# Sheffield Domestic Homicide Reviews (DHRs) Needs Assessment

# 2024



1. **The criteria for Domestic Homicide Reviews**

Under section 9(3) of the 2004 Domestic Violence Crime and Victim’s Act, a domestic homicide review means:

a 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) a person to whom he was related\* or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

\*Diagram below shows the relationships that could be considered – in the stat definition of DA it talks about people who are ‘personally connected’.

Any of the people on this family tree would qualify as being **personally connected** to Person B, making any abusive behaviour between them domestic abuse. Abuse towards in-laws (whether by common law or marriage) is also domestic abuse.

1. **Data**

Since DHRs became a statutory duty in April 2011 Sheffield has started or undertaken 21 reviews involving 22 adults.

* 1. Gender
* 18 of the victims were female and 4 were male.
* 18 of the perpetrators were male and 3 females.
	1. Homicide or suicide

7 suicide cases have been reviewed as DHRs and 15 homicide cases. 6 were females and one male. The number of suicide cases has risen sharply since 2019. This is not simply because more domestic abuse related suicides are happening, it because agencies are now recognising that domestic abuse has played a part in the suicide and that these deaths meet the statutory criteria for Domestic Homicide Reviews.

Suicides can prove complicated cases to review as DHRs, especially where there is little tangible proof that domestic abuse has taken place e.g. when the allegation is made in a suicide note but nowhere else. The current review of the DHR statutory guidance may help with this situation.

* 1. Relationships

In 17 of the 21 Sheffield cases the victim and the perpetrator had been in an intimate partner relationship however in 9 of these cases, over half, they had separated prior to the death. This demonstrates the prevalence and seriousness of post separation abuse and the high risk of serious harm following separation.

In 4 cases the perpetrator was an adult family member – in three of the cases an adult child, and in one case a sibling. In these cases, agencies were less likely to identify that there was a risk of domestic abuse.

* 1. Children

In 10 of the cases the victims and / or perpetrators had dependent children at the time of the death (i.e. under 18s): 21 dependent children in total. This does not include adult children, grandchildren, children who had been removed from the parent’s care or with whom they had no contact.

* 1. Ethnicity

12 of the victims were white British (54.5% of the total number), one was white East European and one was white other (South African). Three victims were British Asians from Pakistani background families. One victim was from an Arab background. Three victims were from black African families. Compared to the Sheffield population, victims were disproportionately from ethnic minority (global majority) backgrounds. This indicates that victims / survivors from black and minoritised backgrounds may find it harder to access support at an early stage.

* 1. Method of killing

In line with national data[[1]](#footnote-1) most deaths that were homicides (as opposed to suicides) in Sheffield were as a result of stabbing with a knife or other sharp instrument – 12 victims in 11 DHRs. 2 victims died as a result of blunt force trauma.

* 1. Themes from Data

Sheffield DHR cases demonstrate that domestic homicides are gendered - many more women than men are victims of both murders and suicides. Over 75% of cases were intimate partner relationships. Compared to the Sheffield population, victims were disproportionately from non-white British backgrounds. Suicide cases have risen since 2019 so that in the last 5 years, 6 out of 10 of the cases have been suicides rather than homicides. This does not mean that more suicides are happening in the context of have but instead that more suicides are being identified as related and meeting the statutory criteria to be reviewed as a DHR.

* 1. Rate of DHRs

20 cases have been reviewed over 13 years – a rate of 1.54 per year. However the rate has risen since the increase in identification of related suicide cases – 10 in the last 5 years meaning a rate of 2 per year.

* 1. South Yorkshire overview



1. **Serious Incident Reviews**

If there has been a serious incident that has arisen due to domestic abuse, or if the criteria for a DHR is not met but there is likely to be learning for agencies, the Safer Sheffield Partnership may undertake a Serious Incident Review. The aim of this is the same as for a DHR, but the process is shorter and may not include an independent chair. A learning brief including recommendations for action is produced, published, and shared with professionals in Sheffield.

12 such reviews have been started or completed in Sheffield.

