Overview of Domestic Homicide Reviews

2021 – 2023

Cambridgeshire & Peterborough
Domestic Abuse & Sexual Violence Partnership

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Introduction

Domestic abuse and domestic homicide are destructive crimes and have a devasting impact on society. They require a thorough multi-agency approach to reduce and eradicate. To help tackle them, domestic homicide reviews are carried out. These are an opportunity to focus on individuals who have been victims of domestic homicides/ suicides where there was an element of domestic abuse present. They look to producing recommendations for multiple agencies with the aim of reducing domestic abuse and domestic homicide.

This report has been produced by the DASV Partnership to provide an overview of domestic homicide reviews (DHR's) that have occurred between 2021 and 2023. A report into DHRs between 2011 and 2021 has already been published and is available on the Cambsdasv.org.uk website.

This report looks to identify themes and similarities that have arisen in the last three years and the analysis produced will provide a set of key findings and recommendations to help inform future strategies and policies, with the aim of reducing homicides and suicides.

What is a Domestic Homicide Review and who carries them out?

A Domestic Homicide Review (DHR) is a review into the circumstances around a death of an individual following domestic abuse.

Since 2016Domestic Homicide Reviews also review circumstances of those who die by suicide where there is evidence to suggest domestic abuse was present.

Domestic Homicide Definition

A domestic homicide is defined to have occurred when the death of a person aged 16 or over has, or appears to have resulted from violence, abuse or neglect by:

a person they were related to
a person they were, or had been in an intimate personal relationship with, or
a member of the same household.

If one or more of these criteria are met, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

DHR's are not inquiries into how the victim died and who is responsible, nor do they form any part of the disciplinary inquiry. That is a matter for coroners and courts to decide.

Purpose of DHRs

DHRs establish what can be learned from the death regarding the way in which local professionals and organisations work individually and together to safeguard victims. They are a way to ensure that public bodies – such as police, councils, social services and other community and voluntary based organisations – understand and learn from the circumstances that led to the death.

They will identify lessons that need to be learned, how and what timescale changes will be made in and what is expected to change as a result.

These reviews can also help raise awareness in the wider community of how to help victims of domestic abuse.

The overall aim of a DHR is to prevent homicides and suicides and improve service responses for domestic violence victims, adults, and children both, through improving multi agency responses.

Domestic Abuse and Sexual Violence Partnership (DASV)

Under guidance published by the Home Office, a DHR is to be carried out by the local Community Safety Partnership. Across Cambridgeshire and Peterborough this sits within District Councils, but the process is coordinated and led by the Domestic Abuse and Sexual Violence Partnership to ensure consistency and quality.

The DASV Partnership is made up of key agencies across the county that have a role in providing support to individuals subjected to domestic abuse and sexual violence and preventing it from occurring. The key aim of the Partnership is to "reduce the harm, risks and costs associated with domestic abuse and sexual violence and to prevent these crimes occurring across Cambridgeshire and Peterborough."

Legislation surrounding DHRs

- April 2011: Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act 2004 (DVCA 2004) and came into force on 13 April 2011.

- December 2016: Domestic Homicide Review (DHR) guidance was updated, introducing DHRs for suicides with coercive control, expanding purposes, and urging a victim-centric, holistic approach.

- March 2022: Tackling Domestic Abuse Plan published, outlining DHR reforms, refreshed guidance, and commitments to roles for Domestic Abuse Commissioner and Police and Crime Commissioners.

- Proposed Amendments: Seeking views on amending DHR legislation (Domestic Violence, Crime and Victims Act 2004) to align with the Domestic Abuse Act 2021's broader definition of domestic abuse. Considering changes to the term 'homicide' in DHRs to reflect a wider range of deaths within scope.[1]

This report looks at 13 DHRs, 6 homicides and 7 suicides. Please note not all the reviews have been published yet however all case details are included in this analysis. They will be published on the relevant Community Safety Partnership website when complete.

[1] Domestic homicide review legislation consultation - GOV.UK (www.gov.uk)

The domestic homicides/suicides addressed in this report took place between 2021 and 2023. Themes that will be analysed across the reports are:

- Area
- Victims Sex
- Ethnicity/nationality of victim
- Age of victim at death
- Location of death
- Home ownership
- Sub typology
- Method of killing
- Age of perpetrator
- Sex of perpetrator
- Perpetrators relationship to victim
- Parent child relationship
- Care needs

At the time of writing this report, only 7 of the DHRs have recommendations. Recommendations will be looked at closely at the end of the report, with similar themes being highlighted.

National Picture

Currently, the latest data available on domestic homicide reviews from the Home Office and the ONS ranges from March 2019 to March 2021[2]. Many DHRs from the last three years are yet to be published, making it difficult to paint a picture of national trends over these years.

Homicides

There are a range of themes, attributes, and circumstances that can characterise a domestic homicide case. This section of the report will look at the demographics of both the victims and perpetrators, as well as the case itself, in the 6domestic homicide cases in Cambridgeshire and Peterborough between 2021 and 2023.

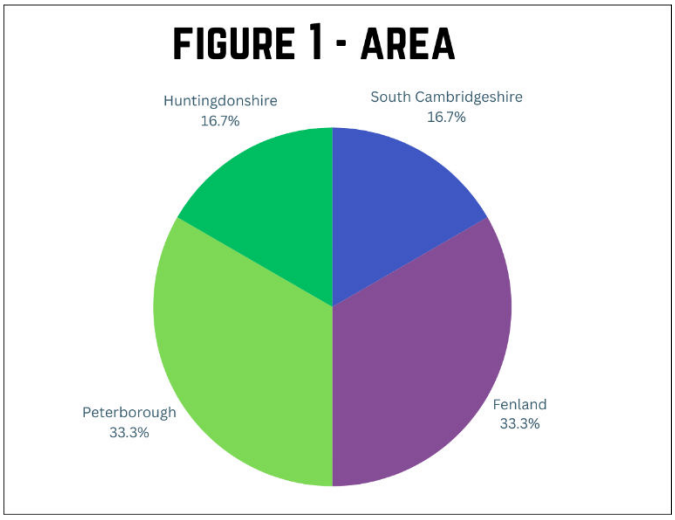
Each section will be followed by a comparison of the same characteristics over the years 2011 - 2021. In these years, 15 domestic homicides happened throughout Cambridge and Peterborough.

