Welcome

Martin Morgan
Chair Belfast Domestic Violence Partnership
Domestic Violence Partnerships

Bring together agencies, organisations, groups and individuals who share a common interest and purpose in improving services and support for all victims of Domestic Violence.
Listening Sharing Learning

Sheila Simons
Chair SE Domestic and Sexual Violence Partnership
Domestic Violence is...

“threatening, controlling, coercive behaviour, violence or abuse (psychological, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender or sexual orientation) by a current or former intimate partner or family member”
Domestic Violence ........

affects people right across our society - from all walks of life, from all cultural, social and ethnic backgrounds and across all age groups. The vast majority of victims are women, but a significant number of men are also affected and abuse also occurs in same-sex relationships.
The main characteristic of domestic violence is that the behaviour is **intentional** and is calculated to exercise power and control within a relationship:-

- **Psychological/emotional abuse** eg: intimidation, threats, social isolation, verbal abuse, humiliation, constant criticism, enforced trivial routines.

- **Physical violence** eg: slapping, pushing, kicking, stabbing, damage to property or items of sentimental value, attempted murder/murder

- **Physical restriction** of freedom eg imprisonment,

- **Sexual violence** eg: any non-consensual sexual activity including rape, refusing safer sex

- **Financial abuse** eg: depriving/taking control of money, withholding benefits/bank cards
Local Statistics 2012-2013

• Police responded to 27,190 domestic abuse incidents – one every 19 minutes

• On average 74 incidents every day

• Approx. one crime every 47 minutes of every day

• There are likely to have been 33 incidents before a woman reports to Police

• An average of two women die every week in the UK as a result of domestic violence (Not including death by suicide)
Statistics in Context

- The estimated cost of domestic violence in Northern Ireland is £180 million.
- There were two and a half times as many Domestic Abuse related crimes drug offences.
- There were 5 times more domestic abuse crimes than thefts of motor vehicles.
- There were more domestic abuse crimes than there were burglary offences.
Homicides in 2012-2013

• In Northern Ireland there were 5 murders recorded with a domestic abuse motivation.
• The number of all recorded offences of murder in 2012/2013 was 17. Therefore, 29% of all murders in NI had a domestic abuse motivation.
Victims are at greatest risk of homicide at the point of separation or after leaving a violent partner.
Stockholm Syndrome?

- It is a form of traumatic bonding which describes “strong emotional ties that develop between 2 persons where one person intermittently harasses, beats, threatens, abuses or intimidates the other.”

- The victim expresses empathy and sympathy and has positive feelings towards their abuser, sometimes to the point of defending them. These feelings are generally considered irrational in light of the danger or risk endured by the victim who essentially mistakes a lack of abuse from their abusers for an act of kindness. It is usually an unconscious act of self-preservation.
Jaycee Lee Dugard

- Kidnapped at aged 11 years on 10/06/1991 whilst waiting on the school bus by Phillip and Nancy Garrido.
- Remained missing for more than 18 years
- On 24th & 25th/08/2009 Phillip (a convicted sex offender) visited the campus of University of California in Berkeley accompanied by 2 girls aged 11 years and 15 years.
- Their unusual behaviour resulted in the uni staff contacting Phillip’s parole officer and he was asked to attend his office on 26th/08/2009. He was accompanied by Jaycee and the 2 girls.
- They were separated from Phillip to ascertain their identity.
- Despite this Jaycee maintained her false identity as “Allissa” but advised the girls were her daughters and spoke fondly of Phillip. The girls also spoke warmly of him.
She was 13yrs old when she first became pregnant.
The children were brought up believing Nancy was their mum and Jaycee their sister.
During her captivity, Jaycee had access to a phone/e-mail and left the family home to accompany the couple on errands.
It was 34 months into her captivity before the Garridos removed Jaycee’s handcuffs for short periods.
It was only after Garrido admitted he had kidnapped and raped Jaycee did she acknowledge her real identity.
On the day of the couples sentencing on 02/06/2011 Jaycee sent the following statement to the court:-
“I chose not to be here today because I refuse to waste another second of my life in your presence. Phillip Garrido, you are wrong. I could never say that to you before, but I have the freedom now. I hated every second of everyday because of you and the sexual perversion you forced on me. For all the crimes you have both committed I hope you have as many sleepless nights as I did. Yes as I think of all of those years I am angry because you stole my life and that of my family.
Domestic & Sexual Violence Helpline