**DA Serious Incident Reviews Criteria**

* A near miss – a victim of domestic abuse who has been considered by the MARAC process within the last 12 months receives life threatening injuries, or
* A charge of attempted murder is brought against the perpetrator of a domestic abuse incident, or
* A victim that has been to MARAC within a twelve-month period dies and the circumstances, while not meeting the DHR criteria, warrant consideration of agency involvement and response,
* Or other circumstances that partners consider will result in significant learning by more than one agency.
1. **Process and governance**

The DHR process in Sheffield is supported by the Domestic Abuse Commissioning Team in the Integrated Commissioning and Public Health Directorate in Sheffield City Council. This team commissions the DHRs, convenes and administers the necessary meetings, seeks independent chair / authors, shares learning and manages the implementation of action plans. A multi-agency DHR / SIR sub group meets quarterly to review progress and this reports to the Domestic and Sexual Abuse Strategic Board. The Board acts as the Violence Against Women and Girls theme group of the Safer Sheffield Partnership which as the community safety partnership for Sheffield holds statutory responsibility for the conducting of DHRs. Training on writing Individual Management Reviews is provided twice yearly for any agency in the city in partnership with the Safeguarding Children’s Partnership and the Safeguarding Adult’s Partnership.

The Sheffield process is outlined in the diagram below:



The first panel agrees a draft Terms of Reference for the Independent Chair / Author to review when appointed. There the following meetings are held (there may be some variation depending on the Chair’s preferences or the needs of the case:

* IMR Briefing Meeting
* IMR Review Meeting
* Practitioner’s Meeting (not in every case)
* Panel Meetings to review drafts of the Overview Report

**Funding:** there is no central government funding made available for DHRs. Funding is not referred to in the statutory guidance, or in the draft revised statutory guidance (as of July 2024). This means that the financial burden is subject to local negotiation between statutory partners (Safer Sheffield Partnership, Police, ICB, Probation and the Council) with the Council taking on the cost of managing the process: estimated at £4,500 minimum per case.

**Family involvement:** in each review efforts are made to involve the family (and friends and colleagues) of the victim. Review Chairs often also reach out to the alleged perpetrator to seek their views. Reviews are immensely enriched by engagement of family and friends. Some family members have met the review panels and asked questions about the process. However, in some cases it has not been possible to engage family or friends despite many approaches and the decision not to be involved must be respected. Thus far there has not been any engagement in reviews of children under the age of 18 although this has been discussed with parents/carers, but the offer has been declined.

1. **Themes**



* 1. Top local themes
* **Risk assessment** has been a theme in 15 Sheffield reviews – risk assessments are not always conducted at point of disclosure. Professionals sometimes think that someone else has done the assessment, and therefore they don’t need to – especially if the police are involved. DHR learning demonstrates that this is not the case and that staff must always act as if no one else is aware or has acted upon the disclosure unless there is clear evidence to the contrary. Even if the Police have done a DASH, it is possible that more information may be shared with a non criminal justice agency for many reasons e.g. fear of repercussions of reporting, no desire to see perpetrator criminalised, fear of Police action in relation to other issues such as drug use, lack of trust in Police from some communities etc. Lack of risk assessment also means that cases do not get referred to MARAC when they should be. Training on DASH and MARAC is available via IDAS the commissioned training provider and regularly promoted.
* **Professional curiosity** has been a theme in 14 Sheffield reviews – reviews have demonstrated that staff have missed opportunities to ask questions and try and understand more about a situation and the underlying issues. Asking more questions in a sensitive way can lead to earlier disclosures and allow for earlier intervention. Training on professional curiosity has been developed by the Safeguarding Partnerships.
* **Asking about / routine enquiry** has been a theme in 14 reviews –some agencies have routine enquiry built into processes as standard however reviews have demonstrated that these processes have not always been followed. Promoting asking about in a sensitive way has been recommended for agencies such as GPs and the hospital Emergency Department. Training and briefings have been developed to support staff in asking the question about in a sensitive way that is not just a ‘tick box’ exercise.
* **Perpetrator’s mental health** has been a theme in 13 reviews – indicating the importance of asking about relationships and considering whether partners or family members (including children) may be at risk if someone’s mental health is deteriorating. GPs have been asked to consider the ‘trilogy of risk’ and to remember to think about if patients are presenting with mental health or substance misuse issues.

