Final Version for Publication

safer new forest
Targeting Crime and Antisocial Behaviour

NEW FOREST DISTRICT COUNCIL COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Adam

December 2013

Independent Chair and Author of Report: Nicole Jacobs

Standing Together Against Domestic Violence

March 2016

STANDING together against domestic violence

1. Executive Summary

1.1 The Review Process

1.1.1 In late 2013, police and ambulance services were called to an address in New Forest where an adult male was found to be unconscious and taken to the local hospital. He was pronounced dead later that same evening. His brother was arrested the following morning and charged with his murder. A trial date was set for late 2014 where the defendant was found guilty of murder and was given a sentence of life imprisonment with a 13-year minimum term. Pseudonymous are used to describe these parties in this summary as required by Home Office guidance.

1.1.2. This event described above led to the commencement of this domestic homicide review (DHR) at the instigation of the Safer New Forest Partnership, the area where the family lived. The initial meeting was held on 11th March 2014 to consider the circumstances leading up to this death. There have been five subsequent meetings of the DHR panel to consider the circumstances of this death.

1.1.3. The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and was conducted in accordance with the Home Office revised guidance.

1.1.4. The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply those lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

1.1.5. This review process does not take the place of the criminal or coroner's courts proceedings nor does it take the form of any disciplinary process.

1.1.6. The process of this DHR began quickly as New Forest District Council had already conducted a task and finish group to increase the knowledge base of their elected members and officers. In addition, they had scoped agency involvement, in preparation for the first panel meeting. This organisation and understanding helped the process considerably.

1.1.7. There were delays due to the criminal trial proceeding in the latter part of 2014 and the need to take some time for leave to appeal against the sentence and conviction and settling of prison location. Also, given the nature of this homicide, with one brother convicted of killing another brother, the panel and Chair felt that the family required some time before being approached again post-trial about the domestic homicide review process.

1.1.8. The Chair notes that there was a delay in the finalisation of this Overview report which was due to personal circumstances of the Chair and not the responsibility of New Forest District Council or panel members.

1.1.9. As noted in the recommendation section, New Forest District Council, Hampshire Police and other panel members are commended for the progress they have made to take forward actions related to this review as quickly as possible.

1.2 Contributors to the Review

1.2.1 The approach adopted was to seek Individual Management Reviews (IMRs) from all organisations and agencies that had contact with Adam and Doug, and their respective families, since 2005. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. Details of those agencies providing IMRs or summaries of information held are outlined in the terms of reference.

	Summary of Engagement/Information	IMR
Hampshire County Council Children's Services Department	x	x
New Forest District Council Tax and Benefits Housing Customer Services Licensing	x	x
Hampshire Constabulary	x	x
Hampshire Probation Trust	x	x
Victim Support	x	x
West Hampshire CCG	x	x
Hampshire County Council Adult Services Department		x

University Hospital Southampton NHS Foundation Trust		x

1.2.2 Once the IMRs had been provided, panel members were invited to review them all individually and discuss the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. Subsequently, further information was then sought and a draft overview report was further considered by the panel. This report is the product of that process.

1.2.3 Additional information sought and contributed by:

(i) Hampshire Police relating to the Multi Agency Risk Assessment Conference (MARAC) in New Forest,

(ii) Southampton City Council regarding the IDVA service provision,

(iii) The Society of St. James related to substance misuse services offered,

(iv) The Hampshire Operational Model Enabling Recovery (HOMER) services offered,

(v) The Family Liaison Officer (FLO) from Hampshire Police,

(vi) Hampshire County Council commissioners of substance misuse treatment.

1.2.4 No IMR was requested from the IDVA service because of the limited nature of their contact with the partners of Doug and Adam. However, the Chair interviewed the IDVA service and discussed with panel members the provision of service during this time. The Chair also interviewed local partners and reviewed IDVA commissioning plans and arrangements.

