Learning from Domestic Homicide & Near Miss Reviews: Implications for Practice

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Outline

• Welcome and introductions
• Introduction to the Domestic Homicide Review process
• Overview of key learning nationally
• Consideration of local reviews and lessons learnt
• Reflections on practice
• Questions
• Feedback forms and close.
Statutory context

- Implemented through section 9 of the Domestic Violence, Crime and Victims Act 2004
- Following a homicide, local authorities should conduct a ‘Domestic Homicide Review’ (DHR) into what happened
- In some circumstances, local authorities may decide to conduct a ‘Near Miss Review’ (NMR)
  - Into those cases that did not result in a homicide but are of particular concern, e.g. because of a life changing incident and/or extensive contact with local services
  - Not a statutory requirement
- In Brighton & Hove the Safe in the City Partnership is responsible for commissioning reviews.
Purpose

• Identify what lessons can be learned about the way in which local professionals and organisations work individually and together to safeguard victims
• Identify how these lessons will be acted on, and what is expected to change as a result
• Apply these lessons to service responses including changes to policies and procedures as appropriate
• Prevent domestic violence and abuse homicide and improve service responses through improved intra and inter-agency working.
National learning

- Home Office published ‘lessons learnt’ based on 54 DHRs which had been received between 13 April 2011 and 31 March 2013
- Key themes included:
  - Risk assessment
  - Information sharing & multi agency working
  - Complex needs
  - Perpetrators and bail
  - Awareness of safeguarding needs of children.
Local learning

- Brighton & Hove Partnership Community Safety Team has prepared a ‘Summary of Learning in Brighton & Hove 2012 & 2013’
- Based on three DHRs (Mrs A, Mrs B and Mr C) and one NMR (Ms D)
- Aim is to identify key learning for:
  - Professionals (in order to inform practice)
  - Policy makers and commissioners (to inform the shape of services locally)
- Supported by a single combined action plan, to ensure services are improved.
Mrs A
70-74
White British Female
Heterosexual
Retired
Married
Living together

Mrs B
20-24
White British Female
Heterosexual
Employed
Married
Separated

Mr C
60-64
White British Male
Gay
Not in employment
Significant relationship
Co-habiting

Ms D
40-44
White British Female
Heterosexual
Not in employment
Significant relationship
Periods of living together

Reviews

Safe in the city
Brighton & Hove Community Safety Partnership

Brighton & Hove City Council
Mrs A: Overview

- Unlawful killing of Mrs A by her husband in 2012
- No specific weaknesses or errors identified
- Limited information about Mrs and Mr A
  - There was an absence of information from Mrs A herself
  - Unable to rule in or out the presence of DVA
- Questions relating to contact with services, Mr A’s as a ‘carer’, interagency work, social isolation, vulnerability and capacity
- Identified the broader learning relating to older women.
Mrs A: Lessons Learnt

• Access to information about support services
• Challenge of working with individuals where help is not sought, particularly where there is no other information at the time that might have lead to a safeguarding referral or concern
• The importance of timely discharge notifications
• Better understanding of the issues for older women, including barriers to disclosure and service responses
• The importance of professional curiosity.
“In their contact, albeit limited, with a range of professionals, no one had any sense of Mr and Mrs A as real people. For example, no one was aware of their likes, history or interests or a broader context to their engagement with services”.
Mrs B: Overview

- Unlawful killing of Mrs B by her husband in 2013
- No specific weaknesses or errors identified
- Neither Mrs B or Mr B (the perpetrator) was well known to services
  - Engagement with statutory services was limited
  - No contact with any DVA services
- Mr B had sought psychological support in the past
- (Possible) prior abuse by Mr B.
Mrs B: Lessons Learnt

- Accurate record keeping, inc. response
- How information on psychological interventions is made available to members of the public
- Availability of clear, accessible information
- Clear referral pathways to ensure that help and support are available (in particular, from health)
- Importance of wider societal awareness and understanding of domestic abuse, inc. employers and support for family & friends.
“This illustrates the complexity of identifying relatively minor situations that may occur often, but have the possibility of becoming, or indicating, something more serious”.

