London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process

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MOPAC | MAYOR OF LONDON OFFICE FOR POLICING AND CRIME

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Contents

A tribute

We must always remember that every DHR carried out involves a mother, father, daughter, son, brother, sister, auntie, uncle or friend has been killed, and they should not be forgotten. We need to remember that they were real people who loved and laughed, had children, families and friends, and that their futures were cut short by a terrible act. The effect of this on the families and friends will last forever, as nothing we can do will bring them back. To do them justice we need to actively learn from these tragedies and work hard to make sure those lessons are embedded into our practices. We can aim through our work and research to make their lives matter and never forget who they were or what their families and friends are left coping with. By identifying our mistakes and lost opportunities through this analysis, we hope to improve the future response to survivors and perpetrators.

Introduction

Thank you to all who have taken part and supported this report.

We would like to thank firstly and most importantly all of the families and friends who have contributed to the reviews. Your contributions have enabled your loved one's voices to be heard and we hope to do justice to your contributions. We will aim in this report to keep their experiences at the forefront of the work. We hope the lessons learnt in this report will contribute to better focus on risk factors and responses to future victims.

Standing Together would like to thank MOPAC for their commissioning of this analysis of Domestic Violence Homicides in London and the Local Authorities DHR process. We would like to thank Aisha Sharif at MOPAC for her patience and counsel on this report. We would like to thank the staff at Standing Together, Laura Croom for her contributions and Gemma Snowball for her assistance, also our interns, Alessandra Baratelli and Tamina Summersgill, for their support. Thank you to Sheila Wesa for supporting the work of this report.

We are very grateful for the support and expertise provided by Nicola Douglas and Thien Trang Nguyen Phan at Standing Together, Galop, Peter Kelley & Dr Jasna Magic, Imkaan, Baljit Banga and Sumanta Roy, and Dr Marilia Calcia, South London and Maudsley NHS Foundation Trust, who all provided specialty insight related to their specific fields.

This report follows on from the work conducted by Standing Together and London Metropolitan University analysing DHRs in 2016. This work will look at the report's key findings and recommendations and see what comparisons or differences there are in London. We will be analysing the DHRs to highlight learnings and gaps that are not only relevant to London, but at a regional and national level. Recently, violent crime, specifically, street crime, in London and across the country has largely been the focus of the news. We are saddened by what we see happening to the children of this generation and we hope some of the learnings in this report can also inform future work intended to tackle street violence. Most domestic violence happens behind closed doors within the home and by perpetrators that are known to the victim. Accompanying these particular dynamics are unique challenges which all agencies, employers, family and friends supporting survivors face.

We hope the learnings from this report will shed light on the work that needs to be completed to ensure an improved response to survivors. We hope the findings will also inform and support boroughs to implement and fully integrate a Coordinated Community Response (CCR) to Domestic Abuse across London, where lessons can be shared nationally. In this report, we will also be looking at the individual local authorities' processes for carrying out a DHR. This report will focus on how a DHR is decided, the process for appointing a chair, and if the recommendations and action plans are followed after completion of the final report. For a DHR process to mean something more than the paper it is written on, all the agencies involved must take on board the recommendations and be accountable for their implementation. We hope this work will enhance or support the work already happening in boroughs.

Broadly, much of these findings fall into two categories. Firstly, there are findings which could be characterised as implementation gaps. These gaps are comprised of failures or missed opportunities where best practice is understood but not implemented. Secondly, there are findings which demonstrate that 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. Much of these findings are underpinned by a lack of fundamental understanding of coercive control, a lack of focus on the perpetrator and the risks they pose and a 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 also want to focus on the process of conducting and chairing DHRs. We hope the learning from this will enable Local Authorities to review their processes and share good practice. We hope it will also inform the Home Office in their review of the guidance for DHRs.

STADV continue to build and develop an effective UK-wide CCR to address domestic abuse. We want this report to also expand on the emerging discussions around Adult Family Violence and we are eager to hear about your area's good practice responses. Please actively use this report and share it widely with partners and colleagues.

Bear Montique, Interim CEO

October 2019

Executive Summary London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process

Bear Montique
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At a Glance

Out of the 84 DHRs analysed for this report, 59 were interpersonal homicides and 25 were adult family homicides.

Between April 2011 and March 2019, 196 domestic homicides occurred.

Feedback from 28 boroughs surveyed about the DHR process advised that clearer procedures need to be put in place to ensure the quality of the reviews, which are not limited to but included:

Key themes in the DHR process

- Boroughs wanted the Home Office to keep a complete library of completed DHRs
- Boroughs wanted a qualification or code of practice for chairs to ensure quality
- Need for better inclusion of intersectionality within the DHR process
- Funding for local authorities to carry out DHRs
- The introduction of further DHR guidance on complex DHRs
- Ensuring action plans and recommendations are monitored for progress by the Home Office

Key themes in IPH DHRs

- 56% of Risk Assessments were not undertaken, or done poorly
- 54% had a lack of understanding of domestic abuse by non-DA agencies
- 49% missed opportunities to ask about victims' relationship
- 46% lacked information sharing between health agencies
- 39% lacked a referral to MARAC where needed
- 37% lacked DV policies or didn't follow them
- 32% lacked enquiry to victim even when complex and multiple disadvantages were present

Key themes in AFH DHRs

- 60% had a lack of understanding of domestic abuse by non-DA agencies
- 48% missed opportunities to share information
- 44% missed opportunities to ask about victims' relationship
- 40% lacked information sharing between health agencies
- 40% lacked enquiry to victim even when complex and multiple disadvantages were present
- 28% lacked a referral to MARAC where needed

Key issues found around BME

- A need for agencies to liaise more with BME specialists when supporting victims of domestic abuse
- Immigration status was a barrier for some individuals seeking support; access to services may be limited by the agencies' misunderstanding of immigration law
- DHR panels did not always take an intersectional approach to DHRs or include a diverse range of members on the panel

Key issues found around LGBT+

- Lack of understanding of the dynamics of LGBT+ abuse amongst agencies
- Lack of perpetrator programs available for non-heterosexual men
- Trans people can be particularly vulnerable in situations of domestic abuse

Key issues around Mental Health

- Mental health issues were quite prevalent in both IPH and AFH; mental health issues were found in 42 perpetrators and 23 victims out of the 84 cases analysed in this report
- Mental health problems were identified in 64% 16/25 cases of perpetrators in **AFH** cases, with
  56% 14/25 of the cases diagnosed with a psychotic disorder, of these cases 40% were open to mental health services at the time of the murder. 12% of victims had mental health issues.
- Mental health problems were identified in 44%, 26/59 cases of perpetrators of **IPH** cases, with 32% of the cases diagnosed with a psychotic disorder. 11% of cases were open to mental health services at the time of the murder. 33% of victims had mental health issues.

Key issues found around older people

- Cases analysed aligned with national figures for DA with 78% victims being female, and 22% being male
- Agencies dealing with older clients failed to link injuries with abuse and instead saw the injuries as part of clients being older individuals
- Most victims fell into the 'young-old' category (60-69)
- Mental health was a factor in older people DHRs
- 78% of cases involved a caring relationship between the victim and perpetrator

Most frequent themes across all DHRs:

- Lack of awareness of DA and its impacts
- Lack of information sharing between agencies
- Missed opportunities to ask about victim's relationships
- Lack of consistent DASH risk assessments carried out
- Lack of focus on perpetrators and risk they pose to others

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, manage risk factors, hold perpetrators to account, and ultimately, work to 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 agreed **action plan** is in place.

Written **policies and procedures** are in place within every **organisation** covering their response to domestic abuse. Regular compulsory **training** embedded within every level of an organisation should supports these.

Written **policies and procedures** are agreed covering **multi-agency** systems and working (including the MARAC and specialist domestic abuse courts). 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 more likely to happen to women, there are clear differences in the dynamics and motivations underpinning Interpersonal Violence (IPV) and Adult Family Violence (AFV). The analysis and recommendations are therefore split into two separate sections.

There is a significant dearth in research around AFV, as opposed to the more established body of evidence around best practice in the context of IPV. Accordingly, we have focused a section of the report on this issue to increase our learning of the issues and our understanding of the problem.

We have also included a chapter on intersectionality to explore the specific experiences of the BME community, LBGT+ people, people with mental health issues. and for older people.

London Boroughs DHR Process

In this report, we wanted to explore the process each borough undertook to carry out a DHR. Local Authorities were asked in a questionnaire to explain their process from decision to completion. We asked how they appointed a chair, chose a panel and developed action plans. 28 boroughs completed the questionnaire. We then carried out an interview with 18 of the boroughs to get a more in-depth insight into their processes. Below is the direct feedback from boroughs.

Home Office guidance on DHRs

Since the implementation of section 9 of the Domestic Violence, Crime and Victims Act (2004), as of 2011, every local council is required to carry out a Domestic Homicide Review.

Section 9 (3) of the Domestic Violence, Crime and Victims Act 2004 requires that a review of the circumstances surrounding the 'death of a person aged 16 or over [who] has, or appears to have, resulted from violence, abuse or neglect by –

- A person whom he [sic] was related or with whom he [sic] was or had been in an intimate personal relationship, or a member of the same household as himself,
- [is] held with a view to identifying the lessons to be learnt from the death.'

Key Findings and feedback from boroughs

- Several boroughs found it difficult to retrieve all their DHRs since 2011. No one agency has a complete library of finished DHRs which were approved for publication.

- There are no systems currently in place to check for compliance in resubmitting finished DHRs to Home Office after panel decisions.
- DHRs and SCRs should be more linked up around findings and recommendations to compare and reflect on the learnings.

Chairs

- 20 boroughs fed back they had difficulties finding a good chair and wanted the Home Office to supply a list of recommended chairs.
- Boroughs wanted a qualification, or code of practice for chairs to ensure quality.
- 60% of boroughs felt there was a need for more intersectionality and relevant professionals on Panels.

Process

- Changes in staff can derail or slow a DHR, Problems with quality of chairs caused delays or led to the DHR being rewritten.
- Some chairs did not have an understanding of the dynamics of DA/VAWG.
- Responses from health services, especially GPs was a large and constant issue raised by boroughs.
- Inter communications between Safeguarding Adults and Children and Mental Health Services were poor.

Funding a DHR

- 99% of boroughs said they had real struggles funding the DHRs
- The majority of DHRs were funded through the Community Safety budget, some using the dedicated VAWG budget
- The resource implications of action plans are not always thought through, resulting in no action.

Local Authorities wanted clearer guidance on:

- What to do in the cases that fall outside the usual definition or a suicide with DA/VAWG present
- When to proceed with a DHR without compromising the criminal trial when the perpetrator has fled the country or found not guilty on appeal.
- The process for the Q and A panel at the Home Office which they feedback was too slow, with boroughs waiting 6 months or more for a decision on publication.

Publication

- How long to publish the finished reports online, this varied in boroughs.
- Publication when a case is found not guilty on appeal.
- Where there were young children involved, whether to only publish for a short time, as the children's feelings need to be considered as they get older.

Action plans

- 46% of VAWG leads were responsible for the development of the action plan with 10 VAWG leads responsible for the whole management of the action plan.
- Only 9 boroughs provided updates to families about the progress of the action plans.

- Lack of capacity to make organisational wide changes affected the action plan
- Changes of Health Trusts, CCGs amalgamating, and Probation changes affected continuity of input
- Recommendations for GPs were hard to achieve as lack of time for any input or training was an issue.

Police Process

The police have gone through a complete restructure since government cuts to their budgets. This has resulted in the introduction of Basic Command Units (BCU) merging 32 boroughs into 12 new policing areas. Plans in 2020 will see the transfer of standard risk DA cases to Emergency Response Policing Teams (ERPT), this will also free up capacity for specialists working with medium to high cases. This new process will introduce a single point of contact for standardisation and consistency of risk assessment review. A new pilot risk assessment DARA has been being piloted and will be extended to several other forces this year to trial. This development of the DARA must include an engagement with the specialist services, to ensure a survivor and diversity focus in the final outcome. The Met police, despite cuts, have invested heavily in training across the force on DA, coercive control and its impacts, Domestic Violence Prevention Notices, MI investigation and CPS improving outcomes. This shows the commitment invested in tackling perpetrators and supporting victims.

Findings

The findings of this survey have highlighted the challenges boroughs face regarding funding and carrying out DHRs. The funding of DHRs needs to be addressed by the Home Office and boroughs. The Home Office are currently carrying out a review of DHR guidance. This should be reviewed not only by consultation but by also using the findings from this report and holding solution focused days with chairs and DA/VAWG leads in the boroughs. This would result in user-led improved guidance.

Health services were cited as difficult to engage with the DHR process with GP's needing more training and engagement. In boroughs where Iris [1]was present the response was much improved from GP's.

The feedback highlighted a need for more diversity on panels to reflect the intersectionality present in the DHRs. By including the specialist community agencies on every panel, the boroughs would gain more insight into diverse communities, their specific needs and experiences.

Recommendations for Practice

- DHR chairs should have a code of conduct and a recognised qualification.
- Funding for DHRs should be reviewed and more assistance given to boroughs by the Home Office.
- Funding of DHRs should be a joint responsibility of the Home Office and all Safeguarding statutory agencies within the local authority.
- Create a national database of DHRs and their analysis to enable wider learning from the themes and data.
- The Home Office should provide boroughs with further guidance on publication and storage of DHRs.
- Create a statutory duty for health services including GPs to participate in DHR reviews.
- The Home Office should develop a system of reviewing action plans to completion.

[1] https://Iris.org/

- DHR panels should reflect the diversity of the borough and the DHR case and include specialist agencies relevant to the case.
- All boroughs should create a DHR template work plan to provide consistency of process.
- The Home Office should provide clearer guidance for boroughs on complex cases of suicide with DA/VAWG present, appeals and not guilty verdicts.
- NHS and other relevant health services, especially mental health, need to create guidance and training for GPs and mental health services on involvement in DHR processes.
- Police should ensure that any changes in risk assessments include engaging with specialist services to ensure a survivor and diversity focus is embedded into the final outcome.

Domestic Homicide Statistics

In London between 2013 and 2019, 196 domestic homicides took place. At the time of writing in 2020, 10 domestic homicides have taken place so far (see Appendix 1 and 2 for UK statistics before 2011.

Below are the figures for the number of domestic homicides solely recorded by the Metropolitan and City of London Police Forces, between April 2010 and March 2019. (Homicide figures recorded by Home Office can be found in Appendix 2)

Table 1: Metropolitan and City of London Police Forces Statistics

Recorded Financial Year	Domestic Homicides
2010/11	25
2011/12	21
2012/13	21
2013/14	30
2014/15	21
2015/16	27
2016/17	11
2017/18	15
2018/19	25
Grand Total	**196**

Domestic Homicides taken place between 2019 and 2020 to date: 10

For this section, we analysed 59 reports of Interpersonal Homicide (IPH) and 25 reports of Adult Family Homicide (AFH). We have separated them into IPH and AFH as both relationships have different dynamics. All themes statistics are listed in Appendix 4.

Interpersonal Homicide: Themes

In 39% of cases there was a lack of understanding within agencies of the dynamics of DA/VAWG and its impacts. In 46% of cases there was a lack of professional curiosity to ask further questions about relationships. This was true even in cases where there were complex and multiple needs.

In 20% of cases where there was a disengagement with services, this was often not followed up with any further investigation by agencies as to why. This was particularly important for MARAC cases and those cases where mental health issues were present.

In these DHRs the victim and perpetrator met many agencies during their lives. If there had been routine enquiry built into the policies of these agencies about DA/VAWG there may have been earlier opportunities to offer support and assess risk factors with a DASH risk assessment.

In 54% of DHRs, family, friends and employers knew abuse was happening in the relationship but did not know that the behaviours constituted domestic abuse. Community education is an important part of providing information about what DA/VAWG is and the referral routes to support. Research tells us that family and friends can be the first responders to support for victims. Many victims from BME communities first approach is to their faith leaders for support and it is important that any community work includes those faith and community groups. The Safe project and the VAWG and Faith coalition coordinated by Standing Together works to include faith groups in the response to DA/VAWG.

In 46% of DHR cases, agencies including health missed opportunities to share information or delayed sharing, resulting in increased risk to victims. 37% missed opportunities to share information for multi-agency coordination and make referrals to MARAC or support services. Initiatives like Pathfinders and Iris where health has had an embedded routine enquiry, access to IDVA support and training for staff have shown an increase in staff awareness in identifying DA and disclosures.

In 56% of cases risk assessments were done poorly or not at all. In 39% of cases, the known risks by agencies should have resulted in a referral to MARAC. In cases where mental health was present, no mental health service carried out DASH risk assessments with families on the risks posed by the perpetrator to their family or friends.

In 37% of DHRs, policies and procedures were not adhered to. This includes, but is not limited to, domestic abuse policies

49% of cases missed opportunities to ask about the victim's relationship.

32% of cases missed opportunities to ask victims questions in situations where there was increased vulnerability due to drug or alcohol use and/or mental ill health.

25% missed opportunities to hold the perpetrator accountable or offer support, with 10% missing opportunities to offer support around mental health.

43% of DHRs showed that agencies knew about domestic abuse being present in cases but did not share this information. Agencies need to be clear when and how they share information with other agencies, where they have the responsibility to share information and where they have the power to do so.

Recommendations for Practice Relating to IPH Themes

Lack of Understanding of Domestic Abuse

- Recognise that the key findings from DHRs is the absence of help or support offered due to lack of understanding, and naming domestic abuse, despite signs and symptoms of abuse. Most victims of domestic homicide were not offered specialist help because the abuse they suffered was not identified as domestic abuse.
- Ensure that training programmes for all front-line services are based on coercion and control as a basis to understanding domestic abuse.
- Training on risk and domestic abuse must 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.

- Ensure that all safeguarding board training includes fully developed training on risk identification and assessment for domestic abuse.

"Disengagement" with Services

- Change the language used relating to lack of engagement and focus on the ways in which the survivor of abuse has tried to address the abuse and keep her or her children safe under coercively controlling abuse.
- Ensure that before anyone is characterised as "disengaging with services," it is clear that the service has adequately reached out to the victim in a way that is accessible, inclusive and understands their potential barriers to support.

Friends and Family

- Professionals should bear in mind that often, friends and family or 'informal networks' hold vital information around the levels of risk.
- Recognise the findings that those subject to domestic abuse will most likely disclose to their friends, family and community networks. Invest time and resources to develop mutual understanding about community groups and to develop their understanding of domestic abuse and services.
- Connections should be developed with associations for voluntary or third sector organisations to help disseminate learning and understanding of training opportunities related to domestic abuse.
- 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.
- Consider the use of community development programmes such as "Ask Me" by Women's Aid or the SAFE [2] Communities programme
- 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 issues. Consider learning from London Borough such as Sutton who have developed the Not Alone in Sutton campaign: https://notaloneinsutton.org.uk/
- 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.

Missed Opportunities and Delays in Information Sharing

- 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.

[2] http://www.standingtogether.org.uk/local-partnership/safety-across-faith-andethnic-safe-communities-project

- Professionals need to be aware of and trained on how to respond appropriately to the risks posed and understand the potential impact of IPV on children and any vulnerable adults within the household.

Risk Assessing

- 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 victims/perpetrators 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.
- 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.

Missed Opportunities – Victim, Missed Opportunities – Perpetrator, Policy and Procedures and Information Sharing

The following sections relate to key services where there are findings related to missed opportunities, policy and procedure and information sharing. These recommendations for practice are separated for each service area.

GPs' Recommendations for Practice

General

- IRIS is a proven intervention to improve the health care response to domestic violence and abuse. Evaluation of IRIS has found that women attending intervention practices were 22 times more likely than those attending control practices to have a discussion with their clinician about a referral to an advocate. This resulted in them being six times more likely to be referred to an advocate. Commissioning IRIS would address much of the following recommendations for practice. A link to IRIS related recommendations can be found at: http://www.irisdomesticviolence.org.uk/iris/about-iris/about/

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 it, and how to support and risk assess survivors and perpetrators.

Enquiry about DA

- In accordance with RCGP, IRIS, 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 needs 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' and develop joint strategies to carers in line with the Care Act.

Mental Health 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 DA.
- Identification of DA/VAWG among people presenting with mental health difficulties should not rely on direct disclosure; indirect signs such as unexplained injuries, 'stress' and psychological difficulties, or reports of problems in the family environment should prompt sensitive exploration of family circumstances and enquiry about DA.
- 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.
- The overall response of mental health services to DA, including enquiry and referrals, should be supported by policies for safe enquiry, immediate support and safety planning, and inter-agency referral protocols

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.
- Involving families and partners in mental health assessments and risk assessments was a recommendation in several DHRs, particularly in relation to individuals who present with suicidality in the context of relationship problems or separation.
- Individuals who are carers for partners or family members should be offered an assessment of their needs, particularly with regards to the impact of caring on their mental health and wellbeing.

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' and 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 leads 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.

- Consider the resources developed by Pathfinder, specifically a DOHSC funded whole health economy approach to domestic abuse, which can be found at: http://www.standingtogether.org.uk/localpartnership/pathfinder

Adult Safeguarding 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, and 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 DA 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's Social Care Recommendations for Practice

Training

- All children's social care staff should receive training on the dynamics of domestic abuse; how to identify it, assess risk and respond safely. Training should take an intersectional approach.
- Added emphasis should always be given to the complexities of leaving an abusive relationship and the importance of holding perpetrators to account for the abuse.
- 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's social care needs 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.
- Share learning from pilots and models across London where there is targeted work to support front line workers to engage with survivors as a partner and to hold perpetrators of abuse to account[3].

[3] Information relating to this can be found at: https://www.bbc.co.uk/news/uk-england-london-49879597.

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 Recommendations for Practice

Training

- All designated teachers for safeguarding (and their respective networks) 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.
- Use of resources such as AVA's Whole School Approach[4] to begin developing practice in schools.
- Added emphasis should always be given to the complexities of leaving an abusive relationship and the importance of holding perpetrators to account for the abuse.
- Strong links should be established between schools and specialist domestic abuse services.
- Staff should be alerted to the risk of perpetrators making false allegations.
- Shared learning from schools should be established so that schools who have developed robust practice in this area can share what they have learned with other schools.

Adult Family Homicide

Although the current cross-government definition of domestic violence and abuse in England and Wales, which applies to Domestic Homicide Reviews, encompasses both interpersonal and family members, it has been recognised that there is a dearth of research into Adult Family Violence (AFV) and abuse of parents in particular.

Consistent with previous analyses of Domestic Homicide Reviews (Sharp-Jeffs and Kelly, 2016), Adult Family Homicide (AFH) cases in the current sample discriminate by sex, both in terms of victimisation and perpetration, albeit more pronounced in the latter (67% of victims were female, and 90% of perpetrators were male).

Age

Victims in parricide cases ranged from 43 to 86 years of age, with the vast majority aged 58 or over (13 out of 17 cases), thus qualifying them as older people. This is consistent with recent research into domestic homicide of older people which showed that 'older people are almost as likely to be killed by a partner as they are their child' (Bows, 2018, pp. 7-8). Perpetrators ranged from 15 to 55.

Invisibility was a salient feature in the AFH cases we examined, with a majority of reports mentioning serious failures in identifying domestic abuse, assessing risk, and referring victims to appropriate support services by a range of agencies, and a noticeable lack of understanding of dynamics of violence and abuse within a familial context.

The 2014 report HMIC (now known as HMICFRS) notes that despite 'the wide range of relationships covered by the current definition' … when the force policy sets out that the police response to a

[4] https://avaproject.org.uk/ava-services-2/children-young-people/whole-schools-approach/

range of very different situations should be identical, this risks making police officers increasingly cynical about supporting all victims of domestic abuse' (HMIC, 2014, p. 37).

Risk

Most of the existing practice guidance and tools in responding to domestic abuse are geared towards interpersonal violence and potentially unsuitable for dealing with adult child to parent abuse.

It has been recognised that the evidence base of the DASH is primarily built around dynamics of interpersonal violence. Focused research by McManus et al. on the DASH in relation to cases of child-to-parent domestic abuse (including both adolescent and adult children) revealed that 'few DASH risk factors were able to identify risks of child-to-parent domestic abuse recidivism' and called for research to help 'understand and develop risk factors that capture the different types of DA incidents' (McManus, Almond and Bourke, 2017, p. 130).

Recurring Themes

Similar to the Standing Together DHR Analysis in 2016, the following prominent features are present in the AFH cases:

- Mental health issues for perpetrators in 16 cases. 12 cases of these cases resulted in a verdict of either manslaughter with diminished responsibility or not guilty by reason of insanity and sentenced to a Hospital Order.
- Substance use issues for perpetrators in 44% 11/25 cases. In some cases, illegal drug use had led to paranoia and psychosis. There is a need for further research into drug induced psychosis, especially in AFH.
- The majority of victims were elderly parents (mainly mothers) caring for their mentally ill or substance dependent adult sons, often in an informal capacity.

We cannot ignore the strong relationship between the gendered dynamics of these homicides and the wider cultural context of gender expectations surrounding caring roles and responsibilities.

While it could be, and has been, argued by several the reports that most of the homicides could not have been prevented due to their sudden and out of character nature, some common practice issues have consistently emerged:

Practice Issues

- Risk to other family members never considered as part of mental health assessments. There was a consistent lack of involvement of families in the care of individuals and of consultation or liaison with families and other agencies around assessment or treatment plans by mental health services. Assessments and treatment plans took place without a full picture of risk and issues pertaining to safety. The onus was often put on family members and carers to contact mental health services for information and updates, and not the other way around.
- Family members – often aging caring mothers – were ignored and marginalised by mental health services and saw their concerns dismissed.
- There was a consistent lack of carer's assessments. Either they were not considered, or were only 'offered' a cursory option, even in cases where there were clear signs of carer strain and question marks about the carer's ability to cope or to care appropriately. The curious near-systematic invisibility of Adult Social Care (through lack of referrals or NFA taken by ASC) and internal Adult Safeguarding processes was striking, even though most of the individuals concerned were either elderly carers or people with significant support needs in terms of their mental health.
- There was a consistent absence of the victim's voice, as well as a lack of consideration and understanding of their needs. The use of family members (in particular those caring for the victims) as interpreters.

- There was a real lack of professional curiosity vis-à-vis patients and their family or carers. As ever, GPs are a constant thread running through the lives of people who have mental health and drug issues. The lack of information sharing between mental health services and GPs was a constant issue through all the reports. As noted in several reports, although matricide (the killing of mothers) is fortunately infrequent, it is largely to be committed by those with severe psychiatric disorders (Carabellese et al., 2013). Research by Marleau et al. agrees with other literature that a 'majority of adult parricide offenders suffer from mental illness, specifically paranoid schizophrenia (56%) (2006). A correlation has also been found between the age of the offender and parental victimization; those between 20 to 50 years of age were most likely to kill their mothers (Heide, 1993).

There was a high degree of instability in the lives of those who committed the murders: inability to sustain employment due to mental health and associated issues; lack of stable, long-term relationships; high degree of transience due to lack of housing options or difficulties in sustaining independent living; breakdown of intimate relationships; work-related stress; etc. In many cases perpetrators were financially and emotionally dependent on their parents. Social isolation was an additional poignant feature in the lives of perpetrators (and in some cases of victims). There was a noticeable number of mothers who were divorced from their partners or widowed and had taken care of their children as single mothers, which might be worth interrogating as part of the gendered dynamics of AFV and AFH. Furthermore, the AFH cases reviewed showed that the abusive behaviours often took place within a wider context of family abuse.

Most of the reports are fluent in identifying practice issues but pay insufficient attention to wider structural issues such as lack of housing solutions, increased pressures on mental health resources, lack of appropriate care for vulnerable adults and their informal carers, numerous service restructures/reorganisations that were disruptive to access to care, or austerity measures and general deprivation, as well as issues facing BME communities and people with insecure immigration status.

