Scrutiny for Policies, Adults and Health
24th January 2018
Report for information

Domestic Homicide Reviews

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Summary:	Domestic Homicide Reviews are a statutory requirement. All public bodies must participate in and support these reviews. A Domestic Homicide Review considers the circumstances in which a death has occurred when it has been the result of harm perpetrated by an intimate partner / person or member of the same household. The purpose of the review is to learn lessons and identify good practice which can be applied to reduce and prevent domestic violence and homicide. The Safer Somerset Partnership has overall oversight and responsibility for Domestic Homicide Reviews. The practical process of facilitating multi agency participation, appointing the reviewer, publication and record keeping is managed on behalf of the Partnership by Somerset County Council. Since 2011 a total of ten Domestic Homicide Reviews have been undertaken in Somerset. The Somerset Domestic Abuse Board, on behalf of the Safer Somerset Partnership, monitors implementation of recommendations and has oversight of an annual domestic abuse self-assessment process.
Recommendations:	**The Adults and Health Scrutiny Committee note the system in place to carry out and implement recommendations from Domestic Homicide Reviews.**
Links to Somerset Health and Wellbeing Strategy	Some groups and communities systematically experience poorer health than others. These are, in the main, often the same groups who experience victimisation or the impacts of crime. The community safety agenda overlaps with health and wellbeing work streams in many areas but in particular, theme 2 of the Somerset Health and Wellbeing Strategy - *Families and communities are thriving and resilient.*

Financial, Legal and HR Implications:	Somerset County Council (Public Health) invests £1000 per annum to the Safer Somerset Partnership pooled budget which is utilised for the commissioning of Domestic Homicide Reviews. The management and coordination for Domestic Homicide Reviews is undertaken by Somerset County Council community safety specialists.
Equalities Implications:	Equalities Impact Assessments are carried on specific pieces of work that relate to services and our communities, however, no assessment has been conducted in relation to providing the Board with this report.
Risk Assessment:	N/A

1. Background

1.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011.

1.2 A DHR is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by -

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

1.3 Domestic abuse includes physical violence, psychological, sexual, financial and emotional abuse involving partners, ex-partners, other relatives or household members. In 2009/10, domestic violence accounted for 14% of all violent incidents and affects both men and women. In 2013 the definition expanded to include coercive control

2. Responsibility, Accountability and governance

2.1 When a domestic homicide occurs, the relevant police force should inform the relevant Community Safety Partnership in writing. Additionally, any professional or agency may refer such a homicide to the Community Safety Partnership in writing if it is believed that there are important lessons for inter-agency working to be learned.

2.2 Overall responsibility for establishing a review rests with the local Community Safety Partnership. Community Safety Partnerships are ideally placed to initiate a Domestic Homicide Review and Review Panel due to their multi-agency membership and their reach across England and Wales.

2.3 The chair of the Community Safety Partnership holds responsibility for establishing whether a homicide meets the specific criteria for a Domestic Homicide Review.

2.4 When criteria are met, the Community Safety Partnership is responsible for commissioning and publishing a review; and for oversight of recommendations. All reviews for Somerset are published on the Somerset Survivors Website (www.somersetsurvivors.org.uk). A briefing is also sent to all Elected members at the point of publication.

2.5 All Domestic Homicide decisions and reviews are subject to approval from the Home Office Quality Assurance Overview Panel.

2.6 The Somerset Domestic Abuse Board, which reports to the Safer Somerset Partnership, has a quality assurance role for the whole domestic abuse system. The Board is responsible for ensuring that Domestic Homicide Review actions are completed and learning embedded. All statutory partners are represented at the Board.

2.7 Each agency has a designated Domestic Homicide Review lead, who takes responsibility for the implementation of actions for their own agency.

3. Why does Somerset County Council take a leading role?

3.1 Section 9 of the Domestic Violence Crime and Victims Act 2004 states that Local Authorities are required to participate in Domestic Homicide Reviews.

3.2 Somerset County Council has a leadership and management role for Domestic Homicide Reviews on behalf of the Safer Somerset Partnership. This includes:

- Coordinating the decision making process
- Managing the review process
- Commissioning of the independent Chairs
- Coordinating the action plans to ensure that recommendations and actions are completed.

4. Summary of Domestic Homicide Reviews undertaken in Somerset

4.1 Since the first Domestic Homicide review in 2011, the Safer Somerset Partnership has received 22 notifications of deaths to consider as possibly meeting the criteria for Domestic Homicide Review

4.2 Of these 22 notifications for consideration, 10 have met the criteria for Domestic Homicide Review.

4.3 Of the 10 cases which net the criteria for a Domestic Homicide Review, 7 had associated children.

4.4 In terms of location, 5 cases were in Taunton Deane, three in South Somerset and two in Mendip.

4.5

A further 3 cases are currently being considered as to whether a Domestic Homicide Review is required.

5.

Lessons learned

5.1

In 2016/17 a number of thematic reviews were carried out on Domestic Homicide Reviews.

5.2

Public Health undertook a review of Somerset cases, the themes most common were:

- Public awareness raising and training for professionals
- Risk identification and recording
- Multiple needs and families

6.

National themes

6.1

Two other reports have been published which have analysed the findings from numerous Domestic Homicide Reviews across the Country.

6.2

Domestic Homicide Reviews: Key Findings From Research (2016). This report was produced by the Home Office in 2016, and has used evidence from a sample of 40 reviews Domestic Homicide Review (DHR) Case Analysis produced for Standing Together (2016)

6.3

Taking the findings from the Somerset's review and the two national reports the following recurring themes are evident across all:

- Communication should be improved, including for diverse groups and friends/family
- Policies need to be effectively implemented across all agencies
- Training should be improved including the consideration of multiple needs and diverse groups
- Information sharing should be improved
- Multi-Agency Domestic Abuse Conferences (MARAC) need greater consistency in approach, representation and monitoring of actions

7.

Implementing Lessons learned

7.1

The Somerset Domestic Abuse Board monitors the implementation of the recommendations from all domestic homicide review.

7.2

Domestic Homicide Review leads form each agency is provided with a list of agreed actions and asked to report back on a quarterly basis.

7.3

In addition, each agency is asked to complete an annual self-assessment which informs the Domestic Abuse Board how well each agency is able to evidence how they have implemented action and how these changes have improved responses to domestic abuse.

Consultations undertaken

7.4

The Domestic Homicide Review process is based upon national legislation and has been developed locally to gain consistency across the Avon and Somerset police Force area.

Consultation was not required but stakeholder engagement took place from the outset to ensure that partner agencies were aware of their responsibilities.

8.

Background papers

8.1

Avon and Somerset Domestic Homicide Review Protocol

8.2

Somerset Domestic Homicide Pathway

Note For sight of individual background papers please contact the report author