CMB

Overview and Summary of DA Assurance

July 2020

Overview and Summary of Domestic Abuse Assurance

1. Introduction

In order to provide assurance and learning for the Domestic Abuse thematic, three separate reviews were commissioned from Transformation and Improvement. This was to explore different angles and aspects of domestic abuse; for various reasons, including the start of the COVID lockdown, each review was conducted differently, however this has enabled additional learning to be gained through comparing the alternative approaches. This is the first time reviews have been carried out on this scale within the Improvement team; as part of the new Assurance and Audit framework.

2. Description and Methodology

The **High Risk Victims Review** looked at 50 cases involving DA victims assessed as High Risk on DASH. The service that victims who fall into this category should include automatic referral to the Lighthouse Safeguarding Unit (LSU) and onward referral to our DA service delivery partners. This may also include a referral to MARAC. This review was completed by one person reviewing a wide range of aspects of each case including officer actions, LSU actions, referrals made and outcomes including re-victimisation.

The **Incidents Review** looked at 235 domestic abuse cases and the reviews were completed by a group of seven reviewers. A domestic incident usually occurs when an altercation of some sort occurs within a domestic setting but what has happened does not potentially amount to an offence. Often what has happened will be a verbal argument between the parties present and Communications staff will have assessed the level of the incident before tasking to officers, but it will not always be obvious what situation officers will find as they respond. The nature of DA incidents is often such that they are high in volume but low in risk. From a policing perspective it is important that these incidents are not being minimised and should be being recorded as crimes. A wide range of aspects of each case were reviewed looking at initial response, officer actions, reviews done and what referrals were made.

The **Crimes Review** looked at 373 cases, by three reviewers. A DA crime is any crime that is tagged as DA in some way, so the types of crime can be DA specific such as coercive control, or other crime types such as assault, harassment or criminal damage. DA crimes make up around 16.5% of total recorded crime. Many DA crimes involve repeat victims and offenders, but often the victim does not want to make a complaint. The fear that victims feel, even if violence is not being used, means that the use of the DASH risk assessment tool is fundamental to the onward help and support these victims can be given. The aim with this review was to try and reach a statistically significant sample of incidents and crimes being reviewed to ensure confidence in the findings reported. This review looked at a much narrower set of criteria concentrating on completion of the OEL template, DASH, the presence of BWV and how children are recorded.

All of the cases reviewed for all three reports were samples taken from November 2019.

Although these three reviews were conducted differently and considered different criteria they all found similar themes in terms of the learning and recommendations that are summarised in this report.

3. Review Findings

3.1 First Point of Contact & Attendance

The DA Incidents review included questions around professional curiosity and it has shown that call handlers are well trained and asking appropriate questions to be able to inform officers accordingly with what they can expect to find. They are also providing a lot of detail for officers about the background and offending history of the parties involved. These covered timelines of events, details of all involved parties, medical information including any mental health issues known for either party, or whether weapons might be involved.

There were several cases where the caller rang 999 but hung up after the call was connected, or after speaking briefly to the Call Handler. These cases then require work to be done to trace the call and re-call the person who rang. Although this does not happen in a lot of cases, when it does need to be done it is important that the caller is traced and responded to, to ensure their safety in an unknown situation.

Attendance at DA Incidents is strong with them being attended in 85% of calls regardless the source of the call.

3.2 DASH

Of the occurrences reviewed DASH completion at the start of an investigation was on average at 78%, and the gatekeeping role of LSU was highlighted as good practice. The LSU will review the DASH and background of each case and are able to increase or decrease the risk level on the DASH according to their findings. This ensures a level of consistency – and also will bring in other information that may impact on the risk level of the victim.

The reviews found there was an inconsistency in the quality of the DASH forms completed by officers. Of the DASHs reviewed 45% were deemed by the reviewers to have been completed very well or well (see DA Crimes Assurance Report for full details). This indicates that while compliance is high for DA cases having a DASH completed, they are only being well completed, and therefore adding value in 45% of those cases. It is thought that a general lack of understanding of the importance and value of the information recorded in the DASH is leading to it being added for compliance only in many cases.