Themes for AFH

We extracted all the most frequent themes present in the 25 reports of AFH and created a data base to capture these. Below are the most reoccurring themes. All themes are listed in Appendix 5.

Lack of understanding of the range of behaviour that constitutes DA/VAWG and its dynamics and impact

In 60% of cases, there was a lack of understanding within agencies of the dynamics of DA/VAWG in AFH cases and its impacts. In 16% of cases, there was a lack of professional curiosity to ask further questions about relationships. This was true even in cases where complex and multiple disadvantages were present. This was especially true for mental health services and caring services.

Missed opportunities to offer support to the victim

44% of cases missed opportunities to ask about the victim's relationship. 32% of cases missed opportunities to ask questions in situations where there was increased vulnerability due to drug or alcohol use and/or mental ill health.

Missed opportunities to hold the perpetrator accountable

24% missed opportunities to hold the perpetrator accountable or offer support, with 28% missing opportunities to offer perpetrator support around mental health. 48% of perpetrators had mental health issues.

Family and Friends

In 54% of DHRs family, friends and employers knew abuse was happening in the relationship but did not know that the behaviour's constituted domestic abuse. In addition, family and friends and employers often do not know where to go for help and fear making the situation worse by bringing in outside agencies.

Lack of information-sharing between agencies

43% of DHRs showed that agencies knew about domestic abuse being present but did not share this information. Health services can be reluctant to share information about patients because of consent issues and further policy work is needed around when they can share.

Risk assessment

In 46% of cases, risk assessments were done poorly or not at all. In 39% of cases, the known risks by agencies should have resulted in a referral to MARAC. In cases where mental health was present, no mental health service carried out DASH risk assessments with family on the risks posed by the perpetrator to their family or friends.

Missed opportunities (or delays) to share information

In 46% of DHR cases, agencies including health missed opportunities to share information or delayed sharing, resulting in increased risks to victims. 37% missed opportunities to share information for multi-agency coordination and make referrals. 28% of cases did not risk assesses or refer to MARAC even though they were high risk cases.

Relevant policies and processes either were not there or not followed

In 28% of DHRs, policies and procedures were no adhered to. This includes, but is not limited to, domestic abuse policies.

Recommendations for practice relating to AFH Themes

- The Home Office should utilise Domestic Homicide Review findings to develop and share nationally a greater understanding of the nature and risk factors relating to familial abuse, and any trends to be aware of. Providers of community health services, substance misuse services and mental health services should be increasingly aware of adult child to parent violence and the gendered nature of these crimes and consider the risks to parents or family members of their adult service users, especially when living together and when the service user is financially dependent on them.
- An understanding of risk factors for adult children who are dependent on their parent(s) financially, emotionally or due to substance misuse of mental ill-health requires much more awareness raising and proactive encouragement for early help and support.
- A better understanding of the experience of older people linked to caring responsibilities and domestic abuse.
- NHS England and the Home Office to utilise the learning gained from Domestic Homicide Reviews (and other Mental Health Reviews) to develop a greater understanding of the issues surrounding domestic homicides committed by individuals with diagnosed mental health conditions.
- IDVA co-located at Substance Use and Mental Health services, ensuring their briefings and consultations with staff include specific information on familial abuse, in particular, adult child to parent abuse.
- Better recognition of caring roles and responsibilities: The Carers Trusts define a carer as anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction, cannot cope without their support. This stresses the importance of having carer's teams within Mental Health and Substance Use services.

Intersectionality for IPH and AFH

Black and Minority Ethnic (BME)

Service Provision for BME communities

In the BME DHR reports, there was a reliance on the statutory pathways of the Criminal Justice and Social Care systems without the active involvement of the specialist VAWG sector in the DHRs.

Where the perpetrators behaviour did not fit the government definition of IPV/AFV, voices of concerned family members were not heard or acted on. Police intervention in harassment, intimidation and violent behaviour towards neighbours, family members and others in the community were not framed as VAWG. It is important that there is an awareness of the history of discrimination that minoritised communities have and do experience which can prevent disclosures to certain agencies like the Police.

Immigration was a key factor which prevented some victims from accessing early support that they were eligible to receive through social care, health and specialist VAWG organisations. Opportunities to disclose violence and abuse were missed because of a tendency to view these situations solely as immigration cases instead of through a holistic lens which incorporates safeguarding, housing and health within a VAWG framework.

Often references to culture and faith that amount to justifications for abuse are used by perpetrators to silence and control victims yet, such dynamics were not challenged or even understood as such in the context of a review. Where the so-called honour code under 'honour-based violence' is indicated, statutory services fail to understand it in their assessments around risk factors. A wider understanding of so-called honour-based violence and its impact is needed across agencies.

Agencies still use family members as interpreters despite the risks this can pose. Where a person is subjected to coercive control, either using them as interpreters or interpreting for the perpetrator increases risk.
Independent and good quality interpreting services should form part of consistent practice across sectors. In several cases, women accessing GPs did not have any access to interpreters, even when seen on their own, missing opportunities to ask about their relationship. This was even seen when they accessed help with STI's, fertility issues, and abortions.

DHR Panels

The lack of an intersectional inclusive panel to ensure that diversity issues are appropriately considered leads to inaccurate assumptions about how such issues should be interpreted. A better understanding of intersectionality is needed by the chair and report writers of DHRs. A wider focus on cultural, social, economic, psycho-social, environmental and familial factors would give a better intersectional approach in DHRs.

LBGT+

It is estimated that more than 1/4 gay men and lesbian women and more than 1/3 bisexual people have reported at least one form of domestic abuse since the age of 16

Evidence from a GALOP report also suggest increased reporting of domestic abuse from transgender people[5] (Magic & Kelley, 2019, p15). LGBT+ domestic abuse appears significantly

[5] Prevalence of intimate violence among adults aged 16 to 59, by category and sexual identity of the victim, year ending March 2016 CSEW: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/adhocs/005986prevalenceofintimateviolenceamongadultsaged16to59b ycategoryandsexualidentityofthevictimyearendingmarch2016csew (accessed on 5 October 2019).

underreported and LGBT+ survivors are disproportionally underrepresented in voluntary and statutory services, including criminal justice services[6]..

There is a lack of perpetrator programmes accessible to perpetrators who are not heterosexual men, including LGBT+ perpetrators.

It is important that a DHR does not seek to 'exoticize' a LBGT+ identity or use to it to explain the murder. Rather, it contextualises the murder in the wider cultural context of not only VAWG, but also specifically the experiences of LBGT+ people. LGBT+ domestic abuse experiences have rarely featured as part of a local commissioning process or strategic plan (the Tri-boroughs being one of the few exceptions). A greater understanding of the dynamics of LGBT+ abuse is required in both IPV and AFV violence to ensure that murders of LGBT+ people by interpersonal, household and family members are identified.

Recommendations for Practice

- Galop recommend that the experiences of LGBT+ victims be embedded in the Coordinated Community Response to ensure that there is an appropriate response to murders of those who identify as LGBT+.
- Sex, Gender identity and sexuality should always be taken into consideration when examining the risks to LGBT+ victims/survivors/perpetrators and when conducting any future DHR/Serious Case Review involving LGBT+ people.
- Galop would recommend that DHRs involving LGBT+ should always seek the input of LGBT+ organisations/stakeholders with specialist knowledge of domestic abuse/community issues.
- Agencies should engage with specialist LBGT+ projects to increase their awareness of support services available.
- Community Safety Partnerships to map out the size and necessities of the local LBGT+ communities to inform strategy decisions to best support them.
- Carry out an audit of local agency practice to see which are trans inclusive and which are woman only and what (if any) other provisions are available in women only.
- Probation should explore perpetrator programmes accessible to LGBT+ perpetrators.

Mental Health Key findings

- Mental health problems were identified in 64% 16/25 cases of perpetrators in **AFH** cases, with 56% 14/25 of the cases with a diagnosed psychotic disorder, of these cases 40% were open to mental health services at the time of the murder. In victims only 2/25 of victims had mental health issues present.
- Mental health problems were identified in 44%, 26/59 cases of perpetrators of **IPH** cases, with 32% of the cases with a diagnosed psychotic disorder. In victims 33% 20/59 cases had mental health issues with only 6% 4/59 with a diagnosed psychotic disorder.
- The most common diagnosis in **AFH** was depression, 16% of perpetrators and 12% of victims were depressed.

  In **IPH** 18% of perpetrators had depression and 17% of victims

The relationship between mental health and violence is complex, and a direct causal relationship should not be assumed. However, enquiry about DA is crucial in mental health services (and other

[6] A. Roch, G. Ritchie, and J. Morton. (2010) 'Out of sight, out of mind? Transgender People's Experiences of Domestic Abuse'. Edinburgh: LGBT Youth Scotland, Equality Network, Scottish Transgender Alliance. Available at: https://www.scottishtrans.org/wpcontent/uploads/2013/03/trans_domestic_abuse.pdf (Accessed 05 October 2019)

health services that have contact with people with mental health problems) due to the higher risk of DA victimisation and perpetration among people with mental disorders. Half of the perpetrators in the mental health DHR sample had reported suicidality to healthcare services; a third had been suicidal in the month prior to the homicide. 11% (7/59) of perpetrators of IPV killed themselves after the homicide. Caring responsibilities was an area of concern in the mental health DHR sample, particularly with regards to perpetrators who were carers, and the lack of carers' assessment and support when carers are not coping with their role.

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 DA.
- Identification of DA/VAWG among people presenting with mental health difficulties should not rely on direct disclosure; indirect signs such as unexplained injuries, 'stress' and psychological difficulties, or reports of problems in the family environment should prompt sensitive exploration of family circumstances and enquire about DA.
- 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.
- The overall response of mental health services to DA, including enquiry and referrals, should be supported by policies for safe enquiry, immediate support and safety planning, and inter-agency referral protocols.

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.
- Involving families and partners in mental health assessments and risk assessments was a recommendation in a number of DHRs, particularly in relation to individuals who present with suicidality in the context of relationship problems or separation.
- Individuals who are carers for partners or family members should be offered an assessment of their needs, particularly with regards to the impact of caring on their mental health and wellbeing.

Older people

For this research we have defined older victims as anyone over 58 years, with 18 of 84 victims falling into this category.

Data on the prevalence of domestic abuse among this group is still sparse with a lack of understanding within agencies of identifying domestic abuse, assessing risk, and referring victims to specialist domestic abuse service.

In most of the cases we examined, conclusions were drawn that the homicide was neither preventable nor predictable, however there are a number of key themes which emerged and can therefore be considered as significant.

Sex

The cases we examined align with national figures with 78% (14/18) of the victims being female, 22% (4/18) male. The relationship between the female victim and the perpetrator deviates from national findings with 64% (9/18) adult family homicide (AFH) and 36% (5/18) interpersonal homicide (IPH). The vast majority of perpetrators of AFH were adult sons (89% [8/9]).

Similar figures were represented for male victims with 75% (3/4) being AFH and 25% (1/4) IPH. All 3 of the AFH perpetrators were male.

Age

The average age of victim was 69.4 years with the greatest number of victims falling into the 'young-old' category. 17% of victims were in their late 50s (3/18) 44% were in their 60s (8/18), 28% (5/18) were in their 70s (5/18) and 11% were over 80 (2/18).

Where victims presented with injuries or signs of mental health needs, their condition is presumed to be the result of health or social care needs.

Mental Health in Older People

The links between mental health and both AFH & IPH are significant in this cohort. 89% (16/18) of the perpetrators had diagnosed mental health conditions and 50% (9/18) were open to mental health services when they killed their victim. In some cases, the perpetrator had exhibited violent and aggressive behaviour to others and expressed feelings of violence towards their victim in the lead up to the homicide. The risk factors for family and friends associated with the perpetrator were not taken into consideration by mental health services nor were they notified about the risks to them from the perpetrator.

Carers

A large proportion of cases, totalling 78% (14/18) involved a caring relationship between the victim and perpetrator. These cases often involved a wide range of agencies providing numerous services and with varying levels of awareness of the risks presented. In some cases, safeguarding concerns were raised but information was rarely shared among agencies, allowing a true picture of risk to emerge.

An apparent lack of professional curiosity is present in many of the reports, even where risk indicators or safeguarding concerns were raised. Professionals were more likely to direct questioning towards the perpetrator and used them to interpret on a regular basis. This resulted in an apparent invisibility of their wishes, views and any concerns they might have had about the perpetrator.

Recommendations for Practice

- Training, in particular for health and social care practitioners, around recognition and response to domestic abuse is much needed which explore the specific barriers and needs related to older victims. This is particularly important where there is mental health present.
- More research is needed around the role of carers where there is DA/VAWG. There needs to be greater collaboration between agencies to manage the needs of carers, particularly where they have their own needs related to mental health.
- Trusts should review their approach to risk assessment and risk management, including the weight given to allegations of abuse and/or threats and the actions taken to address such allegations

London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process

Bear Montique
October 2019

MOPAC | MAYOR OF LONDON OFFICE FOR POLICING AND CRIME | STANDING together against domestic violence

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 agreed **action plan** is in place.

Written **policies and procedures** are in place within every **organisation** covering their response to domestic abuse. Regular compulsory **training** embedded within every level of an organisation should 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 Interpersonal Violence (IPV) and Adult Family Violence (AFV). The analysis and recommendations are therefore split into two separate sections.

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. Accordingly, we have focused a section of the report on this issue to increase our learning of the issues and our understanding of the problem.

We have also included a chapter on intersectionality to explore the complex issues experienced by the BME community, the LBGT+ community, people with mental health issues and for older people.

Local Authority Process for a DHR

In this report, we wanted to explore the process each borough undertook to carry out a DHR. Local Authorities were asked in a questionnaire to explain their process from decision to completion. We asked how they appointed a chair, chose a panel and developed action plans. 28 boroughs completed the questionnaire. We then carried out an interview with 18 of the boroughs to get a more in-depth insight into their processes. Below is the direct feedback from boroughs.

Home Office Guidance on DHRs

Since the implementation of section 9 of the Domestic Violence, Crime and Victims Act (2004), as of 2011, every local council is required to carry out a Domestic Homicide Review.

Section 9 (3) of the Domestic Violence, Crime and Victims Act 2004 requires that a review of the circumstances surrounding the 'death of a person aged 16 or over [who] has, or appears to have, resulted from violence, abuse or neglect by –

- A person whom he [sic] was related or with whom he [sic] was or had been in an intimate personal relationship, or a member of the same household as himself,
- [is] held with a view to identifying the lessons to be learnt from the death.'

Key Findings and Feedback from Boroughs

- Several boroughs found it difficult to retrieve all of their DHRs since 2011 due to staff changes, computer system changes and lack of continuity of information sharing.
- After the Q and A panel, each borough should resubmit their reports to the Home Office. There are no systems currently in place to check this for compliance.
- No one agency including Police, or the Home Office has a complete library of finished DHRs that have been approved for publication.
- Only 3 boroughs had records of carrying out a SCR where there was DA present.

DHRs and SCR should be more linked up around findings and recommendations to compare and reflect on the learnings.

Appointing a Chair and a DHR Panel

- Most chairs are appointed through recommendations and previous work and few boroughs used a tender process. In 19 boroughs, the decision to appoint a chair is made by the Community Safety lead, and in 5 boroughs this decision is made by the VAWG lead.
- 20 boroughs fed back they had difficulties finding a good chair and/or problem with past or current chairs.
- Local Authorities wanted the Home Office to supply a list of good recommended chairs.
- Boroughs wanted a qualification or code of practice for chairs to ensure quality.
- Regular changes of LSB chairs effected the decisions to hold a DHR and the process. One borough had 10 chairs in 10 years.
- Boroughs wanted more involvement of specialist participation in DHRs, including funding this where relevant.
- 60% of boroughs felt there was a need for more intersectionality and relevant professionals on Panels.

15 boroughs created a new panel for each DHR with 8 boroughs having standing panels they called on. Several boroughs kept a list of previous panel members they used, and 2 boroughs had a DHR steering group which agreed the panel.

Process

- Changes in staff can derail or slow a DHR
- Problems with quality of chairs caused delays or led to the DHR being redone
- Some chairs did not have an understanding of the dynamics of DA/VAWG which was reflected within the reports and recommendations
- Changes of chairs in the CSP and MARAC during a DHR led to lack of understanding and ownership of the case
- Getting a response from health services, especially GPs was a large and constant issue raised by
  boroughs.
- Inter communications between Safeguarding Adults and Children and Mental Health Services were poor.
- This effected the gathering of information for the reviews
- Work was needed on including equalities and diversity with an intersectional approach into the DHRs
- To get an in-depth analysis of the case, an emphasis should be placed on relevant professionals attending the panel and not just those involved in the case.

Funding a DHR

- 99% of boroughs said they had real struggles funding the DHRs, with some boroughs having up to 10 DHRs since 2011. Only 1 borough had all CSP partners contribute to the DHR costs.
- The majority of DHRs were funded through the Community Safety budget.
- Most boroughs are funding them from the VAWG funding budget which takes away money from the specialist work.
- Boroughs wanted to explore ways of sharing costs within and between boroughs.
- The resource implications of action plans are not always thought through, resulting in no action.

Guidance on process

Local Authorities wanted clearer guidance on

- Carrying out a DHR when a death was a suicide with DA/VAWG present.
- What to do in the cases that fall outside the usual definition.
- When to proceed with a DHR without compromising the criminal trial when the perpetrator has fled the
- country.
- Whether to continue or abandon the DHR process when a case is found not guilty on appeal.
- The process for the Quality Assurance panel at the Home Office was seen as too slow, with boroughs waiting 6 months or more for a decision on publication.

Several boroughs reported problems with the chairs completing the changes required on a report after the Home Office Quality Assurance panel feedback, and the costs involved.

Several boroughs fed back they wanted more diversity of the Quality Assurance readers of the DHRs to reflect the reports.

5 boroughs wanted to see IRIS brought into their boroughs as they felt it improved GPs involvement in DHRs.

Publication

Local Authorities wanted clear guidance on

- How long to publish the finished reports online, this varied in boroughs.
- Publication when a case is found not guilty on appeal.
- Where there were young children involved, whether to only publish for a short time, as the children's feelings need to be taken into account as they get older.
- Local Authorities wanted a central storage of London DHRs that would assist in research across DHRs.

Action Plans

- In 13 boroughs the VAWG leads were responsible for the development of the action plan with 10 responsible for the whole management of the action plan.
- In 50% of boroughs, the VAWG lead was responsible for the progress of action plans. This, some fed back, has led to no clear ownership of the actions within the borough and its agencies.
- Action plans were disseminated in a variety of ways, all went to the Adult and Children's CSBs. 15 through the strategic board. 8 also went to the MARAC steering group. 3 went to the DHR steering groups. Some also went to local councillors and some through a wide range of VAWG operational groups. This meant that not all the
- specialist services or partnership agencies were aware of a DHR sometimes or the action plans. This goes against the theory of the CCR where all agencies are accountable and respond to DA/VAWG.
- Only 9 boroughs provided updates to families about the progress of the action plans
- More work was needed across London boroughs on how to share information and learnings across boroughs.
- It is difficult to complete actions when the responsibility for the plan sits across a number of partnerships
- Some actions were unattainable due to the lack of influence over national and regional bodies.
- Lack of capacity in some organisation to make organisational wide changes affect the action plans completion
- Several changes of the Chair of MARAC since the relevant DHR mean recommendations for MARAC work are not addressed
- Changes of Health Trusts, CCGs amalgamating, and Probation changes meant it was harder to get continuity of input from some statutory agencies.
- Recommendations for GPs were hard to achieve as lack of time for any input or training was an issue
- Boroughs wanted funding allocated to carry out the action plans.
- 5 boroughs completed their action plans in 6 months, 16 boroughs in a year or more and 7 could not say how long

Good Practice

Many boroughs fed back about the all good practice and innovative work being carried out in their specific boroughs. This work needs to be highlighted and shared across London and nationally to enhance service delivery for DA/VAWG.

- A DHR and its recommendations in 2006, changed the DA field in Merton. The first IDVA in 2009 with the first MARAC in 2010 has resulted in a huge change in response and service provision
- The main DA service that sits in the council has become more accessible.
- GP Training resulting in some GPs arranging to see clients alone when needed.
- Our hospitals have reviewed their DA policy and implemented training. They now consider DA in a patient's welfare check.
- New systems for sharing information with local drug and alcohol services.
- A new case management system for social care in LBBD has resulted in better communication between agencies.
- Joint working protocol between the VAWG Strategic Board, the LSCB and the LASB.
- A comprehensive training brochure has been developed.
- Child Maintenance Service changing their call script and training of staff on responses to DA/VAWG disclosures.
- Creation of a DHR template and plan to provide more consistency and clarity during the entire process.
- Establishing a DHR task and finish group to action the DHR action plan work.
- Work to amalgamate and review all the action plans across the DHRs in a borough to focus the work needed.

Police Process

The police have gone through a complete restructure since government cuts to their budgets. This has resulted in the introduction of Basic Command Units (BCU) merging 32 boroughs into 12 new policing areas. Plans in 2020 will see the transfer of standard risk DA cases to Emergency Response Policing Teams (ERPT), this will also free up capacity for specialists working with medium to high cases. This new process will introduce a single point of contact for standardisation and consistency of risk assessment review. A new risk assessment, DARA has been being piloted and will be extended to several other forces this year to trial. This development of the DARA must include an engagement with the specialist services, to ensure a survivor and diversity focus in the final outcome. The Met police despite cuts have invested heavily in training across the force on DA, coercive control and its impacts, Domestic Violence Prevention Notices, MI investigation and CPS improving outcomes. This shows the commitment invested in tackling perpetrators and supporting victims.

Findings

The findings of this survey have highlighted the challenges boroughs face funding and carrying out DHRs. The funding of DHRs needs to be addressed by the Home Office and boroughs. There is no system currently in place for the action plans, developed by the boroughs after a DHR, to be assessed for progress. Alongside this, the responsibility for the action plans vary in boroughs leading in some cases, to no joint responsibility across the partnerships. The Home Office are currently carrying out a review of DHR guidance, this should be reviewed not only by consultation but by also using the findings from this report and holding solution focused days with chairs and DA/VAWG leads in the boroughs. This would result in user-led improved guidance.

Health services were cited as difficult to engage with the DHR process with GP's needing more training and engagement. In boroughs where Iris was present within boroughs the response was much improved from GPs. https://Iris.org/

The feedback highlighted a need for more diversity on panels to reflect the intersectionality present in the DHRs. By including the specialist community agencies on every panel, the boroughs would gain more insight into diverse communities and the issues within them.

Recommendations for Practice

- The Home Office guidance should be reviewed not only by consultation but by also using the findings from this report and holding solution focused days with chairs and DA/VAWG leads in the boroughs. This would result in user-led improved guidance.
- DHR chairs should have a code of conduct and a recognised qualification.
- Funding for DHRs should to be reviewed and more assistance given to boroughs by the Home Office.
- Funding of DHRs should be a joint responsibility of the Home Office and all Safeguarding statutory agencies within the local authority.
- Create a national data base of DHRs and their analysis to enable wider learning from the themes and data.
- The Home Office should provide boroughs with further guidance on publication and storage of DHRs.
- Create a statutory duty for health services including GPs to participate in DHR reviews.
- The Home Office should develop a system of reviewing action plans to completion.
- DHR panels should reflect the diversity of the borough and the DHR case and include specialist agencies relevant to the case.
- All boroughs should create a DHR template work plan to provide consistency of process.
- The Home Office should provide clearer guidance for boroughs on complex cases of suicide with DA/VAWG present, appeals and not guilty verdicts.
- Work with NHS and other relevant health services, especially mental health, to create guidance and training for GPs and mental health services on involvement in DHR processes.

Domestic Homicide Statistics

In London between 2013 and 2018, 101 domestic homicides took place. In 2019, 25 domestic homicides have taken place so far (see Appendix 1 and 2 for UK statistics).

Below are the figures for the number of domestic homicides solely recorded by the Metropolitan and City of London Police Forces, between April 2010 and March 2019. DHR figures recorded by Home Office can be found in Appendix 2.

Table 1: Metropolitan and City of London Police Forces Statistics

Recorded Financial Year	Domestic Homicides
2010/11	25
2011/12	21
2012/13	21
2013/14	30
2014/15	21
2015/16	27
2016/17	11
2017/18	15
2018/19	25
Grand Total	**196**

Domestic Homicides taken place between 2019 and 2020 to date: 10

Interpersonal Homicide: Themes

For this section, we analysed 59 reports of Interpersonal Homicide (IPH) and 25 reports of Adult Family Homicide (AFH). We have separated them into IPH and AFH as both relationships have different dynamics. We extracted the most frequent themes present across all the reports and created a data base to capture these, and other themes related to other categories. Below are the most reoccurring themes. All themes statistics are listed in Appendix 4.

Lack of Understanding of Domestic Abuse

In 39% of cases, there was a lack of understanding within agencies of the dynamics of DA/VAWG and its impacts. In 46% of cases, there was a lack of professional curiosity to ask further questions about relationships. This was true even in cases with complex and multiple disadvantages. This has been a consistent theme throughout the DHRs and their recommendations. Very few of the reports contained any form of risk assessment with the victim. Where a risk assessment had taken place, most were judged to be standard risk. Only a few cases were referred to MARAC.

There was no emphasis on looking at the risks the perpetrator posed to family members by mental health and substance misuse services. 16 of the AFH cases had mental health as a factor for the perpetrator and 26 IPH cases had mental health and substance abuse as a factor for the victim. These services must begin to address the risk factors their clients pose to immediate family and others.

In these DHRs the victim and perpetrator met many agencies during their lives. If there had been routine enquiry built into the policies of these agencies about DA/VAWG there may have been earlier opportunities to offer support and assess risk factors with a DASH risk assessment.
Where agency staff do not understand the dynamics of domestic abuse, they may assume that that the victim has the opportunity to make different decisions. They may misinterpret a perpetrator's controlling behaviour as just part of his mental health issues or illness. They may discount the victim's fear and unintentionally collude with the perpetrator. They may hold the victim responsible for the perpetrator's behaviour.

Missed Opportunities to offer support to Victim

49% of cases missed opportunities to ask about the victim's relationship.

32% of cases missed opportunities to ask questions in situations where there was increased vulnerability due to drug or alcohol use and/or mental ill health.

Research tells us that 85% of victims sought help on average 5 times from professionals in the year before they got effective help[7]. Their vulnerability is increased if they suffer from mental ill health or have a substance misuse problem. Long-term abuse can also lead to mental health and substance misuse problems. These issues are often linked and professionals working with victims of domestic abuse, those with poor mental health and those who misuse drugs or alcohol should be

[7] SafeLives (2015) *Getting it right the first time,* England: Available at: http://www.safelives.org.uk/sites/default/files/resources/Getting%20it%20right%20first%20time%20-%20complete%20report.pdf (Accessed 4 November 2019)

aware of the interrelationships between these issues. Professionals should ask about these other needs so that all the victim's support needs can be addressed.

Where there were perpetrators who had terminal illnesses, the risk factors were increased. In DHRA28 the perpetrator had abused his wife during their entire marriage, and she presented to her GP on multiple occasions with injuries. Despite them living completely separately in their divided house, and despite the GP being aware of the abuse, she still was his interpreter for him at consultants' appointments. Even when an occupational assessment was carried out for the wife after an operation and she disclosed they lived separately within the house, no further questions were asked as to why or her vulnerability assessed in any way by the health service.

Missed Opportunities to hold Perpetrator accountable

25% missed opportunities to hold the perpetrator accountable or offer support, with 10% missing opportunities to offer support around mental health.

Most of the perpetrators in this report had contact with their GP on several occasions but opportunities to explore their family relationships were missed. Several perpetrators had drug and alcohol issues, but these services were not inquisitive about their intimate or family relationships and the impacts. In one DHR, the perpetrator told the GP he had hit his wife, but no further investigation was undertaken by the GP. In some DHRs the perpetrator would accompany the wife to the doctor and no attempts were made to see her on her own.