**Other key themes:**

**Trauma / ACES**

Several reviews have highlighted the impact of trauma as significant in either the actions of the perpetrator or the decisions of the victim. Adult V DHR - Kirsten pointed to the impact of cumulative trauma as an adult that meant that Kirsten felt unable to extricate herself from the abusive relationship – she was entrapped by the perpetrator who she had been in relationship with since she was a teen and she felt that her only way out was to take her own life. Adult S DHR – Leah noted that the perpetrator had experienced domestic abuse as a child and was care experienced, while this was not an excuse it pointed to the need for trauma informed support for him as he grew into adulthood

**Domestic abuse and carers**

Caring responsibilities has been a theme in 8 reviews. The learning being that it is important to think about risk to informal carers and whether the caring arrangement is appropriate and safe. Some carers have their own vulnerabilities such as mental health or substance misuse issues which may mean that caring is too much responsibility for them. Several reviews have emphasised the need for carers to be referred for carers assessments at the Sheffield Carer’s Centre to enable these issues to be explored.

**Multi Agency Risk Assessment Conferences (MARAC)**

As a result of Adult V DHR – Kirsten, and concerns around there not being full consideration of historical factors at MARAC, a review of MARAC was recommended to ensure that the MARAC process is effective and timely.

* 1. **Learning in relation to Sheffield DHRs where there have been dependent children.**

This learning was summarised for a report to the Learning Practice Improvement Group of the Safeguarding Children Partnership in February 2024 as follows:

These themes are echoed in the findings in the recent [HALT research](https://domesticabusecommissioner.uk/wp-content/uploads/2023/12/Summary-of-Findings-Childrens-Services-Domestic-Homicide-Oversight-Mechanism-2023.pdf). In Sheffield a lot of these issues are addressed in the [Safe and Together](https://safeandtogetherinstitute.com/) training and briefings. This training, aimed primarily at the Children’s workforce, encourages partnering with survivors to keep children safe instead of using victim blaming narratives. It also firmly emphasises holding perpetrators to account for their behaviour and frames this as a parenting choice. A conference on Coercive Control was held in Sheffield Town Hall in February 2023 because of a DHR recommendation.

Children and Domestic Abuse is currently a priority for the Sheffield Children’s Safeguarding Partnership.

**5.3** **Themes and learning in relation to multiple disadvantage in Sheffield DHRs.**

Analysis of victim and perpetrator vulnerabilities in Sheffield DHRs is as follows:

* 4 victims had experienced homelessness
* 4 perpetrators had experienced homelessness
* 1 perpetrator had moved in with parents due to relationship breakdown (his use of domestic abuse)
* 6 victims had problematic substance use – mostly alcohol but one was a recovering opiate user and one was using cocaine
* 9 perpetrators had problematic substance use - alcohol, opiates and non-opiates
* 8 victims had mental health issues
* 9 perpetrators had mental health issues
* 9 perpetrators had a history of offending

Three or more of these vulnerabilities, indicating multiple disadvantage, can be found in five of the Sheffield reviews.

Some of the learning is as follows:

* raise **awareness of where the abuser is a family member** rather than an intimate partner.
* need to enquire about / assess **within the wider family** where individuals are presenting with alcohol misuse and mental health issues
* always **ask questions about home circumstances** when assessing patients who present with issues of substance misuse.
* Consider risk of suicide and raise awareness of **attempted suicide as a potential indicator of domestic abuse.**
* Understand **impact of coercive control**
* Need to use **trauma informed approaches** to build trust and engagement
* Consider if a victim’s behaviour has been the use **violent resistance or self defence**
* Consider the evidence of the **links between adverse childhood experiences, family violence & youth offending** & put in place interventions to mitigate the risk
* Professionals need to be supported to **identify and support victims who may be experiencing controlling behaviour from a family member**.
* Agencies should be more aware that **men can also be victims of**
* **Cultural issues** around dishonour and shame **may be barriers to disclosure**
* Where there is a long history of abuse this should be considered and **incidents not seen in isolation**
* **Substance misuse can be a means of coping** with domestic abuse
* Ensure referrals are made for **Carer’s Assessments**
* Agencies must **ensure that staff are confident in using risk assessments**. That **training on this is mandatory for frontline staff**. training should stress increasing **awareness of high-risk factors such as non-fatal strangulation, coercive control, pregnancy and separation**.
1. **Dissemination of learning**

