Domestic Homicide Review (DHR)
Case Analysis

Report for Standing Together

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STANDING together
against domestic violence

LONDON METROPOLITAN UNIVERSITY

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The sisters, mothers, daughters, sons and brothers who have been murdered at the hands of their current/former partners or family members are at the heart of this report. It is in their memory that we feel compelled to learn as much as we can from their tragic experience. The responsibility of their deaths rests with those who killed them. But to do justice to the intent of Domestic Homicide Reviews (DHRs) we must share these findings as broadly as possible and learn from them.

I would like to thank Comic Relief for the ability to compile these findings related to the initial DHRs we have chaired at Standing Together Against Domestic Violence (STADV). It has been a tremendous opportunity to work with colleagues at the Child and Women Abuse Studies Unit at London Metropolitan University but to also draw from a wide range of expertise in the workshops we have conducted related to each of these chapters.

Thank you to the families who have participated in these reviews. It is often hard but much appreciated and I hope we have done justice to your views as we all strive to enhance your voice in the DHR process.

This report is our contribution to fully highlight the learning from Domestic Homicide Reviews as most of us recognise the need for national, regional and local work required to embed a true coordinated community response (CCR) to domestic abuse. In essence, much of what we have learned from the DHRs outlined in this report demonstrates what can happen in absence of a CCR. The Executive Summary represents STADV's distillation of key learning and those which we are actively addressing in our day to day operational work in West London.

Broadly, much of these findings fall into two categories. There are findings which could be characterised as implementation gaps. They are failures or missed opportunities where we understand the best practice but fail to implement it. In other areas such as mental health, adult child to family abuse, adult safeguarding practice and issues such as support for carers, more work is required to establish better, safer and more appropriate ways of working. And much of these findings are underpinned by a lack of fundamental understanding of coercive control, a lack of focus on the perpetrator and the need for more professional curiosity in thinking beyond basic policy and procedure.

Not only do we want to discuss more openly and broadly the learning from DHRs, we would like to improve the process of conducting and chairing DHRs which is why we have included the chapter which relates to improvements that we and others can make related to improvements in the process of DHRs.

We hope our collective work will help you to begin or enhance your work on the lessons we must learn from DHRs. We also want to point out the work of the Femicide Census and Counting Dead Women as well as the work of AVA and Alcohol Concern related to findings from DHRs and Change Resistant Drinkers.

STADV continue to build and develop an effective UK-wide CCR to address domestic abuse and we would love to hear from you about your area's good practice responses. Please actively use this report and share it widely with partners and colleagues.

Nicole Jacobs, CEO

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Executive Summary

Learning for practice

Compiled by: Miranda Pio and Gillian Dennehy

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The overarching approach

The Coordinated Community Response (CCR)

The Coordinated Community Response (CCR) is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

For an effective CCR to be in place the following components need to be embedded in all agencies' structures:

- A **common purpose** and approach to domestic abuse including a stated commitment to the CCR.
- **Definitions of domestic abuse and risk** are agreed and shared by agencies.
- Defined mechanisms are in place for the **coordination, governance and monitoring** of the CCR to ensure **accountability** and to enable a flexible and evolving approach.
- An **action plan** is in place.
- Written **policies and procedures** are in place within every **organisation** covering their response to domestic abuse. Regular compulsory **training** at every level of the organisation supports these.
- Written **policies and procedures** are agreed covering **multi-agency** systems and working (including the MARAC and SDVC). Regular compulsory **training** supports these.
- An agreed **dataset** is in place and monitored on a regular basis.
- Agencies responses are informed by survivors. **Survivors' voices** (and the views of their advocates) are regularly sought, listened to and responded to.
- Adequately resourced **specialist services** are in place to respond to adults, children and young people: survivors and perpetrators.

Interpersonal Violence (IPV) & Adult Family Violence (AFV)

The government definition of domestic violence and abuse conflates violence committed by intimate partners with that by family members.

While both forms of violence are gendered, there are clear differences in the dynamics and motivations underpinning Intimate Partner Violence (IPV) and Adult Family Violence (AFV). The analysis and recommendations are therefore split into two separate sections.

It should also be noted that there is a significant dearth in research around AFV as opposed to a more established body of evidence around best practice in the context of IPV. These differences are reflected in the recommendations for practice.

Inter-Personal Violence (IPV)

Risk

Key Findings:

- Steps to identify risk were undertaken by police in only a third of the IPH cases. (8/24)
- A lack of understanding around the risks of non-physical coercive controlling behaviours has meant that some domestic abuse cases that were assessed as medium/standard risk remained below the radar of services and threshold for intervention.
- The report shows inconsistencies in professionals' use of the Safe Lives RIC risk assessment tool. Practitioners across different services can be seen to 'weight' different parts of the risk assessment differently and this impacts problematically on their professional judgement of the risk posed to the victim.
- Where it was noted in the review reports, DASH was used to identify risk on 12 occasions, SPECSS on three occasions and Form 124D on two. All were assessed as standard risk apart from two cases where medium risk was graded.
- Risk identification, assessment and management is often one-sided and is almost exclusively used with survivors/victims. The presence of some of the risk factors, or their frequency/severity, may only be known by talking to a perpetrator directly.

Recommendations for Practice:

Training, Risk Identification and Assessment

- There is an important distinction to be made between risk identification and risk assessment. While risk identification involves knowledge and use of the checklist and identification of risk factors, risk assessment requires more in-depth knowledge and is an on-going, sustained process. All front line staff who are likely to come into contact with victim/perpetrator should be trained in carrying out risk identification. Specific members of staff with additional skills/knowledge/training should then conduct a more detailed risk assessment.
- Professionals should keep in mind that the victim's perception of danger is crucial in assessing potential lethality.
- When assessing risk, practitioners need to move away from stereotypical understandings of domestic abuse as isolated incidents of physical violence. Awareness of the inherent high-risk posed by coercive controlling behaviours that are not physical or sexual - such as harassment and jealous surveillance - is paramount.
- It is essential that risk factors are recorded accurately for future assessments.
- It is imperative that risk is seen as dynamic, fluid and is regularly reassessed at 'critical points' within each case.

- Agencies should always refer to the MARAC based on professional judgement when information is limited and the victim/survivor is perceived to be minimising the risks/is unable or too fearful to disclose the full extent of the abuse.
- In the process of risk assessing, increased emphasis should be placed on the perpetrator who poses the risk to the victim survivor but also to any other partners, children and vulnerable family members.
- There is a need for risk assessment with perpetrators to be built into practice.
- Professionals should bear in mind that often friends and family or 'informal networks' hold vital information around the level of risk.
- All professionals should be aware of their MARAC lead and how to refer to the MARAC.
- Expand referral pathways to specialist services so that low and medium risk cases are supported and escalation of risk prevented.
- All agencies have a responsibility to follow up referrals to MARAC and proactively work together outside of MARAC meetings. MARAC is not an intervention in and of itself. Actions need to be taken to increase safety and hold perpetrators to account.
- Professionals need to be aware and trained on how to respond appropriately to the risks posed and potential impact of IPV on children and any vulnerable adults within the household.

Informal Networks

Key Findings

- Evidence shows that victims of IPV are more likely to contact friends or a family member for help and support before a formal agency.
- Professionals should bear in mind that often friends, colleagues and family ('informal networks') hold vital information around the level of risk to victims of IPV.
- Prevention initiatives should consider the involvement of wider community members, such as religious institutions, and the development of peer networks, creating 'circles of support' within the wider community.

Recommendations for Practice

Public Awareness

- Better public awareness around the dynamics of domestic abuse, coercive control and specialist support services. Campaigns should challenge victim blaming attitudes and widely held views around domestic abuse being purely physical, caused by alcohol and substance misuse or mental health.
- Public awareness campaigns should be tailored to specific minority communities who may face multiple barriers when accessing services and support.
- Campaigns should raise awareness about the importance of third-party reporting.

GP Practices

Key findings:

- As the only stakeholder group that consistently and actively engages with both victims and perpetrators, GP surgery staff have a crucial role in preventing homicides.
- GPs are well placed to identify both victims and perpetrators through connected health needs including amongst other things injury, depression and substance misuse.
- Just over half (13/24) of the interpersonal homicide (IPH) reports note that the GP missed opportunities to ask the victim about IPV. Most frequently was observed a lack of professional curiosity about relationships with partners/children's fathers.
- In a quarter (6/24) of the DHR reports missed opportunities for GPs to enquire about IPV with perpetrators are noted.
- The information held by GPs is often invaluable, it helps 'fill the gaps', especially when a victim and/or perpetrator has not had contact with any other statutory body.

Recommendations for Practice:

Training

- GPs should have a 'whole surgery' approach to training, where both clinicians and administrative staff are provided with integrated training and referral pathways for domestic abuse, responding to both survivors and perpetrators through a whole family approach.
- The training should take an intersectional approach, it should include information on the dynamics of domestic abuse, how to appropriately identify, support and risk assess survivors and perpetrators.

Enquiry about DVA

- In accordance with RCGP, IRIS, CAADA (Safe Lives) and NICE guidance, GPs should ask about abuse where a patient has presented with repeated 'accidental' injuries, a history of psychiatric illness, alcohol or drug dependence, and a history of depression, anxiety, failure to cope and social withdrawal.
- In heterosexual relationships perpetrators of IPV often exert control over a woman's reproduction; GPs should be alert to indicators such as urinary tract infections, unprotected sex, lesion of nipple, STIs, pregnancy and requests for a termination.
- GPs should consider potential indicators for perpetrators of domestic abuse who may present as aggressive, controlling, involved in multiple violent altercations and with substance misuse and mental health issues.

DA Policy

- For training to be effective it needs to be complemented with a surgery-wide domestic abuse policy which responds to the needs of staff as well as patients experiencing domestic abuse and has clear and established referral pathways.
- This policy should be separate from the safeguarding policy within the surgery.

- Information about local specialist services should be displayed in surgeries and waiting rooms raising awareness of services and creating an environment where disclosure can be made.

Record keeping

- Consistent and comprehensive record keeping are crucial in ensuring appropriate continuity of care and an integrated response.
- Confidentiality needs to be a key consideration especially when the GP is in contact with both victim and perpetrator and other family members.
- When both survivor and perpetrator are registered at the surgery, this should be recorded and linked. Potential differences in surnames need to be kept in mind and checked.
- GPs records could be aligned with those of any children – this would enable a 'family approach' where GPs can act as a more effective conduit for a system of coordinated family support.
- Importance of following up referrals.
- Importance of transferring records between GP surgeries when a patient moves.
- Links between health services are crucial in ensuring a holistic overview of patterns in appointments, walk-ins and emergency attendances rather than them being viewed in isolation.
- GPs and Mental Health services need to be better 'carer aware', develop joint strategies to carers in line with the Care Act.

Mental Health Services

Key Findings:

- Mental Health was recorded as the second most common health-related theme in the DHR reports (15/24).
- Mental health problems may increase vulnerability to IPV or develop as a consequence of it. Nearly two thirds (15/24) of IPH victims had support needs related to their mental health.
- The same number of IPH perpetrators also had a history of mental health problems.
- Depression was the most common mental health issue for both victim and perpetrator.
- A direct causal relationship should not be assumed for the perpetrators' mental health problems and IPH. It is however important to note that mental health services will likely come into contact with both victims and perpetrators.
- When responding to complex needs, agencies tend to focus on addressing mental health and substance misuse while missing the opportunity to identify and risk assess for domestic abuse, potentially the underlying drive for both issues.
- Alcohol and mental health have emerged as areas of concern for both victim and perpetrator – this cluster of issues should be recognised as an alert for domestic abuse.

Recommendations for Practice:

Training

- All staff should receive training on identifying; risk assessing and safely responding to domestic abuse.
- All staff should be expected to enquire about DVA.
- Training should take an intersectional approach and explore the multiple barriers faced by particular groups.
- Some consideration should be given to including the screening of perpetrators within mental health services and establish referral pathways with Respect accredited perpetrator programmes.

DA Policy

- For training to be effective it needs to be complemented with a trust-wide domestic abuse policy, which responds to the needs of patients as well as staff experiencing domestic abuse and has clear and established referral pathways.

Joint assessment

- Mental Health and Addictions Services should develop guidance on dual diagnosis and referrals. Programmes that tackle both mental health and addictions are better able to reach and retain patients in services.

Integrated working

- Importance of transition in care – mental health staff need to ensure appropriate handover of perpetrator/victim mental health plan back to his/her GP.
- All visits to A&E should be recorded on the patient's electronic mental health record regardless of whether the patient self-discharges or in cases where the mental health team refuses to see the patient.
- GPs and Mental Health Trusts need to be better 'carer aware', develop joint strategies to carers in line with the Care Act. This involves arranging assessments for carers which address their own mental health needs and ensure that they are not placing themselves/and or the cared for person at risk.
- Domestic abuse should automatically trigger a discussion with the internal safeguarding lead to consider appropriate course of action.
- Ensure appropriate referral (with victim/survivor consent) to specialist domestic abuse services when thresholds for statutory intervention are not met.

Health Services

Recommendations for Practice:

Integrated working and information sharing

- Better coordination across health services would help pick up patterns in attendances. Health professionals need to ensure a more joined-up approach which integrates a holistic overview of patterns in appointments, walk-ins and emergency attendances rather than them being viewed in isolation.
- All referrals to other agencies should be appropriately followed up.
- Better joined up working between schools, social care and community health.
- Establish links with Respect accredited perpetrator programmes.
- Information about local specialist services should be displayed in waiting rooms raising awareness of services and creating an environment where disclosures can be made.
- Introduce an automatic referral (with victim/survivor consent) to specialist domestic abuse services when thresholds for statutory intervention are not met.

Adult Safeguarding

Key Findings:

- IPV is not always recognised as an issue for older people. Assumptions about age mean that when older people present as injured or depressed their condition is presumed to be the result of health or social care needs.
- Over a quarter (7/24) of IPH victims were aged 58 and above.
- The potential for IPV in a caring relationship tends to be greater when the carer is a partner or close relative and where the carer is trying to support a relative with problematic use of substances.
- A quarter (6/24) of the IPH cases involved an ex/current partner who was also the carer of the partner. In more than half of these cases the victim was disabled.
- Disabled survivors face complex and additional barriers when accessing support, especially when their abuser is their carer.
- Caring situations should be considered carefully in relation to the pressures that carers face but also how such contexts may facilitate abuse.
- Universal services must recognise their responsibility to proactively enquire about patient's general well-being and take action to safeguard them from harm.

Recommendations for Practice:

Training

- Adult social services should receive training on the dynamics of domestic abuse, identification and risk assessment. Training should take an intersectional approach and explore the multiple barriers and increased risk faced by particular groups.
- A particular focus on older people's experiences and specific needs should be covered as part of the training. There is a need to challenge institutional ageism.
- All services need to be alerted to the increased risk for abuse in a caring relationship when the carer is a partner.
- All services should be alerted of the increased risk of domestic abuse for disabled women.

Integrated working

- Adult social services should strengthen links with other agencies such as health, mental health, specialist domestic abuse services.
- Break down boundaries and promote collaborative working across adult and children's services. Where there are concerns that an adult is experiencing DVA then there should be concurrent exploration of whether there are any child safeguarding concerns and vice versa.
- Consideration should be given to making a referral to the local early intervention team for individuals who do not meet the threshold for safeguarding.
- Strengthen links with Respect accredited perpetrator programmes.
- Ensure referrals are made (with victim/survivor consent) to specialist domestic abuse services when thresholds for statutory intervention are not met.

Children Social Care

Key Findings:

- Child safeguarding issues emerged in over a third (9/24) of IPH cases.
- A range of professionals came into contact with the children and their mothers including health, education and police. Yet, consideration of the risks facing children was not always automatic in IPV cases.
- Women experiencing abuse are often held accountable for safeguarding their children, while perpetrators remain invisible and are not challenged for their behaviour.
- Several reports highlight how the low threshold at which information is shared by the police is in contrast to the high threshold at which Children's Services will conduct a statutory safeguarding assessment. This means that many women and children are left unsupported.
- Perpetrators of domestic abuse will often use statutory services to make false allegations about victims or will make counter allegations to dismiss the victim's account of the facts. This has resulted in victims being arrested and their children being removed.

Recommendations for Practice:

Training

- Children social care should all receive training on the dynamics of domestic abuse; how to identify, assess risk and respond safely. Training should take an intersectional approach.
- Added emphasis should be given to the complexities of leaving an abusive relationship and the importance of holding perpetrators to account for the abuse at all times.
- Agencies' tendency to hold mothers living with domestic abuse responsible for safeguarding children needs to be challenged. Language and practice need to move away from victim-blaming approaches. Professionals need to recognise the potential they have to enable victims to expand their 'space for action' by recognising how coercive control limits their freedom.
- Children social care need to be aware of the specific risks to children living with domestic abuse and that in most cases the best way to keep a child safe is to increase the non-abusive parent's safety.
- Staff should also be alerted to the risk of perpetrators making false allegations.

Integrated working

- Break down boundaries and promote collaborative working across adult and children's services. Where there are concerns that an adult is experiencing domestic abuse then there should be concurrent exploration of whether there are any child safeguarding concerns and vice versa.
- Joined up working between schools, social care and community health.
- Ensure links with Respect accredited perpetrator programmes are established. Establish a culture where perpetrators are held to account and expected to engage with such programmes.

Schools

Key Findings

- Some of the cases of IPH have shown that lack of information sharing and joined up working between school, community health services and social care have led to missed opportunities to offer support to the mother and child. It may have also contributed to survivors' general lack of confidence in the system.
- Schools have been identified as important settings to raise awareness of domestic abuse and specialist services.

Recommendations for Practice:

Training

- All designated teachers for safeguarding should receive training on how to identify, risk assess and safely respond to domestic abuse, with a specific focus on the impact on children and young people.

- Added emphasis should be given to the complexities of leaving an abusive relationship and the importance of holding perpetrators to account for the abuse at all times.
- Strong links should be established with specialist agencies.
- Staff should be alerted to the risk of perpetrators making false allegations.

Integrated working

- Joined up working between schools, social care and community health.

Adult Family Violence

Key Findings:

- Research shows that AFV is gendered. When parents are killed, it is typically by their sons. In this review all perpetrators were also male and the highest number of cases involved sons killing their mothers.
- The dynamics underpinning IPV and AFV are however different and more research is needed in the area of risk identification, assessment and management in cases of AFV.
- There is a gap in research on effective risk identification and assessment tools in the context of adult family violence. Although the DASH RIC tool is often used with AFV cases, this was developed from IPV research and some risk factors are not relevant to AFV (such as coercive controlling behaviours and abuse over child contact).
- Caring responsibilities emerges as a theme in both IPV and AFV. However, while the victims of IPV were mostly being cared for, with AFV the victim was a carer.
- Mental health issues are a common feature of the majority of the perpetrators of AFV, including depression, self-harm, psychosis and paranoid schizophrenia.
- The most frequent risk factors for perpetrators of AFV, to emerge from this analysis, are mental health issues, alcohol or substance misuse and previous criminality. Several review reports have also noted that perpetrators of AFV displayed patterns of threatening behaviour towards women and had also committed some other form of violence against women.
- Three quarters (6/8) of the AFH reviews were unable to draw on information from informal networks. This is probably a reflection of the fact that perpetrators of such homicides are frequently kin relatives to both parties, making family involvement difficult.

Recommendations for Practice:

Training and Information Sharing

- Improved awareness and training around risk identification, management and access to support for AFV with a particular emphasis on access to mental health services.
- Improved information sharing between health professionals, GPs, hospitals and substance misuse services in order to promote co-working pathways and holistic responses to AFV.

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June 2016

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Introduction

Crime statistics for England and Wales (Flatley, 2016) show that 332 women and 78 men were killed by their partners/ex-partners between March 2012 and March 2015 – the time period within which the domestic violence homicides analysed in this report took place. In the same time period, 35 women and 46 men were killed by a son/daughter or other family member[1] (see appendix one for details).

Since the implementation of Section 9 of the Domestic Violence, Crime and Victims Act (2004) in 2011, Domestic Homicide Reviews (DHRs) have been a statutory requirement. Local areas are expected to undertake a multi-agency review after a domestic homicide to identify lessons learned and help prevent future incidents. In order to ensure that DHRs effectively draw out relevant learning, the Home Office has established a Quality Assurance process. A Panel of experts from across the statutory and voluntary sectors reviews each report and provides feedback to local areas. Since April 2011, over 300 reviews have been examined by the Quality Assurance Panel.

There has been increasing interest in understanding the national picture on domestic homicide from the information contained within these individual reviews. In November 2013, the Home Office published a *Lessons Learned* (Home Office, 2013) document drawing out common themes from the first 54 cases reviewed by the Panel. However, many partners expressed the view that, although useful, the themes presented within the Home Office document provided limited insights (HMIC, 2014). Neville and Sanders-McDonagh, (2014: 56) describe the document as an 'inadequate response to the complex findings that have emerged from DHR reports across the country'.[2]

In recognition of this, the charity Standing Together Against Domestic Violence (STADV) commissioned the Child and Woman Abuse Studies Unit (CWASU) at London Metropolitan University to undertake an analysis of 32 Domestic Homicide Reviews (DHRs) chaired by its associates (see appendix two for details of the STADV DHR Process). The aim of the analysis was to identify and explore in more depth the themes emerging from the STADV sample, thereby contributing learning to the national picture.

Since a good quality DHR will identify gaps and inconsistencies as well as make recommendations for change, the process represents a potential contribution to developing coordinated community responses to domestic violence (Regan et al., 2007; Westmarland, 2015).

Methodology

Each DHR case has a specific set of circumstances (Neville & Sanders-McDonagh, 2014). However, the purpose of this analysis was to identify common themes and learning across the sample. Thirty-two DHR reports from across England were assigned numbers from 1-32 and anonymised[3]. They were then qualitatively analysed using Nvivo 10 (data analysis software). The following six issues were the most frequently coded themes.

- Victim/perpetrator contact with General Practitioners (GPs)
- Mental health

1 Excluding parents

2 The Ending Violence against Women and Girls Strategy 2016-2020 published in March 2016 states that: We will continue to promote learning from these reviews and update statutory guidance on DHRs in 2017 so that best practice is embedded and further learning is shared (HM Government, 2016: 37).

3 The project methodology was approved by London Metropolitan University's Ethics Committee.

- Safeguarding adults
- Safeguarding children
- The role of informal networks in the DHR process and what informal networks knew
- Risk assessment

Discussion papers

For each theme, a discussion paper was written, drawing on the information contained with the DHR reports. Although the government definition of domestic violence conflates violence committed by intimate partners with that by family members, the dynamics underpinning both forms of violence are not the same (Kelly & Westmarland, 2014) and have different motivations (Monckton-Smith et al., 2014). In order to identify and explore the similarities and differences between the different types of homicide, the sample was therefore split into two for analysis: Intimate Partner Homicide (IPH) and Adult Family Homicide (AFH) with findings presented separately.

Interpretation of the IPH findings draws on the existing research literature. However, there is very limited research in the area of AFH (Heide & Frei, 2009; Condry & Miles, 2014; Hunter & Nixon, 2012) leading Westmarland (2015) to observe that:

> A disservice is being done by subsuming… parent abuse under the heading of domestic violence in definition and policy. This has almost certainly contributed to its invisibility and the relative lack of research attention and therefore theoretical development (Westmarland, 2015: 58).

The decision to present the findings of the AFH cases separately is intended to address this gap.

The learning from the STADV DHR reports is also considered in relation to the findings of other homicide overview reports; both at national and regional levels (see Table 1 for these sources). Since the themes identified in these reports also fail to differentiate between IPHs or AFHs it is assumed that they arise from IPHs unless the report reviews state otherwise. This assumption is made on the basis that IPHs make up the majority of DHRs (Oram et al. 2013).

