



Executive Summary London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process

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M O P A C

MAYOR OF LONDON
OFFICE FOR POLICING AND CRIME

**STANDING
together**
against domestic violence

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A tribute

We must always remember that every DHR carried out involves a mother, father, daughter, son, brother, sister, auntie, uncle or friend has been killed, and they should not be forgotten. We need to remember that they were real people who loved and laughed, had children, families and friends, and that their futures were cut short by a terrible act. The effect of this on the families and friends will last forever, as nothing we can do will bring them back. To do them justice we need to actively learn from these tragedies and work hard to make sure those lessons are embedded into our practices. We can aim through our work and research to make their lives matter and never forget who they were or what their families and friends are left coping with. By identifying our mistakes and lost opportunities through this analysis, we hope to improve the future response to survivors and perpetrators.

Introduction

Thank you to all who have taken part and supported this report.

We would like to thank firstly and most importantly all of the families and friends who have contributed to the reviews. Your contributions have enabled your loved one's voices to be heard and we hope to do justice to your contributions. We will aim in this report to keep their experiences at the forefront of the work. We hope the lessons learnt in this report will contribute to better focus on risk factors and responses to future victims.

Standing Together would like to thank MOPAC for their commissioning of this analysis of Domestic Violence Homicides in London and the Local Authorities DHR process. We would like to thank Aisha Sharif at MOPAC for her patience and counsel on this report. We would like to thank the staff at Standing Together, Laura Croom for her contributions and Gemma Snowball for her assistance, also our interns, Alessandra Baratelli and Tamina Summersgill, for their support. Thank you to Sheila Wesa for supporting the work of this report.

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This report follows on from the work conducted by Standing Together and London Metropolitan University analysing DHRs in 2016. This work will look at the report's key findings and recommendations and see what comparisons or differences there are in London. We will be analysing the DHRs to highlight learnings and gaps that are not only relevant to London, but at a regional and national level. Recently, violent crime, specifically, street crime, in London and across the country has largely been the focus of the news. We are saddened by what we see happening to the children of this generation and we hope some of the learnings in this report can also inform future work intended to tackle street violence. Most domestic violence happens behind closed doors within the home and by perpetrators that are known to the victim. Accompanying these particular dynamics are unique challenges which all agencies, employers, family and friends supporting survivors face.

We hope the learnings from this report will shed light on the work that needs to be completed to ensure an improved response to survivors. We hope the findings will also inform and support boroughs to implement and fully integrate a Coordinated Community Response (CCR) to Domestic Abuse across London, where lessons can be shared nationally. In this report, we will also be looking at the individual local authorities' processes for carrying out a DHR. This report will focus on how a DHR is decided, the process for appointing a chair, and if the recommendations and action plans are followed after completion of the final report. For a DHR process to mean something more than the paper it is written on, all the agencies involved must take on board the recommendations and be accountable for their implementation. We hope this work will enhance or support the work already happening in boroughs.

Broadly, much of these findings fall into two categories. Firstly, there are findings which could be characterised as implementation gaps. These gaps are comprised of failures or missed opportunities where best practice is understood but not implemented. Secondly, there are findings which demonstrate that in other areas such as mental health, adult child to family abuse, adult safeguarding practice and issues such as support for carers, more work is required to establish better, safer and more appropriate ways of working. Much of these findings are underpinned by a lack of fundamental understanding of coercive control, a lack of focus on the perpetrator and the risks they pose and a need for more professional curiosity in thinking beyond basic policy and procedure.

Not only do we want to discuss more openly and broadly the learning from DHRs, we also want to focus on the process of conducting and chairing DHRs. We hope the learning from this will enable Local Authorities to review their processes and share good practice. We hope it will also inform the Home Office in their review of the guidance for DHRs.

STADV continue to build and develop an effective UK-wide CCR to address domestic abuse. We want this report to also expand on the emerging discussions around Adult Family Violence and we are eager to hear about your area's good practice responses. Please actively use this report and share it widely with partners and colleagues.

Bear Montique, Interim CEO

October 2019

At a Glance

Out of the 84 DHRs analysed for this report, 59 were interpersonal homicides and 25 were adult family homicides.

Between April 2011 and March 2019, 196 domestic homicides occurred.

Feedback from 28 boroughs surveyed about the DHR process advised that clearer procedures need to be put in place to ensure the quality of the reviews, which are not limited to but included:

Key themes in the DHR process

- ◆ Boroughs wanted the Home Office to keep a complete library of completed DHRs
- ◆ Boroughs wanted a qualification or code of practice for chairs to ensure quality
- ◆ Need for better inclusion of intersectionality within the DHR process
- ◆ Funding for local authorities to carry out DHRs
- ◆ The introduction of further DHR guidance on complex DHRs
- ◆ Ensuring action plans and recommendations are monitored for progress by the Home Office

Key themes in IPH DHRs

- ◆ 56% of Risk Assessments were not undertaken, or done poorly
- ◆ 54% had a lack of understanding of domestic abuse by non-DA agencies
- ◆ 49% missed opportunities to ask about victims' relationship
- ◆ 46% lacked information sharing between health agencies
- ◆ 39% lacked a referral to MARAC where needed
- ◆ 37% lacked DV policies or didn't follow them
- ◆ 32% lacked enquiry to victim even when complex and multiple disadvantages were present

Key themes in AFH DHRs

- ◆ 60% had a lack of understanding of domestic abuse by non-DA agencies
- ◆ 48% missed opportunities to share information
- ◆ 44% missed opportunities to ask about victims' relationship
- ◆ 40% lacked information sharing between health agencies
- ◆ 40% lacked enquiry to victim even when complex and multiple disadvantages were present
- ◆ 28% lacked a referral to MARAC where needed

Key issues found around BME

- ◆ A need for agencies to liaise more with BME specialists when supporting victims of domestic abuse
- ◆ Immigration status was a barrier for some individuals seeking support; access to services may be limited by the agencies' misunderstanding of immigration law
- ◆ DHR panels did not always take an intersectional approach to DHRs or include a diverse range of members on the panel

Key issues found around LGBT+

- ◆ Lack of understanding of the dynamics of LGBT+ abuse amongst agencies
- ◆ Lack of perpetrator programs available for non-heterosexual men
- ◆ Trans people can be particularly vulnerable in situations of domestic abuse

Key issues around Mental Health

- ◆ Mental health issues were quite prevalent in both IPH and AFH; mental health issues were found in 42 perpetrators and 23 victims out of the 84 cases analysed in this report
- ◆ Mental health problems were identified in 64% 16/25 cases of perpetrators in **AFH** cases, with 56% 14/25 of the cases diagnosed with a psychotic disorder, of these cases 40% were open to mental health services at the time of the murder. 12% of victims had mental health issues.
- ◆ Mental health problems were identified in 44%, 26/59 cases of perpetrators of **IPH** cases, with 32% of the cases diagnosed with a psychotic disorder. 11% of cases were open to mental health services at the time of the murder. 33% of victims had mental health issues.