A key outcome of DHRs is to disseminate and embed learning. Reviews are published [here](https://www.sheffield.gov.uk/public-health/domestic-homicide-reviews-dhrs) unless there is a strong reason for not publishing e.g. for safeguarding reasons when the perpetrator has not been convicted. Learning dissemination is currently achieved by the use of learning briefs for each case which is [published](https://www.sheffield.gov.uk/public-health/domestic-homicide-reviews-learning-briefs) and agencies are asked to promote them to staff. A joint DHR and SAR (Safeguarding Adults Review) newsletter is prepared and shared [quarterly.](https://www.sheffieldasp.org.uk/assets/1/version_for_sharing_january_2024_sar-dhr_quarterly_update.pdf) Subject specific briefings are also shared e.g. on the intersections of Dementia and Domestic Abuse, Multiple Disadvantage and Domestic Abuse or identifying and responding to Violent Resistance. Presentations on these and other issues such as Suicide and Domestic Abuse have been delivered at multi agency meetings. Locally commissioned training is also adapted regularly because of DHR learning e.g. in relation to learning on domestic abuse and suicide. In June 2024 an online workshop was held on the Homicide Timeline in relation to the Sarah DHR. A video extract can be seen [here](https://www.youtube.com/watch?v=XXoDwas9Ohw). Further free online training on the Homicide Suicide Timeline by Professor Jane Monkton Smith has been commissioned for October 14th, 2024. A conference on DHRs and SARs is also planned for October 2024.

However, it is clear that key messages from DHRs need regular reinforcement with the workforce.

**6.1 Implementation of Recommendations**

Ensuring recommendations can be translated into SMART actions is an ongoing challenge with DHRs particularly in relation to multi agency actions where it can be difficult to adapt one recommendation to fit all agencies. It is therefore important for the panel to support the Chair / Author to ensure that such recommendations are achievable as each review progresses.

A local DHR / SIR subgroup meets quarterly to monitor the implementation of actions supported by the DACT team.

6.2 Recommendations

An analysis of Sheffield DHR recommendation has been conducted in line with that undertaken nationally (see section 4 below). The national categories have been aligned with Sheffield recommendations as follows:

* **Record** – flagging MARAC cases and DA on systems / other recording issues
* **Assessments** – e.g. including past history, undertaking routine enquiry, wider family members, alcohol assessment, trilogy of risk, carers
* **Information** – sharing within and without services, information about support services shared with staff
* **Referral** – to external services when risk or vulnerability is evident. Correct pathways e.g. re. Mental Heath
* **Training / awareness raising** – need to develop or encourage staff to attend DA training or safeguarding training, audit of training needs, newsletters for staff, awareness of different types of DA including Adult Family Violence
* **Strategy and policy** – identify staff for working groups, develop DA policies, update procedures, promote awareness of them, sharing of learning from review to inform policy and procedures
* **Awareness raising** – with public
* **Support** – e.g. commitment to ensure services are funded / re-commissioned, pilot new forms of support
* **Staff support** – e.g. access to clinical supervision
* **Risk** – use of dash or other domestic abuse related risk issues.
* **Contact:** the need for greater contact with victims and recognition that the perpetrator

can control the victim’s contacts with agencies.

Training / awareness raising is the top recommendation in Sheffield. While we have excellent commissioned training in the city, the capacity of this to meet the needs of the workforce is not sufficient. There are also barriers in that some services do not mandate domestic abuse training as essential for their workforce. Therefore, the training recommendation is a recurrent one and likely to remain so.

Recommendations on ensuring relevant policies / strategies and procedures are in place, fit for purpose and followed accounts the second highest number. This is unsurprising as there have been many developments around emerging best practice in relation to domestic abuse in the last 13 years – many prompted by the learning from DHRs. There has also been the introduction of the Domestic Abuse Act 2021 and related policy changes needed.

By far the highest number of recommendations have been for health agencies. This is not surprising as this category accounts for the three main trusts in Sheffield, plus the ICB (formerly the CCG) and out of city health trusts (where victims or perpetrators have lived in other areas before coming to Sheffield). However, this also reflects the impact DHRs have had on responses to domestic abuse but health agencies.

Multi agency / partnership recommendations are the second highest category reflecting the fact that responding to domestic abuse is a whole system responsibility.

**6.3. Achievements and impact**

DHRs are important as they show respect for the person that died, they help families and friends understand some of the circumstances of their loved one’s life, and because of the positive change that can arise from the close review of a situation that sadly ended in tragedy. Some examples of the achievements and impact in Sheffield because of DHR learning are below.

