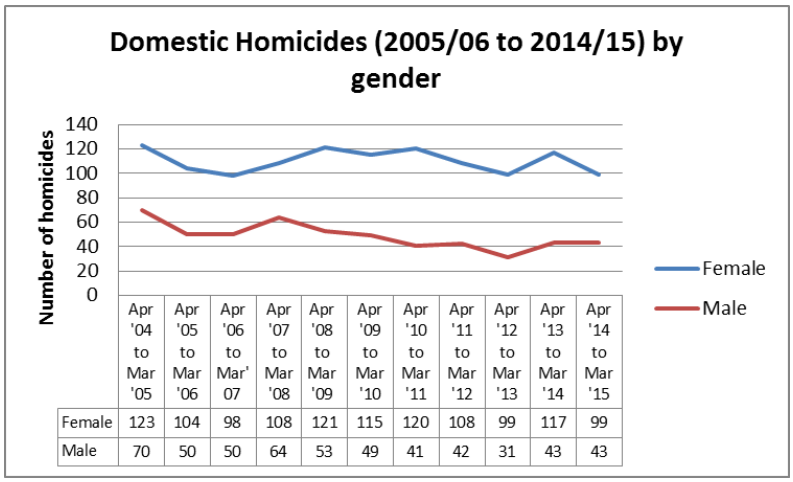
Section 5 Domestic Abuse Homicides

The Local guide to Domestic Homicide Review Guidance provides the following definition:-

> *'A domestic homicide is when someone has died as a result of domestic violence. This can include murder or manslaughter, causing death by neglect, and can include suicides in some circumstances. Very often a domestic homicide will have been preceded by a history of domestic abuse – physical, psychological, sexual, financial and/or emotional abuse involving partners, ex-partners, other relatives or household members. However this is not always the case'.*

The CSEW 2015[1] monitors the number of deaths and the relationship of the perpetrator to the victim. The table below shows the number of domestic abuse deaths (the perpetrator was the current or ex-partner, parent, son or daughter, other family member) for the last ten years, by the gender of the victim.

- In 2014/15 there were a total of 142 deaths where the perpetrator was a relation of the victim.
- The 142 is within the range of 168 to 130 DA deaths per annum but lower than the average of 158 observed over the last ten years.



	Apr '04 to Mar '05	Apr '05 to Mar '06	Apr '06 to Mar' 07	Apr '07 to Mar '08	Apr '08 to Mar '09	Apr '09 to Mar '10	Apr '10 to Mar '11	Apr '11 to Mar '12	Apr '12 to Mar '13	Apr '13 to Mar '14	Apr '14 to Mar '15
Female	123	104	98	108	121	115	120	108	99	117	99
Male	70	50	50	64	53	49	41	42	31	43	43

- 100 or 69% of the 143 DA victims were killed by their current or ex-partner.
- A higher proportion of females (82% or 81 victims) were killed by their current or ex-partner than male victims (44% or 19 victims).
- 25 of the victims were killed by a parent

On average there are two victims of domestic homicides per week in England and Wales. These victims have been killed by their current or an ex-partner.

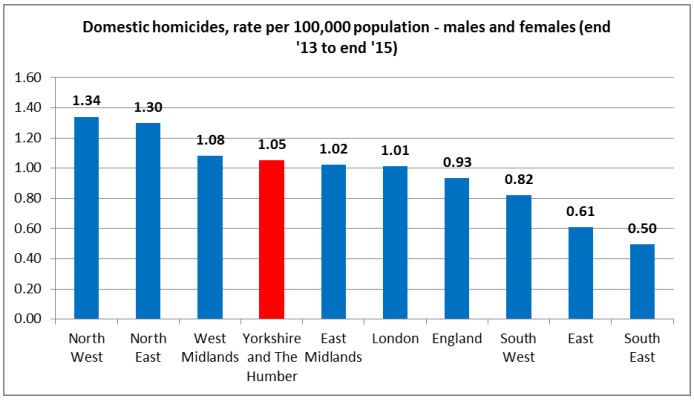
Total National Domestic homicides recorded by the police – April 2012 to March 2015
The ONS data tool[2] reveals that in the three years between April 2012 to March 2015 there have been 432 domestic homicides (315 female victims and 117 male victims), a ratio of 0.93 per 100,000 populations.

