Report to Health and Wellbeing Board

Date: 7 June 2018
Subject: Domestic Homicide Reviews
Authors: Richard Carpenter and Sarah Haywood
Presented by: David Munro

1. Purpose

This report presents the legislative background of Domestic Homicide Reviews (DHRs), and presents figures outlining the level of domestic abuse in Surrey. The report then details the progress made in improving the process of undertaking a DHR and embedding the learning into practice.

The report includes a summary thematic analysis of learning collated from the reviews competed so far and a status update of DHRs to date.

2. Background

Domestic Abuse Statistics

The Crime Survey for England and Wales estimates that nationally 1.9 million adults aged 16 to 59 years experienced domestic abuse in the 12 months to March 2017 (1.2 million women, 713,000 men). In the same period, the police recorded 1.1 million domestic abuse-related incidents and crimes nationally; domestic abuse-related crimes recorded by the police accounted for 32% of violent crimes.

14,363 incidents were reported to Surrey Police in the 12 months to March 2017. This doesn't equate to 14,000 individual victims, however, as there is a significant element of re-victimisation. Commissioned outreach services in the county received 3,805 new referrals over the same period.

The estimated cost to public services associated with this level of domestic abuse in Surrey is £111 million per year.

Domestic Homicide Reviews

DHRs were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004 and the provision came into force on 13th April 2011. A DHR is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death

15 DHRs have been initiated in Surrey since the provision came into force in 2011. These reviews encompass the homicides of 17 victims, as a small number of reviews are for multiple victims. The profile of victims is not what might be typically expected given the general profile of domestic abuse. The victims include men and women, cover a wide age range, and with varying range of relationships to the perpetrator.

The rationale of a DHR is to identify and put in place appropriate support to prevent future incidents by assessing the robustness of policies and procedures locally, and the understanding of these policies by staff. A DHR is not about finding who is guilty or culpable, and it is not a disciplinary process which looks to blame agencies for any perceived failings.

The expected outcome of a DHR is a report which clearly identifies what the lessons are both within and between agencies, how and within what timescales they need to be acted on, and what should change as a result. By applying these lessons to service responses, it is hoped that domestic abuse is identified and responded to more effectively in future, and at the earliest opportunity, to improve the support for all domestic abuse victims and their children.

3. Improving practice in Surrey

In 2015 the Community Safety Board began a process of reviewing and improving the approach to DHRs in the county. This initially began with a discussion around concerns about the delay in sharing the lessons learnt, and the CSB tasked the county council Community Safety Unit with coordinating early findings and holding information on all actions and lessons learned from DHRs. The aim was to develop a county wide process for capturing and disseminating the learning and good practise from DHRs, and for DHR actions to be tracked at the county level more effectively to be able to identify common themes and recurring issues.

The Community Safety Team has explored the parallels with both the Safeguarding Children Board and Safeguarding Adults Board case review processes because of the expertise and clear overlap that exists with this area. The findings were used to shape further work and to inform improvements in the DHR processes, resulting in publication of revised local guidance and a DHR 'toolkit'.

Key improvements in process made following collaboration with Safeguarding colleagues include:

- When drafting their recommendations, the DHR panel discusses them with the organisations concerned in order that that all parties are clear about the purpose of the recommendation, what is expected, and that the appropriate technical or organisational language is used. This is something the Safeguarding boards routinely do and it leads to better recommendations, better outcomes and the actions being owned and consistently delivered against.
- When issuing the report, the CSP sends the recommendations to the relevant Chief Officers and outlines when it is they expect to receive a response
- On completion of a DHR, the CSP reports to the next available meeting of the CSB with a brief overview report and the recommendations from the DHR. This information will in turn be shared with the DA Management Board (DAMB) at its next meeting and the Safeguarding boards.
- A link to the published DHR report will be put up on the Surrey community safety website, with this site acting as a central resource.
- The county council Community Safety Unit liaises with CSPs holding DHRs and maintains a county-wide spreadsheet of all the DHRs that have or are taking place in Surrey. The unit provides a report showing the overview and progress on the delivery of recommendations as a standing item to the CSB. The spreadsheet and the overview report are also routinely shared with the Safeguarding boards and the DAMB.
- The CSB receives a) an update on the progress of implementation of recommendations 6 months after the report has been published, and b) a 'learning leaflet' that will demonstrate how the learning from the DHR has been embedded in practice. The leaflet is produced by the CSP, with support of the county council Community Safety Unit, and is shared with the DAMB, all CSPs and the Safeguarding boards.

