Home Office

Domestic Homicide Reviews

KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS

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1 Introduction

1. A Domestic Homicide Review (DHR) is a multi-agency 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 person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. Since 13 April 2011 there has been a statutory requirement for local areas to conduct a DHR following a domestic homicide that meets the criteria.

2. Since April 2011, in excess of 400 DHRs have been completed. DHRs provide a rich source of information on the nature of domestic homicide, the context in which it occurs and, most importantly, in the lessons that can be learned from the tragic event. This analysis sets out what we know about domestic homicide and draws out common themes and trends and identifies learning that emerged across the sample of DHRs.

3. The purpose of this analysis is to promote key learning and trends from the sample of DHRs with the aim of informing and shaping future policy development and operational practice both locally and nationally.

4. We encourage local areas to reflect on the learning identified and to consider how this can be used to deliver improvements to practice within their local context furthering their ability to safeguard victims and prevent domestic homicide.

5. This paper also reports on what is being done nationally to tackle these issues.

2 Key Findings

Statistics

General

- In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over.
- Although the number of both male and female domestic homicide victims fluctuated from year to year, there is a clear downward trend.
- Among women, the majority of domestic homicide victims were killed by a partner / ex-partner.
- Among both men and women the highest proportion of domestic homicides was among those aged 30 to 50 (around two-fifths).
- The most common method of killing for both male and female domestic homicide victims was by a knife or other sharp instrument.
- The majority of principal suspects in domestic homicide cases were male (87% for combined years 2010/11 to 2014/15) and nearly one half were aged between 30 and 50 years old.

Intimate Partner Homicide

- Of the 33 intimate partner homicides considered as part of this analysis, just under half (15 cases) included dependent children in the family structure.
- Mental health issues were present in 25 of the 33 intimate partner homicides.
- In just over half of all DHRs (21), substance use was mentioned.
- In 24 of the 33 intimate partner homicides, the perpetrator had a history of violence.
- In six cases the victim had a history of violence towards the perpetrator.

Familial Homicide

- Of the 40 cases analysed, seven were familial homicides.
- All involved a male perpetrator who committed the homicide.
- Six of these cases involved the son killing a parent; in one case it was the father.
- Mental health issues were factors in all seven cases.
- Substance use by the perpetrator was also noted in all but one familial homicide cases.

Main Findings

- The most common theme occurring in intimate partner homicide DHRs was record keeping. This was highlighted as an issue in 28 out of 33 (85%) intimate partner homicide DHRs sampled.
- Risk assessment was the next most commonly occurring theme with 27 out of 33 DHRs (82%) highlighting this as an issue.
- Communication and information sharing between agencies was identified as an issue in 25 out of 33 (76%) DHRs sampled.
- There were 24 cases (73% of those sampled) where victims or perpetrators presented to agencies with possible signs of domestic abuse and/or domestic violence but this was not recognised or explored further.
- Across the four years in which the DHRs in this sample were analysed, there were a total of 600 recommendations made by these DHRs.
- Although recommendations made to each agency will have been affected by the exact circumstances surrounding each DHR and the way in which recommendations were captured in DHRs, Community Safety Partnerships (CSP) and health bodies were identified as having the highest proportion of recommendations (both around a quarter of all recommendations) across the four years.
- In 2013, agencies receiving the largest proportion of recommendations were in the health sector, in both 2014 and 2015 this was the CSP and in 2016 the highest proportion of recommendations was for the police.
- Across all four years, training was consistently the highest proportion of recommendations.

3 Homicide Index: What we know about domestic homicide

6. Data presented here have been extracted from the Home Office Homicide Index, which contains detailed information about each homicide recorded by police in England and Wales. It is continually updated with revised information from the police and the courts.

7. The term 'homicide' covers the offences of murder, manslaughter and infanticide. However, it should be noted that the threshold for conducting a DHR is lower than the criminal threshold. A DHR should be conducted "when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect…"[1]. So, for example, a DHR may be conducted on an apparent suicide, where it appears the suicide was caused by abuse, but such a case would not be logged in the Homicide Index.

8. Homicide Index data are based on the year when the offence was first recorded, not when the offence took place or when the case was heard in court. While in the vast majority of cases the offence will be recorded in the same year as it took place, this is not always the case. The data refer to the position as at 13 November 2015, when the Homicide Index database was 'frozen' in order for analysis to be conducted[2]. These data will change as subsequent court hearings take place or as other information is received.

Domestic homicide victims

9. The definition of domestic homicide used here approximates to that used in DHRs and includes victims killed by a partner/ex partner[3] or a relative or by someone else living with the victim at the time of the killing.

10. In 2014/15, there were 50 male and 107 female domestic homicide victims aged 16 and over.

11. Figure 1 shows the trend in the number of domestic homicides for men and women aged 16 and over since 2007/08. Although the number of both male and female domestic homicide victims fluctuated from year to year, there is a clear downward trend.

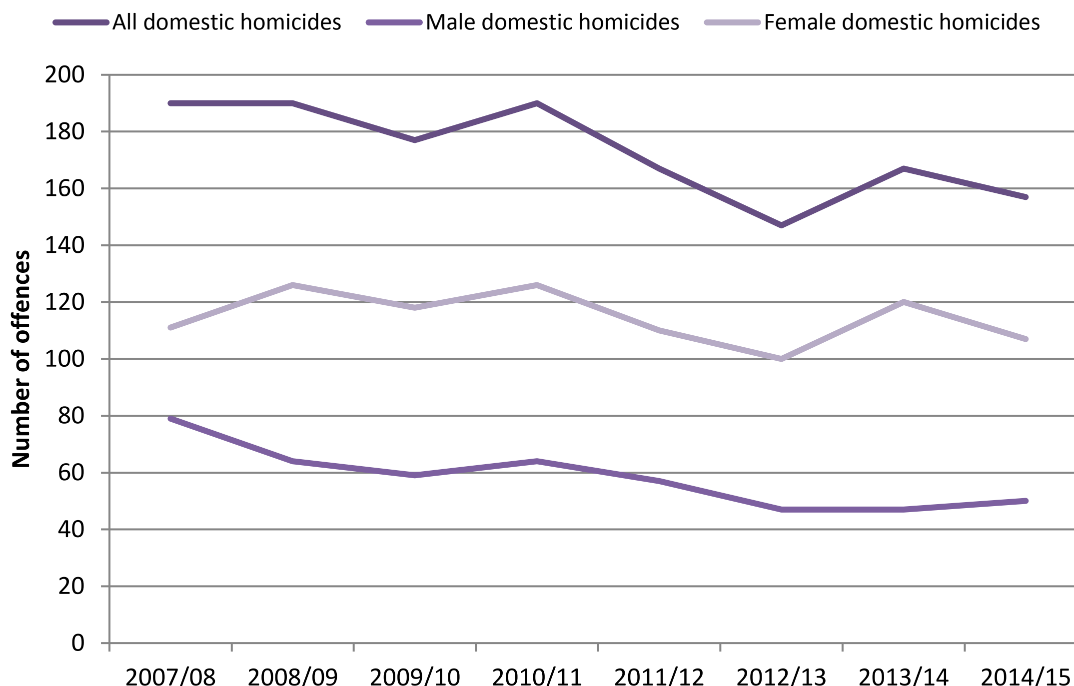
12. Among women, the majority of domestic homicide victims were killed by a partner/ex-partner (76%, for combined years 2010/11 to 2014/15), with a further 20% (on average) killed by a relative and the remaining by another household member. There was no clear pattern among men, with a fairly equal split between the three categories (Table A1 – Annex A). Among both men and women, the highest proportion of domestic homicides was among those aged 30 to 50 (around two-fifths) (Table A1).

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf

[2] Information from the Homicide Index is published annually, in the Office for National Statistics series: Focus on: Violence and Sexual Offences.

[3] This differs from the definition used in the Focus on violence release as it excludes 'emotional rival'.

Figure 1: Domestic homicide offences currently recorded by the police in England and Wales, by gender of victim, aged 16 and over - 2007/08 to 2014/15



Method of killing

13. In all years shown, the most common method of killing for both male and female domestic homicide victims aged 16 and over was by a knife or other sharp instrument, with 73 such homicides (46% of the total) recorded in 2014/15. The second most common method of killing in 2014/15 for female domestic homicide victims was 'strangulation/asphyxiation', accounting for 29 homicides (27% of the total for women). There was no consistent pattern among male victims.

Location of the homicides

14. The majority (87%, or 137 offences) of all domestic homicide cases in 2014/15 occurred in a house or dwelling. This proportion was similar in all the years shown in the table. The pattern was similar for males and females.

Age of Suspects

15. Table A1 shows the age and gender of the principal suspect in domestic homicide cases. The majority (87% for combined years 2010/11 to 2014/15) were male and nearly one half were aged between 30 and 50 years old.

Ethnicity

16. Ethnicity of the victim and perpetrator was often missing from the DHRs sampled and it has not, therefore, been possible to capture this data from reports. As a result, the revised statutory guidance on conducting DHRs will invite report authors to record key information of the parties involved, such as age, gender, ethnicity and other characteristics.

4 Analysis of Domestic Homicide Reviews

Methodology

17. The 40 DHRs included in this analysis were sampled from 195 DHRs that were assessed as suitable for publication, having been quality assured by the Home Office Quality Assurance (QA) Panel between January 2013 and March 2016. Further details on how the 40 DHRs were selected can be found in Annex B.

18. The case attributes were analysed for each of the DHRs to explore the types of domestic homicide (classified as either familial or intimate partner) and the characteristics of those involved (e.g. the age and gender of victims and perpetrators). Only seven familial cases were found in the sample. This is consistent with findings elsewhere[4] showing that the majority of domestic homicides are perpetrated within an intimate partner relationship rather than familial or other domestic arrangement. Due to the small number of familial homicide DHRs and the known differences between violence perpetrated in intimate relationships and that between family members, only intimate partner homicide DHRs were included in the main analysis to avoid conflating issues within the findings.

19. Content analysis of the case histories contained within the 33 intimate partner homicide DHRs was performed. These histories were coded using qualitative analysis software[5]. Coding was based on a framework developed and widely used in the health context for understanding adverse events[6]. The framework covers seven broad categories of factors. These categories cover the individuals involved in the case, issues relating to the identification and handling of cases, and issues with how cases were managed across different organisations (the framework can be found in Annex C). These seven categories represent both national and local policy issues. It is not possible to determine whether each category represents exclusively national or exclusively local policy issues as some issues may be directed by national policy but their implementation and delivery is guided by local policy.

