk.

3. When agencies receive information from another agency which might identify a person is at increased risk of domestic abuse they should have a plan to deal with that information which includes recognising and responding to any risk. It is not satisfactory simply to leave it on a file.

04 Learning:

4. Professionals need to 'think family' and recognise all the factors that are present that may impact upon the levels of risk of domestic abuse including mental health and pregnancy.

05 Learning:

5. Professionals need to recognise when there may be a risk to life and ensure that an appropriate response is provided.

06 Learning:

6. All disclosures concerning incidents of domestic abuse should be explored. There may be evidence of a crime that requires recording and investigation. Professionals need to ask questions, establish the facts, establish the risks that are present and recognise the appropriate response to take when they receive such information.

7. When reviewing and assessing the mental health of patients, professionals need to ensure that they do not just concentrate upon the needs of the patient and the risks they present to themselves. They should also give consideration to the risks the patient presents to others.

8. It is important that employers create a culture, and have processes in place, that encourage and facilitate victims to make disclosures. These processes should also provide guidance so that they know what to.

07 Learning:

9. It is important that professionals recognise when a person poses a risk to an unborn child and when this happens they should always make sure a safeguarding referral is submitted.