The learning leaflets referred to above are an attempt to demonstrate how the lesson identified during a DHR have been embedded in practice, and the resulting outcome. The expectation was that, after a DHR has been published, the CSP will review the progress of the recommendations at 6 and 12 months and produce a brief paper that can be shared with partners to highlight a successful change in policy or service response, or flag up issues where an outcome has not be reached as expected and more work is required.

This objective comes from the stated purpose of a DHR to help prevent homicides in domestic settings and improve service responses for all victims and it is worth pursuing, although it hasn't always been easy to find the evidence of effective change. This is something that will be revisited in future in partnership with CSPs to find a process that works better and is easier to implement.

One of the benefits of collating the recommendations from DHRs centrally has been the ability to produce a thematic analysis of common themes in order to provide the CSB and CSPs with a baseline of issues uncovered to date. This analysis is presented in more detail in the appendices, but the recommendations fall into a small number of general categories.

- Application of / adherence to policy – 29.5%
- Staff training and awareness – 21.3%
- Recording and sharing of information – 21.3%
- Assessment / identification of risk – 16.4%

Many of the actions cut across more than one category, and there is often a relationship between areas. For example there is a clear overlap between staff training and risk assessment: in many cases inadequate staff training led to a failure to correctly identify risk and deal with incidents appropriately. There is also a notable overlap between policy management and risk assessment.

This sort of information needs to drive change – in practise, in procedure and in outcomes for those with whom we work.

Work with Safeguarding colleagues also raised the idea of holding an event, such as a learning seminar, to spread the learning and improve practice particularly amongst practitioners. A successful event was delivered by the Office of the Police and Crime Commissioner on the 11th January 2018. The aim was to bring together professionals who play a role in reducing DA and those supporting victims/survivors to listen and learn from those who have taken part in DHRs to bring about meaningful change and positive consequences.

The agenda was deliberately interactive and the day was facilitated by Frank Mullane the CEO of Advocacy After Fatal Domestic Abuse. Frank has had first-hand experience in a DHR when his sister, Julie Pemberton and her son, Frank's nephew were murdered by Julie's husband. From this he has become a leading advocate for victims and supports the Home Office in developing DHRs.

An important part of the event was to allow practitioners the opportunity to share information, discuss their roles in DHRs and build relationships so that when another DHR is called there is a practitioner community in Surrey able to support each other.

The event was held in the HG Wells and 87 people attended on the day. Following the event those that attended were asked to take a few minutes to provide some feedback on the day. 51 people answered the six questions with 80% of those who attended felt the overall workshop was excellent (33%) or very good (47%) and 56% of respondents feeling the day was extremely useful (23%) or very helpful (33%).

4. Moving forward

The responsibility for completing a DHR sits with the CSP where the victim was resident. It is recognised that this is a significant undertaking, both financially and in terms of staff time and skill to coordinate the work required. The CSB has put in place a structure and process to support this work and make sure that the best possible outcome can be realised from a review.

The CSB has been actively discussing DHRs and a considerable amount of work has been achieved to improve the how they are delivered. The CSB has general oversight, while the DAMB is the strategic body which leads on domestic abuse in the county. The DAMB has been keen for a process to be developed whereby it may support the CSB and CSPs in reassuring all relevant agencies that DHR actions are being progressed in a timely manner, and offer its influence as a multi-agency strategic board to effect the expediency and effectiveness of recommendations and learning indicated by each DHR. The DAMB is also aware of some long standing constraints to the DHR process. These barriers include;

- Suitable Chairs

Over the last six years there has been a difficulty in finding well trained and appropriate chairs. Some training has taken place but people have since moved out of these roles. There are also some concerns about the Chairs being from a local District or Borough council as it is felt there wouldn't be the objectivity required.

- Funding

Funding, or lack of it is a common concern for Community Safety Partnerships. The cost of running an efficient review costs about £10k. The costs have been taken from CSPs reserves, Local Authorities budgets or a contribution from each statutory partner.

- Resources

Alongside funding a DHR requires both administrative support and practical support. The administrative support can be burdensome and often falls to the District and Boroughs to pick up.

- Role of Family

It is challenging following the death of a loved one to engage with a DHR. The Panels have found there is little guidance or support in this area. The workshop held in January went someway to provide some guidance.

- Role of perpetrator

Similar to family involvement is the role of the perpetrator who does have a right to contribute to the review. I am not aware of any panel who have engaged with the perpetrator.

- Delivery and oversight of the recommendations

Despite improvements being made once the review is complete the delivery and oversight of the recommendations is vitally important to see change that lasts. Unfortunately, completion of the action plan can be complex and unachievable.