20. Only incidents during case histories that were considered directly relevant to the homicide were coded. Deciding whether an incident was 'directly relevant' was informed by known risk factors from academic literature and/or whether the DHR author had noted that this was a key event prior to the homicide. Following the coding process, key areas of commonality between the case histories were drawn out into themes, which were analysed in greater detail to determine common underlying issues.

21. The number of DHRs in which each code was identified were counted in order to identify recurring themes that could highlight aspects of agency working that could be improved. The most commonly occurring themes were further analysed for the frequency with which different agencies (e.g. the police, social services, health etc.) were mentioned. While each set of circumstances leading up to a domestic homicide is unique, efforts were made to further group details together under each theme in order to draw conclusions about lessons that could be learned to improve practice.

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[4] Standing Together Against Domestic Violence and analysis of the Home Office Homicide Index (section 1) showing that the majority of domestic homicides are perpetrated within an intimate partner relationship.

[5] NVivo

[6] Vincent *et al*. (1998). Some of the factor headings have been re-named to make them more relevant for this analysis.

Key limitations of the analysis

- The coding was constrained by the quality and content of the reports themselves, which varied in length, structure and writing style. The content of the reports differed, for example some reports included a separate chronology of events and analysis, whilst other reports combined the chronology and analysis. This meant that the same event may have been coded twice in some DHRs.
- This analysis focused on the case histories presented in the reports and did not identify commonalities between other sections of DHRs, such as recommendations made to local areas. A separate analysis of the recommendations made by the DHRs sampled is detailed later in the report.
- Decisions about which passages to code are likely to be affected by the subjective opinion of the coder. Wherever possible, decisions about coding were based on academic literature of risk factors associated with domestic homicides.

Case Attributes Analysis

22. In order to explore the circumstances around domestic homicides and any commonalities that may be present, various case attributes were analysed.

23. As set out in the methodology, the following findings relate to the 33 intimate partner homicide DHRs. Attributes of the seven familial homicide DHRs are included in Annex D for information.

Gender

24. Of the 33 intimate partner homicide DHRs the majority (29) involved a male perpetrator and female victim(s). In the remaining four DHRs the victim was male and the perpetrator was female. The sample did not include any homicides involving same sex relationships.

Age

25. The most common age group for perpetrators of intimate partner homicide in the DHRs analysed was 51-60 years of age (8). This was followed by the 21-30 age group (7). For victims, the two most common age groups were 21-30 and 31-40 (both n=7) Table 1.

Table 1: Frequency of age groups for perpetrators and victims involved in intimate partner homicide DHRs

Age groups	Count of DHRs involving perpetrators in each age group	Count of DHRs involving victims in each age group
11>20	1	1
21-30	7	7
31-40	6	7
41-50	6	6
51-60	8	6
61-70	3	2
71-80	1	0
80+	1	1
DHRs involving multiple victims/perpetrators	0	3
Total number of DHRs	**33**	**33**

Dependent children

26. Of the 33 intimate partner homicide DHRs, the family structure included dependent children in 15 cases, with no dependent children in the remaining 18 cases. In the majority of the 15 DHRs with dependent children, the victim and perpetrator were the parents of the dependent children (11).

27. DHRs were further examined to see whether children witnessed or were affected by any abuse, violence or the homicide itself. This was the case in 12 of the 15 DHRs involving dependent children.

Mental health

28. Mental health issues were present in 25 of the 33 intimate partner homicide DHRs. Twenty-one cases involved perpetrators with mental health issues: 15 cases where only the perpetrator had mental health issues and six cases where both the perpetrator and the victim had mental health issues. The remaining four cases involved victims with mental health issues but not perpetrators.

29. Of the 21 DHRs involving perpetrators with mental health issues, the majority (16) were known to health professionals. Of the 10 DHRs involving victims with mental health issues, all were known to health services. Table 2 shows the different types of mental health issues mentioned in the DHRs.

Table 2: Frequency and type of mental health issues for perpetrators and victims involved in intimate partner homicide DHRs

	Count of DHRs involving perpetrators with mental health issues	Count of DHRs involving victims with mental health issues
Depression	11	9
Psychosis	3	-
Self harm	3	1
Suicidal thoughts	3	1
Suicide attempt	2	1
Low mood/anxiety (no diagnosis)	2	-
Adjustment disorder	1	-
PTSD	1	-
Anxiety	1	-
Panic attacks	-	-
Not specified	1	1
Total number of DHRs	**21**	**10**

Substance use

30. Substance use was mentioned in 20 DHRs: nine DHRs mentioned substance use by the perpetrator only, two by the victim only and nine by both the perpetrator and victim.

31. In seven of the 20 DHRs where substance use was mentioned, this was not reported to health services. In the remaining 13 DHRs, the substance use was known to health services as being problematic. Table 3 shows the breakdown of substance use by types.

Table 3: Frequency and type of substance use issues for perpetrators and victims involved in intimate partner homicide DHRs

	Count of DHRs involving victims with substance use issues
Alcohol	10
Drugs	4
Alcohol & Drugs	6

Co-occurrence of substance use and mental health issues

32. Among perpetrators and victims the presence of both substance use and mental health issues was more common than either issue occurring alone. For example, 12 DHRs involved perpetrators and seven involved victims with both mental health and substance use issues (Figure 2).

33. It is important to note that both substance use and mental health issues individually or together amongst perpetrators and victims are aggravating factors that escalate violence in relationships already abusive.

Figure 2: Frequency of DHRs involving perpetrators and victims with only mental health issues, only substance use issues and both mental health and substance use issues

History of violence

34. In 24 of the 33 intimate partner homicide DHRs the perpetrator had a history of violence. In seven of these cases the history of violence was not known to any agency. Of the other 17 cases, agencies had recent knowledge of this in 12 cases.

35. In 13 of the 24 DHRs where the perpetrator had a history of violence, the violence mentioned was towards the victim only. Of the remaining 11 DHRs, nine had a history of violence towards others, seven had a history of violence towards women specifically, and six had a history of general criminality.[7]

36. In six cases the victim had a history of violence towards the perpetrator. The victim was female in four of these cases and male in the remaining two. The violence was mutual in all six cases and was associated with significant relationship strain and other stressors, such as substance use. While not clear from the DHR case histories, an element of this may be retaliatory violence from a perpetrator, who themselves have experienced prolonged abuse. Due to the small number of cases included in the current analysis, it is

[7] Categories are overlapping (a perpetrator may have a history of violence to others *and* a history of general criminality) so total comes to more than 11.

difficult to draw firm conclusions. Research into risk factors for domestic abuse has however shown that female violence towards a partner increases their risk of victimisation.[8]

Analysis of common themes

37. From the coding framework used to categorise content in the DHRs the number of cases in which each code was identified were counted in order to identify recurring themes that could highlight aspects of agency working that could be improved. The most commonly occurring themes were further analysed for the frequency with which different agencies were mentioned and the detail of the circumstances. While each set of circumstances leading up to a domestic homicide is unique, efforts were made to further group details together under each theme in order to draw conclusions about lessons that can be learned to improve practice.

Figure 3: Frequency of themes mentioned in intimate partner homicide DHRs

Common issues related to record keeping

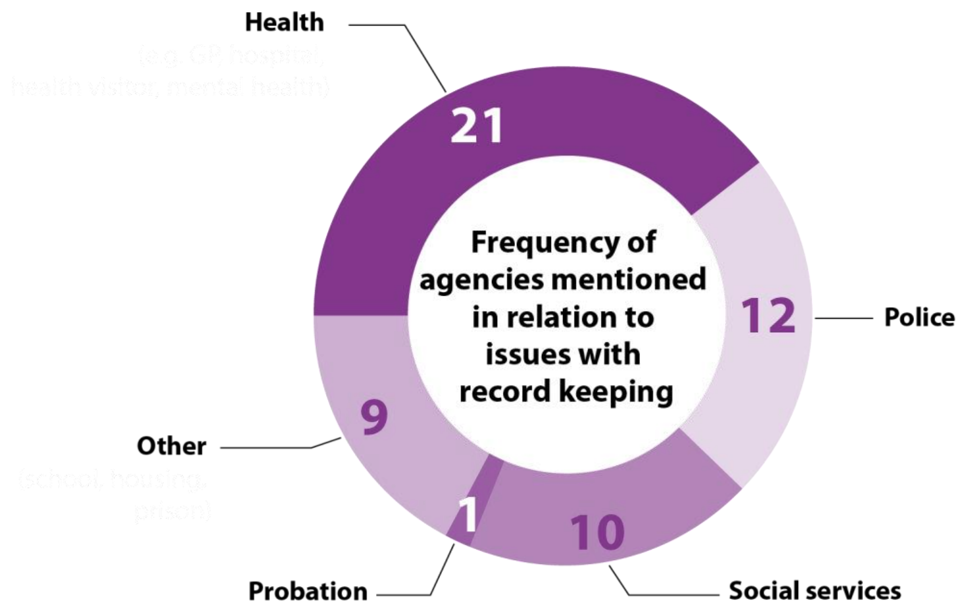
Frequency of agencies mentioned in relation to issues with record keeping

38. The number of times different agencies were mentioned across the 33 intimate partner homicide DHRs in relation to issues with record keeping were counted. Each agency has

[8] http://www.college.police.uk/News/College-news/Documents/DA_ROR_Summary_14-12-15.doc

only been counted once per DHR, although they may have been mentioned multiple times in relation to record keeping.

- Health (e.g. GP, hospital, health visitor, mental health) – 21
- Police – 12
- Social services – 10
- Probation – 1
- Other (school, housing, prison) – 9



Common issues related to record keeping

39. In all 28 cases, there were examples of poor quality or inadequate records. This was particularly the case for GP records.

40. In 12 of the cases highlighted here, there were instances where no records were found. This meant that there were instances where it was not possible to know if an expected action had not been taken, or that action had been taken without being documented.

41. Linked to the issue of information sharing and communication, there were 9 cases where information systems meant that records were not properly shared within or between organisations.

