Domestic Homicide Review – Learning from Somerset's Cases

Introduction

This report provides an overview of the key facts from each of the DHRs that Somerset has commissioned. To date there are in excess of 170 recommendations from Somerset's reviews. Rather than reciting all recommendations/actions, this report highlights just a few key learning points from each DHR.

For all details/recommendations, please refer to each individual report. The cases that have been approved by the Home Office Quality Assurance Panel are published online at www.somersetsurvivors.org.uk.

Additionally, this report compares these findings with the Home Office DHR Findings (December 2016) report, and also the Standing Together DHR Findings report (December 2016).

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Profile of Somerset's Domestic Homicide Review Cases

	Characteristics of Victim									
Review Reference	District	Gender	Age	Employment status	Children (any age)?	Ethnicity	MARAC case?	Substance misuse issues?	Mental Health issues (any type)?	Sexual Orientation
003	South Somerset	Female	23	Full time employment	0	White British	No	No	No	Heterosexual
005	Taunton Deane	Female	49	Unemployed (*previously employed)*	2	White British	No	Yes	Yes	Heterosexual
006	Mendip	Female	28	Unemployed	3	White British	Yes	Yes	Yes	Heterosexual
007	Mendip	Male	48	Unemployed	3	White British	Yes	Yes	No	Heterosexual
008	South Somerset	Female	42	Full time employment	2	White British	No	Yes	Yes	Heterosexual
010	Taunton Deane	Female	57	Full time employment	1	White British	No	No	No	Heterosexual
012	Mendip	Female	45	Full time employment	5	White British	Yes	No	Yes	Heterosexual
013	South Somerset	Female	41	Part time employment	3	White British	No	No	Yes	Heterosexual
014	Taunton Deane	Female*	84	Retired	2	White British	Yes	No	No	Heterosexual
015	Taunton Deane	Female	53	Unemployed	2	White British	Yes	Yes	Yes	Heterosexual

*Victim of domestic abuse was female but was not the deceased of this review, this was her son.

Somerset DHR 003

Type of Death	Murder
Date of Death	12 September 2012
Perpetrator	Partner and Others
Number of Actions/Recommendations	13

Summary

The victim in this case was murdered by her current partner with his former (current) girlfriend and the girlfriend's relative also involved, with the motive understood to be for financial gain.

The victim and her partner both had employment at the same organisation, together with other members of the victim's family. Approximately 10% of this organisation's workforce was Polish, and whilst the company policy is for English to be spoken, on the production lines many Polish employees spoke in Polish – subsequently it was found that the perpetrator had spoken derogatorily about the victim during work. Availability of domestic abuse promotional material including how to access local support should be ensured in any type of workplace, and in both English and other languages as appropriate. **Learning Point 1**

There was not a pattern of abusive behaviour or incident which should or would have triggered a referral to MARAC. The victim was not understood to have been in an abusive relationship.

The victim accessed local primary care services for apparently non-domestic abuse related issues; however, the DHR found that literature promoting awareness of domestic abuse and accessibility of local support was minimal. **(Learning Point 2).**

003 LP 1: Domestic abuse awareness materials in workplaces (private, statutory and voluntary sectors), and in non-English if appropriate.

003 LP 2: Primary Healthcare (GP's, Minor Injuries Units, etc) and other public facing services to have domestic abuse information with local support promotion.

Somerset DHR 005

Type of Death	Suicide
Date of Death	12 October 2013
Perpetrator	Partner and child
Number of Actions/Recommendations	16

Summary

The victim took her own life by hanging. Although she had a history of substance misuse on/off for 31 years, it was not believed to be the cause of death. Her two children had different fathers, and both of those relationships (one was a marriage) were known to have been violent. The youngest child was removed from her custody shortly after birth to reside with another relative.

It's also understood that her relationship with her eldest child was violent, and she was fearful of being harmed by him. The victim herself had record of criminal convictions for minor offences including cultivating cannabis. Her most recent partner had a history of domestic abuse with a previous partner (case had gone to MARAC).

The victim was a trained nurse who lost employment as a result of a criminal act. Although she was for a short time on benefits, she had various jobs and was also financially supported by family.

As a result of the history of substance misuse, the victim had had support by the Somerset Drugs and Alcohol Service (and its predecessors) for several years. Although domestic abuse was noted, it had not led to a referral to specialist domestic abuse support. **Learning Point 1**

The victim was reported to have had depression, but had not been in receipt of mental health services for several years.