0808 802 1414

Open to all women and men affected by domestic & sexual violence

text support to 07797 805 839  24hrsupport@dvhelpline.org
Guest Speaker
FAMILY INVOLVEMENT
DOMESTIC HOMICIDE REVIEWS

AAFDA (Advocacy After Fatal Domestic Abuse)  www.aafda.org.uk
• Over 20 years married
• Control, Mental abuse
• Superiority
• Julia wants to leave
“THIS IS FACT. I WILL TAKE MY LIFE, I WILL TAKE YOUR LIFE. YOU ARE NOT GOING TO MESS UP MY LIFE. YOU CAN’T DO THIS TO ME”
Call Police. Injunction.

Police make a note to the Force control rooms:
“Threats to kill occupant, Julia Pemberton, by her husband, Alan. Also in house two children, 18 and 13. .............. perceived threat level has escalated during the past ten days.............. Alan says he will kill her then himself”.

Advice/guidance for the benefit of any officer being required to attend:
“any calls, even silent 999 calls, to be treated as urgent. Perceived threat level to victim very high. Positive intervention required.”
• Julia certain she’ll face kill attempt
• Sorrow, begging, blackmail.
• More abuse
• Big spending by Alan
• Hardening of threats
“I’ve got officers on the way Julia”

“We’ve got people coming up there now”

“Keep hidden”

“There are police officers coming there. ...they’re just trying to approach carefully. “
NO UNITS
TO ATTEND
Letter found in Alan’s car

“I have paid a substantial amount of cash to have her killed if I fail myself ….there are also bonus payments for key dates.”

“Money has also been paid to destroy others.”
“Constitutes a landmark achievement in the field of domestic violence fatality or homicide review. It is meticulous in its approach, honest in its conclusions…… As such, the review sets a gold standard in terms of its detailed appreciation of the complex issues in domestic violence cases””””. Neil Websdale
PEMBERTON REVIEW

Agency Learning

• Huge problems – Police. No strategic direction. No DV policy. Inadequate or no training. No investigation. ill-informed officers, isolated, poorly supervised or supported. Poor record keeping. Not recognise DV.
• Health not requiring enough of GP’s.
• GP very helpful but not informed.
• School similar.

AAFDA (Advocacy After Fatal Domestic Abuse)  www.aafda.org.uk
PEMBERTON REVIEW

Learning for Reviews

• Comprehensive
• Interviewed friends & family, employer.
• Broad based (Including Coroner)
• Understood coercive control
• Challenged public bodies
• Provided analysis of evidence
• *Felt like some reviewing was done*

AAFDA (Advocacy After Fatal Domestic Abuse)  www.aafda.org.uk
BENEFITS OF PHR

• Shifted a police force to change
• Answered our questions
• Showed how Julie tried so hard to get help
• Showed the compromised lives of Julie & Will
• Informed the recorded narrative

AAFDA (Advocacy After Fatal Domestic Abuse) www.aafda.org.uk
AAFDA

• Information centre for DHRs
• Members’ Forum for Chairs
• Working/working with 30 families direct. Many more indirectly.
• International connections

AAFDA (Advocacy After Fatal Domestic Abuse)  www.aafda.org.uk
INVOLVING FAMILIES, FRIENDS AND COMMUNITY MEMBERS
HOW DOES AAFDA HELP FAMILIES WITH DHRS

- Explain purpose and process
- Map & differentiate concurrent processes
- Answer their questions
- Help to contribute to & navigate process
- Liaises with and helps Chairs
- Manages expectations
- Gives this help nationally
- Professional help from peers

AAFDA (Advocacy After Fatal Domestic Abuse)  www.aafda.org.uk
“Big difference having AAFDA helping us. Independent, knows the process and can answer our questions.”

“It is too much and becomes overwhelming. AAFDA has overcome these difficulties for us.”

“We never had the review process explained to us until AAFDA did. We think the FLO was the designated advocate. How could he have told us about the process? He was not trained.”

“There is a need for someone to explain what the DHR is all about. AAFDA has done that for us.”

“It is imperative to have an advocate like yourself involved “Thank you for all your help with this; it's invaluable.”