Through this, we will be able to ascertain if there are any continuing or changing trends and those working in the sector can make a more informed decision on how effective their policies and ways of working are.

[2] Key findings from analysis of domestic homicide reviews: October 2019 to September 2020 (accessible) - GOV.UK (www.gov.uk)

1. Area

Within Cambridgeshire, there are 5 district councils; these are South Cambridgeshire, East Cambridgeshire, Fenland, Cambridge City and Huntingdonshire. Peterborough is governed by a unitary authority adjacent to Fenland and Huntingdonshire.



In the years between 2021 and 2023, Fenland and Peterborough have the highest prevalence of domestic homicides, with 2 out of the 5 homicides occurring here each.

After this, we see an equal number of homicides occurring in South Cambs, Peterborough and Huntingdonshire, with 1 occurring in each area.

In the years between 2011 – 2021, Peterborough had the highest number of homicides, with 6 out of 15 homicides occurring here. This was followed by Fenland and Huntingdonshire, with 3 domestic homicides occurring in each area.

There were no domestic homicides in East Cambridgeshire between those years.

Continuing trends since 2011 include:

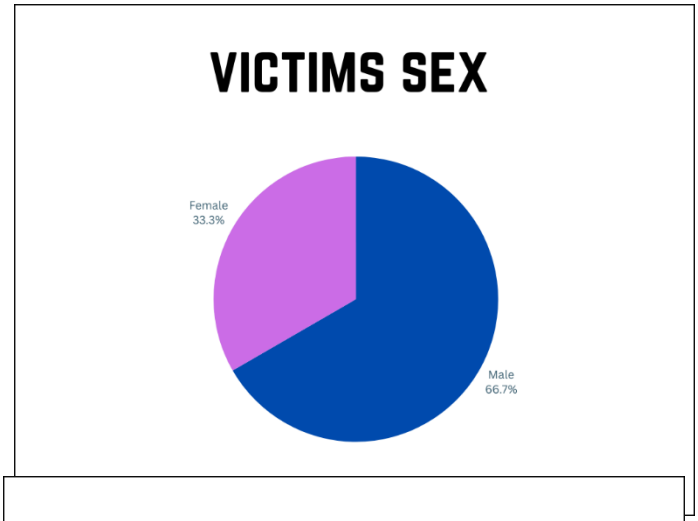
- Peterborough having a high number of domestic homicides.
- East Cambridgeshire having no reported domestic homicides.

2. Victim Sex

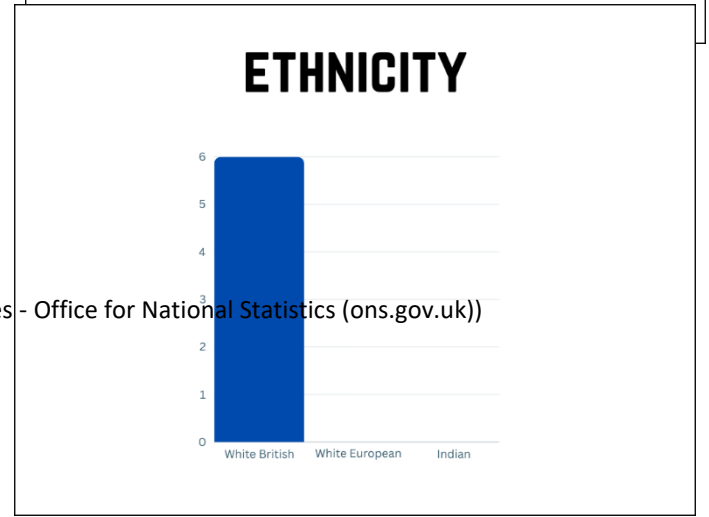
Looking at the graph, we can see that there were more male victims (4) than female (2).

This trend is the opposite of what we have seen over the years 2011 – 2021, where there were 13 female victims out of a total of 15.

This trend is also the opposite of what we saw nationally between 2018 – 2020, where 76% of victims were female and 24% were male[3].



3. Ethnicity



[3] domestic abuse victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk))

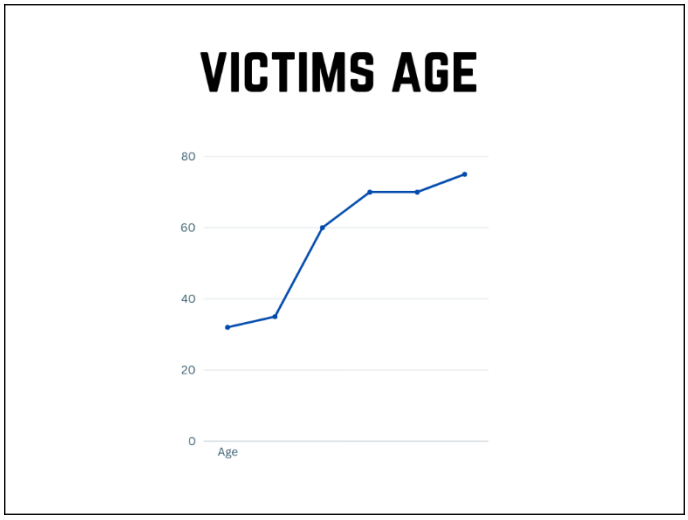
All the victims of domestic homicides were White British.