> *"Organisations should seek to have systems in place that allow those responding to incidents to be provided with the previous history to enable them to provide the best support to the victim and assess the incident in the light of a developing pattern of behaviour."*

> *"[Police] knew that [the victim] has a non-molestation order and was a high risk victim of domestic violence, yet their databases did not contain her current address."*

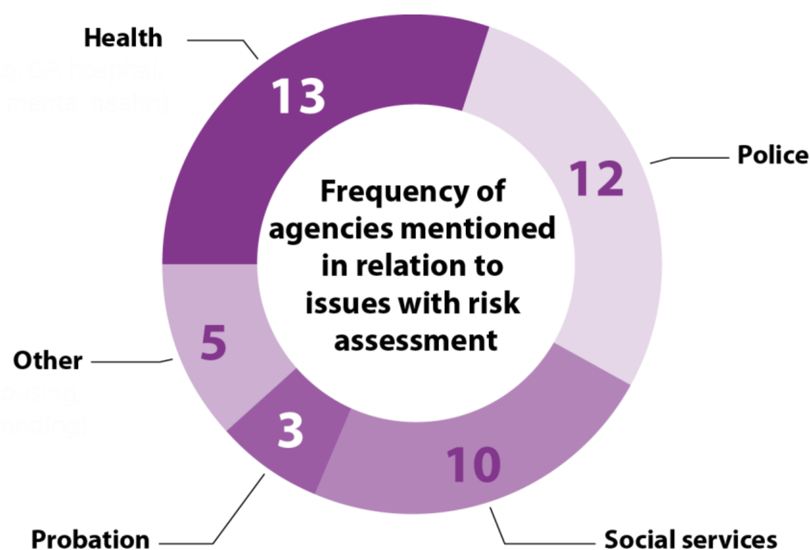
42. In four cases records were lost, destroyed, or unavailable. This was particularly the case where paper records were still in use. This created problems not just for the review team in establishing evidence, but also for practitioners at the time the events were occurring

Issues in relation to risk assessment

27 DHRs identified issues with risk assessment

Frequency of agencies mentioned in relation to issues with risk assessment

- Health (e.g. GP, hospital, health visitor, mental health) – mentioned in relation to issues with risk assessment in 13
- Police – 12
- Social services – 10
- Other (Local Authority, housing, youth offending) – 5
- Probation – 3



Common issues related to risk assessment

43. In order to further understand the context for issues with risk assessment the detail of this theme was further examined and particularly frequently occurring elements were noted. Of the 27 cases where the DHR identified issues with risk assessment there were:

- 14 DHRs where risk assessment was not completed when it should have been.

> *"If there is doubt as to who is the victim and who is the perpetrator best practice would have been to complete 2 DASH forms, one for each party"*

> *"There is no record of sexual risk assessment framework (SERAF) assessment being completed".*

- Five DHRs where risk assessment was of poor quality, such as generally lacking detail or failing to fully interrogate circumstances.

> *"However, this approach was not based on good quality risk assessment and the resulting effectiveness of support plans was therefore compromised".*

- Five DHRs where risk assessment was given an incorrect rating, for example where DASH was graded as standard when the situation warranted at least a medium grading (e.g. threats to kill had been made or there were multiple DV incidents in the previous 12 months).
- Four DHRs where incidents were assessed in isolation. This was an issue in terms of individual agencies, for example police officers assessing each incident as separate so no pattern was observed, previous incidents not being used to inform subsequent risk assessment and issues with agencies assessing risk in isolation from each other.

"It appears that the repeated domestic incidents involving [the victim] and [the perpetrator] were considered and risk assessed by the police as individual incidents."

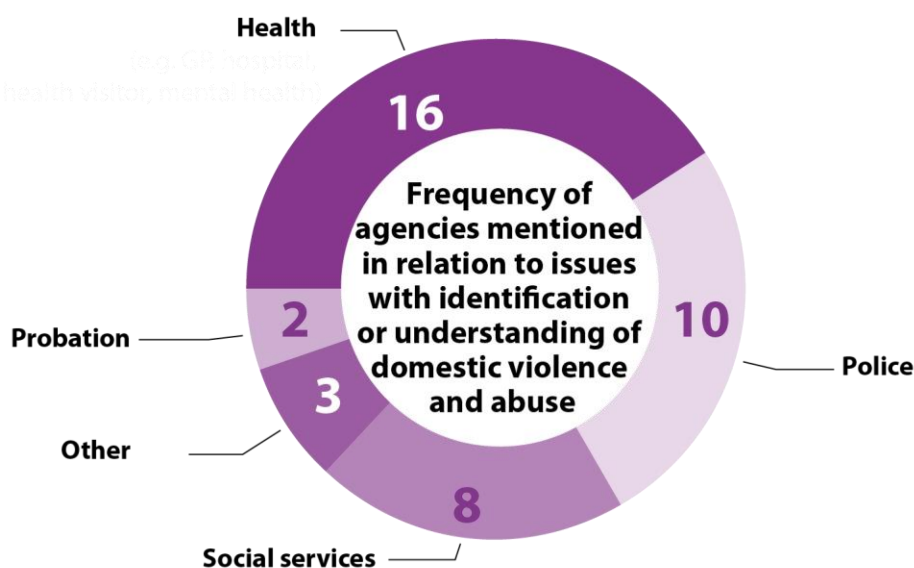
- Three DHRs where domestic abuse incidents were not recorded as domestic abuse, for example where incidents were logged as other types of incidents, such as criminal damage, civil dispute, anti-social behaviour.

Issues with the identification or understanding of domestic violence and abuse

24	Cases where victims or perpetrators presented to agencies with possible signs of domestic violence and abuse but this was not recognised or explored further

Frequency of agencies mentioned in relation to issues with identification or understanding of domestic violence and abuse

- Health (e.g. GP, hospital, health visitor, mental health) – 16
- Police – 10
- Social services – 8
- Other (school, housing) – 3
- Probation – 2



Common issues related to identification or understanding of domestic violence and abuse

44. Of the 24 cases where the DHR highlighted issues with identifying or understanding domestic violence and abuse:

- 13 DHRs where elements of the case or risk factors were not fully explored.

> *"Although [the victim] was under 18 years of age, the principle of a domestic abuse investigation should have been considered."*

- Nine DHRs where vulnerability issues were overlooked. This included instances related to not recognising times when vulnerability is heightened (e.g. following a separation or during pregnancy) and others were around social services focusing on the protection of children but overlooking the vulnerability of a mother. In one case, as highlighted by the quote below, the fact that the victim was male was felt by the DHR panel to impact on agencies' view of his vulnerability:

> *"The panel is of the view that his gender, together with agencies' perceptions of him and his lifestyle, played a part in the failure to recognise [the victim's] vulnerability."*

- Nine DHRs where non-physical violence elements were not taken seriously (e.g. coercion and control, threat to kill, sexual exploitation, grooming, stalking and harassment).
- Seven DHRs where there were missed opportunities to investigate or intervene.

“Had [the victim’s] file been ‘flagged’ for domestic abuse it may have resulted in the GP making further enquiries when she presented for stress”.

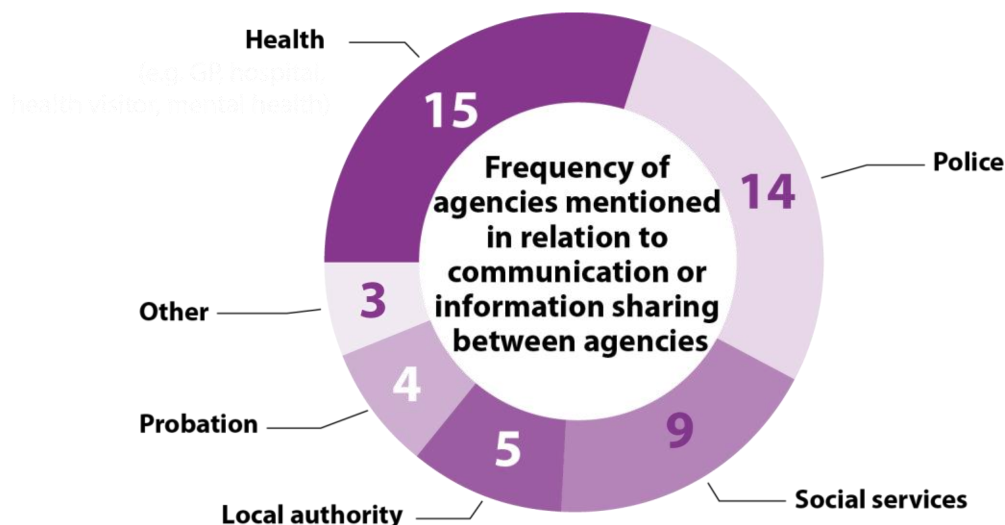
- Six DHRs identified that there should have been routine enquiry but this did not take place. In three of these cases this was because either the perpetrator or other family members were present and it was rightly felt to be inappropriate, but no efforts were made to follow up. In other cases there is simply no evidence of inquiry where this should have been recorded.
- While not as common, there were also issues around identification in terms of the age and gender of parties involved. Three of the cases involved young persons who agencies struggled to determine whether to treat as a child or adult and subsequently failed to either identify the domestic violence occurring or protect them as a child. There were also instances where the male partner was the eventual victim of the homicide but the DHR revealed that agencies failed to identify the risks and vulnerability, either due to the gender of the victim or because they did not adequately recognise that instances of mutual violence may have been retaliatory and therefore identify the risks to both parties.

Communication and information sharing issues both intra-agency and between agencies

25 | **Cases where issues were identified with communication or information sharing between agencies**

Frequency of agencies mentioned in relation to communication or information sharing between agencies

- Health (e.g. GP, hospital, health visitor, mental health) – 15
- Police – 14
- Social services – 9
- Local Authority – 5
- Probation – 4
- Other (housing, education) – 3



Common issues related to communication or information sharing between agencies

45. In ten of the 25 cases where this was an issue, the DHR only notes that information was not shared or that communication was poor. No specific reasons for this are detailed, though in a number of cases it seems that either this was an omission by professionals or that the incident or information in isolation did not seem sufficiently significant to that agency to warrant sharing but if viewed alongside other information already held by another agency would have highlighted a concerning pattern.