“We were not going to get involved with the review until you helped us understand it. Now we realise we want to get involved and we are so grateful to get a second bite at the cherry”
RESEARCH BASPCAN

A Study of Family Involvement in Case Reviews: Messages for Policy and Practice
FINDINGS (BASPCAN)

- Families want to see change
- Agencies unclear on their purpose
- Independence important for families
- Families need navigation help
- 4 phases, initial contact, negotiation, information gathering, feedback.
- First contact key to more engagement
SKILLS AND PRACTICES VALUED IN DHRs – VIEW OF FAMILIES (BASPCAN):

- Good preparation before meeting family
- Careful and clear communications
- Non judgmental attitudes
- Sensitivity and respect
- Probing questions. Good structure
- Skilled use of Interpreters and translators
- Demonstration of care and seeing reality of lives / engaging with the emotion
- Seeing learning and change beyond the DHR
- Emotional intelligence, compassion & empathy
OTHER THINGS VALUED BY FAMILIES:

• Truth telling
• Revealing the full facts
• Deceased honoured in report
• Including the victim’s voice (re-balancing forensic narrative)
DIFFICULTIES:

- Conflict
- Family members controlling others
- The deceased had secrets
- Families may have contributed
- Families & friends may have different stories
- Unrealistic expectations
- Trauma
- The establishment is conducting the review
- Officials not have a good understanding of domestic abuse
BENEFITS OF FAMILY / FRIENDS INVOLVEMENT

• Fill in information gaps
• Friends know an awful lot
• Show the compromised situations in which victims are trying to survive
• Show how victim and those around her perceived her chances and the available services

AAFDA (Advocacy After Fatal Domestic Abuse)  www.aafda.org.uk
QUESTIONS / COMMENTS

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fmullane@hotmail.com

AAFDA (Advocacy After Fatal Domestic Abuse)  www.aafda.org.uk
Domestic Violence and Primary Care Team
Domestic violence is an abuse of human rights and a major public health problem because of the long-term health consequences for people who have experienced it. Many people experiencing abuse believe that their GP can be trusted with disclosure and GPs can offer practical support to protect people who disclose abuse.
Women speak.

- I’ve been treated for depression for quite a long time. They never really ask you about your personal situation at all. They don’t really ask. You suffer with depression and they just take it as a medical thing and not really like there’s something behind it.

- I think GPs have to have all the information, all the links to the right people so if you have a problem, the first person you go to is your GP.

Quotes from women taken from IRIS project
Is it a Primary Care Problem?

Prevalent

- Health consequences
- Potentially fatal condition
Recognising

- Targeted enquiry
  Recognising indicators and asking relevant questions

- Routine enquiry;
  Ask all women in specific settings and raise awareness of help available
Asking the Question?

- Safe enquiry
- HARKS questionnaire;
- Humiliation, Afraid, Rape, Kicks, Safety
- Asking when English is not first language
Responding

- Initial response to a patient when violence is disclosed is critical
  - Non judgmental
  - Risk assessment
  - Information essential
  - Numbers, websites, discrete cards
  - Referral Pathway
Reporting

- Consent
- Confidentiality
- Information sharing
- Safeguarding children and vulnerable adults
Training:

- Personal development
- Multidisciplinary/ integrated
- Undergraduate/ postgraduate
- Continued professional development
- Level 2 understanding epidemiology, how to ask question, how to respond effectively, knowing roles other professionals and their interventions
Commissioning

- DOH Guidance re routine enquiry
- NICE draft guidance
- IRIS; Identification and Referral to Improve Safety project
- Primary care in DV Partnerships
- RCGP Clinical Priority for action (2011-2014)
- RCGP, IRIS and CADDA have produced joint guidelines for practices, e-learning modules.
NICE

- Commissioning: LCGs and Partnerships
- Service delivery
- Pathways of care
- Integrated training
- Enquiry about DV in hard to reach groups.
IRIS

A commissionable model providing specific domestic abuse training, support, referral and recording for general practice. The whole practice team receives in-house training and ongoing support from a specialist domestic abuse advocate and a clinical lead. The domestic abuse advocate provides a direct referral route for patient referrals and care pathways are provided for female survivors, male survivors and perpetrators.

Practice Team

• Designated person
• Resources in practice
• Training

• Employees as victims
• Perpetrators as patients
ARE WE LEARNING?