This follows the trend we have seen from 2011 to 2021, where 53% of victims were White British. In these years, we have also seen victims of different nationalities, including Lithuanian, British Chinese, Pakistani and Polish.

4. Age of victims at death

The mean age of the victims was 56. Three of the victims were 70 or over at 70, 70 and 72 years of age.

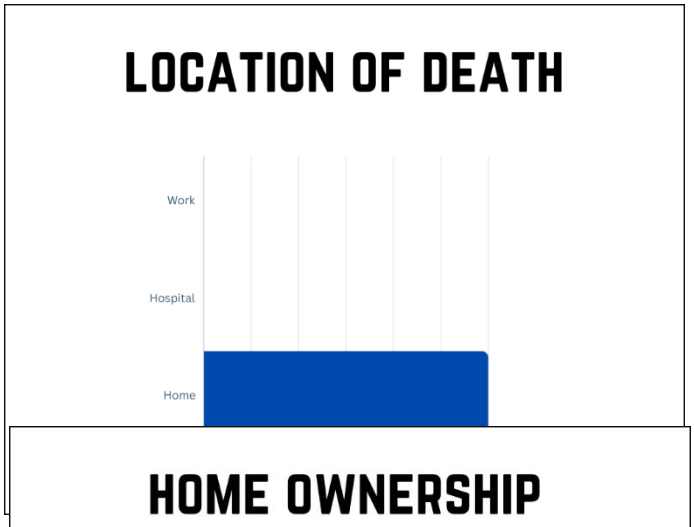
This is slightly higher than the mean age of death for victims between 2011 – 2021, which was 45. The youngest victim between those years was under 20 years old. We can see that, in recent years so far, there has not been a victim as young.



5. Location of death

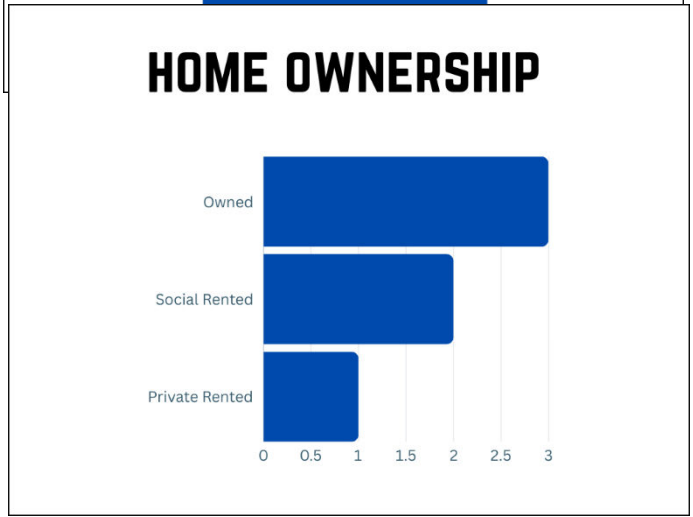
All the deaths took place in the victim's home.

This is very similar to what we saw in 2011 – 2021, where the majority, 67%, of deaths occurred at the victim's home.



6. Home ownership

Home ownership varied among the victims and there was no clear trend.



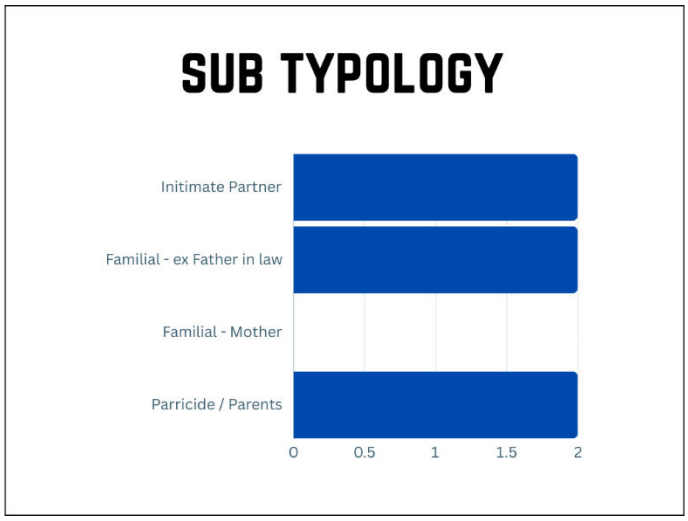
Out of the six victims, three of them owned their homes. Two victim's socials rented their homes and the final victim lived in private renting.

This is like the previous years, 2011 – 2021 where we see a range of home ownership and accommodation situations. Here, 33% of victims privately rented, 27% of victims social rented, 20% privately owned their homes and the remainder had an unknown living situation.

7. Sub typology

The sub typology refers to the specific 'type' of domestic homicide that occurred. This graph shows us that an intimate partner committed two of the homicides, an ex-father-in-law a further two and the final two were parricide/parental.

Data between 2011 – 2021 showed a similar trend, that many homicides were carried out by intimate partners. In these years, 13 out of 15 homicides were committed by intimate partners.