* + 1. Improved engagement of health agencies in responding to domestic abuse has been a key impact in Sheffield and nationally since DHRs were introduced. Sheffield has established a Domestic Abuse Routine Enquiry Scheme with local GPs and some trusts such as Sheffield Children’s NHS Foundation Trust have their own Domestic Abuse policies and procedures. Sheffield Health and Social Care Trust regularly reviews and updates it’s safeguarding training following DHRs. Recently Sheffield Teaching Hospitals Trust has produced a clinical pathway in relation to Non-Fatal Strangulation.
		2. Domestic Abuse risk assessment processes are now embedded in most of the public and voluntary sector agency processes enabling earlier identification of people at high risk of serious harm or homicide.
		3. Agencies understanding of Adult Family Violence has increased. It is now more widely recognised that domestic abuse is not just about intimate partner relationships and there are key risk factors to be aware of.
		4. There is greater awareness of Coercive and Controlling Behaviour in the Sheffield workforce, and of the cumulative impact that this kind of abuse can have on mental health and on the ‘space for action’ that victims / survivors have. The presence of recent physical abuse is now less likely to be necessary for a case to be assessed as high risk resulting in a greater emphasis on identifying the pattern of abuse a perpetrator is using not just focussing on individual incidents. A conference on Coercive Control was held in Sheffield in February 2023.
		5. Caring responsibilities and being cared for are now more widely understood as needing greater consideration by professionals e.g. regarding the appropriateness of family members as carers, or the possible risks posed to carers by those they are caring for.
		6. Recognition of how domestic abuse intersects with other vulnerabilities, particularly mental health issues and problematic substance use, has seen domestic abuse included in the Hidden Harm agenda and strategy locally.
		7. Agency understanding of the fear of statutory services felt by parents who are victims / survivors of domestic was influenced by findings in DHRs and has been supported by the introduction of the [Safe and Together](https://safeandtogetherinstitute.com/the-sti-model/model-overview/) model in the city. This is supporting professionals to use a more trauma informed approach to gain trust to partner with survivors to keep children experiencing domestic abuse safe.
		8. The link between domestic abuse and suicidality is recognised more widely in Sheffield and a presentation on mothers whose cases were reviewed as DHRs following suicide was delivered at the Parental Mental Health Conference in November 2023. A local finding shared was that dependent children are not necessarily a protective factor against suicide for mothers experiencing domestic abuse.
		9. DHR findings, confirmed by local data from support services, have told us that women from racialised communities experiencing domestic abuse may be less likely to access community based (i.e. not accommodation based or refuge) support services as women from white British communities. This increases vulnerability and is an issue that will be a strategic priority for addressing.
1. **National Learning**

In September 2021 [Key Findings from Analysis of Domestic Homicide Reviews](https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews#:~:text=Across%20all%20the%20reviews%20there,the%20average%20age%20was%2040).), commissioned by the Home Office and prepared by Analytics Cambridge and QE Assessments Ltd was published. This reviewed 124 DHRs where the deaths had occurred in 2017 and 2018. It closely reviewed 50 of these cases.

Key themes from recommendations were:

* **Contact:** the need for greater contact with victims and recognition that the perpetrator

can control the victim’s contacts with agencies.

* **Assessment:** the need to improve risk assessments, carer’s assessments, or mental

health assessments.

* **Records:** information can be missing and not shared between agencies.
* **Support:** for staff whose work involved cases of domestic abuse and cases where support for victim was not identified or, where the need for support was identified, but

there was no plan to provide it.

* **Information:** the need to improve information sharing between agencies, to hold

accurate information and then use it effectively to manage risk.

* **Risk:** the right risk level needs to be identified, with information held by other agencies

included.

* **Referrals:** are not always made when needed.
* **Training:** the need to update training and make it accessible.
* **Policy:** occasions when action taken was not in line with policy and there were agencies

without a policy.

*‘From the recommendations in the DHRs, 25% were for partnerships (typically community safety partnerships), 24% for health organisations (including clinical commissioning groups, GPs, hospitals, and mental health trusts) and 13% for the police.*

*Twenty-eight percent of the recommendations were to review existing practice.*

*Twenty-six percent of the recommendations were to raise awareness, of which 72% were recommending raising awareness about domestic abuse to staff.*

*Sixteen percent of the recommendations concerned information: including the quality of information and sharing information between agencies.’*

The research found that 60% of perpetrators had previous offending history

**7.1** **The** [**HALT**](https://domestichomicide-halt.co.uk/) **project** [**Homicide Abuse Learning Together**](https://domestichomicide-halt.co.uk/) based at Manchester Metropolitan University has conducted research by reviewing published 300+ publicly available DHRs (from 322 Community Safety Partnerships (CSPs) in England & Wales covering 2011-2018) focussing on responses of Adult services, Children’s Services, Health Services and Criminal Justice agencies.