Officers need to be completing the DASH in more detail to ensure that the rating given and comments they add have a real impact on the onward processing of the victims in these cases. There can be a direct impact on a victim where the DASH is marked as high risk as they will be helped and supported as a priority. If they are incorrectly rated then the Victim and Witness Care Officers have to spend time correcting this mistake before they can progress with supporting and safeguarding the victim.

The PPN/DASH on Niche has fields for recording more detail that they are used for, including children, their school and the GP. If these fields were completed fully it would improve the efficiency of VWCOs and save them effort searching through the Niche.

There therefore needs to be more work done to raise awareness with officers of the purpose of the DASH as a decision making tool, and how to use it correctly. They also need to be aware of is issues caused by not doing this fully and correctly; and how that impacts on decision making, and the victim getting the right support and services. It is accepted that there is little in the way of guidance available to officers and there is already work underway to address this gap.

Recommendation 1 *– to carry put a comprehensive refresh of the DASH and to provide officers with further guidance on how to complete an effective and high quality risk assessment. This must increase officer understanding of how to use the DASH to aid decision making. This work also needs to include ensuring officers understand the need for quality information when completing the DASH - and that they are not needed simply for compliance.*

3.3 BRAG

BRAG formed part of the High Risk Victims Review and the DA Incidents review, but not the DA Crimes. As with DASH the completion of the BRAG form was inconsistent, with the reviews findings that BRAG was completed in 54% High Risk Victims cases and 32% DA Incidents (in the opinion of the reviewer should, have had a BRAG form completed). There appears to be a lack of awareness of when BRAG should be being used; or it is being used but not being correctly filled out. This is worsened by apparent confusion over when BRAG should be used alongside DASH.

BRAG is required to highlight any vulnerabilities, although there does not need to be a DASH and a BRAG for a domestic abuse victim. If the victim and perpetrator are the only parties involved and affected by the incident then just a DASH for the victim will suffice; if there are any other parties involved, including children (even if they did not see the incident), then a BRAG is also required. A BRAG should also be completed if the perpetrator is vulnerable.

There is already guidance available covering the BRAG on Pocketbook, but officers at the point of the reviews were struggling to use BRAG correctly. In response to this the LSU have circulated additional guidance in the form of a flow chart – and asked for refresher briefings by supervisors with their staff. This will need to be followed up to identify if this has resulted in any sustained improvement and consideration be given if further work is required. This could link in with any work being done refreshing the DASH and a single message covering both communicated. Further assurance work is planned which will focus specifically on the use of BRAG for some other vulnerability themes so this may draw out additional learning in this area.

3.4 OEL Templates

The Niche initial investigation template reflects the building blocks of an investigation and it was developed as best practice. It gives officers structured start to an investigation. As such, each DA Crime occurrence was examined to see if an OEL Initial Occurrence Template was used as a sign of best practice.

It was evident that the template is rarely used in full as it is generic, and lengthy; and not all parts will be relevant to all investigations. Therefore, the question asked was whether or not it had been ‘well completed’ or ‘partially completed’, rather than ‘fully’ or ‘very well’.

The initial OEL Template is completed well or very well in 72% of DA crimes. An equally good, detailed report of another sort has been identified in a further 10% of cases, so a total of 82% have a good foundation for investigations to move forward from. It was, however, identified that the question referring to DA is at the very bottom of the template and could benefit from being moved further up to give it a higher likelihood of being seen by officers and therefore completed.

The reviewers observed that while it is often well used it is rarely fully completed, with the second half of it a lot less likely to be completed that the first. This could be because the fields are not mandatory and officers completing this at the scene or within an hour of attending will be less likely to complete anything non-mandatory. The non-completion of non-mandatory fields does not necessarily mean that the template is of poor quality.