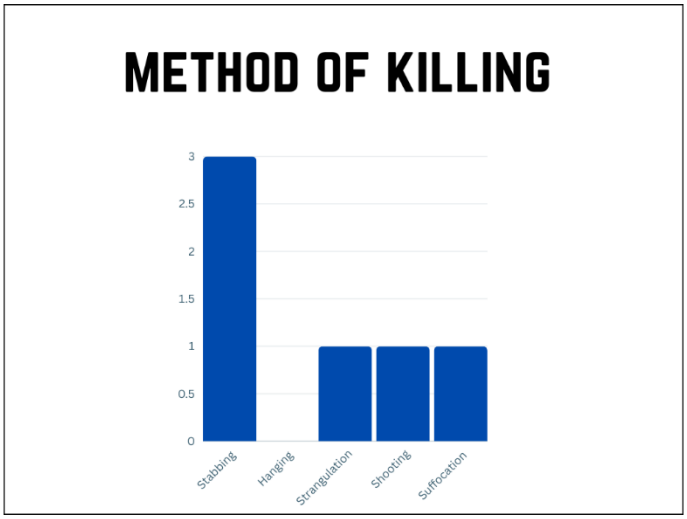


8. Method of killing

Stabbing was the most common method of killing, with 2 of the victims being reported as stabbed.

Strangulation, shooting and suffocation had been utilised in one case each.

In the years 2011 – 2021, we also see stabbing as the primary method of killing. In these years, 33% of victims were stabbed.

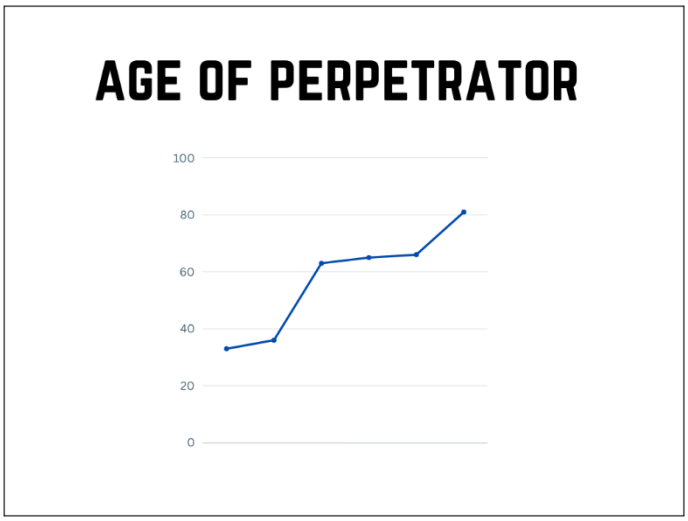


9. Age of perpetrator

The mean age of the perpetrators was 62.2, slightly higher than the mean age of the victims.

The youngest perpetrator was 36 and the oldest was 81.

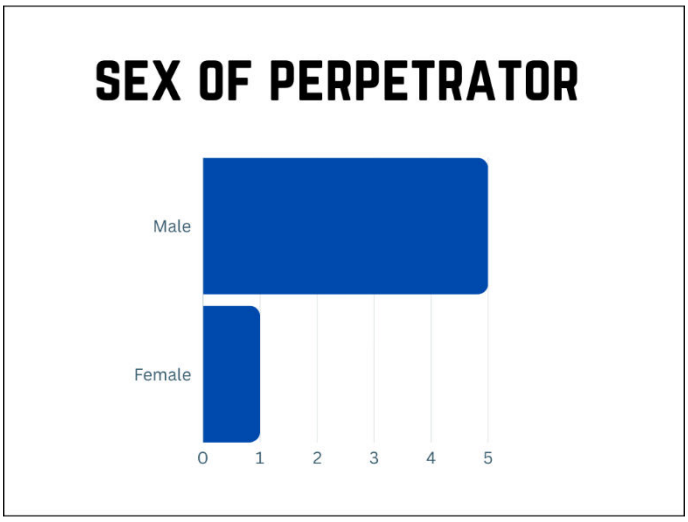
The mean age for perpetrator for the years 2011 – 2021 was 45, much younger than what we have seen so far since 2011.



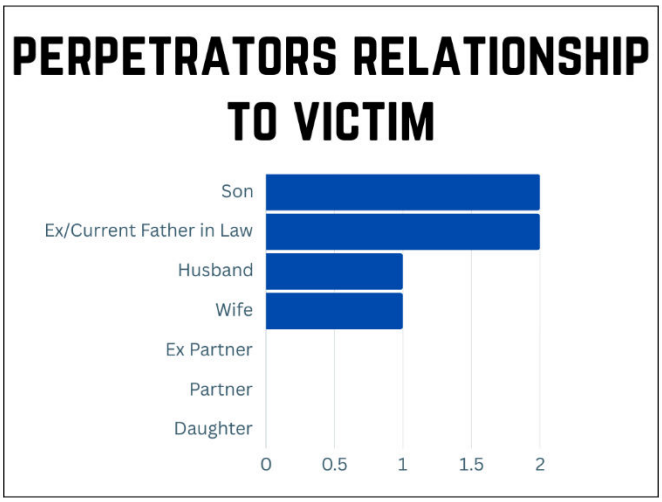
10. Sex of perpetrator

Five out of the six perpetrators were male.

In the years 2011 – 2021, 87% of perpetrators were male.



11. Perpetrator relationship to the victim

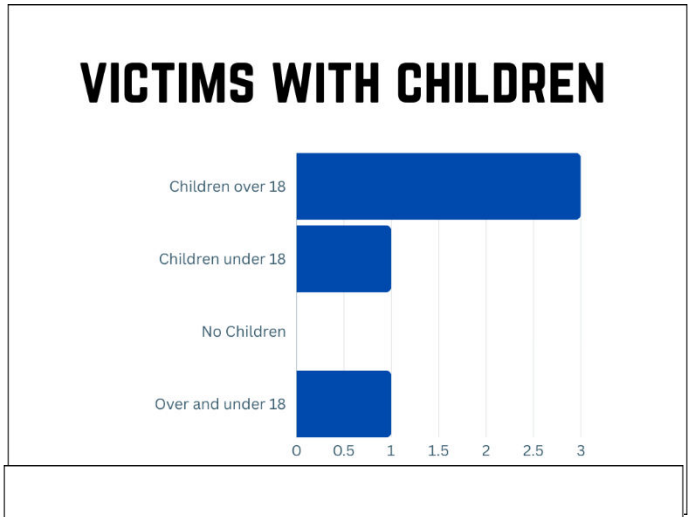


Interestingly, a father-in-law/ex-father-in-law committed two of the six attacks.