> *"Although the police officer reported this to the Child Abuse Investigation Unit it does not appear to have been referred to Children's Social Care (CSC) by the police. This incident is a classic example of how an event, which in itself may appear minor, could have provided important information if passed to another agency."*

46. In other instances information was shared but practice was patchy or sporadic. This includes delays in sharing information, a lack of detail in reports, and numerous agencies being involved but information shared only between some and not others, across a total of six cases.

"In this case, various agencies each held significant information about [the perpetrator and victim's] current situation and historical factors, yet only shared this with each other in small snapshots, if at all."

47. Problems with information sharing are often thought to be due to policies within agencies preventing the sharing of information with others. However, contrary to this six of the DHRs specifically noted that lack of information sharing was in direct contravention of agency policy.

"The review has highlighted that following a verbal argument between [the perpetrator] and his ex-partner…probation should have been notified of this call out as [the perpetrator] was on an Order for an offence of violence against [ex-partner], and probation had submitted the relevant documentation to notify the police of this."

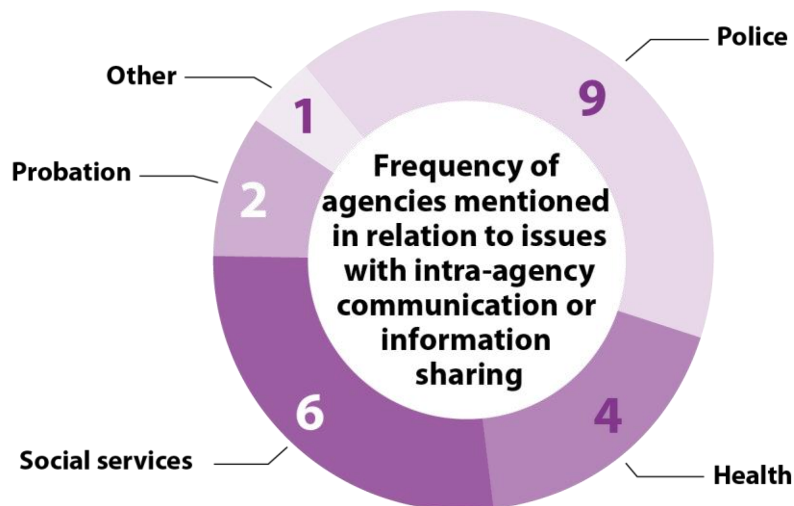
48. Although occurring in a smaller number of cases, issues were also noted regarding no feedback being received on the outcome of a referral, systems not permitting effective interrogation of information, cases being closed without informing any other agency, and risk assessments not being shared with other agencies. What is clear is that in a large number of cases the lack of information sharing had serious implications for the effectiveness of risk assessment and actions taken to safeguard victims.

"During [the victim's] antenatal care, I believe the midwifery service…might have acted differently had they known about the previous concerns around grooming."

16 Cases where issues were identified with intra-agency communication or information sharing

Frequency of agencies mentioned in relation to issues with intra-agency communication or information sharing

- Police – 9
- Health (e.g. GP, hospital, health visitor, mental health) – 4
- Social services – 6
- Probation – 2
- Other (refuge) – 1



Common issues related to information sharing

49. There were a number of different commonly occurring issues within this theme:

- In three DHRs, issues were identified with systems preventing information held by the organisation being accessed by frontline professionals.

> *"A further important area for learning and improvement that has been highlighted is the way in which information shared in the MARAC meeting is communicated to front line professionals. Several of the organisations involved with [the victim] were not aware that she had been subject to a MARAC".*

- Multiple professionals working on a case not always communicating with each other were mentioned in three DHRs.
- Instances of poor communication between different parts of an organisation, such as health providers or departments in a police force, were also mentioned in three DHRs.

> *"In dealing with intra-agency communication it is not apparent that information held by the NHS GP on [the perpetrator's] compliance to prescribed medication was passed to [the mental health service]."*

- Issues were also mentioned where an agency was subdivided into different area teams and these did not communicate effectively with each other.

> *"[The Multi Agency Support Team (MAST)] in one locality did not communicate effectively with MAST in another locality, on two separate occasions."*

- Lastly, there were issues with the flow of information either up or down the organisation; with instructions given not being cascaded effectively leading to conflicting practice, or problems not being escalated when appropriate.

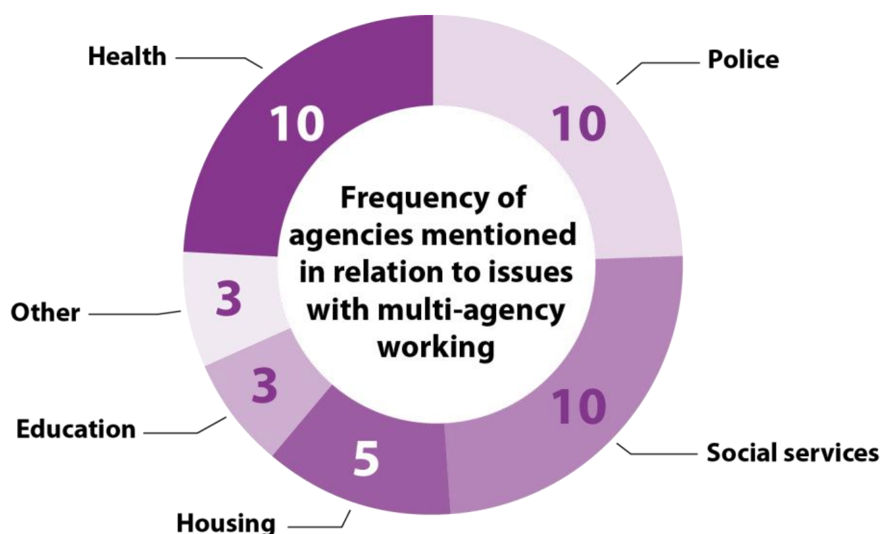
Multi-agency working practices

19	Cases where general issues were identified with multi-agency working practices

Frequency of agencies mentioned in relation to issues with multi-agency working practices

50. Issues around multi-agency working practices are closely linked to issues with information sharing, but worthy of separate analysis given these can be more general.

- Health (e.g. GP, hospital, health visitor, mental health) – 10
- Social services – 10
- Police – 10
- Housing – 5
- Education – 3
- Other (LA, probation) – 3



Common issues related to multi-agency working practices

51. In eight of the 19 cases where issues with multi-agency working were identified there were issues with MARAC or other multi agency meetings. Examples include:

- Not referring to MARAC
- Agencies not being invited to multi-agency (including MARAC) meetings
- Agencies failing to attend scheduled multi-agency (including MARAC) meetings
- Agencies not being made aware that the victim is subject to MARAC
- Agencies unaware of local multi-agency structures

> *"Numerous opportunities to refer [the victim] to MARAC were missed by both the police and Children's Social Care."*

> *"This raises the question of what other support services are not aware of the [multi-agency] structure and how to exchange information with other agencies."*

52. Across all 33 intimate partner homicides in the sample, only 3 victims were ever subject to a MARAC. A further 2 were in the process of referral when the homicide occurred.

53. Equally common were issues with agencies lacking coordination, which was also noted in eight cases.

> *"When cases are on-going, i.e. over one year, and patients are accessing services via a number of providers, there should be a multi-agency review to ensure that all of the supporting agencies are working towards the same goals for the patient, and coordinating that care for the best outcomes."*

54. There were four cases where two geographical areas failed to work together, whether this was two police forces or different area teams of social services.

> *"Between December 2009 and May 2010 there was continuous contact between [CSC area 1] and [CSC area 2] regarding a joint strategy meeting to review the [child] allegation. This was never convened."*

55. There were also four cases where there was lack of clarity over agency roles or lead profession.

> *"There also appears to be a lack of understanding about the roles of [mental health provision] and [probation trust] in relation to the assessment and administration of a community order with a mental health requirement."*

56. In three cases where there were missed safeguarding opportunities by agencies collectively.

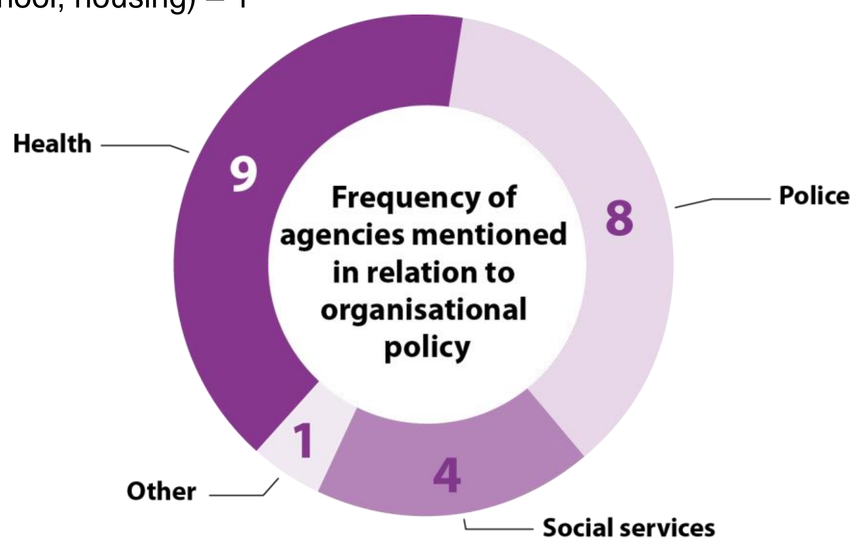
> *"There is little evidence to suggest that agencies recognised his vulnerability and opportunities to implement appropriate safeguarding procedures were repeatedly missed."*

Agencies' organisational policy in relation to domestic abuse

19	Cases where issues with agencies' organisational policies in relation to domestic abuse were identified

Frequency of agencies mentioned in relation to organisational policy

- Health (e.g. GP, hospital, health visitor, mental health) – 9
- Police – 8
- Social services – 4
- Other (school, housing) – 1



Common issues related to organisational policy

57. This theme was fairly evenly split between cases where there was no policy in place for domestic abuse or for safeguarding adults (10 cases) and where there was a failure to understand or apply the policy (9 cases).

58. In the cases where a lack of policy was highlighted, this was mainly – but not exclusively – in health settings. There was one police force identified (in 2014) as lacking a policy on domestic abuse.