Table 1: DHR report reviews

National	Regional
54 cases across England (Home Office , 2013)	13 cases in the West Midlands (Neville & Sanders-McDonagh 2014)
27 cases across England (Neville & Sanders-McDonagh, 2014)	
67 cases across 17 areas (Home Office, undated)	

Workshops

A series of six workshops was organised to discuss each of the discussion papers (see appendix three for list of participants). Experts were invited to attend from across the violence against women and girls sector as well as from the specialist fields that were being explored e.g. mental health. The draft papers were shared with participants ahead of the workshop to maximise discussion time. Nearly 140 experts took part, with some attending more than one. In small groups, participants were asked to feedback:

- Their reactions to, and view of, the discussion paper;

- Good practice principles to improve responses to IPV/AFV;
- How analysis of the themes might be further developed;
- Levers for change; and
- Useful resources on domestic violence for professionals.

Limitations

The discussion papers drew on information contained within the DHR reports. It should be noted that these varied in length and level of detail. In addition, although some of the DHR reports had been finalised and published, others were still underway. The data presented here therefore is not exhaustive although efforts have been made to refer to other sources[4] to 'fill in' the gaps wherever possible. Since some of the data presented in this report was uncovered after the workshops took place, the findings may vary somewhat from the discussion papers. It should also be noted that during the course of the research, one case was removed from the analysis so another case was introduced in its place.

Report structure

As noted above, the government definition of domestic violence conflates violence committed by intimate partners with that by family members and assumes that the dynamics underpinning both forms of violence are the same (Kelly & Westmarland, 2014). In line with the discussion papers, the report is split into two sections:

1. Intimate Partner Homicide (IPH); and
2. Adult Family Homicide (AFH).

Since there was a clear distinction between homicides that took place in the context of Intimate Partner Violence (IPV) and homicides that took place in the context of Adult Family Violence (AFV) within this sample, categorisation was straightforward. However, as noted by one workshop participant, some domestic homicides may be preceded by both IPV and AFV and involve multiple perpetrators – for example a killing that takes place in the context of so-called 'honour'. We acknowledge this but none of the cases in this sample fitted this category.

Sections one and two present an overview of the cases that fell into the respective category according to the gender, age, ethnicity, immigration status and disability of victims and perpetrators. Given the small sample size it has not been possible to draw any conclusions in relation to these, although the Panels considered the intersectional location of each victim within the review process when exploring protected characteristics. This is followed by presentation of the findings that formed the basis of the six discussion papers. Given the proportion of IPH (n=24) compared to the AFH cases (n=8) and the dearth of knowledge related to AFH, the second section is correspondingly shorter.

Section three draws out the similarities and differences between the IPH and AFH cases. Section four then presents the feedback from the workshops. The final section then pulls together learning from the workshops and the learning gained from undertaking the research to highlight issues related to the DHR process. These will be useful for the Home Office to consider when it updates national guidance.

4 i.e. Individual Management Reviews (IMRs)

Section one: Intimate Partner Homicide (IPH)

Overview of victim demographics

Intimate partner homicide made up three-quarters (n=24) of the 32 DHR cases. Within these, 22 of the victims were women and two were men. That 92 per cent of the victims were women is consistent with research which shows that IPH disproportionately affects women (ONS, 2014). Seventeen (71%) of the victims had children.

The youngest victim was twenty and the oldest eighty-one. One study (Moracco et al., 2003) suggests that women under the age of thirty-five are particularly vulnerable to IPH whilst other studies report no association (Campbell et al. 2003; Dobash et al., 2007). In this sample, half (n=12) of victims were thirty-five and under, although the mean age was forty-one.[5] Table 2 shows that just over three-quarters of victims were under forty-three years of age (n=17; 70%) with the remaining thirty per cent (n=7) over fifty-eight.

Table 2: Age of victim in IPH cases

Age of victim	Number of victims
20-29	8
30-39	6
40-49	3
50-59	1
60-69	4
70-79	1
80-89	1

Three quarters of the victims had British citizenship (n=18, 75%). The majority were White (n=14), followed by Black Caribbean (n=2, 8%) and Asian (n=2, 8%). Six were non-British nationals: four were Black African (17%); and two were Eastern European (8%). A third (n=8) were black women. National level data on the ethnicity of domestic homicide victims is not available, making it impossible to situate these findings within wider demographics. This information is important since, as the report will illustrate, one of the victims within the STADV sample was in the UK on a spousal visa and this negatively impacted upon her ability to seek help.[6]

Similarly age, sexual orientation and ability emerged as important factors. All of the victims were heterosexual (n=23, 96%) apart from one male victim who was gay. The DHR report in this case concludes that his gender, sexuality orientation and age contributed to masking the abuse he was experiencing. In addition five of the victims had a disability.

5 The average age of partner/ex-partner homicides for victims aged 16 and over (combined data for 2010/11 to 2012/13) is 41 for women and 44 for men

6 Language barriers were not identified within any of the DHR reports

Overview of perpetrator demographics

Twenty-three of the perpetrators were men and one perpetrator was a woman. The youngest perpetrator was nineteen and the oldest was eighty. Half were twenty to thirty-nine. The mean age was forty-three.

Table 3: Age of perpetrator in IPH cases

Age of perpetrator	Number of perpetrators
16-19	1
20-29	4
30-39	8
40-49	3
50-59	2
60-69	4
70-79	1
80-89	1

Just over half (n=13, 54%) of the perpetrators were British citizens: eight of whom were White British and five Black British/Black British Caribbean. Eleven were not British nationals (46%): four were Black African (17%); four were Asian (17%); and three were Eastern European (13%). Again national level data on the ethnicity of domestic homicide perpetrators is not available to see how this compares but a higher proportion of perpetrators than victims were black and minority ethnic (BME). Where immigration status was known, two of the perpetrators were in the UK on a spousal visa; one was believed to be in the country illegally and another was on a student visa.

All but one of the perpetrators were believed to be heterosexual. The sexual orientation of the perpetrator who killed the gay man is unclear. The victim believed they were in an intimate partnership; the perpetrator claimed at times to be his partner, at others his carer and was also believed to have been married to a woman. One of the perpetrators was disabled.

Relationship of perpetrator to victim

In half of the cases (50%) the perpetrator was the victim's husband (n=6) or partner (n=6). In ten cases (42%), the perpetrator was the ex-partner of the victim. In one case (4%) it was unclear whether the couple were together or had separated and in the final case (4%) the couple were friends but had, on one occasion, been sexually intimate.

Location and method of murder

Three-quarters (n=18) of the victims were murdered in their own home. Five women were killed at another residential address and one woman was murdered outside her place of work. Over half (n=14, 59%) were stabbed to death. This reflects data on all homicides from the Office of National Statistics (ONS, 2014) which shows that the most common method of killing is by knife or other sharp instrument. For female homicide victims the second most common method of death is strangulation or asphyxiation, and the third is head injury from a blunt instrument. The cases in this sample follow this national trend. Four women (17%) were strangled and one of the men was asphyxiated (4%). Two women died from a head injury (8%) and the other man was beaten to death (4%). One woman died from blunt trauma (4%) and another died from carbon monoxide poisoning (4%).

GP contact

GPs are well placed to identify victims of domestic violence through connected health needs including, for example, injury, depression and substance misuse. Research has also suggested that perpetrators often have contact with their GPs meaning that effective engagement with this group is vital in ensuring that they are held accountable for their behaviour and directed towards effective interventions (Hester et. al., 2006).

GP contact with both victim and perpetrator

In their analysis of 13 DHR cases in the West Midlands, Neville and Sanders-McDonagh (2014: 34) found that General Practitioners (GP) were the only stakeholder group that both victims and perpetrators were 'consistently and actively engaged with'. This was also the case in relation to the STADV sample. Several of the DHR reports note that the information supplied by GPs was invaluable because it helped to 'fill in the gaps', especially when a victim and/or perpetrator had not had contact with any other statutory body.

> The only recorded contact for [the victim] with any statutory bodies comes from her time as a patient with her NHS General Practice (DHR8).

This section therefore explores victim and perpetrator contact with their GPs.

Victim contact with GP

Information was shared by GPs for every IPH victim (n=24). Fourteen reports made reference to how regular the victim's contact with their GP was prior to their death. Six recorded the number of contacts the victim had in the review period, ranging from eight to fifty-two. The descriptors in the other eight reports included: a number of times (n=1); regular (n=1); routine (n=1); rarely/minimal (n=3); and irregularly (n=2). Nine victims are known to have had contact with their GP in the three months preceding their murder: in four the last contact took place in the same month and in one case on the same day.

Enquiry about IPV

Guidance produced by the Royal College of General Practitioners, IRIS[7] and CAADA[8] includes a list of 'health markers' that should prompt an enquiry about IPV. GPs are urged to ask about abuse where a review of the medical record reveals that a patient has: presented with repeated 'accidental' injuries; a history of psychiatric illness; alcohol or drug dependence; and a history of depression, anxiety, failure to cope and social withdrawal.

The most common presenting problem mentioned in the DHRs was depression (n=8) followed by physical injury/falls (n=7). Other issues included: alcohol misuse (n=2); anxiety (n=2); headache (n=2); panic attacks (n=2); sleeping difficulties (n=2); feeling suicidal (n=2); inability to cope with children (n=1); hair-loss through stress (n=1); self-harm (n=1); and weight loss (n=1).

Five of the victims also had long term health conditions and in three of these cases were being cared for by the perpetrator. Overlap between IPV and caring responsibilities is explored in more detail in the safeguarding adult section.

7 Identification and Referral to Improve Safety

8 Coordinated Action Against Domestic Abuse (now Safe Lives)

Missed opportunities for enquiry

Just over half (n=13) of the IPH reports note that the GP missed opportunities to ask the victim about IPV. Most frequently observed was a lack of professional curiosity about relationships with partners/children's fathers, with reports suggesting that exploration of the circumstances of the victim's life could have led to discussions about IPV.

Suggested 'links in' to enquiry that could have been 'opportune, relevant and possibly beneficial' are identified within some DHR reports as including routine contacts such as: registration as a new patient; a smear test; or when a woman approaches her GP to talk about conceiving a child.

> The routine appointments… can offer an opportunity to ask questions to assess the home environment (DHR19).

Of course, reports also note that enquiry should have been made in circumstances where attendance at the GP surgery gave cause for concern. Falls and injuries were noted here.

> The combination of his alcohol use, depression, and 5 falls in 3 months might have prompted a question about abuse, or at least about his living situation and any help he might have had at home (DHR3).

> On occasions these interactions were opportunities that were missed. An obvious example is her visit to the GP [when] she reported having 'an accident or fight' and had been punched but also had tenderness in her lower abdomen (DHR17).

> [The victim] attended the GP with what is described as a trauma like injury to her ear, although she denied knocking or pulling it. It is not recorded if any further enquiry was made (DHR29).

Given that research demonstrates how perpetrators of IPV may exert control over women's reproduction (Chamberlain & Levenson, 2012) missed opportunities were also identified in relation to conversations about sexual and reproductive health. Examples here included: urinary tract infections; unprotected sex; lesion of nipple; testing for sexually transmitted infections; pregnancy; miscarriage; and requests for a termination.

> The request by [the victim] for a termination of pregnancy was another lost opportunity for discussion of domestic issues…. the issue of intimate relationships and domestic abuse needs to be become routine within general practice and in particular when STI and unwanted pregnancy are discussed (DHR26).

> [The victim] attended several routine cervical screening appointments, appointments for contraception, queries about possible pregnancy and tests for sexually transmitted infections… these appointments provide an ideal opportunity to ask female patients (when they are usually attending on their own) further questions about their relationship and any problems they may have (DHR29).

Other potential warning signs of domestic violence suggested included: missed appointments; compliance with medication; and homelessness.

Disclosure of IPV

In only two of the cases were GPs aware of IPV. In DHR5 the victim disclosed that she had been shouted at and hit by her husband. She presented to her GP with a fractured rib but reportedly said that she did not want the police to be involved, preferring to divorce her husband. The report notes that, because the victim had capacity, the GP respected her wishes and offered unspecified advice. Whilst the report acknowledges that the GP would have wanted to protect his relationship with the victim and not jeopardise this by sharing information about the incident without the woman's consent, it states that the injury with which the victim

presented was significant and could have constituted an offence of Actual or even Grievous Bodily Harm warranting a referral based on professional judgement to a Multi-Agency Risk Assessment Conference (MARAC). In the second case the victim disclosed to her GP that her ex-partner had been arrested and charged for ABH (DHR23).

In a third case, IPV was suspected by the GP surgery staff but the victim was never asked whether she was experiencing abuse, even though an adult safeguarding referral was considered. In another case the GP was aware of the victim having experienced IPV in a previous relationship.

Perpetrator contact with GP

Research has suggested that perpetrators often have contact with their GPs offering opportunities for effective engagement (Hester et. al., 2006). Information was provided by GPs for all of the perpetrators except for one whose records could not be located. In four cases nothing of significance was found within the records. Fifteen of the DHR reports made reference to how regular the perpetrator's contact with their GP was. Four reports recorded the number of contacts in the review period, ranging from fifteen to twenty-seven. The other eleven reports described the contact as: regular/routine (n=5); numerous (n=1); frequent (n=1); complex (n=1); intensive (n=1); limited (n=1); and infrequent (n=1). Ten of the perpetrators are known to have had contact with their GP in the three months preceding the homicide: in three the last contact took place in the same month.

Presenting issues included: mental health (n=7); depression (n=6); problematic substance use (n=5); stress (n=4); difficulty sleeping (n=3); anxiety (n=2); injury following fight (n=2); sexual health (n=2); and self-harm (n=1). Two of the perpetrators were removed from the GP list due to their behaviour.

Missed opportunities for enquiry with perpetrators

Six DHR reports note missed opportunities for GPs to enquire about IPV with perpetrators. In DHR6, for instance, the man presented with injuries following three violent altercations. One of these was the result of a fight with a driver and another followed him assaulting a policeman. However the reason for the third (fractured hand) was not recorded.

In DHR7 the perpetrator disclosed that he had 'urges to kill someone from his previous job. He felt angry and felt like 'destroying things'. No enquiry was made about his family circumstances. Similarly, correspondence from the hospital to the GP in DHR18 stated that the perpetrator 'had consumed 6 cans of lager and phoned police to say he needed help or would kill himself or his girlfriend'. Yet no actions to identify and/or assess risk were initiated by the police, hospital or GP. Nor was an attempt made to identify his girlfriend.

As noted in the section on victims above, the GP surgery staff in DHR13 suspected that the perpetrator might be abusive but no enquiry was made of either party despite, on one occasion, the perpetrator ringing the surgery and 'requesting a home visit for an injection to put [the victim] to sleep.' In DHR23 the perpetrator presented with a painful shoulder which was a consequence of him having tried 'to throw a bottle'. The DHR report notes that there was no follow up about why he had done this.

The GP records in DHR29 state that the perpetrator was 'impulsive, controlling and [had] anger issues'. Yet these were not considered as risk factors in his relationship with the victim. Psychiatric records indicate that he was depressed following the breakdown of a long term relationship and he disclosed thinking 'If I can't have her then no one can'. In addition, this man was noted to be aggressive in the GP surgery on two occasions. The report notes that:

> These incidents do not appear to have been explored or considered as risk factors which was, again, an opportunity to identify and assess risk posed by [the perpetrator] that may have been missed (DHR29).

Finally DHR20 suggests that the perpetrator, in this case also a carer, had a history of depression but that there was no note of any formal review of this. Such a review could have led to her being 'screened about her living situation, domestic violence and stress'.

Disclosure of domestic violence by perpetrators

Two of the GPs were aware that their patients were perpetrating domestic violence (DHR5 & DHR15). The man in one of these cases was the partner of one of the women known to be a victim of domestic violence (DHR5, see above). In addition to the assault she disclosed, he spoke to the GP about being paranoid that his wife was unfaithful. In light of the fact that he further disclosed twisting his wife's arm 'in an angry manner' to a mental health professional, the DHR report notes that these disclosures could potentially have been an attempt by the perpetrator to seek help for his behaviour. It is posited within the report that because he was a carer for his wife, he may have been struggling to cope. A carer's assessment was, however, never conducted, despite the fact that caring responsibilities were raised by both parties throughout their contact with their GP.

The perpetrator in DHR15 disclosed that he had separated from his partner after seeking treatment for injuries that he alleged were inflicted by the police when they arrested him for a 'a domestic incident'. Yet, despite disclosing this, he maintained to his GP that 'his relationship with his wife [was] ok'. The GP did not question him about his behaviour. When he was asked if he was a risk to himself or others the DHR report notes that his answer of 'no' was taken at 'face value'. The report goes on to note that his presentation to the GP was cause for concern given that he had been arrested for assaulting his wife but took no responsibility for his actions. It is also noted that had the GP been involved in the MARAC process then a referral could have been made.

Domestic violence policies and training

Following disclosure of domestic violence, it is important that a victim pathway is in place. This section of the report reinforces how GPs are perhaps the only statutory service that both victims and perpetrators of domestic violence have regular contact with but if domestic violence policies are absent, then the ability of GPs to identify appropriate pathways is compromised.

The Home Office (2013) in *Lessons Learned* note that GPs do not always follow up victim disclosures or refer on. Similarly, Neville and Sanders-McDonagh (2014) noted that in five cases within their sample (n=10), GPs had either not had training in domestic violence, there was no identified lead for domestic violence, or there was no formal pathway for responding to disclosure.

Whether a domestic violence policy existed and/or training had been delivered within GP surgeries was noted in a quarter (n=6) of the reports. Three GP surgeries had addressed the issue of domestic violence whilst three had not. The reports in the latter cases observe that outcomes could have been different if the GPs were more aware of the dynamics of IPV.

> The GP practices concerned in this review have confirmed that they do not have a domestic violence policy or had ever received specific training on domestic violence awareness and conducting clinical screening and enquiry for domestic violence. The lack of a domestic violence policy for GPs and ensuring staff receive specific domestic violence training for GP practice staff is recognised as a borough wide issue and not specifically isolated to the 2 GP practices concerned in this review (DHR9).

> When [the victim] described to her GP an incident whereby [the perpetrator] had been drinking and was verbally aggressive causing [her] to sleep downstairs because she was scared, there is no record of this being further explored or recognised as an indicator of risk (DHR29).
>
> Neither practice has provided its staff with specific domestic violence and abuse training. This perhaps explains why triggers or indicators of abuse were not identified or further explored (DHR29)..

These comments suggest that despite years of guidance and policy development, domestic violence is not integrated into primary care (see also United Nations, 2015).

Continuity of care/integration of responses to victims and perpetrators

Issues also arose in relation to continuity of care/integrated responses to victims and perpetrators in cases where both the victim and perpetrator were registered with the same GP practice (n=7). One report observes that the continuity of care for both patients was good. However it is noted within other reports that this was not the case. For instance in DHR10 the GP Individual Management Review (IMR) indicated that although the surgery had a weekly clinical meeting to discuss patients and cases, there were only ever informal discussions within the practice about the victim and perpetrator. The DHR report notes that it is not clear why this happened but that the GP surgery felt that had a formal discussion taken place then this 'may have led to a fuller understanding of the situation and an intervention'.

In DHR19, the report observes that the GP practice was large and consequently the victim and perpetrator were often seen by different doctors. Although it is noted that this could have potentially led to a new perspective on the case, it made consistency difficult. This was also the case in relation to the GP practice in DHR20 where the victim and perpetrator could see any GP. Although this was observed to 'aid access' it did not 'promote continuity of care'. The DHR report in this case goes on to note the importance of good record-keeping.

> Record keeping practice needs to be exemplary to ensure that all consideration of the patient's case is captured. In addition it is more important in these circumstances to fully record all responses to requests for action so that all practitioners are completely clear about who is doing what (DHR20).

A similar point is made by Neville and Sanders-McDonagh (2014) within their analysis of DHRs in the West Midlands. They observed that in four cases there were poor standards of record keeping by GPs. Similarly an unpublished Home Office document notes the importance of accurate health records, particularly if a patient does not have steady contact with one GP but a range of GPs.

The report in DHR18 also notes the importance of patient records being marked as linked.

> Around the 2 occasions when [the perpetrator] reported more acute mental health crises linked to his separation from [the victim] she also sought help for depression from her GP practice approximately a week or two later (DHR18).

In DHR26 the report notes that had a link been made between the records 'then it may have been appropriate to discuss [the case] at a practice meeting'. A similar scenario arose in DHR7 where the lack of connection between patient records was thought to be due to the couple not sharing the same surname.

It is suggested in DHR29 that had the perpetrator's depression and problematic substance use been flagged alongside the victim's schizophrenia then this could have triggered an exploration of their relationship. The family of the victim also expressed concern within the review process about 'the lack of information sharing at the GP practice where [they were] both patients'. The DHR report notes that revision of the Caldicott information sharing guidelines in March 2013 makes clear to staff how they can safely share such information in certain circumstances.

The report in DHR6 further suggests that a couple's GP records could be aligned with those of any children. This would enable a 'think family' approach where GPs can act as a more effective conduit for a system of coordinated family support. In this case the victim was openly raising concerns that she had about her children's behaviour. Although a referral was made to CAMHS on this basis, it was not followed up by the GP at subsequent appointments.

Interestingly it is observed both in this report and in another two that where family members are registered at different surgeries, this discourages GPs from considering relationships between them.

> During [the perpetrator's] contact with clinicians, it seems that [the victim] is invisible. This may have been reinforced by the fact that they were registered at different practices and the limits of sharing information due to patient confidentiality. Despite a partner being referred to in [the perpetrator's] consultations, there is no evidence of consideration of the risks presented to her and what safeguarding action may need to be considered (DHR9).

> In addition the GP referred to the fact that the whole family were not registered with the practice; they knew only [the perpetrator] and he was reluctant to discuss anything other than his physical symptoms (DHR15).

Yet another issue arising in relation to record-keeping was the importance of transferring records between GP surgeries when a patient moves. In DHR7, the perpetrator's claim that he had been diagnosed with Bipolar Disorder appeared to have been accepted as fact. There was no evidence this was checked, a situation complicated by the fact that he had been registered with different surgeries. In DHR9, a documented history of periods of poor mental health became 'lost'. This meant that the perpetrator was prescribed unsuitable medication for another condition.

> A significant gap identified is how [the perpetrator's] mental health concerns faded with time and that there was no recognition of his mental health history (particularly in the GP records) and an absence of considering the potential of safeguarding adults issues. The lack of a diagnosis code being added to his GP records concerning his mental health meant that information about his historical contact with mental health services became lost in the passage of time (DHR9).

Across the healthcare system

One DHR report described difficulties associated with sharing patient information across the health care system as a 'national problem'. In this case, different health attendances were viewed in isolation and it is suggested that had they been linked up then a different picture might have emerged.

> It is a national problem for clinicians being able to share information across health trusts and services and link up attendances across different services and areas. Due to the difficulties of linking up different health attendances across different sites and trusts, the frequent attendances by the family at Accident and Emergency (A&E) and the GP walk in centre, were viewed in isolation (DHR14).

Reference was made to the lack of information sharing between GPs, Emergency Department's (EDs), mental health, health visiting and maternity services in another four reports. This was also noted to have a negative impact on the help-seeking behaviour of patients, especially when they have to keep repeating the same information to different health professionals.

> Each professional appeared to assess the situation afresh every time [the perpetrator] presented himself, rather than looking at the pattern of information and help-seeking, and using information supplied by others. Indeed, [he] was upset when the GP did not have his notes from his meeting with the psychologist – he had to repeat information yet again. The GP practice suggests that, having

> reviewed the file, the various assessments led to similar conclusions and that one professional having an overview and co-ordinating care might have been more supportive of [him]. The other professionals appeared to think that this was the role of the GP (DHR10).

Mental Health

As experts in the GP workshop observed, primary care is just one part of the health care system. Links need to be made between health services to develop a holistic overview of patterns in appointments, walk-ins and emergency attendances rather than them being viewed in isolation. This section focuses on mental health since it was the second most common health-related theme in the DHR reports. In fact support in relation to mental health is also one of the themes identified by the Home Office (2013) *Lessons Learned* document under 'complex needs' of the victim and/or perpetrator (see also HMIC, 2014; Home Office, unpublished). At the same time however it is important to note that analysis also identified victim and perpetrator contact across a range of services including, but not limited to: maternity; emergency departments; walk-in centres; drug and alcohol services; and private health care.