Looking nationally at statistics, the relationships between the victims and perpetrators shows that for 73% of the victims the perpetrator was a partner or ex-partner (Key findings from analysis of domestic homicide reviews, 2022, Home Office).

Research shows that separation is often the riskiest time for domestic abuse victims, with one study showing that 76% of the homicides reviewed having involved separation. (Domestic Homicide Review- Key findings from analysis of DHRS Dec 2016, Home Office).

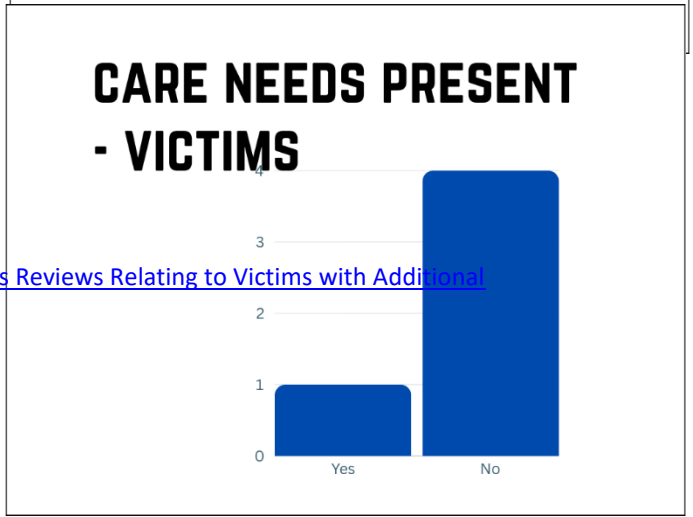
12. Victims with children



All the victims had children. Three of the five victims had children over 18.

Nationally, when looking at DHR's from 2018 – 2019 it was determined that there were dependent children in 52% of the households where the victim was aged under 60.[4]

13. Care needs present



[4] A Review into Domestic Homicide and Safeguarding Adults Reviews Relating to Victims with Additional Vulnerabilities - Shaping Our Lives

Of the victims. Only had care and support needs present as defined under the Care Act 2014.

A Review into Domestic Homicide and Safeguarding Adults Reviews relating to Victims with Additional Vulnerabilities 2021 (A Warburton 2021), found that 14 DHRs and 6 SARs from the periods 2013 onwards (DHRs) and 2014 onwards (SARs) involved victims with additional vulnerabilities. Please note, this review looked at the Eastern Region DHR's.

Of the perpetrators, none of them had care needs as defined under the Care Act 2014.

Suicides

Domestic Homicide Reviews are not only conducted in relation to homicides; where suicides arise and there is a history of domestic abuse, a DHRs is commissioned.

In Cambridgeshire and Peterborough, between 2021 and 2023, there were 7 cases of domestic abuse related suicides.

This section will outline the demographics of victims and abusers in domestic abuse related suicides, as well as looking at the cases themselves and commonalities between them. It will follow broadly the same structure as the demographic review of homicides above.

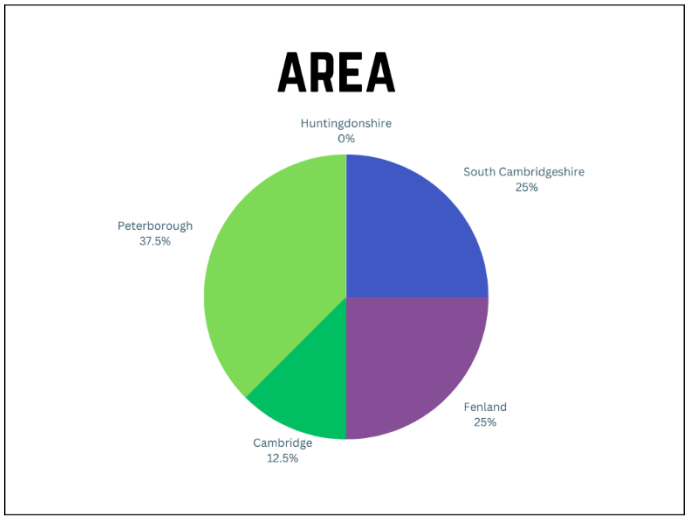
As above, comparisons will be drawn between the current trends in domestic related suicides and trends that occurred in 2011- 2021.

1. Area

The areas in which the suicides occurred do differ slightly to the homicides. Where for the homicides, Fenland was the most prevalent area, here is it Peterborough.

There were 3 suicides in Peterborough, and 2 in Fenland and South Cambridgeshire each.

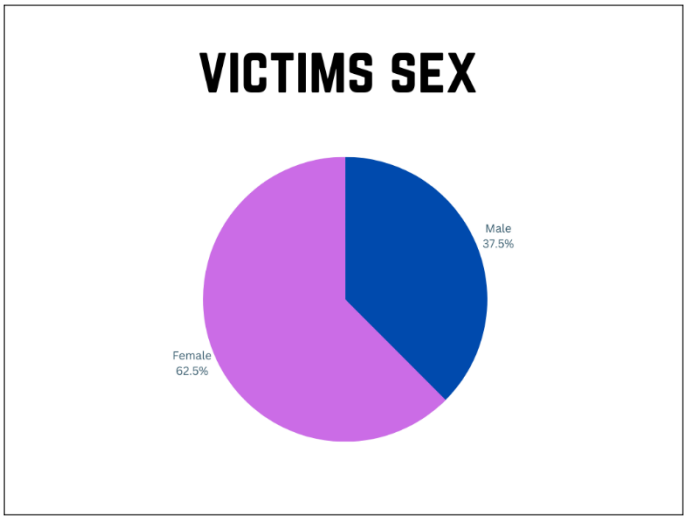
This is starkly different to what we see in the years 2011 – 2021 where there were no domestic related suicides in Peterborough.