When aged 10, the eldest child had involvement with Children's Social Care (child in need), but it did not appear that his experiences of witnessing violence in the home were captured. There appeared to be little understanding by social care or education professionals of the impact of living in a home where domestic abuse and substance misuse were taking place. **Learning Point 2**

005 LP 1 – Improve understanding of impact between substance misuse and domestic abuse, and referral pathways into both specialist services.

005 LP 2 – Improve understanding by Children's Social Care, Early Help and Education professionals of the links between domestic abuse, substance misuse and the impact on children.

Somerset DHR 006

Type of Death	Suicide
Date of Death	31 March 2013
Perpetrator	Partner
Number of Actions/Recommendations	13

Summary

The victim took her own life by hanging, with the coroner's inquest determining that she did so "whilst the balance of her mind was disturbed". She's understood to have had a succession of abusive relationships since 2003 (although the review noted that not all relationships had been), and had been subject to MARAC three times – in 2007, 2012 and 2013. Also she had made previous suicide attempts.

Additionally, the victim had an extensive history of substance misuse and mental health issues, both of which had led to support from Somerset Partnership and referrals to Turning Point. The review found that her case with Somerset Partnership was open and closed several times, often due to her non-engagement. Also she had chosen several times not to take up support from Turning Point and the IDVA. Children's Social Care had involvement with her children as had the Parent Family Support Advisor, this reportedly included "ultimatums" for her to change her behaviour to see her children. **Learning Point 1**

The victim made frequent visits to her GP and discussed her depression, substance misuse, sexual assault and domestic abuse. She also confirmed to the GP that she told agencies/people what they wanted to hear. **Learning Point 2**

The Police had investigated several domestic and sexual violence incidences, and the victim refused to support a prosecution on multiple occasions. An incident 3 months prior to her death culminated in her most recent partner being remanded in custody. The review found that the victim was very anxious about this (ex) partner controlling her via threats from his associates and his being released from prison. **Learning Point 3**

006 LP 1 – That agencies should have increased understanding of the challenges that people who have multiple issues of substance misuse, mental health and domestic abuse/sexual violence (with or without children) face, and should avoid "silo-working" and seek to maximise engagement through creative and effective inter/intra agency working.

006 LP 2 – That GPs should be a central component of the co-ordinated community response to tackle domestic abuse, including greater participation in the MARAC process.

006 LP 3 – Agencies should have greater awareness of coercive control and the impact that it has, and so take effective action to support victims.

Somerset DHR 007

Type of Death	Murder (manslaughter)
Date of Death	28 November 2012
Perpetrator	Partner
Number of Actions/Recommendations	28

Summary

The victim (aged 48) was murdered (manslaughter conviction) by his female partner (aged 24), following a relationship of approximately 7 years. As a couple they had lived in various locations around the UK and had what the review described as an "itinerant lifestyle" before residing in Somerset between 2010 and 2012, and then moving to Merseyside in 2012, for approximately 4 months until the death.

Both the victim and perpetrator had the same long-term health condition, which is understood to enable them to forge a close relationship by offering mutual support. As a result of their health needs, they frequently attended GP surgeries (they were registered with a practice in Somerset) and Hospital Emergency Departments. Additionally, they both had a history of criminal activity – the victim having been arrested on eighteen different occasions and the perpetrator being arrested on fifteen occasions. Offences for both parties included dishonesty, assault, drunkenness, and for the victim also drug possession.

Prior to the relationship being established, the perpetrator is understood to have lived with grandparents and had a "difficult" relationship with her father. The perpetrator herself was reported to have experienced violence and abuse from her partner, and was risk assessed for domestic abuse in several English authorities including Somerset. The DHR found several failings in multiple police forces systems for recording her abuse.

In Somerset they were discussed at MARAC three times in 2011 and 2012, and she was offered Independent Domestic Violence Advisor (IDVA) support. She did not engage with the IDVA service, and told the Overview Report author that she had no recollection of being offered support, which given her chaotic lifestyle and alcohol use at the time is credible. Support was offered by other agencies (e.g. substance misuse) and likewise this did not take place. **Learning Point 1**

The victim was identified as being a male victim of abuse at the MARAC too, but was not offered the direct support of an IDVA, and instead the IDVA signposted to a male domestic abuse helpline. Other agencies also recorded that the relationship was "mutually violent". **Learning Point 2**