Disengagement with Services

In 20% of cases where there was a disengagement with services, this was not followed up with any further investigation by agencies as to why. This was particularly important for those cases where mental health was present. Some agencies closed cases because the victim or perpetrator had immigration issues and the agency had misunderstood the law around provision of services.

Family and Friends

In 54% of DHRs, family, friends and employers knew abuse was happening in the relationship but did not know that the behaviour's constituted domestic abuse. In addition, family and friends and employers often do not know where to go for help and feared making the situation worse by bringing in outside agencies.

Families and friends can find, depending on when they raise their concerns with the victim, that the victim denies the abuse or tries to minimise their experiences. Also, the perpetrator may use such interventions to disparage them, further isolating the victim. Many victims try to manage the situation by placating their abuser to protect their wider family or work colleagues. Publicity around what DA/VAWG is and how to seek or provide support should be easily available to the public. All employers should look at ways they can contribute to the education of their staff around DA and the routes to support services. Support services that also advise family and friends around how to deal with disclosures and supporting the victim, are key to referral pathways for the victim.

Lack of Information Sharing

43% of DHRs showed that agencies knew about domestic abuse being present in cases but did not share this information. Agencies need to be clear on when and how they share information with other agencies, where they have the responsibility to share information and where they have the power to do so. The MARAC is the place to share information about victims assessed as being a high risk but few of the victims in the DHRs analysed in this report were referred to it.

Missed Opportunities and Delays in Sharing Information

In 46% of DHR cases, agencies, including health, missed opportunities to share information or delayed sharing, resulting in increased risks to victims. 37% missed opportunities to share information for multi-agency coordination and make referrals.

Where staff do not understand that domestic abuse is their responsibility, the need to share information or make referrals can seem to be just one more task that can be added to the bottom of their 'to do' list. They may not understand that the information they hold is an important part of the risk indicators or see the urgency of the work. Yet without full information, their partner agencies can misunderstand information they have, believe that they do not need to respond, or may respond inappropriately to a victim or a perpetrator. To correct this need, an area-wide understanding of the importance of the work of all agencies in identifying domestic abuse and supporting change for the victim and perpetrator must be implemented.

Failures of information-sharing systems, such as MARAC

Many of the cases showed a lack of information sharing around the risk indicators for abuse. Some agencies did their own risk assessments around their own services, but these were not joined up or shared. A lack of understanding around a shared responsibility for identifying risk and sharing this cross agency was evident in many of the DHRs

There are many ways that a MARAC can fall short of its goals. It is worth remembering that MARACs and other multiagency meetings are not ends in themselves and do not hold cases. MARACs allow for the sharing of information so that agencies can do their jobs better; it facilitates the work but is not an answer in itself. It is a place to create a joint action plan to help reduce the risks that victims face from their perpetrators. Some DHRs showed that MARAC cases that were not actioned because of non-engagement of the victim in services, did not try again to engage, leaving the victim off the radar of services.

Risk Assessing

In 46% of cases, risk assessments were done poorly or not at all. In 39% of cases, the known risks by agencies should have resulted in a referral to MARAC. In cases where mental health was present, no mental health service carried out DASH risk assessments with family on the risks posed by the perpetrator to their family or friends.

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. This lack of focus on the wider risks led to missed opportunities to involve family and friends or employers in exploring safety planning. Areas differ in their approach to risk assessment some asking that all agencies be able to assess risk in situations of domestic abuse and others that victims are sign-posted or referred to agencies who are specialists in this, such as the police or domestic abuse services. Regardless of the approach different boroughs take, all professionals need to be able to identify domestic abuse and a victim's

vulnerability, which might attract a perpetrator, and know how to respond appropriately. 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.

Policies and Procedures

In 28% of DHRs, policies and procedures were not adhered to. This includes, but is not limited to, domestic abuse policies. Professionals need guidance and training to respond to DA and identify the risk indicators. This training needs to be reflected in the policies of the organisation, so staff are confident in asking the question and knowing what to do with the answer.

Summary of Results

These DHRs from 2011-2018 show us that the same types of recommendations appear throughout the DHRS across the period. It is clear that our approach to protecting those at risk and response to perpetrators is still failing in several areas, despite all the work and effort invested in the work. Some agencies still do not understand, engage or feel part of the local coordinated efforts of the partnerships tackling DA. New work is needed to explore ways we can at a local and national level look at the huge gaps in coordination. We need to make all agencies feel part of the coordinated systems approach to the work and feel accountable for their part in keeping victims safer and holding perpetrators accountable. We know the Coordinated Community Response works. Done in its entirety, and not in bits being adopted, it is the best system available in the UK to provide cross agency accountability for keeping victims safer and perpetrators accountable. A whole systems approach is needed across all statutory agencies.

Whole Systems Approach to DA

In many of the DHRs, non-specialist DA agencies show a lack of embedded polices and systems that focus on earlier interventions and identification of risk indicators. Lack of information sharing, through either delays or because agencies do not understand the importance of the information in building a picture of the risks was often present. Having staff trained in DA and professional curiosity about clients and patients' relationships would help to support these earlier interventions. DA champions within agencies that are trained specifically in risk assessments, which is a different skill to identification of risk, would provide victims with access to support services within agencies where DA is not their core focus. This training cannot be a one-off and has to be built into the core systems of the agencies.

Most victims and perpetrators will have contact with primary and secondary health services within their lifetime. These may be the only opportunities given to identify risk factors and offer support to both victims and perpetrators. It is therefore imperative that these agencies are involved on a London and national level in the coordinated responses to DA. GPs are a good example of where with proper training and systems in place can play a vital role as first responders to patients that present with signs of abuse. Lack of GP involvement was a frequent issue raised in the DHRs. Mental health services feature frequently within the reports, especially with perpetrators. The reports show that they fail to address the risks perpetrators pose to partners and family members. The focus is mainly on the risks the perpetrator poses to themselves or staff. There is no system in place to enquire about the impacts of their mental state on others and share that information with those at risk or other agencies. Considering the percentage of the DHR cases with a mental health element, this work is urgent. Some DHRs showed that those people who have life threatening illnesses or chronic conditions can be more at risk because of the stresses of being cared for. DHRs also show that carers coping with their medical conditions are also more at risk. Health services that deal with end of life care or chronic illnesses need to be more aware of the impact of these

on partners and families. These services should be asking more questions about the impact on relationships to identify any DA and risk factors present.

There are many current excellent approaches to DA within health, but these are only local level initiatives and do not exist across health nationally. Notably, the IRIS project is an excellent example of a program which works on risk identification, sharing of information and referral to support services within health. The Pathfinders project has shown that embedding training in health settings for staff and on-site DA coordinators and IDVA services has improved identification of risk, responses and has increased victims' access to relevant support. These health services feel they are part of a coordinated approach and understand the accountability they have to the partnerships (see Appendix 6 for Levers of Change).

Specialist Support

Adequately funding specialist services that address survivor's needs in a holistic way would help earlier interventions and engagement, especially for those who find it difficult to engage with services. These services need to be a reflection of the communities they serve to truly reach those in need.

Having workers that focus on those at high risk of harm or murder can greatly improve a person's safety and reduce risk factors. However, it must be remembered that many of the DHR cases did not score high on risk assessments or were not even assessed as they had little involvement with specialist agencies. Therefore, it is important that risk and need is everyone's responsibility and all agencies coming into contact with victims and perpetrators should be aware of the pathways to specialist support.

Commissioners of specialist services and IDVAs need to take account the training and case management systems of advocates, as not all IDVA services provide the same quality of service and attention to detail of risk identification, risk management and sharing of information. Several DHRs featured an IDVA service where the staff training in risk identification and management was below national standards. Commissioners need to be more robust in identifying quality over costs when looking at recommissioning services.

Demographics of IPH Victims and Perpetrators

Table 2: Age of victims

Age of victim	Number of victims
16-19	0
20-29	19
30-39	17
40-49	11
50-59	2
60-69	5
70-79	1
80-89	1
Unknown/Not Stated	3

Table 3: Age of perpetrators

Age of perpetrator	Number of perpetrators
15-19	1
20-29	11

30-39	18
40-49	14
50-59	3
60-69	8
70-79	0
80-89	0
Unknown/Not Stated	4

Table 4: Relationship to victim

Relationship to victim	Number of perpetrators
Boyfriend	4
Ex-partner	9
Husband	5
Friend (Sexual Relationship)	1
Partner	25
Spouse	14
Wife	1

Table 5: Number of children in family

Number of children in family	Number of cases
0 children	26
1 child	7
2 children	15
3 children	5
4 children	3
5 children	1
6 children	2

Table 6: Number of children taken into care

Number of children taken into care	Number of cases
0 children	24
1 child	3
2 children	3
3 children	2
Unknown	1

Table 7: Number of children present at homicide

Number of children present at homicide	Number of cases
0	16
1 child	3
2 children	3
3 children	0
4 children	1
Details unknown	7
Unknown	3

Table 8: Number of cases where victim was a carer

Victim carer	Number of cases
Yes	2
Yes (for work)	1
No	55
Unknown/Not specified	1

Table 9: Number of cases where perpetrator was a carer

Perpetrator carer	Number of cases
Yes	9
No	49
Unknown/Not specified	1

Table 10: Number of cases where victim had a disability

Victim disability	Number of cases
Yes	8
No	51

Table 11: Number of cases where perpetrator had a disability

Perpetrator disability	Number of cases
Yes	8
Unknown	2
No	49

Table 12: Number of cases where victim had substance misuse issues

Victim substance abuse	Number of cases
Yes	19
No	40

Table 13: Number of cases where perpetrator had substance misuse issues

Perpetrator substance abuse	Number of cases
Yes	23
No	36

Recommendations for Practice Relating to IPH Themes

Lack of Understanding of Domestic Abuse

- Recognise that the key findings from DHRs is the absence of help or support offer due to lack of understanding and naming domestic abuse despite signs and symptoms of abuse. Most victims of domestic homicide were not offered specialist help because the abuse they suffered was not identified as domestic abuse.
- Ensure that training programmes for all front-line services are based on coercion and control as a basis to understanding domestic abuse.
- Ensure that all safeguarding board training includes fully developed training on risk identification and assessment for domestic abuse.

"Disengagement" with Services

- Change the language used relating to lack of engagement and focus on the ways in which the survivor of abuse has tried to address the abuse and keep her or her children safe under coercively controlling abuse.
- Ensure that before anyone is characterised as "disengaging with services," it is clear that the service has adequately reached out to the victim in a way that is accessible, inclusive and understands their potential barriers to support.

Friends and Family

- Professionals should bear in mind that often, friends and family or 'informal networks' hold vital information around the levels of risk.
- Recognise the findings that those subject to domestic abuse will most likely disclose to their friends, family and community networks. Invest time and resources to develop mutual understanding about community groups and to develop their understanding of domestic abuse and services.
- Connections should be developed with associations for voluntary or third sector organisations to help disseminate learning and understanding of training opportunities related to domestic abuse.
- 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.
- Consider the use of community development programmes such as "Ask Me" by Women's Aid for the SAFE Communities programme[8]
- 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 issues. Consider learning from London Borough such as Sutton who have developed the Not Alone in Sutton campaign: https://notaloneinsutton.org.uk/
- 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.

Missed Opportunities and Delays in Information Sharing

- 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 the potential impact of IPV on children and any vulnerable adults within the household.

Risk Assessing

- 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 victims/perpetrators

[8] http://www.standingtogether.org.uk/local-partnership/safety-across-faith-andethnic-safe-communities-project

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 coercively 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.

Missed Opportunities – Victim, Missed Opportunities – Perpetrator, Policy and Procedures and Information Sharing

The following sections relate to key services where there are findings related to missed opportunities, policy and procedure and information sharing. These recommendations for practice are separated for each service area.

GPs' Recommendations for Practice

General

- IRIS is a proven intervention to improve the health care response to domestic violence and abuse. Evaluation of IRIS has found that women attending intervention practices were 22 times more likely than those attending control practices to have a discussion with their clinician about a referral to an advocate. This resulted in them being six times more likely to be referred to an advocate. Commissioning IRIS would address much of the following recommendations for practice. Information on this can be found at: http://www.irisdomesticviolence.org.uk/iris/about-iris/about/

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 it, and how to support and risk assess survivors and perpetrators.

Enquiry about DA

- In accordance with RCGP, IRIS, 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 needs 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' and develop joint strategies to carers in line with the Care Act.

Mental Health 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 DA.
- Identification of DA/VAWG among people presenting with mental health difficulties should not rely on direct disclosure; indirect signs such as unexplained injuries, 'stress' and psychological difficulties, or reports of problems in the family environment should prompt sensitive exploration of family circumstances and enquiry about DA.
- 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.
- The overall response of mental health services to DA, including enquiry and referrals, should be supported by policies for safe enquiry, immediate support and safety planning, and inter-agency referral protocols

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.
- Involving families and partners in mental health assessments and risk assessments was a recommendation in a number of DHRs, particularly in relation to individuals who present with suicidality in the context of relationship problems or separation.
- Individuals who are carers for partners or family members should be offered an assessment of their needs, particularly with regards to the impact of caring on their mental health and wellbeing.

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' and 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 leads 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.
- Consider the resources developed by Pathfinder, specifically a DOHSC funded whole health economy approach to domestic abuse, which can be found at: http://www.standingtogether.org.uk/localpartnership/pathfinder

Adult Safeguarding 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, and 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 DA 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's Social Care Recommendations for Practice

Training

- All children's social care staff should receive training on the dynamics of domestic abuse; how to identify it, 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's social care needs 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.
- Share learning from pilots and models across London where there is targeted work to support front line workers to engage with survivors as a partner and to hold perpetrators of abuse to account. More information can be found at: https://www.bbc.co.uk/news/uk-england-london-49879597

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 Recommendations for Practice

Training

- All designated teachers for safeguarding (and their respective networks) 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.
- Use of resources such as AVAs Whole School Approach to begin developing practice in schools, which can be found at https://avaproject.org.uk/ava-services-2/children-young-people/whole-schools-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.
- Strong links should be established between schools and specialist domestic abuse services.
- Staff should be alerted to the risk of perpetrators making false allegations.
- Shared learning from schools should be established so that schools who have developed robust practice in this area can share what they have learned with other schools.

Integrated working

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

Adult Family Homicide

Learning

For this report, we analysed 25 DHR reports of Adult Family Homicide, and for this section we then carried out a more in-depth analysis on 21 cases with mental health as a key factor.

There was a total of 21 cases of Adult Family Homicide (AFH) or 25% of all Domestic Homicides examined in the sample. These include:

- 17 cases involving adult children killing parents (including parents-in-law) (parricide)
- 3 cases involving siblings (fratricide)
- 1 case involving an adoptive father killing his adoptive son (filicide)

Although domestic abuse-related reports to police in England and Wales are not broken down between interpersonal and family abuse, research consistently indicates that 35.3% of domestic abuse against adults in England and Wales is perpetrated by family members (Walby, Towers and Francis, 2014; Office for National Statistics, 2018a[9]). Local research by Kerss et al. (Kerss, Whyman

[9] Findings from the Crime Survey for England and Wales (CSEW) for the year ending March 2018 estimated that 6.1% of people aged 16 to 59 had experienced some form of domestic abuse (2 million victims) and 2.2% of all people aged 16 to 59 had experienced domestic abuse by a family member in the last year. It is worth noting, however, that until very recently, CSEW data was limited to people aged 59, thus excluding a significant proportion of individuals who are likely to experience abuse from adult family members and in particular adult children. The age range for respondents eligible

and Dunling-Hall, 2017) shows that a quarter of domestic abuse offences reported to police in Cambridgeshire involved family members, mostly committed by adult children towards a parent. An evaluation of the 'Access to Justice' Pilot in Wales found that the most common type of perpetrator in domestic abuse against older people was not an interpersonal but a son (Clarke et al., 2012, p. 21).

Between April 2014 and March 2017, the Home Office Domestic Homicide Index recorded 400 domestic homicides, of which 59 involved the killing of parents, or parricide (almost 15% of all domestic homicides) (Office for National Statistics, 2018b). Parricide cases make up 20% of all Domestic Homicides examined in the current sample.

Sex

Consistent with previous analyses of Domestic Homicide Reviews (Sharp-Jeffs and Kelly, 2016), AFH cases in the current sample affected by sex, both in terms of victimisation and perpetration, albeit more pronounced in the latter (67% of victims were female, and 90% of perpetrators were male):

Table 14: Types of AFH Cases

	Child to Parent (in-law)		**Sibling**		**Adoptive Parent to Child**	
	17		3		1	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**
Victim sex	12	5	2	1	0	1
Perpetrator sex	2	15	0	3	0	1

This disparity in the affect on women was recognised in individual reports, but the overall impression is that the risk according to sex has not been interrogated as thoroughly as it should be. Sex is mentioned in each report as part of the protected characteristics, with a rather generic recognition that women are at higher risk of homicide than men. However, the analysis stops short of considering the wider culture of impunity that fails to hold men to account for their violence towards women.

Additionally, the wider context of gendered norms that either imposes the burden of caring for sons on mothers, or reinforces their dependence on them, is often ignored.

Age

Victims in parricide cases ranged from 43 to 86 years of age, with the vast majority aged 58 or over (13 out of 17 cases), thus qualifying them as older people. This is consistent with recent research into domestic homicide of older people which showed that 'older people are almost as likely to be killed by a partner as they are their child' (Bows, 2018, pp. 7-8). Analysis of parricide data elsewhere (Holt, 2017) also suggests that fatal violence against parents most likely happens in parents' later life. Perpetrators ranged from 15 to 55.

Victims in fratricide cases ranged from 29 to 39 years of age. Perpetrators ranged from 29 to 35.

The victim in the filicide case was 24 years of age, and the perpetrator was 59 years of age.

for the self-completion module of the CSEW was expanded in April 2017, changing from adults aged 16 to 59 years to adults aged 16 to 74 years.

The Invisibility of AFV in Research and Practice

Although the current cross-government definition of domestic violence and abuse in England and Wales, which applies to Domestic Homicide Reviews, encompasses both interpersonal and family members, it has been recognised that there is a dearth of research into Adult Family Violence (AFV) and abuse of parents in particular. Thus, the inclusion of AFV – and Adult Child to Parent Abuse in particular – in this definition has two important implications:

On the one hand, the lack of research means that most of the existing practice guidance and tools in responding to domestic abuse are geared towards interpersonal violence and potentially unsuitable for dealing with Adult Child to Parent Abuse.

On the other hand, '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, p. 58; emphases added).

Such invisibility is only too apparent when we examine practice responses to domestic abuse in the UK. In its now landmark 2014 report, HMIC (now known as HMICFRS) notes that despite 'the wide range of relationships covered by the current definition' … when the force policy sets out that the police response to a range of very different situations should be identical, this risks making police officers increasingly cynical about supporting all victims of domestic abuse' (HMIC, 2014, p. 37). It concludes that 'the current definition … needs to be well understood so that domestic abuse and the risks to the victim can be correctly identified, with the response of the police targeted to address the particular risk that they find. This will require greater discretion from officers. However, in order for this to work, officers need to be well-trained, well motivated and well-supervised. Based on HMIC's evidence this is not the case universally' (Ibid., p. 37). Subsequent College of Policing research into the use of discretion by police officers in responding to domestic violence has highlighted the 'extremely broad and perhaps overreaching' definition of domestic violence as problematic, leading to incidents of domestic violence not being recorded as such (Myhill and Johnson, 2016, p. 14).

Following a recommendation by the 2014 HMIC report, a review of the use of the DASH risk model within the police – and the first of its kind – highlights a lack of consistency among police officers in recognising what constitutes domestic abuse, after having observed 'incidents that involved domestic abuse but were not responded to as such because they did not involve interpersonals' (Robinson et al., 2016, p. 13). Indeed, although the DASH is expected to be used by police officers for assessing risk in all domestic abuse incidents (both interpersonal and adult family violence) with the non-police version widely used by Independent Domestic Violence Advisors (IDAs), domestic abuse services, and a range of frontline professionals, it has been recognised that the evidence base of the DASH is primarily built around dynamics of interpersonal violence. Focused research by McManus et al. on the DASH in relation to cases of child-to-parent domestic abuse (including both adolescent and adult children) revealed that 'few DASH risk factors were able to identify risks of child-to-parent domestic abuse recidivism' and called for research to help 'understand and develop risk factors that capture the different types of DA incidents' (McManus, Almond and Bourke, 2017, p. 130).

This invisibility was a salient feature in the AFH cases we examined in the current sample, with a majority of reports mentioning serious failures in identifying domestic abuse, assessing risk, and referring victims to appropriate support services by a range of agencies, and a real lack of understanding of dynamics of violence and abuse within a familial context.

Thus, one report helpfully suggested that the Home Office should utilise Domestic Homicide Review findings to develop – and share nationally – a greater understanding of the nature and risk factors relating to familial abuse, and any trends to be aware of.

Recurring Themes

Similar to the Standing Together DHR Analysis, the following prominent features are present in the AFH cases of this current sample:

- **Mental health** issues for perpetrators in 16 cases. 12 cases of these cases resulted in a verdict of either manslaughter with diminished responsibility or not guilty by reason of insanity and sentenced to a Hospital Order.
- **Substance use** issues for perpetrators in 11 cases
- **Caring relationships and responsibilities** between the victims and the perpetrators, or between the victims/perpetrators and another vulnerable family member (often a mother). The majority of victims were elderly parents (mainly mothers) caring for their mentally ill or substance dependent adult sons, often in an informal capacity. In the only two parricide cases where daughters were the perpetrators, the daughters were caring extensively for their parents. In one of these cases, the daughter showed evident signs of carer strain. The other, while never displaying any external signs of distress before the homicide, suffered a psychotic break on the day of the incident. In two of the three fratricide cases, conflict had arisen between the siblings around the care of their vulnerable mothers.
- **The gendered dynamics** of these cases is demonstrated in the remaining fratricide case whereby a brother came to stay with his sister following a relationship breakdown. There was an expectation on his part to be supported and cared for by his sister in the face of his housing issues. He threatened to kill her rather than leave her home and ended up killing her. Thus, we cannot ignore the strong relationship between the gendered dynamics of these homicides and the wider cultural context of gender expectations surrounding caring roles and responsibilities.

While it could be, and has been, argued, by a number of the reports, that most of the homicides could not have been prevented due to their sudden and out of character nature, some common practice issues have consistently emerged:

Practice Issues

- Risk to other family members never considered as part of mental health assessments. Family members were often relied on to care for the person with mental ill-health as a taken-for-granted resource and support network.
- Linked to the above, there was a consistent lack of involvement of families in the care of individuals and of consultation or liaison with families and other agencies around assessment or treatment plans by mental health services.
- Assessments and treatment plans took place without a full picture of risk and issues pertaining to safety.
- The onus was often put on family members and carers to contact mental health services for information and updates, and not the other way around.
- Family members – often aging caring mothers – were ignored and marginalised by mental health services and saw their concerns dismissed.
- There was a consistent lack of carer's assessments. Either they were not considered, or were only 'offered' a cursory option, even in cases where there were clear signs of carer strain and question marks about the carer's ability to cope or to care appropriately.
- The curious near-systematic invisibility of Adult Social Care (through lack of referrals or NFA taken by ASC) and internal Adult Safeguarding processes was striking, despite the fact that most of the individuals concerned were either elderly carers or people with significant support needs in terms of their mental health.

- There was a consistent absence of the victim's voice, lack of consideration and understanding of their needs, which might have been exacerbated by the assumptions made about the nature of the relationship (parent/child, carer/cared for), which are themselves linked to lack of understanding of the dynamics of domestic abuse involving family members, especially those in caring relationships and the wider culture of treatment of mothers and older mothers.
- The use of family members (in particular those caring for the victims) as interpreters, or lack of direct interaction with the victims (in health settings for instance) noted in some of the cases is linked to this. Even where language is not a barrier, the person receiving care is unseen and unheard.
- There was a real lack of professional curiosity vis-à-vis patients and their family carers, and little effort made to engage with the patients directly. This absence is reflected in some of the reports themselves, with very limited information on the victims and their needs.

- As ever, GPs are a constant thread running through the lives of people who have mental health and drug issues (quote from WX report). In cases where GPs were responsible for administering ongoing mental health care and reviews with the individuals in the community, the lack of information sharing between mental health services and GPs was a constant issue through all the reports
- As noted in several reports, although matricide (the killing of mothers) is fortunately infrequent, it is considered to be committed by those with severe psychiatric disorders (Carabellese et al., 2013). Research by Marleau et al. agrees with other literature that a 'majority of adult parricide offenders suffer from mental illness, specifically paranoid schizophrenia (56%) (2006). A correlation has also been found between the age of the offender and parental victimization; those between 20 to 50 years of age were most likely to kill their mothers (Heide, 1993).
- There was a high degree of instability in the lives of those who committed the murders: inability to sustain employment due to mental health and associated issues, lack of stable, long-term relationships, high degree of transience due to lack of housing options or difficulties in sustaining independent living; breakdown of intimate relationships; work-related stress etc.
- In many cases perpetrators were financially and emotionally dependence on their parents, which was evident in the fact most of the adult children were living with their parents.
- Social isolation was an additional poignant feature in the lives of perpetrators (and in some cases of victims).
- There was a noticeable number of mothers who were divorced from their partners or widowed and had taken care of their children as single mothers, which might be worth interrogating as part of the gendered dynamics of AFV and AFH.
- Evidenced in the case of a 43-year-old mother killed by her 15-year-old son, is a wider culture of mother blaming, where the breakdown of parental control and authority by mother in the home was reinforced by the constant references to her limited parenting abilities and skills and the imposition of parenting courses as part of child protection processes, which would have exacerbated her sense of failure. The report recognises 'there was a lack of focus on the needs of [victim] as a mother' but does not go far enough in recognising the culture of institutional woman- and mother-blaming that is pervasive in society and among child-facing agencies.
- The AFH cases in our current sample shows that the abusive behaviours often take place within a wider context of family violence – domestic abuse by one parent against another; abuse by the perpetrator towards other family members and siblings in particular. Therefore, risk needs to be considered for all family members living in the home.

- Most of the reports are fluent in identifying practice issues but pay insufficient attention to wider structural issues such as lack of housing solutions, increased pressures on mental health resources, lack of appropriate care for vulnerable adults and their informal carers, numerous service restructures/reorganisations that were disruptive to access to care, or austerity measures and general deprivation, as well as issues facing BME communities and people with insecure immigration status.

Adult Family Homicide: Themes

We extracted all the most frequent themes present in the 25 reports of AFH and created a database to capture these. Below are the most reoccurring themes. All themes are listed in Appendix 5.

Lack of Understanding of Domestic Abuse

In 60% of cases there was a lack of understanding within agencies of the dynamics of DA/VAWG in AFH cases and its impacts. In 16% of cases there was a lack of professional curiosity to ask further questions about relationships. This was true even in cases where victims experienced complex and multiple needs. This was especially true for mental health services and caring services.

In one DHR, the mental health services on re-assessment of their client agreed that his psychosis, which was fixed on wanting to kill his mother, was so serious that after his review they extended his stay after. They had no communication with the mother around the risks he posed to her or his fixation on wanting to kill her before Christmas. He carried out the murder shortly after his release. Even though the findings found the death was not preventable, it is reasonable to surmise if the service had warned the mother about the risk he posed, the outcome may have been different. Another case found that the mental health service was so focused solely on administrating his daily injections that no thought was given to the risks he posed to his mother.

As mentioned above, there is no dedicated risk assessment to deal with AFV. This deters agencies from focusing on risk factors. The lack of agencies' recognition of the dynamics of AFH was very evident in the DHRs analysed in this report. There is an immediate need for training for agencies working with adult children to support them in identifying risk factors within the wider the family, and not just their client, alongside the skills to engage with those at risk and refer to support pathways. Risk identification needs to be seen as an ongoing assessment and not a one-off event as risks change constantly, especially where there the multiple and complex needs.