Victims

Mental health problems may increase vulnerability to intimate partner violence (IPV) or develop as a consequence of it (AVA, 2013). Nearly two-thirds (63%, n=15) of the IPH victims had support needs related to their mental health. Where specified,[9] these included: depression (n=8), panic attacks (n=2), self-harm (n=2) and PTSD (n=1).

It was specifically noted in four of the reports that victims experiencing mental health problems were in contact with health services prior to their murder. In two, mental health issues were accompanied by injury. However the health professionals involved did not ask questions about IPV.

> Her GP had information about most of her needs (except domestic abuse), but the focus was on her alcohol use, depression, or the presenting medical need on that day. On two occasions she presented with injuries (a broken collar bone and a black eye) and there is no record of enquiry over how these came about, specifically no record of enquiry about domestic abuse/violence (DHR32).

In addition, one report (DHR14) noted that screening for mental health within the health visiting service does not happen for pregnant women. The murdered woman in this review disclosed anxiety to her GP yet no further enquiry was made; nor was follow up about this recorded or information passed to her health visitor.

Perpetrators

The same number (63%, n= 15) of perpetrators were also reported to have problems with mental health[10]. In their analysis of thirteen DHR reports in the West Midlands, Neville and Sanders-McDonagh (2014) found that a slightly higher proportion of perpetrators (n=9, 69%) had recorded mental health needs; however their study made no distinction between perpetrators of IPH and AFH. However when the proportion of perpetrators with mental health issues are calculated across both IPH and AFH within the STADV sample (n=32) then the figure is 66 per cent (n=21).

Where specified[11] issues included: depression (n=6), psychosis (n=4), self-harm (n=3), personality disorder (n=2), bipolar disorder (n=2), schizophrenia (n=2) and delusion (n=1). Three of the perpetrators had more

9 In three cases not specified

10 in ten cases both victim and perpetrator had mental ill health

11 In three cases not specified

than one mental health issue, with the female perpetrator reported as experiencing the most conditions (n=4).

Perpetrator mental health issues, including personality and dissociative disorders, depression and schizophrenia have been found to be a risk factor for domestic homicide in other studies (Aldridge & Browne, 2003; Belfrage & Rying, 2004). For example, in a Swedish study of 164 perpetrators, thirty-eight per cent had personality disorders and thirty-six per cent demonstrated symptoms of psychosis (Belfrage & Rying, 2004). However care needs to be taken not to assume a direct causal relationship between perpetrator mental health problems and IPH.

Depression and suicide

The connection between depression and IPH appears to be especially significant. In a Canadian review of sixty-two IPH cases, two-thirds (65%) of the perpetrators were considered to be depressed by family members and friends (OCCPO, 2007). In fact depression was the third most commonly identified risk factor in the sample after separation and previous IPV (see also Aldridge & Brown, 2003; Belfrage & Rying, 2004; Hester et al. 2006). As noted above, six perpetrators of IPH had been medically diagnosed as having depression and three self-diagnosed as being depressed.

Within the six confirmed cases of depression, three perpetrators were known to have had suicidal thoughts/ previously attempted suicide. In addition, three of the six perpetrators with confirmed depression went on to attempt suicide immediately following the homicide (two successfully through hanging; and one unsuccessfully through monoxide poisoning).

Whilst the perpetrator in DHR7 was not recorded as being depressed, he had previously attempted suicide 'multiple times' and he too attempted suicide after he killed his partner (unsuccessful overdose). It is interesting to note here that the unpublished Home Office overview report recommends that mental health services and GPs should develop multiagency working around multiple suicide attempts. Whilst connections between actual or potential suicide and femicide have been found in previous research (Campbell et al, 2003; Belfrage & Rying, 2004) this is rarely integrated into mental health services.

Caring responsibilities

Links between IPH and caring responsibilities are explored in more depth within the section on adult safeguarding. However it should be noted that in one case the perpetrator was over 70 years of age and had poor mental health. The DHR report makes particular reference to the need for strategies to be developed so that mental health professionals are 'carer aware'. In other words, mental health trusts and GP surgeries need to develop their response to carers in line with the Care Act (2014). This involves arranging assessments for carers which address their own mental health needs and ensure that they are not placing themselves and/or the cared-for person at risk.

In DHR9, the carer (girlfriend) was herself the homicide victim – in this case highlighting risks associated with caring for someone with severe mental health needs. The perpetrator was diagnosed as having paranoid schizophrenia and drug induced psychosis. Here, the report discussed the importance of the content of professional training.

> A specific focus on carer abuse and the dynamics of domestic violence that may feature and also the connection between the use of alcohol, substances, mental health and the incidence of domestic violence (DHR9)

Overlapping issues: IPV, mental health and problematic substance use

The quote above highlights that, in some cases, IPV may overlap with both mental health and problematic substance use. This is sometimes referred to as the 'toxic trio' although use of this phrase is not without criticism. Eleven of the fifteen perpetrators (73%) with mental health problems were also known to abuse substances: six alcohol; two drugs; and in three both alcohol and drugs.

Neville and Sanders-McDonagh's (2014) regional analysis of West Midland homicides found that just over half (n=7; 54%) of the thirteen cases involved multiple factors (mental health issues, drug use/and or alcoholism) and/or dual diagnosis. Similarly, they note that alcohol and mental health emerged as an area of concern for both victims and perpetrators, leading them to conclude that this cluster of issues should be recognised as an alert. They go on to suggest that mental health and addiction services should develop an assessment tool to identify potential perpetrators of domestic violence and integrate guidance on dual diagnosis and referrals. Here they cite Mueser et al. (1998) who conclude that programmes that tackle both mental illness and problematic substance use are better able to reach and retain patients in services.

The Home Office (2013) notes that, when responding to complex needs, agencies focused on addressing mental health or substance misuse generally miss the opportunity to identify and risk assess the potential for violence to intimate partners and family members.

Transitions of care

The report for DHR18 highlights another theme about integrated working – the importance of effective 'transition in care'. In this case, the handover of the perpetrator's mental health care plan back to his GP was described as 'inadequate'. The lack of specific information about the trigger factors that had previously precipitated his crises and which could potentially trigger more in the future meant that in the intervening period between the end of treatment and the murder of victim, no professionals were involved.

Similar observations are made in a further two reports. In DHR9, the perpetrator is noted to have had a documented history of experiencing periods of poor mental health. However it transpired that this history was insufficiently captured in the transfer of his records between GPs. This resulted in no mental health diagnosis marker appearing on his records which negatively impacted on the health care and support he subsequently received. In DHR29, it is highlighted that it was not unusual for the perpetrator to attend A&E but leave before treatment could be offered. Here it is noted that such visits should be recorded on the patient's electronic mental health record, regardless of whether the patient self-discharges or in cases where the Mental Health Team refuses to see the patient. Lack of formal handovers and lost information and institutional knowledge are also noted within the West Midlands analysis (Neville & Sanders-McDonagh, 2014).

Medication

In the Neville and Sanders-McDonagh (2014) West Midlands report, four of the thirteen homicides involving mental health problems highlighted perpetrator non-compliance with prescription medicine. This was the case in one DHR in this sample. The perpetrator had been made subject to a Community Order with a Supervision and Mental Health requirement for 12 months. He was said to be generally compliant with probation and healthcare, but that there were reported episodes of him failing to take prescribed medication.

> Had there been regular communication, NHS primary/secondary care and probation would have identified his failure to comply with treatment (DHR21).

Several weeks before he killed his girlfriend, the perpetrator's GP noted that he had not been taking

medication for a week and a new prescription was issued; however on that day the perpetrator missed his appointment. He then attended a day late for the rescheduled appointment; this was the last contact before he was arrested for the murder of his girlfriend two days later.

Another two reports identify medication as an issue in relation to suitability. In DH9, the perpetrator told the police that medication for a condition unrelated to his mental health had 'made him feel strange'. He also stated that before the homicide he heard 'abusive voices' in his head. The medication prescribed in this case had documented side-effects.

In DHR13 the perpetrator's dosage of anti-depressants was halved in line with new guidance. He is described as having 'reacted aggressively' to being told that his medication had changed and said that it was 'the only thing getting him through his current situation'. There is no record that this new level of medication was reviewed to ensure that he was at the right dosage to address his symptoms.

Adult safeguarding

Adult safeguarding is a developing field of practice (ADASS, 2015). Statutory Guidance issued under the Care Act (2014, Section 14.2) states that safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the authority is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

A significant proportion of adults who need safeguarding support may be experiencing domestic violence. Yet despite the overlap between domestic violence and adult safeguarding work, the two have developed as separate fields. The Association for Directors of Adult Social Services therefore stresses that strategic and practice links need to be made between the two framings (ADASS, 2015). Drawing on guidance developed for Directors of Adult Social Services (DASS, 2015) this section explores the overlap between IPH and adult safeguarding with respect to five specific groups: older people; people with mental ill-health; people who misuse substances; people with learning disabilities; and carers who harm and/or are at risk of harm. IPH is then explored as a safeguarding issue in and of itself.

Safeguarding and older people

IPV is not always recognised as an issue for older people (Pillemer & Finkelhor, 1988). Assumptions about age mean that when older people are seen to be injured, depressed or have other injuries, then it may be presumed to be the result of health or social care needs (ADASS, 2015). As outlined within the demographic section above, over a quarter (n=7, 30%) of the IPH victims were aged 58 and above. Two of the DHR reports specifically considered the age of the victim within a discussion on protected characteristics. In DHR3, it was noted that the victim was an 'older white gay man' in a relationship with a younger Black African man. Whilst the nature of the relationship between them was unclear to health professionals, the Panel considered that 'the presentation may have been more familiar to them in a carer relationship'. Thus they did not enquire about IPV, despite the fact that the victim disclosed that he had been assaulted. The perpetrator variously described himself as the victim's friend and the victim's carer; however the victim considered himself to be in a relationship with the perpetrator. The DHR Panel concluded that, in this case, the victim's age meant that the professionals did not 'consider domestic abuse and ask questions when told by an older man that he was assaulted by a younger man' (DHR3).

In DHR5 the Panel did not think that the professional responses to the victim were shaped by her age. Rather they suggested that the victim may not have disclosed IPV due to a 'generational understanding and acceptance of domestic violence'. ADASS (2015) guidance outlines a number of reasons why older women may not disclose intimate partner violence including: no experience of work outside the home or independent economic resources; shame/embarrassment about the length of abuse; concern about being isolated if the relationship was to end; a lack of awareness about services and options available; the perception that services are only available to younger women with children; unfamiliarity with 'self-help' models and disclosing personal problems to a stranger; and the absence of services that are 'older woman' friendly with specialist support and facilities that can accommodate women with, for example, disabilities. Whilst undoubtedly the case for many, there remains a responsibility on professionals to provide opportunities for disclosure, this is not a responsibility that should be located with victims, especially those who may find it harder to tell.

Safeguarding and caring responsibilities

The Care Act (2014) defines a 'carer' as someone who 'provides or intends to provide care for another adult'. There are three main considerations in relation to adult safeguarding, IPH and carers. Carers may cause harm through abuse or neglect of the person they care for; they may be caused harm by the person they care for; or they may observe abuse by others (ADASS, 2015). Local authorities have a duty to assess a carer's needs in order to maintain their well-being. Guidance states that support should be offered if abuse is causing a carer's physical or mental health to deteriorate or prevent them from caring for another adult.

A link between IPH and caring responsibilities was made by two areas within the unpublished Home Office document as well as the West Midlands overview report (Neville & Sanders-McDonagh, 2014). Neville & Sanders-McDonagh (2014) cite research by Livingstone et al. (1996) which suggests that the potential for violence in a caring relationship tends to be greater when the carer is a partner or close relative and where the carer is trying to support a relative with problematic use of substances. This leads them to suggest that caring situations should not only be considered carefully in relation to the pressures that carers face but also how such contexts may facilitate abuse.

Overall, six cases involved an ex/current partner who was also the carer of the victim, representing a quarter of the overall IPH sample (n=24). Five of these six cases involved older victims. The DHR Panels spent considerable time trying to establish whether intimate partner violence (IPV) existed prior to the caring situation or whether the homicide arose as a consequence of it.

IPV not present

In two cases (DHR10 & 20) it was concluded that IPV did not characterise the victim-perpetrator relationship. Thus any abuse that was present was believed to be related to the caring pressures faced by the perpetrator. In DHR10 the review therefore focused on what external support was being provided to the victim and the perpetrator who went on to take his own life.

> The focus of the review moved to the support that [the perpetrator] and [the victim] had and were offered to address their mounting concerns over their increasingly debilitating mental health and [the perpetrator's] expressed anxiety about his ability to care for [the victim] (DHR10).

Panel members established that there was no record of a carer's assessment having been requested for the perpetrator. This was despite the fact that he was experiencing what the report describes as 'obvious struggles' in his role as carer. As indicated above, both the victim and perpetrator in this case were experiencing mental ill health. In addition, the perpetrator had been diagnosed with a life-threatening disease. Yet despite contact with health practitioners, his inability to care for his wife was not addressed. The Panel suggested that, in this case, the perpetrator's own mental health needs obscured his role as carer.

> Responses to [the perpetrator's] efforts to get help were very narrowly focused on a medical response to him, on responding to his symptoms rather than what he said was the cause: his inability to cope with [the victim's] needs. He was not offered a carers assessment by any of the professionals and there is no record of anyone asking [him] what would help his situation (DHR10).

Further enquiry may have led workers to identify the risk he posed to his wife and resulted in safeguarding action.

In DHR20, the perpetrator was an older woman who was nearly 70 years old. She had previously been in a relationship with the victim (who was several years younger than her) but this was not the case at the time of the homicide. The woman had a long history of mental ill health for which she received intermittent treatment. She also had a history of problematic substance use and was in poor physical health. In this case, a carer's assessment was completed but despite the perpetrator wanting care support, the victim declined this. Although a number of interventions took place and there was a certain level of communication between agencies, the Panel concluded that no agency had a full understanding of the situation and, in particular, the perpetrator's historic and current mental health issues. In the absence of a multi-agency case conference, safeguarding hub meeting or risk identification and assessment forum, the Panel concluded that it would have been difficult for each agency to respond any differently. However there was broad agreement among the Panel members that had a multi-agency meeting been held, then a safeguarding alert could have been triggered. Whilst this would not necessarily have met the threshold, it was agreed that it might have at least resulted in more social work support being offered.

> Had one or more of the agencies involved raised concerns about this case and spoken to Adult Safeguarding this may have led to inter-agency discussion and better outcomes, especially bearing in mind [the perpetrator's] ability to cope with [the victim's] care in the context of her significant and well-recorded mental health and substance misuse issues. Had [the perpetrator] also been offered carer support at an earlier stage, this along with other factors, could have led to an increased level of support (DHR20).

IPV known/suspected

Of the remaining four cases, IPV was known to be present in two and suspected in two. DHR5 involved a homicide-suicide. In this case, both the victim and perpetrator had stated that they were the main carer for each other. The victim had a fluctuating health condition and the perpetrator was believed to suffer from mental ill health. A carer's assessment had never been conducted although both parties had raised concerns about their respective caring responsibilities through their contact with their GP. The victim in this case had also disclosed domestic violence and 'relationship issues' something which the DHR Panel note 'should have triggered consideration of a safeguarding adult alert'. However this was not the case.

The victim in DHR3 had disclosed on three separate occasions that he was being abused by his intimate partner. However, as outlined above in the older people section, health professionals did not act on these allegations. It is suggested that the victim's allegations may also have been discounted because he abused alcohol and his many falls could have been attributed to this instead.

> The triage nurse says that [the victim] was reluctant to say what had happened but remembers that [the perpetrator] arrived during this conversation and introduced himself as [the victim's] carer. [The victim] said, 'He beats me up' and [the perpetrator] replied, 'You know I don't beat you up'. He said that [the victim] did not react to this and did not show signs of being anxious. The triage nurse notes in his statement to the police that [the victim] was under the influence of alcohol. He also says that he did not include [the victim's] accusation in his notes as he did not know if it was true (DHR3).

The Panel in the third case (DHR13) believed that the perpetrator may have previously been abusive to his wife. In this case, the perpetrator was over seventy years of age. As in DHR20, he had poor mental health[12] and was caring for his wife who also suffered from mental ill health. Although domestic violence was later considered at a safeguarding meeting, the Panel concluded that the professionals' discussion did not reflect an understanding of the dynamics of intimate partner violence.

In the case of DHR19 adult family violence was suspected; however the killer turned out to be the victim's partner and not her son who was also initially arrested. The local authority had been providing support with care for several weeks before the homicide took place. This was because the possibility of carer stress had been identified. It was noted by the care staff that the victim 'could be aggressive and demanding and that [the perpetrator] was caring and doing his best to meet [her] needs'. Yet when it was suggested to the perpetrator that she thought he was finding it difficult to cope, the couple's son intervened in the conversation and was verbally aggressive to both his mother and the carer. The carer subsequently cut the visit short but did not report what had happened. Since the care staff had been trained in adult safeguarding but not IPV the Panel concluded that they could not have expected them to enquire about this possibility.

Carers at risk of harm

As the introduction to this section illustrates, some people with care and support needs are abusive to their carers – either intentionally or unintentionally (i.e. they lack capacity). This was the case in DHR9 where the victim was the carer of the perpetrator who had paranoid schizophrenia and drug induced psychosis. The victim and perpetrator were living apart. One of the perpetrator's children described the victim as having become a carer to her father rather than his girlfriend. However, although the victim had described the perpetrator as her ex-partner to a health professional, she described him as her partner when she called the police to report that he had stabbed her.

Again there was no evidence in this case of a carer's assessment having been requested. The DHR Panel concluded that this was just one of a number of missed opportunities to engage with the victim and enquire about IPV. As such, it was not possible for the Panel to establish whether abuse preceded the victim's death or whether the perpetrator reacted badly to new medication which had reportedly caused his mental health to deteriorate days before he murdered her.

Safeguarding and mental ill-health

The previous section on mental ill health revealed that nearly two-thirds (63%, n=15) of the IPH victims had support needs related to their mental health. Links to adult safeguarding were explicitly made within the reports of four of these cases.

One of the clearest links is illustrated in DHR13. The victim had previously been detained under Section 2 of the Mental Health Act (1983). Although no safeguarding referral was made after two suicide attempts, the controlling behaviour displayed by the perpetrator led a nurse to state that she believed a safeguarding alert might need to be considered. This was later agreed with by the GP who was concerned about the victim's self-harm. Thus a referral was made to Adult Services. Just before the murder took place, the victim scored highly in a risk assessment for future self-harm and a decision was taken to set up a safeguarding strategy meeting as soon as possible. Unfortunately, however, this decision came too late.

In another case (DHR7), the victim had disclosed that her partner had mental ill health and could be aggressive (smashing chairs or mirrors) although he had never hit her. She was assessed as having depression and, on one occasion, attempted suicide. Although safeguarding issues were discussed, they

12 This is explored further in a discussion paper on DHRs and Mental Health

were excluded by the Mental Health Liaison team. This led the Panel to conclude that:

> There were many missed opportunities to appropriately assess the safeguarding concerns, risks and needs of the family. Disclosures made by [the victim] were not fully represented in the risk assessments. The mental health care coordinator did not make a timely home visit in order to assess any child safeguarding or presence of domestic violence issues (DHR7).

In DHR29, the victim also had diagnosed mental health concerns. Yet although professionals observed the 'influence' of her partner on her finances and drinking no support was offered around IPV. This was still the case when the victim later disclosed that she wanted to end the relationship with the perpetrator because she was 'frightened of his anger when he was drinking' and after she had done so that 'she couldn't get him to accept that she just wanted to be friends'. The DHR report notes that:

> Sadly there appeared at times to be an acceptance that this is common in 'so called' chaotic relationships (DHR29).

In DHR32 the victim had mental ill health, problematic substance use and was homeless because she was fleeing IPV. Whilst the Panel considered that she was vulnerable, it transpired that there would have had to have been additional, exceptional circumstances for the housing threshold in her local authority area to be met. The Panel agreed that the GP, and possibly other agencies, could have considered seeking advice and information from the safeguarding adult service in this case. This could have led to the victim accessing support through a different route that looked at the risk she faced as a result of her circumstances and how to minimise that through supporting her – rather than focusing on only one of her issues.

Safeguarding and problematic substance use

Victims of IPV may use substances in order to cope with or 'block out' what is happening to them. There is also potential for a perpetrator to exercise control over a victim who is dependent upon substances, including prescription medication, by controlling access to drugs or alcohol or to treatment. Six of the IPH victims were known to have problematic substance use: four alcohol; one drugs; and one both alcohol and drugs. In DHR3 it is noted that the victim was vulnerable to abuse as a result of his problematic substance use and that this should have prompted questions from the GP, the hospital and the alcohol liaison service.

Safeguarding and disability

Disability was mentioned in relation to five cases. In DHR19, reference is made to an application for a disability facility grant. Similarly it is noted in DHR5 and DHR13 that the victims were in receipt of disability allowance. Although it was not clear what the victim's long-term condition was in DHR5, the report notes that:

> Disabled people face complex and additional barriers when seeking help for domestic violence, especially when their abuser is also their carer (DHR5).

It is suggested in DHR20 that the victim's mental ill health may have been a disability which potentially played a role in the circumstances of the case. In DHR4 the victim was found to have had moderate learning difficulties. The Panel believed that in the context of this and her family circumstances she was a vulnerable individual.

In DHR12 the victim had a physical disability. The Panel asked the local authority's adult safeguarding service to be part of the DHR process so that they might gain a greater insight into how the victim's disability might have impacted her access to support and help. It was suggested that her disability would have added to her isolation. Even though the victim had come into contact with Children's Services

following the perpetrator alleging that she had been abusive towards him and their children, no questions were asked about the victim's disability nor was it assessed whether she could have physically carried out the abuse that she was accused of. The Panel suggests that advice should have been sought from specialist organisations about evaluating the claims and counter-claims in this situation, and to assessing and addressing her vulnerabilities. The Panel also observed in this case that signs of abuse in those with a disability can be attributed to other health problems, thus disguising the abuse.

Adult safeguarding and IPV

Experiencing IPV was viewed in some DHR reviews as a reason in and of itself to trigger a safeguarding alert. In DHR23 it is stated that universal services must recognise their responsibility to proactively enquire about patient's general well-being and take action to safeguard them from harm. Similarly in DHR29 it is noted that not all of the professionals who came into contact with the victim had covered IPV within their safeguarding training.

> At the time that [the victim] was involved with key services such as primary and mental health services and supported housing, training about domestic abuse was not a key requirement for staff. It was generally covered in the wider safeguarding adults agenda, often within a section of the training that identified that domestic abuse could be a safeguarding issue, but without much detail on indicators and risk factors and response (DHR29).

It is also noted in this case, like others that have been discussed within the paper, that despite the victim's mental ill-health and disclosure of IPV, both issues failed to meet the threshold required for further action.

> In this case the Health NHS Trust provided coordinated care for [the victim's] mental health issues and did notice and record indicators of domestic abuse, however these always appeared to be just below the threshold for further action which may have been a safeguarding referral or refer to a specialist agency (DHR29).

Indeed another DHR report suggests that onward safeguarding referrals should be made for individuals who may not be statutorily 'vulnerable' but who would benefit from early intervention. This is advocated by Women's Aid (England) and Welsh Women's Aid through their 'Change that lasts' model which aims to shift from a risk based approach to one that instead starts with the individual needs of survivors.

Child safeguarding

It is noted within the Home Office (2013) *Lessons Learned* document that, in a small number of reports, there were cases where opportunities were missed to refer cases to Children's Services. This included those cases where children were in households where domestic violence and abuse occurred. In their review of thirteen homicide cases in the West Midlands, Neville and Sanders-McDonagh (2014: 64) also observe that:

> A number of child protection issues emerged across the DHRs, particularly around policies, procedures, training and supervision.