As a result, it has been proposed that a DHR Oversight Group be established as a sub-group of the DAMB that would sit as a tactical and delivery facilitation group for DHRs in Surrey and support the

process of disseminating learning with the CSPs on behalf of the DAMB and the CSB. The group will have its inaugural meeting on the 28th June.

Surrey Community Safety

APPENDIX A: DHRs in Surrey – Progress to March 2018

Ref.	Area	Date of Homicide	Publication date	Current status	Progress since last update / Key issues
RB4	Reigate and Banstead	Nov-17		2	A preliminary steering group meeting has taken place in January 2018. An Independent Chair has been appointed and organisations have been asked to lock down information. An initial panel meeting will take place in March. Due to a number of other investigation and proceedings taking place relating to this case it is likely that the DHR will take much longer than six months. The Chair of ESCSP has informed the Home Office about the review and the Independent Chair has informed the Coroner.
WV5	Waverley	Oct-17		2	Chair and admin support secured. The first panel meeting is in the process of being arranged.
RB3	Reigate and Banstead	Jan-17		2	Combined DHR and SCR. Panel meetings took place on December 13 2017 and February 15 2018. All IMR have been received and interviews have taken place with relevant organisations, employers and friends The family has been contacted abroad and the family in this country has now made contact with the Independent Chair. A draft report has been produced and is being updated as required by the Panel. It is expected that the final draft will be presented to the Surrey Safeguarding project group in late April for approval and then the family will have an opportunity to review the report with sign off, of the final report late April, early May ready for submission to the Home Office and Ofsted.
RB2	Reigate and Banstead	Jun-16		2	Combined DHR and SCR. The family of the victim (adult) were invited to the panel on December 13 2017. This was a very informative and powerful meeting. A further panel meeting took place on February 15 2018. Chronology has been collated and key practice episodes identified. Interviews with key individuals has been concluded and this has included workshop sessions with the relevant offices/staff involved in the key practice episodes (front line staff). Due to an appeal in relation to the family court case the family court and welfare hearing are unlikely to be concluded until June 2018. Due to the complexities of the case (combined review, trial outcome, and ongoing family court proceedings) an outline draft report is being prepared in March and April but will not be concluded until after the welfare hearing (children). The Independent Chair is drafting further update for Chair of ES CSP to inform Home Office of likely timescale. Permission is to be sought for the final publication to be restricted.

Status key: 1) DHR Notification received 2) DHR in progress 3) Report drafted 4) Report with Home Office QA Panel 5) Report published 6) DHR complete 7) Learning disseminated

Ref.	Area	Date of Homicide	Publication date	Current status	Progress / Key issues
EL2	Elmbridge	May-16		2	The third panel meeting was held in October where a draft report was discussed. Further work is being undertaken on the report.
WV4	Waverley	Oct-15		3	The third panel meeting has taken place and the report is being drafted.
RB1	Reigate and Banstead	Jun-15		5	85% of actions completed. Report approved by Home Office and published on website at www.reigate-banstead.gov.uk/info/20093/community_safety/760/domestic_homicide_review
EL1	Elmbridge	Jun-15		5	'The report has been shared with the family, the Home Office and the panel members. Whilst the report isn't published the action plan has been progressed. The majority of recommendations were not asking organisations to change the way they do things, instead they were around information sharing and raising awareness.
WV3	Waverley	Feb-15		4	The report and action plan have been approved by the Home Office. The proposed date of publication is 6th March. Action plan being followed up.
WV2	Waverley	Feb-14		4	Report written and signed-off by the Safer Waverley Partnership. Awaiting quality assurance by Home Office. Action plan being followed up.
GF2	Guildford	Aug-13	Feb-16	5	Review complete and approved. Summary to be published (currently being written). Action plan 50% complete.
SH2	Surrey Heath	Dec-12	tbc	6	Action plan recommendations 95% complete - outstanding recommendation relates to roll-out of IRIS. Report approved by Home Office and published online.
GF1	Guildford	Mar-12	Mar-13	6	Report published and review phase complete. Action plan 98% complete
WV1	Waverley	Oct-11	tbc	6	Action plan 100% completed. Agreed with the Home Office that the report would not be published. Recommendations are published on the borough council website. All panel members were asked to destroy their copies of the report.
SH1	Surrey Heath	Aug-11	tbc	7	Action plan 100% complete. Report approved by Home Office and published.

Status key: 1) DHR Notification received 2) DHR in progress 3) Report drafted 4) Report with Home Office QA Panel5) Report published 6) DHR complete 7) Learning disseminated.

APPENDIX B: Thematic Analysis

Notes: This summary is based on an analysis of 68 recommendations from 5 DHR action plans available at the time of writing. Two additional reports have since been published and the recommendations from these will be included in the next update.

