Partnership and Place Overview and Scrutiny Committee

6 December 2012

Report from the Director of Strategy, Partnerships and Improvement

For Information	Wards Affected: ALL

Domestic Violence Homicide Reviews

1.0 Summary

1.1 This report briefly looks at the process, terms of reference and limitations of Domestic Violence Homicide Reviews. It goes on to give an insight into the lessons learnt from the first two inquiries to be held in Brent.

2.0 Recommendations

2.1 The Committee are asked to note the report

2.2 That the Committee notes the correlation of weak points between the two reviews, particularly communication breakdowns

2.3 That the Council through the Committee note the financial burden imposed by this additional statutory duty.

3.0 Detail

3.1 Current Domestic Homicide Review in Brent

3.1.1 The first fatality occurred within days of the legislation coming into force. The second sadly happened six weeks later.

3.1.2 These reports are both in their final draft stages. One has been approved by the Home Office. It now awaits clearance from partners before an executive summery is published.

3.1.3 The second is ready for submission to the Home Office.

3.1.4 The third case relates to an interfamily fatality and work is continuing in this instance. In this instance the case involves an uncle and a nephew, the initial information trawl, indicates that they had no contact with agencies; other than for very run of the mill age related health matters.

3.2 Legislative Framework

3.2.1 Section 9 of the Domestic Violence, Crime and Victims Act (2004) established the requirement on Local Authorities to conduct Domestic Homicide Reviews where a domestic homicide had been committed pertinent to its area. This provision came into force in April 2011 and it is under this provision that this review has been conducted.

3.2.2 There was no real guidance in place; and those boroughs like Brent with cases immediately after the enactment of the legislation, had to test and probe every step looking at legality, practicality and ethically. For example what could be discussed pre trial in a forum bound by confidentiality, but quite large with agencies sometimes sending different representatives.

3.2.3 For many years the Association of Chief Police Officers (ACPO) have conducted Domestic Violence Murder Reviews, whilst the central focus is Police conduct, they also look at other agency input where it overlaps with the work of the Police services. Their reviews focus almost exclusively on possible misconduct or dereliction of duty and hence have a very different ethos and framework to these reviews. ACPO investigators attended the meetings and offered invaluable advice, however marrying the two outlooks proved problematic at first. The considerable time spent resolving this dichotomy enabled information to flow in a blame free environment. The caveat to that is, had wrong doing or gross failures been found participant knew this information would haven passed on to the relevant authorities or senior staff.

3.3 Purpose of Domestic Violence Homicide Reviews

3.3.1 The purpose of a domestic homicide review is to consider the circumstances that led to the death and identify where responses to the situation could be improved in the future. In so doing, the lessons learned will be taken on board by the professionals and agencies involved, such as the police, social services, councils, and other community based organisations.

3.4 Domestic Violence Homicide Review Process

3.4.1 Appendix one maps out the process.

3.4.2 A review panel, led by an independent chair, is commissioned to undertake the Domestic Homicide Review and a panel overseeing the review is made up of members of local statutory and voluntary agencies. This panel reviews each agency's review of their involvement in the case and consider

recommendations to improve responses to domestic violence in the future. This is a peer learning not a judging process. They will also have the chance to hear from family, friends and work colleagues who may be able to help the panel understand the impact of agency's involvement with the victim or the perpetrator.

3.4.3 Domestic homicide Reviews are not inquiries into how someone died or who is to blame; they are not part of any disciplinary process. They do not replace, but will be in addition to, an inquest or any other form of inquiry into the homicide.

3.4.4 In this way, it is intended that agencies will improve their responses to domestic violence and work better together to prevent such tragedies occurring in the future.

3.4.5 To find out more detail about Domestic Homicide Reviews, follow these links:

1. Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

2. Support for families involved in Domestic Homicide Reviews

3.4.6 Both reports are nearing their conclusion, the panels drew together information from all organisations that were potential sources of support for the victims. These organisations were:

- The Metropolitan Police Brent, Ealing and Harrow Borough
- Ealing Hospital NHS Trust (including Ealing Community Services, Harrow Community Services and Brent Community Services)
- Brent Council's Housing Department
- Brent Social Care
- North West London Hospitals NHS Trust
- NHS Brent, Harrow and Ealing (relevant GPs)
- London Probation Service
- Advance (domestic violence project)

3.4.7 Agencies gave chronological accounts of their contact with victims and perpetrators prior to the murder. Only agencies that had relevant or significant contact with the victims or perpetrators were a part of these reviews. From these accounts, an overall chronology of interactions with these families was created.