2. Victims sex

There were more females, 5, who were victims of death by suicide than males, 3. This is opposite to the trend we saw above, where there were more males who were victims of homicide.

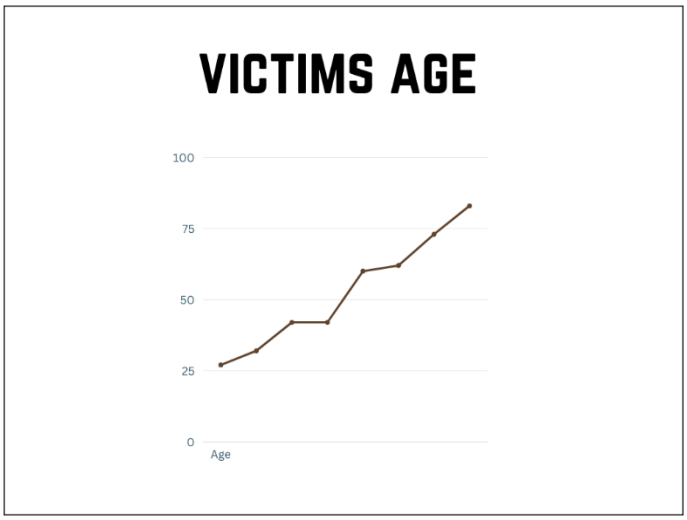
This is like what we saw in 2011 – 2021, where 3 out of 5 victims were female.



3. Age at death

The age of the victims ranges greatly with the mean age being 52.6. The youngest victim was 27 years old, which was younger than the youngest homicide victim, who was 32.

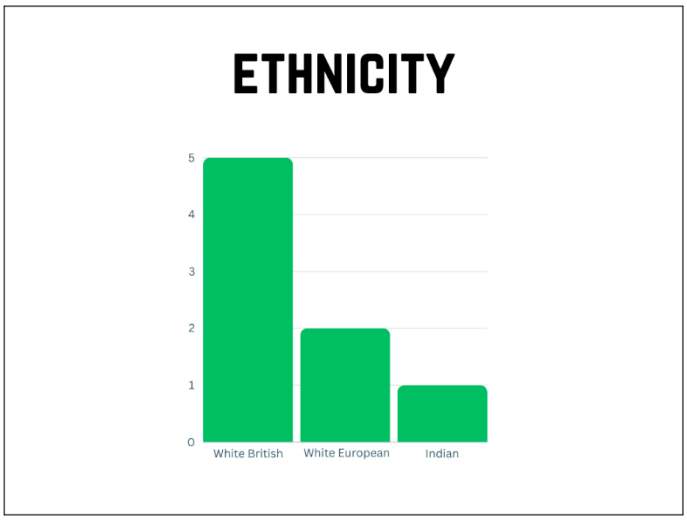
The mean age of victims between 2011 – 2021 was 47 years of age.



4. Ethnicity of victims

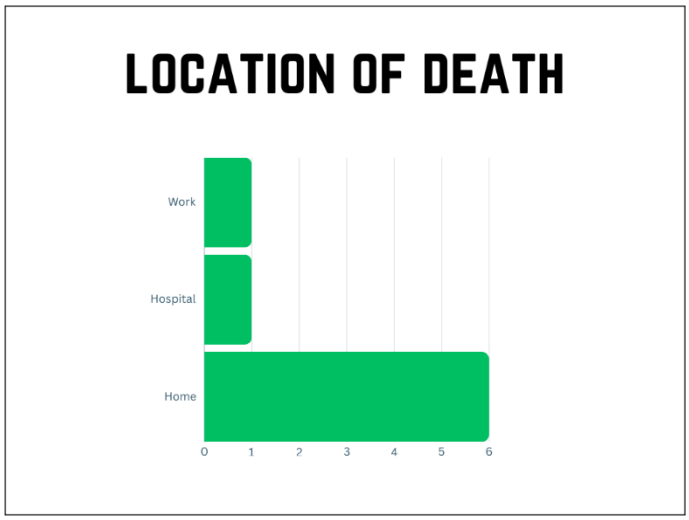
The ethnicity of victims here ranged more than what we saw above. However, the greatest number of victims were still White British.

In the years between 2011 – 2021, 4 out 5 victims were White British.



5. Location of death

Like above, most deaths occurred at home. Above we saw that all the deaths occurred at home. Here, six out of eight deaths occurred at home. The other two deaths occurred at a hospital and at work.

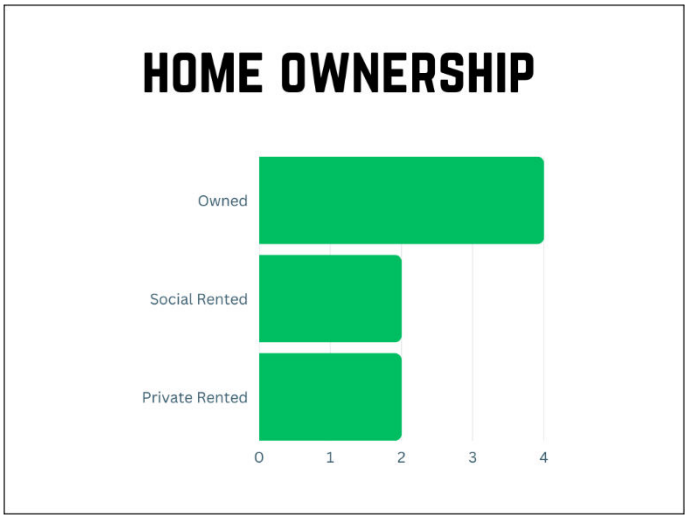


The home address of victims was also the most common death location for the years between 2011 – 2021.