Within the IPH sample, 17 of the victims had children. Nineteen children (under 18 years of age) were living in the household at the time of the murder and one woman was pregnant with the perpetrator's child (see Table 4). The majority of children were under 10 years (n=15) although ages ranged from less than a month to 15 years. In all of the cases the victim was the children's mother. In two cases, the perpetrator was not the biological father of the children. In one case the perpetrator was the father of only the youngest child.

Table 4: Age of children under 18 living in the household when the victim was murdered

Age of child (ren)	Number of children
Up to five years	6
5-10 years	9
10-17 years	4

Child safeguarding issues emerged in over a third (n=9, 38%) of the IPH cases. A range of professionals came into contact with mothers and their children including health and educational professionals and the police. Yet consideration of the risks facing children was not always automatic in IPV cases. Prior harm to children and support for children who may witness and/or lose their mothers also emerge as considerations.

IPV Enquiry/exploration of child safeguarding concerns in health settings

Within their analysis of thirteen DHRs in the West Midlands, Neville and Sanders-McDonagh (2014: 11) recommend that mechanisms need to 'break down boundaries and promote collaborative working across the divide between adult and child focused services'. This suggests that where there are concerns that an adult is experiencing IPV then there should be concurrent exploration of whether there are any child safeguarding concerns and vice versa.

Missed opportunities for health professionals to undertake enquiry about IPV were identified within four DHR reports (DHR1, 6, 14 & 26). Women and their children were in contact with emergency departments, midwives, health visitors, GPs and Child and Adolescent Mental Health Services (CAMHS). Two reports observe the absence of coordination across health services which might have picked up patterns in attendances. In these cases there were multiple attendances at A&E both by women and their children.

> The response of A&E to the family was isolated and operated without any effective connection to the multi-agency response to domestic violence (and the safeguarding of children). Attendances were viewed in isolation not as a pattern of need (DHR6).

> The child was seen on four occasions at A&E for minor illnesses, and these attendances appear not to have been reviewed as part of a pattern but as individual presentations (DHR14).

In one case where historical and current IPV was disclosed by the woman on three occasions (to maternity services, CAMHS and A&E) no advice was recorded as having been given to her and no consideration was given to the risk also posed to her children.

> She expressed that she wished 'she was dead' and had tried taking tablets with alcohol…[her] stress and depression was not seen as ongoing and the risks of self-harm were not viewed in the context of safeguarding the children or responding to a vulnerable adult (DHR6).

Whilst action was taken in another case where the victim disclosed IPV, follow up was not believed by the DHR Panel to be sufficient. A referral to universal services was allocated to the school nurse without reference to the existing involvement of CAHMS and the GP (DHR26). Similarly, when a referral was made to a health visitor by the police and this was noted within the child's health record, no mention of it was made when the woman and her child visited a clinic just a few weeks later (DHR14).

In DHR15 two referrals were made to health by the police. On the first occasion, records state that the case was to be transferred to the area that the victim had moved to so no further action was taken. On the second occasion, a decision was taken by health to contact the victim but this was not recorded as having happened. A social worker was contacted by the Health Visiting service; they stated that an initial assessment had been completed but that no further action was to be taken. A plan was then made by the

health visiting service to re-contact the victim but records are again unclear as to whether this happened.

As indicated above, in two of the DHR reports it is noted that children had contact with CAMHS. In one case, the mother was concerned about her child's behaviour within the home and at school (DHR6). The mother did not, however, engage with CAMHS which led to the service eventually discharging the case. The DHR report notes that although a parent has a right to decline the offer of services, this 'should be a concern when there may be safeguarding children issues' and questions why there was no follow up. In the second case the woman's daughter was known to CAMHS following a referral from the hospital after it was considered that there might be a psychological component to her presenting illness. Panel members questioned why domestic abuse and child sexual abuse were not considered within the assessment that then took place given that both are known to be a cause of emotional distress for children (DHR26).

Enquiry about IPV in schools

In one case, it was the child's school which made a referral to Children's Services (DHR11) after the child disclosed being hit by her father. When the father was informed of this by the school he was reported as being cross that 'the child was believed' and that a referral had been made. The referral was followed up by the school a few days later by an administrator rather than the designated teacher for safeguarding and a letter requesting further information was received the following week. After this, the family was placed in the universal partnership plus caseload indicating that the family were receiving multi-agency on-going work/support by the school nurse. The school nurse did not discuss this with the safeguarding lead in the school. The DHR report suggests that there appeared to be a lack of curiosity displayed by the safeguarding lead as to what was happening with the assessment. Further, the lack of information sharing and joined up working between the school, community health services and social care led to missed opportunities to offer support to the woman and her child and 'did little to establish confidence in systems that were there to help them'.

Possible opportunities for referral were believed to have been missed in a further two cases (DHR14 & DHR26). In DHR14, reference is made to a school record of an incident where the child put their hands around the neck of another child. In DHR26, the school attendance record of the children was poor. Whilst steps were taken to improve attendance, no underlying issues were explored. One child was absent for medical reasons but the review notes that there appears to have been no communication between the school nurse and the Attendance Officer which would have highlighted health professionals' concerns about the psychosomatic element of this illness. It is suggested that communication at this stage would have alerted the Attendance Officer and allowed concerns to be raised, including an opportunity to explore how things were at home.

In DHR15 the school was aware that the children's mother was experiencing domestic violence from her ex-partner after she contacted them to explain why the children were absent. Following this, the school spoke to Children's Services who advised giving the victim details of the local IDVA service. The school made contact with Children's Services again after the victim then disclosed that the children's father was on bail and should not be allowed to pick up the children.

Referral to Children's Services by the police

Previous research shows abused women and their children are most likely to have contact with health services and the police (Harne & Radford, 2008). Women in six of the cases (DHR6, 7, 12, 14, 15 & 26) were known to have been in contact with the police prior to their murder. As noted above, this is something that can facilitate a child safeguarding referral.

Referrals were made by the police to Children's Services in half of these cases. Following assessment of the risk to the victim in DHR6 as standard, the police created a report which was shared with Children's

Services. A report was also sent by the police to Children's Services in DHR7 relating to a 'family/relationship problem'. In DHR14, the police were called because the perpetrator had not fed the children. No allegation of any crime was made and the children were observed to be safe and well. A police report was shared with Children's Services.

In two cases referrals were not made. Police analysis of their involvement in DHR12 identified areas of missed opportunity in relation to: risk identification, risk assessment, referral to a Multi-Agency Risk Assessment Conference (MARAC), referral to dedicated specialist domestic abuse services, identification of 'red flag' indicators linked to Honour Based Violence (HBV), safeguarding children, recording information and supervision.

In DHR26 no 'child coming to notice' forms were completed and the risk was classified as standard. This was despite the fact that the victim provided positive responses for high level risk factors, including: separation from her partner; escalation in arguments; controlling behaviour; and pregnancy. In addition there was no reference to a sworn statement made by the victim which was in the possession of the police. Within this she had disclosed her fears for her children and, in particular her daughter. Over a short period, the victim in this case obtained a non-molestation order and a non-occupancy order, reported breaches of these orders (including abduction and rape) yet no action was taken to protect her and her children.

> The supervisory processes of the police did not identify these failings. This case demonstrates a complete police systems failure in providing protection for [victim] and her family (DHR26).

In DHR15 the police were called by the victim on six different occasions but on only two occasions was a referral made to Children's Services. On four occasions, a notice to Children's Services was not created despite at least one incident report noting the children were present.

Victim contact with Children's Services

Contact between the victim and Children's Services was noted in six DHR reports (DHR6, 7, 11, 14, 15 & 16). It is noted in DHR6 that one of the children was clearly a child-in-need but that this was not the conclusion reached by the assessment of Children's Services. The victim did not meet the criteria for services, although the assessment stated: 'it remains clear that [the victim] needs additional support and is near breaking point'. In this case, there had been six contacts in all – four via the police following incidents and two from the victim herself stating she was struggling to cope with her children.

> Given her fears of involvement by Children's Services it is significant that she decided to approach them herself as she was seemingly struggling to cope with her young children and was desperate for help. Their response should have been more positive, and should have been able to recognise the level of concern she was experiencing to have approached them independently for help… more should be done to attempt to positively engage people who independently approach Children's Services for help and support when they do not meet the threshold for statutory intervention (DHR6).

This case was in contrast to DHR11 where the report notes that the victim 'felt she could not speak about her concerns of abuse to statutory agencies or services for fear of losing [her child]'. Unfortunately her experience of intervention by Children's Services on an earlier occasion had left her so fearful that she did not contact statutory services for help despite the escalation of the abuse. This raises critical issues about agencies being approachable. DHR7 also highlights how abused women are often held responsible for safeguarding their children. In this case the perpetrator was 'invisible' and not challenged or held to account for his behaviour.

> Had the agencies involved with [the perpetrator], [the victim] and [the child] worked more effectively both as individual organisations and as a functioning partnership, with all that entails, [the victim] may not have died (DHR7).

The family in DHR14 came to the attention of Children's Services on one occasion via the police following a non-crime domestic incident. This incident did not meet the threshold for statutory children services intervention and was therefore not progressed to assessment. Several DHR reports highlight how the low threshold at which information is shared by the police is in contrast to the high threshold at which Children's Services will conduct a statutory safeguarding assessment (also DHR12). This means that many women and their children are left unsupported. DHR14 argues this is a 'national issue' and the report recommends that 'more comprehensive (and tested) systems are needed to ensure that all victims of domestic violence are identified and supported'. Indeed the victim's family in this case did not think that she would have proactively approached statutory services because she too was fearful of possibly losing her children and also because of her immigration status.

In DHR15, two notifications were made to Children's Services. The first did not meet the threshold for initial assessment. The second did and contact was made with the woman who stated that she was concerned about her ex-partner seeing the children. Information was sought from her, the children and their school but there was no evidence that the perpetrator was contacted. The case was closed since the mother was seen to be safeguarding the children because she was going to apply for a legal injunction. In another case a child was subject to a child protection plan at the time of the mother's murder due to concerns about the perpetrator's violence (DHR16).

Contradictions were raised by the low threshold for police referral and the high threshold for Children's Services to provide support to women and their children. This results in a lack of support for some women who would welcome involvement, although it should be recognised that some women fear this. Additional issues also emerged through analysis including use of statutory services by violent men to make false allegations (see also Kelly et al. 2013) as does support for women who have experienced IPV and who have had their children taken into care as a consequence.

Table 5 summarises the extent of contact that agencies had with women and their children prior to the homicide. In four of these cases, four agencies were involved with them.

Table 5: Agency contact with children

	1	6	7	11	12	14	15	16	26
Health	Y	Y				Y	Y		Y
CAMHS		Y							Y
School				Y		Y	Y		Y
Police		Y	Y	Y	Y	Y	Y		Y
Children's Services		Y		Y		Y	Y	Y	
Total	1	4	1	3	1	4	4	1	4

Prior harm to children

Harm to children by the perpetrator prior to the homicide were noted in two of the cases and implied in one. One child disclosed at school that her father hit her with a stick (DHR11). Similarly family members revealed that the perpetrator in DHR12 hit one child and was aggressive and verbally abusive towards another. In DHR26 the report hints at child sexual abuse of a daughter by the perpetrator of the homicide (her stepfather). Child safeguarding issues arose in over a third (n=9, 38%) of the IPH cases. A range of professionals came into contact with mothers and their children, including health and educational professionals and the police. These are discussed in turn below.

Witnessing homicide

In six cases, the children were known to be in the house at the time of the murder.[13] In one case, a child was abducted by the perpetrator after the killing but was later found unharmed. It is reported in one case that a child was found with a minor injury. In another, it is suggested within the DHR report that had the police not arrived when they did, then the children may have also been killed.

> It must be seen as a testament to [the victim] that when the police came to her house her young children stood up to [the perpetrator]. They had originally made the call that brought police to the home and then when [the perpetrator] tried to send the police away they challenged him. The importance of that intervention by the children cannot be overemphasised. Given the danger represented by [the perpetrator] it is not unreasonable to suggest that the call to the police may have saved the lives of the young children who were the witnesses in the house where their mother lay dying (DHR26).

In another case, the children were known to have witnessed the murder and a police report describes how one child tried to stop the assault. One report (DHR26) gives consideration to what impact the homicide had on the children: it concludes that the involvement of Children's Services and links to education would have ensured that the interests of the children were considered. It is not known what support was in place for any of the other children and young people in the aftermath of their mothers' murders. A previous review of DVH cases found that support for children was haphazard (Regan et al. 2007).

Perpetrator contact with children's services

In two of the DHR reports it was discovered that the perpetrator had made an allegation about his partner harming their child (DHR12 & 15). In DHR12 the victim came into contact with Children's Services following the perpetrator alleging that she had been abusive towards him and their children. In DHR15, the perpetrator contacted Children's Services on two occasions post-separation to make accusations against his ex-partner. On the first he claimed that the children were being cared for by 'an illegal asylum seeker'. On this occasion he was advised to contact Ofsted. On the second occasion he alleged physical abuse by his ex-partner against the children. Children's Services contacted the victim who denied the allegation. The social worker saw the children at school and there were no concerns so the case was closed. Given that IPV was known about in this case it is interesting that this behaviour did not alert professionals to the perpetrator's continuing attempts to control.

Victims and perpetrators in contact with the leaving care team

Also of note is that one of the victims and one of the perpetrators were themselves involved with Children's Services via the leaving care team (DHR16 & DHR24).

In DHR16 the murdered young woman had been a looked after child and had recently moved into independent accommodation. It is noted in the report that although there were activities, processes and pathway plans in place the victim should have experienced more proactive and supportive intervention. She was believed to be particularly vulnerable due to disclosure of childhood sexual abuse as well as suspected sexual exploitation and also assault from an ex-partner.

In DHR24 the perpetrator had also previously been in regular contact with the looked after children service. Here it is noted that more could have been done between the service, his GP and probation to work collaboratively. The report states that each agency had relevant information that, had it been shared,

13 Also of note is that one victim lived with her parents at the time of the murder and her siblings were stabbed too, one of whom was under 18 year of age (DHR16).

could have shown a more complete picture of the perpetrator. Issues included: housing and benefits; enrolling at college; immigration; issues around alcohol and cannabis use; and trouble with the police. Whilst all contact with him was in line with procedure there is no evidence that there was any follow up by the looked after children service to understand what his contact with the police had been.

> Had the service sought information from the police, information could have been disclosed about the nature of the incidents in which he had been involved, creating an opportunity to explore with him any need for additional support (DHR24).

His later involvement with the criminal justice system was followed up, via probation. However after this, the perpetrator's personal adviser was unable to reach him and his case was closed as per procedure.

Support for victims following a child being taken into care

In one review (DHR32) the Panel requested specific information from Children's Services in relation to whether there had been any discussions at Child Protection Conferences, or during other engagement with the victim and her family, concerning support or referrals for the victim after her child had been removed from her care. In this case, the victim had alleged abuse from her child's father. However he had been granted custody at the end of the relationship due to her alcohol use.[14] One of the most significant recurring issues for the victim in her interaction with services was contact with her child but the exclusive focus appears to have been on her alcohol use. The report concludes that:

> The most important factor for her when she was engaging with services was the issue for which she received the least support (DHR32).

Informal networks

Klein (2012) defines informal networks as including family members, friends, co-workers and neighbours. Although the involvement of informal networks in the DHR process can be contentious with some commentators suggesting that it may heighten their distress (Websdale et al. 2001), Regan et al. (2007) argue that it is important not to underestimate the contribution that they can bring. This is recognised within Home Office guidance on conducting DHRs which states that:

> The quality and accuracy of the review is likely to be significantly enhanced by family, friends and community involvement (Home Office, 2013: 16).

The benefits of such involvement are identified in the guidance as including:

- Obtaining relevant information held by family members, friends and colleagues which is not recorded in official records.
- Assisting the victim's family with the healing process and helping them satisfy the often expressed need to contribute to the prevention of other domestic homicides.
- Enabling the Review Panel to get a more complete view of the lives of the victim and/or perpetrator, putting in context the decisions and choices they made.
- Revealing different perspectives of the case, thus enabling agencies to improve service design and processes.

14 Note that the victim's ex-partner and father of her child was not the killer in this case

Mullane (2014) further suggests that family members can influence the scope of DHRs, assist in ensuring that the review is accurate and play a role in monitoring its recommendations.

Participation was successfully facilitated in 58 per cent (n=14) of the 24 IPH reviews with a total of 36 informal network members contributing. Table 6 shows that the vast majority of participating informal network members were family members of the victim (n=32). It is important to note that in two of these cases the DHR report states that a family member acted as the 'family spokesperson' indicating that, in actual fact, more family members were involved. In one case, two members of the perpetrator's family participated in the review. Other informal network members who were involved included: the godmother of a victim; the friend of a victim; work colleagues of the victim; and a neighbour of the victim.

Table 6: Informal network members who participated in IPH reviews

Informal network support member	Number of contributors
Husband of victim	1
Mother of the victim	4
Father of the victim	5
Sister of the victim	5
Brother of the victim	2
Siblings of the victim	1
Daughter of the victim	2
Aunt of the victim	2
Uncle of the victim	1
Niece of the victim	1
Cousin of the victim	1
Brother of the perpetrator	1
Sister-in-law of the perpetrator	1
Godmother of the victim	1
Friend of the victim	1
Manager of the victim	1
Neighbour of the victim	1
Family members of victim (not stated whom)	7

Where the gender of participants was known, women appeared to be more likely (n=16) to take part in the review process than men (n=10).

Reasons for non-involvement

In just under half (10 of the 24) IPH cases, there was no involvement of informal network members. In some of the DHR reports, efforts to engage informal network members were ongoing reflecting the fact that not all of the reports had been completed. In several cases contact with families was also pending due to the criminal case either not having started or being ongoing. In one of these cases, the Chair shared the draft terms of reference with the family so that they were still able to influence the shape of the review. In another case there was a lengthy break in the review as Panel members awaited the conclusion of the criminal trial. This made it difficult to sustain contact with the family. When the review was resumed immediately after the trial, the timing coincided with the first anniversary of the victim's death which the family found particularly difficult.

In two cases, family members chose not to engage with the review at first but did so at a future juncture. In one of these cases, this was after the perpetrator had admitted responsibility for the murder; in the other it was after the perpetrator had stood trial and been sentenced. Other families chose not to be involved at all: in one case this was because they thought being part of the review would expose them to additional pain; in another the victim had been disowned by her family due to her choice of marriage partner so they declined to take part. In a third case, the family had been advised against taking part by a former partner of the victim. A family member of another victim was a foster parent and so was kept informed of the process but not involved in it.

The involvement of children

In two reports, it is stated that consideration was given to involving the children in the DHR process (DHR12 & 26). The police communicated that the child in one case had not disclosed anything about the parents' relationship, thus a decision was taken not to interview them. In another case a social worker spoke to the oldest child about talking to the Panel Chair. However the child in this case said talking about what happened would be too painful. Thus it was thought best not to pursue this with the other children.

What did involvement look like?

It was not always clear what mechanisms were used to facilitate involvement. Where it was stated, contact with informal network members took place via: face-to-face interviews (n=6); telephone interviews (n=3); email (n=3); and statements written specifically for the DHR Panel (n=2). In two cases, contact was recorded as involving a combination of these methods. The means of contact was not described in three DHR reports; rather reference was made to informal network members having: contributed to the review; spoken to the DHR chair; or had 'extensive contact' with the Panel.

The level of involvement varied across reviews. In one DHR, three meetings had taken place with family members. However, another family chose to have only limited contact with the process. This was because intimate partner violence was not believed to have prefaced the homicide-suicide and the family described feeling hesitant about being involved in the process because doing so might suggest otherwise.

> We are looking forward to having the matter closed so that we can remember both of them peacefully and together as they should be (DHR10).

Knowledge of informal network members

Studies consistently highlight that victims of intimate partner violence (IPV) are more likely to contact friends or a family member for help and support before a formal agency (McGibbon et al., 1989; Kelly, 1999; Bagshaw et al., 2000). For this reason, members of 'informal networks' are believed to hold vital information about the context prior to an intimate partner homicide taking place that may not be known to formal agencies (Regan et al. 2007).

Control and jealous surveillance are core aspects of the coercive control that characterises IPV. Stark (2007) provides a detailed breakdown of the behaviours that comprise coercive control:

- Violence (including sexual coercion and jealously)
- Intimidation (including threats, surveillance, stalking, degradation and shaming)
- Isolation (including from family, friends and the world outside the home); and
- Control (including control of family resources and 'micromanagement' of everyday life

One or more of all these elements was evident in what informal network members knew. Using categories developed by Regan et al. (2007), Table 7 in the risk section (page 46) sets out what risk factors informal network and agencies were aware of via analysis of the reports.

Two of the DHR reports in the STADV sample explicitly note that the information known to informal network members was particularly valuable to the review process due to little/no involvement of formal agencies with the victim or perpetrator.

> It was clear from the first Panel meeting that there was little involvement from services and that to adequately learn lessons from this tragedy, the input and views of family members would be essential (DHR11).

> This contact [with informal network members] has been essential for this review and is particularly relevant given the lack of statutory agency contact with either [victim] or [perpetrator] (DHR27).

The absence of input from informal networks was also keenly felt within another two reviews. In one case formal agencies had limited information.

> It is a matter of regret that no one who knew [victim] personally has come forward to date to provide this Panel with any additional information that she may have shared with them about her involvement with [perpetrator], beyond what IMR[15] authors have been able to uncover during their enquiries (DHR17).

In another review the Panel noted that without informal network involvement it was difficult for them to gain an insight into the victim as a person.

In those cases where family, friends, co-workers and/or neighbours did not actively engage in the review process, some Panel Chairs turned to statements that had been gathered as part of the police investigation. In two cases, family members agreed for these statements to be passed onto the Panel. In another case, a police representative provided a summary of a statement.

Actions of informal network members

Some of the DHR reports note actions that were taken by informal networks as a consequence of what they had learned. Whilst these were mostly supportive of the victim, sometimes different family members would suggest conflicting courses of action.

In DHR11, for example, the victim's sister and father advised her to go the police but other family members stressed the importance of her keeping her problems to herself. This was also the case in DHR12. Here the victim's sister advised her to report the assaults to the police whereas their mother encouraged her to forgive her husband and put up with the abuse for the sake of her family.

Several family members who had advised their relative to go to the police and report abusive behaviour highlighted to the Panel the reasons why they believed the victim had chosen not to do so. In one case, and as noted in the child safeguarding section, she feared the involvement of children's services (DHR11). In another, she was concerned about the impact disclosure might have on her immigration status (DHR12).

In DHR14 it is noted that the extended family came together to try and help the couple to 'resolve their problems'. The victim was advised to 'tone down' her complaints whilst the perpetrator was told 'to face his family responsibilities and to change his behaviour'. The propensity for family and friends to hold women wholly or partly responsible for the abuse they experience is well-established in the research literature (Glass,

15 Individual Management Review (IMR)

1995, cited in Regan et al. 2007). Kelly and Coy (forthcoming) describe this as women being 'responsiblised' for their own safety.

In only one DHR report is a situation described where an informal network member explicitly held the perpetrator to account and confronted him about his behaviour (DHR18). However the report notes that this course of action could potentially, although unintentionally, have increased the risk that the victim faced.

> Had [previous intimate partner] sought advice from domestic violence or stalking specialists, he would most probably have been advised to refrain from any direct contact with [perpetrator] to avoid increasing any risk to [victim] (DHR18).

This is particularly pertinent to DHR16 where family members knew a great deal about the abuse that their daughter was experiencing. However they reported feeling scared of the perpetrator and what he might do to her if they intervened directly. Since this family had already engaged extensively with statutory agencies in order to try and support their daughter but were constantly let down, this begs the question of what else they could have done.