3.4.8 Each agency was then required to produce an Independent Management Review which must incorporate the following:

- a chronology of interaction with the victim, the perpetrator and/or their children
- action regarding the family unit
- whether or not internal procedures were followed

- conclusions and recommendations for improvements from that agency's perspective

3.4.9 The various accounts of involvement with these family units covered different periods of time prior to both women's death. Some of the accounts proved to be of more significance than others.

3.4.10 All agencies responded in both reviews. No agencies invited to respond returned a nil response. There was openness and co-operation among the agencies involved in the two reviews. At meetings, participants were ready to identify areas demanding attention within their own organisation and there was, predominantly constructive questioning and overall a lack of defensiveness.

3.4.11 Throughout the process, the families were kept updated by the homicide case workers at Victim Support. On two occasions, Victim Support facilitated an extended visit by the chairs to meet the two families. This was to gain insights into their perspectives on what had happened and make the review more humane for the families at this difficult time.

3.5 Key Issues Arising from the Reviews

3.5.1 Victims of domestic violence are, for a range of reasons, often reluctant to report or reveal their circumstances. This places the onus on agencies to make the connections and draw out a wider picture where possible. Being able to do that depends on three factors:

- staff awareness, skill and experience at noticing any indication that domestic violence might be an issue underlying the presenting issues
- communication within the organisation, in particular between departments
- communication between organisations

3.5.2 In these cases these factors were variable in quality (at some points very good but at others in need of improvement).

3.5.3 Turning to the perpetrator, some criminal charges and interaction with Police were not set in context of a pattern of repeated and escalating criminal behaviour where violence was becoming more and more a key feature.

3.5.4 Shortfalls in information sharing were highlighted in both cases. For example the perpetrator in the one case was accused of a rape offence. This triggered a referral to the Barnet MAPPA panel and the case was discussed in January 2010. Although this case did not involve his partner who he eventually killed, there was no evidence that this additional information was passed to Brent Social Services so that they could re-assess the risk to his former partner.

4.0 Terms of reference

4.1 The full terms of reference for these reviews are available on request. In summary, the overall aims of the review were to:

- establish whether there are lessons to be learned about the way in which local professionals and agencies worked together to safeguard domestic violence victims and their children
- clarify what any lessons are, how they will be acted upon and what is expected to change as a result
- improve inter-agency working and improve protection for domestic violence victims and their children

4.2 The principle responsibilities of the review panel were to:

- establish the chronological order of events
- analyse organisational links within the partnership
- assess the quality and quantity of available information from across the partnership
- examine the effectiveness and suitability of relevant protocols
- critically evaluate partnership working practice
- remain a paper-based review

5.0 Financing Domestic Homicide Reviews

5.1 Whilst this is a statutory requirement there are no additional funds attached to this work. In Brent the part time officer has been financed through additional funds gained from the European Daphne fund.

5.2 This particular source of money will not be available in the next financial year. The Integrated Community Safety Team will, through job realignment and some restructuring seek to incorporate this additional work. Including implementing the recommendations and monitoring and driving the action plan within the current staff budget.

5.3 The Community Safety Partnership Board will hold the corporate responsibility for implementing the recommendations.

5.4 As Brent has successfully worked and almost completed three such reviews the Home Office are funding a programme here so we can develop the national guidelines. Our first step is to host a day in December 2012. At this all councils and Police services who have overseen Domestic Violence Homicide Reviews will come together to share experiences, tips, knowledge and highlight pitfalls.

5.5 From this information we will develop the “How To” pack which will incorporate the excel workbook we developed to assist with the complex chronologies we have had to undertake.

6.0 Legal Implications

6.1 None

7.0 Diversity Implications

7.1 None

8.0 Staffing/Accommodation Implications (if appropriate)

8.1 None

Background Papers

None

Contact Officers
Genny Renard
Head of Integrated Community Safety