6. Home ownership

Four out of the eight victims owned their homes. Two privately rented their homes and the other two lived on social renting.

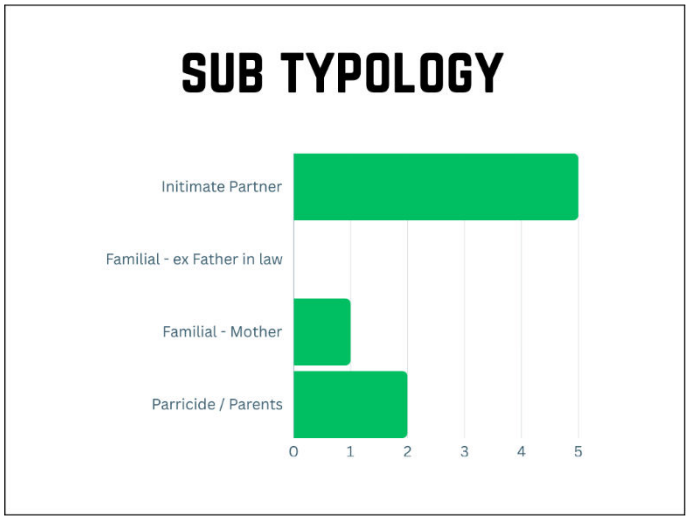
In the years 2011 – 2021, 40% of victims lived in private accommodation.



7. Sub typology

In this graph, we can see that most of the cases comes under the type – intimate partners.

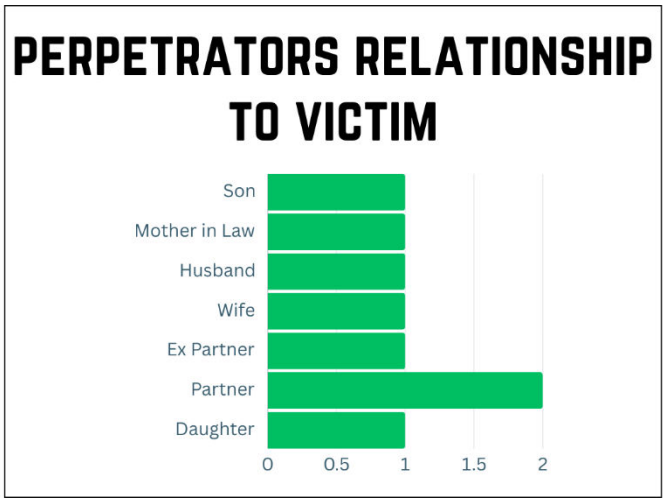
In the years 2011 – 2021, all the deaths came under the type 'intimate partners.



8. Perpetrators relationship to victim

As mentioned above, five of these suicides were categorised as – intimate partner suicides. From this graph, we can see that two of the perpetrators were the victim's partners, one was a husband to the victim, one a wife and one an ex-partner.

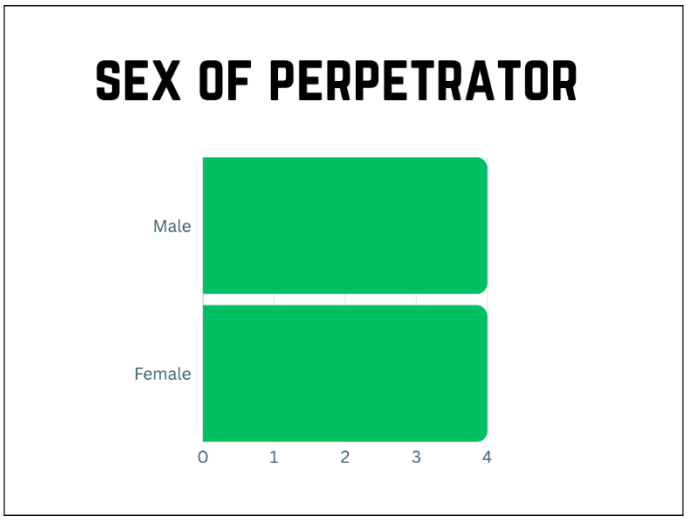
Abuse was also carried out by a son, a daughter, and a mother-in-law.



9. Sex of perpetrators

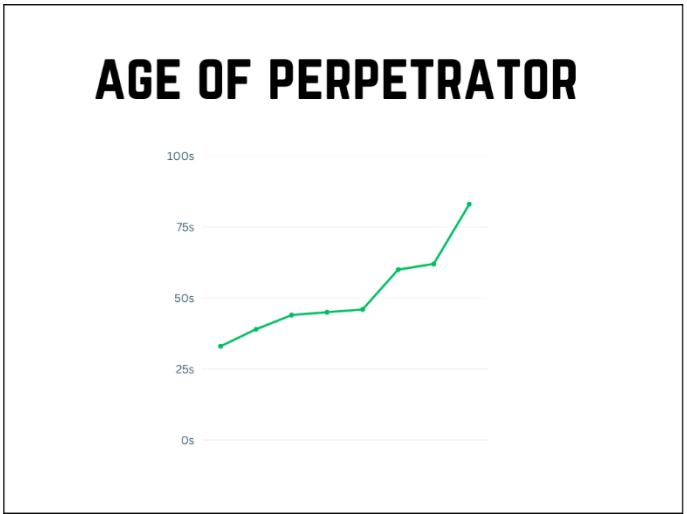
There was an equal amount of male and female perpetrators.