1.2.5 Additional information sought but not available for the review were the GP records for Doug despite enormous effort by the CCG. Permission was sought from Doug but was not granted. Some records for Adam were provided. The review panel feel that the review process has suffered because of a lack of engagement from GPs.

1.3 The Review Panel Members

1.3.1 The panel, convened by the panel Chair consists of representatives from the following agencies.

STADV, Chair of Review
New Forest District Council, Community Safety Coordinator
New Forest District Council, Head of Public Health and Community Safety and Chair of the Community Safety Partnership
West Hampshire CCG, Locality Manager
National Probation Service, Operations Manager

Hampshire County Council Children Services Department, New Forest District Manager.
Hampshire Constabulary Serious Case Review Team
University Hospital Southampton, Patient Safety Manager
Victim Support, Senior Service Delivery Manager
Hampshire County Council Adult Services, District Service Manager
Hampshire Children's Services, Area Director - West
West Hampshire CCG, Consultant Nurse for Safeguarding Adults

1.3.2 The panel represented the range of services which had direct contact with the family and who also could advise on a range of services locally and district wide. The Chair also interviewed substance misuse and Independent Domestic Violence Advice (IDVA) services who either did not have contact or had minimal contact with this family to clarify the wider, past and current, service pathways. It must be noted that the IDVA provision has been recommissioned during the process of this DHR. The Chair also notes the information provided by New Forest District Council regarding commissioned services for substance misuse treatment.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The independent Chair of the DHR was Nicole Jacobs. Nicole is Chief Executive of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. She has no connection with New Forest District Council or any of the agencies involved in this case.

1.4.2 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The 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, hold perpetrators to account and ultimately prevent domestic homicides.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the Review Panel shared brief information about agency contact with the full terms of reference (TOR) included in Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons could be learnt for the future.

1.5.2 One important feature to note in this TOR is that the panel decided, in view of the domestic abuse within the lives of both brothers, to take a comprehensive view of both brothers and not limit the

TOR to their relationship only. There were police incidents related to both intimate partners of each brother as well as incidents with neighbours and other acquaintances. The panel agreed that there may be possible missed opportunities to intervene and that the review process had to take a more comprehensive view.

1.5.3 The panel also decided that the full scope of Children's Services intervention would be reviewed. Adam was in a relationship with Jill who had four children but none of those were his biological children. Doug had been in a relationship with Helen who had five children only one of which (the youngest) was he the biological father. Again, the panel felt that given the involvement of Children's Services with both families, that the TOR would include all nine children.

1.6 Summary of Chronology

1.6.1 In late 2013, police and ambulance services were called to an address in the New Forest where an adult male was found to be unconscious and taken to the local hospital. He was pronounced dead later that same evening. His brother was arrested the following morning and charged with his murder. A trial date was set for late 2014 where the defendant was found guilty of murder and was given a sentence of life imprisonment with a 13-year minimum term.

1.6.2 This led Safer New Forest to commence a domestic homicide review (DHR), chaired independently and in which a range of local statutory and voluntary agencies fully participated. This review encompassed a wide range of information and analysis supplied by services about the lives and experiences of both brothers and included information about the brothers and their relationships with family, partners, neighbours and their interactions with statutory and voluntary services. This document represents a summary of a more detailed report which was produced by the independent chair and the review panel. The full report has been considered by Safer New Forest as well as all panel members and their respective agencies and services. The panel felt that this summary rather than the full report is appropriate to publish as the details in the full report are not relevant to the wider public and may upset and harm the extended family and close relations of this individual who have already suffered tragic loss. In addition, the family and relations chose not to participate in this review so therefore will not have had the opportunity to comment on its contents. The aim of a domestic homicide review is to consider the experience of the victim and think carefully about the lessons to be learned from this tragedy and although this review would have benefitted from the views of the family, the panel accepts that the family did not feel they wished to participate in the review.