Risk assessing is different to identifying risk and should be carried out by staff trained in the process to enable proper safety planning and referral to support and to ensure referrals to MARAC are carried out.

Missed opportunities to offer support to Victim and Perpetrator

Missed opportunities to offer support to the victim

44% of cases missed opportunities to ask about the victim's relationship. 32% of cases missed opportunities to ask questions in situations where there was increased vulnerability due to drug or alcohol use and/or mental ill health.

Missed opportunities to hold the perpetrator accountable

24% missed opportunities to hold the perpetrator accountable or offer support, with 28% missing opportunities to offer perpetrator support around mental health. 48% of perpetrators had mental health issues.

In the DHRs, the focus for agencies was on the perpetrator and their needs. This was especially true for those perpetrators with additional needs due to mental health and drugs. In cases where the perpetrator had an illness that was a terminal or chronic illness, the health services involved in their care had little understanding of the dynamics of DA/VAWG. This resulted in no identification of risk factors the perpetrator posed to family. Even when care assessments were carried out, the victim was not asked about DA/VAWG.

Only a few cases were referred to Adult Safeguarding and the lack of understanding of the risk factors involved resulted in some cases being closed and no actions being assigned to other cases. Even when hospital staff, home helps and care staff raised concerns around cases, this was not seen through a lens of the dynamics of DA/VAWG and the coercive control that was present in 5 of the cases went unnoticed.

Disengagement with Services

In 8% of cases where there was a disengagement with services, this was not followed up with any further investigation by agencies as to why. This was particularly important in these cases as mental health was present and was a factor in the murder. In one DHR, the victim was cared for by the perpetrator who ended the care support provided by the local authority and disengaged with services. An assessment as to their suitability to provide care was not carried out, despite several incidents of neglect reported by care staff.

Family and Friends

In 54% of DHRs family, friends and employers knew abuse was happening in the relationship but did not know that the behaviours constituted domestic abuse. In addition, family and friends and employers often do not know where to go for help and feared making the situation worse by bringing in outside agencies. Families and friends can find, depending on when they raise their concerns with the victim, that the perpetrator may use such interventions to disparage them, further isolating the victim. Publicity around what DA/VAWG is and how to seek support should be easily available to the public. All agencies should look at ways they can contribute to the education of their staff around DA/VAWG and the routes to support services.

Lack of Information Sharing

43% of DHRs showed that agencies knew about domestic abuse being present in cases but did not share this information. Health services can be reluctant to share information about patients because of consent issues and further policy work is needed around when they can share. Many of the mental health cases highlighted this as an issue that stopped the services sharing information across services. In one DHR, a hospital did not inform the GP that the woman had tried to kill herself and no notification was received by the GP. This resulted in the woman only being treated by the GP for her presenting issue and no exploration took place about her suicide or her reasons for the attempt.

Agencies need to be clear about when and how they share information with other agencies, where they have the responsibility to share information and where they have the power to do so.

The MARAC is the place to share information about victims assessed as being a high risk but is only one part of the process of information sharing. It needs to be an ongoing process between agencies as risk is ever changing.

Risk Assessing

In 46% of cases, risk assessments were done poorly or not at all. In 39% of cases, the known risks by agencies should have resulted in a referral to MARAC.

In cases where mental health was present, no mental health service carried out DASH risk assessments with family on the risks posed by the perpetrator to their family or friends.
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. This lack of focus on the wider risks missed opportunities to involve family and friends in exploring safety planning. Areas differ in their approach to risk assessment, some asking that all agencies be able to assess risk in situations of domestic abuse and others that victims are sign-posted or referred to agencies who are specialists in this, such as the police or domestic abuse services. Regardless of how boroughs do this, all staff members need to be able to identify domestic abuse and a victim's vulnerability, which might attract a perpetrator, and know how to respond appropriately. A lack of understanding around the risks of non-physical coercive controlling behaviors has meant that some domestic abuse cases that were assessed as medium/standard risk remained below the radar of services and threshold for intervention.

Sharing Information

Missed opportunities (or delays) to share information for multi-agency coordination and to make referrals

In 46% of DHR cases, agencies including health missed opportunities to share information or delayed sharing, resulting in increased risks to victims. 37% missed opportunities to share information for multi-agency coordination and make referrals

Where staff do not understand that domestic abuse is their responsibility, the need to share information or make referrals can seem to be just one more task that can be added to the bottom of their 'to do' list. They may not see the urgency of the work. Yet without full information, their partner agencies can misunderstand information they have, believe that they do not need to respond, or may respond inappropriately to a victim or a perpetrator. To correct this, an area-wide understanding of the importance of the work of all agencies in identifying domestic abuse and supporting change for the victim and perpetrator needs to be implemented.

Information Sharing

Failures of information-sharing systems, such as MARAC or International Child Protection Certificate (ICPC)

There are many ways that a MARAC can fall short of its goals. It is worth remembering that MARACs and other multiagency meetings are not ends in themselves and do not hold cases. MARACs allow for the sharing of information so that agencies can do their jobs better; it facilitates the work but is not an answer in itself. It is a place to create a joint action plan to help victims reduce the risk that they face from their perpetrators.

Policies and Procedures

Relevant policies and processes either were not there or not followed

In 28% of DHRs, policies and procedures were no adhered to. This includes, but is not limited to, domestic abuse policies.

Agencies that do not understand their own role in addressing domestic abuse may not have the policies and procedures to address it when it arises. This requires senior management engagement and action. The work needs to be seen as an important part of the role as all services' users need to be helped to stay safe.

Demographics for AFH victims and perpetrators

Table 15: Age of victim

Age of victim	Number of victims
15-19	0
20-29	6
30-39	2
40-49	2
50-59	2
60-69	6
70-79	4
80-89	2
Unknown/Not Stated	1

Table 16: Age of perpetrator

Age of perpetrator	Number of perpetrators
15-19	1
20-29	4
30-39	9
40-49	7
50-59	2
60-69	0
70-79	0
80-89	0
Unknown/Not Stated	2

Table 17: Relationship to victim

Relationship to victim	Number of perpetrators
Adoptive Parent	1
Boyfriend	1
Boyfriend of victim's sister	1
Sibling	3
Child	14
Child-in law	3
Partner	1
Spouse	1

Table 18: Number of children involved

Children involved	Number of cases
Yes	4
No	21

Table 19: Number of children present at homicide

Number of children present at homicide	Number of cases
0 children	1
2 children	2
Unknown/Not Stated	1

Table 20: Number of cases where victim was a carer

Victim carer	Number of cases
Yes	7
No	17
Unknown/Not specified	1

Table 21: Number of cases where perpetrator was a carer

Perpetrator carer	Number of cases
Yes	4
No	21

Table 22: Number of cases where victim had a disability

Victim disability	Number of cases
Yes	7
No	18

Table 23: Number of cases where perpetrator had a disability

Perpetrator disability	Number of cases
Yes	10
No	15

Table 24: Number of cases where victim had substance misuse issues

Victim substance abuse	Number of cases
Yes	3
No	22

Table 25: Number of cases where perpetrator had substance misuse issues

Perpetrator substance abuse	Number of cases
Yes	13
No	12

Recommendations for Practice Relating to AFH Themes

- The Home Office should utilise Domestic Homicide Review findings to develop – and share nationally – a greater understanding of the nature and risk factors relating to familial abuse, and any trends to be aware of.
- Providers of community health services, substance misuse services and mental health services should be increasingly aware of adult child to parent violence and the gendered nature of these crimes and consider the risks to parents or family members of their adult service users, especially when living together and when the service user is financially dependent on them.

- An understanding of risk factors for adult children who are dependent on their parent(s) financially, emotionally or due to substance misuse of mental ill-health requires much more awareness raising and proactive encouragement for early help and support.
- A better understanding of the experience of older people linked to caring responsibilities and domestic abuse.
- NHS England and the Home Office to utilise the learning gained from Domestic Homicide Reviews (and other Mental Health Reviews) to develop a greater understanding of the issues surrounding domestic homicides committed by individuals with diagnosed mental health conditions.
- IDVA co-located at Substance Use and Mental Health services, ensuring their briefings and consultations with staff include specific information on familial abuse, in particular adult child to parent abuse.
- Better recognition of caring roles and responsibilities: The Carers Trusts define a carer as anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. This stresses the importance of having carer's teams within MH and SU services.

Intersectionality Related to IPH and AFH

Black & Minority Ethnic DHR Cases

Interpersonal Homicide Cases

Lack of Safeguarding, Lack of Information Sharing

- In most cases, there was a lack of holistic response to the family which could have led to early intervention and safeguarding. Records of previous convictions for violence were viewed more as isolated incidents and not considered as a pattern of behaviour under a VAWG framework.

Child Safeguarding and Protection

- Cases showed that issues regarding child contact in post separation indicates escalation of abuse and direct abuse of children involved, escalation of coercive and other controlling behaviour and threat of lethality. Unfortunately, child contact was viewed from 'a father's rights' perspective and significant harm and risk escalation were not taken into consideration under a VAWG approach.

- Where the so-called honour code under 'honour-based violence' is indicated, statutory services fail to understand it in their assessments of child contact, in understanding the long history of violence and ensuring adequate protections for the woman who is seeking support culminating in missed opportunities. This can also occur if a specialist support organisation is involved which is confronting institutional obstacles in obtaining support for the woman.

Lack of Questioning

- The notion of the 'obedient wife' is a patriarchal notion of power and control and an indicator of DA/VAWG however it is ignored by statutory agencies who fail to see the seriousness of the disclosure made by the woman. Deeper analysis is needed on institutional interactions the victim had with police and social services without which, there remains a disconnected system of support for women.
- Participation in anger management should not be viewed as a solution to VAWG in any case where there are significant indicators of VAWG.
- Some cases suggested the absence of a VAWG framework in questioning, assessment and in understanding VAWG. Cases revealed that broader networks/witnesses who may have

heard about the violence or been threatened by it themselves were not included in developing a more comprehensive picture of the violence. This was found in cases where immigration status was a concern for the woman or her entire family. There is a need to consider improved pathways for accessing information and advocacy and addressing obstacles to support such as immigration status. Cases DHR A5, A6, A7

Lack of involvement of a Specialist Voluntary and Community Sector Agencies

- For some women there could be multiple perpetrator networks that operate, impacting women's safety and access. Attention must be paid to numerous sources of information that could support early detection, more effective monitoring and improved access. Addressing power and control in these situations rely on empowerment-based approaches for wider networks.
- Professionals need a better understanding of particular barriers/vulnerabilities that women face in the context of poly-victimisation for example, in the off-street sex industry and IPV.
- Routine enquiry needs to focus on a broader VAWG framework. Women in the sex industry are less likely to access public health/support provision - stigma, fear of police intervention and criminalisation of the victim, risk of further physical / sexual violence from the perpetrator/networks, not knowing support pathways would have prevented disclosure.

Table 26: Ethnicity of victims from IPH cases

Ethnicity of victim	Number of victims
African	1
Asian	2
Asian Other: Central Asian Republic	1
Asian/Asian British: Bangladeshi	1
Asian/Asian British: Indian	3
Asian/Asian British: Pakistani	2
Black/Black British: African	3
Black/Black British: Caribbean	3
Black/Black British: Other, unspecified	1
Congolese	1
Eastern European	4
Greek Cypriot	1
Irish	1
Jamaican	1
Kosovo Albanian	1
Mexican	1
Mixed/Multiple Ethnic Backgrounds: British and African	1
Mixed/Multiple Ethnic Backgrounds: White and Black Caribbean	3
North Korean	1
Romanian	1
Russian	1
Somalian	1
Turkish	1
White: British	17
White: European	2
White: Other, unspecified	1
Unknown/Not Stated	3

Table 27: Ethnicity of perpetrators from IPH cases

Ethnicity of perpetrator	Number of perpetrators
Afro-Caribbean and Irish	1
Angolan	1
Arab	1
Asian	2
Asian/Asian British: Bengali	1
Asian/Asian British: Bangladeshi	1
Asian/Asian British: Indian	1
Asian/Asian British: Pakistani	5
Black/Black British: African	6
Black/Black British: Caribbean	5
Black/Black British: Other, unspecified	4
Eastern European	3
Greek Cypriot	1
Grenadian	1
Kosovo Albanian	1
Latin American	1
Mexican	1
Mixed/Multiple Ethnic Backgrounds: White and Black Caribbean	1
North Korean	1
Romanian	1
Somalian	1
Turkish	2
White: British	9
White: European	1
White: Other, unspecified	1
Unknown/Not Stated	6

Table 28: Immigration status of victims from IPH cases

Victim immigration status	Number of victims
Asylum Seeker	2
EEA National – Details unknown	4
EEA National – Exercising treaty rights	2
EU National	4
Indefinite Leave to Remain	2
Settled	1
Spousal Visa	1
Student Visa	1
Tourist Visa	1

UK National	30
Visitor's Visa	1
Unknown/Not stated	10

Table 29: Immigration status of perpetrators from IPH cases

Perpetrator immigration status	Number of perpetrators
Asylum Seeker	3
Discretionary Leave to Remain	1
EEA National – Details unknown	4
EEA National – Exercising treaty rights	1
EU National	1
Indefinite Leave to Remain	2
Settled	1
Spousal Visa	1
Student Visa	2
Tourist Visa	1
UK National	25
Unknown/Not stated	17

Adult Family Homicide Cases

Lack of Involvement of a Specialist Voluntary and Community Sector Agencies

- There was a lack of involvement of specialist voluntary and community sector agencies that work in particular ways around issues and that bring a higher level of engagement because of the non-institutional focus of grassroots community work, enabling outreach to communities to identify supportive community resources and address isolation and marginalisation.

- Many cases suggested a heavy reliance on a statutory pathways approach involving police, GP and social services, without the active involvement of voluntary and community sector organisations including specialist by and for ending VAWG organisations to address barriers to support. Case references: AFH: AB DHR 49; AFH: DHRA6; AFH: DHR30.

Adult Safeguarding not well-linked to Domestic Abuse

- In some cases, there was involvement of diverse statutory agencies and reports from family of the concerns they had regarding the behaviour of perpetrators but there were a number of issues: cases not fitting the cross government definition meant that they were not identified as DA/VAWG, voices of female members of families raising significant concerns were disregarded, and numerous interventions by police did not result in safeguarding alerts.
- In some cases, several health services were involved regarding the mental health status of the perpetrator. There is a lack of framing regarding specialist VAWG intervention. No evidence of specialist support from a by and for organisation for female members.
- Critical in intervention is how the questions are framed – the lens through which assessments are completed, needs understood, and factors weighed. In some cases, there was significant period of intervention by police and GPs but there is a lack of framing of the questioning that is taking place regarding the history of abuse because it is not viewed under violence against women and girl's framework.

- In some cases, police intervened several times regarding harassment, intimidation and violent behaviour towards neighbours, family members and others in the community. In some cases, there was a long record of history of abuse recorded by police. However, these issues were not framed as VAWG and therefore the questioning in these cases lacked an understanding of the dynamics of abusive relationships and how perpetrators may use coercion, manipulation and controlling behaviours.
- A VAWG framework helps to understand the complex dynamics involved in violence as a power and control process, and considers a number of social, economic, psycho-social, environmental and familial factors under a comprehensive holistic approach to the framing of the issues presented, the ways in which victims/survivors are likely to be impacted, and provides more in-depth and contextual framing of perpetrator behaviour. These issues were not present in intervention and there were significant failures to connect the presenting issues/problems to the wider dynamics.
- Heavy reliance on a clinical approach in the absence of psychosocial, social and other factors being taken into consideration. A holistic approach also prevents the single lens of the criminal justice system approach which raises concerns regarding diverse communities and their access to support and allows for early detection and intervention.
- It is critical to think about VAWG and how power and control dynamics operate, as well as the many ways in which VAWG manifests in relationships across family dynamics. There is a general understanding of VAWG and a specialist approach impacting BME communities. There is opportunity to think about the positive impact by and for specialist organisations can have in awareness raising and in specialist intervention to address some critical gaps in the knowledge of the agencies that were involved. This goes beyond training (as recommended) to creating community resources (community organisations operating at grassroots), including through the use of specialist organisations, to address the complexities of VAWG. Cases: AFH, DHRA11, DHRA21

Risk Assessment -- Not Done or Poorly Done

- It is critical to have needs-led approaches rather than risk-led (and going beyond the DASH risk assessment) to create the space for interaction and engagement so that information can be disclosed. Risk-led approaches and the lens through which these are assessed is very limiting and cannot address the holistic response that is needed because they operate on the basis of thresholds where the lived experiences of individuals is not fully reflected specifically by the abuse that women are subjected to. Cases: AFH: DHR30, DHR20, DHR1

Lack of Specialist Knowledge in Assessment

- In DHRA6 case there is misuse of so-called honour-based violence[10]. Within the context of the review, a statement is made solely on the basis of the ethnic and religious background of the family and the conduct of family members. The review of the case suggests a lack of understanding of specific issues relating to VAWG which places women from certain backgrounds outside the approach and subsequent intervention. Often references to culture and faith that amount to justifications for abuse are in fact used by perpetrators to silence and control victims yet, such dynamics are not challenged or even understood as such in the context of a review. The lack of inclusion on panels to ensure that diversity issues are appropriately considered within the correct context leads to inaccurate assumptions about how such issues should be interpreted as they often become essentialised and instrumentalised. Where this occurs, barriers to support from diverse communities are exacerbated not alleviated. Further, the cultural expert should not be an add-on, called in to either challenge an interpretation or add context to one. VAWG cultural expertise should be a critical and integrated part of the whole process. The recommendation for cultural training across professions is welcome however, the whole economy of service

[10] V. Meetoo, H. S. Mirza, "'There is nothing "honourable" about honour killings': Gender, Violence and the Limits of Multiculturalism." Social Policy Research Centre, Middlesex University, London, 2007: https://www.sciencedirect.com/science/article/abs/pii/S0277539507000295

provision must reflect the diversity of the populations served and this must be viewed as specialist knowledge.

- In some cases, so-called honour-based violence extended cross country borders to the origin country where extended family reside who were subjected to threats and intimidation. All such issues must be viewed in the context of VAWG with the full incorporation of specialist by and for organisations to offer appropriate interpretation and intervention.
- There is a need for improved understanding of VAWG and the dynamics of power and control as rooted in gender inequality (political, social, cultural and economic manifestation) and patriarchy. Often without this understanding at conceptual, theoretical and representational level especially by non-specialist services can mean that opportunities are missed to scrutinise the argument of 'cultural justification' for violence against women and girls.

Lack of a Culture of Questioning, Including Enquiries with cases of multiple and complex needs. Lack of Information Sharing - including between Health Services

- Elder abuse is a growing concern but under-represented as a problem and which should be addressed from a needs-led and survivor centred empowerment framework. Responses to older victims tend to be generic, with a focus on the presenting physical health symptoms or general elderly care needs. A clinical response for physical health problems without consideration of the social, familial and environmental situation leave elderly victims voiceless and invisible within the system.
- A more nuanced understanding of elder abuse within a VAWG framing would enable greater opportunities for enquiry, disclosure and multi-agency working. More work is needed to increase awareness and understanding of the dynamics of gendered familial abuse contexts specifically in BME cases where there may more than one perpetrator or where the perpetrator is their carer should be increased.
- There is a gap in specialist VAWG support for older victims of abuse from minoritised communities and support and advocacy pathways which are barriers to support.
- Agencies still use family members as interpreters despite the risks this can pose. Independent and good quality interpreting services should form part of consistent practice across sectors. Cases: DHRs 49,20, A11, 36

Carer responsibilities and Barriers of being able to Seek Help

- Those who are subject to violence by their carers face significant barriers to independent advocacy and support on VAWG and this is exacerbated by other intersecting factors e.g. immigration status, lack of mobility, lack of same-language support, inter-generational context. There were examples of carer assessments which could have provided critical opportunities for enquiry on VAWG, the identification of vulnerable adults and referral to specialist VAWG services. However, carer assessments tend to focus on practical issues linked to equipment or respite needs and in doing so, underlying causes of stress, fear, poor health linked to violence and abuse are not sufficiently explored. Systems for undertaking carer assessments and assessments of vulnerability should be better integrated with systems for identifying VAWG. CASES: DHR 20 and 11.

Lack of Training - Dynamics and Practice

- It is important that there is an awareness of the history of discrimination that minoritised communities have and do experience which can prevent disclosures to certain agencies like the police.
- Training for statutory agencies in of itself is unlikely to build trust and effective engagement with support unless there is a recognition of the importance of diverse pathways rather than single statutory pathways of support. For example, agencies should as a result of

training better understand the role of non-clinical and non-institutional survivor-centred community organisations where specialist support and interventions can be delivered, and this should include being more confident to refer to these organisations.

- Agencies with safeguarding responsibilities across the social care, housing and health sector, including those involved in reviewing and chairing of DHRs should access training on VAWG from an intersectional perspective. Training should be delivered by the VAWG sector with expertise in this area.
- There can be a tendency to frame cases as 'HBV' or DA without a consideration of intersecting forms of violence and/or poly-victimisation and multiple perpetrator contexts. More work is required to help agencies identify indicators of violence within these contexts.

Table 30: Ethnicity of victims from AFH cases

Ethnicity of victim	Number of victims
Arab	1
Asian/Asian British: Bangladeshi	3
Asian/Asian British: Bengali	1
Asian/Asian British: Indian	2
Asian/Asian British: Sri Lankan	1
Black/Black British: African	2
Black/Black British: African-Caribbean	1
British, unspecified	2
Fijian	1
Mauritian	2
Spanish	1
Romanian	1
Russian	1
White: British	5
White: Irish	1

Table 31: Ethnicity of perpetrators from AFH cases

Ethnicity of perpetrator	Number of perpetrators
Arab	1
Asian/Asian British: Bangladeshi	3
Asian/Asian British: Bengali	1
Asian/Asian British: Indian	1
Asian/Asian British: Sri Lankan	1
Black/Black British: African	2
Black/Black British: African-Caribbean	1
Black/Black British: Bangladesh	1
Black/Black British: Other, unspecified	1
Black/Black British: Somalian	1
British, unspecified	1
Mauritian	1
White: Danish	1
White: British	6
White: Irish	1

White: Romanian	1
Unknown/Not stated	1

Table 32: Immigration status of victims from AFH cases

Victim immigration status	Number of victims
EEA National – Details unknown	1
EEA National – Exercising treaty rights	1
Limited Leave to Remain	1
UK National	11
Undocumented	1
Unknown/Not stated	10

Table 33: Immigration status of perpetrators from AFH cases

Perpetrator immigration status	Number of perpetrators
EEA National – Exercising treaty rights	1
Indefinite Leave to Remain	1
UK National	15
Over stayer	1
Two Year Visa	1
Undocumented	1
Unknown/Not stated	5

Related to all Cases

Perpetrator's Mental Health

- Where there were significant concerns about the mental health of the perpetrator, inadequate systems for monitoring and follow-up, sharing information with key agencies such as the police and GP, emerged as an issue. Agencies also tend to focus on mental health and miss opportunities for identifying VAWG[11].
- Assessments can lack vital information held by family members, professionals e.g. GPs, as well as information from the person with the mental health problems, in particular their own assessments of harm. A more holistic enquiry would lead to a more thorough needs and safety assessment.
- Non-engagement with community and clinical mental health interventions emerges as a key issue. There is significant research about mental health in BME communities and the need for appropriate holistic interventions away from the clinical model and CBT models which present barriers to support. There is also an over-representation in sectioning BME people, both men and women in institutional care settings and an overmedication of BME women.
  - Presenting clinical issues such as depression, anxiety and other mental health categories must be viewed in the context of the wider experience. For example, a universal generic approach to someone who has been subjected to civil war and trauma will not be effective and without a broader approach there could be missed opportunities in referrals to adult safeguarding. However, adult safeguarding must also be equipped to support such cases.

[11] J. Watson, "Drop the Disorder! Challenging the culture of psychiatric diagnosis." PCCS Books, Monmouth, 2019.

- NHS Commissioners need to consider deinstitutionalised community-based interventions and mental health support pathways that are specifically geared towards BME people. Cases: DHR30, A6,36,49,20

Immigration Context

- Immigration was a key factor which prevented some victims from accessing early support that they were eligible to receive through social care[12], health and specialist ending-VAWG organisations[13].
- Opportunities to disclose violence and abuse are missed because of a tendency to view these situations solely as immigration cases instead of a holistic lens which incorporates safeguarding, housing, and health within a VAWG framework. In practice where there may be an immigration component, cases are too easily closed, victims are refused support and/or referred onto other more generic agencies. Creating pathways for support is essential given the huge barriers to support that already exist including a hostile environment towards migrant communities where public services can operate as an extension of immigration and border control.
- Agencies should carry out safeguarding and human rights assessments within a VAWG framework and start with a presumption of belief.
- Practitioners across the health and social care sectors with safeguarding responsibilities need to have a better awareness of this area including rights and entitlements.
- Current systems for assessing needs and risks do not sufficiently draw the links between coercive control within an immigration context and how this is used to maintain silence and control. Cases: DHRA21 and 20.

LGBT+ DHR Cases

In our sample of 85 DHRs looked at there were only 2 LBGT+ cases

LGBT+ People's Experiences of Domestic Abuse

Estimates suggest that somewhere between 2.5% to 5.9% of the adult population of England identifies as lesbian, gay, bisexual or 'other' and 0.35% and 1% of the adult population of the UK identifies as Trans.[14]

It is estimated that more than 1/4 gay men and lesbian women and more than 1/3 bisexual people report at least one form of domestic abuse since the age of 16. While lesbian women report similar rates of domestic abuse to that of heterosexual women, gay and bisexual men might be twice as likely to experience domestic abuse compared to heterosexual men. Evidence also suggest reporting rates of domestic abuse may be higher for transgender people than any other section of the population [15](Magic & Kelley, 2019, p15). There is also some evidence to suggest that the

[12] N.J. Farmer, "'No Recourse to Public Funds'", Insecure Immigration Status and Destitution: The Role of Social Work?." Policy Press, Bristol, 2017.

[13] R. Dudley, "Domestic Abuse and Women with 'No Recourse to Public Funds': The State's Role in Shaping and Reinforcing Coercive Control." Families, Relationships and Societies, Bristol, 2017: https://www.ingentaconnect.com/content/tpp/crsw/2017/00000005/00000003/art00008;jsessionid=7n5joiimmlcbf.x-ic-live-02

[14] S. Van Kampen, M. Fornasiero, and W. Lee, "Producing modelled estimates of the size of the lesbian, gay and bisexual (LGB) population of England." Public Health England, London, 2017: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf (accessed 05 October 2019)

[15] Prevalence of intimate violence among adults aged 16 to 59, by category and sexual identity of the victim, year ending March 2016 CSEW: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/adhocs/005986prevalenceofintimateviolenceamongadultsaged16to59b ycategoryandsexualidentityofthevictimyearendingmarch2016csew (accessed on 5 October 2019).

severity of abuse can be higher for some LGBT+ people, such as gay/bi men in comparison to heterosexual men.[16]

LGBT+ victims/survivors share similar types of domestic abuse as their heterosexual/cisgender peers and disclose abuse from both interpersonals and family members. However, in addition to abuse rooted in patriarchy and harmful and negative gender stereotypes, lesbian, gay, bisexual and transgender survivors may also experience abuse of power and control closely linked to their sexual orientation and gender identity. It is also important that LGBT+ survivors are not seen as a single homogenous group as their experiences will also intersect with gender, ethnicity and class.

LGBT+ domestic abuse appears significantly underreported and LGBT+ survivors are disproportionally underrepresented in voluntary and statutory services, including criminal justice services. Survivors can be overlooked because the identities of the victim/survivor and perpetrator do not fit the 'public story' of domestic abuse. For example, LGBT+ experiences of interpersonal violence might be viewed as mutual abuse because it involves a same-sex couple. Similarly, adult family violence/abuse against a young LGBT+ person may influence agencies to focus on the young person's 'problematic' behaviour, rather than the abusive behaviour stemming from family response to the young person disclosing their sexuality or gender identity. Issues such as 'so-called honour-based violence involving LGBT+ people can understandably be conflated with hate crime because of the homophobic or transphobic motivation by the perpetrators.