The learning from this study so far has been promoted by the Commissioner through webinars and published [reports](https://domesticabusecommissioner.uk/reports/).

**HALT Adult Social Care findings**

Several of the recommendations and themes in the reviewed DHRs echoed Sheffield review findings e.g.:

* 83% of the DHRs highlighted the need for **better multi-agency working**, specifically regarding information management and the improved gathering, reporting, sharing, and recording of information, referral into other agencies, and clear advertising of domestic violence and abuse (DVA) support pathways.
* 50% of the DHRs included recommendations for **better assessment processes**, including:
	+ identifying the needs of carers and those being cared for
	+ assessing and relational risk,
	+ improving co-ordination and sharing of assessments, and
	+ taking a holistic and systemic approach
* 54% of the DHRs suggested **improving frontline practice** by:
	+ increasing professional curiosity,
	+ separating service users from potentially risky family members,
	+ thinking holistically,
	+ ensuring care assessments are carried out,
	+ prioritising care and safeguarding, and
	+ implementing methods to share good practice
* 67% of the DHRs included recommendations for **staff training and development**:
	+ increasing or developing training including different types of abuse (e.g. Adult Family Abuse),
	+ training should explore intersections between domestic abuse, care, and age-related health conditions,
	+ understanding the support needs of carers, improving supervision, and
	+ evaluating the effectiveness of any changes
* Recommendations to **implement, revise, update or expand organisational policies**, **practice and process** appeared in 16 of the 24 DHRs (67%):
	+ developing or amending policy – including routine enquiry
	+ reviewing or complying with adult safeguarding procedures
	+ reviewing risk escalation processes

A thematic area that has yet to be identified in Sheffield reviews was around **privately funded care**

* *Where care was privately funded, there was no oversight of the context of care or the changing nature of care needs. However, the principles and concepts inherent in the Care Act 2014 should be adhered to, regardless of how care is financed.*

**HALT Criminal Justice findings**

Key Messages

Out of these the key areas not identified in Shefield are highlighted in bold

* All but two of the victims (96%) experienced victimisation or trauma prior to the homicide, largely at the hands of the domestic homicide perpetrators.
* Where victims have vulnerabilities such as alcohol misuse and/or mental health difficulties, organisational and individual understanding of the Vulnerable [Safeguarding] Adults Framework is key.
* Barriers to victim non- or dis-engagement should be understood and the onus placed on the service rather than the victim to increase engagement.
* Risk assessments need to be conducted with more detail, processes for referral need to be followed, and these should be regularly reviewed and audited, including the management of these by MARAC and MAPPA.
* Histories for both the suspected perpetrator and victim should be looked at to see if there are any patterns of behaviours, criminal reports, or past DVA
* DVA training was widely recommended by DHRs. **This should also include specific training on reducing the influence of problematic assumptions related to victims and perpetrators.**
* Training in adult and child safeguarding; record keeping, information sharing, multi-agency professional working, and on missing persons enquiries were recommended. All of these should be monitored for effectiveness.
* **Unconscious bias training should also be conducted, as cases involving Minoritised victims were found to be assessed at a lower risk than those cases involving white British victims.**
* The ethnicity of victims and perpetrators must be recorded by the police and sustained efforts made to counter cultural stereotypes and ensure interpreting services are routinely offered.
* **Risk assessments should be conducted at crucial points such as being released from prison, or after a significant reduction in physical health or mobility.**
* The dynamic and changing nature of risk, the influence of victims’ and perpetrators’ characteristics and the type of abuse experienced needs to be better understood and assessed.
* **Those assessed at standard or medium risk, or where victims do not want to pursue criminal justice outcomes, meaningful support via referral to other agencies is needed that can monitor changing circumstances and offer responsive services.**
* Building strong and collaborative relationships with the DVA specialist sector (including Black and Minoritised DVA organisations) may well help to offer standard and medium risk victims more tailored support.
* Continuing with perpetrator programmes whilst at the same time ensuring that survivor-centred services are adequately resourced, should be key priorities.
* **A survivor-centred approach should also ensure that victims are kept informed of the progress of their case, and if the perpetrator is being bailed, release dates from custody and any court orders imposed.**
* DVA policies and processes should be regularly reviewed, updated and operationalised.
* **No DHR recommendations were made pertaining to tackling the systemic discrimination or ‘institutional racism’, misogyny or homophobia of criminal justice services, but this remains a concern**

Out of these the key areas not identified in Shefield are:

* Training on missing persons enquiries
* Unconscious bias training (although the need for training on race equality and intersectionality has been identified locally)
* Risk assessments should be conducted at crucial points such as being released from prison, or after a significant reduction in physical health or mobility.
* Those assessed at standard or medium risk, or where victims do not want to pursue criminal justice outcomes, meaningful support via referral to other agencies is needed that can monitor changing circumstances and offer responsive services.

