Learning From Domestic Homicide Review
Adult A – Quality Assured by the Home Office March 2012

Domestic Homicide Reviews (DHRs) aim to improve practice and outcomes for people affected by domestic abuse. This learning sheet is designed to highlight the key areas of learning and practice in relation to the Adult A DHR. We hope you will reflect on your own practice in light of this information.

Adult A lived in Sheffield with her two daughters (aged 10 and 3 years).
She was killed at her home in June 2011 by Adult B. The couple did not live together and were in the process of separating. Adult B was sentenced in December to 25 years in prison for her murder.

The Domestic Homicide Review process began in July and the Overview report has now been completed and approved by the Safer and Sustainable Communities Partnership Board (12th Jan). The review was chaired and authored by Professor Pat Cantrill.

The review has found **no evidence that any agency knew of any domestic violence** between the deceased and the perpetrator: **there were not missed opportunities to prevent the death.**

Nonetheless, the review process has generated a number of recommendations for improving services more generally.

Lessons to be learnt

1. The role of the universal services provided by health, education and early years provision is crucial to addressing issues associated with safeguarding children and young people from domestic violence. **Professionals need to become more aware of the power of their role, and to use it to safeguard children and to support parents experiencing domestic violence.** It is vital that teachers and health professionals undertake a complete assessment including asking questions about relationships and the home environment.

2. General Practice is the main point of contact for all primary healthcare services. It can be expected that General Practitioners will have a holistic overview of their patients and their needs. The recognition of factors which, particularly in combination, may indicate that someone is experiencing or could potentially be harmed as a result of domestic violence is very important. As the contact time that GPs have with patients is limited it is important that they have a trigger list of indicators in the same way that they have for assessment of illness. These factors would include clinical matters e.g. disability, chronic health problems, mental health problems, stress, threatened suicide; and social issues e.g. recurrent non-attendance for appointments, not engaging with education services, recurrent injuries, frequent changes of address and/or GP. **It is recommended that NHS Sheffield, through their contractual arrangements with GPs, recognise the important role of GPs in relation to victims of domestic abuse and their families and that appropriate training, guidance and support is provided by commissioners and professional bodies, including identifying the risk indicators associated with perpetrator behaviour.**

3. What is obvious from reviewing the IMRs from the different agencies that provided services for Adult A and her two daughters is that **there has been a considerable amount of good practice.** Agencies shared information and as a result there was the required level of shared analysis, planning and inter-agency practice. There is evidence of good ongoing inter-agency activity and communication between professionals particularly around meeting the needs of the elder daughter.

4. The Initial Assessments undertaken by social workers were identified by the IMR author as child-focussed and the children were seen. However **the children were not spoken to alone during the**

second referral, which would have enhanced the quality of the assessment. The expectations of speaking to children alone are mandatory, and were mandatory at the time of the referral.

5. There is professional concern about the disclosure/confidentiality of patient/client information leading to litigation. Added to this feeling of professional vulnerability is a perception of a lack of organisational support causing practitioners to feel that they are 'on their own' which escalates the feeling of risk. This can be identified from the comments made by the GP that they would not know what to do if they identified domestic violence. **Having agreed policies and procedures in place assists professionals in their practice. Information about the services available to victims of domestic abuse should be included in NHS Sheffield's website and other ways of disseminating this to GPs explored.**

6. Whilst both public and professionals are often told that the Data Protection Act does not inhibit agencies from sharing information, it does not positively encourage or require it; nor, critically, does it explicitly offer protection to those charged with making the judgments about sharing sensitive personnel data in cases of suspected risk. **Sharing information from client patient records for DHRs appears to create more difficulty than that for serious case reviews. Further clarity is required particularly for access to medical records**.

7. **Raising public awareness of domestic violence is an ongoing issue**. Sheffield Domestic Abuse Partnership (DAP) is well aware of this and they need to not only increase awareness for victims but also to establish collective community responsibility. The role that partner organisations, both statutory and voluntary, can play is crucial and the professionals that work in them need to act as champions to provide information to individuals and communities.

8. Leadership is crucial to having successful domestic violence services and having a strategic approach with **clear** priorities is crucial, particularly as partnership organisations deal with fiscal constraints. Sheffield Safer and Sustainable Communities Partnership and Sheffield DAP should finalise the partnership and information agreements to demonstrate the commitment from all partner agencies and the voluntary sector to the strategic priorities associated with domestic violence. **Sheffield Safer and Sustainable Communities Partnership and Sheffield DAP need to review existing priorities for domestic violence and develop a new strategic plan which encompasses commissioning as well as delivery of services**.

9. While the ACPO DASH Risk Assessment tool is in use by some agencies, **decisions need to be made at a strategic level regarding the embedding of the ACPO DASH tool in frontline practice when domestic abuse is identified.** A task and finish group of key agency and service leads should be established in order to develop a multi agency protocol regarding the risk assessment of victims of domestic violence.

10**. Sheffield Homes**

a) Sheffield Homes to review its procedure for securing a forwarding address both at the time of notification of termination and at the pre quit visit with the aim of identifying safeguarding, vulnerability or domestic abuse concerns with a view to making the appropriate referral.

b) Sheffield Homes to refer cases to the MAST Team via the new Housing and Children's Services Improving Joint Working protocol details where a notice of termination has been received with no forwarding address.

c) Sheffield Homes to refer cases to the MAST Team via the new Housing and Children's Services Improving Joint Working protocol details of families of abandoned properties where children have been known to reside.