> *"There are currently no domestic abuse policies or protocols in the GP practice, or any developed locally for practices to use as a basis for drafting their own procedures for staff to follow."*

59. Failure to understand or apply policy was more prevalent in police forces but was also seen in health settings.

> *"The Trust's response…demonstrates a lack of clarity or understanding of its own current safeguarding policy."*

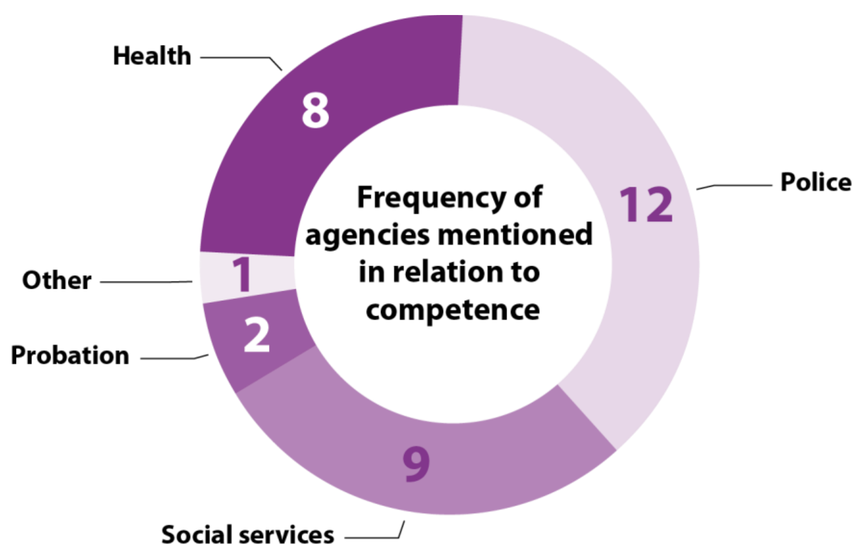
> *"[The police force] domestic abuse policy includes a requirement that when six DASH assessments have been completed within 12 months (regardless of their classification) a DI in the Combined Safeguarding Team should examine the case… However, there is no system or process that will flag up a case that fits this criteria; for this reason the requirement cannot be met."*

Professional and practitioner competence

19	DHRs identified failings in individual practitioner competence

Frequency of agencies mentioned in relation to practitioner competence

- Police – 12
- Health (e.g. GP, hospital, health visitor, mental health) – 8
- Social services – 9
- Probation – 2
- Other (school, housing, IDVA) – 1



Common issues related to competence

60. The most common issue, being noted in 10 cases, was service standards being inadequate or organisations not following their own policies and procedures. This links to the findings regarding the following of organisational policies above. Understanding of domestic abuse policies may relate to training needs, which are discussed below.

> *"Advising any victim of domestic abuse to report this herself rather than ensuring she had some support to do so would not have been good practice. Given that the victim was a 16 year old girl, legally a child, this was unacceptable."*

61. In seven cases, organisations failed to take any action following disclosures or failed to action requests due to the inaction of individual professionals involved.

> *"The IMR author reports that the family court adviser and a service manager involved in the case "…are at a loss to understand their failure to contact the local authority Children's Services Dept with relevant inter-agency referral information about alleged harm to children". Therefore the DHR Panel felt this was poor individual practice rather than an organisational weakness."*

62. Also noted in seven cases was the issue of risk assessment processes not being properly understood or not being properly carried out.

> *"On the next three occasions where threats to kill were reported, the assessment was standard risk. This was incorrect. There is evidence that some of the questions on the DASH risk assessment completed by the police in March 2010 had been incorrectly scored."*

63. There were six cases where agencies did not identify children at risk, either as the children of a victim, or as victims themselves.

> *"There was also evidence across the services that [the victim] was often viewed by professionals as a difficult young person and as a result this meant that she was not always recognised as a child who needed safeguarding."*

> *"There was no evidence in any of the records that the concerns about the child's behaviour were assessed at any point in the context of the impact on the children of the domestic violence and abuse taking place."*

64. In six cases individual professionals were noted as having lacked 'professional curiosity' or taken things at face value.

> *"The police failed to use professional curiosity when completing the DASH form to further explore the comment that [the victim] had tripped over a child's cycle when [the perpetrator] failed to give a positive answer to 'any children in the household'."*

65. Finally there were three cases where incidents were wrongly classified as anti-social behaviour or criminal damage without taking into account the wider context or pattern of domestic abuse.

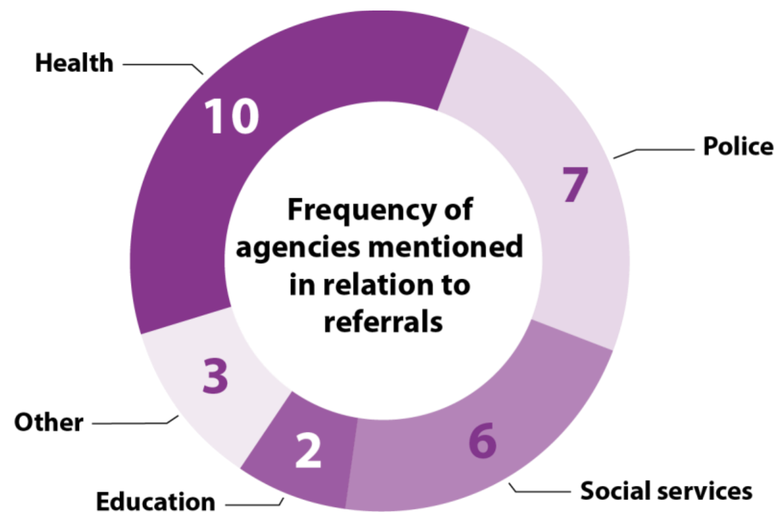
> *"She then followed their advice by reporting the next day to [the police] the damage to her home and the stolen house keys. These offences, whilst clearly meeting the Home Office definition of domestic abuse, were dealt with and recorded as criminal damage… As a result, a DASH assessment was not triggered and no domestic violence flag placed on police systems for this address."*

Practice in relation to referrals made between agencies

17	Cases where DHRs noted issues with referrals made between agencies

Frequency of agencies mentioned in relation to referrals

- Health (e.g. GP, hospital, health visitor, mental health) – 10
- Police – 7
- Social services – 6
- Education – 2
- Other (LA, probation, housing) – 3



Common issues related to referrals

66. Within the 17 cases where the DHR identified issues with referrals there were 12 instances where referrals should have been made but were not. Of these there were:

- Four cases where a MARAC referral should have been made;
- Three cases where victims should have been referred to a DV service but were not;
- Three cases where there were child safeguarding issues but referral to CSC was not made; and
- Two cases where there should have been referral to either mental health or substance misuse services.

67. There were also seven cases where there were errors with referrals or made to the incorrect agency.

> *"Having been outside CAMHS remit it appears [the victim] received no subsequent support for mental health. This points to a clear gap between CSC and Adult Social Care (ASC) into which it appears [the victim] fell."*

68. In three cases referrals were not actioned by the receiving agency.

> *"[CSC] received information about threats to kill [the victim] in March 2010. This information was logged as an enquiry by social care when it should have been taken as a referral."*

69. Finally there were two cases of confusion about which agency should make a referral.

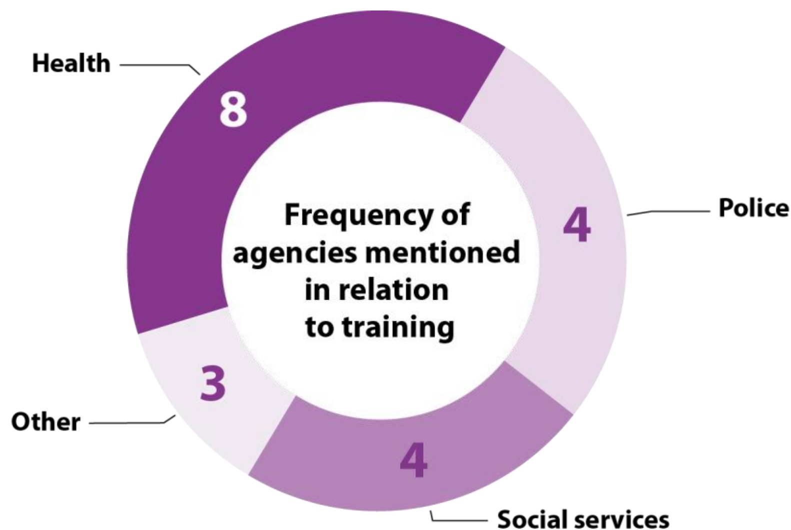
> *"Among the cases highlighted under this theme, there were 3 cases in particular, involving young persons, where issues were noted with the crossover between child and adult services. This caused confusion, delay or lack of appropriate referral."*

Training in domestic abuse

16 Cases where training was identified as an issue by DHR review panels

Frequency of agencies mentioned in relation to training

- Health (e.g. GP, hospital, health visitor, mental health) – 8
- Police – 4
- Social services – 4
- Other (school, housing, IDVA) – 3



Common issues related to training

70. GPs and GP practice staff needing training in DV was mentioned in 10 cases.

> *"The IMR records that the GP Practice…had not received any safeguarding adults or domestic abuse training; adding "This [training] is considered to be a need that goes beyond this practice and has in fact been recognised as a national issue in relation to GPs"."*

71. In seven of these cases, implementing IRIS (Identification and Referral to Improve Safety) training and care pathways was suggested by DHR authors.

72. Other themes to emerge were:

- Police forces not ensuring all staff had undertaken the DASH training, or being unable to establish how many officers had completed the training.

> *"All frontline officers and staff of all ranks and grades were required to undertake DASH risk assessment training before the new system was implemented. However, [the police force] have been unable to establish how many members of staff have or have not completed the training."*

- Adult safeguarding training not being prioritised compared to child safeguarding training

> *"As previously highlighted there is a real disparity in the level of training within adult safeguarding, when compared to children's safeguarding."*

- The importance of cases being allocated to staff with appropriate training and experience

> *"The case was allocated to a Family Support Worker who had limited experience and no formal training to fully understand the impact of domestic violence. This was poor practice. This has now changed and all social care cases are allocated to qualified social workers."*

- Social workers not receiving training in domestic violence

> *"The Children's Social Care social worker from February 2012 to July 2012 had not undergone any training related to domestic violence and abuse."*

Public awareness of domestic abuse and avenues of support

14	**DHRs discussed the level of public awareness of domestic abuse, particularly about avenues for help and support.**

73. In these cases the full extent of violence only came to light during the police investigation into the homicide, revealing that friends, family and neighbours knew about the abuse but either did not know what to do about it or were asked by the victim to not report it and complied with this. Of these 14 cases there were:
    - 7 cases where friends knew;
    - 7 cases where family knew;
    - 4 cases where neighbours knew; and
    - 4 cases where someone else knew (e.g. employer).