Key issues found around older people

- ◆ Cases analysed aligned with national figures for DA with 78% victims being female, and 22% being male
- ◆ Agencies dealing with older clients failed to link injuries with abuse and instead saw the injuries as part of clients being older individuals
- ◆ Most victims fell into the 'young-old' category (60-69)
- ◆ Mental health was a factor in older people DHRs
- ◆ 78% of cases involved a caring relationship between the victim and perpetrator

Most frequent themes across all DHRs:

- ◆ Lack of awareness of DA and its impacts
- ◆ Lack of information sharing between agencies
- ◆ Missed opportunities to ask about victim's relationships
- ◆ Lack of consistent DASH risk assessments carried out
- ◆ Lack of focus on perpetrators and risk they pose to others

Overarching Approach

The Coordinated Community Response (CCR)

The Coordinated Community Response (CCR) is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, manage risk factors, hold perpetrators to account, and ultimately, work to prevent domestic homicides.

For an effective CCR to be in place, the following components need to be embedded in all agencies' structures:

A **common purpose** and approach to domestic abuse including a stated commitment to the CCR.

Definitions of domestic abuse and risk are agreed and shared by agencies.

Defined mechanisms are in place for the **coordination, governance and monitoring** of the CCR to ensure **accountability** and to enable a flexible and evolving approach.

An agreed **action plan** is in place.

Written **policies and procedures** are in place within every **organisation** covering their response to domestic abuse. Regular compulsory **training** embedded within every level of an organisation should support these.

Written **policies and procedures** are agreed covering **multi-agency** systems and working (including the MARAC and specialist domestic abuse courts). Regular compulsory **training** supports these.

An agreed **dataset** is in place and monitored on a regular basis.

Agencies responses are informed by survivors. **Survivors' voices** (and the views of their advocates) are regularly sought, listened to and responded to.

Adequately resourced **specialist services** are in place to respond to adults, children and young people: survivors and perpetrators.

Interpersonal Violence (IPV) & Adult Family Violence (AFV)

The government definition of domestic violence and abuse conflates violence committed by intimate partners with that by family members.

While both forms of violence are more likely to happen to women, there are clear differences in the dynamics and motivations underpinning Interpersonal Violence (IPV) and Adult Family Violence (AFV). The analysis and recommendations are therefore split into two separate sections.

There is a significant dearth in research around AFV, as opposed to the more established body of evidence around best practice in the context of IPV. Accordingly, we have focused a section of the report on this issue to increase our learning of the issues and our understanding of the problem.

We have also included a chapter on intersectionality to explore the specific experiences of the BME community, LGBT+ people, people with mental health issues. and for older people.

London Boroughs DHR Process

In this report, we wanted to explore the process each borough undertook to carry out a DHR. Local Authorities were asked in a questionnaire to explain their process from decision to completion. We asked how they appointed a chair, chose a panel and developed action plans. 28 boroughs completed the questionnaire. We then carried out an interview with 18 of the boroughs to get a more in-depth insight into their processes. Below is the direct feedback from boroughs.

Home Office guidance on DHRs

Since the implementation of section 9 of the Domestic Violence, Crime and Victims Act (2004), as of 2011, every local council is required to carry out a Domestic Homicide Review.

Section 9 (3) of the Domestic Violence, Crime and Victims Act 2004 requires that a review of the circumstances surrounding the 'death of a person aged 16 or over [who] has, or appears to have, resulted from violence, abuse or neglect by –

- ◆ A person whom he [sic] was related or with whom he [sic] was or had been in an intimate personal relationship, or a member of the same household as himself,
- ◆ [is] held with a view to identifying the lessons to be learnt from the death.'

Key Findings and feedback from boroughs

- ◆ Several boroughs found it difficult to retrieve all their DHRs since 2011. No one agency has a complete library of finished DHRs which were approved for publication.
- ◆ There are no systems currently in place to check for compliance in resubmitting finished DHRs to Home Office after panel decisions.
- ◆ DHRs and SCRs should be more linked up around findings and recommendations to compare and reflect on the learnings.

Chairs

- ◆ 20 boroughs fed back they had difficulties finding a good chair and wanted the Home Office to supply a list of recommended chairs.
- ◆ Boroughs wanted a qualification, or code of practice for chairs to ensure quality.
- ◆ 60% of boroughs felt there was a need for more intersectionality and relevant professionals on Panels.

Process

- ◆ Changes in staff can derail or slow a DHR, Problems with quality of chairs caused delays or led to the DHR being rewritten.
- ◆ Some chairs did not have an understanding of the dynamics of DA/VAWG.
- ◆ Responses from health services, especially GPs was a large and constant issue raised by boroughs.
- ◆ Inter communications between Safeguarding Adults and Children and Mental Health Services were poor.

Funding a DHR

- ◆ 99% of boroughs said they had real struggles funding the DHRs
- ◆ The majority of DHRs were funded through the Community Safety budget, some using the dedicated VAWG budget
- ◆ The resource implications of action plans are not always thought through, resulting in no action.

Local Authorities wanted clearer guidance on:

- ◆ What to do in the cases that fall outside the usual definition or a suicide with DA/VAWG present
- ◆ When to proceed with a DHR without compromising the criminal trial when the perpetrator has fled the country or found not guilty on appeal.
- ◆ The process for the Q and A panel at the Home Office which they feedback was too slow, with boroughs waiting 6 months or more for a decision on publication.

Publication

- ◆ How long to publish the finished reports online, this varied in boroughs.
- ◆ Publication when a case is found not guilty on appeal.
- ◆ Where there were young children involved, whether to only publish for a short time, as the children's feelings need to be considered as they get older.

Action plans

- ◆ 46% of VAWG leads were responsible for the development of the action plan with 10 VAWG leads responsible for the whole management of the action plan.
- ◆ Only 9 boroughs provided updates to families about the progress of the action plans.
- ◆ Lack of capacity to make organisational wide changes affected the action plan
- ◆ Changes of Health Trusts, CCGs amalgamating, and Probation changes affected continuity of input
- ◆ Recommendations for GPs were hard to achieve as lack of time for any input or training was an issue.