Both parties had contact with many statutory and voluntary agencies over a number of years, and attempts were made to assist the perpetrator particularly with housing, often due to her "fleeing violence". The DHR found that the accommodation they obtained in Merseyside appeared to be the first "settled accommodation" they had for many years. But the MARAC to MARAC protocol was not followed. So Merseyside agencies were unaware that both parties had been subject to MARAC in Somerset and the support by the

Merseyside voluntary sector agency who they were in regular contact with was not tailored with any information on a history of domestic abuse, (the couple did not disclose any issues). Additionally no IDVA support was offered in Merseyside as the abusive history was unknown. **Learning Point 3a and 3b**

007 LP 1 – If victims of domestic abuse have multiple needs (e.g. no permanent housing, alcohol use, long term health condition), it may require "creative" multi-agency working by both the domestic abuse service provider and other relevant agencies to engage. They are often at greatest risk of abuse and potential homicide, and staff trained in understanding the issues and how to effectively work with other relevant agencies is vital.

007 LP 2 – Male victims of domestic abuse should receive an equitable service to that of females, and so should be referred into the local SCC commissioned domestic abuse service for them to offer/provide support.

Where relationships are stated to be "mutually violent", this should in fact be explored further with no assumptions being made. Specialist domestic abuse support should be offered/delivered to break the pattern of behaviour (both "perpetrator" and "victim)".

007 LP 3a – When an agency becomes aware that a client(s) have moved to another area, they should take responsibility for completing a MARAC to MARAC transfer and informing the new area.

007 LP 3b – When an agency is contacting a service in another area for information about a client who has moved, that agency should directly ask the question "are there any known domestic abuse incidences".

Somerset DHR 008

Type of Death	Suicide
Date of Death	November 2013
Perpetrator	Partner
Number of Actions/Recommendations	18

Summary

The female victim took her own life through taking an overdose. The alleged perpetrator was her husband with whom she had been married for five years and had what is described as a "volatile relationship" where arguments, injuries and separation had taken place.

Both parties had been married previously, and also had children from these relationships, although all children (she had 2 and he had 2) did not live with them, and instead lived with their ex-partners. The couple had lived in other parts of the UK and so the DHR obtained information from two other Community Safety Partnerships. The victim's husband had worked for the Armed Forces until 2012, and the victim is believed to have felt that the Military Police response to an incident was unhelpful.

The victim was known to have been prescribed anti-depressants for 15 years, although it was not clear what form the depression took or why. It's not believed that the victim was in receipt of any specialist mental health service intervention at any time. She had a history of alcohol misuse which was linked to her having violent outbursts. She had attended a GP regularly and her local Emergency department just a few weeks prior to her death. The hospital discharge notice sent to the GP did not reference the domestic abuse (that they had identified) or that a referral was made to the local alcohol support service.
Learning Point 1

Domestic abuse was disclosed by the victim in both Somerset a few weeks prior to her death and also in North Wales in 2010. A referral was made on professional judgement to the North Wales MARAC but was rejected on the grounds that the victim was being supported by a local Women's Aid service, the victim stated the risk was low and the perpetrator was not living in the local area. Her relatives believed he was manipulating her.
Learning Point 2

008 LP 1 – hospital discharge notices and referrals should contain all key information regarding a victim so that appropriate follow up can occur

008 LP 2 – Professionals should receive training and CPD to be clear of the risks and indicators of domestic abuse, including:

- That victims often minimize the extent of abuse,
- That receiving support by a local domestic abuse specialist does not mean that no other agency should be involved.
- A perpetrator does not need to be living locally to inflict psychological and emotional abuse and exert coercive control.

Somerset DHR 010

Type of Death	Murder
Date of Death	30 September 2014
Perpetrator	Child
Number of Actions/Recommendations	5

Summary

The victim was single and had one child who was 27 years old. The victim was employed by a local care-home, and was reported to be private, well organized and laid-back. The DHR found that she had separated from her ex-partner when their son was 3 years old, and that their son had sporadic contact with his father. He had moved to Kent to be nearer to his father in 2010, and had returned to Somerset in June 2014 following a relationship breakdown with a girlfriend and the loss of employment.

The perpetrator was diagnosed with a behaviour disorder when he was 11 years old and received an assessment by the mental health team and prescribed medication. He did receive support from them until he was 15 years old. Additionally, he started using drugs from aged 11 years, and continued to do so until the murder – he described himself as a "recreational" drug user. No specialist substance misuse support was ever offered or sought.

It's understood that his relationship with his mother was good. The only statutory agency he had contact between 2010 and the murder, was his GP with whom he had several contacts including for his low mood and was referred to a counselling service (which received 3 sessions of support).

