Kirklees COUNCIL

Safeguarding Briefing

Domestic Homicide Review Bethany

How we have improved our practice in response to the death of Bethany
B – Believe R – Respond F – Fast

Why review this case?

Bethany was killed by her ex-partner, Mr G, in 2019.

Local agencies would like to offer their deepest condolences to Bethany's family and friends.

Bethany's death met the criteria for conducting a Domestic Homicide Review. Local agencies wanted to understand how Bethany and Mr G came to the attention of local services, and whether those services could have protected Bethany.

Case characteristics

- Mr G had long-standing mental ill health and was in the care of mental health services at the time of Bethany's death.
- Following Bethany's death, Police described Mr G as a serial perpetrator of domestic abuse.
- When they were in a relationship, Bethany was his carer.
- The relationship ended approx. two months before Bethany was killed.

Key findings

The review found that some agencies, including police and mental health services, did not deliver their duty to protect Bethany due to:

- inappropriate handling of important information;
- failure to correctly assess risk;
- failure to follow policy/procedure in respect of domestic abuse;
- lack of adequate supervision and inadequate experience, training and knowledge to deal with domestic abuse and assess risk.

Upskilling staff

- WY Police investing in Domestic Abuse Matters, a bespoke cultural change programme for police officers/staff responding to domestic abuse
- Mental health services conducted Oxford model learning event
- Staff advice line for domestic abuse
- Learning included in multi-agency training on DHRs

Supporting carers

- Briefings delivered to GPs to increase awareness of support services for carers
- Raising awareness of domestic abuse with sessions through Carers Count and Carers Trust
- Mental health services have implemented better practices to support carers

Managing serial perpetrators

- New Integrated Offender Management officers (Police) that specifically manage and disrupt domestic abuse offenders
- All agencies to have a policy in place to promote Domestic Violence Disclosure Scheme

Recording and sharing information

- Police improved oversight of recording in DA cases
- Improved training on recording intselligence for staff and supervisors
- Improved processes to link crimes connected to the same perpetrator

Assessing risk

- Mental health services have improved risk assessments to include consideration of domestic abuse and wider risks to family
- Specific mental health staff now in probation to support clients and provide advice to staff
- Police review of DASH risk assessment
- All threats to life reported to police to be seen by Inspectors

Further information

- The executive summary of the review report in relation to Bethany is available from:
- Further information about the DHR process is available from DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)
- Findings from national DHRs is available from Key findings from analysis of domestic homicide reviews - GOV.UK (www.gov.uk)

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