1.6.3 The Chair and panel wish to extend their deepest condolences to the family and loved ones of the deceased.

1.6.4 In summary, it is the belief of the panel that this death was not preventable. There are clear missed opportunities which could have changed the course of events but there is no single action which demonstrates that this tragic death was preventable

1.6.5 **A lack of identification of domestic abuse**: There was a lack of understanding of the breadth of domestic abuse and the violence between the brothers and was often obscured by incidents of domestic abuse in their intimate relationships. Both brothers had a history of domestic abuse to partners, and a history, albeit it less extensively known to services, of violence towards each other

and violence in their parents' home. The relationship between the brothers did not feature highly in the work of any agency.

1.6.6 **A questioning and coordinated culture:** Additionally, what appeared to be lacking was a process where all the agencies examined the perpetrator's behaviour over an extended period of time. Each case was dealt with largely separately and, while some of these were dealt with effectively and considerable resources were committed to this end, the perpetrator's behaviour remained largely unchanged.

Likewise, the intimate partner of the perpetrator was known to be at risk of domestic abuse and the police and other agencies committed considerable resources supporting her. What appeared to be lacking was a coordinated and comprehensive view of the considerable risks he posed to her and her children. This review has identified that it would be beneficial for the multi-agency risk assessment conference (MARAC) to have an overview process where it could look at fewer but more complex, longer term cases. There is an opportunity for MARAC to provide the oversight and co-ordination for the more complex cases that require a longer-term involvement from agencies.

1.6.7 **Police response:** Due to multiple callouts to the Police for incidents of domestic abuse between the brothers but also between the brothers and their partners at that time, there were incidents when the response from the police was not in line with expected practice in relation to risk assessment. Complicating this was the fact that the local referral pathways to additional support via the MARAC were not adequate for their volume of referrals, and it is unclear that the victims of domestic abuse, whether it be the brothers in some instances, their partners, were offered the full range of intervention and support. On a number of occasions, the risk assessment was not completed because the officer recorded that the victim did not wish to participate. There is limited evidence that officers researched previous history, as required under the Hampshire Constabulary Force Policy, which may have helped determine the correct level of risk. There were also a number of occasions where the officer attending failed to complete the appropriate CYPR forms, in line with the force's policy. This meant that other agencies were unaware of the incident which could have promoted their intervention and a safer plan for the family. The grading of risk assessments by police officers was inconsistent and not in line with the force's policy. This meant that not only were the risks incorrectly identified but that the threshold for MARAC and other types of interventions were inconsistent. There was also an apparent lack of intrusive supervision of risk assessment at both sergeant and inspector ranks. It is noted that in 2012, the Central Referral Unit's responsibilities were expanded from dealing solely with child abuse referrals to become the intake and grading team for all reports of children at risk, vulnerable adults at risk and domestic abuse. This ensures consistency as to how the police respond across a number of public protection functions. Hampshire Constabulary now has dedicated safeguarding officers who specialise in safeguarding victims of domestic abuse and the Constabulary has also trained front line officers in the use of the CAADA DASH risk indicator tool.

1.6.8 **MARAC and lack of Independent Domestic Violence Advisor (IDVA) services:** By definition, with violence between the brothers, they could have been considered for referral to domestic abuse services but they were not. This was because their violence towards each other was often not considered as domestic abuse. When it was defined as such by the Police, there was little engagement by the brothers or their family to substantiate the allegations. As a result, these incidents did not result in a referral to support services. The domestic abuse suffered by both