The GP also referred him to a panel to determine whether a full mental health assessment was required or not, and although the panel advised the GP should refer him to the local community mental health team, this was not completed. **Learning Point 1**

His ex-girlfriend said that no form of domestic abuse took place during her relationship with him. Due to the lack of contact with agencies and no known history of domestic abuse, organisations policies were reviewed as part of the DHR, to see what would happen if either someone disclosed abuse or the signs were recognized by a professional. **Learning Point 2**

010 LP 1 – Where a recommendation for any agency (including GPs) is that a referral should be made to a specialist service this should be completed.

010 LP 2 – All organisations – statutory, voluntary or private sector should have HR policies and also customer policies (if applicable) to effectively describe their approach to domestic abuse (in accordance with the Home Office definition) and how they will respond, including details of local support services.

Somerset DHR 012

Type of Death	Murder
Date of Death	February 2015
Perpetrator	Partner
Number of Actions/Recommendations	44

Summary

The victim had been married to the perpetrator for approximately 25 years, although they had separated 7 months prior to the death. Together they had 5 children, who at the time of the death were aged between 10 and 23 years old.

Family and friends confirmed to the DHR that domestic abuse had taken place for many years. However it wasn't until the summer 2014 that the victim felt she had the strength to leave him, and at that time she had sought help from the local domestic abuse helpline. Following this contact, she was assessed as "high risk" and referred to the Independent Domestic Violence Advisor (IDVA) service and Multi-Agency Risk Assessment Conference (MARAC). The DHR did not find that the MARAC had been a successful intervention to improve the victim's safety, and many of the agencies involved appeared to largely work independently of each other. The DHR found that the victim had recounted that she felt she was receiving conflicting advice and unhelpful support in the last 6 months of her life. This was partly due to her having expressed significant fears for her safety, which didn't appear to have been given sufficient weight by professionals. **Learning Point 1**

There was extensive contact with a number of statutory and voluntary sector agencies over many years by all members of the family. Some of these agencies did record incidences of domestic abuse. Throughout the DHR it appeared that the recording of information was inconsistent and not always detailed. **Learning Point 2**

The perpetrator had a history of violence, and there were frequent arguments with his children that resulted in injury. Following a suicide attempt in 2013 he received assessment from Somerset Partnership but did not attend the appointment offered for Community Mental Health Team support. Many professionals appeared to have an optimistic view that he would change his abusive behaviour to his wife and children. On occasion he would accuse the victim of perpetrating violence against him, which is not uncommon in abusive relationships. It appeared the opportunity for identifying domestic abuse and safeguarding issues was not always made. **Learning Point 3**

The marital home was rented from a local registered social landlord and the tenancy was in the victim's sole name. When she left her husband, he refused to leave stating he had "marital rights" to the property, but she continued to pay the rent as tenancy holder. This caused her significant difficulties, trying to juggle the rent on that property and that of her temporary accommodation. This was a form of financial abuse by her husband. Although she stated her wish to keep her job and support links, many professionals told her she should flee the area to a refuge. **Learning Point 4**

All 7 members of the family had frequent contact with primary healthcare services over many years. The DHR found that information sharing with the GP was patchy, e.g. often receiving information direct from the perpetrator despite the Police, CSC and Somerset

Partnership all being involved. The victim is reported to have seen her GP for “low mood” on a number of occasions, although social history does not appear to have been discussed. **Learning Point 5**

Although they had 5 children, at the time of the murder, only the youngest still lived “at home”. There were no formal residency arrangements for this child and the perpetrator is described as “dictating contact”, not allowing the victim to have the child for overnight stays and constantly changing the contact arrangements and refusing access to the youngest child. Children’s Social Care (CSC) had had sporadic contact with the family between 2006 and 2014. Following the escalation of abuse in August 2014, the youngest child did become subject to a Child Protection Plan, (although relevant meetings did not take place as per statutory guidance). The second eldest child is a vulnerable adult living in supported living accommodation, and his father “removed him” in 2014. The DHR found that effective action to ensure this young vulnerable adult’s safety wasn’t taken, and he was being abused by his father and used to manipulate the victim. The DHR could not determine why the youngest child was considered safe to remain living with the perpetrator. **Learning Point 6**

The victim was employed by a local registered social landlord/care and support company, who were aware of her abusive situation and offered advice to her.

012 LP 1 – Where a client is a victim of domestic abuse, their fears should be included in the DASH RIC and (any) agencies should proactively work with other services (as appropriate) in order to provide a “joined up service”, and improve the victims’ safety.