At the very end of the template is a question regarding reviewing previous DA incidents and the review found that very few of the templates had this question answered – it is suggested that this is more likely due to its position on the template and that this is simply missed by officers.

While the OEL template covers all crimes, not just DA, the reviews show the value it can add to investigations. A few small changes to this template could improve the recording for DA and help with the onward processing of the case. A review of this template could be done in conjunction with all other stakeholders to ensure that the template is providing the maximum benefit for all users of it and avoid any unintended consequences. It currently has many fields and the review has shown that very often it is only around half completed as a lot of fields are non-mandatory and do not relate to the type of case or investigation.

The importance of using this template could be reiterated with officers as it is very simple for them to use and by completing even just the mandatory fields provides a solid basis for the investigation. Again, if the officer completing it understands how it is used by colleagues down the line it may help them to focus on providing quality information.

3.5 Body Worn Video (BWV)

While BWV may be widely used by officers responding to DA incidents and crimes, it is very difficult to understand the true picture. Anecdotally most officers will say that they would always have their BWV on when they attend a DA incident/crime report, the only record of that will be if it is marked as evidential following uploading onto DEMS. What is not clear is the cases where is has not been used and if it had it would have been useful to the investigation. Ultimately all that can be done is ensure that officers know what they should be doing and that they are being supervised so that if issues should arise, they are being dealt with.

Recommendation 2 *– There needs to be a review and refresh of all tools that are available that have been developed to aid positive action from officers when dealing with DA. This includes consistent and comprehensive completion of the OEL template (which may require a review) and BRAG; and widespread use and retention of Body Worn Video to enable Supervisors and Inspectors to decide on further action. This also includes work on ensuring that Supervisors and Inspectors understand their role in taking positive action in cases, for example encouraging the use of DVPN's, evidence led prosecutions; and how this links to the use of Body Worn Video. Following these reviews and any work undertaken to refresh there may be a requirement to develop some training or briefing to communicate it to officers.*

3.6 Children (including Op Encompass)

Very few children were found to be included within the PPN/DASH. Usually only two people are added; victim and suspect or involved party. As such children are rarely added, even when they are present and involved, the requirement for their inclusion on the PPN/DASH is not obvious from the point of view of a front line officer. There are only 17 crimes where it was observed that linked children were included within the PPN/DASH. It was not assessed statistically, but it was also noted that in several cases, children were not only not included in the PPN/DASH but also not linked to the occurrence despite being mentioned or referred to which is a bigger issue.

There needs to be a debate on whether the details of children should be included on the PPN/DASH if they are already on the Niche and linked correctly. On the one hand this is a duplication of inputting, but on the other it might allow us to engage better with schools and Operation Encompass if we were to have these details correct on the DASH.

Operation Encompass is seen as best practice recognised by HMICFRS. The way we currently engage with Op Encompass is indirectly by sharing information the required details with Local

Authorities rather than schools directly. This is currently seen as the best solution in Avon and Somerset, and many other forces have also struggled with how best to provide the information required directly to the schools.

3.7 Support for Victims

LSU are able to effectively prioritise DA cases through a triage process and therefore contact can be made with these victims promptly to get them the help and support they need. Further work is already ongoing to try and reduce the number of duplicate and unnecessary tasks sent to LSU which can get in the way of this prioritisation.

Referral to an IDVA is being made in every appropriate case so these victims are being offered support. 82% cases were also referred to the MARAC triage process showing good multi-agency communication and cooperation.

3.8 Inter-Directorate Working

There is a lot of good work going on within the individual directorates, but there could be improvements made in how the directorates work together. An improved understanding of the information that LSU require and the mechanism for getting that information to them would probably improve what is received from Response. If there is an understanding of why particular information is required and the consequences of not having it are understood it might help officers to improve. There could also be greater joined up working between Response and Neighbourhoods.