partners of these brothers was understood by the Police and other services but there was very little offer of specialist support. The IDVA provision in the New Forest was inadequate for a significant period including that of this review. Recent commissioning in Hampshire County Council and the PCC has altered the provision. At the time of the police incidents outlined in this report, IDVA waiting lists were long and it was not unusual for the IDVA service to have periods of time when they would not take on new referrals due to caseloads being over capacity. In essence, this meant that for periods of time, sometime weeks or months, referrals to the IDVA team would refer to an outreach service who also had limited capacity. There were times when, despite the fact the Police would refer based on high risk that the victim would have not been picked up by any service at all. Until April 2015, IDVA had capacity to accept two referrals a week, although there have at times been as many as eleven referrals in a day. There is an arrangement where high risk cases which the IDVA cannot accept are referred to an outreach service. But they too were limited in capacity. The partner agencies reported being unaware when the IDVA is working at capacity and unable to accept referrals and lack of confidence in the operational and contractual arrangements for the IDVA service. There was a time when the partner of the perpetrator was correctly referred to IDVA but they were at 'breaking point' and unable to accept the referral.

Governance and co-ordination roles and responsibilities for the MARAC are held in the County Domestic Abuse Management Group and the Hampshire Domestic Abuse Steering group. However, there remained a lack of co-ordination of the work of the MARAC, IDVA, Victim Support and statutory agencies. In practice, this means that some cases were not accessing the right level of support and difficulties were not escalated to propel channels to correct malfunction early. This was due to the complex commissioning arrangements which did not always provide resource in the identified areas of highest need.

The history of abuse between the brothers and their use of violence towards others and their intimate partners, combined with the fact that there seemed to be no point of contact or centralised service that was holding or case managing the entire and wider family situation, reflects the need for establishing a case management system between all services for complex case management. It is clear that high risk and complex cases would benefit from having a co-ordinated approach. This is something which could be addressed by way of a review of the MARAC function.

1.6.9 **New Forest District Council Housing:** The focus by housing services on the noise nuisance or anti-social behaviour rather than correctly identifying domestic abuse and safeguarding issues almost certainly reflected a lack of awareness among professionals working in this area. There is emerging best practice related to work by housing providers to take more pro-active steps to help staff to identify domestic abuse and refer to appropriate services. In this case, the noise nuisance was well noted but the only intervention was to warn the tenant that she was in breach of her tenancy agreement. It is therefore essential that the Council's housing staff are adequately trained on both recognising domestic abuse and safeguarding concerns and the importance of acting appropriately in response.

1.6.10 **Hampshire Children's Services**: Children's services had very little interaction with the brother who was killed. They had occasion to assess the family where he was the boyfriend of the mother of four children (from previous relationships). He did not feature strongly in these assessments mainly because he did not reside with the family although he lived on the same road. Children's services were active with the family of the perpetrator where he was the father of one child and a

presence with four other children of his girlfriend. He did not live with the family but he did live on the same road. There were significant periods of time when this family was supported by Children's Services although there are occasions when decisions to close their case are questionable due to ongoing police incidents for domestic abuse. The lack of engagement with the non-resident boyfriends in assessments meant that Children's Services was lacking crucial information and would have benefited from more engagement with the primary perpetrators of abuse.

1.6.11 **Children's Services:** The role of Children's Services was, arguably, less concerned or aware with the relationship between the brothers, but more focused on the risks posed to their partners and children. To this end, the focus was on working with the mothers to ensure the safety of their children and that the outcome for the children was satisfactory. Children's Services was often aware of multiple police calls to both the homes of the mothers and acknowledges that due to the proximity and frequency of these incidents that possible further assessment should have been undertaken. However, the view of the panel was that a similar course of actions would have been advised with the exception of an encouragement to engage with specialist domestic abuse services had they been available in New Forest at the time. In some respects, with both families there was a mixed picture of positive and negative aspects of children's safeguarding.

1.6.12 **Drug and alcohol services**: Alcohol was a feature in the lives of both brothers who appeared to have had a long-term issue with alcohol misuse and binge drinking. The risks and anti-social behaviour associated with alcohol misuse including risk of violence is well documented. While the victim sought help from his GP and appeared to have some success in controlling his consumption, there was a general concern during this review about the lack of drug and alcohol resources available in the New Forest area. It is also understood that the victim made several calls to the alcohol advice hotline but was unable to gain access. There is new guidance from Alcohol Concern regarding treatment resistant drinkers in relation to findings of domestic homicide reviews which should be disseminated and considered.