Safe Lives' national data found a higher prevalence of all types of abuse among LGBT+ clients compared with those who do not identify as LGBT+. Except for harassment and stalking, these differences were found to be statistically significant.[17] There are also some additional risk factors and experiences that may apply specifically to LGBT+ victims:

- The use of and impact of homophobia/biphobia and transphobia, including intimidation and threats of disclosure of sexual orientation and gender identity to family, friends, work colleagues, community and others.
- Disclosing gender history, sexual orientation or HIV status without consent.
- Undermining sense of sexual and/or gender identity/self-expression, or making a person feel guilty or ashamed of their sexual orientation and gender identity.
- Blaming a person for identifying as LGBT+ or for causing the discrimination they have experienced.
- Limiting or controlling access to LGBT+ spaces or resources. The abuser may isolate the abused from contact with the LGBT+ community, including isolation from friends and family.
- The abuser might use immigration law/status to threaten with deportation to the country of origin, which might be unsafe due to e.g. anti-gay legislation.
- Other factors, including the use of recreational drugs; chems' (Crystal Meth/G)
- There are very limited opportunities to identify and carry out intervention work with LGBT+ perpetrators, as there are almost no LGBT+ perpetrator intervention programmes in the UK and the few LGBT+ specialist domestic abuse services do not work with perpetrators.
- Not all these specific risk factors will be identified through the DASH risk assessment and it is important that professionals are able to draw on professional judgement or seek advice from LGBT+ specialists.[13]

[16] Unofficial ONS data available around GBT+ men reporting much higher physical violence as opposed to hetero men. Here: Prevalence of intimate violence among adults aged 16 to 59, by category and sexual identity of the victim, year ending March 2016 CSEW: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/adhocs/005986prevalenceofintimateviolenceamongadultsaged16to59bycategoryandsexualidentityofthevictimyearendingmarch2016csew

[17] SafeLives, "Free to be Safe: LGBT People Experiencing Domestic Abuse." SafeLives, Bristol, 2018: http://www.safelives.org.uk/sites/default/files/resources/Free%20to%20be%20safe%20web.pdf [accessed 05 October 2019] [13] Magić, J. & Kelley, P. (2019). Recognise & Respond: Strengthening Advocacy for LGBT+ Survivors of Domestic Abuse. London: Galop

Murders of LGBT+ People Not Subject to Domestic Homicide Reviews

There have been several murders of gay/bi men and trans women in the last 10 years involving interpersonal violence, largely from casual sexual partners or 'hook-ups' made via social media. These cases have not been subject to a DHR or a serious case review as they do not meet the current criteria. Nevertheless, these cases fall under the definition of interpersonal and/or gender-based violence.

There are also some common factors to these murders. Noticeably, the perpetrators were male; many of the victims have been young people in their 20s, and in the case of Trans people recently murdered in London, all were of BME background.

While some of these murders have been subject to scrutiny, the same opportunities for lessons to be learnt provided by DHR process might be missed because the scope for non-DHR scrutiny will not be as rounded. For instance, an IOPC investigation into the police response to the Port murders, will primarily focus on police processes. LGBT+ community responses to recent murders of gay/bi and Trans women focus largely on the use of social media apps and recreational drugs (chems) by victim and/or perpetrator rather than the IPV context.

Galop acknowledges that murders by casual interpersonals should not be conflated with DHRs. Nevertheless, in the absence of significant DHRs to draw on, these cases may provide opportunities to carry out serious case reviews of murders of LGBT+ people who have been killed by casual intimate/sexual partners and to highlight lessons learnt, as demonstrated in an exercise carried out by the MPS LGBT Independent Advisory Group Report into unsolved murders of LGBT+ people (2010).

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

Some LGBT+ relationships might not present as conventional hetero-gender normative relationships. A greater understanding of the dynamics of LGBT+ abuse is required in both IPV and AFV violence to ensure murders are not missed. In the case of Mr C, where the DHR did pick up on the dynamic of the relationship, the perpetrator was viewed by some health professionals as the victim's carer rather than an abusive partner.

A case (GK2015) was initially overlooked as a DHR by the CSP, despite him briefly living with the perpetrator at the time he was murdered, meeting the criteria for a DHR.

Although there is no evidence that there are many unidentified LGBT+ domestic homicides, more research may be needed to ascertain how many deaths of LGBT+ people involving adult family violence might have been overlooked. LGBT+ victims of domestic abuse are twice as likely to attempt suicide and there may be cases where the victim has ended their own life because of homophobic, biphobia or transphobia from family members.[18]

Awareness campaigns

The cross-government definition of domestic violence and abuse recognises domestic violence and abuse can affect anyone regardless of their gender or sexuality. There is more work to be done to increase professional and public awareness.

The Home Office has recognised the need for this work and has funded Galop to deliver a national project to help develop understanding and awareness of LGBT+ experiences of domestic abuse.

Community impact of LGBT+ homicides

Consideration needs to be given to the impact of LGBT+ homicides on the LGBT+ community and the impact on how these homicides are reported by the media.

[18] British LGBT domestic abuse victims twice as likely to attempt suicide: https://www.reuters.com/article/us-britain-lgbt-crime/british-lgbtdomestic-abuse-victims-twice-as-likely-to-attempt-suicide-idUSKCN1LR1OY

Reports are often salacious and derogatory. They often disclose the victim or perpetrator's gender identity, when this has little relevance to the murder. One DHR led to a report of her conviction appearing on the transphobic website, which alludes to 'documenting crimes committed by trans people in the UK,'.

Domestic Homicide Reviews Involving LGBT+ People

Two recently completed DHRs were reviewed, both involving Trans women.

The first victim (DHR 23) was murdered by her husband and the second victim (DHR A19) was killed by his daughter.

Domestic Homicide Review: DHR A23

The DHR date was delayed for several reasons and although there were complicating circumstances, the Chair concluded that none were insurmountable to the completion of the DHR. It is unacceptable for the DHR to have been published almost 4 years after the murder and for the family of the victim not to have been contacted for one year. Whilst this delay may not be directly related to the DHR involving an LGBT+ victim/perpetrator, it may have potential impact on the LGBT community's trust and confidence in statutory services. Similarities can be drawn from the IOPC investigation into police conduct surrounding the Port murder case, which has still not published its findings 4 years after the murders took place.

The DHR recommends that the CSP ensure it has a picture of the size and needs of the local Tran's community to inform local commissioning and strategy decision. There is currently very little available data to draw on. For example, Public Health England, (2017) investigated prevalence on LGB identifying people, but found little information collected on trans identifying people. Similarly, it can be difficult to identify needs of the local Trans community in relation to IPV.

The DHR identified some wider research and areas for development, for example, highlighting knowledge of friends/ family of the victim and referencing wider research on the experiences of Tran's communities and sex-workers.

Forthcoming reports by Galop will highlight specific DA experiences of LGBT+ communities and include commissioning guidance on how to commission LGBT+ specialist domestic abuse services. The Angelou/MSWTA project has evidenced the presence of an LGBT+ specialist service (see below) can increase the number of victims/survivors coming forward, e.g. to MARAC and contribute towards meeting the needs of survivors.

The DHR recommended that the CSP undertake an audit of local agency practice to see if domestic abuse services are Trans inclusive and to ensure that there are appropriate referral pathways for Tran's victims/survivors of abuse.

The DHR also noted the absence of Latin American specialist services in the initial DHR panel and subsequently invited Latin American Women's Aid to attend the final review panel meeting. LAWA currently has a project that supports LBT+ Latin American Women experiencing VAWG and refuge accommodation that is accessible to Tran's women.

Several recommendations highlight the need to consider the intersectional identities of the victim and perpetrator, including their gender and ethnic identity, age, that they were temporarily staying in the UK and that the victim made a living through sex working. In this respect, the DHR Chair draws attention to the need for DHRs to fully consider equalities and the relevance of protected characteristics, and found several that were relevant to consider, including age, ethnicity, immigration status, sex and gender identity. All of these protected characteristics may have been factors in the power/control dynamics within the relationship and may have been barriers to help-seeking.

The DHR draws attention to the complexities of the relationship between a Trans woman and 'cis' gendered (non-trans man) and speculates how this dynamic may have played out in the relationship. It explores financial dependency of the perpetrator on the victim who was the

primary financial provider through sex working. The DHR also briefly considers how the relationship dynamics might have deviated from conventional hetero-gender normative relationships. The DHR draws on the need to consult with wider groups outside of those that might otherwise be considered in a DHR, particularly as the victim did not have contact with services before she was murdered. As well as her family, she also had a small network of friends and clients.

However, it is important that this DHR does not seek to 'exoticise' victim's Trans identity or use to it to explain her murder. Rather, it contextualises the murder in the wider cultural context of not only VAWG, but also specifically the experiences of Tran's women.

Domestic Homicide Review: DHR A19

There were no LGBT+ or specialist VAWG services on the DHR panel, apart from Victim Support. Galop was approached but involved in another DHR so could offer limited support.

The perpetrator identified as a Trans woman and as with the above DHR, the report uses appropriate language/pronouns, and there is a sense that her identity is treated with dignity and respect.

The DHR briefly explores background in terms of her isolation, depression and her initial steps taken towards transition and engaging with her GP who referred her to the Gender Reassignment Service. Her parents appear to have largely accepted her identity.

The DHR does consider that equality issues (in this case gender identity) to be a consideration simply because "*The Review found no evidence of (S) being discriminated against on the grounds of her gender reassignment by services...*" (p28). On this basis, the DHR found no evidence/insight that (S)'s Tran's identity was a contributory factor to the homicide.

The DHR also touches to (S)'s life leading up to the murder of her father, particularly her role as his carer and her social isolation that in turn isolated her father who was living with a diagnosis of MS. (S) had few friends, didn't engage with neighbours, and at times appears to have taken steps to avoid contact with services, ultimately leading to neglect and possibly contributing to her decision to end her father's life. We wonder whether (S) could have accessed carer support services and what might have been some of the barriers for Tran's people. Several services were involved in her father's care at home and on admittance to hospital, but none were able to really understand the coercive control (S) had over her father, which stopped him from receiving appropriate care. There may have been uncomfortable in dealing with a Trans woman and this may have been an additional factor in the level of engagement

Although there may not be evidence of direct discrimination, (S)'s trans identity may have benefitted from further examination in providing a context for the circumstances in which she found herself, though not as a reason for her father's death. For example, (S)'s behaviour and apparent deterioration in her ability to cope with her father's illness may have been linked to her wider experiences of being trans and possibly her experiences as a trans woman living in an Outer-London borough.

Research by Galop and others highlights that Trans people experience high levels of discrimination and transphobia that in turn can lead to poor mental health, suicide ideation and isolation from the wider community. It would be surprising if (S) hadn't experienced this at least at some points in her life. There would have been few or no services for Trans people in the borough and no LGBT+ perpetrator services, had (S) wanted support with her behaviour. Although (S) took part in the DHR, it is unclear if she was asked about this. It is not possible to conclude that (S)'s experiences of living as a Trans woman directly contributed to her inability to cope. However, it may in some way explain how she became even more isolated from both services and the community, and this was a contributory factor to the neglect of her father.

Recommendations for Practice

- Galop recommend that the experiences of LGBT+ victims be embedded in the Coordinated Community Response, to ensure that there is an appropriate response to murders of those who identify as LGBT+.
- Gender and sexuality should always be taken into consideration when examining the risks to LGBT+ victims/survivors/perpetrators and when conducting any future DHR/Serious Case Review involving LGBT+ people.
- Galop would recommend that DHRs involving LGBT+ should always seek the input of LGBT+ organisations/stakeholders with specialist knowledge of domestic abuse/community issues.
- Agencies should engage with specialist LBGT+ projects to increase their awareness of support services available.
- Community Safety Partnerships to map out the size and necessities of the local LBGT+ communities to inform strategy decisions to best support them.
- Carry out an audit of local agency practices to see if they are trans-inclusive in their domestic abuse work. In the case that agency practices are not trans-inclusive, training should be provided to staff to meet the needs of victims of domestic abuse who are Trans or establish referral to those that are.
- Community safety Boards should be aware of transphobic websites which allude to 'documenting crimes committed by trans people in the UK' and deal with any media requests with this in mind.
- Probation should explore perpetrator programmes accessible to LGBT+ perpetrators.

Mental Health DHR Cases

For this chapter, 10 DHR overview reports were selected for analysis of themes related to the mental health of the victim and/or perpetrator. This chapter includes analysis of the responses of healthcare services, including mental health, primary care, acute Trusts and addiction services, to victims or perpetrators with mental health problems.

The relationship between mental health and DA is complex and its mechanisms are not yet known. However, systematic reviews have shown that men and women who have a mental disorder are at higher risk of experiencing and of perpetrating DA compared to the general population (Trevillion et al 2012; Oram 2013). Recent studies in the UK have shown an association between mental disorder and perpetration of domestic homicides. In England and Wales, 20% of convicted perpetrators of interpersonal homicide and 34% of convicted perpetrators of adult family homicides between 1997 and 2008 had symptoms of mental illness at the time of the offence (Oram 2013b); similarly, a recent analysis of 40 domestic homicides by the Home Office revealed that mental disorder was a factor in 75% of the 33 interpersonal homicides and in all of the 7 familial homicides analysed (Home Office, 2016).

Mental health was one of the key areas identified in the 2016 STADV DHR case analysis, particularly with regards to the identification of DA perpetration and the response to the risk of DA by clinicians working in mental health services (Sharp-Jeffs & Kelly, 2016). It should be recognized, however, that there may not always be a direct relationship between an individual's mental health problems and the perpetration of DA. The 84 DHRs looked at in this study showed a very high percentage of **AFH** DHRs had perpetrators with mental health as a factor 64% and 44% of **IPH** DHRs. The 2104 Adult psychiatric morbidity survey finds 17% of common mental health disorders (depression and anxiety) in the general population, with psychotic disorders at 0.3% in the general population. (see table

Please see table in Appendix 7 for a summary of sample characteristics.

Mental Health Symptoms and Diagnosis

Victims' Mental Health

- Half of the victims in this sample had a history of depression or anxiety; in two cases, the victim had a historical diagnosis of depressive disorder which had required treatment in the past, but there was no evidence of symptoms of depression around the time of the homicide.
- Three victims had symptoms of depression in the year prior to the homicide; the severity of depression and level of impairment was different in each case. In DHR 9, the victim had depression with comorbid personality disorder and substance use; she had been discharged from mental health services 3 months before the homicide. Her mental health presentation was complex and may have affected how professionals viewed her in relation to the allegations of domestic abuse, as discussed in themes 2 (vulnerability) and 9 (agencies' responses to DA).
- One victim (DHR 5) had recurrent depressive disorder which was severe and disabling. She had been discharged from mental health services 3 years before the homicide; she and her partner (the perpetrator), who was also her carer, felt hopeless about her mental health treatment.
- One victim (DHR 10) reported 'anxiety and negative thoughts' to her GP 1 year before the homicide, at a time when the perpetrator's abuse towards her and her children was escalating. She disclosed to the GP that 'domestic hassle' had been a trigger to her mental health symptoms, but there is no evidence that this disclosure was explored or that she was asked about DA.

Perpetrator's Mental Health

- Nine perpetrators in the sample had mental health problems. The mental health diagnoses identified were depression and/or anxiety disorder (3/10), personality disorder (3/10) (including emotionally unstable personality disorder and dissocial personality disorder); psychosis (2/10) (including drug-induced psychosis and schizophrenia); agoraphobia (1/10); and suicide attempt with no clear psychiatric diagnosis (1/10). One perpetrator (DHR 7) had two diagnoses (dissocial personality disorder and drug-induced psychosis). The perpetrator in DHR 10 did not have a mental health diagnosis prior to the incident but reported suicidal thoughts after the homicide when interviewed by the DHR chair.
- The diagnoses represented in this sample are consistent with evidence on the mental health of DA perpetrators. Cross-sectional and retrospective studies indicate that depression may be a risk factor for aggression (Dutton & Karakanta, 2013), and men who perpetrate interpersonal violence have higher rates of depressive symptoms and other mental disorders such as post-traumatic stress disorder (PTSD) (Rhodes et al., 2009; Machisa & Shamu, 2018). Emotionally unstable and dissocial personality disorders have also been reported among perpetrators of IPV, particularly among those who perpetrate moderate and severe IPV (Sesar, Dodaj & Simic, 2018).
- Two perpetrators in this sample had a diagnosis of psychotic disorder and had symptoms of psychosis at the time of the homicide. There is evidence that people with psychosis are at higher risk of perpetrating violence against families and carers (Solomon, Cavanaugh & Gelles, 2005), although the relationship between psychosis and violence is complex (Fazel et al., 2009).

Suicidality

- A prominent sub-theme identified in this sample was suicidality among perpetrators of domestic homicides. Studies have shown a high prevalence of suicidal threats or behaviours among male perpetrators of interpersonal violence who are in contact with the criminal justice system (Conner, Cerulli & Caine, 2002; Wolford-Clevenger et al., 2015).

  Out of 9 perpetrators with mental health problems in the sample, 5 had reported suicidality to health services (mental health services, GP, acute Trust or emergency department) prior to the homicide. In 3 cases the perpetrator displayed suicidal behaviour or thoughts in the month before the homicide: in DHR 8, the perpetrator mentioned relationship separation as a trigger to the suicide attempt. In DHR 5, the perpetrator was referred to a community mental health team for treatment of depression but was deemed not to meet the

threshold for secondary care mental health services and continued to receive treatment from his GP. He reported to health services that his relationship with his partner was a protective factor against suicide; he committed homicide-suicide less than 1 month later.

Two perpetrators had been suicidal more than one year before the homicide; both had disclosed to mental health services that they had relationship difficulties and thoughts or plans to kill their partners.

One perpetrator (DHR 2) had long contact with mental health services due to emotionally unstable personality disorder and had expressed suicidal thoughts several times throughout his contact with the mental health team but had never been deemed as requiring acute intervention. He died by suicide while on remand awaiting trial for the murder of his partner. One perpetrator (DHR 1) made a suicide attempt two years before the homicide and had come to the attention of acute mental health services, who were aware of his relationship difficulties.

Two DHRs (DHR 1 and DHR 8) made recommendations for NHS services to assess risk of harm to families and partners in all patients who present with suicidality. In both DHRs, the perpetrators had disclosed relationship difficulties to mental health services, but their partners were not involved in the risk assessment processes or contacted to give collateral information.

The perpetrator in DHR 10 did not have a mental health diagnosis prior to the incident but reported suicidal thoughts after the homicide when interviewed by the DHR chair.

Staff within agencies need to be able to spot the signs of suicidality not just in specialist health services but in all support agencies. Thrive LDN, is an organisation that is tackling the issue of suicide and has developed London's first multi-agency information sharing hub. Organisations should ensure staff are aware of resources available.
https://www.thriveldn.co.uk/core-activities/suicide-prevention/

Vulnerability

In two of the DHRs sampled, there were clear vulnerability factors apart from mental health problems.

- In DHR 4, the victim was an older man with a chronic neurological condition, and he and the perpetrator (his daughter) had expressed hopelessness about his prognosis. There were signs that he was experiencing neglect and financial abuse by his daughter. He was discharged from secondary care health services for his chronic condition due to non-attendance; the discharge process lacked an exploration of why he was failing to attend appointments. There was little evidence of assessment of his psychological wellbeing, despite his diagnosis of a serious long-term condition which is associated with cognitive, psychiatric and mobility problems. His care package had been cancelled by his daughter without clear documentation of an assessment of his capacity to make that decision. The DHR report makes a series of recommendations in relation to vulnerable victims, including 1) assessment of psychological wellbeing of people with long-term conditions; 2) a review of NHS 'Did Not Attend' ('DNA') policies, as in this case the reason for non-attendance was high vulnerability and neglect by the carer; and 3) clear documentation of capacity assessments for decisions such as cancelling a care package.

- Other vulnerability factors as evidenced in DHR 3: the victim was a middle-aged man who had unclear immigration status and was known to community addiction services due to heroin and crack cocaine use, of which he was on remission. In this case, the perpetrator was also a vulnerable person due to unstable housing and a diagnosis of paranoid schizophrenia. He had contact with the police via repeated phone calls in the month before the homicide, and there was evidence that the phone calls were a sign of vulnerability and poor mental health. Although the police did eventually request a home

visit to ascertain the perpetrator's welfare, the visit did not happen and the DHR panel felt that the police response to the perpetrator's mental health overall was weak.

- In DHR 9, the victim was vulnerable due to her diagnoses of depression and personality disorder and self-harm, and her history of DA. The DHR report comments on how agencies often expected her to be proactive in managing the risk that the perpetrator posed to her, rather than understanding the effects of coercive control in her ability to seek help. In DHR 5 and DHR 10, victims had depression and/or anxiety, which would have placed them at risk of being victims of abuse. However, healthcare services did not treat them as vulnerable adults and did not ask them about relationship difficulties, despite one of the victims having disclosed that 'domestic hassle' was a trigger to her anxiety.

Mental Health and Substance Use

- There is an association between the use of psychoactive substances, particularly alcohol, and perpetration of interpersonal violence, though the exact mechanisms involved in this relationship are not yet clear (Choenni, Hammink & van de Mheen, 2015). Substance use was present in three DHR reports in this sample; in DHR 9, both victim and perpetrator used psychoactive substances and were referred for treatment but did not engage with addiction services. Both also had comorbid diagnoses of personality disorder and were known to mental health services. - One perpetrator (DHR 7) was known to misuse alcohol and had physical health problems associated with alcohol dependence. He had also been diagnosed with dissocial personality disorder and drug-induced psychosis (previously schizophrenia) several years before the homicide. At the time of the homicide, he was experiencing psychotic symptoms; these were thought to have been induced by medication prescribed for viral hepatitis.
- One victim (DHR 3) was known to addiction services for heroin and crack cocaine dependence and was engaging well with treatment. There is no clear indication that his substance use played a role in the homicide.

Inter-Agency Working

Inter-agency working and information-sharing was highlighted by 6 of the 10 mental health DHRs. Agencies were seen as often focusing on their own area of practice; there was a lack of effective partnerships between agencies to share information and improve their understanding of the victim and perpetrator.

- In DHR 3 and DHR 9, there were significant child protection and mental health concerns, but mental health and social care agencies, despite some attempts at joint working, did not work together effectively. In DHR 9, agencies did not proactively seek or share information with other agencies despite the complex needs of both the perpetrator and victim, and the fact that both had contact with a young child, the victim's daughter. There were no successful referrals to MARAC, MAPPA or adult safeguarding, despite the information known to the agencies. In DHR 3, child safeguarding concerns were referred to children's social care, but the referral was declined, and concerns were not escalated.
- In DHR 1 and DHR 8, there were gaps in the information-sharing from mental health services to other agencies. In DHR 1, the mental health team did not share information about the perpetrator's mental health with his GP surgery as the perpetrator was in a relationship with a member of staff in the surgery, despite that relationship being associated with significant problems around professional boundaries. In DHR 8, the perpetrator presented to mental health services following an overdose and disclosed his plan to abduct his child due his relationship difficulties with the victim and child's mother; this clear safeguarding issue was not identified by mental health services or shared with children's social care. The perpetrator killed his partner in the presence of their 2-year old child a few weeks later.
- In DHR 7, the Acute Trust prescribed medication that is associated with risk of serious mental health side effects but did not request historical mental health information from the perpetrator's GP. However, even if that had been requested, the full risk history was also not available to the GP, as it had been lost during transfer from a previous GP practice.

- In DHR 4, there was little effective communication between the GP and the other agencies looking after the victim. A safeguarding alert was raised in relation to suspicion of financial abuse of the victim by his daughter and carer, but this was not communicated to the GP nor did it lead to a multi-agency strategy meeting. There was another example of lack of inter-agency consultation when the victim's care package was terminated. The lack of coordination and information-sharing in that case contributed to agencies missing the whole picture of the difficulties within the family.

Caring Responsibilities

A significant proportion of care for people with physical and mental health problems is provided in the community by family members and partners. The carer role is associated with a high risk of psychological distress for the carer, known as caregiver burden; the risk is particularly high for carers who live with the person for whom they provide care, and if the carer has mental health problems (Adelman et al., 2014). Conflict in the relationship between carer and recipient of care, carer strain, carer history of physical or mental health problems, and carer and care recipient living together have all been identified as risk factors for abuse by carers (Kohn & Verhoek-Oftedahl, 2011).

- In two DHRs (4 and 5) the perpetrators were carers for the victims. In both cases there was evidence that the carers were not coping with their role, which in DHR 4 resulted in neglect and financial abuse, and in DHR 5 was one of the underlying reasons for the perpetrator's low mood and suicidality. Despite the knowledge that the perpetrators were individuals with mental health problems who were providing care for a relative, healthcare services (including mental health services, acute Trust and primary care) involved with the carer and the recipient of care did not identify the impact of the caring role on their mental health and did not offer them an assessment of their needs as carers. Both cases were associated with perpetrator suicidality in the month before the homicide, and one (DHR 5) was a homicide-suicide.
- In DHR 7, the victim was a carer for the perpetrator, who had alcohol misuse, viral hepatitis and liver cirrhosis, and for her son, for whom the type of caring needs was not mentioned. It was noted by the DHR panel that she had not been offered a carers' assessment.

Agencies' Responses to DA

Healthcare services were made aware of serious relationship difficulties in a number of DHRs in this sample.

Victims

- In DHR 9, agencies, including the Mental Health teams, were aware of the victim's experiences of DA, but had an expectation for her to be proactive about managing the risk to herself. There was a lack of understanding of the dynamics of coercive and controlling relationships and the reasons why the victim may have minimised the impact of DA to professionals. She was never referred to MARAC or had a formal DA risk assessment. In DHR 10, the victim reported to her GP that she was experiencing anxiety and negative thoughts in relation to 'domestic hassle'. She was prescribed medication and referred for psychological therapies; however, her comment about 'domestic hassle' does not appear to have been explored or seen as indicative of domestic abuse.

Perpetrators

- In a number of DHRs, perpetrators had mentioned relationship difficulties to healthcare services, though often in indirect ways. Examples of this were perpetrators disclosing separation as a trigger to suicidality, having unauthorised access to ex-partner's emails and planning to abduct their child (DHR 8); making 'oblique references' to DA (DHR 9); disclosing injuries due to 'domestic incidents' and depression due to recent separation and loss of contact with their children (DHR 6). Those statements were not explored or shared between agencies, despite representing signs that the individual was experiencing serious relationship difficulties that could amount to DA.

Risk Assessment Processes

Mental health risk assessment processes were highlighted in 7 of the 10 DHRs where mental health issues had been identified.

- In 5 DHRs (DHR 1; DHR 2; DHR 8; DHR 6; and DHR 5), mental health services had not involved the partner when assessing the perpetrator, despite perpetrators disclosing thoughts to kill their interpersonal (DHR 1; DHR 2), disclosing that relationship difficulties had been the trigger to their mental health difficulties (DHR 8; DHR 6), or despite the perpetrator being a carer for their partner (DHR 5).

- In two DHRs, the risk assessments conducted by mental health services for the perpetrators were considered to lack sufficient information. In DHR 1, the assessment of the perpetrator was felt to be superficial due to a language barrier, as the perpetrator lacked fluency in English and an interpreter was not used. In DHR 3, the risk assessment lacked information on relapse indicators or response to mental health treatment.

- Sharing of historical risk information was an issue in DHR 7. The perpetrator had a history of drug-induced psychosis, dissocial personality disorder and violence towards partners (including the victim); the information had not been transferred when the perpetrator changed GP surgery and therefore was not available to be shared with the acute health Trust who was providing treatment which involved a risk of serious mental health side effects.