1 http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2015/chapter2homicide

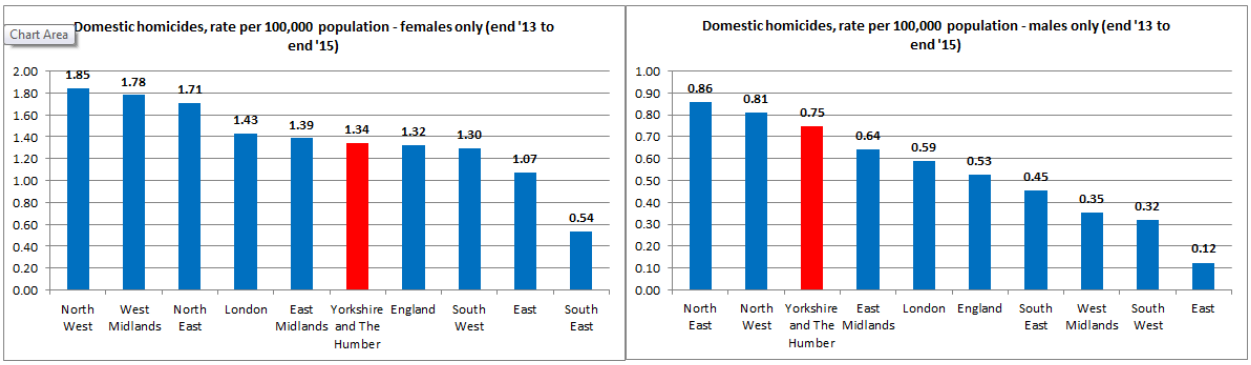
2 The Domestic Abuse Office of National Statistics Data Tool was published on 8th December 2016 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseinenglandandwalesdatatool

In South Yorkshire there have been **16 domestic homicides** recorded by South Yorkshire Police in the same time period (12 female and 4 male). In comparison West Yorkshire has had 19 (13 female/6 male), Northumbria 21 (13 female/8 male), Nottinghamshire 15 (7 females/8 males).

Ratios provide further in-sight; the Yorkshire and Humber region has a domestic homicide ratio of 1.05 per 100,000 populations, which is very similar to the England rate (0.93).



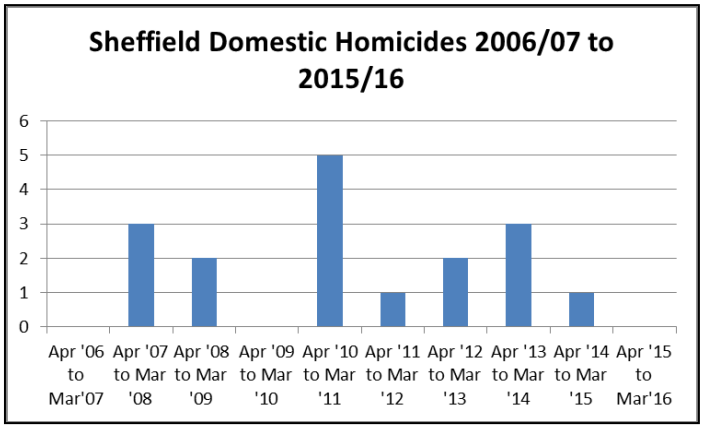
When split by males and females, Yorkshire & Humber is similar to the England rate for females (1.34 compared to 1.32 per 100,000 populations) but appears higher for males (0.75 compared to 0.53 per 100,000 populations).