Police Process

The police have gone through a complete restructure since government cuts to their budgets. This has resulted in the introduction of Basic Command Units (BCU) merging 32 boroughs into 12 new policing areas. Plans in 2020 will see the transfer of standard risk DA cases to Emergency Response Policing Teams (ERPT), this will also free up capacity for specialists working with medium to high cases. This new process will introduce a single point of contact for standardisation and consistency of risk assessment review. A new pilot risk assessment DARA has been being piloted and will be extended to several other forces this year to trial. This development of the DARA must include an engagement with the specialist services, to ensure a survivor and diversity focus in the final outcome. The Met police, despite cuts, have invested heavily in training across the force on DA, coercive control and its impacts, Domestic Violence Prevention Notices, MI investigation and CPS improving outcomes. This shows the commitment invested in tackling perpetrators and supporting victims.

Findings

The findings of this survey have highlighted the challenges boroughs face regarding funding and carrying out DHRs. The funding of DHRs needs to be addressed by the Home Office and boroughs. The Home Office are currently carrying out a review of DHR guidance. This should be reviewed not only by consultation but by also using the findings from this report and holding solution focused days with chairs and DA/VAWG leads in the boroughs. This would result in user-led improved guidance.

Health services were cited as difficult to engage with the DHR process with GP's needing more training and engagement. In boroughs where Iris ¹was present the response was much improved from GP's.

The feedback highlighted a need for more diversity on panels to reflect the intersectionality present in the DHRs. By including the specialist community agencies on every panel, the boroughs would gain more insight into diverse communities, their specific needs and experiences.

Recommendations for Practice

- ◆ DHR chairs should have a code of conduct and a recognised qualification.
- ◆ Funding for DHRs should be reviewed and more assistance given to boroughs by the Home Office.
- ◆ Funding of DHRs should be a joint responsibility of the Home Office and all Safeguarding statutory agencies within the local authority.
- ◆ Create a national database of DHRs and their analysis to enable wider learning from the themes and data.
- ◆ The Home Office should provide boroughs with further guidance on publication and storage of DHRs.
- ◆ Create a statutory duty for health services including GPs to participate in DHR reviews.
- ◆ The Home Office should develop a system of reviewing action plans to completion.
- ◆ DHR panels should reflect the diversity of the borough and the DHR case and include specialist agencies relevant to the case.
- ◆ All boroughs should create a DHR template work plan to provide consistency of process.
- ◆ The Home Office should provide clearer guidance for boroughs on complex cases of suicide with DA/VAWG present, appeals and not guilty verdicts.

¹ <https://iris.org/>

- ◆ NHS and other relevant health services, especially mental health, need to create guidance and training for GPs and mental health services on involvement in DHR processes.
- ◆ Police should ensure that any changes in risk assessments include engaging with specialist services to ensure a survivor and diversity focus is embedded into the final outcome.

Domestic Homicide Statistics

In London between 2013 and 2019, 196 domestic homicides took place. At the time of writing in 2020, 10 domestic homicides have taken place so far (see Appendix 1 and 2 for UK statistics before 2011).

Below are the figures for the number of domestic homicides solely recorded by the Metropolitan and City of London Police Forces, between April 2010 and March 2019. (Homicide figures recorded by Home Office can be found in Appendix 2)

Table 1: Metropolitan and City of London Police Forces Statistics

Recorded Financial Year	Domestic Homicides
2010/11	25
2011/12	21
2012/13	21
2013/14	30
2014/15	21
2015/16	27
2016/17	11
2017/18	15
2018/19	25
Grand Total	196

Domestic Homicides taken place between 2019 and 2020 to date: 10

For this section, we analysed 59 reports of Interpersonal Homicide (IPH) and 25 reports of Adult Family Homicide (AFH). We have separated them into IPH and AFH as both relationships have different dynamics. All themes statistics are listed in Appendix 4.

Interpersonal Homicide: Themes

In 39% of cases there was a lack of understanding within agencies of the dynamics of DA/VAWG and its impacts. In 46% of cases there was a lack of professional curiosity to ask further questions about relationships. This was true even in cases where there were complex and multiple needs.

In 20% of cases where there was a disengagement with services, this was often not followed up with any further investigation by agencies as to why. This was particularly important for MARAC cases and those cases where mental health issues were present.

In these DHRs the victim and perpetrator met many agencies during their lives. If there had been routine enquiry built into the policies of these agencies about DA/VAWG there may have been earlier opportunities to offer support and assess risk factors with a DASH risk assessment.

In 54% of DHRs, family, friends and employers knew abuse was happening in the relationship but did not know that the behaviours constituted domestic abuse. Community education is an important part of providing information about what DA/VAWG is and the referral routes to support. Research tells us that family and friends can be the first responders to support for victims. Many victims from BME communities first approach is to their faith leaders for support and it is important that any community work includes those faith and community groups. The Safe project and the VAWG and Faith coalition coordinated by Standing Together works to include faith groups in the response to DA/VAWG.

In 46% of DHR cases, agencies including health missed opportunities to share information or delayed sharing, resulting in increased risk to victims. 37% missed opportunities to share information for multi-agency coordination and make referrals to MARAC or support services. Initiatives like Pathfinders and Iris where health has had an embedded routine enquiry, access to IDVA support and training for staff have shown an increase in staff awareness in identifying DA and disclosures.

In 56% of cases risk assessments were done poorly or not at all. In 39% of cases, the known risks by agencies should have resulted in a referral to MARAC. In cases where mental health was present, no mental health service carried out DASH risk assessments with families on the risks posed by the perpetrator to their family or friends.

In 37% of DHRs, policies and procedures were not adhered to. This includes, but is not limited to, domestic abuse policies

49% of cases missed opportunities to ask about the victim's relationship.

32% of cases missed opportunities to ask victims questions in situations where there was increased vulnerability due to drug or alcohol use and/or mental ill health.

25% missed opportunities to hold the perpetrator accountable or offer support, with 10% missing opportunities to offer support around mental health.

43% of DHRs showed that agencies knew about domestic abuse being present in cases but did not share this information. Agencies need to be clear when and how they share information with other agencies, where they have the responsibility to share information and where they have the power to do so.

Recommendations for Practice Relating to IPH Themes

Lack of Understanding of Domestic Abuse

- ◆ Recognise that the key findings from DHRs is the absence of help or support offered due to lack of understanding, and naming domestic abuse, despite signs and symptoms of abuse. Most victims of domestic homicide were not offered specialist help because the abuse they suffered was not identified as domestic abuse.
- ◆ Ensure that training programmes for all front-line services are based on coercion and control as a basis to understanding domestic abuse.
- ◆ Training on risk and domestic abuse must move away from stereotypical understandings of domestic abuse as isolated incidents of physical violence. Awareness of the inherent high-risk posed by coercive, controlling behaviours that are not physical or sexual - such as harassment and jealous surveillance - is paramount.
- ◆ Ensure that all safeguarding board training includes fully developed training on risk identification and assessment for domestic abuse.