012 LP 2 – All agencies should ensure accurate, timely and comprehensive recording of information for their clients.

012 LP 3 – Agencies should proactively consider safeguarding and domestic abuse in their work, and make appropriate referrals as required to ensure these concerns are addressed – escalating as required.

012 LP 4 – Professionals should be aware of the range of measures that domestic abuse victims can take, and that these extend beyond refuge. These should be explained to victims with the practicalities of all stated.

012 LP 5 – Domestic abuse should be asked about routinely where it is safe to do so. Professionals should be trained to know “how to ask” sensitively.

012 LP 6 – Social Care professionals should proactively work with fellow professionals (especially where a case has been identified as high risk) in order to minimise the abuse of children or vulnerable adults and the victim.

Somerset DHR 013

Type of Death	Murder
Date of Death	July 2015
Perpetrator	Partner
Number of Actions/Recommendations	24

Summary

The victim was killed by her husband and he then took his own life. Together they had three children aged 9, 7 and 3 years old, the children were with their grandparents at the time of the murder/suicide.

They had been married for 6 years (and in a relationship for 10 years), but had separated around 3 months prior to their deaths. They had also separated in 2011 for 3 months. Family and friends have described them as having very different relationship expectations, which caused tension.

It's understood that the victim had 2 part-time jobs, and the perpetrator had periods of employment and unemployment, which caused financial difficulties. This in turn caused tension between them. Family and friends stated that whilst the victim was clear she wanted to separate because she was no longer happy, the perpetrator did not feel the same way. Additionally, they told the DHR that he had a fixation with her, and was jealous. **Learning Point 1**

The victim told a friend that she was depressed however the DHR could not conclude why she did not seek help for this, and what the cause was.

Following the separation in 2015, the perpetrator made three suicide attempts which resulted in him having multiple mental health assessments. Subsequently, he had frequent visits to his GP and also he engaged in some secondary mental health care services (he failed to attend some appointments). On occasion the victim accompanied him to these appointments, but it's not known whether any assessment/support was offered to her, although a carers' assessment was offered to his mother. He is reported to have repeatedly felt suicidal and at other times he had not. **Learning Point 2**

As the perpetrator felt he needed more help, he accessed a private therapist. The DHR found that although Somerset Partnership was informed by the perpetrator about the private therapist, the GP had been unaware of this other professional's involvement. The private therapist was unaware of the perpetrator's involvement with Somerset Partnership. Both Somerset Partnership and the private therapist recorded that he was jealous of his wife. **Learning Point 3**

Although several agencies had had contact with the victim or perpetrator (e.g. Police, Registered Social Landlord, Hospital, and Local Authority) and had been made aware of their separation, none had any concern about domestic abuse being a feature. The DHR noted good practice from the Police in its approach to suicide prevention. **Learning Point 4**

013 LP 1 – Agencies should contribute to raising awareness for family and friends of victims to recognize the signs of abuse and what to do.

013 LP 2 – That agencies should “think family” when making assessments/ completing support and consider dynamics of domestic abuse.

013 LP 3 – The dynamics of jealousy, coercive control and psychological abuse in intimate or familial relationships (including trigger points such as when people separate) should be better understood by professionals, and DASH RIC assessments completed as required.

013 LP 4 – Do all agencies have a sufficient understand of suicide prevention – within their workforces and also for their customers and what to do?

Somerset DHR 014

Type of Death	Suicide
Date of Death	January 2016
Perpetrator	n/a
Number of Actions/Recommendations	12

Summary

This death of a male (aged 57 years) who allegedly perpetrated domestic abuse against his mother (84 years old) was notified to the Safer Somerset Partnership as a potential domestic homicide review. The decision was taken to have a joint Safeguarding Adult Board/ MARAC Steering Group review, and not a formal DHR. A case debrief meeting was held 29 September 2016.