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Mr C: Overview

• Unlawful killing of Mr C by Mr Y in 2012
• Assaulted at least over a period of months and probably years. He was physically, emotionally and financially abused.
• Mr C had a history of alcohol use and was isolated
• Many health professionals saw Mr C in the last year of his life did not pick up the signs of abuse or ask about it
• When Mr C did disclose, professionals did not respond pro-actively. This was a key practice episode: a different response may have changed the outcome.
Mr C: Lessons Learnt

- Mr C’s reluctance to talk about the abuse limited the opportunities to help.
- Being an older gay man may have made it difficult for
  - Mr C to seek
  - Professionals to identify domestic abuse.
- Professionals did their specific job, but without an understanding of their role in the coordinated response and of health to include safety.
- This included responding to disclosure, risk identification and subsequent information sharing.
“They [health professionals] responded with a narrow set of options or discounted what he said and did not take pro-active steps to help him. They addressed his immediate health needs but did not prioritise his safety”.
Ms D: Overview

- Complex and chaotic lifestyle
  - A range of needs including mental health problems, alcohol misuse and other health problems
- Agencies struggled to retain Ms D in services
  - Like many other victim/survivors of DVA, she would resort to a number of strategies to minimize the difficulties she was facing
- Agencies had an ‘event’ based approach
- Multi-Agency Risk Assessment Conferences (MARACs), did not construct sufficiently robust action plans.
Ms D: Lessons Learnt

• A range of lessons were identified, with these relating to the response to complex cases by a range of services locally, with regard to risk assessment, information sharing and case management.

• A key lesson was that services were:
  – Unconnected in many ways
  – No agency or professional took the initiative to step up and provide a central role in overseeing the care that Ms D needed.
“The process as a whole failed to achieve the broader understanding that would have been required to coordinate a response to someone with so many needs as Ms D”.
Key themes

• Awareness raising and communication
• Skilled workforce
• Consistent care pathways
• Assessing and responding to risk
• Information sharing
• Coordinated community response.
Further information

Go to [http://www.safeinthecity.info/domestic-homicide-reviews](http://www.safeinthecity.info/domestic-homicide-reviews) to access:

- A more detailed report ‘*Domestic Homicide Reviews and Near Miss Reviews: Summary of Learning in Brighton & Hove 2012 & 2013*’
- The individual, published review for each case.
Local services – women and LGBTQI people

RISE: Crisis and ongoing support for women and LGBTQI people: helpline; refuge; advocacy; counselling; housing; legal and financial help; support for children and young people
http://www.riseuk.org.uk/ or 01273 622 822

Survivors’ Network & Independent Sexual Violence Advisory service (ISVA): Help and support for survivors (women and men) of sexual violence, rape and childhood sexual abuse
www.survivorsnetwork.org.uk or 01273 203380
Local services – women and LGBTQI people

**Victim Support:** Emotional and practical help and support for heterosexual men

[www.victimsupport.org.uk](http://www.victimsupport.org.uk) or 0845 38 99 528

**Mankind:** Support for men who have been sexually abused

[www.mankindcounselling.org.uk](http://www.mankindcounselling.org.uk) or 01273 911680
Other local services

**Domestic Abuse Surgery:** A private, safe space to talk through concerns & find out more about the options available locally. Every Wednesday morning between 9am and 12 noon at the Customer Service Centre at Hove Town Hall.

**Sussex Police: Safeguarding Investigation Unit:** Ring 101 and ask to be put through to the unit. In an emergency ring 999.

**The Saturn Centre (SARC) – Crawley:** Services to women and men who have been raped or sexually assaulted.

[www.saturncentre.org](http://www.saturncentre.org) or 01293 600469 (9am-5pm).
National services

- **24hr National Domestic Violence Helpline**: 0808 2000 247
- **National Stalking Helpline**: 0808 802 0300
- **Men's Advice Line**: (male victims): 0808 801 0327
- **Respect Phone Line** (for anyone concerned about their violence and/or abuse towards a partner or ex-partner): 0808 802 4040
- **Broken Rainbow Domestic Violence Helpline** (LGBT victims 0300 999 5428
- **Further information on these services and other help and support is also available from the Safe in the City website at** [http://www.safeinthecity.info/getting-help](http://www.safeinthecity.info/getting-help).