“Disengagement” with Services

- ◆ Change the language used relating to lack of engagement and focus on the ways in which the survivor of abuse has tried to address the abuse and keep her or her children safe under coercively controlling abuse.
- ◆ Ensure that before anyone is characterised as “disengaging with services,” it is clear that the service has adequately reached out to the victim in a way that is accessible, inclusive and understands their potential barriers to support.

Friends and Family

- ◆ Professionals should bear in mind that often, friends and family or ‘informal networks’ hold vital information around the levels of risk.
- ◆ Recognise the findings that those subject to domestic abuse will most likely disclose to their friends, family and community networks. Invest time and resources to develop mutual understanding about community groups and to develop their understanding of domestic abuse and services.
- ◆ Connections should be developed with associations for voluntary or third sector organisations to help disseminate learning and understanding of training opportunities related to domestic abuse.
- ◆ Prevention initiatives should consider the involvement of wider community members, such as religious institutions, and the development of peer networks, creating ‘circles of support’ within the wider community.
- ◆ Consider the use of community development programmes such as “Ask Me” by Women’s Aid or the SAFE² Communities programme
- ◆ Better public awareness around the dynamics of domestic abuse, coercive control and specialist support services. Campaigns should challenge victim blaming attitudes and widely held views around domestic abuse being purely physical, caused by alcohol and substance misuse or mental health issues. Consider learning from London Borough such as Sutton who have developed the Not Alone in Sutton campaign: <https://notaloneinsutton.org.uk/>
- ◆ Public awareness campaigns should be tailored to specific minority communities who may face multiple barriers when accessing services and support.
- ◆ Campaigns should raise awareness about the importance of third-party reporting.

Missed Opportunities and Delays in Information Sharing

- ◆ All professionals should be aware of their MARAC lead and how to refer to the MARAC.
- ◆ Expand referral pathways to specialist services so that “low” and “medium” risk cases are supported, and escalation of risk prevented.
- ◆ All agencies have a responsibility to follow up referrals to MARAC and proactively work together outside of MARAC meetings. MARAC is not an intervention in and of itself. Actions need to be taken to increase safety and hold perpetrators to account.
- ◆ Professionals need to be aware of and trained on how to respond appropriately to the risks posed and understand the potential impact of IPV on children and any vulnerable adults within the household.

Risk Assessing

- ◆ There is an important distinction to be made between risk identification and risk assessment. While risk identification involves knowledge and use of the checklist and identification of risk factors, risk assessment requires more in-depth knowledge and is an on-going, sustained process. All front-line staff who are likely to come into contact with victims/perpetrators

² <http://www.standingtogether.org.uk/local-partnership/safety-across-faith-andethnic-safe-communities-project>

should be trained in carrying out risk identification. Specific members of staff with additional skills/knowledge/training should then conduct a more detailed risk assessment.

- ◆ Professionals should keep in mind that the victim's perception of danger is crucial in assessing potential lethality.
- ◆ It is essential that risk factors are recorded accurately for future assessments.
- ◆ It is imperative that risk is seen as dynamic, fluid, and is regularly reassessed at 'critical points' within each case.
- ◆ Agencies should always refer to the MARAC based on professional judgement when information is limited, and the victim/survivor is perceived to be minimising the risks/is unable or too fearful to disclose the full extent of the abuse.
- ◆ In the process of risk assessing, increased emphasis should be placed on the perpetrator who poses the risk to the victim survivor but also to any other partners, children and vulnerable family members.
- ◆ There is a need for risk assessment with perpetrators to be built into practice.

Missed Opportunities – Victim, Missed Opportunities – Perpetrator, Policy and Procedures and Information Sharing

The following sections relate to key services where there are findings related to missed opportunities, policy and procedure and information sharing. These recommendations for practice are separated for each service area.

GPs' Recommendations for Practice

General

- ◆ IRIS is a proven intervention to improve the health care response to domestic violence and abuse. Evaluation of IRIS has found that women attending intervention practices were 22 times more likely than those attending control practices to have a discussion with their clinician about a referral to an advocate. This resulted in them being six times more likely to be referred to an advocate. Commissioning IRIS would address much of the following recommendations for practice. A link to IRIS related recommendations can be found at: <http://www.irisdomesticviolence.org.uk/iris/about-iris/about/>

Training

- ◆ GPs should have a 'whole surgery' approach to training, where both clinicians and administrative staff are provided with integrated training and referral pathways for domestic abuse, responding to both survivors and perpetrators through a whole family approach.
- ◆ The training should take an intersectional approach. It should include information on the dynamics of domestic abuse, how to appropriately identify it, and how to support and risk assess survivors and perpetrators.

Enquiry about DA

- ◆ In accordance with RCGP, IRIS, Safe Lives and NICE guidance, GPs should ask about abuse where a patient has presented with repeated 'accidental' injuries, a history of psychiatric illness, alcohol or drug dependence, and a history of depression, anxiety, failure to cope and social withdrawal.
- ◆ In heterosexual relationships, perpetrators of IPV often exert control over a woman's reproduction; GPs should be alert to indicators such as urinary tract infections, unprotected sex, lesion of nipple, STIs, pregnancy and requests for a termination.

- ◆ GPs should consider potential indicators for perpetrators of domestic abuse who may present as aggressive, controlling, involved in multiple violent altercations and with substance misuse and mental health issues.

DA Policy

- ◆ For training to be effective, it needs to be complemented with a surgery-wide domestic abuse policy which responds to the needs of staff as well as patients experiencing domestic abuse and has clear and established referral pathways.
- ◆ This policy should be separate from the safeguarding policy within the surgery.
- ◆ Information about local specialist services should be displayed in surgeries and waiting rooms raising awareness of services and creating an environment where disclosure can be made.

Record Keeping

- ◆ Consistent and comprehensive record keeping are crucial in ensuring appropriate continuity of care and an integrated response.
- ◆ Confidentiality needs to be a key consideration especially when the GP is in contact with both victim and perpetrator and other family members.
- ◆ When both survivor and perpetrator are registered at the surgery, this should be recorded and linked. Potential differences in surnames needs to be kept in mind and checked.
- ◆ GPs records could be aligned with those of any children; this would enable a 'family approach' where GPs can act as a more effective conduit for a system of coordinated family support.
- ◆ Importance of following up referrals.
- ◆ Importance of transferring records between GP surgeries when a patient moves.
- ◆ Links between health services are crucial in ensuring a holistic overview of patterns in appointments, walk-ins and emergency attendances rather than them being viewed in isolation.
- ◆ GPs and Mental Health services need to be better 'carer aware' and develop joint strategies to carers in line with the Care Act.