Sheffield Domestic Homicides

In the last ten financial years (2006/07 to 2015/16[3]) there have been a total of 17 domestic homicides in Sheffield. This averages at around two per year (1.7) however in three of these years there were no homicides and in one year there were five. In the most recent year 2016/17 (and not shown on the graph) there has been one death year to date.

[3] Police data, provided by Karen Jackson for 2006/07 to 2012/13 and taken from the DHR reports for 2014/15 onwards https://www.sheffieldfirst.com/the-partnership/safer-and-sustainable-communities/key-documents.html .



Sheffield is part of a Core Cities group for Domestic abuse. Liverpool in August 2015[4] completed a piece of work on DHRs within Core cities, and asked the Core cities to provide their domestic homicide per 100,000 population ratio. The table below has been created and shows that Sheffield with a ratio of 0.31 per 100,000 populations is at the lower end of the ratios.

CSP Area	Average deaths per year 2011/12 to 2014/15	Population Size	Domestic Homicide per 100k Population
Liverpool	2.66	469,700	0.56
Bristol	2.3	432,500	0.54
Leeds	4	751,500	0.53
Birmingham	5.33	1,129,167	0.47
Nottingham	1.3	305,700	0.44
Manchester	2	503,127	0.40
Sheffield	*1.75*	560,085	0.31
Average of the core cities	16.68	4,151,779	0.40

The ratios observed by the Core cities had a range of 0.31 to 0.56 per 100,000 populations and an average of 0.40 per 100,000 populations.

Domestic Homicide Reviews

There is a statutory requirement to carry out Domestic Homicide Reviews (DHR), under Section 9 of the Domestic Violence, Crime and Victims Act (2009)[5]. The recent DHR review report (2016) explains that DHRs should be completed on homicides where *'when the death of a person aged 16 of over has or appears to have resulted from violence, abuse of neglect'*. The definition means that DHRs should be completed on all murder, manslaughter and infanticide abuse deaths and also victims of apparent suicide where circumstances may mean the victim has been abused.

The DHR process was introduced on 13th April 2011 and the current national guidance *'Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* was updated and applicable to all cases that happened on or after the 1st August 2013.

The aim of a DHR is as follows *'to review 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 learnt from the death'*[6].

[4] Jenny Ewels, Head of Safer and Stronger Communities, Liverpool City Council
[5] Multi-agency statutory guidance for the conduct of domestic homicides reviews, Home Office, page 3
[6] Ibid page 6

The key issues / themes identified in DHRs Nationally

Demographics and key factors

Data has been taken from the CSEW 2015[7] (423 domestic homicides observed over the three year period from March 2013 to March 2015).

- The average age of the victims was 46 years old but the ages range from 16 to over 70 years old.
- The relationship to the suspect was 70% partner or ex-partner, 17% parent, 12 son / daughter and 10% other family member.
- 78% of victims were white British, 7% were Black, 11 Asian (Indian subcontinent) and 11 other and 4% unknown / not recorded.
- 49% were killed by a sharp instrument, 11% blunt instrument, 18% were strangled / asphyxiation and 8% were hit, kicked etc.
- The gender of the suspect was male in 89% of domestic homicides and 11% were female.

Additional demographical and key factor information is available from the most recent DHR key findings report, 2016[8] which adds to the findings of the CSEW.

- The victim was killed in the house or dwelling in 87% of all the 137 homicides in 2014/15[9].
- Around one half of suspects were aged 30 to 50 years old (2014/15 data)[10].

The Home Office[11][12] 2016 report *'DHRs: KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS'*

This is an update of the 2013 report *'Common Themes Identified as Lessons to be Learned'*. The aim was to review key themes identified in homicide cases and highlight where agency working *'could have been improved'*.