Treatment and Follow-Up for Mental Disorders

Mental health treatment and follow-up was highlighted in 3 DHR reports.

- In DHR 3, the perpetrator had paranoid schizophrenia and had disengaged with mental health services several times. He had also not been concordant with his antipsychotic medication, in part due to side effects. The report commented on the lack of contingency planning to manage disengagement and made two recommendations to secondary care mental health services: 1) for services to attempt a home visit before discharging service users due to non-attendance; and 2) for services to ensure appropriate monitoring of medication that was started as part of the care plan they recommended.

- In DHR 9, both victim and perpetrator had difficulties engaging with mental health services. The DHR report draws attention to the lack of arrangements for mental health follow-up of the perpetrator after he had been released from prison, where he served a sentence for DA-related offences; he was released from prison with no registration with a GP, no medication and no referral for mental health follow-up despite his diagnosis of dissocial personality disorder and repeated presentations to emergency departments with violence and selfharm. That, and the lack of housing provision, were felt by the DHR panel to have increased the risk to the victim, to whom he was already known to have been abusive.

- The third DHR that mentioned mental health follow-up highlights a different theme, which is that of individuals with mental health difficulties who are assessed as not meeting the threshold for secondary mental health services. In DHR 5, the perpetrator sought help for his mental health after he received a diagnosis of cancer, which triggered low mood and feelings of hopelessness. He was also experiencing difficulties in fulfilling his role of carer to his partner. He disclosed low mood and suicidal thoughts to the acute Trust that was treating him for cancer and sought help via acute psychiatric services and a cancer charity. He was referred to a Community Mental Health Team for assessment but was assessed as not meeting threshold for secondary care. His GP was providing adequate treatment for depression. However, the DHR panel felt that although all agencies involved with the perpetrator collected information about him, the assessments were somewhat superficial and did not explore the causes of his distress, which were related to his role as a carer and the prognosis for his partner's depression and did not manage his distress

effectively. The DHR panel made a recommendation to the local CCG to establish a clear pathway for mental health treatment for individuals who do not meet the threshold for secondary care mental health services.

Discussion

This section summarised the mental health themes in a sample of 10 DHR reports that were selected specifically due to a mental health history in the perpetrator, victim or both. A total of 8 themes were identified in this sample: mental health symptoms and diagnosis; vulnerability; substance use; inter-agency working; caring responsibilities; agencies' response to DA; risk assessment processes; and treatment and follow-up for mental disorders. Most of these themes overlapped with the themes identified in the 2016 STDAV report (see table 33). The additional themes identified (vulnerability, risk assessment processes and agencies' response to DA) were also highlighted in the 2016 report in relation to overall service response to victims and perpetrators.

In the wider sample of 84 DHRs analysed in this report (which contained the 10 DHRs described in the chapter), 23 victims and 39 perpetrators had mental health problems. Other victim and perpetrator characteristics such as being a carer and having a history of substance use were also present in a number of DHRs in the wider sample. Depression was the most common diagnosis for perpetrators (15/84) and victims (7/84) in the wider sample. Other common diagnoses for perpetrators in the wider sample were personality disorders (10/84, all IPH perpetrators) and psychosis (9 IPH and 15 FH perpetrators).

Themes related to identification of DA, inter-agency working, and risk assessment or management were also identified in a number of DHRs in the wider sample. This suggests that certain elements of a safe and effective response to DA, as well as gaps in the current response, may not be agency specific.

Table 34: Comparison of 2016 and 2019 mental health DHR data

2016 sample	2019 sample
Depression and suicide	Mental health symptoms and diagnosis (includes depression and suicidality among other diagnoses)
Mental health and substance use	Mental health and substance use
Caring responsibilities	Caring responsibilities
Transitions of care	Inter-agency working (includes transitions of care and communications between agencies before transfers or discharges)
Medication	Treatment and follow-up for mental disorders (includes medication and other forms of treatment)
	Vulnerability
	Agencies' response to DA
	Risk assessment processes

The analysis of this sample indicates that healthcare services need to be attentive to the risk of domestic abuse in individuals with mental health problems, as this group is at higher risk of being both survivors and perpetrators of DA. In more than half of the cases analysed, the victims and/or perpetrators had made disclosures of relationship difficulties to healthcare teams prior to the

homicide, often in indirect ways, mentioning arguments, recent separation, disputes about child contact, injuries and psychological difficulties such as depression, anxiety and 'stress' in relation to problems at home. Most, but not all, agencies involved with the victims and perpetrators in this sample of DHRs had policies for assessment and management of DA. Clear policies for the assessment of suspected or confirmed domestic abuse need to include guidelines for professionals' recognition of indirect signs of DA, safe enquiry about DA experiences or perpetrators, response to disclosures of DA and local DA agency contacts and referral pathways. As with previous reports, collaboration between agencies, including active information-sharing and joint planning, are also essential; DA is a complex problem that cannot be effectively address by a single agency or team.

Recommendations for Practice in Mental Health Settings

Training

- All staff should receive training on identifying; risk assessing and safely responding to domestic abuse.
- All staff should be expected to enquire about DA.
- Identification of DA/VAWG among people presenting with mental health difficulties should not rely on direct disclosure; indirect signs such as unexplained injuries, 'stress' and psychological difficulties, or reports of problems in the family environment should prompt sensitive exploration of family circumstances and enquire about DA.
- 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.
- The overall response of mental health services to DA, including enquiry and referrals, should be supported by policies for safe enquiry, immediate support and safety planning, and inter-agency referral protocols.

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.
- Involving families and partners in mental health assessments and risk assessments was a recommendation in a number of DHRs, particularly in relation to individuals who present with suicidality in the context of relationship problems or separation.
- Individuals who are carers for partners or family members should be offered an assessment of their needs, particularly with regards to the impact of caring on their mental health and wellbeing.

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' and 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.

IPH Mental Health Data

Table 35: Victims with mental health issues

Victim Mental Health issues	Number of cases
Yes – details unknown	6
Yes – diagnosed, not open to mental health service at time of death	8
Yes – diagnosed, open to mental health service at time of death	2
Yes – previously open to mental health team at hospital	1
Yes – self-reported, not open to mental health service at time of death	3
No	38
Unknown	1

Table 36: Specific mental health issues experienced by victims

Victim Mental Health issues	Number of cases where type of mental health issue is present
Adjustment disorder related to social issues	1
Anxiety	2
Attempted suicide	1
Bipolar Affective Disorder	1
Depression	10
Emotionally unstable personality disorder	2
Dual Diagnosis (Unknown details)	1
Obsessive compulsive disorder	1
Panic attacks	1
Paranoia	1
Psychosis	1
Schizoaffective Disorder	1
Self-harm	1
Unknown	3

Table 37: Perpetrators with mental health issues

Perpetrator Mental Health issues	Number of cases
Yes – details unknown	7
Yes – diagnosed, not open to mental health service at time of homicide	7
Yes – diagnosed, open to mental health service at time of homicide	7
Yes – previously open to mental health team at hospital	1
Yes – self-reported, not open to mental health service at time of homicide	4
No	31
Unknown	2

Table 38: Specific mental health issues experienced by victims

Perpetrator Mental Health issues	Number of cases where type of mental health issue is present
Anxiety	**1**
Avoidant personality disorder	1
Depression	11
Dissociative personality disorder	1
Dissocial personality disorder	4
Emotionally unstable personality disorder	4
PTSD	1
Dual diagnosis (Unknown details)	1
Drug-induced psychosis	1
Substance use disorder	1
Delusional disorder	1
Hallucinations	1
Delusions	1
Paranoia	2
Paranoid schizophrenia	1
Panic attacks	1
Psychosis	2
Self-harm	1
Unknown	3

AFH Mental Health Data

Table 39: Victims with mental health issues

Victim Mental Health issues	Number of cases
Yes – details unknown	1
Yes – diagnosed, open to mental health service at time of death	2
No	22
Unknown	0

Table 40: Perpetrators with mental health issues

Perpetrator Mental Health issues	Number of cases
Yes – details unknown	1
Yes – diagnosed, not open to mental health service at time of homicide	3
Yes – diagnosed, open to mental health service at time of homicide	10
Yes – self-reported, not open to mental health service at time of homicide	2
No	9
Unknown	0

Table 41: Specific mental health issues experienced by victims

Victim Mental Health issues	Number of cases where type of mental health issue is present
Anxiety	1
Depression	3
Registered Sex Offender	1

Table 42: Specific mental health issues experienced by perpetrators

Perpetrator Mental Health issues	Number of cases where type of mental health issue is present
Anxiety	3
Depression	4
Agoraphobia	1
Paranoid Psychosis	1
Psychotic Symptoms	1
Schizophrenia/Schizoaffective disorder	3
Drug-induced psychosis	1
Mental psychosis	1
Panic attacks	2
Paranoia	3
Paranoid Schizophrenic	4
Bipolar affective disorder	1
Unknown	2

Older People DHR Cases

There are various measurements of old age which explain the chronological, biological, physical and psychological changes that happen as we get older. These can impact on how an individual and society define what stage of life someone has entered and there are limitations of each. For this study we have defined older victims as anyone over 58 years, with 18 victims falling into this category.

Violence against older people touches on issues of gender inequality, human rights and ageism. The term elder abuse is sometimes used to describe violence against older people, but this term is gender neutral and fails to acknowledge that it is rooted in gender inequality and harmful gender norms. We must consider the cumulative nature of discrimination that older women face and the

'triple jeopardy' in that they are women, of older age and have experienced abuse (Penhale, 2003).

As the population of older people grows, we can expect that abuse and homicide of this group will subsequently increase. Yet data on the prevalence of domestic abuse among this group is still sparse and the domestic homicide reviews we researched outline some of the structural and institutional barriers which can perpetuate this. The cases we examined reinforce the lack of understanding agencies often have in identifying domestic abuse, assessing risk, and referring victims to specialist domestic abuse service.

In most of the cases we examined, conclusions were drawn that the homicide was neither preventable nor predictable, however there are a number of key themes which emerged and can therefore be considered as significant.

Sex

The cases we examined reinforce the gendered dynamics of domestic abuse and align with national figures with 78% (14/18) of the victims being female and 22% (4/18) being male. The relationship between the female victim and the perpetrator deviates from national findings with 64% (9/18) being adult family homicide and 36% (5/18) being interpersonal homicide. The vast majority of perpetrators of AFH were adult sons (89% [8/9]).

Similar figures were represented for male victims with 75% (3/4) being AFH and 25% (1/4) being IPH. All three of the AFH perpetrators were male.

Table 43: Victim and Perpetrator Gender

	AFH		**Partner / ex-partner**	
	12		6	
	Female	**Male**	**Female**	**Male**
Victim sex	9	3	5	1
Perpetrator sex	1	11	0	6

Age

The average age of victim was 69.4 years with the greatest number of victims falling into the 'young-old' category. 17% of victims were in their late 50s (3/18), 44% were in their 60s (8/18), 28% (5/18) were in their 70s (5/18) and 11% were over 80 (2/18).

The lack of exploration and action taken with the victims identified in this report reinforces previous research findings that domestic abuse is not often considered as an issue affecting older people. Where victims presented with injuries or signs of mental health needs, their conditions were presumed to be the result of health or social care needs.

Mental Health

The links between mental health and both AFH & IPH are significant in this cohort. 89% (16/18) of the perpetrators had diagnosed mental health conditions and 50% (9/18) were open to mental health services when they killed their victim. In some cases, the perpetrator had exhibited violent and aggressive behaviour to others and expressed feelings of violence towards their victim in the lead up to the homicide. In one case this was the reason stated for declining the perpetrator's application to participate in unsupervised leave. There is no evidence that this was communicated to the victim, that safety planning was completed nor were any outgoing referrals made to other agencies to provide support.

One report concluded;

"The records show the recurring issue of paranoia and negativity about his mother and yet no one had anything other than a superficial understanding of the relationship between mother and son. Similarly, the family dynamics at the various points in his care history were not explored to increase understanding" (DHRA1)

Carers

A large proportion of cases, totaling 78% (14/18) involved a caring relationship between the victim and perpetrator. These cases often involved a wide range of agencies providing numerous services and with varying levels of awareness of the risks presented. In some cases, safeguarding concerns were raised but information was rarely shared among agencies, allowing a true picture of risk to emerge. In one case, the fear of a victim was minimised by services, with the chair commenting;

'Clinical records report a difficult relationship between mother and son. Victim told mental health services that Thomas had been violent to her and threatened her on several occasions' (DHR A11). It should be noted that a theme emerging from a number of these reports is the apparent lack of professional curiosity, even where risk indicators or safeguarding concerns were raised. Professionals were more likely to direct questioning towards the perpetrator and used them to interpret on a regular basis. This resulted in an apparent invisibility of their wishes, views and any concerns they might have had about the perpetrator.

Recommendations

The recommendations are sadly not new and have been outlined in various other studies and research papers. However, it is important they are outlined in the pursuit of learning and to honour the victims who lost their lives, especially in cases where professionals should have identified risks posed to them.

It is clear from the 18 cases studied that training, in particular for health and social care practitioners, around recognition and response to domestic abuse is much needed. This should include case studies and practice examples which explore the specific barriers and needs related to older victims.

Services need training and tools which acknowledge the potential risks of both Interpersonal violence (IPV) and adult family violence (AFV) within a caring relationship. Whilst carers do face stress, agencies should be alert to the ways in which these contexts can facilitate abuse. There needs to be greater collaboration between agencies to manage the needs of carers, particularly where they have their own needs related to mental health.

There were many recommendations made within the DHRs we examined, with some outlined below:

- Police and specialist services should review their referral processes around support for people who are experiencing domestic violence in a familial setting, including where those cases appear in a court setting.
- More robust information sharing mechanisms are established with Mental Health services, Probation and Police to ensure that effective risk management takes place. Procedures to enact a joined up, problem solving approach should be considered.
- Trusts should review their approach to crisis treatment and seek to avoid putting in place treatment plans at the home address of someone who has made allegations of abuse against the service user or who has reported threats or fears of violence.

- Trusts should review their approach to risk assessment and risk management, including the weight given to allegations of abuse and/or threats and the actions taken to address such allegations.
- The GP practice to review its policy and procedures for identifying and responding to domestic abuse and to ensure all staff receive appropriate training to support contemporary practice for healthcare practitioners, and to report to the Community Safety Partnership on this.

Recommendations for Practice

- Training, in particular for health and social care practitioners, around recognition and response to domestic abuse is much needed and should explore the specific barriers and needs related to older victims. This is particularly important where mental health issues are present.
- More research is needed around the role of carers where there is DA/VAWG. There needs to be greater collaboration between agencies to manage the needs of carers, particularly where they have their own needs related to mental health.
- Trusts should review their approach to risk assessment and risk management, including the weight given to allegations of abuse and/or threats, and the actions taken to address such allegations
- Trusts should review their approach to crisis treatment and seek to avoid putting in place treatment plans at the home address of someone who has made allegations of abuse against the service user or who has reported threats or fears of violence

Engagement of Family and Friends in DHRs

Over 50% of family and friends of IPH and AFH victims contributed to the evidence gathering for the reviews. It is important, where possible, to involve families and friends in the DHR process to ensure that the voice of the victims is heard and to keep families and friends updated on the review process. Notably, the participation of families and friends in DHR reviews is extremely beneficial as it allows the DHR unique insight into the lives of victims and the events leading up to a victim's death which agencies may be unaware of. For DHR chairs to get an in-depth picture of the life of victims and perpetrators allows for a more informed report. Given the positive impact that the contribution of families and friends can have on the DHR process, it is imperative that DHR chairs develop strong relationships with family members and friends where possible, and also offer them different ways to contribute when face-to-face meetings cannot take place, such as through telephone or Skype. Families and friends can find engagement with the DHR process quite difficult and chairs should therefore ensure that they are given the opportunity to engage not only at the beginning of the DHR process, but throughout its later stages. Ultimately, chairs need to be as sensitive as possible in their approach to families and friends while also being very clear about their role and boundaries. When families and friends attend panel meetings there needs to be some preparation with them and the panel around what to expect as it can be a very traumatic experience. Panel members need to aware of this and be patient and understanding. Family and friends may not know all the terminology being used and may exhibit frustrations or strong feelings about their loved ones and the process, which is understandable. In many DHRs, the engagement with family and friends was done in a dedicated and sensitive way and they were given updates at all stages of the process. In a few DHRs, this process was weak and better efforts could have been made to include interested parties.

Offering advocacy support around the death of victims for families and friends is provided by two main bodies: Victim Support and Advocacy After Fatal Domestic Abuse (AAFDA). AAFDA offer advocacy and support throughout the DHR process and provide expert training for DHR chairs. Victim Support have also recently started providing support and advocacy through the DHR process for families. These services can provide a valuable service for those left behind to

help them demystify the processes of the criminal justice systems and the DHR process. Utilisation rates of these services by families and friends were low for both IPH and AFH and more work should be done around whether these services are being offered. The Family Liaison Officer should ensure these services are offered at every stage, as a death by murder is traumatic for family and friends and they may need several opportunities to accept support.

IPH Family and Friend Data

Table 44: Number of reviews where victim's family was involved

Victim family involved in DHR	Number of cases
Yes	33
No	23
Unknown	3 (1 blank)

Table 45: Number of reviews where AAFDA was involved

AAFDA involvement in DHR	Number of cases
Yes	2
No	51
Leaflet given	3
Unknown	3

Table 46: Number of reviews where Victim Support was involved

Victim Support involvement in DHR	Number of cases
Yes	6
No	50
Unknown	3

AFH Family and Friend Data

Table 47: Number of reviews where victim's family was involved

Victim family involved in DHR	Number of cases
Yes	14
No	11

Table 48: Number of reviews where AAFDA was involved

AAFDA involvement in DHR	Number of cases
Yes	3
No	21

Unknown	1

Table 49: Number of reviews where Victim Support was involved

Victim Support involvement in DHR	Number of cases
Yes	5
No	19
Unknown	1

Recommendations Listed in the 84 London DHRs Analysed in this Report

In this section, we looked at all of the recommendations that were made across all of the 84 DHRs and categorised them according to the agencies that the recommendations were made for. Below are the most frequently recommendations directly extracted from both the IPH and AFH DHRs analysed in this report. Many of the DHRs had the same recommendations across all 84 reports.

General

These were recommendations that cut across all agencies

Training

Analysis of all 84 DHRs included in this report highlighted the lack of awareness that professionals have of domestic abuse. Recommendations were made advising professionals who are likely to engage with victims or perpetrators of domestic abuse be trained in how to recognize the signs and dynamics of abuse. Also, that domestic abuse trainings focus on providing guidance on how to recognize coercive control and economic abuse. One recommendation noted that attention should be paid to providing training to professionals on how to manage disclosures made by children to ensure their concerns are dealt with. Recommendations suggested that agencies should take a shared approach to developing and facilitating domestic abuse trainings to ensure training is available for all staff members.

Knowledge on Dynamics of Domestic Abuse and Support Services

Various DHRs called for boroughs to publish a document listing all services available in a borough for people affected by domestic abuse. Using this document, boroughs were requested to review any gaps that exist in support, especially for individuals with complex needs. In relation to this recommendation, numerous DHRs advised that more awareness needs to be raised about domestic abuse on a community level, in particularly for young people. For communities that can be difficult to reach or who think of domestic abuse as acceptable, specific recommendations were made to ensure that they too are informed of the dynamics of domestic abuse and support services in their area through contact with various community groups such as faith leaders, food banks and libraries, and information dissemination through these bodies. It also suggested that Community Ambassadors be established within boroughs and trained in conjunction with the 'Ask Me' project to create a network which eliminates the silence on domestic abuse. Numerous recommendations also called for boroughs to hold campaigns about domestic abuse to raise awareness about the issue.

Victims with Protected Characteristics

Several recommendations were made for boroughs to identify minoritised communities who have recently arrived in the area and any specific cultural barriers and vulnerabilities they may face. In conjunction with this, multiple recommendations were made to ensure that any language barriers are taken into consideration for victims of domestic abuse who may not speak English as their first language and that professional interpreters who are not family members or friends of victims should be used in these instances so that victims can fully express themselves and those who are supporting them.

Referral Pathways

Many recommendations requested that various referral pathways be reviewed and improved so that all individuals receive robust support in a timely manner, especially individuals in complex circumstances, such as refugees.

Evoking Disclosures

Recommendations were made for frontline professionals to use professional curiosity to elicit disclosures of domestic abuse from victims that they work with, and to refer clients on accordingly. In relation to this, a recommendation was also made advising professionals to make attempts to gather information from extended family members if safe and appropriate to do so, who may be able to provide valuable insight on domestic abuse cases and how to subsequently safeguard.

Risk Assessments

Too many DHRs recommended that agencies increase their use of risk assessments where domestic abuse is evident, even if cases are at a low threshold. One recommendation stated that the DASH risk assessment should be used regularly and another one noted that where applicable, fathers must always be considered in assessments, to properly and robustly assess risk. One also recommendation noted that risk assessments should especially be used by professionals when high risk factors are present such as pregnancy or separation. Notably, one DHR recommended that the CSP of a borough should develop a procedure so that risk assessments are carried out if evidence of domestic abuse is retracted during court proceedings.

Single Point of Enquiry (SPOE)

Recommendations for SPOE focused on how SPOE can better support victims of domestic abuse. One recommendation advised that SPOE should work towards providing assessments and support to victims who do not have children and who have not met the MARAC threshold. Another recommendation suggested that SPOE should think about creating an automatic referral to children's centers as part of the help given to families who are affected by domestic abuse.

Government

Home Office

Publicity

One DHR advised that the Home Office should work towards providing more information to individuals entering the UK about domestic abuse and the support available in the country for those impacted by it. A subsequent recommendation was also made advising that Home Office should provide a more robust description to professionals and the public of what controlling behaviour looks like in order to address a gap in understanding of what actions are used by perpetrators to abuse victims.

DHR Process

Many similar recommendations were made regarding agencies improving their contribution to the DHR process. One recommendation advised that Home Office liaise with NHS England to make clear the responsibility that NHS England has when commissioning the Individual

Management Reviews (IMRs) of GPs in order to tackle delays DHRs face from GPs when submitting IMRs. Another recommendation advised that Home Office also work with the Crown Prosecution Service to better their engagement with the DHR process. Finally, a recommendation was made by one DHR stating that the Home Office should modify statutory guidance to ensure that the DHR process is more transparent by necessitating that the Crown Prosecution Service regularly report on key milestones related to the DHR process.

United Kingdom Border Agency (UKBA)

Multiple recommendations advised that UKBA should provide individuals who've applied for indefinite leave to remain with information about domestic abuse, and services that are available for those who are experiencing it. Importantly, this information should also include the rights of those applying for indefinite leave to remain, as some immigrants are unable to access certain services based on their immigration status. Another recommendation suggested that this information also be included in the "Life in the UK Test."

Criminal Justice Agencies

Police

Training

Many of the recommendations made for police focused on providing training to officers. Not solely limited to providing training on the signs of domestic abuse, multiple recommendations advised that police officers be given training on the various referral pathways that can be used, and on how to properly carry out risk assessments (i.e., using the DASH 2009 risk identification assessment). One recommendation stated that police officers should also be provided training on how to identify cases of domestic abuse where no physical violence has been used in order to best support victims who do not present with physical injuries.

Knowledge on Dynamics of Domestic Abuse and Support Services

One DHR recommended that more effort should be made on behalf of police to provide victims of domestic abuse with information about support services in their area. The recommendation also specified that information outlining services available to individuals with insecure immigration status should also be disseminated to those who need it. Subsequent to this, another recommendation was made stating that the funding allocated to domestic abuse services be reviewed in relation to support that is provided to victims' whose cases are categorized as police non-crime domestics.

Record Keeping

In line with many other recommendations for other agencies, a recommendation was made regarding the accuracy of record keeping within the police. This recommendation advised that police stations review the extent to which case records of domestic abuse are missing contact details for victims or have inaccurate contact details so that procedure can be set up to fill these information gaps.

Crown Prosecution Services

Victimless Prosecutions

Across all 84 DHRs reviewed in this report, very few recommendations were made for Crown Prosecution. Of the recommendations made, one DHR deemed it necessary for a review to be conducted regarding the possibility of increasing the amount of "victimless" prosecutions, in partnership with Crown Prosecution.

Violence Against Women and Girls Policies

Another recommendation advised that Crown Prosecution should ensure that their policies on violence against women and girls are adhered to at an operational level in response to concerns regarding the lack of prosecutions of a particular DHR analysed in this report.

Prison

Sharing of Health Information

Most of the prison-related recommendations found that actions needed to be taken regarding the sharing of health information within prisons and between prisons and other health agencies. Recommendations advised that clear sharing pathways must be developed between courts and prisons to ensure that the transition doesn't hinder inmates, especially the ones with long-term health issues, from receiving adequate, continuous and effective care. Recommendations also advised that clear sharing pathways be developed between the courts and prisons so that these records can advise prison assessments and screenings. A recommendation was also made regarding the discharging of prisoners and advised that an Offender Healthcare Service member should attend discharge boards to ensure that they continue receiving the appropriate health care once they exit prison. Subsequently, another recommendation was made for HM Prison Service and Department of Health to review the NHS IT system to ensure it allows offender health care services access the national SPINE, or access to an individual's health records if they are in custody. Work is underway to support information sharing across the SPINE and has goner live in many places.

Probation

Information Sharing

Few recommendations were made for Probation. However, one DHR noted that Probation must always share knowledge regarding risk with appropriate agencies to ensure that reports and risk assessments are well-informed.

Evoking Disclosures

Numerous recommendations advised that Probation, in conjunction with MPS, produce guidance that outlines what questions Probation should ask when eliciting information from perpetrators. Subsequently, another recommendation was made advising that Probation carry out an audit of how police intelligence checks using specific and open questions are implemented.

Health Services

General

Information Sharing

Multiple recommendations were made regarding the communication between different parts of the health services. Focus was shed on creating robust information sharing pathways, especially for information on patients who are linked but are registered at different practices, such as parents. Recommendations were also made suggesting that more robust pathways be developed between different Trusts and GP practices. The need for improved pathways between different parts of a health service were also deemed necessary in order to provide more well-informed and holistic care to patients.

DHR Involvement

One recommendation was made for NHS England to provide guidance to GP practices regarding their active engagement with domestic homicide reviews.

Flagging of Cases

One DHR recommended that a system be implemented to ensure that cases which are potentially high risk or confirmed high risk are flagged so that all professionals are made aware of the risks and are subsequently prepared to support the victim.

Data Collection

For more robust records, a recommendation was made in one DHR for health staff to ensure that data relating to family members and dependents is gathered when patients register with a particular service.

Depression Screenings

In one DHR, NHS England was advised to create a depression screening and care pathway for GP's and to carry out a review of the tools that are utilized to link domestic abuse and mental health with psychological and social aspects.

Threats to Staff

One DHR advised that the NHS review the procedures in place for when threats to staff are made. Included in this recommendation was for staff and managers to be trained on how to manage and subsequently record such instances to ensure the safety of staff and patients.

Training

Multiple referrals advised that training be provided to NHS staff on domestic abuse and its indicators so that staff understand their roles and responsibilities when supporting patients who are affected by domestic abuse. Subsequently, another recommendation advised that staff also be made aware and trained on the Multi-Agency Risk Assessment Conference (MARAC) and the risk assessment that should be conducted prior to a referral.

Victims with Protected Characteristics

Multiple recommendations were made regarding the specialist support of patients who do not speak English as their first language. Various recommendations noted that when a language barrier exists between patients and staff, an interpreter who isn't a family member or friend of the patient must be present to ensure transparent communication.
Any interpreter used must be a professional who understands confidentiality issues.

Pregnancy

Multiple recommendations focused on routine domestic abuse enquiry by midwives. Numerous recommendations suggested that policies regarding routine domestic abuse enquiry be developed and implemented in Trusts, and that subsequently, training be provided to midwives on how to appropriately ask about domestic abuse during appointments.