Unanswered questions

The aftermath of an IPH often leaves family members, friends, work colleagues and neighbours struggling with unanswerable questions (Regan et al. 2007). Thus the opportunity to take part in the DHR process emerged as a mechanism through which informal network members might find answers to some of their questions. This was reflected by the family members in one case.

> The family have indicated that they have found the DHR process helpful in enabling them to get some answers to the questions that arose following [victim's] death (DHR29).

At the same time, the information uncovered through the review process could raise further questions, especially with respect to the responses of formal agencies. In this sample the actions of health professionals and the police were most often questioned by informal network members, but other agencies mentioned included social services and housing. In one case a family voiced the belief that multi-agency responses could have been more robust, observing that they and the victim would have appreciated more specialist and non-judgemental support.

Recommendations made by families

Unsurprisingly, the DHR review process elicited strong views from informal network members on what might have made a difference. Five reports specifically note that informal network members had an opportunity to comment on the final report before publication and in several cases this led to additional recommendations.

In one case, it transpired that the perpetrator was known to have been abusive to a former partner. Thus the family member involved in this review talked about the need for a system that enables this to be communicated.[16]

> Keen to stress her view that, where the police are aware of someone's violence in the way that they were about the perpetrator that this should be communicated in some way to others he is in contact with (DHR1).

16 Note that this case predated the Domestic Violence Disclosure Scheme; however the victim' mother was given information about this.

In the case involving the victim with insecure immigration status, the family stressed how important it was that women coming to the UK were advised about their rights.

> Given the issue of [victim's] immigration application, the family want to see the process for visas changed so that women are fully advised about their rights in this and other legal issues before they enter the country (DHR14).

Two families believed that more public-facing work should be undertaken to educate about IPV. The family in DHR14 stated that men should be educated not to 'feel entitled to own or control women'.

> [Victim's] family felt that it is important that men are educated to understand the more modern concept of gender equality and do not feel entitled to own or control women.

In another case the family argued that the dynamics of IPV are not sufficiently understood, meaning that responses are not always appropriate.

DHR report recommendations related to informal networks

The Home Office (2013) in its *Lessons Learned* document notes that

> There appears to be gaps in awareness and understanding of what constitutes domestic violence and abuse. A key misunderstanding is that domestic violence only means physical violence. There are also some examples where financial and emotional abuse are not regarded as forms of domestic violence. A clear understanding of domestic violence and abuse is important as in many of the cases there was evidence of domestic abuse incidents prior to the homicide. There have also been reports where the power and control aspects of domestic violence have not been recognised *(*Home Office, 2013: 3).

Panels in six of the cases analysed here (DHR1, 3, 11, 14, 17 & 18) also focused on this issue. In DHR1, for example, the Panel concluded that, although the victim had experienced controlling and abusive behaviour, this was not recognised as such by her family so that – from their perspective – her murder 'came completely out of the blue'. The Panel did not criticise the family; rather it recognised that this is a widely held perception.

> It is relevant to ask what role a public awareness raising campaign or information around the nature of domestic violence – particularly where the behaviour is not as obvious and is not physically violent – could have played in increasing [victim] and her family's understanding of [perpetrator's] behaviour and what support they could get about it. It is key for these campaigns to be carried out and that they emphasise the non-physical violence aspects of domestic violence (DHR1).

Similarly, the Panel in DHR3 noted the importance of the public being able to recognise the dynamics of IPV, in this case highlighting that drug and problematic substance use is not a cause of IPV, alongside making information about specialist support organisations more widely known. Two Panels noted the importance of tailoring awareness-raising to specific communities: LGBT and minority communities being both specifically mentioned. The presence of high risk indicators (such as harassment and stalking, obsessive behaviour following separation, threats of suicide, threats to kill) were also identified as an important component of public awareness-raising (DHR11 & DHR18).

DHR11 and DHR18 addressed the need to provide information about where victims, family and friends can go for advice and explore options for action. In this respect DHR17 also identified the need to stress the importance of reporting IPV, including third party reporting. This latter point is interesting given that it was considered by the family of one of the victims who ultimately decided against doing so.

> There were times when the family debated if they should contact the police on [her] behalf but they took the practical approach that she would have to substantiate the allegations and left the decision to her (DHR11).

In contrast, three other reports note third party reports to the police by concerned neighbours (DHR7, DHR9 and DHR30). These reports were all related to disturbances where screaming and noise (banging and crockery being smashed) could be heard.

Finally, one of the DHR reports recommended that the Community Safety Partnership (CSP) should consider approaching the victim's family via a police Family Liaison Officer (FLO) or Victim Support to explore whether they would like to be part of future awareness-raising. This links back to the Home Office guidance which suggests that participation in the review provides an opportunity to contribute to the prevention of other domestic homicides. Indeed one report observes that:

> They [family] have taken some consolation in the fact that the process has initiated changes that would improve the provision of support and care for someone who was in a similar position in the future (DHR29).

In the aftermath – support for family members

Victim Support operates a service for family members who have experienced homicide. Several of the 32 reports referenced this service. In one case, the support from Victim Support was noted to have been offered to the family but declined. A second report notes that family members should be made aware of the service. A third states that, when contacting the family, a leaflet was given to them about the service offered by Advocacy After Fatal Domestic Abuse (AAFDA) – a specialist charity that supports families after domestic homicide. It was also the case that, where stated (n=8), family involvement in the review process was facilitated via FLOs suggesting that they also represented a source of support.

However one report concluded that such support needs to be strengthened and tailored to reflect the different situations of each family.

> Support systems for families affected by fatal domestic violence should be strengthened. Family structures, dynamics and relationships vary significantly and a uniform approach to the provision of support can mean that certain family members can be isolated from information and support. The potential issue of conflict of interest needs to be sensitively and carefully managed. This is particularly relevant for step or blended families when the biological parent is the perpetrator (DHR9).

Risk identification, assessment and management

A developing body of international research identifies a range of risk factors for IPH including socio-demographic and personal characteristics of victims and perpetrators, relationship characteristics, situational and cultural contexts (Dobash et al. 2007). One of the aims of identifying risk factors is to inform professional judgment of those cases in which the potential for lethal violence is strongest.

Risk identification, assessment and management processes were developed originally in the United States as 'checklists' but have become increasingly detailed and many now also incorporate weighting systems. The most common tool used in England and Wales is the Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification Checklist (ACPO & CAADA, 2009) intended for use across criminal, statutory and voluntary sector agencies (HMIC, 2014). In London, the police have also traditionally used a response tool which identifies six key risk factors found in DASH - Separation, Pregnancy, Escalation,

Community Isolation, Stalking and Sexual Assault (SPECSS)[17] within the 124D form which was designed as an 'aide memoire' for officers responding to domestic violence incidents.

Risk identification and assessment

Steps to identify risk factors were undertaken by the police in only a third (n=8) of the IPH cases. In one case a risk identification tool was used on a single occasion; in six cases risk was identified on two separate occasions. Of these seven cases, both identification and assessment was undertaken by the police. In the eighth case, risk was identified and assessed five times: by the police (n=2), an Independent Domestic Violence Advocate (IDVA) (n=2) and a specialist provider of Black and Minority Ethnic (BME) domestic violence services (n=1).

Where it was noted in the review reports, DASH was used to identify risk on twelve occasions, SPECSS on three occasions and Form 124D on two occasions. All were assessed as standard risk apart from two cases where medium risk was graded (DHR16 &23). Both of these were referred to a Multi-Agency Risk Assessment Conference (MARAC) (see below).

Missteps in the process of identifying risk

Two of the DHR reports note that when risk factors were identified they were not recorded accurately: the police 'did not fully explore [the victim's concerns] particularly how the incidents had escalated, around his [the perpetrator's] use of alcohol, drugs and his mental health' (DHR7). This is significant since research has suggested that the victim's perception of dangerousness is important in assessing potential lethality (Richards, 2003). Moreover: 'the assessment level of standard would undoubtedly have changed if all the facts and intelligence were known'.

In DHR12, risk was identified only after the victim's husband made false allegations that she and her family were being abusive towards him. Just one risk factor was identified despite the fact that she was experiencing significant coercive control. Police analysis of their involvement identified a number of areas of missed opportunity, including in relation to risk identification, assessment and referral to MARAC. The DHR report concludes:

Although no attempt was made to identify risk in DHR4, the report notes the importance of ensuring that all intelligence is recorded in order to inform risk identification and assessment. This is because the DHR process discovered that the perpetrator had been abusive to previous partners. Had the risk he posed to multiple women been identified and acted upon at the time then the victim may not have even come into contact with him.

> It is very debatable whether the assessment of the women [that the perpetrator had previously] assaulted were graded correctly. The simple fact of his previously violent behaviour towards his partners does not seem to have carried sufficient weight… any woman who came into contact with him as a partner was undoubtedly at more than standard risk of violence… what appears to be lacking is a process where all the different police commands examined his behaviour in the round. Each case was dealt with largely separately… This review has been able to identify [this] through a joint examination of the cases in which he is involved. This does not seem to have happened as a matter of practice or policy and such an approach may have made a difference. For example it could have led to warnings to future or existing partners about the threat they may be under (DHR4).

17 Or SPECCS+ (including child contact)

Questioning risk thresholds

Two DHR reports refer to there being a 'national problem' where domestic violence cases assessed as being standard or medium risk 'can often remain below the radar of services and the threshold for intervention, as the impact of ongoing coercive control is not understood'.

One report states that although practitioners across different services may use the same tool to identify risk, when it comes to assessing or 'weighing' risk they approach this differently.

> The inaccuracy of the risk assessment raises a wider question: the extent to which the Police recognise medium or high risk situations in which there has been no physical violence. Practitioners across many services can be seen to 'weight' different parts of the risk assessment differently and this impacts problematically on their professional judgement of the risk posed to the victim (DHR23).

Research on IPH by Regan et al. (2007) found that coercive control and, in particular, jealous surveillance, was a more prominent risk factor than physical and sexual violence.

Failure to identify and assess risk

Although the police were called in two cases, risk was neither identified nor assessed. In DHR9 the police were called three times (criminal damage and breach of peace, perpetrator refusing to leave property and neighbour heard woman screaming). The perpetrator was arrested on one occasion but the victim later withdrew her statement. On the other two occasions, the incidents were recorded as non-crime domestics.

In DHR11 the police were called by the victim following a verbal argument about household chores. The DHR report states:

> At the time of the incident [the victim] was 8 months pregnant. Police recorded that the couple had an argument over household chores but when they arrived 31 minutes after the initial call [the perpetrator] was in bed asleep and no allegations were alleged or disclosed. Advice was given to both parties (DHR11).

Failure to identify risk is also noted in DHR13 where the police intended to complete a DASH form following an upcoming safeguarding meeting. However the meeting was delayed by two months during which time the victim was murdered. Whilst risk had been identified by the police in DHR7, the report notes that it could have been reviewed and reassessed at 'critical points' including when the perpetrator was being discharged from hospital, highlighting the importance of recognising that risk is dynamic.

Multi Agency Risk Assessment Conferences (MARAC)

Three of the cases in which risk was identified and assessed (DHR15, 16 & 23) were referred to MARAC, including the two cases which were graded as medium. It is noted in DHR15 that the IDVA shared her assessment of risk and safety plan and that Children's Services shared that they were conducting an initial assessment. No other information was shared with the other agencies and no actions were recorded. The case was reviewed a month later where bail conditions were noted and the case was closed. Analysis of this case by the DHR Panel suggests that management of the risk was inadequate with too much emphasis being placed on the victim's location (she had gone to stay with family outside of the area) and the perpetrator's bail conditions.

> Despite the outcomes of these risk assessments, all the agencies were swayed by either [the victim's] location or [the perpetrator's] bail conditions. The assumption seemed to be that [her moving away to stay with family] meant that she was safe despite her disclosure of high risk factors including [the perpetrator's] threats to kill and the separation (DHR15).

DHR16 was categorised as standard risk initially but following developments in allegations and a subsequent investigation, the police officer referred the case to MARAC on the basis of increasing knowledge about the perpetrator and also because the victim was pregnant. The MARAC notes stated that the victim did not want to substantiate any allegations and that a specialist domestic violence service was having difficulty contacting her. However, as in DHR15, 'the chair of the MARAC felt that the bail conditions and the work being undertaken by the Investigating Officer were 'managing' the risk'.

The victim in DHR23 was assessed by police as medium risk, but on the professional judgement of a police officer was referred to MARAC. The only action allocated by the MARAC was for the IDVA to attempt contact with the victim. The DHR report in this case observes that information was held by other agencies who did not attend the MARAC and that had this been known, other actions may have been allocated.

> The discussion that took place at the MARAC raises issues. While it was positive that the Police Officer took the step of referring [the victim], the lack of relevant agency attendance can be seen as impacting on the case. Most importantly, the GP, College and Leaving Care Service were not at that time part of the MARAC and therefore did not receive information about the case (DHR23).

Risk factor analysis

The following section presents a risk factor analysis across the 24 IPH cases drawing on data contained within the DHR reports. Several important caveats should be highlighted here: first this analysis is reliant on what was available to the review, which is unlikely to be a complete account of the history of the relationship: that said most risk assessments do not have access to this either. Secondly, the analysis does not capture risk factors at particular points of time, as is the case in risk identification, but draws only on the totality of evidence unearthed through the DHR. It is retrospective[18], with possibly more information available than when a single agency uses a risk identification and assessment tool.

The frequency of risk factors

Table 7 sets out the risk factors identified through analysis of the DHRs. The most frequently occurring risk factors (n=8 or more) in relation to the perpetrator's use of violence were: physical violence in the current relationship found in just over two-thirds of the cases (n=17) followed by physical violence in a previous relationship found in a third of cases (n=8). Four reports mention one previous partner; three reports refer to two previous partners; and, as already noted, one report notes that the perpetrator had been violent to four previous partners.

> It is clear that [the perpetrator] is an individual that presented a significant risk to women throughout his previous relationships. There were domestic abuse incidents involving four previous partners… these included 5 incidents of violence and 4 Non Crime Book Domestic Incidents. There were similarities throughout all these cases. [The perpetrator] indicated controlling and coercive behaviour throughout (DHR4).

Violence in pregnancy has been noted as a risk factor (McFarlane et al. 2002) but was a feature in only four of the cases. Similarly sexual assault was only disclosed in two cases.

18 Three of the DHR Panels (DHR3, 15 & 18) also chose to retrospectively complete the CAADA-DASH risk assessment tool based on the information that emerged from the review process.

Coercively controlling behaviours were identified in just over half of the cases (n=13) and jealous surveillance in a slightly smaller number (n=11). Other risk factors that were recorded for a lower number of cases included isolation (n=6) and stalking/harassment (n=5). Previous criminality was present in over half of the cases (n=15). This included violence towards others (n=8) including police officers (n=3). Consistent with previous research (Dobash et al. 2007) problematic substance use was also high in this sample (n=14).

In over two-thirds of cases (n=18) either an informal network member or a statutory agency was aware of some kind of 'problem' with the relationship. This included such observations as 'the relationship was stormy/not good' and 'there were arguments'. Ten of the victims were separated from the perpetrator at the time of the murder. Separation ranged from 1 month to 6 years. The DASH tool asks if separation has taken place in the past year. In half (n=5) of the ten cases, separation had taken place within 12 months of the murder: that half had not suggests that this time frame may not be a good discriminator in risk assessment. It is further noted that in two of the cases separation had not yet taken place (DHR11 & 16). Thus separation, actual or intended, was present in twelve cases.

Table 7: Risk factors recorded in relation to 'who knew'

Perpetrator's use of violence	**Agency**	**Informal**	**Unclear**	**Total**
Physical violence	6	11	0	17
Violence in previous relationship	8	0	0	8
Threats to kill	3	3	1	7
Escalation	2	1	3	6
Violence towards child, family member	1	3	2	6
Believes perpetrator capable of killing her, frightened	0	1	4	5
Use of, threats of use weapons prior to murder	2	2	1	5
Attempted to strangle, choke, suffocate	2	2	0	4
Violence during pregnancy (or recent birth – 18 months)	4	0	0	4
Sexual assault to current partner	2	0	0	2
Perpetrator's use of coercive control				
Controlling behaviour	5	7	1	13
Jealousy, surveillance	4	4	3	11
Isolation	0	0	6	6
Stalking, harassment	1	3	1	5
Perpetrator characteristics				
Previous criminality	15	0	0	15
Alcohol, problematic substance use	5	3	6	14
Depression	6	4	0	10
Suicidal thought, attempts, threats	7	0	0	7
Money/debt issues	3	3	0	6
Breach of a protection order	2	0	1	3
Relationship characteristics				
Relationship 'problems'	5	9	2	16
Separation (recent)	0	0	10	10
Conflict over child contact	4	0	0	4
Separation (imminent)	0	0	2	2
Total	**87**	**56**	**43**	**186**

Clustering of risk factors

Whilst the above analysis reveals the levels of factors identified across the sample as a whole, what is significant in risk assessment is the clustering within individual cases. The highest number of factors found in any individual case was eighteen and the lowest was one. Excluding the one case in which no risk factors were identified,[19] the average across the remaining 23 cases was eight. This is considerably lower than the 'visible high risk' threshold of 14 identified within DASH guidance (Safe Lives, 2014).

Domestic Violence Perpetrator Programmes (DVPPs)

None of the perpetrators within this sample were known to have attended a Domestic Violence Perpetrator Programme (DVPP) including those men who had been prosecuted for domestic violence against their current/former partner. One perpetrator told the Panel during his interview that:

> Although he was told by the police that the relationship was not healthy and that he should get out, no help was offered - unlike his ex-partner… the police could have told him that… he should go to meetings, therapy or classes (DHR1).

It is noted in another report that despite being imprisoned for an offence against a previous partner, the perpetrator did not undertake the Healthy Relationships programme which was available at that time.

> [The perpetrator] was recognised as being suitable for placement on an Integrated Domestic Abuse Programme (IDAP) but his licence period was too short to complete the course. At this time there was no opportunity to offer structured individual interventions which have become available since [the perpetrator] was supervised by Probation (DHR4).

Given this was the perpetrator who had previously been violent in four relationships, the report observes:

> The history of [the perpetrator] continuously begs the question as to what should or could have been done differently to safeguard existing and future victims (DHR4).

DHR26 notes that a probation report relating to a former partner assessed that 'violence in a domestic setting would be an aspect of [the perpetrator's] future offending' and it was recommended that perpetrator programme would be 'the most suitable sentencing option'.

> Due to [the perpetrator's] complete denial and intention to appeal he was considered unsuitable for the programme. [He] had been violent in previous relationships. This had been to the extent that he had been prosecuted for domestic assault… In his dealings with probation services he was assessed as demonstrating distorted thinking and controlling behaviour (DHR26).

There were, therefore, no risk reduction measures undertaken with perpetrators beyond the conventional sanctions of police involvement in a few cases. This, when compared to the victims referred to MARACs raises the troubling issue that currently risk framing often focuses only on the person *at* risk and does not routinely consider the person who *is* the risk.

19 DHR19 represented the only case in which nothing was known about IPV and where the perpetrator did not have an identified mental health issue or problematic substance

Section two: Adult Family Homicide (AFH)

Family related homicide made up a quarter (n=8) of DHR reviews; seven involved a parent killed by their child:

- 5 cases involved sons killing mothers (matricide)
- 2 cases involved sons killing fathers (patricide)
- 1 case involved a brother killing his brother (fratricide)

Hunter and Nixon (2012: 211) describe the issue of parent abuse as 'one of the most unacknowledged and under-researched forms of family violence'. The Crime Survey for England and Wales does not routinely measure child-to-parent violence, last doing so in the mid-1990s when the British Crime Survey found that this form of violence reflected around 3 per cent of domestic violence cases (Mirrlees-Black et al., 1996). Moreover, Home Office data does not differentiate the sex of those who kill their parents. Analysis of 7,124 homicide convictions in England and Wales between 1 January 1997 and 31 December 2008 by Oram et al. (2013) found that 251 (4%) were related to AFH and whilst the majority of these (n=213) involved the murder of parents, twelve siblings and twenty-six adult children were also among the victims.

International studies spanning more than four decades have consistently concluded that AFV is gendered (Westmarland, 2015). When parents are killed it is typically by their sons (Morris & Blom-Cooper, 1964; Green, 1981; Walsh et al. 2008; Hunter & Nixon, 2012). The STADV sample was consistent with these findings. Wilcox (2012) points out that approaches to children's abusive behaviour towards parents has tended to ignore structural influences such as gender and has instead constructed such abuse as an individual, medical, behavioural or criminal issue.

Overview of victim demographics

Apart from a 31 year old man who was killed by his brother, Table 8 shows that all the victims of family-related homicide were over 40 years of age. Nearly two-thirds (n=5) were 56 or older and three were over 70 years of age. The mean (average) age of mothers (n=5) killed by their sons is sixty-four. Interestingly this was also the finding of Ingala Smith (2014, cited by Westmarland, 2015) who analysed eight such cases. In the STADV sample, the youngest mother was forty-three and the oldest was seventy-nine.

Table 8: Age of victim in AFH cases

Age of victim	Number of victims
30-39	1
40-49	2
50-59	1
60-69	1
70-79	3

Three of the victims were White (one White British), three were Black African/African Caribbean and two were Asian. This is consistent with research from Australia, Sweden and Spain that indicates that women from ethnic minority communities appear to be at increased risk of femicide (Mouzos, 2001; Belfrage & Rying, 2004; Echebuura et al. 2008). The immigration status of the victims was not clear. All of the victims were believed to be heterosexual and none were known to have a disability.

Overview of perpetrator demographics

The perpetrators were all men. As noted above, seven of the perpetrators were the sons of the victim and one was the brother. Following the lowering of age from 18 to 16 in the Westminster Government definition of domestic violence, adolescent to parent homicide is now also captured in this category. One such case is reflected in the STADV sample with the youngest perpetrator being fifteen. The oldest perpetrator was forty-eight and the mean age was thirty-three. Excluding the fifteen year old boy from analysis increases the mean age to thirty-six.

Table 9: Age of perpetrator in AFH cases

Age of perpetrator	Number of perpetrators
15-19	1
20-29	1
30-39	3
40-49	3

Four of the perpetrators were Black African/African Caribbean, two were White (one White British) and two were Asian. Again, immigration status was not clear. All of the perpetrators were believed to be heterosexual. One was known to be disabled with a hearing impairment.

Location and method of murder

All of the victims were murdered at home. Three-quarters (n=6) were stabbed to death. One suffered a head injury and one was asphyxiated. In an analysis of mothers murdered by their sons, Ingala Smith (2014 cited by Westmarland, 2015) found that the most common method of killing was stabbing. This was the case in four of the five AFHs involving sons killing their mothers.

GP contact with both victim and perpetrator

Victim contact with GP

In half (n=4) of the cases, GP contact with the victims was considered routine. However in the remaining four cases, review Panels identified information that indicated Adult Family Violence (AFV) may have preceded the murder. In DHR22, for instance, the victim had attended her GP with 12 suspected injuries over a 14 year period. It is noted in the Internal Management Review (IMR) that she attended more frequently than might be expected for minor injuries.

In DHR24 the victim is noted as having said that she sometimes felt depressed. In addition, her son's interaction with the GP about her care is revealing in that, following a telephone consultation with the GP, he 'angrily' requested a home visit because he did not think the telephone consultation had been sufficient. In DHR25 the victim had a history of contact with his GP for minor physical injuries and alcohol related concerns. He was later diagnosed with reactive depression and antidepressants were prescribed. A month before he was murdered by his brother, the victim attended with minor injuries at the local hospital due to a physical fight between them. Although there was limited contact with the victim during the period under review in DHR30, the GP practice was alerted to 'concerns' for the family in a letter from social services which advised that counselling may be helpful.

Missed opportunities

Missed opportunities to enquire about AFV were identified in three of the DHR reports. In DHR22, the report notes that 'the indicators of domestic violence were apparently never considered' despite the victim's injuries and that these were not fully explored or recorded. In DHR24 it is suggested that the GP could have asked more questions about her low mood and why her son became so angry. In DHR30, the Panel questions why the letter sent to the family was never followed up by the GP.