In the 40 cases reviewed the demographics were as follows:-

- 29 of the 33 intimate partner homicides had a male perpetrator
- The most frequent age category for perpetrators was 51 to 60 years old (8 of 33)
- **Dependent children** - In 15 of the 33 cases analysed (45%) where the homicide had an intimate partner victim there were **dependent children** and in 11 of these 15 cases the victim and the suspect were the parents of the children. 12 of the cases had children who were affected by *'any abuse, violence or the homicide itself'.*

Perpetrator and History of violence – The majority (24 of the 33 cases) of the cases where the homicide had an intimate partner victim had a perpetrator who had a history of violent behaviour (12 agencies had recent knowledge, 5 had historic knowledge and there were 7 cases where no agencies were aware of the current or historic violent behaviour).

  - 13 of the 24 perpetrators with a history of violence this was violence to the victim alone
  - 9 had a history of being violent towards others
  - 7 had a history of being violent towards women specifically
  - 6 had had a history of general criminality

Victim violence towards the perpetrator – this was present in 6 cases, 4 were female victims and 2 male victims. Analysis of this data was limited due to the small sample size (e.g. not clear if the violence was two way, self-defence).

[7] CSEW 2015 Appendix table 2.10: Characteristics of domestic and other homicides for victims aged 16 and over, combined data for year ending March 2013 to year ending March 20151,2,3

[8] https://www.gov.uk/government/publications/domestic-homicide-review-lessons-learned

[9] Ibid

[10] Ibid

[11] The Home Office, *DHRs: KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS'* https://www.gov.uk/government/publications/domestic-homicide-review-lessons-learned#history December 2016

[12] The latest report analysed a sample of 40 DHRs that occurred between January 2013 and March 2016. Using coding applied to each case, key areas of commonality between cases histories were identified and common underlying issues were identified.

Mental health and substance misuse can be aggravating factors[13] in violent behaviour. The 2016 review found that:-

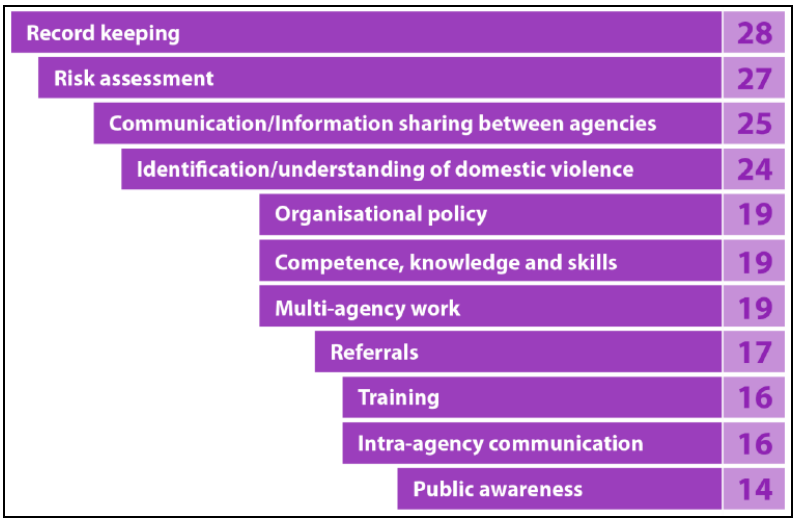
- **Mental Health** - The majority (75% of 25 - of the 33 cases where the homicide had an intimate partner victim), had **mental health issues present**.
    - In most of the cases the mental health as an issue was present for the perpetrator (21 of 25 cases), in 10 cases it was present for the victim and in 6 cases mental health issues affected both the victim and the perpetrator.
    - Where mental health was present as an issue, depression was the overriding main mental health condition for both groups (52% perpetrators and 90% female victims).
    - The majority of perpetrators (16 of 21) and all 10 female victims with mental health issues were known to mental health services.
- **Substance misuse** was present in half (20 of 40) of the DHRS analysed.