The review found that his mother had disclosed that she had been a victim of domestic abuse from her husband (his father), this was disclosed following his father's death in early 2015. Following this death, her son became her carer as she had long-term health issues. Between February 2015 and her son's death in January 2016, she had multiple contacts with her GP, Adult Social Care and Musgrove Hospital. In 2015 both the GP and Adult Social Care recorded that he was demonstrating abusive behaviour towards her, however, no DASH RIC appears to have been completed until January 2016. Shortly afterwards, Adult Social Care referred her to MARAC, with her son as the perpetrator of abuse. **Learning Point 1**

Her son had mental health issues for which in 2015 he was assessed by Somerset Partnership and had some ongoing contact with him. However it didn't appear that there was always join up between Somerset Partnership, Adult Social Care and the GP regarding the sharing of information about both of them. Additionally, it appeared that the impact of psychological and emotional abuse and coercive control were not fully understood. It's unclear if this was because of it being a familial relationship rather than an intimate partner situation. **Learning Points 2 and 3**

014 LP 1 - Whenever a professional recognizes abusive behaviours in any intimate (or ex) or familial relationship a Safe Lives DASH RIC should be completed, irrespective of the age of the victim and referrals to MARAC or specialist services made as appropriate.

014 LP 2 – Professionals should ensure sufficient sharing of information in order to address safeguarding and domestic abuse concerns. This to include ability of client record systems to flag "significant" others linked to victim.

014 LP 3 – All agencies to have greater understanding of domestic abuse in familial (i.e. non intimate partner) relationships, and also of older victims and how to effectively support.

Somerset DHR 015

Type of Death	Suicide
Date of Death	August 2015
Perpetrator	Partner
Number of Actions/Recommendations	To Be Confirmed

Summary

The victim died whilst living in a domestic abuse safe-house in the Torbay area of Devon, and had lived there for 2 months prior to her death. Until June 2015, she had lived in Somerset for many years, (so is why Somerset took the lead on the review).

She had multiple needs, and had been in receipt of services from Somerset Drug and Alcohol Service (SDAS) and Somerset Partnership for several years. SDAS identified that she was experiencing stalking and signposted her to Paladin (national stalking advocacy service) in March 2015. Paladin then referred her to MARAC in April 2015, and she then also received support from Somerset Integrated Domestic Abuse Service (SIDAS) between March 2015 and June 2015. SIDAS enabled her to access the Torbay Domestic Abuse Service.

A key line of enquiry for this review was to determine understanding of stalking by professionals. Despite being in receipt of specialist support for stalking, the review found that many agencies were unsure about whether the victim had really experienced stalking. This doubt was compounded by the fact that she had been in receipt of secondary mental health support for over 10 years, and also had received SDAS support. SDAS confirmed that prior to her moving to Torbay she had been abstinent and no longer required their support. Paladin were clear that from the information they knew she had experienced stalking, and it was not uncommon for victims to be doubted. **Learning Point 1**

The review also focused on the learning arising from the victim moving from Somerset to Torbay, did agencies work well to ensure the move was efficiently handled to avoid any negative impact on the victim? Despite the victim having multiple needs, the review did not find that all agencies had proactively sought to ensure that her move was “seamless”. In particular she experienced significant difficulty in obtaining mental health service support in Torbay as a result of not being able to register with a GP, (despite Somerset Partnership sharing a great deal of information with Devon Partnership). **Learning Point 2**

015 LP 1 Professionals from all agencies to be trained in recognizing the signs of stalking and how to effectively respond, even if the victim has multiple needs.

015 LP 2 When a client moves to another area, agencies should ensure that prior to their leaving, they are supported to be able to access all the relevant services in their new area.

Key Learning Points from Somerset's DHRs

Public Awareness Raising & Professionals Training

- (003 LP 1) Domestic abuse awareness materials in **workplaces** (private, statutory and voluntary sectors), and in non-English if appropriate.
- (003 LP 2) Primary Healthcare (GP's, Minor Injuries Units, etc) and other **public facing services** to have domestic abuse information with local support promotion.
- (008 LP 2) **Professionals should receive training and CPD** to be clear of the risks and indicators of domestic abuse, including:
  - That victims often minimize the extent of abuse,
  - That receiving support by a local domestic abuse specialist does not mean that no other agency should be involved.
  - A perpetrator does not need to be living locally to inflict psychological and emotional abuse and exert coercive control.
- (010 LP 2) All organisations – statutory, voluntary or private sector should have **HR policies** and also customer policies (if applicable) to effectively describe their approach to domestic abuse (in accordance with the Home Office definition) and how they will respond, including details of local support services.
- (012 LP 4) Professionals should be aware of the **range of measures that domestic abuse victims** can take, and that these extend beyond refuge. These should be explained to victims with the practicalities of all stated
- (013 LP 1) Agencies should contribute to **raising awareness for family and friends** of victims to recognize the signs of abuse and what to do.
- (013 LP 4) Do all agencies have a sufficient understand of **suicide prevention** – within their workforces and also for their customers and what to do?
- (014 LP 3) Greater understanding of domestic abuse in **familial relationships**, and also of **older victims**.
- (015 LP 1) Professionals from all agencies to be trained in recognizing the signs of **stalking** and how to effectively respond, even if the victim has multiple needs.