Knowledge on Dynamics of Domestic Abuse and Support Services

A recommendation was also made advising that information be made available for women accessing antenatal or post-natal care about domestic abuse and support.

Nursing

One nursing recommendation stated that a robust electronic back-up system for home notes be developed in case of information loss or destruction, and so that staff have access to these records at any given time.

Another recommendation was made for District Nursing regarding consent. The recommendation advised that before referring patients onto social services, their consent must be acquired, and then clearly documented so that the referral process is not delayed.

A&E

Numerous recommendations were made in relation to A&E staff providing improved support to victims of domestic abuse. One recommendation suggested that Trusts review the processes that exist within A&E when dealing with domestic abuse and subsequently provide training to staff on recognizing domestic abuse and safeguarding accordingly. Another recommendation advised that clinical domestic abuse enquiry be implemented within A&E to better identify and address cases of domestic abuse. In relation to providing better support to patients affected by domestic abuse, one DHR recommended that an audit be conducted on the number of attendances made to A&E as a result of domestic abuse, and if these cases were appropriately managed. A recommendation was also made advising that A&E departments look into commissioning independent domestic abuse advocacy services within A&E to provide special support to victims of abuse.

Mental Health

Training

Numerous recommendations were made in the DHRs reviewed in this report which instructed mental health services to provide staff with training on how to support patients who are suffering from domestic abuse. Consequently, various recommendations were also made regarding safeguarding policies, and ensuring that professionals were also trained on how follow this guidance. Recommendations were also made about how to conduct specific tasks relating to mental health services; one recommendation advised that that staff should be trained to carry out a community order relating to a mental health treatment requirement.

Information Sharing

Various recommendations focused on information sharing protocols between mental health services and other agencies. Specifically, recommendations were made for the improvement of information sharing protocols between mental health services and Adult Social Care, the police, primary care services and hospital trusts so that records are shared more effectively and confidentially, and to ensure the care of patients is kept seamless if they are transferred between services.

Referral Pathways

A recommendation was made regarding the development and improvement of referral pathways; specifically, one DHR advised that referral pathways to substance misuse services should be reviewed and modified to fit with new referral pathway protocols within mental health services.

Evoking Disclosures

Recommendations were also made regarding information gathering from patients. Suggestions were made about the development of a briefing document outlining what questions mental

health professional should ask in conjunction with police in order to elicit necessary information. Relating to this recommendation was another recommendation advising that mental health trusts should review the setting of health visitor clinics to ensure they encourage enquiry and disclosures of domestic abuse.

Knowledge on Dynamics of Domestic Abuse and Support Services

Various recommendations were also made about publicizing information about services available for individuals suffering from mental health conditions. Suggestions were made in multiple DHRs about ensuring families are made aware of local children's centres and how to access them, and information on emergency contacts for individuals who need urgent care for mental health issues, as well as for friends and families.

Service Expansion

Various recommendations also focused on providing care to those who do not always meet certain thresholds. Specifically, one recommendation advised that a distinct care pathway for individuals who are experiencing mental health issues but who do not qualify for secondary mental health services should be developed. Another recommendation noted that the way in which mental health services respond to the needs of carers of those who have mental health issues should be reviewed, including carers' assessments.

GP Practices

Training, Policies and Procedures

Commonly found through analysis of all 84 DHR cases referred to in this report were recommendations for the facilitation of domestic abuse training for all professionals working in GP practices for the purpose of improving their knowledge on how to identify and respond to patients who are either experiencing or perpetrating domestic abuse. Importantly, recommendations for GP practices also advised that procedures should be developed to ensure that GPs proactively enquire about domestic abuse, especially for patients who present with complex needs. Subsequent to this, many recommendations were made advising that domestic abuse policies and procedures for staff be updated.

IRIS

Numerous recommendations were made regarding the IRIS project and successfully setting it up in GP practices to ensure that patients experiencing domestic abuse are adequately supported and correctly referred onto the appropriate agencies.

Knowledge on Dynamics of Domestic Abuse and Support Services

Many DHRs also recommended that GP practices clearly display and distribute information about the signs of domestic abuse as well as contact information for services that can support those who are experiencing it. Not limited solely to GP surgeries, various recommendations advised that GP practices should also include this information on their websites, as well as in new patient registration packages.

Information Sharing

Multiple DHRs raised concerns regarding the information-recording and information-sharing practices within a GP practice, and between GP practices and other agencies. Recommendations suggested that all GPs, nurses, clinicians and administrators ensure they are accurately recording all patient activity and instances of contact according to RiO Standard Operating Procedures to better keep track of occurrences of domestic abuse that are either disclosed by patients or visibility evident during appointments. Subsequently, numerous recommendations also advised that information-sharing protocols and procedures between staff at GP surgeries and outside be refined to ensure that the appropriate professionals and agencies are made aware of cases of domestic abuse, and that the necessary support is consequently provided.

Ambulance

Safeguarding

Few recommendations were made for ambulance agencies within the DHRs analysed for this report. All recommendations related to safeguarding concerns and advised that ambulance services should ensure that all safeguarding concerns that staff encounter should be referred to the appropriate local authority safeguarding agency. Another recommendation stated that ambulance staff should be reminded of their safeguarding children and adult at risk responsibilities, including confirming all received safeguarding referrals.

Substance Misuse

Referral Pathways

One recommendation advised that all substance misuse services review their current practices and procedures regarding client transferring to ensure these pathways are operating successfully. Subsequently, a recommendation was made to make sure that staff who are unaware of these pathways are informed of them.

Implementing Domestic Abuse Dynamics within Practice

One DHR called for drug services to keep in mind and review domestic abuse dynamics when working with certain individuals, specifically, users who use anabolic steroids, as there are sometimes links between individuals who use anabolic steroids and the perpetration of domestic abuse.

Safeguarding

Community Safety Partnership

Perpetrator Support

Multiple recommendations were made regarding the perpetrator services that exist for men who perpetrate abuse, and the pathways that exist to refer them to these programs. One recommendation advised that in order to better support men who are concerned about their abusive behaviour, CSPs should advertise specialist domestic abuse perpetrator services across multi-agency partnerships and within communities. Relating to pathways, another recommendation suggested that that CSPs evaluate and report on the pathways in place for perpetrators to access support, especially when repeat arrests are made and charges are not made following these arrests.

Other Forms of Abuse

One CSP recommendation asked that the focus of Community Safety Plan's annual refresh include FGM, trafficking, emerging crimes types, such as modern slavery, and emerging communities and minorities to better counter these crimes.

Knowledge on Dynamics of Domestic Abuse and Support Services

A recommendation was made advising that new channels of communication or venues should be developed to disseminate information and messages about the unacceptability of domestic abuse and the support available for victims, especially to refugee communities. In relation to this, one recommendation suggested that professionals engage with food banks to disseminate information to the public about domestic abuse. A recommendation also advised that a CSP engage with local businesses regarding their response to domestic abuse, and to help ensure they are made aware of specific domestic abuse Human Resources policies to support staff if the occasion arises. Another recommendation advised that a CSP review the information on domestic abuse and how victims can be supported which is available to friends and family members.

DHR Process

Assigned by multiple DHRs were recommendations designed to improve the workings of the DHR process. One recommendation stated that procedures should be developed to better monitor the progress of DHRs, and in cases where delays are present, to develop protocols so that delayed DHRs are still completed in a timely fashion. Another recommendation stated that another DHR procedure be developed ensuring that the frequency of family contact is regularized. One recommendation advised CSPs to ensure that the expectations of Independent Chairs are made apparent through the terms of their engagement, and explicitly outlined in the procedures of DHRs. A final recommendation regarding the DHR process requested that CSPs ensure that all agencies provide information regarding the contact that they've had with family members connected to the DHR, and that this information is shared with the Chair in a timely fashion.

Support for Trans-Victims

Multiple recommendations were also made requesting the CSP of a borough to map out the size and necessities of the local Trans community in order to inform strategy decisions to best support them. In relation to this, another recommendation was made for the CSP to carry out an audit of local agency practices and if they are trans-inclusive in their domestic abuse work. In the case that agency practices are not trans-inclusive, the recommendation advised that training should be provided to staff to meet the needs of victims of domestic abuse who are Trans or establish specialist referral pathways.

Support for Women involved in prostitution

Numerous recommendations were made also advising that information regarding the support that those involved in prostitution can access must be publicized, and that to do this, a robust dissemination strategy must be developed. A related recommendation advised that CSP also carry out an audit of the support provided to those in the sex industry who are at risk of domestic abuse, and in instances where support is not robust, to provide training to fill in the gaps. A recommendation was also made requesting that CSPs work with sexual health services and domestic abuse agencies to ensure that support is in place for victims of domestic abuse who are also involved in prostitution

Adult Safeguarding

Training

Similar to other agencies, a recommendation was made for Adult Social Care in conjunction with mental health to facilitate training about domestic abuse for all staff members to better support those who are victim to it. Subsequently, another recommendation advised that guidance be developed to inform staff on how to conduct consistent risk assessments, share information properly, and how to use professional curiosity when inquiring about domestic abuse.

Agency Communication

Numerous recommendations were made regarding communication between Adult Social Care and Children's Social Care. One recommendation advised that better communication between both agencies be established so that vulnerable adults who are brought to the attention of Children's Social Care are supported. Subsequently, a second recommendation noted that a policy of transferring care be developed to ensure a more seamless transition for instances when cases are transferred between both agencies.

Routine Enquiry

Echoed by various other agencies was a recommendation to explore how to implement or expand selective or routine enquiry across services in order to better identify victims of domestic abuse and provide them with support.

Information Sharing

Various recommendations were made regarding information sharing between Adult Social Care and other services. Recommendations were made for Adult Social Care to review their information

sharing procedures with Mental Health Services, medical practitioners and the police to ensure the continuation of effective and confidential information sharing.

Multi-Agency Working

Numerous recommendations were made regarding the improvement of multi-agency workings. Recommendations focused specifically on improving the relationship between Adult Social Care and specialist domestic abuse support services to better respond to adults experiencing domestic abuse. One recommendation advised that Adult Social

Care develop a systemic infrastructure that will allow for improved multi-agency working.

Carers

Support for Carers and those they Care for

A recommendation was made regarding the support that is available for carers and those that they care for; specifically, the recommendation advised that organizations should review and improve their policies for individuals who refuse their service. Subsequently, it should then be explored how support can be provided, especially in situations where cared-for persons choose not to accept support from any other agencies. Linking to this was another recommendation which advised that all organizations should decide how they can best identify and meet the needs of carers early on in their caring role.

Training

Echoing the sentiments of many other agency recommendations was a recommendation for Adult Services to review commissioning and delivery of training to staff in relation to understand domestic abuse dynamics within the context of safeguarding adults, with focus on the role of carers and partners.

Screening

Various recommendations were made suggesting that screening processes be refined and made more robust; specifically, one recommendation stated that the Safeguarding Adults Board evaluate carer assessments and subsequently incorporate a domestic abuse screening enquiry. Consequently, another recommendation was made suggesting that interview procedures for carers and patients take place separately to ensure that both individuals have the opportunity to speak in a safe space about any issues or concerns.

Children's Safeguarding

Leaving Care Services: Declined Referrals

Two recommendations were made regarding the way in which risk is managed for individuals who decline a referral to Leaving Care Services. One recommendation advised that an audit should be undertaken to review the processes and risk assessments in place for young people who live independently, and the outcomes for these young people when they decline a referral. A second recommendation also advised that an audit take place of unaccompanied minors to deduce how their emotional needs are met, especially if they have declined a referral to Leaving Care Services.

Agency Communication

Numerous recommendations were made regarding communication between Adult Social Care and Children's Social Care. One recommendation advised that better communication between both agencies be established so that vulnerable adults who are brought to the attention of Children's Social Care are supported. Subsequently, a second recommendation noted that a policy of transferring care be developed to ensure a more seamless transition for instances when cases are transferred between both agencies.

Information Sharing

Multiple recommendations were made to enforce effective information sharing protocols between Children's Social Care and other agencies and subsequent jointly coordinated action planning and support.

Integrating Domestic Abuse Knowledge in Practice

Many recommendations were made throughout the 84 DHRs analysed in this report regarding the development of staff's ability to inquire and support individuals who are suffering from domestic abuse. One recommendation advised that staff's ability to manage domestic abuse cases be improved via training and implementation of routine enquiry, while another recommendation noted that the policies and procedures within Children's Social Care be revised to include guidance on managing the risk of those suffering from domestic abuse and circulated to all relevant professionals.

Holding Perpetrators to Account

Various recommendations were made in an effort to better hold perpetrators to account for the abuse they cause. Specifically, one recommendation advised that Children's Social Care create measures which routinely keep in consideration fathers and male partners during assessments from an early stage. Subsequently, another recommendation suggested that Children's Social Care develop and monitor the effectiveness of a perpetrator program given the apparent limited evidence of their effectiveness.

Safeguarding Children's Board Recommendations

Various actions were made for the Safeguarding Children's Board to review policies intended to support extra vulnerable individuals. For example, one recommendation advised that the Board should review policies on safeguarding children where one of their parents has mental health issues, substance misuse issues or a learning and to include domestic abuse as a risk as well. Another recommendation was made to review the policy for responding to families who choose not to engage with services, as well as to review the early offer of help to review its efficacy and include domestic abuse in the assessment.

Schools

Few recommendations were made for schools. However, one recommendation advised that CSPs create an early intervention domestic abuse program to be presented in schools so that at a young age, children are provided with information on domestic abuse and where to access support.

Housing

Training

Multiple recommendations related to housing addressed a need for training housing staff. Many recommendations advised that housing staff responding to either noise nuisance or anti-social behaviour issues receive training on how to recognize safeguarding issues, how to raise a safeguarding adult alert and how to safeguard vulnerable adults. A recommendation was also made advising that housing providers and all registered social landlords are to be trained on recognizing domestic abuse, services available in the area that can help victims experiencing it, and domestic abuse policies and procedures. In relation to training on domestic abuse, specific

recommendations were made to provide training to housing officials about economic abuse, and how it is a form of coercive control.

Policies and Procedures

One recommendation stated that Housing Providers and Registered Social Landlords develop specific housing and domestic abuse policies and procedures. This recommendation highlighted that these policies and procedures include guidance on how to respond to repairs, noise complaints, and how to send referrals onto specialist domestic abuse services.

Information Sharing

Numerous recommendations were also made regarding the way in which information is held and shared between housing providers and agencies. One recommendation suggested that information sharing protocols between agencies be reviewed in order to develop guidance on how to appropriately and effectively share information. Another DHR recommended that Housing Options Services carry out an audit on multiple cases to evaluate their record-keeping process.

Knowledge on Dynamics of Domestic Abuse and Support Services

Multiple recommendations advised that information about domestic abuse and local services that can support survivors should be clearly presented on the websites of housing agencies, and in other public areas, such as Children's Centres. Information should be available not only for residents, but also for staff members who may be required to support tenants experiencing domestic abuse.

Domestic Abuse Specialist Services Provision

Training

Many similar recommendations were made advising that domestic abuse training be provided to various services in order to better professionals' understanding of domestic abuse and its dynamics. Numerous recommendations stated that domestic abuse training should be tailored to the agency being trained and provide training attendees with the skills on how support victims of domestic abuse in relation to each professional's unique role. Agencies advised to commission training for staff included Adult Services, RISE, CCG and General Practice. One recommendation stated that professionals should also be trained on how to successfully carry out risk assessments in order to better support individuals who are victims of domestic abuse.

Service Expansion

Found within DHRS in this analysis were many recommendations to develop and expand on the services that exist in London. One DHR advised that appropriate adult services be made available out of hours, while another recommendation advised a review take place on how necessary outreach for those involved in prostitution is. Focus was also shed on drug and alcohol services in some reports, and recommendations were subsequently made to better these services to increase engagement with users who professionals find difficulty engaging with, or who have complex needs.

Information Sharing

Various recommendations were also made regarding information sharing protocols. Focusing solely for the NHS, recommendations suggested that communication systems be reviewed and improved to refine and make easier the process of information sharing between different departments in the NHS.

MARAC

Information Sharing

Numerous recommendations related to MARACs advised that information sharing protocols be refined in order to create and maintain effective information sharing processes to better support

victims of domestic abuse and keep track of the involvement that they have with agencies. A recommendation was specifically made regarding the type of information that can be shared at a MARAC, and that representatives be provided clear guidance on what information is relevant to share and what should be kept confidential.

Victim-Focus MARACs

Multiple DHRs analysed in this report contained recommendations relating to victims discussed at MARACs and how their needs must be identified and met. Specifically, one recommendation advised that to successfully manage the risk that victims of domestic abuse face, a process by which the actions made to address and alleviate this risk is created to ensure that actions are carried out within the appropriate timescales. Another recommendation was made regarding the identification of who primary high-risk victim are within cases where violence is bi-direction and ensuring that in cases where both parties are using violence, that MARAC meetings remain focused on supporting and alleviating the risk experienced by the primary victim, recognizing that violent resistance does not indicate the victimhood of a perpetrator.

Agency Engagement

Various recommendations were also made regarding the engagement of agencies with MARAC. The agencies focused on in these recommendations were Adult Social Care and GP practices. The recommendation relating to Adult Social Care advised that they conduct a review to assess the extent to which their engagement with MARAC, specialist domestic abuse agencies and the MARAC steering group is effective. Another recommendation advised that the MARAC Steering Group in a borough should develop a way for GPs to regularly become involved in the MARAC process.

Specialist Domestic Abuse Services

Training

Found within many of the DHRs analysed in this review were recommendations for specialist domestic abuse services to provide training to other agencies on the dynamics of domestic abuse, conducting risk assessments and current referral pathways. These recommendations advised that training should be provided by specialist services to the police, statutory healthcare providers and other charitable organizations that encounter individuals who are experiencing domestic abuse.

Service Availability

Multiple recommendations were made regarding the support that is available to victims of domestic abuse. To address possible shortages and shortcomings of services for those experiencing domestic abuse, numerous recommendations were made to review current specialist support for victims and any areas of improvement within these services, and to review the total amount of specialist services available. One recommendation also stated that a specific review should be held around the services that mothers who are victims of domestic abuse can access when they are at risk of losing contact with their children. These recommendations also outlined that communities and agencies should subsequently work together to ensure that any gaps found through these reviews are filled.

Structures and Procedures

Various recommendations revolving around the structure and procedures of services were also made in relation to specialist domestic abuse services. One recommendation noted that Hestia and the Independent Domestic Violence Advocate (IDA) service commissioner should be reporting on the ways they are dealing with high caseloads to the Violence Against Women and Girls Delivery Group so that improved, more concentrated support can be provided to victims of domestic abuse. Another recommendation relating to the structure and procedure of specialist domestic abuse services advised that a Violence Against Women and Girls Delivery Group in a borough conduct a review to measure its ability to successfully link with other statutory agencies. A recommendation was also made for specialist domestic abuse services to realign themselves

with guidance on how long a referral should be kept for before a victim of domestic abuse is contacted and offered support.

Victim Contact

One recommendation stated that a discussion should be held by Domestic Abuse Forum regarding the agencies which collect and use the email addresses of victims of domestic abuse. Focus was shed on safely and confidentially using the victim's email address to ensure their risk is not increased. Another recommendation for Domestic Abuse Forum also advised that its members should review how to identify and support repeat victims.

Appendix One: Domestic Homicides from year ending March 2005

Number of women and men killed by partners, sons/daughters and 'other family' excluding parents from year ending March 2005 to year ending March 2015. It should be noted that these figures obtained from the ONS do not breakdown the sexuality of victims.

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: Home Office DHR Figures

Home Office

Crime and Policing Analysis Unit
2 Marsham Street
London
SW1P 4DF

www.gov.uk/home-office

Our Ref: FOI 56085
November 2019

Dear Bear Montique,

Thank you for your email of 23 October 2019, in which you ask for a breakdown of the number of domestic homicides in London by interpersonal violence and adult family violence from 2011 to present.

Your request has been handled as a request for information under the Freedom of Information Act 2000 (FOIA).

I can confirm that the Home Office holds the information you have requested and I am able to disclose the information set out in the enclosed Annex.

If you are dissatisfied with this response you may request an independent internal review of our handling of your request by submitting a complaint within two months to foirequests@homeoffice.gsi.gov.uk, quoting reference 56085. If you ask for an internal review, it would be helpful if you could say why you are dissatisfied with the response.

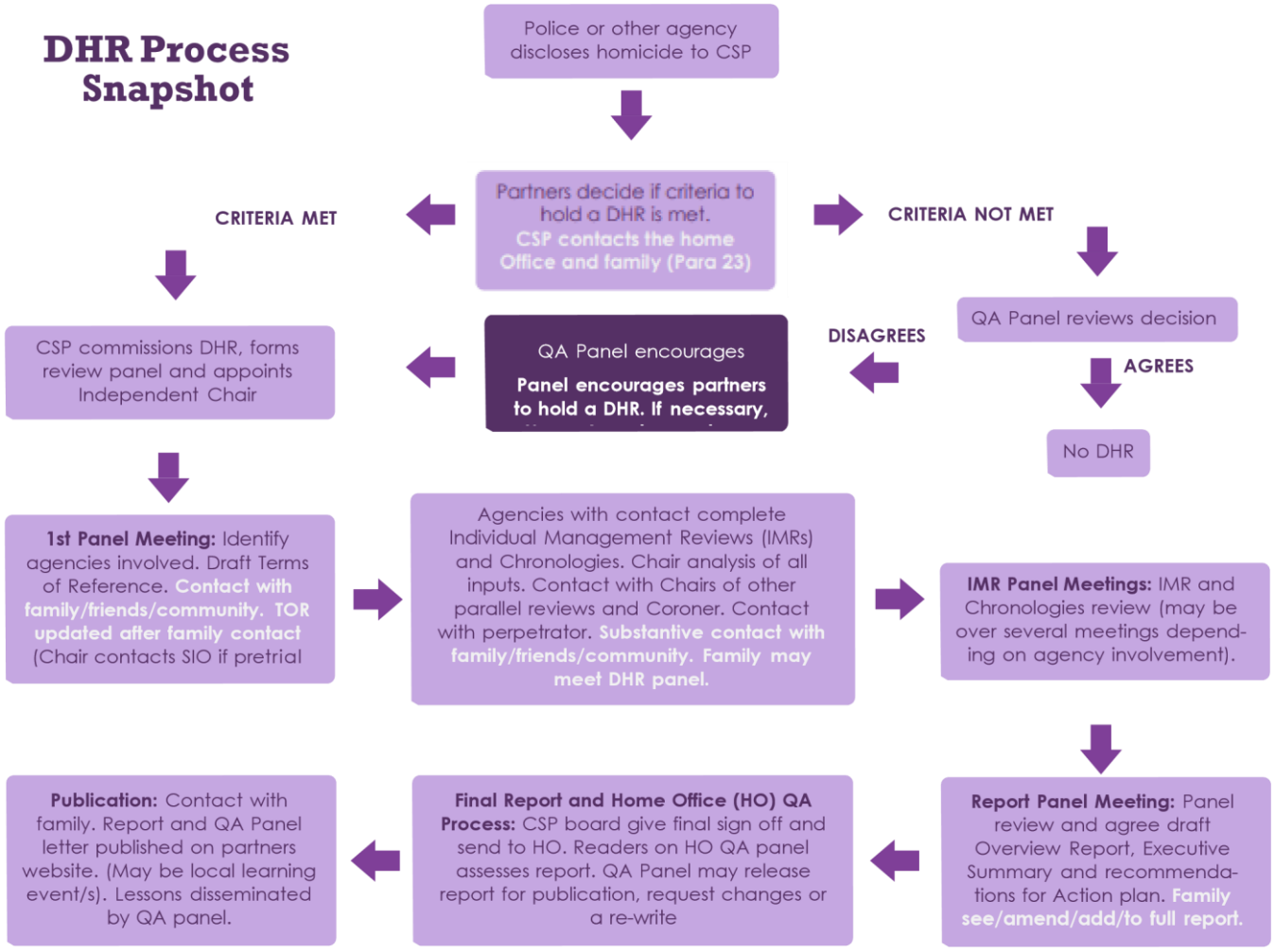
As part of any internal review the Department's handling of your information request would be reassessed by staff who were not involved in providing you with this response. If you were to remain dissatisfied after an internal review, you would have a right of complaint to the Information Commissioner as established by section 50 of the FOIA.

Yours sincerely

Sam Butler
Crime and Policing Analysis Unit

Year	Family Member	Partner/Ex-Partner
April 2010 – March 2011	9	19
April 2011 – March 2012	8	16
April 2012 – March 2013	4	16
April 2013 – March 2014	9	18
April 2014 – March 2015	10	12
April 2015 – March 2016	8	16
April 2016 – March 2017	3	8
April 2017 – March 2018	8	5

Appendix Three: DHR Process Snapshot



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

Appendix Four: Data set for all 84 London DHRs

Below are the figures derived from analysis of 84 London DHRs which took place between 2011 and 2018.