Mental Health Recommendations for Practice

Training

- ◆ All staff should receive training on identifying; risk assessing and safely responding to domestic abuse.
- ◆ All staff should be expected to enquire about DA.
- ◆ Identification of DA/VAWG among people presenting with mental health difficulties should not rely on direct disclosure; indirect signs such as unexplained injuries, 'stress' and psychological difficulties, or reports of problems in the family environment should prompt sensitive exploration of family circumstances and enquiry about DA.
- ◆ Training should take an intersectional approach and explore the multiple barriers faced by particular groups.
- ◆ Some consideration should be given to including the screening of perpetrators within mental health services and establish referral pathways with Respect accredited perpetrator programmes.

DA Policy

- ◆ For training to be effective, it needs to be complemented with a trust-wide domestic abuse policy, which responds to the needs of patients as well as staff experiencing domestic abuse and has clear and established referral pathways.

- ◆ The overall response of mental health services to DA, including enquiry and referrals, should be supported by policies for safe enquiry, immediate support and safety planning, and inter-agency referral protocols

Joint Assessment

- ◆ Mental Health and Addictions Services should develop guidance on dual diagnosis and referrals. Programmes that tackle both mental health and addictions are better able to reach and retain patients in services.
- ◆ Involving families and partners in mental health assessments and risk assessments was a recommendation in several DHRs, particularly in relation to individuals who present with suicidality in the context of relationship problems or separation.
- ◆ Individuals who are carers for partners or family members should be offered an assessment of their needs, particularly with regards to the impact of caring on their mental health and wellbeing.

Integrated Working

- ◆ Importance of transition in care: mental health staff need to ensure appropriate handover of perpetrator/victim mental health plan back to his/her GP.
- ◆ All visits to A&E should be recorded on the patient's electronic mental health record regardless of whether the patient self-discharges or in cases where the mental health team refuses to see the patient.
- ◆ GPs and Mental Health Trusts need to be better 'carer aware' and develop joint strategies to carers in line with the Care Act. This involves arranging assessments for carers which address their own mental health needs and ensure that they are not placing themselves/and or the cared for person at risk.
- ◆ Domestic abuse should automatically trigger a discussion with the internal safeguarding leads to consider appropriate course of action.
- ◆ Ensure appropriate referral (with victim/survivor consent) to specialist domestic abuse services when thresholds for statutory intervention are not met.

Health Services Recommendations for Practice

Integrated Working and Information Sharing

- ◆ Better coordination across health services would help pick up patterns in attendances. Health professionals need to ensure a more joined-up approach which integrates a holistic overview of patterns in appointments, walk-ins and emergency attendances rather than them being viewed in isolation.
- ◆ All referrals to other agencies should be appropriately followed up.
- ◆ Better joined up working between schools, social care and community health.
- ◆ Establish links with Respect accredited perpetrator programmes.
- ◆ Information about local specialist services should be displayed in waiting rooms raising awareness of services and creating an environment where disclosures can be made.
- ◆ Introduce an automatic referral (with victim/survivor consent) to specialist domestic abuse services when thresholds for statutory intervention are not met.
- ◆ Consider the resources developed by Pathfinder, specifically a DOHSC funded whole health economy approach to domestic abuse, which can be found at: <http://www.standingtogether.org.uk/localpartnership/pathfinder>

Adult Safeguarding Recommendations for Practice

Training

- ◆ Adult social services should receive training on the dynamics of domestic abuse, identification and risk assessment. Training should take an intersectional approach and explore the multiple barriers and increased risk faced by particular groups.
- ◆ A particular focus on older people's experiences and specific needs should be covered as part of the training. There is a need to challenge institutional ageism.
- ◆ All services need to be alerted to the increased risk for abuse in a caring relationship when the carer is a partner.
- ◆ All services should be alerted of the increased risk of domestic abuse for disabled women.

Integrated Working

- ◆ Adult social services should strengthen links with other agencies such as health, mental health, and specialist domestic abuse services.
- ◆ Break down boundaries and promote collaborative working across adult and children's services. Where there are concerns that an adult is experiencing DA then there should be concurrent exploration of whether there are any child safeguarding concerns and vice versa.
- ◆ Consideration should be given to making a referral to the local early intervention team for individuals who do not meet the threshold for safeguarding.
- ◆ Strengthen links with Respect accredited perpetrator programmes.
- ◆ Ensure referrals are made (with victim/survivor consent) to specialist domestic abuse services when thresholds for statutory intervention are not met.

Children's Social Care Recommendations for Practice

Training

- ◆ All children's social care staff should receive training on the dynamics of domestic abuse; how to identify it, assess risk and respond safely. Training should take an intersectional approach.
- ◆ Added emphasis should always be given to the complexities of leaving an abusive relationship and the importance of holding perpetrators to account for the abuse.
- ◆ Agencies' tendency to hold mothers living with domestic abuse responsible for safeguarding children needs to be challenged. Language and practice need to move away from victim-blaming approaches. Professionals need to recognise the potential they have to enable victims to expand their 'space for action' by recognising how coercive control limits their freedom.
- ◆ Children's social care needs to be aware of the specific risks to children living with domestic abuse and that in most cases, the best way to keep a child safe is to increase the non-abusive parent's safety.
- ◆ Staff should also be alerted to the risk of perpetrators making false allegations.
- ◆ Share learning from pilots and models across London where there is targeted work to support front line workers to engage with survivors as a partner and to hold perpetrators of abuse to account³.

Integrated working

- ◆ Break down boundaries and promote collaborative working across adult and children's services. Where there are concerns that an adult is experiencing domestic abuse, then there should be concurrent exploration of whether there are any child safeguarding concerns and vice versa.
- ◆ Joined up working between schools, social care and community health.

³ Information relating to this can be found at: <https://www.bbc.co.uk/news/uk-england-london-49879597>.

- ◆ Ensure links with Respect accredited perpetrator programmes are established. Establish a culture where perpetrators are held to account and expected to engage with such programmes.

Schools Recommendations for Practice

Training

- ◆ All designated teachers for safeguarding (and their respective networks) should receive training on how to identify, risk assess and safely respond to domestic abuse, with a specific focus on the impact on children and young people.
- ◆ Use of resources such as AVA's Whole School Approach⁴ to begin developing practice in schools.
- ◆ Added emphasis should always be given to the complexities of leaving an abusive relationship and the importance of holding perpetrators to account for the abuse.
- ◆ Strong links should be established between schools and specialist domestic abuse services.
- ◆ Staff should be alerted to the risk of perpetrators making false allegations.
- ◆ Shared learning from schools should be established so that schools who have developed robust practice in this area can share what they have learned with other schools.