Risk Identification and Recording

- 006 LP 2 That **GPs** should be a central component of the **co-ordinated community response** to tackle domestic abuse, including greater participation in the MARAC process
- 006 LP 3 Agencies should have greater **awareness of coercive control** and the impact that it has, and so take effective action to support victims
- 007 LP 3a When an agency becomes aware that a client(s) have moved to another area, they should take responsibility for completing a **MARAC to MARAC transfer** and informing the new area.
- 007 LP 3b When an agency is contacting a service in another area for information about a client who has moved, that agency should **directly ask the question "are there any known domestic abuse incidences**".
- 008 LP 1 hospital discharge notices and all referrals should contain **all key information regarding a victim** so that appropriate follow up can occur
- 010 LP 1 Where a recommendation for any agency (including GPs) is that a **referral should be made to a specialist service t**his should be completed.
- 012 LP 1 Where a client is a victim of domestic abuse, (any) agencies should proactively work with other services (as appropriate) in order to **provide a "joined up service**", and improve the victims safety.
- 012 LP 2 All agencies should ensure **accurate, timely and comprehensive recording of information** for their clients.
- 012 LP 3 Agencies should **proactively consider safeguarding and domestic abuse** in their work, and make appropriate referrals as required to ensure these concerns are addressed – escalating as required.
- 012 LP 5 Domestic abuse should be **asked about routinely** where it is safe to do so. Professionals should be trained to know "how to ask" sensitively.
- 013 LP 3 The dynamics of jealousy, coercive control and psychological abuse in intimate or familial relationships (including **trigger points such as when people separate)** should be better understood by professionals, and DASH RIC assessments completed as required.
- 014 LP 1 Whenever a professional recognizes abusive behaviours in any intimate (or ex) or familial relationship a Safe Lives DASH RIC should be completed, **irrespective of the age of the victim** and referrals to MARAC or specialist services made as appropriate.

Multiple Needs &Families

- (005 LP 1) Improve understanding of impact between **substance misuse and domestic abuse**, and referral pathways into both specialist services.
- (005 LP 2) Improve understanding by Children's Social Care, Early Help and Education professionals of the **links between domestic abuse, substance misuse and the impact on children.**
- (006 LP 1) That agencies should have increased understanding of the challenges that people who have **multiple issues of substance misuse, mental health and domestic abuse/sexual violence (with or without children)** face, and should avoid "silo-working" and seek to maximise
- (007 LP 1) If victims of domestic abuse have **multiple needs (e.g. no permanent housing, alcohol use, long term health condition**), it may require "creative" multi-agency working by both the domestic abuse service provider and other relevant agencies to engage. They are often at greatest risk of abuse and potential homicide, and staff trained in understanding the issues and how to effectively work with other relevant agencies is vital engagement through creative and effective inter/intra agency working.
- (007 LP 2) **Male victims** of domestic abuse should receive an equitable service to that of females, and so should be referred into the local SCC commissioned domestic abuse service for them to offer/provide support. Where relationships are stated to be "mutually violent", this should in fact be explored further with no assumptions being made. Specialist domestic abuse support should be offered/delivered to break the pattern of behaviour (both "perpetrator" and "victim)".
- (012 LP 6) Social Care professionals should proactively work with fellow professionals (especially where a case has been identified as high risk) in order to **minimise the abuse of children or vulnerable adults and the victim**.
- (013 LP 2) That agencies should "**think family"** when making assessments/ completing support and consider dynamics of domestic abuse.
- (015 LP 2) When a client **moves to another area**, agencies should ensure that prior to their leaving, they are supported to be able to access all the relevant services in their new area.

DHR Case Analysis – Report for "Standing Together"

Standing Together is a national domestic abuse charity, which have completed over 32 DHRs. They worked with London Metropolitan University to analyse the findings from those reviews, and find key themes and recommendations. The report can be found online at http://www.standingtogether.org.uk/news/domestic-homicide-review-case-analysis-report.

Their overarching approach is that there should be a "Co-ordinated Community Response" as no single agency or professional has the complete picture of a domestic abuse survivor.

The table below illustrates some key findings together with a comparison with Somerset.