> *"There is a general lack of awareness amongst the general public on what they can do if they become aware of incidents of domestic abuse involving other people."*

> *"The family reluctantly agreed with [the victim's] wish not to report the domestic abuse to the police."*

> *"In the months leading to the tragic death of [the victim], family, neighbours, and colleagues appear to have held more information than agencies around the nature of the relationship between [the victim and the perpetrator], and the abuse within it."*

Engagement with services

74. Engagement with services was discussed in DHRs in relation to 21 cases regarding the victim and 19 cases regarding the perpetrator. In 16 cases both the victim and the perpetrator had contact with agencies but for various reasons contact diminished after initial engagement.

75. The most common themes with perpetrators was lack of engagement with mental health or substance use services

76. With victims the most common theme was not wanting to continue with police action, often reporting violence but then withdrawing allegations or denying violence occurred when police arrived. There may be a number of barriers to victims engaging with services, which will be unique to each individual but may include their age, cultural beliefs, fear of the perpetrator, previous experiences, not being offered the service they want or not understanding what services are available.

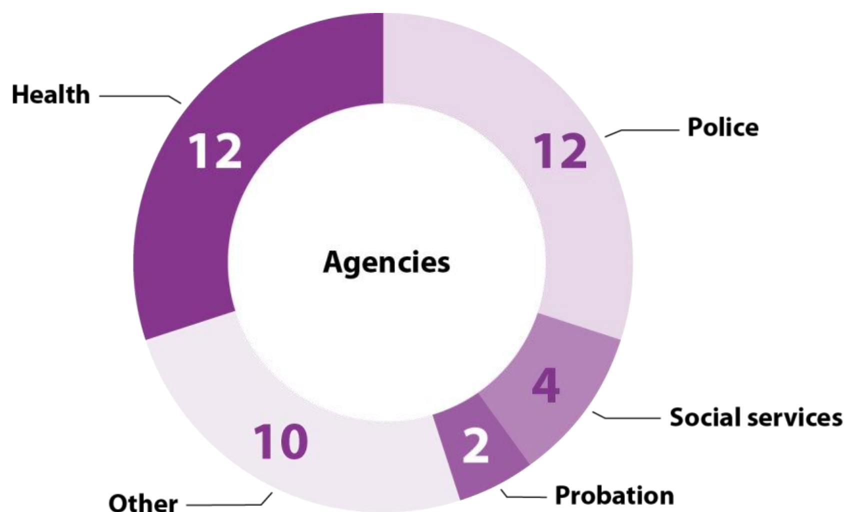
Perpetrator	
Substance use services	6
Mental health services	9
Medication compliance	2
DV support	2
Probation	2
Other	3
Victim	
Substance use services	3
Mental health services	5
Not reporting	2
Police action	8
DV support	6
Medication compliance	1
Other	4

Identification of best practice

14	DHRs in which best practice was identified

Agencies

- Health (GP, hospital, health visitor, ambulance) – 12
- Police – 12
- Social services – 4
- Probation – 2
- Other (school, housing, DV service, employer) – 10



77. There were:

- 14 examples of good practice demonstrating practitioner awareness and understanding
- 13 examples of practitioners demonstrating professional competence
- 10 examples where practitioners built effective relationships or provided a high degree of support
- Seven good examples of multi-agency working
- Five examples where organisational policy helped to deliver a good service to victims, in particular where services were tailored to the needs of the victim

> *"The [County Council Domestic and Sexual Violence Unit] have worked with Crime-stoppers to launch a campaign to encourage third party reporting of domestic violence"*

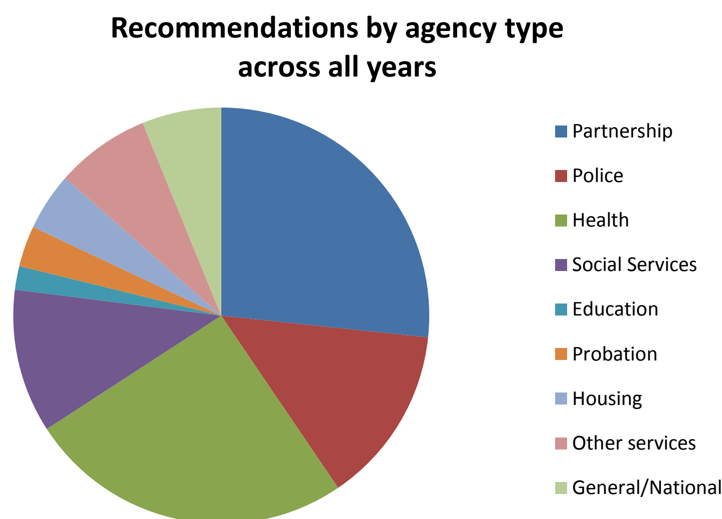
> *"The DASH scored twelve which is two below automatic MARAC referral threshold. However IDVA 1 referred the case to MARAC using the discretionary "professional judgement" criteria. This was good practice."*

5 Analysis of DHR recommendations

78. Domestic homicide reviews vary significantly in the number and detail of recommendations identified. As the individual management reviews (IMRs) of each agency also make recommendations, DHR reports may include only the IMR recommendations, only the DHR Panel recommendations or a mixture of both.

79. A brief analysis has been carried out on the 33 intimate partner homicide DHRs on which content analysis of the case histories was conducted. Across the four years in which the DHRs in this sample were presented to the Home Office Quality Assurance Panel there were a total of 600 recommendations made by these DHRs.

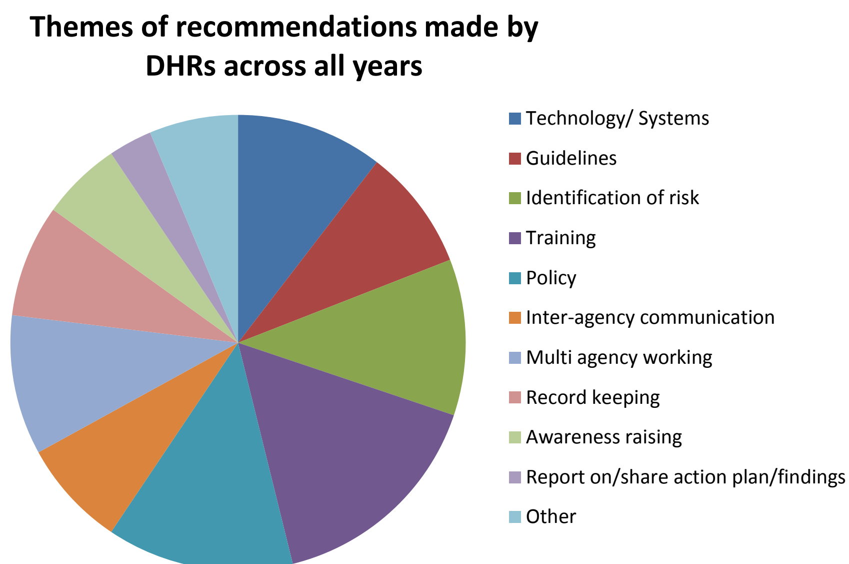
Figure 4: Overall breakdown of recommendations by agency



80. Figure 4 above shows the overall proportion of recommendations directed at each agency. The most common recommendations were directed at Community Safety Partnerships (CSP) and health related agencies both at around a quarter of all recommendations across the four years.

81. The proportion of recommendations made to each agency did vary across the four years, though this will have been affected by the exact circumstances surrounding each DHR and the way in which recommendations were written up in the DHRs, as discussed in paragraph 78. The agencies receiving the largest proportion of recommendations in 2013 were Health related agencies. In both 2014 and 2015 this was the CSP, and in 2016 the highest proportion of recommendations was for police.

Figure 5: Overall breakdown of recommendation themes



82. Broad themes were applied to the content of recommendations in order to analyse the type of issues that have been the focus of recommended actions. Figure 5 above shows that, in total, a marginally higher proportion of recommendations related to training than to any other category. The next largest categories were changes to policy, improvement of technology or systems, and improvements to risk identification or assessment.

83. Training was consistently the highest proportion of recommendations across the four years. Other categories tended to fluctuate between each year with no clear pattern, although the proportion of recommendations for improvements to risk identification and assessment declined.

6 Supporting local areas to deliver a coordinated response to domestic abuse

84. The purpose of this analysis is to promote key learning and trends from the sample of DHRs with the aim of informing and shaping future policy development and operational practice both locally and nationally. We encourage local areas to review the learning from this report and consider improvements to practice that can be made to their services and operational processes.

85. The Government is resolutely committed to tackling domestic abuse. Summarised below are some of the actions we are undertaking to address the themes identified in this report, together with examples of lessons that local areas can draw on to help develop a coordinated response to domestic abuse.

Risk assessment

86. The importance of a consistent approach to risk identification, assessment and management for all professionals was identified in a number of reports. This included the operation of the Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment tool by police.

87. Agencies and organisations should review their risk assessment and management approach to ensure it is robust, e.g. consider using dip-sampling of forms to test effectiveness. They should consider how DASH and equivalent risk assessments are quality assured to ensure they are being carried out appropriately and effectively and that performance management issues are identified swiftly.

88. Local areas in reviewing their risk assessments should be aware of materials that have been developed to support these processes, for example there are materials available on the Safelives website regarding risk assessment and case management which are tailored for a wide range of agencies and available in a number of languages. http://www.safelives.org.uk/knowledge-hub

89. In early 2016 the College of Policing carried out research with three forces to assess how DASH was being used following a recommendation by Her Majesty's Inspectorate of Constabulary. It found DASH was not applied consistently at the frontline and sometimes officers used discretion not to submit a form. The report says police officers and staff acknowledged the value of risk identification and assessment, but there was frustration at a perceived mismatch between the current tool and the practical realities of frontline policing.