Adult Family Homicide

Although the current cross-government definition of domestic violence and abuse in England and Wales, which applies to Domestic Homicide Reviews, encompasses both interpersonal and family members, it has been recognised that there is a dearth of research into Adult Family Violence (AFV) and abuse of parents in particular.

Consistent with previous analyses of Domestic Homicide Reviews (Sharp-Jeffs and Kelly, 2016), Adult Family Homicide (AFH) cases in the current sample discriminate by sex, both in terms of victimisation and perpetration, albeit more pronounced in the latter (67% of victims were female, and 90% of perpetrators were male).

Age

Victims in parricide cases ranged from 43 to 86 years of age, with the vast majority aged 58 or over (13 out of 17 cases), thus qualifying them as older people. This is consistent with recent research into domestic homicide of older people which showed that 'older people are almost as likely to be killed by a partner as they are their child' (Bows, 2018, pp. 7-8). Perpetrators ranged from 15 to 55.

Invisibility was a salient feature in the AFH cases we examined, with a majority of reports mentioning serious failures in identifying domestic abuse, assessing risk, and referring victims to appropriate support services by a range of agencies, and a noticeable lack of understanding of dynamics of violence and abuse within a familial context.

The 2014 report HMIC (now known as HMICFRS) notes that despite 'the wide range of relationships covered by the current definition' ... when the force policy sets out that the police response to a range of very different situations should be identical, this risks making police officers increasingly cynical about supporting all victims of domestic abuse' (HMIC, 2014, p. 37).

⁴ <https://avaproject.org.uk/ava-services-2/children-young-people/whole-schools-approach/>

Risk

Most of the existing practice guidance and tools in responding to domestic abuse are geared towards interpersonal violence and potentially unsuitable for dealing with adult child to parent abuse.

It has been recognised that the evidence base of the DASH is primarily built around dynamics of interpersonal violence. Focused research by McManus et al. on the DASH in relation to cases of child-to-parent domestic abuse (including both adolescent and adult children) revealed that 'few DASH risk factors were able to identify risks of child-to-parent domestic abuse recidivism' and called for research to help 'understand and develop risk factors that capture the different types of DA incidents' (McManus, Almond and Bourke, 2017, p. 130).

Recurring Themes

Similar to the Standing Together DHR Analysis in 2016, the following prominent features are present in the AFH cases:

- ◆ Mental health issues for perpetrators in 16 cases. 12 cases of these cases resulted in a verdict of either manslaughter with diminished responsibility or not guilty by reason of insanity and sentenced to a Hospital Order.
- ◆ Substance use issues for perpetrators in 44% 11/25 cases. In some cases, illegal drug use had led to paranoia and psychosis. There is a need for further research into drug induced psychosis, especially in AFH.
- ◆ The majority of victims were elderly parents (mainly mothers) caring for their mentally ill or substance dependent adult sons, often in an informal capacity.

We cannot ignore the strong relationship between the gendered dynamics of these homicides and the wider cultural context of gender expectations surrounding caring roles and responsibilities.

While it could be, and has been, argued by several the reports that most of the homicides could not have been prevented due to their sudden and out of character nature, some common practice issues have consistently emerged:

Practice Issues

- ◆ Risk to other family members never considered as part of mental health assessments. There was a consistent lack of involvement of families in the care of individuals and of consultation or liaison with families and other agencies around assessment or treatment plans by mental health services. Assessments and treatment plans took place without a full picture of risk and issues pertaining to safety. The onus was often put on family members and carers to contact mental health services for information and updates, and not the other way around.
- ◆ Family members – often aging caring mothers – were ignored and marginalised by mental health services and saw their concerns dismissed.
- ◆ There was a consistent lack of carer's assessments. Either they were not considered, or were only 'offered' a cursory option, even in cases where there were clear signs of carer strain and question marks about the carer's ability to cope or to care appropriately. The curious near-systematic invisibility of Adult Social Care (through lack of referrals or NFA taken by ASC) and internal Adult Safeguarding processes was striking, even though most of the individuals concerned were either elderly carers or people with significant support needs in terms of their mental health.
- ◆ There was a consistent absence of the victim's voice, as well as a lack of consideration and understanding of their needs. The use of family members (in particular those caring for the victims) as interpreters.
- ◆ There was a real lack of professional curiosity vis-à-vis patients and their family or carers. As ever, GPs are a constant thread running through the lives of people who have mental health and drug issues. The lack of information sharing between mental health services and GPs was a constant issue through all the reports. As noted in several reports, although

matricide (the killing of mothers) is fortunately infrequent, it is largely to be committed by those with severe psychiatric disorders (Carabellese et al., 2013). Research by Marleau et al. agrees with other literature that a 'majority of adult parricide offenders suffer from mental illness, specifically paranoid schizophrenia (56%) (2006). A correlation has also been found between the age of the offender and parental victimization; those between 20 to 50 years of age were most likely to kill their mothers (Heide, 1993).

There was a high degree of instability in the lives of those who committed the murders: inability to sustain employment due to mental health and associated issues; lack of stable, long-term relationships; high degree of transience due to lack of housing options or difficulties in sustaining independent living; breakdown of intimate relationships; work-related stress; etc. In many cases perpetrators were financially and emotionally dependent on their parents. Social isolation was an additional poignant feature in the lives of perpetrators (and in some cases of victims). There was a noticeable number of mothers who were divorced from their partners or widowed and had taken care of their children as single mothers, which might be worth interrogating as part of the gendered dynamics of AFV and AFH. Furthermore, the AFH cases reviewed showed that the abusive behaviours often took place within a wider context of family abuse.

Most of the reports are fluent in identifying practice issues but pay insufficient attention to wider structural issues such as lack of housing solutions, increased pressures on mental health resources, lack of appropriate care for vulnerable adults and their informal carers, numerous service restructures/reorganisations that were disruptive to access to care, or austerity measures and general deprivation, as well as issues facing BME communities and people with insecure immigration status.

Themes for AFH

We extracted all the most frequent themes present in the 25 reports of AFH and created a data base to capture these. Below are the most reoccurring themes. All themes are listed in Appendix 5.

Lack of understanding of the range of behaviour that constitutes DA/VAWG and its dynamics and impact

In 60% of cases, there was a lack of understanding within agencies of the dynamics of DA/VAWG in AFH cases and its impacts. In 16% of cases, there was a lack of professional curiosity to ask further questions about relationships. This was true even in cases where complex and multiple disadvantages were present. This was especially true for mental health services and caring services.

Missed opportunities to offer support to the victim

44% of cases missed opportunities to ask about the victim's relationship. 32% of cases missed opportunities to ask questions in situations where there was increased vulnerability due to drug or alcohol use and/or mental ill health.