1.7 Good practice identified or developed during this review process

1.7.1 Multiple changes and improvements have been made by Hampshire Constabulary during the course of this review. It is noted that in 2012, the Central Referral Unit's responsibilities were expanded from dealing solely with child abuse referrals to become the intake and grading team for all reports of children at risk, vulnerable adults at risk and domestic abuse. This ensures consistency as to how the police respond across a number of public protection functions. Hampshire Constabulary is also now training their front-line officers to an enhanced specialist level regarding domestic abuse and the CAADA DASH risk indicator tool.

1.7.2 Currently all Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Assessment (AD232R) forms are assessed by the Central Referral Unit (CRU) and graded for an appropriate response which is tailored to the risk level.

1.7.3 Currently, when a child is identified by the Police and is considered at risk during a domestic incident there are clear guidelines to ensure the submission of a Child at Risk (CYPR) form. This is assessed by the CRU and a decision is made with the MASH if Social Care will investigate jointly or singly. In addition, police can share the AD232R with the social worker if the case has an allocated social worker. This is normally via the police safeguarding officer if a case becomes a

joint agency investigation or if there are disparities/concerns between social care and police information.

1.7.4 In early 2016, the CRU was disbanded and staff were absorbed within three distinct MASHs (Southampton, Portsmouth, Hampshire & IOW). The CRU will not be referred to and referrals will go to each individual MASH directly and the grading of AD232Rs will be completed by the three MASHs daily i.e. staff in each MASH will work collectively to grade and send CYPRs/CA12s. This is an enhanced service with more staff allocated to this process to help make referring/sending/grading more timely. Now, discussion is occurring about how high risk domestic grading can be shared with partners to give a more effective response.

1.7.5 Police are trialling the sharing of High Risk AD232Rs in the MASH before any forthcoming MARAC meeting. Any intervention can then be achieved at an early stage and may negate the need for the subsequent MARAC meeting.

1.7.6 There is also a new police system called PPNR (Public Protection Notification Reports) that is being looked at for 2016 which should share all the information in one report if required but is in the scoping phase with Thames Valley Police.

1.7.7 Development work has taken place with the support of relevant partner agencies across Hampshire to bring together the SafetyNet and new Crime Reports/Command Central systems under the banner of the Information Management Suite. There are over 100 partners using SafetyNet and it has a risk tracker built in which could assist. In this particular case, the pattern and number of domestic abuse incidents may have been more obvious to police and their partners if SafetyNet had been used.

1.7.8 In January 2015, the New Forest Neighbourhood Policing Team piloted the flagging of all MARAC cases on SafetyNet but this was unsuccessful in any ongoing management because those with responsibility for managing the risk (Safeguarding Team) did not have access to the programme and information was not being updated. In reality, participation from police and partner agencies is inconsistent. To achieve real benefits from using SafetyNet to assist in the management of domestic abuse cases, all relevant partner agencies need to commit to its use. Currently there is training occurring throughout the Constabulary to include as many staff as possible. There are also ongoing discussions currently about how the Safeguarding Teams can incorporate the use of SafetyNet and MASH.

1.7.9 Hampshire County Council have commissioned IDASH provision across the county which is a marked improvement on services that existed during the time of this review. The IDASH integrates six elements of support for victims and survivors of domestic abuse:

(i) Community based floating support and outreach services,

(ii) Independent Domestic Violence Advisers (IDVA) support,

(iii) Dedicated support services for children and families,

(iv) Crisis accommodation based services,

(v) Move on and resettlement services,

(vi) Personal support networks and group work.

1.7.10 Body worn videos by police to record damage, general scene of the crime, and excited utterances are now extensively used across the whole force by Hampshire Police and is proving helpful for future similar cases.