Nine DHRs mentioned substance use by the perpetrator only, two by the victim only and nine by both the perpetrator and victim

    - Alcohol was present in 16 of the 40 cases, 4 included drug issues and 6 included both alcohol and drugs.
    - Health services knew of the substance misuse as being problematic in 13 of the 20 cases.
- **Both Substance misuse and mental health (known as dual diagnosis**) was present in perpetrators in 12 of the 40 cases and for 7 of the 40 victims.

DHR Key common themes on improvements required by all agencies working with the perpetrator and victims

Figure 1 below shows the most frequent issues raised in the DHR analysis.



Details of the issues identified and recommendations made are as follows:-

Issue identified	Agency improvement/ best practice required
Poor record keeping	• Accurate recording keeping • Good quality records • Safe storage of records
Poor quality or no Risk assessment undertaken	• Complete a DASH risk assessment when required. • Good quality risk assessment undertaken • All parties should complete a DASH and not rely or assume another service has completed one. • Accurate risk rating following risk assessment

[13] https://www.gov.uk/government/publications/domestic-homicide-review-lessons-learned, page 10, point 33.

	• A DASH assessment should include previous knowledge of abuse within the service (e.g. not assessed just on the current incident. Where known, detail other incidents).
Poor identification or understanding of domestic violence and abuse	• Explore all (physical and non-physical) signs of domestic abuse with the victim and work towards disclosure of the domestic abuse. • Identify vulnerabilities (pregnancy, social services involvement etc). • Use of routine enquiry or follow up following initial investigations • Understand violence can affect all genders and those aged 16 plus.
Poor communication and or information sharing between agencies	• Note the reason for sharing or not sharing the information • Have good quality data, reports and information to share • Agencies have good practice and information sharing protocols on when to share, to whom and how to share information for workers to use. • Workers use and follow the information sharing polices in place
Poor communication and or information sharing within an agency	• Records and information should be accurate at the time the case is presented to MARAC to ensure the representative knows the current status of the case within their own agency. • Effective communication between workers, working on the same case and between workers and managerial staff • Effective communication between different health providers, different departments and teams in the same agency
Poor multi-agency practices and lack of MARAC involvement (only 10% known to MARAC)	• Linked to information sharing. • MARAC – referrals made, agency invited to MARAC, agency attends MARAC, agency knows the case is subject to MARAC, agency knows local MARAC structure process. • Cross border services work with each other, share information • Safeguarding procedures undertaken
No organisational domestic abuse protocol in place or poor understanding of the protocol	• Organisational domestic abuse protocol in place • Staff aware, understand and use the organisational domestic abuse protocol
Individual practitioner failings	• Workers trained in, aware of and follow organisational practice and procedures on domestic abuse. • Workers take action on information received e.g. contact safeguarding. • Workers complete quality risk assessment (explore issue with victim, discuss children, explore incident and history).
Referrals between agencies	• Referrals to MARAC, specialist domestic abuse service, safeguarding and health services to be made when required. • Referrals actioned by the receiving agency • Referrals made correctly and appropriately
Training	• Health services (GPs) receive domestic abuse training • All police staff to receive DASH training • Work forces prioritise adult safeguarding • Trained workers receive the domestic abuse cases before those yet to be trained.
Friends, relatives and others knew the abuse was happening but did not know how to act.	• Increase awareness of the general public and local community based services of domestic abuse and how to respond when hearing about an incident of domestic abuse.
Perpetrator and victim lack of engagement in agencies	• Explore how to remove barriers to:- ○ victim engagement with support services (particularly police and domestic abuse support services) ○ perpetrator engagement with mental health and substance misuse services

Training was the most frequent recommendation made in all the action plans and health services, community safety partnerships and police services had the most recommendations, which is unsurprising given that most victims and perpetrators will be in contact with these services.

