Learning Summary from Domestic Homicide Review (DHR)

1.0 Introduction

1.1 Domestic Homicide Reviews (DHRs) aim to improve practice and outcomes for people affected by domestic abuse. This learning summary is designed to highlight the key areas of learning and practice in relation to the DHR undertaken in relation to the death of Adult N and Adult H.

1.2 This process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

2.0 Summary of case

2.1 Adult N and Adult H resided with their two children in Bromley. Adult N died in May 2019 and Adult H died in June 2019 as a result of injuries sustained at the same time.

2.2 It has been decided that due to the sensitive nature of this case, and to protect the remaining family, the full review will not be made public, however, this Learning Summary will be published.

3.0 Review process

3.1 The Safer Bromley Partnership appointed John Trott, an Associate of Standing Together Against Domestic Abuse, as the independent DHR Chair and Author. The Bromley Safeguarding Children's Board also considered that a Child Learning Review should be undertaken, and it was agreed that Mr Trott would also Chair this process. This report captures the learning from the DHR only.

3.2 The review considered agencies contact and /involvement with Adult N and Adult H from March 2017 until May 2019, which was the period that agencies and services started to interact with Adult N.

3.3 There were delays in completing this DHR for a number of reasons including the Covid19 pandemic and undertaking appropriate consultation with the family who were overseas.

4.0 Key Issues

4.1 In respect of sex, being female is the single greatest risk factor for domestic abuse and domestic homicide.

4.2 Religion/belief was believed to be a protected characteristic in this case. Adult H was understood to have changed his religion in order to marry Adult N but once married he returned to his original faith and would use Adult N's faith to humiliate and discriminate against her in front of the children. The Review Panel engaged an expert for cultural issues and discussed in some depth how this may have impacted Adult N's perceptions of services as well as her perceived options for help.

4.2 There was evidence that Adult N was influenced by traditional family and cultural values. It is possible that she felt pressurised by these factors which may have influenced her decision making and her access to communicate with other members of the family, including Adult H.

4.3 English was not Adult N's first language. There is no mention from any agency whether Adult N required an interpreter but the ability to express herself in her mother language may have helped Adult N to express herself in more detail.

4.4 Adult N did not have financial independence from Adult H. Financial independence, either through employment or access to public funds may have allowed her to plan what was available to her and how best she could end the relationship.

5.0 Learning

5.1 Opportunities were missed to action referrals and liaise with other agencies, particularly across specialities, therefore, the full picture of offending was not visible to the agencies involved in supporting the victim or holding the perpetrator to account which would have resulted in more co-ordinated and consistent action.

5.2 A clearer approach to the multi-agency management of the perpetrator may have provided a stronger safeguarding response by holding the perpetrator to account and providing support to change their harmful behaviour. This should include all relevant partners, including health services such as GPs and school nurses.

5.3 Regular policy reviews are necessary to ensure they reflect changes in legislation and reflect good practice and learning.

5.4 There must be continued momentum to train and provide tools to ensure that professional curiosity and identification of domestic abuse is fostered in all settings. This is particularly true in relation to healthcare and social care settings where there is an opportunity to engage with both the victim and the perpetrator and the wider family.

5.5 Improved understanding by professionals that an individual may be influenced by their culture, affecting how openly domestic abuse is discussed / recognised and when help is or is not sought. Professionals should not use culture as a pseudo-explanation for the prevalence of abuse. Professionals need to be proactive in the identification of abuse rather than waiting for victims to disclose.

5.6 This review has shown the importance of professionals ensuring that domestic abuse victims are proactively advised of the housing options available to them and actively supported to access them.

5.7 Using tools, such as Domestic Violence Prevention Orders (DVPO), may have provided time for enquiries to be undertaken which would have allowed a full picture to have been obtained from the family, particularly in relation to coercive control.

5.8 The review identified the need for victims of domestic abuse to have confidence in the criminal justice system. A decision not to charge a perpetrator with an offence is likely to make it harder for a victim to feel confident making future reports, increasing their feeling of vulnerability and reinforcing the perception that there is no help for the family.

5.9 Strong case management and oversight is important to ensuring that records are appropriately maintained and supervision provides scrutiny, challenge and guidance.

5.10 There are many agencies involved in supporting victims of domestic abuse and holding perpetrators to account. It was highlighted that it is important for agencies to provide appropriate challenge and scrutiny of the action of partners, particularly where they relate to safeguarding.

5.11 Risk assessments need to recognise that risks are likely to increase at key points, for example once a perpetrator has been released following an arrest related to domestic abuse against the victim.

5.12 Professionals can fall into a routine of ‘standardised’ practice meaning that safety and support plans are not individualised to the victim and their situation and therefore actions can be missed that would be helpful for the victim. Through the execution of detailed supervision sessions in case management, as well as refresher training this can be prevented in the future.

5.13 Processes need to be in place when a scheduled programme is cancelled, including what additional provision is to be offered to survivors who were booked to attend the cancelled programme.

6.0 Next Steps

6.1 The Learning from this DHR has and will be used to improve the policies, procedures and practices applied to safeguarding victims of domestic abuse and holding perpetrators of domestic abuse to account.