90. As a result three forces are taking part in a College of Policing pilot which aims to assist frontline officers in identifying patterns of abusive behaviour and in particular it will help improve officers' understanding of the risks around coercive control. Ensure that staff across the CSP and partner agencies have the appropriate training on all forms of domestic abuse (including coercive and controlling behaviour and factors which lead to increased vulnerability and risk), risk assessment and risk management.

Identification and understanding of domestic abuse and violence

91. A number of reports identified the need to improve awareness of domestic abuse amongst healthcare professionals. GPs, midwives, health visitors, mental health, drug and alcohol services, sexual health and Accident and Emergency staff are all well placed to identify abuse. They have the opportunity to intervene early and direct victims to the most appropriate statutory and non-statutory services. The new NHS Mandate recognises the vital role of the NHS in tackling abuse and violence and expects NHS England to ensure the NHS helps to identify abuse and violence early and signpost victims to appropriate support services.

92. The Government recognises the need to support improvements in responses of health professionals to domestic abuse. Department of Health has committed to further roll out of the Identification and Referral to Improve Safety (IRIS) programme, provide free online training and more firmly embed routine enquiry into domestic abuse in maternity and mental health services. They are also producing an updated version of 'Responding to Domestic Abuse: A Resource for Health Professionals'.

93. Health professionals should also be aware of the National Institute for Health and Care Excellence (NICE) guidance on domestic abuse which outlines best practice for identifying, preventing and reducing domestic abuse. https://www.nice.org.uk/guidance/qs116

Information sharing and multi-agency working

94. Many of the reports highlighted the importance of agencies sharing information about the risk of domestic abuse and violence. We know that multi-agency working has had a positive impact on tackling VAWG and it is a model we should continue to develop.

95. Local areas should review information sharing protocols and ensure that there is appropriate means to record domestic abuse incidents in order to identify repeat incidents and patterns of behaviour. They should also consider options for enhancing multi-agency information sharing, both intra-agency and across local boundaries. The Government has published information sharing advice for safeguarding practitioners https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice. Learning and examples of good practice can be found at the Centre of Excellence for Information Sharing here: http://informationsharing.org.uk/our-work/learning-good-practice/

96. We are publishing a National Statement of Expectations for local areas which will set out a framework for service provision and support local services to join up more effectively, undertake a comprehensive assessment of local need, and develop their local strategy in an open and transparent way in consultation with key stakeholders. We are also delivering a series of events to promote existing and new models of multi-agency working both locally and across local boundaries, identify the barriers to information sharing and build a network of local practitioners to share learning.

97. AAFDA (Advocacy After Fatal Domestic Abuse) is delivering training for commissioners, panel members and chairs of DHRs on the complete DHR process and continues to develop approaches to ensure reviews and other statutory inquiries are informed by the victims' perspectives www.aafda.org.uk

98. The Government has committed to implement HMIC's recommendation (from their report into the police response to domestic abuse) for further multi-agency inspections to consider how individual services contribute to keeping victims safe, the quality of local partnerships and the way in which joint working is scrutinised. We are delivering HMIC's recommendation to commission a 'Task and Finish Group' to evaluate the effectiveness of the various models in place for multi-agency safeguarding hubs (MASHs) and central referral units (CRUs) in terms of the outcomes achieved for victims of domestic abuse through the National Oversight Group.

99. Working with voluntary sector partners we will also help local areas to develop a more integrated approach to multi-agency working that looks at victims, their families and perpetrators in the round. Initiatives such as the SafeLives 'One Front Door' and Women's Aid's 'Change That Lasts' models are two approaches based on providing a wrap-around package of care for victims and their families which can help transform how services are structured. The Government has provided £2m in funding to support these models and the findings from these programmes will be used to roll out effective approaches more widely and as a basis for embedding widespread service reform.

Training

100. A number of reports identified the need for improved training on domestic violence and abuse. The College of Policing has developed and is in the process of piloting new training on domestic violence and abuse for first responders, supervisors and coaches which reinforces the need for evidence gathering to apprehend serial perpetrators. The training, "*DA Matters*", supports officers to understand the dynamics of domestic abuse and that their attitudes and behaviours reflect their knowledge. The College of Policing is piloting new training on domestic abuse; the programme, DA Matters, is designed to effect a cultural and attitudinal change and is jointly delivered by approved police trainers and domestic abuse experts.

101. In addition, Public Health England has funded free online training (through Against Violence and Abuse (AVA)) to improve awareness amongst healthcare professionals, based on the National Institute for Health and Care Excellence (NICE) guidance on domestic abuse: https://avaproject.org.uk/ava-training/elearning/

102. The College of Policing is also looking at further professionalising the approach to dealing with high harm crimes such as domestic abuse. The College of Policing will shortly be consulting on proposals to develop minimum training and standards for certain specialist roles and to give the college responsibility to enforce those standards through a system of national accreditation. This will deliver higher standards for specialist investigators.

Public awareness

103. Our ambition is to make awareness of and response to VAWG 'everyone's business' across all agencies, professions and the wider public. We will ensure that women can seek help in a range of everyday settings as they go about their daily lives – for example through interactions with Citizens Advice, housing providers, Job Centres and employers – and secure appropriate support from specialist victim services.

104. Local areas should review their communications to ensure that all forms of domestic abuse, including coercive and controlling behaviour, are covered. A VAWG communications pack is available on Gov.uk to help you develop local campaigns:

https://www.gov.uk/government/publications/violence-against-women-and-girls-communications-insight-pack Information is also available for family or friends of victims, outlining what they should do if concerned about someone affected by domestic abuse, an example of which can be found at https://www.womensaid.org.uk/the-survivors-handbook/im-worried-about-someone-else/

105. The Government is committed to challenging the deep-rooted social norms, attitudes and behaviours that discriminate against and limit women and girls across all communities. We will educate, inform and challenge young people about healthy relationships, abuse and consent. Working with partners like the PSHE Association, leading Head Teachers and other practitioners, we will ensure schools have access to effective and high quality resources for teaching about healthy relationships. Our nationally acclaimed campaign, *This is Abuse,* has had an impact and we have invested £3.85 million in a new campaign to continue to build teenagers' awareness of issues like consent, 'sexting' and relationship abuse. Local areas can access support materials from the campaign by emailing VAWGCampaign@homeoffice.gsi.gov.uk

Complex Needs

106. In a number of cases the victim and/or the perpetrator had complex needs which could include domestic violence and abuse, alcohol and substance use issues, and mental health illness. In cases such as these appropriate multi-agency interventions are needed and there is a need to raise awareness and understanding of how best to engage and work with those with complex needs.

107. We are working to promote understanding of the needs of victims of domestic abuse with multiple complex needs and support commissioners to provide appropriate support.

108. Resources providing an overview of the policy context and approaches to planning and delivering good quality services for women with complex needs can be found here: http://weareagenda.org/policy-research/what-works/. In addition further information on working with substance use and domestic abuse can be found here: http://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf

109. The resources and services signposted here is not an exhaustive list. Local specialist organisations and agencies will be able to direct you to further expertise within your local area. This underpins the importance of embedding specialist support agencies within the DHR process.

Annex A: Analysis of Homicide Index – Additional Table

Table A1: Offences currently recorded as 'domestic' homicide[1,2,3] by relationship to principal suspect and age and sex of principal suspect, victims aged 16 and over, 2010/11 to 2014/15

England and Wales

	2010/11	2011/12	2012/13	2013/14	2014/15
			Numbers		
Male suspects					
Current/ex-partner[4]					
Under 16 years	0	0	0	0	0
16 and under 21 years	2	7	1	1	1
21 and under 30 years	18	15	12	18	7
30 and under 50 years	56	41	42	42	44
50 and under 70 years	14	26	18	24	25
70 years and over	13	3	5	6	8
Relative					
Under 16 years	1	1	0	1	0
16 and under 21 years	6	3	4	5	0
21 and under 30 years	7	9	4	12	15
30 and under 50 years	11	19	22	11	18
50 and under 70 years	8	7	4	9	8
70 years and over	1	1	0	3	0
Other household member					
Under 16 years	0	0	1	0	0
16 and under 21 years	3	0	1	0	2
21 and under 30 years	9	8	7	4	7
30 and under 50 years	10	5	7	4	2
50 and under 70 years	4	3	2	2	3
70 years and over	1	0	0	0	0
Total male	**164**	**148**	**130**	**142**	**140**

England and Wales

	2010/11	2011/12	2012/13	2013/14	2014/15
			Numbers		
Female suspects					
Current/ex-partner[4]					
Under 16 years	0	0	0	0	0
16 and under 21 years	2	0	0	0	1
21 and under 30 years	1	1	4	1	2
30 and under 50 years	6	10	8	6	4
50 and under 70 years	2	1	1	3	1
70 years and over	0	0	0	3	0
Relative					
Under 16 years	1	0	0	0	0
16 and under 21 years	2	0	0	1	0
21 and under 30 years	1	1	2	0	0
30 and under 50 years	6	1	0	5	0
50 and under 70 years	0	1	1	3	1
70 years and over	0	0	0	0	0
Other household member					
Under 16 years	0	0	0	0	0
16 and under 21 years	0	0	0	0	0
21 and under 30 years	0	0	0	0	0
30 and under 50 years	0	2	0	0	1
50 and under 70 years	1	0	0	0	0
70 years and over	0	0	0	0	0
Total female	**22**	**17**	**16**	**22**	**10**
No suspect charged	**4**	**2**	**1**	**3**	**7**

1. *Source: Homicide Index, Home Office*
2. Homicide Index data are not designated as National Statistics
3. As at 13 November 2015; figures are subject to revision as cases are dealt with by the police and by the courts, or as further information becomes available.
4. This differs from the current / ex-partner in Focus on Violent Crime chapter as excludes 'emotional rival'.

Annex B: Analysis of Domestic Homicide Reviews: detailed methodology

Theoretical Approach

This analysis draws on a systems and human factors theoretical approach developed and used widely in the health context. Under this perspective, domestic homicides are viewed as an 'organisational adverse event', where the 'organisation' is the complete set of statutory bodies that should be acting to prevent homicides. This approach aims to understand where there were opportunities to prevent a domestic homicide that may have been missed and what these were. The responsibility of the perpetrator for the event is not diminished under this approach; rather this approach aims to understand any wider conditions that may have led to the adverse event.