Perpetrator contact with GP

Details about GP contact were shared for seven of the eight perpetrators. However, one refused consent for the DHR panel to access his medical records (DHR25). There was nothing in the GP IMRs to indicate that the perpetrator was a risk to others in one of the cases (DHR2). In the remaining six, issues emerged in relation to problematic substance use/dependency and poor mental health.

In DHR8 the perpetrator disclosed to his GP that he was drinking heavily and that his mother (the victim) had encouraged him to get help. The GP assessed him as being alcohol dependant and provided him with details of Alcoholics Anonymous (AA) and a locally based service for those using alcohol and drugs. Contact was made with the local service on one occasion but records indicate that domestic violence was not an issue that was discussed.

The perpetrator in DHR24 was also noted to use alcohol and he told the GP that he had felt 'stressed' since leaving school. Mention is made of him being involved in a fight that resulted in a head wound. The perpetrator disclosed using drugs irregularly but wanted to stop as these were impacting his personal and work life. Five months before the homicide, the perpetrator's sister made contact with the GP expressing concerns about him 'acting strange' and fighting with his mother's neighbours. Although the GP records describe him as 'isolated and unemployed - a drug user with mental health problems' they state that there was nothing to suggest he posed a direct threat to his mother or any other family member. Reference is also made to drug use in DHR30 but the perpetrator in this case had limited contact with his GP.

The perpetrator in DHR22 had psychosis and the GP IMR notes that he had recently changed medication. His medical file also notes that, on one occasion, he had pushed his mother. In DHR28 the perpetrator had diagnosed schizophrenia and there were concerns that he was not consistently taking his medication. In DHR31 the perpetrator moved into his father's home two weeks before murdering him. He had moved out of his previous home with other family members who were no longer able to manage the risk he posed and care for him themselves.

Missed opportunities

In three cases, missed opportunities were identified in relation to GP actions. In DHR8 it is observed that there was no communication between the GP and the local drug and alcohol service to see if the perpetrator was attending. It is noted that had he been referred to statutory services for alcohol treatment then the GP would have been aware of any non-attendance. The GP is also noted not to have discussed the perpetrator's alcohol problems a year after they had first been raised at an examination for another medical complaint.

In DHR22 it is observed that 'there did not appear to be an awareness of the potential for domestic abuse which could have led to further action'. Although the perpetrator admitted to pushing his mother, this did not lead to consideration of safeguarding issues. In DHR24 it is noted that improvements could have been made to the GP records although it is acknowledged that this is unlikely to have affected the outcome of the case. The GP record noted that the perpetrator was unemployed and had problems with substance use. On this basis the review panel observed that 'more formal enquiries might have been made in these

areas affecting his overall health'. After the perpetrator's sister made contact with the GP, his next visit to the GP, 10 days later, appeared to be routine and no discussion of mental health was noted. The report notes that this 'may have been a missed opportunity to get appropriate help to [the perpetrator] for his deteriorating mental health'.

Mental Health

Victims

Only one of the victims was recorded as having a mental health problem – he was on anti-depressants (the sibling case). However, as is the case in IPHs, it was observed that professionals missed opportunities to explore Adult Family Violence (AFV). Although the victim had sought help with his depression from his GP the report notes that:

> There was a marked absence of any consideration of mental health, emotional or behavioural issues for perpetrator and victim by any statutory agency (DHR25).

In addition it is noted in DHR24 that although there was nothing in the victim's medical record to suggest she was at particular risk of AFV, there were missed opportunities to explore her personal situation. The woman in question was screened for depression on an annual basis due to having diabetes. When a nurse made enquiries about the victim's mood, she recorded a reply which, the report suggests, should have been explored further.

> There were a number of opportunities to ask further questions or follow-up on previous conversations with both [the victim] and [the perpetrator] that might have led to a better understanding of [the victim's] home situation and [the perpetrator's] mental state. GPs should have adult safeguarding training as a requirement and would benefit from guidance and training on recording significant particulars about a patient's personal situation (DHR24).

Perpetrators

As noted in the GP section above, three of the perpetrators (DHR22, 28 & 31) were recorded as having confirmed mental health issues. These included: depression (n=2); self-harm (n=1); heard voices (n=1); psychosis (n=1); and paranoid schizophrenia (n=1).[20]

Mental health issues were suspected but not confirmed in relation to another three perpetrators. In one case (DHR2) the perpetrator had multiple psychological assessments following the murder but professionals failed to agree on a diagnosis. In DHR8 no mental health issues were recorded by the GP but the perpetrator's sister had previously raised concerns about her brother's 'strange behaviour'. Whilst in police detention for his mother's murder, he had been assessed by a police Forensic Medical Examiner (FME) for his fitness to be detained and interviewed but was too intoxicated for a full clinical interview. He was later referred to the Crisis Assessment and Intervention Team (CAIT) for a mental health assessment. The issue of mental health was also raised at his trial. The defence argued that he had a schizotypal personality disorder and alcohol dependency syndrome. However this was countered by a consultant forensic psychiatrist for the prosecution who stated that intoxication played a bigger part than any disorder. This supported the CAIT assessment made immediately after the homicide. The trial judge did not make any recommendation for treatment orders on conviction. In the third case (DHR24), it was suggested that the perpetrator had psychosis and his sister also expressed concerns about his mental health deteriorating. She stated that he had not sought help from a doctor but had intended to do so.

20 Some perpetrators were experiencing more than one issue

Overall then, three-quarters of the AFH reviews (n=6) referred to known or suspected perpetrator mental health issues. Heide and Frei (2009) have noted that schizophrenia is commonly diagnosed among male matricide offenders. In the STADV DHR sample this applied to two cases (diagnosed schizophrenia – DHR28; suspected schizophrenia - DHR8). Psychosis was also found to be over-represented in a sample of 26 offenders of matricide (Clark, 1993). In the STADV DHR sample, two of the four matricide cases involved perpetrators with psychosis (one confirmed and one not).

Links between AFH, mental health and drugs

Analysis of Metropolitan Police data on domestic violence homicides in 2008-09 found that all six of the perpetrators who had killed family members (mother or father) were either suffering from mental health problems and/or were under the influence of drugs and/or alcohol (cited by Neville & Sanders-McDonagh 2014). In the STADV sample, four (DHR8, 22, 28 & 31) of the six perpetrators with known/suspected mental health issues also abused substances.[21]

Like the IPH reviews, in two cases mental health professionals were believed to have limited understanding of the connection between complex issues and abusive behaviour. In DHR22 and DHR31, mental health services were observed as having not explored the risks connected to either AFV or problematic substance use.

> This review has highlighted the limited understanding and connection between the response to adults at risk and domestic violence. The issues of substance misuse and mental health have also not been recognised as part of a disastrous nexus with domestic violence. A more holistic approach to his [perpetrator's] mental health may have introduced different responses, medication and activities that could have led to different outcomes (DHR22).

DHR31 states that the risk posed to the community and the perpetrator's family was not understood or explored by mental health professionals. During the two mental health assessments that the perpetrator had in the six months leading up to killing his father, two mental health professionals indicated that, despite historic and forensic evidence, they believed the perpetrator was 'playing the mental health card' in order to gain access to accommodation. The report concludes that the 'consequent lack of exploration of the risks connected to domestic violence' impacted negatively upon the potential for safeguarding his family.

In DHR22 it is recognised some agencies had information about the potential risk of harm that the perpetrator posed to his mother. Yet this was not explored by mental health services. Again, the lack of enquiry impacted on the risk assessment process. DHR28 concludes that, even when previous adult family violence is not present, professionals should:

> Maintain a dynamic view of potential risks to all members of a family and the community, when managing mental health (DHR28).

Similarly, the Home Office (2013) concludes that mental health and substance misuse services should review, amend and make robust use of their risk assessment frameworks in relation to violence and abuse.

In line with the IPH analysis, it is noted in report DHR31 that such risk assessments should also consider risk to young people. The report suggests that routine checks/information sharing should be undertaken by mental health services with housing and children's services to establish if anyone with mental health issues and a history of violence proposes to stay where children are living. If this is the case then a risk assessment should be undertaken.

21 Alcohol 1 (8); Drugs 2 (22, 24) Alcohol and Drugs 1 (31); Of the two perpetrators with good mental health, one (DHR25) was known to have problems with alcohol. Thus three perpetrators were not recorded as misusing substances (DHR2, 24 & 30).

A theme which does not arise in the STADV DHR sample, but which is highlighted in the West Midlands overview report and is relevant to this discussion is the diversity of risk assessment tools. Neville and Sanders-McDonagh (2014) note that in their analysis, several DHRs mentioned the problematic nature of using a variety of assessment tools (both within and across agencies) making it difficult to understand the holistic risk presented by an individual or to monitor and understand fluctuations in risk. Moreover the West Midlands analysis observes that health professionals are entirely reliant on information given by perpetrators when assessing both their needs and any risk they might pose to others (Neville & Sanders-McDonagh, 2014).

Medication

Within the West Midlands analysis (Neville & Sanders-McDonagh, 2014) non-compliance with prescription medicine emerged as a factor within a patricide case. As noted, there were similar concerns in DHR28 that the perpetrator was not consistently taking his medication. Although not violent to family members when this was the case, it was reported that, two weeks before the incident he was 'not himself'. Although his father and brother would ask about his medication, the family felt that they should have had more information about this aspect of his care.

> The family felt that there should have been more regulation of [the perpetrator's] medication. They also felt that [he] should have been visited in his home environment. There should also have been documents telling the family about the medication and what to expect in side effects and signs of him not taking the medication. (DHR28)

Neville and Sanders-McDonagh (2014) go on to note that a number of DHRs in the West Midlands criticised the way prescriptions are issued and managed.

Information sharing

Consistent again with the IPH analysis, information sharing emerges as a theme within the AFH sample. Information sharing between mental health professionals and other health professionals such as GPs (DHR24 & 31), hospitals (DHR22) and drug services (DHR24) is identified as important in order to promote co-working pathways and holistic responses.

Two reports further suggest that there is a need for mental health services to share information about individuals with the police (DHR24 & 31) in order to ensure appropriate responses. Multi-Agency Safeguarding Hubs (MASH) are referred to as a possible mechanism for achieving this in DHR24. DHR31 also suggests that if a relevant agency has concerns in relation to obtaining information about an individual or if the progression of a case is faltering, then a professionals meeting could be called. Procedures to enact a joined up, problem solving approach could also be considered.

Adult safeguarding

Safeguarding and older people

Since the vast majority of the victims in the AFH sample (n=7) were the parents of the perpetrators, the mean age of 64 was higher than the IPH sample. Age was noted in just one case (DHR8) within the protected characteristic section of the report. The victim in this case was over 75 at the time of her death and in consideration of this, the Panel consulted with Age UK who suggested that the number of visits to her GP could have been an indicator of underlying domestic problems.

Safeguarding and caring responsibilities

Mirroring the theme of being 'carer aware' in the IPH section, this issue also emerged in relation to two of the AFH reviews (DHR28 & 31). Both cases involved fathers who were killed by their sons who had known and significant mental ill health.

In DHR28, deterioration in the behaviour of the perpetrator was noted by his mother and brother in the lead up to the father's death. His father was acting as his carer and was invited to review meetings but it was unclear whether he knew what to do in the case of a relapse. The perpetrator had refused to involve his family in his relapse prevention planning even though he lived with his father. Indeed on the morning of his murder, the victim was found to have called his son (the perpetrator's brother) rather than mental health services. The risk level of the perpetrator had recently been raised by his psychologist, leading to the review report suggesting that the care coordinator could have considered making contact with the perpetrator's father who had recently expressed concern about his son relapsing. Indeed Neville & Sanders-McDonagh (2014) note in the West Midlands analysis that families and friends may feel excluded from treatment programmes.

A review of the case undertaken by the mental health trust found that no 'carers pack' or information leaflet had been provided to the perpetrator's father. The Panel concluded that better communication between the perpetrator, his family and the mental health trust might have led the heightened risk to be addressed.

> Whilst there are issues on inter-agency and family communication they are not felt to be of sufficient gravity to indicate that [the victim's] death could have been avoided. However, if the information had been shared with the family then the heightened risk presented by [the perpetrator] could have been addressed. This case demonstrates the importance of establishing the triangle of care between healthcare providers, patients and carers (DHR28).

In DHR31 the perpetrator moved into his father's home two weeks before murdering him. As previously noted, he had moved out of his previous home with other family members. Hospitalisation was recommended by a number of professionals but the Approved Medical Health Professional (AMHP) decided against this. The report noted that it was unclear to what extent the issues of bed availability and financial responsibility had influenced this decision.

> Had [the perpetrator] been appropriately supported, it is unlikely he would have had to move out of [city 1], where his family were no longer able to manage the risk he posed and care for him themselves, in order to live with his father in [city 2]. He would not have been living with his father whom he killed within two weeks of moving, largely as a result of his untreated mental health issues (DHR31).

The West Midlands analysis (Neville & Sanders-McDonagh, 2014) a case is noted where, due to limited resources, it was not possible to place the perpetrator in a secure hospital and so 'the opportunity was missed for him to be admitted to hospital for treatment' despite the victim (his mother and carer) being described as 'desperate' to have her son admitted.

Safeguarding and mental ill health

As noted above, just one of the AFH victims (DHR25) was recorded as having a mental ill health. This was the sibling case and the victim was taking anti-depressants. It was observed that professionals missed opportunities to explore AFV with the victim who had sought help with his depression and alcohol misuse from his GP. The report notes that:

> There was a marked absence of any consideration of mental health, emotional or behavioural issues for perpetrator and victim by any statutory agency (DHR25).

Safeguarding and problematic substance use

Two AFH cases involved victims who had problematic substance use. As well as suffering from depression, the victim in DHR25 misused alcohol which would have represented another opportunity to explore AFV. In DHR31 the victim was reported to have misused drugs but the report does not explore whether this was ever discussed with him.

Safeguarding and disability

None of the AFH cases involved a victim who was known to have a disability.

Child safeguarding

Only two AFH reports refer to the issue of child safeguarding. The perpetrator in DHR30 was under 18 years of age. Child protection procedures were used to identify and assess risk posed to his siblings but not his mother. As Westmarland (2015: 53) observes:

> Public and policy assumption has been that parents are able to assert control over their children and this does not fit in with the idea that they may be victims of their children's actions.

DHR31 involved the perpetrator who was receiving support around mental ill health. As noted previously, neither his housing officer nor mental health worker identified the need to consider a safeguarding referral when he was living with his sister, despite his previously violent behaviour.

Informal networks

Just two of the eight DHR reviews which explored AFH were able to facilitate participation from informal network members with just three family members contributing to the process. These were family members of both the victim and perpetrator; however they are recorded according to their relationships with the victim and were: a daughter, a wife and a son.

That three-quarters (n=6) of AFH reviews were unable to draw on information known by informal network members may reflect the fact that the perpetrators of such homicides are frequently kin relatives to both parties, making involvement particularly difficult. For instance, in DHR25 the parents of the man murdered by his brother had lost one son and were awaiting the trial of another. In another two cases it was conjectured that 'issues within the family dynamic' were part of the reason why family participation was declined. The Panel was advised by the police in a fourth case that contact would be extremely unwelcome and might undermine the family's trust in their Liaison Officer so this was not pursued.

Risk identification, assessment and management

There is a dearth of research on Adult Family Homicide (Heide & Frei, 2010), and none that explores how current risk identification and assessment tools and processes 'fit' the varied contexts involved. Because the government definition of domestic violence currently conflates violence committed by intimate partners with that by family members, the assessment and management of risk also relies on risks identified within DASH. Just one of the eight AFH victims had been subject to a domestic violence risk assessment before the murder (DHR31). The risk that the victim's son posed to him was identified and assessed by the police twice on two consecutive days. It was not known what risk tool was used, however the risk was categorised as standard on the first occasion and medium on the second, indicating an escalation overnight.

Missteps in the process of identifying and assessing risk

It is noted in the DHR31 report that had a secondary risk assessment been conducted (in line with police policy) on the medium risk score, then a review of the facts alongside the professional judgement of a specialist might have suggested that a grade of 'high' was more appropriate, resulting in referral to MARAC. The report also states that had such a referral been made, then information held by other agencies could have been shared and a clearer understanding of the risks posed appreciated. Moreover had information regarding risk 'been shared and collectively addressed' then the victim's death 'may have been prevented'.

Failure to identify and assess risk

DHR31 observes another occasion on which the police failed to identify risk. The police received an emergency call from the perpetrator's brother at his mother's address reporting that the perpetrator had smashed the door down with a hammer, was inside the house smashing it up and was threatening to kill them all.

> No record was made of the initial remarks of [the perpetrator's] brother, who reported that [the perpetrator] was threatening to kill them all. The threat was not explored, risk assessed, risk managed, investigated or brought to the attention of an Inspector, in accordance with the police Threats to Life Policy (DHR31).

The absence of risk identification and assessment is also noted in DHR30 in which the perpetrator had been assessed by social services with respect to the risk he posed to his siblings and not his mother. This is despite the fact that a month before the murder, the victim had told her son's social worker that he had assaulted her. When the social worker questioned the perpetrator he 'described how he became intimidating to his mother' and was quoted to have said 'he could have murdered her'.

The perpetrator in DHR8 also posed a risk to his siblings as well as his mother. Thus even though the police were called to an incident by the perpetrator's sister at which his mother was present, only the risk to his sister was assessed. Similarly both of the brothers in DHR25 perpetrated violence towards their own intimate partners, leading the DHR report to observe that the nature of the relationship between the brothers did not in and of itself 'feature highly in the work of any agency'.

The Individual Management Review of another perpetrator in DHR22 notes that it 'was never seemingly grasped that his mother [was] at risk of serious harm from [her son]'. These findings suggest that risks to mothers from violent sons needs to receive more attention, both in risk identification, assessment and management and in access to support.

Multi Agency Risk Assessment Conferences (MARAC)

In DHR30, the social worker sent a DASH risk assessment to the MARAC coordinator. Although this reflected an incident in which the perpetrator was victim to his older brother, it did state that the perpetrator's brother had also previously hurt his mother and sister. However due to the perpetrator moving out of the family home and area, the family was never discussed through a 'domestic violence' lens. DHR reports 25 and 31 also note at least one occasion where referral to a MARAC could have been made but was not.

Factor analysis

The following section presents a risk factor analysis across the eight AFH cases drawing on data contained within the DHR reports. The same important caveats highlighted in relation to this exercise in the context of IPH should also be noted here.

The frequency of risk factors

Table 10 sets out the risk factors identified in the DHR reports. The most frequent were: violence towards others, including other family members, neighbours and agency workers (n=5) followed by violence towards an intimate partner (n=3). In fact in DHR25 the report notes that 'some practitioners have commented that they had always viewed the most likely victim of [the perpetrator] to have been [his wife]'. Physical violence towards the victim of the homicide was known in a quarter of cases. There was no reference to coercively controlling behaviours in the adult family violence cases, suggesting that this might be specific to IPV.

In terms of perpetrator characteristics the presence of mental health issues was extremely high in this sample (3 confirmed and 3 suspected; n=6, 75%). Depression featured alone in two cases and alongside other mental conditions in another two. Psychosis featured in three cases, bipolar in one, and paranoid schizophrenia in another. A diagnosis could not be decided on for one perpetrator who was assessed only after the murder (DHR2). It is of note that, unlike the IPH cases, three quarters (n=6) of the AFH sample were found guilty of manslaughter by diminished responsibility (n=5) and by virtue of insanity (n=1). Two perpetrators faced a murder charge (outcome unknown).

Problematic substance use was also very high in this sample with five of the perpetrators having problems with drugs and/or alcohol. One of the diminished responsibility defences was that the perpetrator had killed his mother in a 'drunken rage'. Previous criminality was also very high (n=5). This cluster needs to be explored in further AFH samples to see if these should be emphasised in risk assessment of AFV cases.

Table 10: Recorded risk factors

Perpetrator's use of violence	**Formal agency**
Violence towards child, others	5
Violence in an intimate relationship	3
Physical violence to victim	2
Threats to kill	1
Perpetrator characteristics	
Depression	6
Alcohol, drug misuse	5
Previous criminality	5
Suicidal thought, attempts, threats	1
Money/debt issues	1

Clustering

Alongside the fact that many of the factors found in the IPH cases were not present here (coercive control), or not relevant (separation and conflict over child contact), in two cases (DHR2 & 28) there was no clustering of risk factors. In DHR2 only mental ill health is present (although raised only after homicide, diagnosis not agreed). Similarly analysis of DHR28 identifies only mental health concerns and gambling (money/debt issues). It is observed in one of these reports that anybody could have been at risk.

> Whilst the victim of this case is the father of the perpetrator, consideration needs to be given to the fact that he was attacked by his son during a psychotic episode. There were no signs or indicators of domestic violence before this incident and consideration needs to be given to the fact that any other person could have been victim of attack by [the perpetrator] whilst he was in a psychotic state (DHR28).

In contrast, at the other end of the spectrum, two reports (DHR25 & 30) note six risk factors including: violence in an intimate relationship, physical violence, mental health, alcohol/drug misuse and previous criminality.[22] One case notes five risk factors and the remaining three note four factors.

Commonalities across all of these cases include: violence towards child/others, mental health or problematic substance use and previous criminality. But when 'other criminality' is explored, some other form of violence against women is evident i.e. attack of sister, niece; use of women involved in prostitution; and 'a serious incident against a female'. Indeed several review reports specifically note that the perpetrator displayed patterns of threatening behaviour towards women (DHR24, & 30). This suggests that the sons who killed their mothers demonstrated a high level of hostility towards women.

22 DHR25: plus threats to kill; DHR30 plus violence towards child/others

Section three: Commonalities and differences across IPH and AFH CASES

Having explored six themes emerging from both the IPH and AFH cases, this section identifies commonalities and differences across case studies and considers the implications for risk identification, assessment and management.

Commonalities

Analysis of the whole STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31). A number of common issues have also emerged across the IPH and AFH samples, including:

- mental health concerns
- problematic substance use
- caring responsibilities
- overlap between IPV/AFV
- criminal careers

Yet despite these, Hunter et al. (2010) argue that IPV and AFV should not be treated as congruent. As noted in the introduction, the dynamics underpinning these forms of violence are not the same (Kelly & Westmarland, 2014) with different motivations (Monckton-Smith et al., 2014). Holt (2013) argues that what makes 'parent violence' distinctive from sibling abuse and intimate partner violence is that it is particularly transgressive of conventional notions of power relations. Because it is assumed that parents are able to assert control over their children, the idea that parents may be victims of abuse perpetrated by their children turns this on its head.

Differences

Victims of IPH were more regularly in contact with GPs than victims of AFH and with a variety of issues, perhaps reflecting the ongoing nature of IPV within an intimate relationship. Indeed victims of IPH also appear more likely to experience mental health problems than victims of AFH in this sample.

Whilst the mental health of perpetrators has emerged as a strong theme across both IPH and AFH, there appears to be a particular link between depression and domestic violence in IPV and more severe forms of mental health and domestic violence in AFH. These findings are broadly consistent with analysis of the National Confidential Inquiry (NCI) Into Suicide and Homicide by People with Mental Illness database undertaken by Oram et al., (2013). This study concluded that the prevalence of symptoms of mental illness was particularly high among AFH perpetrators[23] with 27 per cent experiencing psychotic symptoms and 7 per cent experiencing symptoms of depression. In contrast, perpetrators of IPH[24] who had symptoms of mental illness were more likely to have depressive symptoms (13%) at the time of the offence.