DHRs

Category	Number of Cases
IPH	59
AFH	25

Interpersonal Homicide (IPH)

Age of victim	Number of victims
16-19	0
20-29	19
30-39	17
40-49	11
50-59	2
60-69	5
70-79	1
80-89	1
Unknown/Not Stated	3

Age of perpetrator	Number of perpetrators
15-19	1
20-29	11
30-39	18
40-49	14
50-59	3
60-69	8
70-79	0
80-89	0
Unknown/Not Stated	4

Sexuality of victim	Number of victims
Heterosexual	42
Unknown	17

Sexuality of perpetrators	Number of perpetrators
Heterosexual	42
Unknown	17

Sex of victim same as at birth	Number of victims
Yes	58
No	1

Sex of perpetrator same as at birth	Number of perpetrators
Yes	59
No	0

Ethnicity of victim	Number of victims
African	1
Asian	2
Asian Other: Central Asian Republic	1
Asian/Asian British: Bangladeshi	1
Asian/Asian British: Indian	3
Asian/Asian British: Pakistani	2
Black/Black British: African	3
Black/Black British: Caribbean	3
Black/Black British: Other, unspecified	1
Congolese	1
Eastern European	4
Greek Cypriot	1
Irish	1
Jamaican	1
Kosovo Albanian	1
Mexican	1
Mixed/Multiple Ethnic Backgrounds: British and African	1
Mixed/Multiple Ethnic Backgrounds: White and Black Caribbean	3
North Korean	1
Romanian	1
Russian	1
Somalian	1
Turkish	1
White: British	17
White: European	2
White: Other, unspecified	1
Unknown/Not Stated	3

Ethnicity of perpetrator	Number of perpetrators
Afro-Caribbean and Irish	1
Angolan	1
Arab	1
Asian	2
Asian/Asian British: Bengali	1
Asian/Asian British: Bangladeshi	1
Asian/Asian British: Indian	1
Asian/Asian British: Pakistani	5
Black/Black British: African	6

Black/Black British: Caribbean	5
Black/Black British: Other, unspecified	4
Eastern European	3
Greek Cypriot	1
Grenadian	1
Kosovo Albanian	1
Latin American	1
Mexican	1
Mixed/Multiple Ethnic Backgrounds: White and Black Caribbean	1
North Korean	1
Romanian	1
Somalian	1
Turkish	2
White: British	9
White: European	1
White: Other, unspecified	1
Unknown/Not Stated	6

Nationality of victim	**Number of victims**
Albanian	1
British	5
Bulgarian	1
Central Asian Republic	1
Greek Cypriot	1
Irish	1
Mexican	1
North Korean	1
Pakistani	1
Polish	4
Romanian	1
Russian	1
Somalian	1
Zimbabwean	1
Unknown/Not Stated	38 (32 blanks)
Nationality of perpetrator	**Number of perpetrators**
Albanian	1
Bengali	1
British	6
Central Asian Republic	1
EEA National	1
Greek Cypriot	1
Grenadian	1
Mexican	1

North Korean	1
Pakistani	1
Polish	1
Somalian	1
Uruguayan	1
Unknown/Not Stated	41 (36 blanks)

Victim immigration status	**Number of victims**
Asylum Seeker	2
EEA National – Details unknown	4
EEA National – Exercising treaty rights	2
EU National	4
Indefinite Leave to Remain	2
Settled	1
Spousal Visa	1
Student Visa	1
Tourist Visa	1
UK National	30
Visitor's Visa	1
Unknown/Not stated	10

Perpetrator immigration status	**Number of perpetrators**
Asylum Seeker	3
Discretionary Leave to Remain	1
EEA National – Details unknown	4
EEA National – Exercising treaty rights	1
EU National	1
Indefinite Leave to Remain	2
Settled	1
Spousal Visa	1
Student Visa	2
Tourist Visa	1
UK National	25
Unknown/Not stated	17

Relationship to victim	**Number of perpetrators**
Boyfriend	4
Ex-partner	9
Husband	5
Friend (Sexual Relationship)	1
Partner	25
Spouse	14
Wife	1

Children involved	**Number of cases**

Yes	33
No	26

Number of children	Number of cases
0	26
1	7
2	15
3	5
4	3
5	1
6	2

Number of biological children	Number of cases
0	1
1	10
2	14
3	5
4	3

Number of children taken into care	Number of cases
0	24
1	3
2	3
3	2
Unknown	1

Number of children present at homicide	Number of cases
0	16
1	3
2	3
3	0
4	1
Present – Details unknown	7
Unknown	3

Total number of children killed	Number of cases
0	32
1	1

Victim carer	Number of cases
Yes	2
Yes (for work)	1
No	55

Unknown/Not specified	1

Perpetrator carer	Number of cases
Yes	9
No	49
Unknown/Not specified	1

Victim disability	Number of cases
Yes	8
No	51

Perpetrator disability	Number of cases
Yes	8
Unknown	2
No	49

Victim substance abuse	Number of cases
Yes	19
No	40

Perpetrator substance abuse	Number of cases
Yes	23
No	36

Victim Mental Health issues	Number of cases
Yes – details unknown	6
Yes – diagnosed, not open to mental health service at time of death	8
Yes – diagnosed, open to mental health service at time of death	2
Yes – previously open to mental health team at hospital	1
Yes – self-reported, not open to mental health service at time of death	3
No	38
Unknown	1

Perpetrator Mental Health issues	Number of cases
Yes – details unknown	7
Yes – diagnosed, not open to mental health service at time of homicide	7
Yes – diagnosed, open to mental health service at time of homicide	7

Yes – previously open to mental health team at hospital	1
Yes – self-reported, not open to mental health service at time of homicide	4
No	31
Unknown	2

Perpetrator Mental Health issues	**Number of cases where type of mental health issue is present**
Anxiety	**1**
Avoidant personality disorder	1
Depression	11
Dissociative personality disorder	1
Dissocial personality disorder	4
Emotionally unstable personality disorder	4
PTSD	1
Dual diagnosis (Unknown details)	1
Drug-induced psychosis	1
Substance use disorder	1
Delusional disorder	1
Hallucinations	1
Delusions	1
Paranoia	2
Paranoid schizophrenia	1
Panic attacks	1
Psychosis	2
Self-harm	1
Unknown	3

Victim Mental Health issues	**Number of cases where type of mental health issue is present**
Adjustment disorder related to social issues	1
Anxiety	2
Attempted suicide	1
Bipolar Affective Disorder	1
Depression	10
Emotionally unstable personality disorder	2
Dual Diagnosis (Unknown details)	1

Obsessive compulsive disorder	1
Panic attacks	1
Paranoia	1
Psychosis	1
Schizoaffective Disorder	1
Self-harm	1
Unknown	3

Perpetrator Suicide at time of murder	**Number of cases**
Yes	7
No	52

Victim with disability	**Number of cases**
Yes	8
No	51

Perpetrator with disability	**Number of cases**
Yes	8
No	49

Victim pregnant at death	**Number of cases**
Yes	1
No	58

Victim family involved in DHR	**Number of cases**
Yes	33
No	23
Unknown	3 (1 blank)

AAFDA involvement in DHR	**Number of cases**
Yes	
No	
Leaflet given	2 51 3 3
Unknown	

Victim Support involvement in DHR	**Number of cases**
Yes	
No	6 50
Unknown	3

Adult Family Homicide (AFH)

Age of victim	**Number of victims**

16-19	0
20-29	6
30-39	2
40-49	2
50-59	2
60-69	6
70-79	4
80-89	2
Unknown/Not Stated	1

Age of perpetrator	**Number of perpetrators**
15-19	1
20-29	4
30-39	9
40-49	7
50-59	2
60-69	0
70-79	0
80-89	0
Unknown/Not Stated	2

Ethnicity of victim	**Number of victims**
Arab	1
Asian/Asian British: Bangladeshi	3
Asian/Asian British: Bengali	1
Asian/Asian British: Indian	2
Asian/Asian British: Sri Lankan	1
Black/Black British: African	2
Black/Black British: African-Caribbean	1
British, unspecified	2
Fijian	1
Mauritian	2
Spanish	1
Romanian	1
Russian	1
White: British	5
White: Irish	1
Ethnicity of perpetrator	**Number of perpetrators**
Arab	1
Asian/Asian British: Bangladeshi	3
Asian/Asian British: Bengali	1
Asian/Asian British: Indian	1
Asian/Asian British: Sri Lankan	1
Black/Black British: African	2

Black/Black British: African-Caribbean	1
Black/Black British: Bangladesh	1
Black/Black British: Other, unspecified	1
Black/Black British: Somalian	1
British, unspecified	1
Mauritian	1
White: Danish	1
White: British	6
White: Irish	1
White: Romanian	1
Unknown/Not stated	1

Nationality of perpetrator	**Number of perpetrators**
Bengali	2
British	4
Iranian	1
Mauritian	1
Somalian	1
Unknown/Not Stated	16 (15 blanks)

Nationality of victims	**Number of victims**
British	5
Fijian	1
Iranian	1
Mauritian	1
Unknown/Not Stated	17 (17 blanks)

Victim immigration status	**Number of victims**
EEA National – Details unknown	1
EEA National – Exercising treaty rights	1
Limited Leave to Remain	1
UK National	11
Undocumented	1
Unknown/Not stated	10

Perpetrator immigration status	**Number of perpetrators**
EEA National – Exercising treaty rights	1
Indefinite Leave to Remain	1
UK National	15
Over stayer	1
Two Year Visa	1
Undocumented	1
Unknown/Not stated	5

Relationship to victim	**Number of perpetrators**

Adoptive Parent	1
Boyfriend	1
Boyfriend of victim's sister	1
Sibling	3
Child	14
Child-in law	3
Partner	1
Spouse	1

Sexuality of victim	**Number of victims**
Heterosexual	18
Unknown	7

Sexuality of perpetrators	**Number of perpetrators**
Heterosexual	17
Unknown	8

Sex of victim same as at birth	**Number of victims**
Yes	25
No	0

Sex of perpetrator same as at birth	**Number of perpetrators**
Yes	24
No	1

Children involved	**Number of cases**
Yes	4
No	21

Number of children	**Number of cases**
0 children	21
1 child	0
2 children	4

Number of biological children	**Number of cases**
0 children	1
1 child	0
2 children	3

Number of children taken into care	**Number of cases**
0 children	4

Number of children present at homicide	Number of cases
0 children	1
2 children	2
Unknown/Not Stated	1

Total number of children killed	Number of cases
0 children	4

Victim carer	Number of cases
Yes	7
No	17
Unknown/Not specified	1

Perpetrator carer	Number of cases
Yes	4
No	21
Unknown/Not specified	0

Victim disability	Number of cases
Yes	7
No	18

Perpetrator disability	Number of cases
Yes	10
No	15

Victim substance abuse	Number of cases
Yes	3
No	22

Perpetrator substance abuse	Number of cases
Yes	13
No	12

Victim Mental Health issues	Number of cases
Yes – details unknown	1
Yes – diagnosed, open to mental health service at time of death	2
No	22
Unknown	0

Perpetrator Mental Health issues	Number of cases

Yes – details unknown	1
Yes – diagnosed, not open to mental health service at time of homicide	3
Yes – diagnosed, open to mental health service at time of homicide	10
Yes – self-reported, not open to mental health service at time of homicide	2
No	9
Unknown	0

Perpetrator Mental Health issues	**Number of cases where type of mental health issue is present**
Anxiety	3
Depression	4
Agoraphobia	1
Paranoid Psychosis	1
Psychotic Symptoms	1
Schizophrenia/Schizoaffective disorder	3
Drug-induced psychosis	1
Mental psychosis	1
Panic attacks	2
Paranoia	3
Paranoid Schizophrenic	4
Bipolar affective disorder	1
Unknown	2

Victim Mental Health issues	**Number of cases where type of mental health issue is present**
Anxiety	1
Depression	3
Registered Sex Offender	1

Perpetrator Suicide at time of murder	**Number of cases**
Yes	0
No	25

Victim with disability	**Number of cases**
Yes	7

No	18

Perpetrator with disability	Number of cases
Yes	10
No	15

Victim pregnant at death	Number of cases
Yes	0
No	25

Victim family involved in DHR	Number of cases
Yes	14
No	11

AAFDA involvement in DHR	Number of cases
Yes	3
No	21
Unknown	1

Victim Support involvement in DHR	Number of cases
Yes	5
No	19
Unknown	1

Appendix Five: Breakdown of Themes Identified in IPH Cases

Interpersonal Homicide Cases	**TOTAL (#)**	**%**
Lack of Awareness of the range of behaviours/ scope that constitutes domestic violence and its dynamics and risks (Family and Friends)	**32**	**54%**
Missed opportunities to hold perpetrator accountable/offer support	**15**	**25%**
Missed opportunities to ask about victim's relationship (Culture of Questioning)	**29**	**49%**
Lack of Information Sharing processes (e.g., MARAC)	**18**	**31%**
Missed opportunities to offer mental health support to perpetrator/family	**6**	**10%**
Missed opportunities to offer victim support (mental health, substance support, general)	**19**	**32%**
General procedural issues and failure to effectively assess and manage risk to public	**11**	**19%**
Missed opportunities (or delays) to share information for multi-agency coordination and make referrals	**22**	**37%**
Issues with formal risk assessment and lack of referral to MARAC	**23**	**39%**
Lack of professional responsibility to follow-up actions and referrals	**10**	**17%**
Lack of information regarding who is responsible for victim or perpetrator's care within NHS	**3**	**5%**
DV services inability to engage with victim (effectiveness)	**8**	**14%**
Lack of Awareness of rights- including around immigration	**2**	**3%**
Lack of adherence to policies/procedures including Issues with Police investigation of DV incidences	**14**	**24%**
Adoption processes	**1**	**2%**
Failure to record victim disclosures of DV	**3**	**5%**
Failure to record perpetrators disclosures of DV	**3**	**5%**
Lack of support for staff, including supervision and support around managing intimidating and threatening clients	**3**	**5%**

Failures of adult safeguarding procedures	**3**	**5%**
Failure to act on safeguarding issues	**6**	**10%**
Failure to address barriers regarding protected characteristics	**19**	**32%**

Lack of Information Sharing - including between Health Services	**27**	**46%**
Risk Assessment -- not done or poorly done	**33**	**56%**
Lack of Understanding and awareness of the dynamics of DV and its impact	**23**	**39%**
Lack of a Culture of Questioning -- including enquiries with multiple and complex needs	**27**	**44%**
Perpetrator's Mental Health	**26**	**44%**
Policies and processes -- not there or not followed	**22**	**37%**
Perpetrator's Substance Abuse	**12**	**20%**
Carer responsibilities and barriers of being able to seek help	**7**	**12%**
Need for early intervention and family support	**6**	**10%**
The role of fathers and perpetrators -- so that agencies support the role of father and also hold them accountable for the impact of their violence	**4**	**7%**
Victims Mental Health	**20**	**33%**
Police Action, poor response	**6**	**10%**
Disengagement with services- failure to explore non-engagement	**12**	**20%**
Role of universal services- including health services -- in providing a service for those suffering domestic abuse	**10**	**17%**
Immigration Status	**10**	**17%**
Dynamic of faith and religion on resolving conflict	**7**	**12%**
Lack of Partnership effectiveness	**5**	**8%**

Disability, caring responsibilities and safeguarding adults at risk	**7**	**12%**
The police Merlin report system	**2**	**3%**
Signposting and referral practices -- passive signposting, rather than engaged referrals ('difference between signposting and a proactive referral -- chasing it up, etc.)	**12**	**20%**
Failure to follow through with actions regarding support	**4**	**7%**
Lack of Training - dynamics and practice	**26**	**44%**
Role and function of the Family Justice Centre	**3**	**5%**
Thresholds for MH care	**4**	**7%**
Serial perpetrators	**6**	**10%**
Helping employers to better support staff	**7**	**12%**
Community awareness of DV needed	**12**	**20%**
Need for routine enquiry	**8**	**14%**
Need for specialist DV support -- may include funding	**6**	**10%**
Holistic approach needed and not actioned	**8**	**14%**
Silo working	**8**	**14%**
Adult Safeguarding not well-linked to Domestic Abuse	**5**	**8%**
Poor Record-keeping -- by individuals and poor systems	**20**	**34%**
Carer assessment should have been made	**2**	**3%**
Lack of general advice services	**3**	**5%**

Appendix Six: Breakdown of Themes Identified in AFH Cases

Adult Family Homicide Cases	TOTAL ()	%
Lack of Awareness of the range of behaviours/ scope that constitutes domestic violence and its dynamics and risks (Family and friends)	16	60%
Missed opportunities to hold perpetrator accountable/offer support	6	24%
Missed opportunities to ask about victim's relationship (Culture of Questioning)	11	44%
Lack of Information Sharing processes (e.g. MARAC)	8	28%
Missed opportunities to offer mental health support to perpetrator/family	8	28%
Missed opportunities to offer victim support (mental health, substance support, general)	10	40%
General procedural issues and failure to effectively assess and manage risk to public	6	24%
Missed opportunities (or delays) to share information for multi-agency coordination and make referrals	12	48%
Issues with formal risk assessment and lack of referral to MARAC	7	28%
Lack of professional responsibility to follow-up actions and referrals	4	16%
Lack of information regarding who is responsible for victim or perpetrator's care within NHS	1	4%
DV services inability to engage with victim (effectiveness)	1	4%
Lack of Awareness of rights- including around immigration	1	0%
Lack of adherence to policies/procedures including Issues with Police investigation of DV incidences	3	8%
Failure to record victim disclosures of DV	1	4%
Failure to record perpetrators disclosures of DV	0	0%
Lack of support for staff, including supervision and support around managing intimidating and threatening clients	3	8%
Failures of adult safeguarding procedures	3	12%
Failure to act on safeguarding issues	5	20%

Failure to address barriers regarding protected characteristics	**7**	**28%**
Lack of Information Sharing - including between Health Services	**11**	**40%**
Risk Assessment -- not done or poorly done	**7**	**24%**

Lack of Understanding and awareness of the dynamics of DV and its impact	**6**	**24%**
Lack of a Culture of Questioning -- including enquiries with multiple and complex needs	**8**	**32%**
Perpetrator's Mental Health	**16**	**64%**
Policies and processes -- not there or not followed	**4**	**12%**
Perpetrators' Substance Abuse	**6**	**24%**
Carer responsibilities and barriers of being able to seek help	**4**	**12%**
Need for early intervention and family support	**4**	**16%**
The role of fathers and perpetrators -- so that agencies support the role of father and also hold them accountable for the impact of their violence	**1**	**4%**
Victims Mental Health	**2**	**8%**
Police Action, poor response	**3**	**12%**
Disengagement with services- failure to explore non-engagement	**2**	**8%**
Role of universal services- including health services -- in providing a service for those suffering domestic abuse	**4**	**16%**
Immigration Status	**1**	**4%**
Dynamic of faith and religion on resolving conflict	**1**	**4%**
Lack of Partnership effectiveness	**1**	**4%**
Disability, caring responsibilities and safeguarding adults at risk	**3**	**12%**
Failure to follow through with actions regarding support	**4**	**16%**

Lack of Training - dynamics and practice	**6**	**24%**
Thresholds for MH care	**3**	**12%**
Serial perpetrators	**3**	**12%**
Helping employers to better support staff	**0**	**0%**
Community awareness of DV	**3**	**12%**
Need for routine enquiry	**3**	**12%**
Silo working	**7**	**28%**
Adult Safeguarding not well-linked to Domestic Abuse	**4**	**12%**
Poor Record-keeping -- by individuals and poor systems	**5**	**20%**
Carer assessment should have been made	**4**	**12%**
Lack of general advice services	**1**	**4%**

Appendix Seven: Levers for Change

In the 2016 review of DHRs carried out by STADV, this was included as an appendix. It is also included in this report as it is a good learning tool.

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 (DA) 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 service.

Appendix Eight: Mental Health Analysis of 10 DHR Cases

	DA type	Perpetrator mental health problem(s)	Victim mental health problem(s)	Relationship problems* known to healthcare services	Main mental health related themes	Children involved
DHR 1 (RB, Haringey)	IPV (man killed expartner)	Depression, suicidal ideation	Depression (historical)	Yes (perpetrator cited separation as trigger to suicidal thoughts; disclosed thoughts to kill ex-partner to mental health services)	Depression and suicidality (Perpetrator) Threats to harm victim Risk assessment: assessment of risk to partners/families in suicidal individuals; Involving partners/families in risk assessment Inter-agency working Healthcare services' response to DA	No
DHR 2 (Mrs A, Merton)	IPV (man killed long-term partner)	Emotionally unstable personality disorder	N/A	Yes (perpetrator disclosed thoughts to kill ex-partner to mental health services)	Suicidality (perpetrator) Threats to harm victim Risk assessment: assessment of risk to partners/families in suicidal individuals; involving partners/families in risk assessment	No

DHR 3 (Tekia, Waltham Forest)	FV (man killed father-inlaw and severely injured wife)	Paranoid schizophrenia	Opiate and cocaine dependence (in treatment)	Yes (DA between perpetrator and his wife)	Risk assessment Risk management plan for individuals with serious mental disorder who disengage from treatment Treatment and follow-up for mental disorders Police response to vulnerable people with mental disorder Escalation of safeguarding concerns and referrals Substance use (victim; historical)	Yes (known safeguarding concerns)
DHR 4 (DHR A19, Barking and Dagenham)	FV (transgender woman killed father)	Agoraphobia, hoarding	Depression associated with multiple sclerosis (historical)	Yes (safeguarding concerns/alert due to suspected financial abuse)	Suicidality (perpetrator) Caring responsibilities Perpetrator suicidality Inter-agency working	No
DHR 5 (Barbara, Ealing)	IPV (man killed long-term partner and killed himself)	Recurrent depression	Recurrent severe depression	No	Caring responsibilities Depression (victim and perpetrator) and suicidality (perpetrator) Treatment and followup for mental disorders	No

					Risk assessment: involving partner in assessment of risk	
DHR 6 (Charlotte, Hillingdon)	IPV (man killed expartner)	Depression, PTSD, 'stress'	N/A	Yes (perpetrator mentioned 'domestic incident'; difficult separation and not seeing children cited as triggers to depression)	Threats to harm victim and children Healthcare services' response to DA Depression (perpetrator) Risk assessment: involving partner in assessment of risk	Yes
DHR 7 (Rose, Ealing)	IPV (man killed partner)	Schizophrenia, druginduced psychosis, dissocial personality disorder, IV heroin dependence (historical); alcohol misuse	N/A	No	Inter-agency working Recording of historical information re: mental health and risk Substance use Risk assessment Caring responsibilities	No

DHR 8 (Agapito, Kingston)	IPV (man killed expartner)	Depression, suicide attempt	N/A	Yes (perpetrator cited separation as trigger to suicide attempt; disclosed unauthorised access to ex-partner's emails; made threat to abduct child)	Inter-agency working Suicidality (perpetrator) Risk assessment: assessment of risk to partners/families in suicidal patients; involving partner in assessment of risk Safeguarding children Healthcare services' response to information suggestive of DA	Yes (perpetrator threatened to abduct child)
DHR 9 (Lottie, Hillingdon)	IPV (man killed partner)	Dissocial personality disorder, substance misuse	Personality disorder, depression , self-harm, substance misuse	Yes	Treatment and followup for mental disorders Safeguarding children Inter-agency working Substance use (victim and perpetrator) Healthcare services' response to reports of DA Vulnerability (victim)	Yes (known safeguarding concerns)
DHR 10 (Sophia, Lambeth)	IPV (man killed expartner)	N/A	Depression and anxiety	Yes (victim reported that 'domestic hassle' was trigger to anxiety	Depression (victim) Healthcare services' response to DA	Yes (known safeguarding concerns)

*The definition of 'relationship problems' for this table includes any pattern of serious relationship difficulties that were known to agencies involved with the perpetrator and/or victim, regardless of whether those difficulties were identified as DA.

Appendix Nine: Useful Resources

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-upreports/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 Ten: Demographic Template for DHR Analysis

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

DHR Information

Assigned DHR no.	
Locality	
Local authority	
Victim's pseudonym	
Published	
Date of first DHR panel meeting	
Date of submission to Community Safety Partnership	
STADV DHR turn-around time	
Date of Publication	
Interpersonal Homicide (IPH) / Adult Family Homicide (AFH)	
Victim's family involved in the DHR process	
Advocacy After Fatal Domestic Abuse (AAFDA) involved in DHR process	
Victim Support Homicide Service involved in DHR process	

Victim's Details

Year of death	
Age at the time of death	
Carer	
Care-leaver	
Sex	
Sex the same as assigned at birth	
Ethnicity	
Nationality	
Immigration Status	
Faith	
Sexual orientation	
Disability	
Type of disability	
Mental health issues	
Type of mental health issues	
Substance use issues	
Housing status at time of death	

Living with perpetrator at time of death	
Repeat victim of DV/A at any point	
Experiencing abuse from multiple perpetrators at time of death	
Involved in prostitution	

Perpetrator Details

Serial perpetrator	
Conviction of homicide	
Violent resistance at point of homicide	
Murder-suicide	
Relationship to victim	
Age at time of homicide	
Carer	
Care-leaver	
Sex	
Sex the same as assigned at birth	
Ethnicity	
Nationality	
Immigration status	
Sexual orientation	
Disability	
Type of disability	
Mental health issues	
Type of mental health issues	
Substance use issues	
Housing stats at time of homicide	

Children's Details

Victim pregnant at time of death	
Children	
Total no. of children	
No. of biological children (Victim)	
No. of children in the household	
No. of children taken into care	
Child(ren) murdered	
Child(ren) present at time of homicide	
Victim's relationship to child(ren) in household	

Perpetrator's relationship to child(ren) in household	

Other Details

Victim referred to MARAC	
Victim and Perpetrator separated	
Relationship ended/attempted separation within 24 months of homicide	
Accompanying notes	

Appendix Eleven: Borough Questionnaire of Local Processes for Carrying out a DHR

Below is the questionnaire that VAWG leads were asked to fill out in relation to this report. In instances where questions were left blank or needed clarification, VAWG leads were asked the same questions at a later interview.

Questions for interviews (from bid document) in red

Questions for the London DHR reviews for borough VAWG coordinators – these were in the questionnaire and Survey Monkey

Please fill in the boxes or open text and highlight the correct answer, as appropriate.

1. Your Borough: _____.
2. Your department: _____.
3. Your name: _____.

Interviewee's role (to contextualise answers and see if there is a named individual responsible for these)

- What is your role? What is your role in relation to DHRs?

- Who do you report to?

Data information

4. How many Domestic Homicides have you had within your borough since 13th April 2011? (please include any recent homicides)?

5. a) How many DHRs have you carried out since 13th of April 2011?

   b) How many of your DHRs related to situations outside the statutory definition, but within the guidance, that is, 'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was a coercive and controlling behaviours in the relationship'.

6. How many have been completed and published?

7. How many are currently in progress?

8. How many have yet to be started?

The local process

9. Please explain your process for carrying out your DHRs, who has overall responsibility for overall management of the DHRs and who manages the process?

10. How are your chairs appointed?

    a. Through a tender process

b. Appointed by a particular person, panel or group
c. Other (please specify)

11. Do you have a regular DHR panel or do you create a bespoke one each time?
    a. Standing DHR panel
    b. New DHR Panel each time
    c. Standing Panel with additional relevant agencies added
    d. Other: (Please specify)_____

12. What operational groups or committees are the published recommendations taken to for discussion?
    a. VAWG strategy group
    b. Community Safety Partnership
    c. Local Children Safeguarding Board
    d. Local Adult Safeguarding Board
    e. MARAC Steering Group
    f. Other ____(Please specify)_____

Creating and implementing the Action Plan

13. Who has responsibility for the development of the DHR action plan?
    a. Yourself
    b. The head of your department
    c. The operational groups (name them)
    d. The Strategic Board
    e. Other please state

14. How is the process of developing the points on the action plan carried out? Describe the journey of the development of the action plan.

15. Do you develop a new action plan for each DHR that remains as a standalone plan?
    Yes ☐ No ☐

    OR

    Amalgamate each DHR action plan into one overarching DHR action plan?
    Yes No ☐

    OR

    Do this in another way? If in another way, could you describe that?

16. Who is responsible for overall management of the action plan once it has been finalised?

    a. Yourself
    b. The head of your department
    c. The operational groups (name them)
    d. The Strategic Board
    e. Other please state

17. What systems do you use to flag and discuss outstanding actions on the action plans?

18. How often are the action plans reviewed? And by whom/what group?
    a. Monthly
    b. Quarterly
    c. Annually
    d. Other: (please specify) _____

19. Do you use a RAG rating system for your action plan? Yes No

Family Engagement

20. Do you regularly report back to the victim's family on the progress on the action plan?
    Yes No

21. Have you ever reported back to the victim's family on the progress of the action plan?
    Yes No

Timeframes

22. On average, how long does it take to complete the action plan from a DHR?
    a. Completed before the DHR is published
    b. 4 months
    c. 6 months
    d. 1 year
    e. Longer than a year, please state average time to completion: _____

Publication of DHRs

23. Where are your DHRs published?
    a. Council website
    b. Community Forums

24. For how long are your reports kept on these public forums?

Where are they stored in the long term and how easy are they to retrieve?

Practicalities of implementation

25. What do you think are the main barriers or issues around completing the actions within the plan?

26. What do you think is unachievable within your current action plans?

27. Are there any special circumstances locally that have slowed or interrupted this implementation of the action plan? (e.g. loss of key staff, change in personnel, restructuring, shift in responsibilities for DHRs, costs, etc.) Please expand as much as possible.

Impact of DHRs

- What significant changes has your borough made following findings from DHRs?

28. What change in policy, procedure or process because of a DHR has made the most impact within your borough? Can you describe and/or quantify the change that this has made?

29. (Q28 in questionnaire) How many of your serious case reviews carried out in the same time period have had a VAWG issue as a factor?

30. (Q29 in questionnaire) How many MARAC cases have you had in the last year?

31. (Q30 in questionnaire) How many MARAC cases did you have at the start of the DHR process on 13 April 2011?

- What themes have emerged from your more recent DHRs that are not yet published?

- What best practice has been identified that you would want to highlight?

Going forward

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32. (Q27 in questionnaire) What change or improvements in the process of DHR reviews would you like to see and why (local and national)?

- Do you have any comments on the Home Office QA process for reviewing completed DHRs? Timeframes? The feedback?

33. (Q31) in questionnaire) Do you have any other feedback that you'd like to give about the DHR process in your area or overall?

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London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process

Written by: Bear Montique
October 2019

MOPAC | MAYOR OF LONDON OFFICE FOR POLICING AND CRIME

STANDING together against domestic violence