Sample

In order to create a geographically representative sample, a randomised stratified sampling methodology was used. The DHRs given permission to be published by the Home Office Quality Assurance Panel in the selected time frame were sorted by police force region areas. Some regions were added together to create more equal groupings as shown below:

London & South East
Eastern
South West & Wales
Midlands (East and West)
North West
North East

For each year, DHRs were randomly sampled from within each regional group on a proportionate basis up to a total of 40 cases. The sample for each year is shown below, as is the number of DHRs sampled in each regional group.

2013	9
2014	12
2015	12
2016	7
Total	**40**

London & South East	10
Eastern	4
South West & Wales	6
Midlands	9
North West	7
North East	4
Total	**40**

Coding and analysis

Case attributes were analysed for the 40 DHRs to explore the breakdown of domestic homicide type (familial or intimate partner), and within these the breakdown of characteristics such as age and gender. Background case characteristics such as the presence of mental health or substance use issues were explored, as well as previous violence. As only a small number of familial cases were sampled (n=7) only intimate partner cases were analysed further for commonalities within the content.

These DHRs were qualitatively coded using NVivo software. This method categorises text according to a set of 'codes' i.e. pre-defined categories, which are the factors listed in Annex C. These categories have been adapted from factors set out in the framework used in previous Home Office analysis of DHRs, which was based on seven factors identified by Vincent et al. (1998) as having the potential to lead to organisations' adverse events.

The most frequent sub-categories coded were identified as common themes. These were further analysed in greater depth to explore potential underlying issues within the broader theme.

Limitations

The following limitations are associated with the methodology and analysis:

- A relatively small sample (n=33) of intimate partner homicide DHRs were analysed. This means caution should be used when interpreting results as this sample is not necessarily representative of all domestic homicides or all DHRs.
- The analysis will be constrained by the quality of the DHRs and the information they contain. The DHRs vary in length, structure and writing style of the author.
- Decisions about which passages to code may be affected by the experience of the coder.
- It was challenging to code historical events in the case histories using the coding framework in Annex C. This was because it was difficult to ascertain the relevance of historical events to the homicide, especially if a historical event may have increased the risk of domestic violence. This is likely to be based on subjective opinion of the coder, although this was supported by any evidence of risk factors of domestic violence from academic literature, where possible.
- Some passages in the DHR can be coded as more than one category. Additionally, in some cases the data does not allow the coder to be certain about which contributory factor is most relevant to the passage. This was not thought to be a problem as one event may represent many different contributory factors to the homicide.
- The analysis cannot make judgements about the nature of the case itself; rather it will indicate the factors which DHR authors felt were most important to a case.

Annex C: Framework

Factors	Sub-categories
1. Individual *Factors relating to the victim and perpetrator*	A. Offender history of violence B. Victim history of violence C. Substance misuse (victim or perpetrator) D. Mental health (victim or perpetrator) E. Difficulty of locating victim F. Child abuse (current – of children involved in relationship) G. Domestic abuse during pregnancy H. Child abuse (past – of victim/perpetrator themselves) I. Caring responsibilities J. Presence of children impacted victim's vulnerability K. Complex needs L. Other victim/perpetrator behaviour M. Employment issues N. Relationship strain/separation O. Financial issues
2. Task & task-related technology *Issues with how the case was picked up and how it was understood/ categorised (inc. contacts by agencies)*	A. Clarity of task for professionals; B. Identification/understanding of domestic violence (inc. control/coercion issues); C. Identification of dangerous individual (e.g. knowledge of weapons); D. Risk assessment E. Other task related
3. Professional Competency *Issues with performance of individuals involved with handling the case*	A. Competence, knowledge and skills (inc. identification of risk, familiarity with risk assessment tools) B. Training; C. Physical/mental health of professionals; D. Personal communication style;
4. Agency Teamwork *Issues with how individuals worked together within agencies to handle the case*	A. Verbal and written communication within particular teams (i.e. between individuals); B. Supervision C. Structure of teams D. Intra-agency communication
5. Agency Work environment *Issues with the particular conditions in which individuals were working*	A. Workload, B. finances/ resources; C. Lack of support; D. Equipment (e.g. IT equipment) E. Record keeping F. Organisational policy

Factors	Sub-categories
6. Organisation and management[9] *Issues with how the case was managed through the entire system*	A. Referrals; B. Placement of offenders; C. Communication / Information sharing between agencies; D. Multi agency work; E. Different agency views of risk
7. Institutional context *Issues with the wider conditions that may have influenced how people acted*	A. Wider economic / financial conditions; B. Policy guidelines; C. Availability of services
8. Wider contextual factors *Any community/cultural factors that may have influenced vulnerability*	A. New arrivals/immigrants B. Cultural barriers to accessing services C. Language barriers to accessing services D. Other non-engagement with services (victim) E. Other non-engagement with services (offender) F. Isolation of victim G. Child neglect as indicator of domestic abuse H. Public awareness
9. Any best practice/good points	n/a

[9] Note: DHRs involve several organisations, and so 'Organisation and management' needs to take into account multi-agency work / communication, while also paying attention to specific conditions within particular agencies.

Annex D: Attributes of familial homicide DHRs

Familial Homicide

Of the 40 cases analysed, seven were familial. All involved a male perpetrator. Six of these were cases of a son killing a parent: in one case it was the father, in the other five it was their mother. In the remaining case a grandson killed his grandfather. Mental health issues were considered as factors in the DHR in all seven cases. This was further analysed for the types of conditions and number of conditions present in each case. A breakdown of perpetrator mental health issues is shown in table D1 below.

Table D1: Perpetrator mental health issues in familial cases

	Count of mentions
Depression	4
Schizophrenia	2
Psychosis	2
Paranoia	1
Bipolar	1
Suicide attempts	1

The number of separate diagnoses, conditions or issues noted in each DHR was also analysed. Of the seven familial homicide perpetrators, four had only one diagnosis, two had two concurrent diagnoses and one perpetrator had three.

Substance use by the perpetrator was also noted in all but one of the familial homicide cases. In all six cases this was at a problem level, with referral to services. Table D2 shows differentiation between different substance types.

Table D2: Perpetrator use of different substance types in familial cases

	Count of cases
Alcohol	1
Drugs	3
Alcohol & Drugs	2

Annex E: DHR coding results

Factors	Sub-categories	Familial	IPV	Total
1. Individual *Factors relating to the victim and perpetrator*	A. Offender history of violence	4	24	28
	B. Victim history of violence	0	6	6
	C. Substance misuse (victim or perpetrator)	6	21	27
	D. Mental health (victim or perpetrator)	7	25	32
	E. Difficulty of locating victim	0	1	1
	F. Child abuse (current – of children involved in relationship)	0	5	5
	G. Domestic abuse during pregnancy	0	6	6
	H. Child abuse (past – of victim/perpetrator themselves)	2	3	5
	I. Caring responsibilities	5	6	11
	J. Presence of children impacted victim's vulnerability	0	5	5
	K. Complex needs	0	4	4
	L. Other victim/perpetrator behaviour	3	13	16
	M. Employment issues	3	13	16
	N. Relationship strain/separation	2	17	19
	O. Financial issues	2	12	14
2. Task & task-related technology *Issues with how the case was picked up and how it was understood/ categorised (inc. contacts by agencies)*	A. Clarity of task for professionals;	1	13	14
	B. Identification/understanding of domestic violence (inc. control/coercion issues);	6	24	30
	C. Identification of dangerous individual (e.g. knowledge of weapons);	0	5	5
	D. Risk assessment	3	27	30
	E. Other task related	4	22	26
3. Professional Competency *Issues with performance of individuals involved with handling the case*	A. Competence, knowledge and skills (inc. identification of risk, familiarity with risk assessment tools)	4	19	23
	B. Training;	2	16	18
	C. Physical/mental health of professionals;	0	2	2
	D. Personal communication style;	0	2	2

Factors	Sub-categories	Familial	IPV	Total
4. Agency Teamwork *Issues with how individuals worked together within agencies to handle the case*	A. Verbal and written communication within particular teams (i.e. between individuals);	1	8	9
	B. Supervision	1	9	10
	C. Structure of teams	0	4	4
	D. Intra-agency communication	2	16	18
5. Agency Work environment *Issues with the particular conditions in which individuals were working*	A. Workload,	1	8	9
	B. Finances/ resources;	2	13	15
	C. Lack of support;	0	1	1
	D. Equipment (e.g. IT equipment)	1	9	10
	E. Record keeping	5	28	33
	F. Organisational policy	4	19	23
6. Organisation and management *Issues with how the case was managed through the entire system*	A. Referrals;	5	18	23
	B. Placement of offenders;	0	1	1
	C. Communication / Information sharing between agencies;	6	25	31
	D. Multi agency work;	5	19	24
	E. Different agency views of risk	1	5	6
7. Institutional context *Issues with the wider conditions that may have influenced how people acted*	A. Wider economic / financial conditions;	1	1	2
	B. Policy guidelines;	0	7	7
	C. Availability of services	4	8	12
8. Wider contextual factors *Any community/cultural factors that may have influenced vulnerability*	A. New arrivals/immigrants	1	2	3
	B. Cultural barriers to accessing services	2	5	7
	C. Language barriers to accessing services	1	1	2
	D. Other non-engagement with services (victim)	2	21	23
	E. Other non-engagement with services (offender)	7	19	26
	F. Isolation of victim	1	5	6
	G. Child neglect as indicator of domestic abuse	0	2	2
	H. Public awareness	0	14	14
9. Any best practice/good points	n/a	5	26	31

Annex F: Further Reading

Domestic Homicide Review Case Analysis Report published by Standing Together Against Domestic Violence

http://www.standingtogether.org.uk/news/domestic-homicide-review-case-analysis-report

Revised Statutory Guidance on the Conduct of Domestic Homicide Reviews:

https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

Ending Violence Against Women and Girls Strategy: 2016 to 2020

https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020

Crown Prosecution Service: Violence Against Women and Girls Crime Report 2015-16

http://www.cps.gov.uk/publications/docs/cps_vawg_report_2016.pdf

HM Inspectorate of Constabulary: Increasingly Everyone's Business: A Progress Report on the Police Response to Domestic Abuse:

https://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/increasingly-everyones-business-domestic-abuse-progress-report.pdf