Dr Christine Kennedy
Consultant Forensic Psychiatrist
29 November 2013
DOMESTIC VIOLENCE & MENTAL HEALTH

Domestic Violence & Mental Health

Edited by
Louise M. Howard
Gene Feder
Roxane Agnew-Davies
THE RELATIONSHIP BETWEEN DOMESTIC VIOLENCE AND MENTAL DISORDER

WHAT IS IT?
DOMESTIC VIOLENCE

• Threatening behaviour, violence or abuse of adults by relatives, partners or ex partners
• Includes abuse from adult children and from parents of adult children
INTIMATE PARTNER VIOLENCE

• Can be physical, psychological, sexual or coercive control
• Gender and social deprivation important
• Prevalence dependent on definition of IPV in research e.g. acts of physical nature, impact of abuse, researcher background etc
TYPES OF MENTAL DISORDER

These include:

- Depression & Anxiety Disorders
- PTSD
- Eating Disorders
- Bipolar and Psychotic Disorders
- Antenatal and Postnatal mental disorders
- Alcohol and drug misuse
DV & MENTAL HEALTH

Bi – Directional Relationship

DV ↔ Poor Mental Health
## PREVALENCE OF IPV IN MENTAL DISORDERS

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Median prevalence</th>
<th>Lifetime IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Depressive</td>
<td>45%</td>
<td>5%/31%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>28%</td>
<td>7%/27%</td>
</tr>
<tr>
<td>PTSD</td>
<td>61%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Trevillion et al 2012
Likelihood of adult lifetime IPV (Odds Ratio) in common disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive Disorder</td>
<td>2.77</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>4.08</td>
</tr>
<tr>
<td>PTSD</td>
<td>7.33</td>
</tr>
</tbody>
</table>

Compared with non mentally ill women
• High prevalence IPV among women with mental disorders

Also

•Victims of IPV (male and female) at ↑ risk of mental disorders
Research suggests a causal association between domestic violence and mental disorder.
The severity and duration of physical IPV is associated with the frequency and severity of depression. Rates of depression also decrease with the time from cessation of violence (Golding 1999).
A review of PTSD found the extent, severity and type of abuse to be associated with the intensity of PTS symptoms.

(Jones et al 2001)
Women who experience more than one form of abuse or who are re-victimised are at increased risk of mental disorder and co-morbidity

(McFarlane et al 1998; Jones et al 2001; Romito et al 2005; WHO 2013)
MENTAL DISORDER AS A RISK FACTOR FOR DOMESTIC VIOLENCE
• Psychiatric disorder can increase vulnerability to domestic violence (Dunedin Study)

and

• Pre existing symptoms may ↑ if a victim of domestic violence  (Neria et al 2005)
• Mental disorder ↑ likelihood of women being in unsafe relationships and environments (McHugo et al 2005)

and

• ↑ vulnerability to violent victimisation (WHO 2010)
Men and Women with Severe Mental Illness face x 12 risk of violent victimisation (of all types) compared with the general population

(Teplin et al 2005)
POTENTIAL PATHWAYS LINKING IPV & MENTAL DISORDER
• Association of IPV and other factors linked with mental ill health e.g. impairments in social functioning, use of medication, poor living conditions, substance misuse
• Previous physical and sexual abuse (including witnessing domestic violence as a child and previous IPV)
• Trauma induced intrusive thoughts (leading to modification of coping styles and subsequent maladapative choices that bring about violence related trauma)
In addition to mental health problems, victims need to deal with multiple other stresses:

  e.g.
  • Fear of further violence
  • Isolation and lack of social support
  • Mourning loss of intimate relationship
• Concerns re welfare of children
• Fear of disruption of social networks in event of relocation
• Fear of Social Services and child protection proceedings
WHY IS THIS IMPORTANT?

• The link between domestic violence and mental disorder underlines its importance as a public health issue

• A substantial proportion of mental disorders is attributable to domestic violence estimated at 20% in major depression and similar in anxiety

• If targeted ↓ burden of mental disorder and costs could result
RECOGNISING
• Acute physical injuries
• Chronic health problems
• Psychological indicators
• Behaviour of victim
• Possible indicators in behaviours of partner/other
ASKING

• Can increase patient’s awareness of the impact of DV on mental health
• Can identify more victims at risk
• Creates an opportunity to disclose and reduce feelings of isolation
• Provide information re services
• Save the health service money and time by preventative intervention
ASKING (continued)

- Safeguard children and reduce long term consequences of abuse
- Play a part in holding perpetrators accountable
ASSESSMENT

• Clinical enquiry about domestic violence should be part of psychiatric assessment.
• So why does it not happen?