1.7.11 Hampshire County Council has commissioned a new service which may have addressed the needs of these brothers. Clients are identified as falling into four cohorts:

(i) Prolific and priority offenders,

(ii) Emerging threat offenders,

(iii) Offenders with a high risk of reconviction for serious violent offences, serious acquisitive crime,

(iv) All women sentenced to less than 12 months custody.

It is a joint service for IOM clients enabling them to achieve positive change and in turn, reduce their risk of re-offending. It has been developed in response to the need for specific services for clients who fall under the remit of IOM.

1.8 Recommendations from the review

The following recommendations stem from the findings of this review.

West Hampshire CCG

Recommendation 1

Implement the NICE guidance on domestic violence and abuse, understanding that the ethos of the guidance is based on effective multi-agency working.

Recommendation 2

Review training for health care professionals on domestic abuse to ensure it is available to all staff and includes dynamics, how to undertake targeted screening for domestic abuse and the need for a pro-active responses.

Recommendation 3

NHS England commissioners support primary care providers and staff to respond to domestic violence and abuse by considering adoption of Recommendation 16 of NICE Guidance by commissioning the IRIS project.

Recommendation 4

Local health commissioners support secondary care providers to respond to domestic violence and abuse specifically by ensuring that staff undertake targeted or routine enquiry.

Hampshire Constabulary

Recommendation 5

Hampshire Constabulary to consider reviewing the MARAC procedures with regards to the completion and review of risk reduction plans and to ensure that they meet local needs and exceed Safelives (CAADA) operational standards.

Recommendation 6

Hampshire Constabulary to consider reviewing level of risk assessment training, its frequency and compliance. For instance, Hampshire Constabulary may want to consider using this case as a specific learning workshop case study.

Recommendation 7

Hampshire Constabulary to consider reviewing the Central Referral Unit – Manual of Guidance (Version 6). For instance, the requirement for 6 or more incidents within the last 3 months (including a crime) may be amended.

Recommendation 8

Hampshire Constabulary to consider reviewing training and quality of supervision from Sergeant and Inspector ranks in relation to reports of domestic abuse and in particular to conduct a dip sampling of cases with multiple police callouts.

Recommendation 9

Hampshire Constabulary to consider incorporating Domestic Abuse referrals into the Multi Agency Safeguarding Hub (MASH) to protect the most vulnerable victims of domestic abuse and implement and action more action related to repeat crimes.

Hampshire County Council Children's and Adults Services Departments

Recommendation 10

Review training for social workers to ensure there is a high level of understanding of domestic abuse and risk factor and to increase skills to engage with perpetrators of domestic abuse.

Hampshire County Council Children's Services Department

Recommendation 11

Hampshire Safeguarding Unit should review in conjunction with Hampshire Police, the interface, functioning and desired outcomes/purpose of a MARAC plan which runs in tandem alongside that of a Child Protection Plan.

New Forest District Council

Recommendation 12

To nominate a single point of contact within New Forest District Council for staff to refer any suspected cases of domestic abuse to and ensure all staff are trained on this procedure.

Recommendation 13

To include domestic abuse in the forthcoming safeguarding policy review.

Recommendation 14

To provide training to New Forest District Council employees on the issue of domestic abuse and to prioritise this training for council employees who interact with members of the public and in particular Housing.

Recommendation 15

To include a procedure within the New Forest District Council employee handbook detailing what help is available to members of staff suffering from domestic abuse and also to include what other members of staff should do if they suspect any of their work colleagues are experiencing domestic abuse.

Hampshire Probation Trust

Recommendation 16

Hampshire Probation Trust programme staff to review the TSP post programme report form to more clearly highlight new risks to NOMs nationally.

Recommendation 17

To conduct a task and finish group with the Police to ensure the sharing of call out information with probation and to review and amend protocols accordingly.

Hampshire Public Health

Recommendation 18

A review should be undertaken of alcohol support provision in the New Forest to see if the needs of binge drinkers can be more effectively treated.