1. Policy

Application or adherence to policy was the most common issue identified by DHRs in Surrey. The overriding issue is the consistent use of common policy across partner agencies, although the recommendations from DHRs can be further separated into the three distinct areas below:

1) Join up of cross organisational or partnership policies

- Safeguarding policies must be consistent within and between organisations, including using the same definition of vulnerable adults
- Domestic abuse should be recognised as a standalone factor for vulnerable adults in safeguarding policies
- All agencies should share an inter-agency escalation policy for resolving professional disagreements relating to safeguarding

2) Review or creation of policy to meet needs

- General practices should have effective policies and procedures in place for dealing with domestic abuse cases
- Procedures for dealing with sanctuary scheme cases must be fit for purpose
- Local voluntary groups who provide support to vulnerable families must have safeguarding protocols in place
- Workplace policies for dealing with domestic abuse and safeguarding must be fit for purpose

3) Need for clarity around roles and responsibilities

- Guidance should be developed for the management and supervision of PR actioner caseloads
- Clear guidelines are needed on the roles and responsibilities of practitioners attending MARACs (and clear communication of these)

2. Staff training and awareness

Staff training and awareness is the second most common issue in the DHRs which have reported so far, although given the relationship between staff training and other issues, such as risk assessment, it is a feature of many more recommendations than identified by the primary analysis.

The actions for training and awareness can be subdivided into the following three contexts:

1) Training staff to work more effectively or be more perceptive

- Staff should receive regular training on safeguarding and domestic abuse.
- Training should be offered to support the introduction of new policies
- Front line staff, particularly police officers, should be trained on the appropriate use of risk assessment tools and onward referral

2) Programmes to raise awareness in specific environments

- Local voluntary sector organisations must receive the appropriate level of safeguarding training
- Maternity / ante-natal staff should be aware of domestic abuse as a risk factor throughout the duration of pregnancy

3) Programmes to raise awareness of specific issues

- Training should cover awareness of male victims
- Work around suicide as a domestic abuse risk factor
- Training should include guidance on substance misuse issues and mental health
- Identification of mandatory training for specific individuals
- Communication and training to raise awareness of coercive control

Public awareness was also raised as an issue in a number of reviews, although to a lesser extent than staff training and awareness. It is regarded as a separate issue by this analysis, but it is worth noting the following recommendations:

- personal education is schools should include age appropriate safeguarding courses, including domestic abuse awareness
- heightened public awareness of coercive control through communications campaigns

3. Recording and sharing information

The overriding recommendation in this section is the prompt sharing of information between agencies. Many of the individuals subject to DHRs were receiving support from a number of multi-disciplinary professionals and this increases the risk of communication breakdown and understanding. It is therefore extremely important that channels of communication, sharing of risk and professional escalation are enhanced. Information sharing has both local and cross border elements, but also some aspects of policy and procedure (as simple as correct form filling).

The actions in this category fall into two distinct areas:

1) Improved cross agency knowledge and working

- Establish a means of sharing information with police forces and partners outside of Surrey
- Sharing of hospital consultation outcomes, particularly from A and E attendance, with GPs
- Regular communication of progress with client to all multi-disciplinary partners involved, and in particular the referring agency
- Sharing of information through effective handover between all stages of health contact (e.g. from maternity to health visitors)
- Safeguarding referrals should be copied to all relevant agencies, and correct receipt of referrals should be confirmed

2) Sign-up to existing information sharing agreements

- Full sign up to the Surrey Multi-Agency Information Sharing Protocol (MAISP)
- Learning from information sharing issues to be incorporated in to future MAISP updates and training
- Organisational cultures that encourage the appropriate sharing of information

4. Assessment of risk

16% of recommendations in DHRs fall into the assessment of risk category, although as discussed above, there is an overlap between risk assessment and other issues such as policy and staff training.

The recommendations in this category fall into the two associated areas below:

1) Opportunity to identify risk

- Assessments should occur in as many places as possible, particularly in healthcare settings
- Frequent attendees to healthcare settings should be identified as high risk to enable appropriate safeguarding procedures to be considered
- Serial perpetrators should be flagged and any appropriate additional action considered by police when attending a non-domestic abuse incident
- Records should be regularly updated to reflect clients evolving circumstances
- Factors commonly associated with domestic abuse must be considered among the triggers for an assessment

2) Competent assessment of risk

- Front line staff, particularly police officers, should be able to complete the DASH risk assessment
- Staff in general practice should be proactive in enquiring about possible domestic abuse
- Staff in all agencies should be fully conversant in the criteria for onward referral, particularly