Caring responsibilities emerge as a theme for a subset in both IPH and AFH cases. Yet whereas the victims

23 Of the 251 perpetrators of AFH, a third (n=85) had symptoms of mental illness at the time of the offence

24 Of the 1,180 IPH perpetrators within the NCI, 20 per cent had symptoms of mental illness at the time of the offence

in the majority of IPV cases were being cared for, the AFH cases all reflect situations in which the victim was a carer. Another difference is that there is a higher reported rate of substance misuse and disability among victims within the IPV sample compared to the AFV sample. This may well reflect the deliberate targeting of victims with 'vulnerabilities' by perpetrators of IPV or the coping strategies used by victims. Only two AFH cases suggest that physical abuse may have preceded the murder.

Implications for risk identification, assessment and management

Analysis of risk as it relates to cases of IPH and AFH raises a set of complex issues about identification, assessment and management of risk for AFV cases. This is because the DASH tool was developed from IPV research and some risk factors are simply not relevant (i.e. child contact). Whilst others feature they are different in relevance. In just one of the eight AFH cases (12.5%) was risk identified and assessed, compared to eight cases in the twenty-four IPHs (25%). This may also suggest that agencies do not consider the DASH appropriate in AFV cases. A report by Her Majesty's Inspectorate of Constabulary (HMIC) in 2014 noted that some forces have developed a policy of not completing the full DASH form in certain circumstances, including cases of adult family violence.

Whilst acknowledging that the College of Policing is reviewing the evidence base for risk assessment in cases of domestic abuse, HMIC has recommended that forces continue to use the DASH risk assessment tool. A revised tool is probably needed for AFV cases, one which will need to be developed as more knowledge accrues. Table 11 presents factors for identifying and assessing risk in AFV cases that were suggested by workshop participants.

Table 11: Risk factors that need to be identified in family violence cases

- Family – complex and intergenerational
- Caring for someone/being cared for by somebody linked to mental health, suicidality, depression
- Suicide and homicidal thoughts
- History of perpetrator – previous violence against women, pattern of previous criminality, anti-social behaviour
- Sense of entitlement, including to financial resources
- Addiction issues
- Social isolation of victim

Section four: Workshop feedback

As noted in the introduction, six workshops were organised to discuss the draft discussion papers on which this report is based. Initially participants were asked to discuss the papers in small groups and then feedback to the wider group. The overall response was positive, the thematic approach appreciated, and content deemed interesting and insightful. Some identified areas that could benefit from further analysis and, where possible, these were addressed and incorporated within the final report. Where this was not possible suggestions have been compiled (appendix four) for future analysis/research. The original intention was that the promising and good practice suggestions to improve responses would be presented within the body of the report alongside each key theme. However, on reflection these contributions threaded through multiple workshops, and most were also transferable. They have, therefore, been compiled and are discussed below.

Leadership

The need for visible and strong leadership in supporting victims of domestic violence and holding perpetrators to account was noted in five of the workshops. Participants highlighted the importance of domestic violence being prioritised and for this to be reflected within and across organisational cultures. Suggestions about how to raise the status of domestic violence included: appointing champions to lead within individual organisations and across sectors i.e. health; the continual identification of poor practice, with professionals being held to an explicit and institutionally embedded duty of care; and the celebration of good practice and positive outcomes.

Policies

The discussion about GP surgeries highlighted that not all agencies have a domestic violence policy. In addition, discussion on adult safeguarding revealed that domestic violence is not always recognised within this framing. Three workshops recommended that all agencies should have a domestic violence policy. The informal networks workshop further recommended that all employers have a domestic violence policy. Perpetrators may target their victims in the workplace (one woman was killed outside of her workplace) so there is a role for employers to play in taking measures to increase their safety at work, as well as provide practical support. When such policies also set out the employer response to perpetrators of abuse then they can also be used as a mechanism for holding perpetrators to account.

Pathways to specialist services

All of the workshops concurred that agencies must establish pathways to specialist domestic violence support services, especially when victims are not considered by those doing assessments as meeting high thresholds for intervention. The workshop on child protection also recognised that engagement with and services for perpetrators need to be identified, although as noted earlier, there is a lack of provision.

Training

Five workshops identified the necessity of ensuring staff receive training on domestic violence, including the overlaps with complex needs and adult safeguarding. Training should be regularly refreshed, particularly in light of high levels of staff turnover in some agencies. DHR reports could be used to inform training,

including consideration of the different dynamics around IPH (particularly coercive control) and AFH. A further area of agreement was inclusion of an intersectional approach so that professionals can reflect on how victims are located in relation to gender, age, ethnicity, sexual orientation and ability. This, in turn, would question presumptions about what a victim 'looks like'. Training also needs to cover how to ask open questions and also how to ask the 'right' questions of both victims and perpetrators. Finally, it was suggested that training should involve staff at all levels of an organisation (i.e. clinical and non-clinical staff in health settings, managers and frontline staff, elected members) and could be undertaken jointly with other agencies in order to underscore how protecting victims and holding perpetrators to account is a shared and collective responsibility.

Routine enquiry

Four workshops concluded that more work needs to be done on routine enquiry, given the number of missed opportunities identified within the DHR reports. Enquiry should be integrated into all routine contacts. In health settings the use of HARK (Humiliation, Afraid, Rape, Kick) questions was suggested. Crucially, the importance of professionals undertaking safe enquiry was raised, ensuring that an individual is spoken to on their own and using only professional interpreters.

Victim centred

Three workshops focused on the importance of being victim-centred, that is taking cues from the victim about their direction of travel and what their justice goals are. In one workshop the view that professionals should be trained to be more confident in supporting victims around their own priorities, rather than following the priorities of 'the system' was identified. This was linked to the voices of victims being fed into decision-making. The significance of pro-active contact with victims, especially in relation to non-attendance/engagement was advocated, rather than closing the case.

Child safeguarding

A theme strongest in the child protection workshop, but also present in relation to health settings, was the need to provide support to the non-abusive parent (usually the mother) and to hold the abusive parent (usually the father) accountable.

Victim-centred

Support for mothers recognises that woman protection can be simultaneously child protection. Women should not be held responsible for keeping their children safe when they themselves are being abused. Language and practice need to move away from this and professionals should recognise the potential they have to enable victims to expand their space for action, through recognising that coercive control limits freedom. Alongside providing support for women themselves and support to the mother-child relationship, professionals should also ensure that there is specialist support for children and link up with other agencies that are child focused. Holding both women and children, and their relationship, in view is the challenge here.

Holding perpetrators accountable

Perpetrators are often invisible in the responses of many agencies. Participants in several workshops suggested that this is because professionals may either be accepting of or paralysed by men's use of violence. Workshop feedback revealed that many agencies do not offer training to their staff nor expect them to engage with/assess actual or potential perpetrators.

Given that none of the perpetrators in this sample of DHRs had attended a Domestic Violence Prevention Programme, this is a fundamental gap in the prevention of domestic violence and homicides. It was argued that good practice should include empowering professionals to be confident in safely engaging in dialogue with violent men, communicating the unacceptability of their behaviour and showing them the impact of their violent behaviours on intimate partners, children and other family members.

Coordinated health responses

Given that half the workshops focused on health related issues, participants identified the need for different parts of the health system to be more coordinated so that dots are joined up: links need to be made between GP appointments, use of NHS walk-in services, use of out-of-hours services, attendance at emergency departments and use of private healthcare. This was described as a whole system approach which includes: common frameworks; integrated policy; and shared data systems and definitions. However this clearly needs to extend into the commissioning of services and multi-agency working more widely, reflecting the ambition to create a coordinated community response to domestic violence.

Multi-agency working

All workshops identified that good practice should encompass individual agencies acknowledging that they have a responsibility to engage in multi-agency working. In some agencies the understanding of professionals needs to be developed so that they have an appreciation of their role within a multiagency environment. Moreover they should be provided with time and resources that would facilitate their involvement in forums such as MARACs.[25]

The cases that went to MARAC draw attention to the fact that MARAC is not an intervention in and of itself. Actions need to be taken that increase safety and hold perpetrators to account and the appropriate agencies need to be around the table. The importance of GPs attending MARAC cannot be overemphasised given their level of engagement with both victims and perpetrators.

Linked to this the safeguarding adult workshop concluded that whilst there should be recognition of and reference to the vital role of specialist domestic violence services, referrals should not be viewed by statutory agencies as simply passing on responsibility, rather they should be followed up. New ways of working were commended, such as colocation which enables learning and exchange through working on cases together.

Recognise links with caring

Recognition of overlaps between domestic violence and caring for an intimate partner/family member were noted in several workshops. In such situations, the use of Carer's Assessments was highlighted in order to identify if an individual feels safe at home or is using violence/abuse.

An expert who provided written feedback on the adult safeguarding paper drew attention to the need to challenge structural ageism which is inherent in many processes. As such it should not be assumed that older people cannot make their own decisions; or that they neither commit nor experience domestic violence.

If domestic violence is identified then appropriate tools should be used to assess and manage the risk with support for victims from an advocate. Consideration should also be given to the possibility that there may

25 Whilst recognising that there are also challenges with MARACS such as high caseloads (HMIC, 2014)

be more than one perpetrator and/or victim. In addition, that there may be particular barriers to accessing help – particularly in relation to housing and ill health for older people. More work also needs to be done on how to best reach older and/or infirm people.

Working with risk

The identification of risk was an issue that emerged in all of the workshops; unsurprisingly however it was discussed in more depth by the risk workshop participants. Concern focused on:

Conflation of the identification and assessment of risk

Experts observed that risk identification is not in itself assessment of risk. Given that front-line staff across all agencies cannot be expected to be experts in domestic violence risk assessment, an expert who provided written feedback on the risk assessment paper suggested that the two stages be separated so that staff who come into contact with either survivors or perpetrators carry out risk identification and then specific staff within each agency with additional skills/knowledge/training conduct a more detailed risk assessment.

Risk identification and assessment is 'one-sided'

Workshop discussions identified that risk identification, assessment and management is commonly 'one-sided'. For example, DASH is used almost exclusively with survivors/victims. The presence of some of the risk factors, or their frequency/severity, may only be known by talking directly to a perpetrator. Thus even the best identification and assessment of risk with the survivor may not reveal:

- the perpetrator's thoughts linked to homicide;
- covert surveillance or stalking that the victim is not, or not fully, aware of, during the relationship or after separation;
- severe financial difficulties;
- sexually abusive behaviour outside of the intimate relationship i.e. pornography; use of women involved in prostitution
- history of violence/abuse in previous intimate relationships that the victim is unaware of; and
- history of other violence/abuse e.g. in perpetrator's childhood, towards acquaintances/ strangers, use of weapons, etc.

So risk assessment with perpetrators needs to be built in to the practice of many agencies.

Similarly the identification of potential risk to others (i.e. intimate partner and family members) in mental health assessments relies only on the responses of the perpetrator prompting some of the experts attending the mental health workshop to suggest that professionals should seek third party reports/corroboration rather than take answers at 'face-value'.

Risk identification is 'one dimensional'

Linked to the previous point was the observation that when professional attention focuses on violence towards intimate partners, less attention may be paid to risks that are also posed to family members. Similarly less attention may be paid to risks posed to intimate partners in adult family violence cases.

Lack of understanding about risk factors

The two IPH cases which went to MARAC highlight how separation was believed to increase safety. Participants expressed concern that, despite separation being a well-established risk factor for IPH, some professionals placed trust in bail conditions which were presumed to reduce risk. One of the workshop experts suggested that an updated risk assessment based on knowledge could be shared at MARAC and circulated to all involved agencies so that the fuller picture filters down to frontline practitioners. Whilst another participant agreed that a compiled list of risk factors could be contained in the MARAC minutes, sharing the information across agencies would be disproportionate.

Access to services

Risk, service thresholds and pathways to specialist support services for women were also themes that arose during discussion. As was also the case for children, levels of risk were often not high enough to meet statutory thresholds, yet professionals rarely referred or sign-posted victims to specialist support services. Within the analysis of IPH cases, only four victims were in contact with specialist services and, in the AFH cases, none. Discussion also addressed problems in relation to the commissioning of specialist services which, in some cases, are funded to work only with medium-high risk victims. As has been noted, it was further acknowledged that there is a shortage of perpetrator programmes and little or no training of professionals about how to challenge and engage perpetrators.

Raise awareness in communities

The GP workshop participants identified displaying information about domestic violence in waiting rooms as good practice, helping to raise awareness about the issue and also creating a climate in which disclosures can be made. Of course, this strategy is also applicable in other health care settings as well as across statutory services more generally i.e. housing and social services. Participants in the informal network workshop believed that public awareness-raising, on coercive control in particular, is vital. Suggestions ranged from running national education campaigns to promoting awareness of domestic violence and the availability of support services like national helplines and local support services using a variety of difference publicity materials and dissemination routes. Improving the ability of friends and family to recognise warning signs and the need for resources containing advice on how to respond if domestic violence is suspected was identified.

Education and more general awareness raising activities was thought to be more effective if targeted at particular groups – examples were given of *Disrespect Nobody* for young people and the *White Ribbon campaign* which encourages men to publicly stand up against violence. Schools and universities were identified as settings in which education about domestic violence should take place. The power of the media was recognised and participants sought responsible reporting of all forms of violence against women. Social media was considered to have a role in promoting the existence of specialist services.

Hairdressers and debt advisors were identified as needing training about domestic violence to recognise warning signs. An interesting new initiative by Women's Aid in England and Wales is the 'Ask Me' pilot which seeks to do just that.

Involving communities

The informal network workshop emphasised the need to involve wider community members (for example, religious institutions) in prevention. Whilst a coordinated community response is advocated, the current model only includes statutory agencies and voluntary groups. The practices of specialist black and minority ethnic (BME) domestic violence services in community engagement was recognised and commended. Some participants spoke about the development of peer networks, creating 'circles of support' within communities more widely.

Based on what informal networks knew, it is also worth exploring what role the wider community might be able to play in risk identification and assessment, via IDVAs for example.

Levers for change

Workshop participants were asked to consider what 'levers for change' could be adopted in order to address the 'implementation gap', i.e. to increase the implementation of what is now known to be safe and best practice. Suggestions below are those which traverse all agencies: those that are specific to particular agencies are compiled in appendix five.

- Develop gender specific services, and simultaneously co-locate expertise in relevant services, such as the alcohol and drug sector.
- Co-locate expertise in statutory agencies.
- Introduce an automatic referral (with victim/survivor consent) to specialist domestic violence services when (increasingly high) thresholds for statutory intervention are not met.
- Expand referral pathways so that low and medium risk cases are supported and escalation of risk prevented.
- Address the issue of lack of services to meet demand generated by increased reporting and identification of domestic abuse.
- Create appropriate tools for AFV.
- Improve the efficacy of MARACs, including their links to safeguarding arrangements.
- Invest in community engagement: put communities into the coordinated community response.

Useful resources were also identified by workshop participants for use by professionals and communities responding to domestic abuse. These are listed in appendix six.

Section five: Improving the DHR process

In addition to providing feedback on the draft discussion papers, participants also provided feedback on the DHR process itself. This has been captured in a separate section so that learning can be disseminated widely, including to the Home Office, the government department that provides national guidance on the DHR process.

Develop a Template summarising key information

As noted within the introduction to this report, it was not possible to draw any conclusions in relation to intersections between characteristics such as gender, age, sexuality, ethnicity, immigration status, social class and disability. This is something that needs to be explored in analysis going forward, especially because the findings presented here are consistent with research that suggests that women from ethnic minority communities appear to be at increased risk of femicide. There is no national 'template' setting out what 'core' information should be included in DHR reports. This is important in order to facilitate macro-level analysis and to establish whether this pattern is evident at national level and overtime.

In order to be able to contribute to the knowledge base on IPH and AFH and to enable analysis of all DHR reports, it would be helpful for DHR Panels to fill in a common template summarising key information. Appendix seven contains the template used in analysing the cases presented within this report. A template to aid national level analysis could be incorporated into Home Office guidance.

Identification of risk factors

Although retrospective, a risk factor analysis exercise similar to that presented within this report could be made a standard process, even if the case under review was not subject to risk assessment. Two of the reports within the STADV sample undertook such an assessment. This was useful in terms of focusing attention on the range and key features of risk factors present, thereby identifying evidence of a history of domestic violence and focusing on the issue of safety for victims and accountability of perpetrators. This would deflect from the tendency to analyse agency responses to the victim and/or the perpetrator only on the basis of internal and established institutional frameworks. Preparation of the internal management review (IMR) process could similarly be underpinned by this approach.

Holding the perpetrator to account

DHR reports explore the experience of a victim, including whether they engaged with services and responded to offers of support. Feedback from workshop participants suggested that DHR reports should be conscious to avoid inadvertently blaming the victim within this process. This would involve not simply describing what the victim did or did not do to 'keep herself safe' but recognising any barriers and/or dangers associated with doing so as well as consideration about how agency (in)action impacted on the victim and how they could have engaged differently. Also under scrutiny should be what sanctions were taken by agencies to hold the perpetrator to account.

Considering intersections

Routinely recording information about victim and perpetrator characteristics i.e. gender, age, sexual orientation, ethnicity, immigration status, and disability would not only contribute to the national evidence base but also facilitate greater consideration of their 'intersectional locations'. This would move away from labelling individuals as 'hard to engage/reach' but focus attention on what agencies need to be doing better.

Use of chronologies

It can be difficult for those reading a DHR report to grasp the order of events and implications. Most Panels develop a chronology of events and it would be useful for these to be contained within the DHR report.

Statutory duty for agencies to participate in DHRs

This report has highlighted the importance of GP involvement in DHRs. However, in four of the reports, reference was made to difficulties that the Panel had in engaging GPs with the review process. This is often linked to independence since in many cases the individual will have been seen by many of the GPs. Issues arose in relation to: funding arrangements; who was formally responsible for commissioning the IMR from the GP; and who would author the GP IMR. One report notes that:

> The issue of securing GP IMRs has been included as this is a fundamental block for all Domestic Homicide Reviews (DHR9).

Associated outcomes with difficulties around engagement included delay to the review process and, in one case, limited information being shared which impacted negatively on the Panel's ability to analyse the events that preceded the homicide.

Diversity of dhr panel members

Workshop participants suggested that a wider cross-section of participants from agencies should be involved in DHRs, reflecting different positions of responsibility since managers can be defensive. Given the knowledge of informal networks, some participants also suggested that family and friends should be viewed as equal partners and invited to attend DHR meetings. Linked to this was the need to identify the best ways to reach out to informal networks, including how to start conversations about what a DHR is. Facilitating greater involvement of children and young people in the review process: their views as to what professionals did well or could have done better may reveal richer insights into what, contextually, is preventing them from doing so.

National learning from DHRs

Feedback from workshop participants illustrated the thirst to learn more from DHRs but currently it is hard to find this information. The idea of a central repository of DHR reports (perhaps attached to Women Aid's Femicide Census) was suggested. Another suggestion was an annual conference that brings together learning and considers how this can be transferred into practice. The possibility of a strategic responsibility to cascade the learning from DHRs was also raised. Another proposal that was strongly supported was for reviews to be written as case studies and used to underpin training of staff on the frontline as well as management, particularly in relation to AFH cases.

Sustainability of DHRs

The sustainability of DHRs, given the cost implications, was a live issue. In addition, some of the factors that cause delays need to be addressed (i.e. input of GPs, criminal prosecutions) since time lags in publishing the reviews means that they lose their immediacy and recommendations may already be outdated. Different methods of undertaking a DHR could be explored. Workshop participants reflected on unintended consequences of Serious Case Reviews (SCRs) i.e. staff exodus, difficulty in recruiting review chairs when reports are under scrutiny and suggested that similar issues might arise in DHRs given the similarity between the two processes. Reference was also made about the need for better connections between and integration of DHRs with SCRs.

Other review processes

Some participants questioned whether some of the cases – such as those where caring situations/mental health were key issues – were suited to the DHR process.

In four cases, IPV was not believed to have preceded the murder. Three of these cases involved perpetrators who were caring for their intimate partner (DHR10, 19 & 20) and who, it is believed, were unable to cope.[26]

> In the course of this review, it became clear through both correspondence and conversations with family members that there were no apparent issues of coercive control… focus of the review moved to the support that [the perpetrator] and [the victim] had and were offered to address their mounting concerns over their increasingly debilitating mental health and [the perpetrator's] expressed anxiety about his ability to care for [the victim] any longer in light of his own deteriorating mental health (DHR10).

In the fourth case (DHR32) the victim had not had an ongoing relationship with the perpetrator but disclosed to her ex-partner (who was abusive) four months prior to the murder that she had had a sexual encounter with him. This disclosure reportedly led to the perpetrator threatening the victim's ex-partner with a weapon whereupon, according to him, he killed her by accident. What makes this Domestic Homicide Review unusual is that the perpetrator posing the most significant risk to [the victim] was not the perpetrator of the homicide. In fact there was no information received within this review that indicated that [the victim] had experienced any abuse from [the perpetrator] (DHR32).

Similarly it is noted in two of the AFH cases that anybody could have been at risk.

> Whilst the victim of this case is the father of the perpetrator, consideration needs to be given to the fact that he was attacked by his son during a psychotic episode. There were no signs or indicators of domestic violence before this incident and consideration needs to be given to the fact that any other person could have been victim of attack by [the perpetrator] whilst he was in a psychotic state (DHR28).

26 DHR19: no risk factor present; DHR10 & DHR20: mental health only risk factor present

Appendix one: Domestic homcides from year ending march 2005

Numbers of women and men killed by partners, sons/daughters and 'other family' excluding parents from year ending March 2005 to year ending March 2015

Flatley, J. (2016) Crime in England and Wales: Statistical Bulletin

https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingmar2016

Women and men killed by partners: year ending March 2005 – year ending March 2015

	Year ending March -										
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Women	106	90	90	80	102	94	97	89	77	85	81
Men	39	23	29	30	32	19	20	18	16	25	19

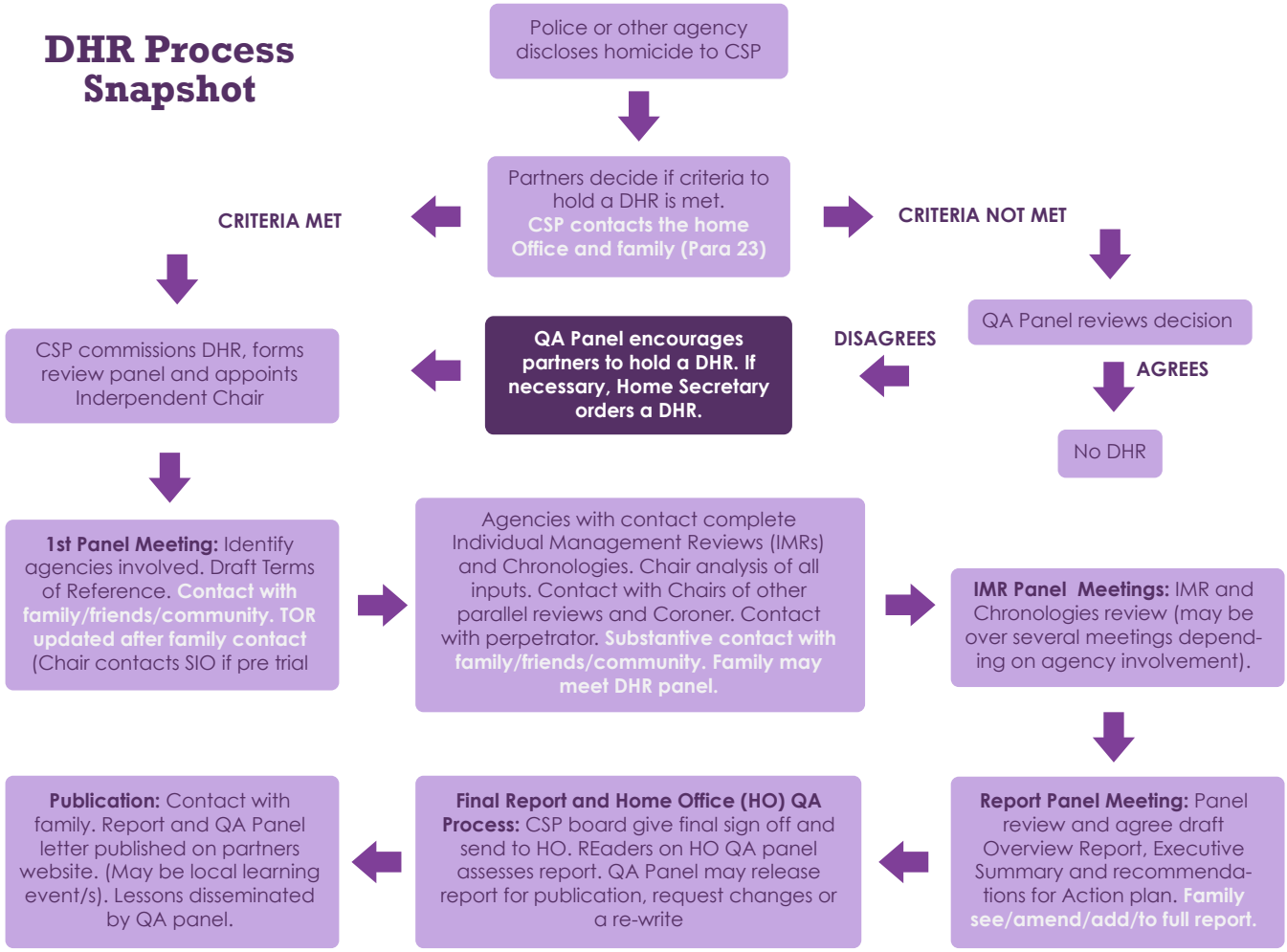
Women and men killed by sons/daughters: year ending March 2005 – year ending March 2015

	Year ending March -										
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Women	2	3	1	4	1	3	1	0	1	4	1
Men	2	1	1	3	3	2	1	1	2	3	1

Women and men killed by 'other family': year ending from March 2005 – year ending March 2015

	Year ending March -										
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Women	8	5	4	12	5	7	6	10	5	10	4
Men	14	12	13	17	9	19	10	14	6	8	11

Appendix two: DHR Process Snapshot



ACKNOWLEDGEMENT TO AAFDA'S CONTRIBUTION (HTTP://AAFDA.ORG.UK)

Appendix three: List of participants

We thank all participants at the themed expert workshops for their time and invaluable feedback on the report. Some listed did not attend the workshop but provided written feedback to the author. The contributions helped shape the report however none of the comments within the report should be individually attributed to participants.