Recommendations from overview report

Recommendation 19

All statutory and non-statutory partners involved in the New Forest MARAC and who sit on the MARAC Steering Committee to hold regular meetings which include robust conversation about the current challenges of MARAC and to devise an action plan related to New Forest MARAC which will ensure the MARAC in New Forest think creatively about how to address safety issues and to build confidence in the survivor to engage with

services. This may be a function of the local domestic abuse forum. This meeting should report to both the County wide MARAC Management Group as well as the Safer New Forest Partnership.

Recommendation 20

In order to ensure that staff benefit from sharing lessons learned from this review, these findings should be used as case examples and briefings within already established safeguarding and domestic abuse related training programmes.

National recommendation

Recommendation 21

Home Office Quality Assurance Group to consider issuing guidance to GPs outlining their duties to engage with the Domestic Homicide Review process.

Appendix 1: Domestic Homicide Review Terms of Reference for Adam

This Domestic Homicide Review is being completed to consider agency involvement with ***Adam***, and **his brother**, ***Doug***, following his death on **31/12/2013**. In addition, summaries relating to domestic abuse records around the ex-partners and children of Doug and Adam, will be included, where relevant. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with ***Adam*** and ***Doug*** during the relevant period of time: **2005 – 21.00hrs 31st December 2013.**

3. To summarise agency involvement prior to **2005**.

4. To summarise the involvement of each individual agency, statutory and non-statutory, with ***the ex-partners and the children of the ex-partners of Adam and Doug*** during the relevant period of time: **2005 – 21.00hrs 31st December 2013.** These summaries should be limited to information relevant to potential lessons learned related to domestic abuse.

5. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

6. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

7. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

8. To commission a suitably experienced and independent person to:

    a) chair the Domestic Homicide Review Panel;
    b) co-ordinate the review process;
    c) quality assure the approach and challenge agencies where necessary; and
    d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

9. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the **New Forest District Council Community Safety Partnership**.

Membership

10. The following agencies are to be involved:
    a) Clinical Commissioning Groups (formerly known as Primary Care Trusts)
    b) Local domestic abuse specialist service provider
    c) Children's services
    d) Adult services
    e) Health Authorities – include hospital, ambulance service, NHS direct and 111
    f) Substance Misuse Services
    g) Local Authority
    h) Police
    i) Prison Service
    j) Probation Service
    k) Victim Support

11. Where the need for an independent expert arises – for example, an expert in family dynamics in relation to twins – the chair will liaise with and, if appropriate, ask the organisation to join the panel.

12. If there are other investigations or inquests into the death, the panel will agree to either:
    a) run the review in parallel to the other investigations, or
    b) conduct a coordinated or jointly commissioned review – where a separate investigation will result in duplication of activities.

Collating evidence

13. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

14. Each agency must provide a chronology of their involvement with the ***Adam*** and ***Doug*** during the relevant time period.

15. Each agency is to prepare an Individual Management Review (IMR), which:
    a) sets out the facts of their involvement with ***Adam*** and/or ***Doug***
    b) critically analyses the service they provided in line with the specific terms of reference;
    c) identifies any recommendations for practice or policy in relation to their agency, and
    d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

16. Each agency must provide a summary of their involvement with the ex-partners of Adam and Doug and the children of the ex-partners. The summary will be limited to information relevant to domestic abuse and potential lessons to be considered in this review.

17. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought ***Adam*** or ***Doug*** in contact with their agency.

Analysis of findings

18. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
    a) Analyse the communication, procedures and discussions, which took place between agencies.
    b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations access to specialist domestic abuse agencies.
    f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and perpetrator's family

19. Sensitively involve the family and ex-partners of ***Adam and Doug*** in the review, if it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

20. Coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

Development of an action plan

21. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

22. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

Media handling

23. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

24. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

25. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

26. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

27. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.