**Children’s Social Care findings**

Many of the findings are echoed in Sheffield’s DHRs – the ones that haven’t been are highlighted in bold.

* Safeguarding children in the context of DVA is complex as a simultaneous focus is required on both child and parents/caregivers (either abusive or non-abusive)
* Improving record-keeping, sharing information with partner agencies and contributing to a multi-agency safeguarding plan is central to safeguarding children.
* **Introduce healthy relationships education in schools and colleges** as it helps to break the silence surrounding DVA, informs children and young people of their rights and where to access support
* Central to many critiques of assessment was the failure to seriously consider the voice and experiences of the child – this needs to be rectified.
* Children and family social workers require a better understanding of DVA including coercive control and how it may impact their assessments.
* In just over half of cases (17/33, 52%) children’s social care and education were aware of domestic abuse in the relationship between the victim and perpetrator.
* A ‘high’ risk rating was given in just over a third of DVA risk assessed cases (7/18, 39%) indicating that risk assessment processes and professional curiosity need to be strengthened.
* In several DHRs, social work practitioners assumed that mothers could and should keep their children safe by managing the perpetrator’s behaviour and DHRs rightly picked up on this, challenging service narratives. The responsibility for DVA rests with the perpetrator, not the victim, and children’s social care should ensure their ‘whole family’ framework holds perpetrators accountable for their role as parents.
* In a DVA context, ‘failure to protect’ is a frequent social work response, but the gendered nature of this needs to be challenged. Demonstrating responsibility for children’s protection is frequently conflated with leaving an abusive relationship despite strong evidence showing separation as a high-risk factor for continued and escalating DVA. Practice needs to be cognisant of the gendered nature of ‘failure to protect’ and post-separation abuse.
* **Specific interventions for adolescent boys at risk of perpetrating DVA** were also recommended in some DHRs.
* It is **crucial to intervene after trauma (such as domestic abuse) to support children and young people** to reduce the chance of unresolved trauma impacting future outcomes. Evidence from these DHRs shows little evidence of this type of support.
* Supporting care leavers so that their care experiences mitigate adverse childhood experiences is central to them developing a positive sense of self and understanding what a healthy relationship looks like. These aspects of professional practice need to be strengthened.
* Development of **practice models to engage with adolescents** need to be developed which are cognisant of them as both vulnerable and as potential aggressors.
* **DVA specialist agencies need to have publicity, campaign materials and resources which are easily accessible and age appropriate to younger victims and children** experiencing DVA.
* The **premise that the child is a victim of domestic abuse should take precedence over the assumption that the abusing parent is entitled to contact**. Contact provides further opportunities for perpetrators to manipulate the child and to further abuse the victim.
* **Post-homicide support to children** bereaved by domestic homicide is key as well as ensuring safe and secure future placements. Similarly, where children are placed with family members, emotional and practical concerns require support for both children and carers.
* Local safeguarding boards should ensure that multi-agency training on domestic abuse, the impact on children, and how to respond, is provided on an ongoing basis and each organisation needs to adopt a systems approach (STADA, 2020) to addressing DVA in their context.
* DVA training for professionals such as teachers and social workers should go beyond statutory responsibilities.
* Improved social worker supervision was recommended in DHRs, with the need to focus on the dynamics of DVA as well as scrutiny of case recording.
* Recommendations to implement, revise, update or expand organisational policies, practice and process appeared in 26 of the 33 DHRs (79%), largely related to DVA.
* A specific recommendation was made for **Child Protection conferences to have a ‘split’ format** where child victims and perpetrators might be in the same conference to enable the child to speak more freely.
* Recording of protected characteristics is an essential first step to recognising how services respond to them and what adaptations are needed to ‘standard’ practice.
* **The specific intersection of DVA and Minoritisation needs to be better understood by professionals** - specifically issues where threats are made by the perpetrator to remove children to their home country or to use the victim’s and children’s immigration status to keep the victim in the abusive relationship.
* DHRs recommended clearer guidance to be issued from the Home Office on the **management of risk for victims of domestic abuse who are under 16 years of age**.
* DHRs also recommended clearer guidance to be issued from the Home Office on the **management of risk for child victims of domestic abuse concerning violent offenders who may be living with children**.
* The voluntary sector should have rigorous processes around child protection.
* **Schools not under local authority jurisdiction should be given guidance on contributing to DHRs** and ensure compliance with safeguarding.