Missed opportunities to hold the perpetrator accountable

24% missed opportunities to hold the perpetrator accountable or offer support, with 28% missing opportunities to offer perpetrator support around mental health. 48% of perpetrators had mental health issues.

Family and Friends

In 54% of DHRs family, friends and employers knew abuse was happening in the relationship but did not know that the behaviour's constituted domestic abuse. In addition, family and friends and employers often do not know where to go for help and fear making the situation worse by bringing in outside agencies.

Lack of information-sharing between agencies

43% of DHRs showed that agencies knew about domestic abuse being present but did not share this information. Health services can be reluctant to share information about patients because of consent issues and further policy work is needed around when they can share.

Risk assessment

In 46% of cases, risk assessments were done poorly or not at all. In 39% of cases, the known risks by agencies should have resulted in a referral to MARAC. In cases where mental health was present, no mental health service carried out DASH risk assessments with family on the risks posed by the perpetrator to their family or friends.

Missed opportunities (or delays) to share information

In 46% of DHR cases, agencies including health missed opportunities to share information or delayed sharing, resulting in increased risks to victims. 37% missed opportunities to share information for multi-agency coordination and make referrals. 28% of cases did not risk assesses or refer to MARAC even though they were high risk cases.

Relevant policies and processes either were not there or not followed

In 28% of DHRs, policies and procedures were not adhered to. This includes, but is not limited to, domestic abuse policies.

Recommendations for practice relating to AFH Themes

- ◆ The Home Office should utilise Domestic Homicide Review findings to develop and share nationally a greater understanding of the nature and risk factors relating to familial abuse, and any trends to be aware of. Providers of community health services, substance misuse services and mental health services should be increasingly aware of adult child to parent violence and the gendered nature of these crimes and consider the risks to parents or family members of their adult service users, especially when living together and when the service user is financially dependent on them.
- ◆ An understanding of risk factors for adult children who are dependent on their parent(s) financially, emotionally or due to substance misuse of mental ill-health requires much more awareness raising and proactive encouragement for early help and support.
- ◆ A better understanding of the experience of older people linked to caring responsibilities and domestic abuse.
- ◆ NHS England and the Home Office to utilise the learning gained from Domestic Homicide Reviews (and other Mental Health Reviews) to develop a greater understanding of the issues surrounding domestic homicides committed by individuals with diagnosed mental health conditions.
- ◆ IDVA co-located at Substance Use and Mental Health services, ensuring their briefings and consultations with staff include specific information on familial abuse, in particular, adult child to parent abuse.
- ◆ Better recognition of caring roles and responsibilities: The Carers Trusts define a carer as anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction, cannot cope without their support. This stresses the importance of having carer's teams within Mental Health and Substance Use services.

Intersectionality for IPH and AFH

Black and Minority Ethnic (BME)

Service Provision for BME communities

In the BME DHR reports, there was a reliance on the statutory pathways of the Criminal Justice and Social Care systems without the active involvement of the specialist VAWG sector in the DHRs.

Where the perpetrators behaviour did not fit the government definition of IPV/AFV, voices of concerned family members were not heard or acted on. Police intervention in harassment, intimidation and violent behaviour towards neighbours, family members and others in the community were not framed as VAWG. It is important that there is an awareness of the history of discrimination that minoritised communities have and do experience which can prevent disclosures to certain agencies like the Police.

Immigration was a key factor which prevented some victims from accessing early support that they were eligible to receive through social care, health and specialist VAWG organisations. Opportunities to disclose violence and abuse were missed because of a tendency to view these situations solely as immigration cases instead of through a holistic lens which incorporates safeguarding, housing and health within a VAWG framework.

Often references to culture and faith that amount to justifications for abuse are used by perpetrators to silence and control victims yet, such dynamics were not challenged or even understood as such in the context of a review. Where the so-called honour code under 'honour-based violence' is indicated, statutory services fail to understand it in their assessments around risk factors. A wider understanding of so-called honour-based violence and its impact is needed across agencies.

Agencies still use family members as interpreters despite the risks this can pose. Where a person is subjected to coercive control, either using them as interpreters or interpreting for the perpetrator increases risk.

Independent and good quality interpreting services should form part of consistent practice across sectors. In several cases, women accessing GPs did not have any access to interpreters, even when seen on their own, missing opportunities to ask about their relationship. This was even seen when they accessed help with STI's, fertility issues, and abortions.

DHR Panels

The lack of an intersectional inclusive panel to ensure that diversity issues are appropriately considered leads to inaccurate assumptions about how such issues should be interpreted. A better understanding of intersectionality is needed by the chair and report writers of DHRs. A wider focus on cultural, social, economic, psycho-social, environmental and familial factors would give a better intersectional approach in DHRs.

LBGT+

It is estimated that more than 1/4 gay men and lesbian women and more than 1/3 bisexual people have reported at least one form of domestic abuse since the age of 16

Evidence from a GALOP report also suggest increased reporting of domestic abuse from transgender people⁵ (Magic & Kelley, 2019, p15). LBGT+ domestic abuse appears significantly

⁵ Prevalence of intimate violence among adults aged 16 to 59, by category and sexual identity of the victim, year ending March 2016 CSEW:

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/adhocs/005986prevalenceofintimateviolenceamongadultsaged16to59bycategoryandsexualidentityofthevictimyearendingmarch2016csew> (accessed on 5 October 2019).

underreported and LGBT+ survivors are disproportionately underrepresented in voluntary and statutory services, including criminal justice services⁶.

There is a lack of perpetrator programmes accessible to perpetrators who are not heterosexual men, including LGBT+ perpetrators.

It is important that a DHR does not seek to 'exoticize' a LGBT+ identity or use it to explain the murder. Rather, it contextualises the murder in the wider cultural context of not only VAWG, but also specifically the experiences of LGBT+ people. LGBT+ domestic abuse experiences have rarely featured as part of a local commissioning process or strategic plan (the Tri-boroughs being one of the few exceptions). A greater understanding of the dynamics of LGBT+ abuse is required in both IPV and AFV violence to ensure that murders of LGBT+ people by interpersonal, household and family members are identified.