The Sheffield approach to DHRs

The Sheffield Domestic Abuse strategy (2014-2017) includes DHRs. The focus is as follows: - to have a process that is *'underpinned by good governance and accountability'*. It will *'ensure systems are in place to conduct good quality DHRs and Serious Incident Reviews when necessary and overseeing implementation of DHR action plans and dissemination of learning'.*

A local Sheffield guidance document *'Sheffield Safer and Sustainable Communities Partnership - Domestic Homicide Review Guidance'* was written in accordance with the DHR guidelines and has been used locally on DHRs since 2011. It was reviewed in line with the national changes to the DHR guidance in March 2014[14]. The National Guidance has now been updated; therefore there will be a need to review the local guidance again. .

Action – Review the local DHR guidance in line with the updated national guidance and following each local DHR (as per the national guidance).

Experience has found that DHRs are thorough, time consuming, have strict deadlines and often involve a considerable number of stakeholders. The outcome of the DHR is a full report with a comprehensive action plan and Learning Brief, all which are submitted to and signed off by the national DHR board. The Action Plan is subsequently monitored quarterly by the DHR / SIR sub group of the DA SA Strategic Board.

Each DHR takes six months from start to finish. The workload is variable because sometimes there are two ongoing concurrently and sometimes there are none. Therefore the work often fluctuates and often overlaps with Serious Incidents reviews (which follows the Council SIR process, with each known incident reviewed in line with the SIR criteria to determine whether it fits with the SIR process). This is likely to continue, given the average of two deaths from domestic abuse over the past five years. **There is a continued need for all stakeholders, including DACT to respond within set timeframes and for all stakeholders to add work on DHRs in their work plans.**

A review of the Sheffield DHRs

Between April 2011 and November 2016 there were eight deaths relating to domestic abuse in Sheffield (one, Adult B, was a potential suicide but treated as a DHR as the cause of death was unknown). All eight have followed the required DHR process and either has had or is in the process of having a Domestic Homicide Review undertaken.

The overview reports, the report summaries and lessons learned reports on the Sheffield DHRs published can be found at the following link https://www.sheffieldfirst.com/the-partnership/safer-and-sustainable-communities/key-documents.html. The lessons learned reports are also available at these reports provide a detailed http://sheffielddact.org.uk/domestic-abuse/resources/domestic-homicide-reviews/.

The cases summarises

- All victims have been female.
- The age of the victims has ranged from 18 to 93 years old.
- All victims were killed in their own home, with the exception of one case

[14] *Sheffield Safer and Sustainable Communities Partnership - Domestic Homicide Review Guidance* http://sheffielddact.org.uk/domestic-abuse/?s=DHR

- The majority were killed by a current or ex-partner/ husband but two were killed by their adult son or daughter (the two elder victims).
- Five of the eight DHRs involved BME families and three were White British families.
- The victims were not all in contact with specialist domestic abuse support services.

The DHRs have revealed that a considerable number of stakeholders and organisations are working with victims, perpetrators and the wider family unit. This includes the GP, the police, social care, mental health services, commissioners, housing services, colleges, schools,

Together the DHRs have recommended a total of 286 actions, and 284 have been completed. On average it takes between a year and 18 months following the completion of the report for all the actions to be completed, however the majority are completed within the first six to nine months. Action completion is extremely encouraging as it shows that all issues identified in each DHR have been addressed. Considerable work has been undertaken across Sheffield in a multitude of services that are in contact with a considerable number of victims and perpetrators the services to improve their response when working with those affected by domestic abuse. The two actions outstanding on DHR H are being worked upon and will be finished in the near future.

The 286 actions are not all unique, indeed a number are repeated and contained within each DHR action plan, (for example reminding workers of the domestic abuse pathway) thus showing that often there is a constant need for workers to continue to keep domestic abuse at the forefront of their minds.