DOH 2008/2010
PROFESSIONAL BARRIERS

• Not my role
• Not my priority
• Not enough time
• Constrained from enquiry by presence of partner
• Focus of interview on something else
• Engagement issue with patient
PROFESSIONAL BARRIERS (continued)

• Lack of knowledge/expertise
• Lack of confidence
• Too complex a subject
• Personal discomfort with topic
• Dominance of medical model
• Focus on symptoms
• No indicators of violence
PROFESSIONAL BARRIERS (continued)

- Gender/culture
- Fear of consequences
- Fear of offending
- Fear of retraumatisation

Rose et al 2011
RESPONDING
What victim wants to hear

- That Disclosure is helpful and important
- She is not alone and it is not her fault
- People with mental ill health have the right to be safe. Domestic Violence can affect mental health
• Safety at home is a priority
• There is help available
• She has a right to talk about abuse in privacy
• She is an expert by experience
• Recognise if she is already trying to change the situation
• Advise a good father does not put his children at risk
• Advise Domestic Violence is against the law
RISK ASSESSMENT
• Immediate Risk Assessment
• An organisational assessment linked to wider trust and safeguarding policies
• Broader multiagency risk assessment e.g. MARAC’s
• Specialist forensic risk assessment report
RISK ASSESSMENT IN CMHT’S

CAADA – DASH Risk Identification Checklist

24 items

High score usually above a cut off indicates need for referral to MARAC
RISK ASSESSMENT IN CMHT’S

• Specialist advice may be sought from a DV agency
• Occasionally a forensic opinion and SARA
• Child protection considered and UNOCINI completed
RISK ASSESSMENT

The DVRIM or Domestic Violence Risk Identification Matrix is a multi-agency child-focussed risk identification tool, developed by Maddie Bell of Barnardo’s over a number of years, in partnership with the London Safeguarding Children’s Board and Social Services agencies in Northern Ireland.
DVRIM

• Its evidence base comes from five main areas which are also the key areas for evaluating risks:
  • what we know about child death inquiries and serious child abuse
  • risk factors associated with domestic violence homicide reviews
• The impact of domestic violence on adult victims and children
• Knowledge of adult domestic violence risk assessment tools i.e. those used in the criminal justice system
• An understanding of the dynamics of domestic abuse (male to female)
Abuser’s use of avoidance/resistance to engage in services increases risk level to children.

Victim fears statutory services - avoidance & resistance to engage increases risk to children.

Family/Relatives/neighbours reports concerning the victim/children.

Victim has experienced domestic abuse relationships.

BME (Black, Minority, Ethnic)

Adult learning difficulties and/or victim raises the possibility.

Disability issues within the household - isolation.

Age disparities of Abuser & Victim - under 25 with limited support and personal vulnerabilities.

History of child protection system.

Collusion issues with perpetrators and children.

Recent life crisis and stress on victim.

Protective factors

Older child/relative

Victim will seek advice.

Victim - attempts to use effective strategies but abuser’s victims control is intense.

Victim will engage with social services and seek safety. Must be alert to abuser’s control interfering with her commitment to an open relationship.

Limited protective factors are lacking. Few personal and psychological abuse of victim, emotional abuse. No evidence risk factors predict recidivism.

Use of kinship placements as a protective factor - be alert to domestic violence having occurred or occurring in extended families.
DISGUISED COMPLIANCE

DEMAND CHANGE OF WORKER

ADULT DECEITFULNESS

PROFESSIONAL IS OVERWHELMED

MISUSE OF COMPLAINTS PROCEDURE

PROFESSIONAL COLLUSION

DISTRACTIVE BEHAVIOURS

FREQUENT MOVES

THREATENING AGGRESSIVE BEHAVIOUR
Responding to intimate partner violence and sexual violence against women: WHO 2013
• Mentally unwell victims are at increased risk of violence and vulnerable to revictimisation in all forms including domestic violence

• Professionals need to be aware of the existence of risk and be able to formulate risk assessments and care plans to address safety and reduce risk
• Staff need to be able to work with other agencies and know when to refer to MARAC
• Staff need more integrated pathways with domestic violence specialist providers
• Refuges for example may feel untrained to manage the mental ill health and addiction
• Equally the victims may live chaotic lives and not keep appointments with CMHTs or be able to live in structured setting
WHAT IS UNHELPFUL