Recommendations for Practice

- ◆ Galop recommend that the experiences of LGBT+ victims be embedded in the Coordinated Community Response to ensure that there is an appropriate response to murders of those who identify as LGBT+.
- ◆ Sex, Gender identity and sexuality should always be taken into consideration when examining the risks to LGBT+ victims/survivors/perpetrators and when conducting any future DHR/Serious Case Review involving LGBT+ people.
- ◆ Galop would recommend that DHRs involving LGBT+ should always seek the input of LGBT+ organisations/stakeholders with specialist knowledge of domestic abuse/community issues.
- ◆ Agencies should engage with specialist LGBT+ projects to increase their awareness of support services available.
- ◆ Community Safety Partnerships to map out the size and necessities of the local LGBT+ communities to inform strategy decisions to best support them.
- ◆ Carry out an audit of local agency practice to see which are trans inclusive and which are woman only and what (if any) other provisions are available in women only.
- ◆ Probation should explore perpetrator programmes accessible to LGBT+ perpetrators.

Mental Health Key findings

- ◆ Mental health problems were identified in 64% 16/25 cases of perpetrators in **AFH** cases, with 56% 14/25 of the cases with a diagnosed psychotic disorder, of these cases 40% were open to mental health services at the time of the murder. In victims only 2/25 of victims had mental health issues present.
- ◆ Mental health problems were identified in 44%, 26/59 cases of perpetrators of **IPH** cases, with 32% of the cases with a diagnosed psychotic disorder. In victims 33% 20/59 cases had mental health issues with only 6% 4/59 with a diagnosed psychotic disorder.

◆ The most common diagnosis in **AFH** was depression, 16% of perpetrators and 12% of victims were depressed.

In **IPH** 18% of perpetrators had depression and 17% of victims

The relationship between mental health and violence is complex, and a direct causal relationship should not be assumed. However, enquiry about DA is crucial in mental health services (and other

⁶ A. Roch, G. Ritchie, and J. Morton. (2010) 'Out of sight, out of mind? Transgender People's Experiences of Domestic Abuse'. Edinburgh: LGBT Youth Scotland, Equality Network, Scottish Transgender Alliance. Available at:

https://www.scottishtrans.org/wpcontent/uploads/2013/03/trans_domestic_abuse.pdf (Accessed 05 October

2019)

health services that have contact with people with mental health problems) due to the higher risk of DA victimisation and perpetration among people with mental disorders. Half of the perpetrators in the mental health DHR sample had reported suicidality to healthcare services; a third had been suicidal in the month prior to the homicide. 11% (7/59) of perpetrators of IPV killed themselves after the homicide. Caring responsibilities was an area of concern in the mental health DHR sample, particularly with regards to perpetrators who were carers, and the lack of carers' assessment and support when carers are not coping with their role.

Recommendations for Practice

Training

- ◆ All staff should receive training on identifying, risk assessing and safely responding to domestic abuse.
- ◆ All staff should be expected to enquire about DA.
- ◆ Identification of DA/VAWG among people presenting with mental health difficulties should not rely on direct disclosure; indirect signs such as unexplained injuries, 'stress' and psychological difficulties, or reports of problems in the family environment should prompt sensitive exploration of family circumstances and enquire about DA.
- ◆ Training should take an intersectional approach and explore the multiple barriers faced by particular groups.
- ◆ Some consideration should be given to including the screening of perpetrators within mental health services and establish referral pathways with Respect accredited perpetrator programmes.

DA Policy

- ◆ For training to be effective, it needs to be complemented with a trust-wide domestic abuse policy, which responds to the needs of patients as well as staff experiencing domestic abuse and has clear and established referral pathways.
- ◆ The overall response of mental health services to DA, including enquiry and referrals, should be supported by policies for safe enquiry, immediate support and safety planning, and inter-agency referral protocols.

Joint Assessment

- ◆ Mental Health and Addictions Services should develop guidance on dual diagnosis and referrals. Programmes that tackle both mental health and addictions are better able to reach and retain patients in services.
- ◆ Involving families and partners in mental health assessments and risk assessments was a recommendation in a number of DHRs, particularly in relation to individuals who present with suicidality in the context of relationship problems or separation.
- ◆ Individuals who are carers for partners or family members should be offered an assessment of their needs, particularly with regards to the impact of caring on their mental health and wellbeing.

Older people

For this research we have defined older victims as anyone over 58 years, with 18 of 84 victims falling into this category.

Data on the prevalence of domestic abuse among this group is still sparse with a lack of understanding within agencies of identifying domestic abuse, assessing risk, and referring victims to specialist domestic abuse service.

In most of the cases we examined, conclusions were drawn that the homicide was neither preventable nor predictable, however there are a number of key themes which emerged and can therefore be considered as significant.

Sex

The cases we examined align with national figures with 78% (14/18) of the victims being female, 22% (4/18) male. The relationship between the female victim and the perpetrator deviates from national findings with 64% (9/18) adult family homicide (AFH) and 36% (5/18) interpersonal homicide (IPH). The vast majority of perpetrators of AFH were adult sons (89% [8/9]).

Similar figures were represented for male victims with 75% (3/4) being AFH and 25% (1/4) IPH. All 3 of the AFH perpetrators were male.

Age

The average age of victim was 69.4 years with the greatest number of victims falling into the 'young-old' category. 17% of victims were in their late 50s (3/18) 44% were in their 60s (8/18), 28% (5/18) were in their 70s (5/18) and 11% were over 80 (2/18).

Where victims presented with injuries or signs of mental health needs, their condition is presumed to be the result of health or social care needs.

Mental Health in Older People

The links between mental health and both AFH & IPH are significant in this cohort. 89% (16/18) of the perpetrators had diagnosed mental health conditions and 50% (9/18) were open to mental health services when they killed their victim. In some cases, the perpetrator had exhibited violent and aggressive behaviour to others and expressed feelings of violence towards their victim in the lead up to the homicide. The risk factors for family and friends associated with the perpetrator were not taken into consideration by mental health services nor were they notified about the risks to them from the perpetrator.

Carers

A large proportion of cases, totalling 78% (14/18) involved a caring relationship between the victim and perpetrator. These cases often involved a wide range of agencies providing numerous services and with varying levels of awareness of the risks presented. In some cases, safeguarding concerns were raised but information was rarely shared among agencies, allowing a true picture of risk to emerge.

An apparent lack of professional curiosity is present in many of the reports, even where risk indicators or safeguarding concerns were raised. Professionals were more likely to direct questioning towards the perpetrator and used them to interpret on a regular basis. This resulted in an apparent invisibility of their wishes, views and any concerns they might have had about the perpetrator.

Recommendations for Practice

- ◆ Training, in particular for health and social care practitioners, around recognition and response to domestic abuse is much needed which explore the specific barriers and needs related to older victims. This is particularly important where there is mental health present.
- ◆ More research is needed around the role of carers where there is DA/VAWG. There needs to be greater collaboration between agencies to manage the needs of carers, particularly where they have their own needs related to mental health.
- ◆ Trusts should review their approach to risk assessment and risk management, including the weight given to allegations of abuse and/or threats and the actions taken to address such allegations