Standing Together Report	Somerset	Somerset RAG
Risk assessments were not consistently or routinely completed. Many cases were medium or standard risk.	Victims were not always identified as being at risk, so risk assessments were not completed.	Unclear if all DA victims in every setting have DASH completed
Friends, colleagues and family (**informal networks**) hold vital information. Better public awareness campaigns regarding signs (particularly non-physical)	People are not confident identifying coercive control/ emotional abuse as being domestic abuse.	Awareness raising is required
Mental health was recorded as the second most common health-related theme and affected both victim and perpetrator.	Mental health was a theme in 60% of Somerset's DHRs	Public Health led "Multiple Needs" project is in progress
Domestic abuse not always recognized as an issue for **older people**, with assumptions about age meaning when someone older presents as depressed or injured, it's presumed to be because of health or social care needs.	Not a recurring DHR theme, although recognized as an issue.	Improvement required for agencies to identify/ effectively support (training last held 2016)
Child safeguarding issue in over a third of cases, with consideration of the risks facing children not always automatic. Perpetrators use statutory services to make false allegations about victims.	9/10 of the cases had children, although many were aged over 18. In some instances risk to children by perpetrator not identified, despite CSC involvement.	Awareness raising is required
Over half of the reviews found that **GPs** missed opportunities to ask the victim about DA, and lack of professional curiosity about partners/children's fathers.	Many of the victims and perpetrators had attended a GP regularly. DA not always identified or discussed by GP.	Awareness raising is required
None of the perpetrators were known to have attended a **DV perpetrator programme (DVPP)**. Risk reduction focuses on victim, and not the person who *is* the risk.	None of the perpetrators had attended the Somerset DVPP.	Work required promoting the Somerset DVPP?

Domestic Homicide Reviews: Key Findings From Research (2016)

This report was produced by the Home Office in 2016, and has used evidence from a sample of 40 of 195 reports assessed as suitable for publication. The report can be found online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf.

The table below illustrates some of their key findings together with a comparison to Somerset.

Home Office Report	Somerset	Somerset RAG
Mental health issues present in 32 of the 40 cases, with majority known to health services	Mental health issues were present in over half of cases	Public Health led "Multiple Needs" project is in progress
Substance use was noted in over half of the cases	Substance use was noted in 50% of cases	Public Health led "Multiple Needs" project is in progress
Among perpetrators and victims, the presence of both substance use and mental issues was more common than either issue occurring alone.	Mental health issues did occur where substance use was not prevalent, however, substance use was only present where mental health issues also occurred.	Public Health led "Multiple Needs" project is in progress
Poor record keeping was a frequent theme.	This also was a recurring theme.	Variable across professionals and agencies
Poor quality or non-existent risk assessments was a common theme	Where it was possible to do a DASH RIC, generally they were completed (although not always). However, the quality was variable and often poor.	Variable across professionals and agencies
Poor identification and understanding of domestic abuse an issue – e.g. not recognizing times when risk heightened (e.g. following separation, social services focusing on protection of children and overlooking vulnerability of the mother)	This was a recurring theme.	Variable across professionals and agencies
Ineffective information sharing, including no feedback on outcome of referral, cases closed without informing another agency.	This is also applicable in Somerset's cases.	Variable across professionals and agencies
Training consistently highest proportion of recommendations	This is also a common theme in Somerset's DHRs	Variable across professionals and agencies

Conclusion

There are many themes common to Somerset and the national Standing Together and Home Office learning lessons reports. Many of these are also repeated in the 2016 Avon and Somerset wide review of DHR's, which considered common lessons arising from the DHRs within the force area. The recurring lessons from that included:

- **Communication** – To be improved, including for diverse groups and friends/family
- **Policies** – All agencies needed to have an effective policy and implement it consistently
- **Training** – To be improved, including consideration of multiple needs and diverse groups
- **Information Sharing** – To be improved
- **MARAC** – Greater consistency in approach, representation and monitoring of actions

Whilst over recent years there has been an improvement across many agencies in the identification of domestic abuse and onward referral to specialist agencies, there remains a great deal of work to be done. There continue to be inconsistencies within and between agencies, and silo working which leads to victims and perpetrators (and their children) not always receiving the most effective help when they need it. For both the public and professionals there continues to be a lack of understanding of coercive control and the "non-physical" abuse types, so victims and their friends/colleagues/relatives are not even aware they are experiencing domestic abuse despite its devastating consequences.

Although this report has focused on the lessons to be learnt it should be noted that within the majority of the Somerset DHRs good practice was also identified, and it provides a good foundation for agencies to work towards achieving an effective co-ordinated community response to domestic abuse.

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