Name	Role	Organisation
Mental Health Workshop (29/01/16)		
Chris McCree	AMH Safeguarding Children's Manager	SLAM
Deirdre MacManus	MA Student	King's College London
Deirdre Brennan	Research Officer	The Femicide Census, Women's Aid
Dr Iris Elliott	Head of Policy and Research	Mental Health Foundation
Dr Siân Oram	Lecturer in Women's Mental Health	King's College London
Karen Ingala Smith	Chief Executive	nia
Mette Vognsen	Head of Independent Investigations	NHS England – Midlands and East Regional Office
Monica King	Named Nurse Safeguarding Children and Young People	West London Mental Health NHS Trust
Priya Shastri	MA Student	King's College London
Sarah Hughes	Mental Health Coordinator	Standing Together Against Domestic Violence
Jessica Donnellan	Senior Projects Coordinator	Standing Together Against Domestic Violence
Sally Jackson	Partnership Manager	Standing Together Against Domestic Violence
Lucy allwright	Stella Project Coordinator	AVA
Shabana Kausar	Stella Project Coordinator	AVA
Amber Cliffe	MARAC Administrator	Standing Together Against Domestic Violence
Della Fallon	Independent Domestic Homicide Review Chair	Associate, Standing Together Against Domestic Violence
Sarah Brennan	Chief Executive	Young Minds
Miriam Sohoraye	Safeguarding Children Advisor and Practice Development Lead	West London Mental Health NHS Trust
Nigel Ballie	Clinical Nurse Specialist	Criminal Justice Liaison and Diversion Team, West London Mental Health NHS Trust
Nicole Jacobs	Chief Executive	Standing Together Against Domestic Violence
Prof Mariane Hester	Head of the Centre for Gender and Violence Research	University of Bristol

Children's Services Workshop (16/03/16)		
Cathal Ryan	Interim Domestic Violence Transformation Manager	Safer Communities, Hackney
Paula Harding	Senior Service Manager	Violence Against Women, Equalities, Community Safety and Cohesion, Birmingham City Council Place Directorate
Sam Monnox	DHR Coordinator	Birmingham City Council
Renata Moriconi	Interim Children's Centres and Early Years Services Coordinator	Haringey Council
Michelle Robson	Senior Practitioner (Domestic Violence)	Children and Young People's Services/ MASH – Haringey
Dr Martha Kirby	Policy and Public Affairs Officer	NSPCC
Della Fallon	Associate	Standing Together Against Domestic Violence
Jo White	Named Nurse for Safeguarding Children	Central London Community Healthcare NHS Trust
Janet Reynolds	Named Nurse for Safeguarding	Central London Community Healthcare NHS Trust
Prof Claudia Bernard	Head of Social Work and Postgraduate Research	Department of Social, Therapeutic and Community Studies, Goldsmiths, University of London
Adila Ahmed	Specialist Health Visitor – Domestic Violence	Central London Community Healthcare NHS Trust
Dr Sheila Fish	Research Analyst, Children's Services Team,	Social Care Institute of Excellence Learning Together supports learning and improvement in safeguarding adults and children.
Miranda Pio	Children and Health Coordinator	Standing Together Against Domestic Violence
Katie Moynan	DHR Administrator	Standing Together Against Domestic Violence
Gillian Dennehy	DHR Coordinator	Standing Together Against Domestic Violence
Felicity Charles	Health and Maternity Coordinator	Standing Together Against Domestic Violence
Nicole Jacobs	Chief Executive	Standing Together Against Domestic Violence
Informal Networks Workshop (11/04/16)		
Deirdre Brennan	Research Officer, The Femicide Census	Women's Aid
Hannah Buckley	Interpersonal Violence Team	Home Office
Helen Clutton	Legal Advisor and Project Manager, Impact Project	Associate, Standing Together Against Domestic Violence
Chris Gaul	Head of Development and Sustainability	The Centre, St. Mary's Church

Angela Grzywacz	Community Safety Partnerships Manager	London Borough of Hounslow
Ioana Hanis	Independent Domestic Violence Advocate	Eastern European Project, Refuge
Sara Kirkpatrick	Services Development Manager	Respect
Feride Kumbasar	Director	IMECE Women's Centre
Jane Lord	Manager	Major Crime Review Team, Surrey Police
Frank Mullane	Director	Advocacy After Fatal Domestic Abuse (AAFDA)
Rachel Ozanne	Knowledge Hub Advisor	Safe Lives
Marc Pigeon	Independent Trainer and Consultant (Domestic Violence)	Associate, Standing Together Against Domestic Violence
Ilenia Piergallini	Project Support Officer	Early Intervention Foundation
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DI Alex Bingley	Ealing MARAC Chair	Community Safety Unit – Ealing, Metropolitan Police Service
Natalie Blagrove	Senior Knowledge Hub Advisor	Safe Lives
DS Pam Chisholm	Critical Incident Advisory Team	Specialist Crime and Review Group, Metropolitan Police Service
Althea Cribb	Independent Domestic Homicide Review Chair	Associate, Standing Together Against Domestic Violence
Laura Croom	Independent Domestic Homicide Review Chair	Associate, Standing Together Against Domestic Violence

DC Helen Debney	Detective Constable	Community Safety Unit – Hammersmith & Fulham, Metropolitan Police Service
Sally Etchells	Policy and Campaigns Assistant	Women's Aid
Birol Mehmet	Domestic Homicide Reviews, Public Protection Unit	Home Office
DS Johnny Moore	Detective Sergeant	Community Safety Unit – Hammersmith & Fulham, Metropolitan Police Service
David Campbell	Village Manager, Fulham North Area Office	Pinnacle Housing
Pragna Patel	Director	Southall Black Sisters
James Rowlands	Strategic Commissioner, VAWG Unit	Partnership Community Safety Team – Brighton & Hove and East Sussex
Mark Yexley	Independent Domestic Homicide Review Chair	Associate, Standing Together Against Domestic Violence
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Thien Nguyen Phan	Lead MARAC Coordinator	Standing Together Against Domestic Violence
Tanya Allen	Specialist Domestic Abuse Court Coordinator	Standing Together Against Domestic Violence
Gillian Dennehy	DHR Coordinator	Standing Together Against Domestic Violence
Nicole Jacobs	Chief Executive	Standing Together Against Domestic Violence
Jessica Donnellan	Senior Projects Coordinator	Standing Together Against Domestic Violence
GP Workshop (14/04/16)		
Adila Ahmed	Specialist Health Visitor – Domestic Violence	Central London Community Healthcare NHS Trust
Fiona Charuy	Senior Midwife	Safeguarding/Domestic Abuse Team, Chelsea and Westminster Healthcare NHS Trust
DS Pam Chisholm	Critical Incident Advisory Team	Specialist Crime and Review Group, Metropolitan Police Service
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DC Helen Debney	Detective Constable	Community Safety Unit – Hammersmith & Fulham, Metropolitan Police Service
Prof Jacqueline Dunkley-Bent	Head of Maternity, Children and Young People for NHS England	Nursing Directorate
Amy Glover	VAWG Manager	Refuge
Trainee DC Kimberley Gray	Trainee Detective Constable	Community Safety Unit – Hammersmith & Fulham, Metropolitan Police Service
Sarah Green	Specialist Midwife for Safeguarding Children, QCCH	Imperial College Healthcare NHS Trust

Dr Megan Hall	FY1 medical practitioner	
Dr Sue Jones	Senior Researcher, Themis Project	Safe Lives
Melanie Jones	IRIS Educator	Refuge
Dr Claire McCamley	Named Safeguarding GP	NHS Central – Westminster CCG
Brenda Otto	Senior Service Delivery Manager – West Area	Victim Support
Dr Sandhu Punt	IRIS Clinical Lead	NHS Enfield CCG
Anna Robinson	Specialist Midwife for Safeguarding	Imperial College Healthcare NHS Trust
Ade Solarin	VAWG Programme and Strategy Manager	Crime Reduction Service, London Borough of Lewisham
Dr Alex Sohal		
Selma Taha	Senior Independent Domestic Violence Advocate	Victim Support
Judith Vickress		
Jo White	Named Nurse for Safeguarding Children	Central London Community Healthcare NHS Trust
Prof Sarah Bewley	Professor of Complex Obstetrics, /Divison of Womens Health /Women's Health Academic Centre	Kings College London
Mark Yexley	Independent Domestic Homicide Review Chair	Associate, Standing Together Against Domestic Violence
Pamela Zaballa	Head of Women and Children's Services – Policy	Hestia
Jessica Donnellan	Senior Project Coordinator	Standing Together Against Domestic Violence
Sally Jackson	Partnership Manager	Standing Together Against Domestic Violence
Gillian Dennehy	DHR Coordinator	Standing Together Against Domestic Violence
Miranda Pio	Children and Health Coordinator	Standing Together Against Domestic Violence
Nicole Jacobs	Chief Executive	Standing Together Against Domestic Violence
Adult Safeguarding Workshop (18/04/16)		
Jess Asato	Public Affairs Manager	Safe Lives
Dr Lucy Allwright	London Stella project Coordinator and AVA Trainer	AVA (Against Violence and Abuse)
Natalie Beccles	Lewisham safeguarding Adults Board Development Officer	Directorate for Community Services/ London Borough of Lewisham
DS Pam Chisholm	Critical Incident Advisory Team	Specialist Crime and Review Group, Metropolitan Police Service

DC Helen Debney	Detective Constable	Community Safety Unit – Hammersmith & Fulham, Metropolitan Police Service
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Mike Howard	Independent Chair	Safeguarding Adults Board – Hammersmith & Fulham, Kensington & Chelsea and Westminster
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Appendix four: Development of report themes/future research agenda

As noted in section five, some workshop participants identified areas that could benefit from further analysis. It was not possible to address and incorporate these all within the final report. Outstanding suggestions for future analysis/research are listed here.

- Explore victim and perpetrator contacts with health professionals across the sector, including private health providers - a 'whole system' analysis
- How to highlight murders where multiple perpetrators/multiple family members are involved?
- Does any pattern emerge where the perpetrator presents with combined depression/ separation/ child contact issues?
- Race equality – is there an over-representation of minority groups experiencing poor mental health; does ethnicity impact access to services?
- Was the perpetrator known to mental health services prior to the homicide; if so, for how long was the perpetrator accessing health services; did any other agencies pick up on mental distress and related risk? Were any of the perpetrators detained under the Mental Health Act?
- If risk was assessed, what instruments were used?
- What was the risk level of the perpetrator at their last contact with mental health services; when was the most recent contact with mental health services?
- Was there evidence that children experienced mental distress before the homicide; where are Child and Adolescent Mental Health Services (CAMHS) within the DHR review process?
- How did families feel when sentencing was linked to mental health? What were the justice outcomes?
- Greater understanding of whether a disproportionate number of women from particular ethnic communities are murdered
- Did the victim access support from religious organisations and other informal sources i.e. hairdresser, dentist, debt services, online community – look beyond family and friends to her networks (social mapping) – go everywhere and anywhere
- Explore the involvement of children and young people in the DHR process (see next section)
- Focus on quality of intervention/assessment, including after MARAC.
- How intersections i.e. gender, age, ethnicity, disability impact
- Educative and preventative models in school/youth settings
- Is there a correlation between DHR findings and Ofsted ratings?
- Focus on debt, housing and financial implications of domestic violence.

- Draw out the different dynamics of abuse i.e. carer stress
- Consider what might be 'masking' recognition of coercive control in complex cases

Appendix five: Levers for change

Workshop participants were asked to consider what 'levers for change' could be adopted in order to address the 'implementation gap', i.e. to increase the implementation of what is now known to be safe and best practice. Suggestions that are specific to particular agencies are compiled here.

Health professionals

- Ensure health professionals are clear about what they can do when capacity is not an issue
- Address the barriers related to information sharing and breaking patient confidentiality: refer to 'Striking the Balance' (Department of Health, 2012) which identifies the underlying ethical considerations helping to resolve the tension between confidentiality and information sharing
- Acknowledge the size of the issue i.e. link between IPV and suicide as well as homicide
- Make the response to DV a key performance indicator
- Introduce IRIS, a GP-based domestic violence and abuse (DVA) training support and referral programme
- Put responses to DV into the 'safety domain' of Care Quality Commission (2016) regulations for NHS GP practices and GP out-of-hours services

Adult safeguarding

- Use the Care Act to: raise awareness; enable discussions; lever training; access resources; request access to data and link to violence against women and girls
- Introduce knowledge and skills statement as assessment tool for social workers working with adults (already exists for children)
- Implement the ADASS guidance on adult safeguarding and domestic abuse
- Ensure greater integration of Multiagency Risk Assessment Conferences (MARAC) with Protection of Vulnerable Adult (POVA) processes
- Widen understanding of what 'disability' means

Mental health

- Consider making suicidal ideation a trigger to consider risk to others
- Ensure domestic violence is part of the Mental Health Crisis Care Concordat (a national agreement between services and agencies involved in the care and support of people in crisis)
- Use the Mental Health Task Force as a way of addressing the issue of mental health within maternity services

Appendix six: Useful resources

Workshop participants gave examples of useful resources that can be used by professionals and informal networks when responding to domestic violence.

GPs

- Caldicott information sharing guidelines (March 2013)
- Bewley, S. & Welch, J. (2014) ABC of Domestic and Sexual Violence, Wiley-Blackwell
- West Midlands Police and Crime Commissioner (2015) Safeguarding Toolkit: Practical Toolkit for Frontline Practitioners

Safeguarding adults

- ADASS guidance on adult safeguarding and domestic abuse
- The Caerphilly practice model: using a chronology approach to identify what does not work with repeats:
- http://www.olderpeoplewales.com/en/adult_protection/aberystwyth_report.aspx
- Choice – Building justice options with older people: http://choice.aber.ac.uk/about/
- Williams, J., Wydall, S and Clarke, A H. (2013) 'Protecting older victims of abuse who lack capacity: the role of the Independent Mental Capacity Advocate'. *Elder Law Review*
- Unilever's Five Levers for Change:
- https://linkingsustainability.com/coming-up-reports/unilevers-5-levers-for-change/

Safeguarding children

- The Learning Together Model (Social Care Institute for Excellence, SCIE) is being used for Serious Case Reviews (SCRs) and Safeguarding Adult Reviews (SARs). The learning activity straddles children and adult services so highlights where and how cross-working can be improved at frontline and management levels. This model could be valuable in DHRs involving children too. Commissioning a child welfare perspective alongside the DHR and then publishing it as an addendum misses the opportunity for collaborative learning.

Informal networks

- Healthy (respectful) relationships in schools/universities – Tender http://tender.org.uk/
- Imkaan's service standards for community organisations

Appendix seven: Template for DHR analysis

The template below was used to analyse the cases presented within this report.

1. Overarching

Victim

Gender	
Age at time of incident	
Sexual orientation	
National origin	
Language	
Immigration status	
Religion	
Last place of residence	
Living with the perpetrator at the time of the incident? If not where?	
Highest Education level achieved	
Employed at time of murder?	
Occupation	

Perpetrator

Gender	
Age at time of incident	
Sexual orientation	
National origin	
Language	
Immigration status	
Religion	
Highest education level achieved	
Employed at time of murder?	
Occupation	
Loss of job within the last year	

Relationship: IPH cases

Perpetrator relationship to victim	
Marital status at time of incident (if IPV)	
Victim living with the perpetrator at the time of the incident? If not where?	
Duration of relationship (in months)	
If separated, time since separation (in months)	
Reason for separation	
Had the victim threatened to leave the relationship?	

If yes who knew this	
Had the victim been planning to leave the relationship?	
If yes who knew this	
Was the perpetrator aware of the intention to leave the relationship?	
If yes who knew this	
Had the victim left on previous occasions	
If yes on how many occasions	
If yes who knew this	
Financial problems?	
If yes who knew about this	

Relationship: AFH cases

Perpetrator relationship to victim	

The homicide

Date of murder	
Place of murder	
Cause of death	
Was a weapon used?	
If yes what type?	

Prosecution

What was the perpetrator charged with?	
How did the perpetrator plead?	
To what?	
Details of verdict	
What was the sentence?	
Minimum sentence	

2. Adult safeguarding

Victim

Any known disabilities?	
If yes what?	
Problematic substance use – what?	
Experienced domestic violence before	
Being cared for?	
Carer's assessment?	
Safeguarding assessment?	
Mental ill-health? If yes, number of contacts, date of last contact	

Perpetrator

Commit suicide following the murder?	
How?	
History of alcohol abuse?	
History of drug abuse?	
Enrolled in a DVPP or a drug/alcohol rehabilitation programme?	
Was the programme completed?	
Known disabilities?	
If yes what disabilities	
Being cared for?	
Carer's assessment?	
Safeguarding assessment?	
Mental ill-health? If yes, number of contacts, date of last contact	
Any issues around medication?	
Any suicide attempts in the past?	
If yes who knew this?	
Any suicide attempts in the year prior to the murder?	
If yes who knew this?	

3. GPs

Victim

Contact with GP	
Number of contacts	
Date of last contact	
Disclosed DV?	
Routine enquiry	
Missed opportunities for enquiry?	
Presenting issues	
Long term condition?	
DV policy/training	
Same GP practice as perpetrator?	

Perpetrator

Contact with GP	
Number of contacts	
Date of last contact	
Disclosed DV?	
Routine enquiry	
Missed opportunities for enquiry?	
Presenting issues	

Long term condition?	
DV policy/training	

4. Child safeguarding

Number of under 18s in household	
Victim number of children with current partner	
Victims number of children with previous partner	
Perpetrator number of children with current partner	
Perp number of children with previous partner	
Were any of the children subject to violence by the perpetrator?	
If yes whose children were abused?	
If abused, details	
Who knew about this abuse?	
Were any of the children present at the murder	
Details of Child 1 ---- Age (in Months)	
Was child 1 indirectly injured?	
Was child 1 directly assaulted?	
Children murdered	
Had any of the children witnessed previous incidents of DV	
Who knew this?	
Age of the victim's youngest biological child (in months)	
Was the victim pregnant at the time of death?	
Or just had baby?	
If pregnant then how long (in weeks)	
Did CYPS know of family	
Were there any child contact issues	

5. Risk

Known to informal networks

Did the Victim talk with informal networks about the abuse	
If yes then who?	
If yes then what?	

Known to agencies

Date reported	
What was the incident?	
Which Agencies knew about the incident/s?	
What action was taken?	
What was the outcome?	

Risk assessment with victim

Was the case risk assessed?	
Who did the risk assessment?	
What was the risk tool?	
What risks were identified?	
How was the risk graded?	
MARAC?	

Risk assessment with perpetrator

Does the perpetrator have a history of violence with the current partner?	
Who knew this?	
Regarding violence with current partner - were there any police call outs?	
If yes how many times?	
Regarding violence with current partner - were there arrests?	
If yes how many times?	
Regarding violence with current partner - were there charges?	
If yes how many times?	
Description of the charges	
Regarding violence with current partner - were there any convictions?	
If yes how many times?	
Description of convictions?	

Were there any DV protection orders against the perp at the time of the incident?	
Did he violate the order to commit the murder?	
Were there any previous DV orders against the perpetrator?	
Were there previous violations of this/these orders?	
Were the previous violations prosecuted?	
If prosecuted were any sanctions applied?	
Were there any fines	
Details of fines	
Probation	
Details of probation	
Custodial	
Details of custodial	
Something else?	
Details	

Previous relationships

Is there a perpetrator history of violence with previous partners?	
Number	
Who knew this?	
Regarding violence with previous partner - were there any callouts?	
If yes how many times	
Description	
Regarding violence with previous partner - were there any arrests?	
If yes how many times	
Description	
Regarding violence with previous partner - were there any charges?	
If yes how many times	
Regarding violence with previous partner - were there any convictions?	
If yes how many times	
Description	

Was the perpetrator ever referred to a DV perpetrator programme?	
If yes what was it in relation to?	
If yes did the perp enrol in the DV perpetrator programme?	
Was the programme completed?	

New relationship

Violence towards a new partner since homicide?	

Other family violence?

Was there another type of family violence?	
If "another type of family violence" please describe	

Violence towards others?

Is there a history of violence towards others?	
If yes who was it against and describe	
Who knew this?	
Regarding violence towards others - were there any call outs	
If yes how many times	
If yes Please describe	
Regarding violence towards others - were there any arrests	

If yes how many times	
If yes Please describe	
Regarding violence towards others - were there any charges	
If yes how many times	
If yes Please describe	
Regarding violence towards others - were there any convictions	
If yes how many times	
If yes Please describe	

6. DHR process

First meeting (within 6 months of homicide?)	
Review period	
Any parallel reviews?	
Preventable?	

Involvement of agencies in DHR: Internal Management Review (IMR) member of Panel (PM) or both?

Police	
CPS	
GP	
Hospital – A&E	
Maternity	
Ambulance	
Clinical commissioning	
NHS Trust	
LA	
Mental health	
Problematic substance use	
CYP	
Adult social care	
Probation	
Prison	
Youth offending	
Education	
Housing	
Support services - Specialist - General which	
Others?	

Awareness of domestic violence?

Did any agencies know that the victim was experiencing, the perpetrator was perpetrating domestic violence?	
Total number of disclosures recorded	

Informal network members involved in the DHR process

Perpetrator	
Perp's previous partner	
Family – name	
Friends – gender	
Employer – gender	
Colleagues – gender	
Neighbours – gender	
Others – gender	
What did involvement in the DHR look like? Name types of contact	
Reasons for non-involvement?	
How were informal network members contacted by the Panel?	
Did informal network members do anything? If so, what did they do?	
Do informal network members have unanswered questions?	
Recommendations made by informal network members	
What support is in place for informal network members?	
Did the family see the final DHR report?	

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