Recommendation 3 *– Further assurance and understanding is needed to determine the effectiveness of the options available to help deal with DA cases and those involved in them. This includes MARAC and DVPNs amongst other things. Further work is also required to ensure that we are dealing with children in an effective and timely manner through the adoption of Operation Encompass, either in its true format or some other more workable solution.*

4. Lessons Learned relating to methodology and approach

This was one of the first times a piece of assurance has been carried out on this scale within the new Assurance and Audit Framework under the Performance and Quality Framework. The parameters of the whole piece of assurance work were set initially by the Domestic Abuse Theme Lead but were refined in his absence. Further refinement happened throughout, due to the size and scope of the work, and the situation around lockdown and home working. There was a period where all work on assurance stopped for a while so some time was lost. This may have resulted in a slight shift of focus as the reviewer's uncovered issues with what they found, but the overall product gives a rounded view of how domestic abuse is being dealt with. In the future it is important that the terms of the review be agreed between all stakeholders so that expectations are set accordingly.

This was the first large scale piece of assurance including the Inspection and Evidence Based Policing Team and the commencement coincided with the Covid lockdown and all those involved starting to work from home. Initially at this point all assurance work was suspended while demand was assessed due to the lockdown, and it took 3-4 weeks for this to then recommence. Working from home meant that is was more difficult to have the constant consultation that would have been beneficial completing this work.

The three areas of review were conducted differently; the high risk victim review looked only at 50 cases and was completed by a single person; the incidents review looked at 235 cases and the crimes at 373. The aim was to try and reach a statistically significant sample of incidents and crimes being reviewed so we can have confidence in the findings reported. The incidents were reviewed by seven reviewers although some of them only looked at a handful of cases,

while the crimes review used only three reviewers. One reviewer reviewed over half of the crimes which has led to greater consistency in the reporting and findings of the dip sample. In order to reach the number of reviews required for a statistically significant sample within the timeframe the question set was limited and it focussed in on the DASH completion including whether it has been well completed or if it appears to have been done just for compliance, presence of BWV and use of the initial OEL template.

High Risk Victims

The review looked at a wide range of questions but having been completed by a single person there is a very consistent view of the cases provided. The review covers the basics of officer actions and then the referral process into LSU, and then in greater detail what the LSU do and how the process the case. Having a smaller sample size means there is no statistical significance to the review, however, the review did include 50 records which is a big enough sample to give some insight. There are some valuable lessons that can be learned from this review even if there is not the statistical significance to back them up.

Incidents

A small team of police officers was used and a pre-defined list of questions prepared but there are some obvious differences in the reviews done and to focus they have had. For example one of the reviewers has picked up the lack of templates used by officers while other reviewers have not mentioned this. In the future it would be beneficial to go through the list of questions with the reviewers after each has had the opportunity to do a few reviews so that these discrepancies in what is being noted can be discussed. This review was started just as the Covid lockdown began and this early catch up phase was not possible due to the deployment of staff to work from home. Also additional reviewers were added to the group once it had begun which has led to a lack of continuity.

This has been somewhat addressed in the reviewing of the DA crimes for that piece of assurance work. A smaller group of officers have worked on that piece of assurance and have worked more closely to identify where there may be differences in what is being recorded to try and minimise that.

Crimes

Initially a larger question set was considered for the crimes review as well, which would have covered a greater range of areas for review but the depth of review that was wanted for this assurance would not have been possible so the Theme Support and members of the Inspection and Evidence Base Policing Team undertaking the review agreed what the in depth review would include. In the future, if possible, the Theme Lead (or original requester of the work) should be involved in any ongoing discussions about the scope of the review to ensure it is covering the initial terms set of the review.

The use of a statistically significant sample size is something that needs to be considered when commissioning assurance work like this. In order to attain a 95% confidence level in the results being seen it was determined that 370 cases needed to be reviewed given the number of cases available to review. Also taken into account were the time of year given the known seasonal trends of DA criminality, and the desire to see cases that had in the majority been resolved one way or another, thus November 2019 was the month selected to review.

In retrospect there are several areas that if included, would have added further weight and value to the review.