• Lack of recognition of trauma
• Failure to provide trauma services
• Making the abuser invisible by focus on mental health of victim
• Blaming the victim for the abuse
• Offering medication rather than counselling
• The negative impact of diagnosis on child contact or child care
WHAT IS HELPFUL

• Encouraged to name Domestic Violence
• Directly asked about their abuse experiences
• Help with safety planning or parenting
• Offered support to recover from experiences

(Humphreys and Thiara 2003)
DVRIM

For details see
www.londonlscb.net
Domestic Homicide Reviews in Action

Davina James-Hanman
Background

- First Domestic Homicide Reviews established 2001 in Metropolitan Police Service (not really multi-agency)

- Domestic Homicide Reviews were established as part of the Domestic Violence, Crime and Victims Act [2004]

- Pemberton Review

- May 2010, Coalition Government made a commitment to implement this provision by the end of March 2011
Implementation

• Section 9 of DVCVA 2004 was implemented in England and Wales on 13th April 2011.

• Creates a duty for local areas to undertake a multi-agency review following a domestic violence homicide.

• Allows the Secretary of State, in particular cases (e.g. when a local area fails to initiate a review itself) to direct that a specified person or body establishes or participates in a review.

• Introduces a duty for every person or body establishing or participating in the review to have regard to statutory guidance.
Domestic homicide definition

- Section 9 (1) Domestic Violence, Crime and Victims Act (DVCVA) (2004) places a statutory duty upon local bodies to establish a domestic homicide review when:

- ‘the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, ...with a view to identifying the lessons to be learnt from the death’. 
Multi-agency DHRs

• DHRs must be multi-agency
• The victim and perpetrator may have used multiple services
• There may be multi-agency recommendations and lessons may need to be learnt
• The Overview Report is likely to have a multi-agency readership
• Even if there has been no contact with agencies there may still be learning
Quality assurance & effective practice

- Quality Assurance for completed DHRs rests with the QA Panel and Readers, managed by the Home Office.

- The QA Panel and Readers have responsibility for quality assuring the reports which is based on set criteria. If the group finds that amendments need to be made to a report, they will explain in a letter to the CSP which must be published alongside the report.

- This group also have the responsibility for examining all decisions not to undertake a review.
New Definition

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

– psychological / emotional
– physical
– sexual
– financial
– coercive control
Coercive Control

‘a strategic course of self-interested behaviour designed to secure and expand gender-based privilege by establishing a regime of domination in personal life’.

(Evan Stark)
Context: Knowing the research

Findings from the (Multi-agency) Domestic Homicide Reviews (2003)

• Lack of informed risk assessment and management

• Lack of positive action in relation to perpetrators

• Details of children of abusive relationships not obtained or shared with children’s services

• Case files lacking history of risk factors and previous allegations

• No effective victim referral or support

• Lack of information sharing
Purpose of the DHR

- Establish what lessons are to be learned, if any, 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 upon, and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate, and,

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
Domestic homicide review process (snapshot)

Domestic Homicide occurs

CSP informed and decides on whether the homicide meets criteria of DHR (Within one month of homicide)

Conduct DHR: Chair to draft Overview Report, Executive Summary and Action Plan (Within 6 months of CSP decision to hold DHR)

Review agreed by Review Panel and sent to commissioning CSP

CSP agree Review and send to Home Office

Criteria met: CSP commission DHR and Review Panel

Review Panel establishes terms of reference, appoints Chair and commissions agency IMRs and relevant reports

QA Group assesses Review as adequate/inadequate according to guidance. Review is published, stored centrally by HO and lessons learned disseminated by QA Group via bulletin and web page.

Review agreed by Review Panel and sent to commissioning CSP
EMERGING THEMES

• Lack of understanding how central the family are to the process

• Widespread belief that DHRs are only about murders but the guidance states death of a person due to (or appears to be due to) domestic violence

• A surprisingly common reluctance to involve the voluntary sector

• Limited knowledge of Coroners and inquests

• We need to have a new conversation about information sharing and risk – professional judgement / listening to women is critical.
• Child contact makes physical permanent separation difficult / impossible
• Issues with thresholds / definitions of vulnerable
• Often the concern is for the children and not at all for ‘Mum’
• Some innovative work re contacting survivors eg using health visitors
• Some issues with IT referrals to children’s social care
• Children are rarely included
• Removal of children into care results in ‘butterfly engagement’ from mother
• Risk is often multi-faceted and complex
• Complex needs – a significant failing
• Awareness and training for GPs
• Perpetrators and bail
• Coercive control and victim perception are far better indicators of risk than physical violence
Lessons from Chairing