**HALT Physical and Mental Health findings**

Again, the findings are in line with local finding. The key differences are highlighted in bold:

* The DHRs show that routine inquiry in a range of health settings is absent, with lost opportunities for intervention. Recommendations for improvement were targeted most often at Health Trusts, CCGs (now ICBs) and GPs.
* Improving DVA risk assessments in health settings is crucial to ensuring safety for DVA victims.
* **Communication between different clinical specialisms** dealing with patients experiencing DVA needs to be strengthened.
* A lack of multi-agency working and poor information management was recorded in 39 of the 58 DHRs (67%).
* Clear and concise **national guidance on when HCPs can share information** with other agencies, particularly where a patient does not give consent is called for.
* Co-ordinated care is also hampered by non-aligned IT systems or not using IT capacity - to ‘flag’ DVA perpetrators, victims, and frequent or non-attenders.
* The key challenges to practice are to develop skills to engage with those who are constructed as ‘difficult’; to consider **the possibility of DVA in ‘devoted’ relationships pertaining to older couples**; working holistically; **awareness of symptoms that may not appear related to DVA** (e.g. unexplained pelvic pain, headaches); frequent attenders at GPs and non-attenders where DVA might be masked.

**7.2 Suicide**

Recent publication [Learning Legacies: An Analysis of Domestic Homicide Reviews in Cases of Domestic Abuse Suicide - AAFDA](https://aafda.org.uk/learning-legacies) recommends: *‘In the context of suicide DHRs, moreover, there must be consideration given to the need for specialist knowledge and greater engagement with, and synergies to, public health suicide prevention strategies. Families bereaved by domestic abuse suicide are currently inadequately supported in respect of their emotional, practical and legal needs. The involvement of advocates in the DHR process to assist families was widely acknowledged to be valuable, but its provision should be routine and sustainably resourced’.*

1. **Chair / Authors**

Some research has focussed on the process of DHRs, including the procurement / recruitment of chair / authors e.g [Reviewing domestic homicide – International practice and perspectives, James Rowlands 2019](https://media.churchillfellowship.org/documents/Rowlands_J_Report_2019_Final.pdf). This research highlighted the lack of consistent training or competency framework for DHR Chair / Authors which has now been rectified by a Home Office procured training course, but this learning prompted local revision of our Chair / Author specification to ensure it included knowledge / experience of trauma informed responses and of working with people who are bereaved.

1. **Needs Assessment Recommendations**
* Briefing on post separation abuse is produced for agencies and survivors
* Evaluate support offer to racialised communities and consider how to reduce barriers to accessing support with specific consideration given to agency understanding of the intersection between minoritisation and domestic abuse
* Continue developing trauma informed training and processes across services in Sheffield
* Continue to train staff on coercive control
* Ensure all agencies have domestic abuse policies / sections of safeguarding policies that are fit for purpose
* Raise awareness of adult family violence
* Continue to embed the Safe and Together model
* Domestic abuse awareness training is mandatory for all staff that may work with survivors or perpetrators or manage those who do
* Consider privately funded care for adults and review mechanisms in place for oversight of the context of care or the changing nature of care needs
* Establish a sustainable and equitable funding mechanism
* Greater linkage with the Public Health Suicide Prevention Strategy
* Agencies to consider the learning from the HALT research that has not yet been identified in Sheffield.
* A key priority in 2024/25 will be to respond to any changes in the national DHR statutory guidance once the current review has been completed.
* Continue to work as a partnership to develop and embed healthy relationships programmes within education and on a targeted basis with children and young people at risk or who have experienced ACEs.
1. [Key findings from analysis of domestic homicide reviews: October 2019 to September 2020 (accessible) - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews#:~:text=Across%20all%20the%20reviews%20there,the%20average%20age%20was%2040).) [↑](#footnote-ref-1)