Sheffield key themes are very similar to those identified nationally, they are as follows:-

- **Domestic abuse Awareness, risk assessment and training for professionals – also on the national list.**
  The actions are all around reminding workers of the domestic abuse pathways, the need for risk assessment, the legal remedies, safeguarding and their role when working with those affected by domestic abuse. This action was contained in most of the DHR action lists, often a few times for a number of different services e.g. (a range of health workers, social workers, housing, police, probation etc.)
- **The internal review of all DA and safeguarding policies within each workforce sector involved in a DHR** (e.g. ensure all local protocols include domestic abuse, protocols are updated after each DHR, protocols are communicated via team meetings and available to all workers to access).
- **Risk assessments** – expanding the process beyond the immediate domestic abuse situation and considering the wider and more complex issues, e.g. mental health, drugs, alcohol, cultural issues, the background of the victim and the wider support needs of family members, carers and children.
- **Accurate record keeping on DA and SA** and **encouraging the use of flagging/ coding on all case management systems** within all services. This ensures that the work undertaken with those affected is recorded for future reference and that those affected by abuse are easily identifiable when accessing the service.
- **Information Sharing** – including reminding workers of their role in sharing information, what information can be and should be shared, review of local information sharing protocols, understanding about gaining consent.
- **Discharge / exiting those affected by domestic abuse from the service** – relevant for all services in contact with those affected - safety plans, factoring in victims who are returning to live with the perpetrator.
- **Review and promotion of the sexual abuse processes, training and pathways**
- **Reviewing and raising awareness to workers of the wider processes and protocols** – e.g. alcohol screening tools and referral system
- **Working with those 'hidden' victims and those who are difficult to engage** e.g. young people, complex needs
- **Clinical supervision and audit of the domestic abuse response within the services**

Suicide and Domestic Abuse

Research shows Domestic violence commonly results in self-harm and attempted suicide:-

- Inner city abused women were found to be five times more likely to attempt suicide compared with those women who are not victims of domestic abuse (Stark and Flitcraft, 1996 & Mullender, 1996).
- One third of all female suicide attempts can be attributed to current or past experience of domestic violence. (Stark and Flitcraft, 1996 & Mullender, 1996)[15].
- Walby (2004) reported that *'500 women who have suffered domestic violence in the last six months commit suicide every year'*, and suggests that just under 200 of these individuals attended hospital for domestic violence on the day they committed suicide[1617]. Based on this data, it is estimated that nationally around 10 victims per week are likely to commit suicide who have suffered domestic abuse in the last six months.
- SafeLives research using the MARAC dataset of high risk victims revealed '*16% of victims report(ed) that they have considered or attempted suicide as a result of the abuse*[18]. Based on the local MARAC data in Sheffield, this would mean that of the 762 victims in cases presented to MARAC in 2015/16 then around 121 victims may have contemplated or attempted suicide.

In 2014 there were a total of 51 individuals who had been residing in Sheffield where their death registered as suicide[19]. Additional information reveals that 75%[20] of all suicide victims are male in South Yorkshire. Therefore applying this percentage to the 51 individuals, then around 12 of the suicides could have been female and one third (or four victims) may have had a history or current experience of domestic abuse.

Serious Incidents Reviews

Two Serious Incident Reviews have been undertaken in Sheffield on victims of domestic abuse in Sheffield and a third is underway. An SIR is defined as a 'near miss'. SIRs are completed in line with the local guidance and the Sheffield City Council policy.

[15] Report on *Statistics: Domestic Violence*, Women's Aid http://www.womensaid.org.uk/
[16] *Commissioning services for women and children who experience violence or abuse – a guide for health commissioners* NICE Gateway ref: 15911. February 2011
[17] Walby, S. and Allen, J. (2004), Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office.
[18] SafeLives (2015), *Insights IDVA National Dataset 2013-14*. Bristol: SafeLives.
[19] *Suicide rates and median registration delays, by local authority, England and Wales, deaths registered between 2002-2014*, Table 2. https://www.ons.gov.uk/
[20] *Suicide in the England and Wales*, 2015 Registrations, Table 4 https://www.ons.gov.uk/