• Costs can be significantly reduced if good administrative support provided
• It’s a more emotional experience than people necessarily anticipate
• Health almost always take the longest
• IMRs often tell you the what but not always the why
• The Guidance is unworkable in places and is too obviously ‘borrowed’ from SCRs
• Chronolator is your friend!
• Humanise the people involved
Reading (Overview Reports)

• Lacks information pertaining to the QA criteria meaning it isn’t always possible to assess

• Lacks contextual information / assumption that local experience is the same nationally

• Lacks references to accompany statements such as ‘research shows…’

• Proof-reading always helps!

• Too focused on process and not enough on the ethos
General – doing DHRs

• There is a need for a good practice guide with examples and a step by step guide
• More checklists would be helpful
• Disclosure and confidentiality issues are complex
• Values matter and will provide a framework for when you hit roadblocks
• IMR author briefings help enormously
Finally...

- Always assume that your report – IMRs and ORs – is being read by those that loved the victim. Would the report seem adequate to you?
- DHRs are a great opportunity to think differently about domestic violence. They are a new framework which allows us to really test our service provision against the needs of real victims and their real circumstances.
Every Body Matters
davina.james-hanman@avaproject.org.uk

www.avaproject.org.uk

Tel: 020 7549 0272

http://twitter.com/AVAproject
Multi Agency Risk Assessment Conference

MARAC

Maria Canning
Principal Officer PPANI
SE HSC Trust
Victim

- Police
- NIHE
- Social Services
  - Children’s
- Adult Services
- Victim Support
- PBNI
- Women’s Aid
MARAC in Northern Ireland

• Piloted in 2006 in Larne area – results positive
• Rolled out in January 2010
• Is a key Ministerial priority
• Is reflected in both DHSSPS’s Priorities for Action and NIO’s Public Service Agreement Target in relation to reducing serious violent crime
What happens at a MARAC?

- Local agencies meet to discuss highest risk victims
- Share information
- Identify risks
- Agree actions to ensure safety – Safety Plan
- Identify resources available – risk manage
Risk Assess (DASH)

Domestic abuse identified

DASH Risk Identification Checklist (RIC) used to establish

If the victim is at high risk of serious harm/homicide
Victim’s perception of risk of harm

Suicide / Homicide

- Controlling and/or excessive jealous behaviour
- Use of weapons
- Alcohol/drugs/mental health
- Strangulation (choking/suffocation/drowning)
- Credible threats to kill

Separation (child contact)

- Pregnancy/new birth (under 18 months)
- Escalation
- Community issues/isolation
- Child abuse
- Animal/pets abuse

High risk factors of serious harm and homicide

Stalking

Sexual assault
DASH RIC 27

A set of 27 questions used to identify, assess and manage risk, eg:

Q. Have you separated or tried to separate from (name of abuser(s).....) within the past year?

Q. Has (.....) ever threatened or attempted suicide?
Referral

There are 3 criteria for victims to be referred to a MARAC:

1. Visible high risk
2. Professional judgement
3. Potential escalation
Recommended Actions – some examples

Police:
- Victim’s address flagged for one year from MARAC
- Referred to Crime Prevention Officer
- If convicted of AOABH (DV), perpetrator referred to PPANI

Women’s Aid:
- Advice / support regarding legal proceedings
- Individual / group support

Housing:
- Rehousing

HSC Trusts:
- Give additional support to family
- Make a referral to Vulnerable Adults Team
Outcome of MARAC

- Advise victim – referrer
- Re-referral
Role of Principal Officer

- Improve information sharing
- Conduit of communication
- Trust point of contact
- Advice and guidance
Principal Officers

- Donna Harvey, Belfast HSC Trust – 07900608756
- Karen McCall, Belfast HSC Trust – 07825 147523
- Stephen Sherry, Southern HSC Trust – 07834 325945
- Derek Ballard, Western HSC Trust – 07958 035065
- Nick Robinson, Northern HSC Trust – 07774 706821
- Maria Canning, South Eastern HSC Trust – 07525 898778