In previous years 2011 – 2021, the trend is similar, and we can see that there were 3 male perpetrators and 2 females.



10. Age of perpetrator

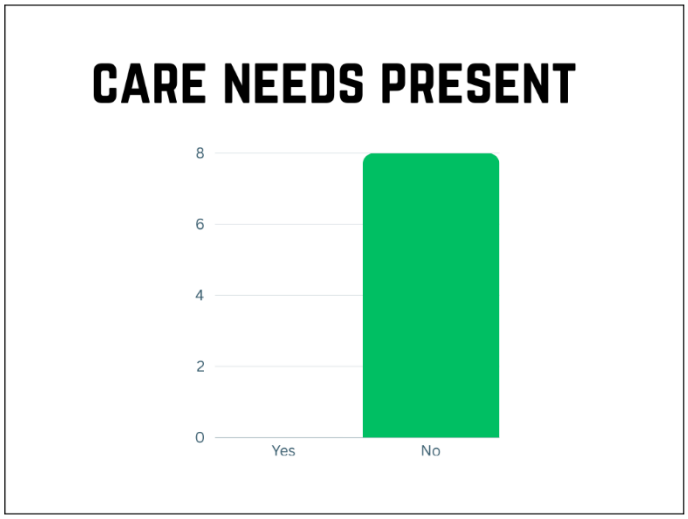
The mean age of the perpetrators was 51.5.



11. Care needs present

None of the perpetrators had any care needs as defined under the Care Act 2014.

None of the victims had care needs present.



Analysis of Domestic Homicide Review Recommendations

The Domestic Homicide Reviews (DHRs) that have been completed thus far have generated a comprehensive set of 70 recommendations, shedding light on critical areas for improvement across various sectors. The following section of the report categorises these recommendations to offer a systematic overview and facilitate a deeper understanding of emerging trends.

Health Recommendations:

1. Integrated Care Board Oversight:
 - Ensure Health Trusts and GP Practices are briefed on cases, emphasizing professional curiosity.
 - Implement training on documentation importance, linking 'carers' and 'cared for' using a national system like SNOMED.
 - Integrate Domestic Abuse awareness in every patient-clinician consultation, emphasizing documentation.

2. GP Involvement and Mental Health Considerations:
 - Establish processes for disclosure of domestic abuse during negative comments, ensuring mental health support.
 - Review how GP practices enquire about the impact on mental health when abuse is disclosed.
 - Strengthen communication channels between GPs and pharmacists to prevent prescription delays.

3. Care and Discharge Protocols:
 - Include 'think family' in discharge plans, involving consultations with both patients and families.
 - Review and enhance procedures for timely signing and administering of prescriptions.

Police Recommendations:

1. Risk Assessment and Communication:
 - Develop an action plan for agencies to review risk assessment policies in reinvestigated cases.
 - Appoint dedicated contact officers for families in statutory reviews and enhance Out of Court Disposal Team processes.
 - Conduct reviews of processes within the Out of Court Disposal Team to ensure effectiveness and accuracy.

2. Training and Language Use:
 - Provide specialised training for police officers in suicide indicators and appropriate language use.
 - Review procedures for attending suicides and emphasise positive language in

interactions.
- Implement training for all staff regarding the use of appropriate and responsive language in all situations, focusing on a willingness to support and safeguard victims throughout the criminal justice process.

3. Information Sharing and Confidentiality:
- Provide confidential sharing of Body worn video or images with other agencies for informed assessments.

4. Referral Procedures:
- Implement a focal point for information gathering following members of the public providing information to Cambridgeshire Police regarding vulnerability.

5. Supervision and Inspection:
- Ensure all Superintendent's receive specific training input in relation to requisites of authorising DVPN's and DVPO's on promotion.
- Review the current Homicide, sudden and unexplained death procedure (BCH09/009) to consider the requisite for the rank of Detective Inspector to attend all suicides.

Housing Recommendations:

1. Application Revisions:
- Revise housing applications to include considerations for escaping violence or harm.

Professional Curiosity Recommendations:

1. Policy Integration:
- Encourage statutory agencies and voluntary sectors to incorporate professional curiosity in policies related to domestic abuse.

Delays in Processes Recommendations:

1. Campaign and Community Engagement:
- Launch campaigns to increase public awareness of familial abuse and available support pathways.

Adult and Children Social Care Recommendations:

1. Collaborative Working and Training:
- Promote collaboration in child to parent abuse cases.
- Ensure mandatory domestic abuse training for social care staff, covering familial and child to parent abuse.

2. Awareness and Risk Assessment:
- Raise awareness of carers at higher risk of abuse using the DASH form.
- Review the use of the older persons DASH and consider its use alongside the standard

DASH when dealing with older persons.

3. Suicide Prevention and Support:
- Work with suicide prevention leads to identify patterns of suicide that have also had domestic abuse in their history.
- Progress data collation into suspected suicides of the LGBTQ+ community.

MARAC Processes Recommendations:

1. Local Escalation Process:
- Establish a local interim process for escalating agency non-attendance and non-compliance in MARAC meetings.

Community Safety Partnership and Council Recommendations:

1. Elderly and Male Victim Support:
- Implement a Community Response Framework for elderly and male victims, mirroring existing provisions.

2. Communication and Public Awareness:
- Implement a communication strategy to inform and remind statutory agencies and professionals about carers.
- Coordinate a campaign to increase public awareness of domestic abuse in Lithuanian translation.

3. Service Promotion and Support:
- Increase promotion of services by organizations such as Caring Together and Lifecraft.

4. Funding and Research:
- Review funding streams and posts to ascertain whether a dedicated Community safety officer for DHR's is required to assist the DASV.
- Review commissioning budget and ascertain whether a trial of an IDVA attending repeat domestic abuse locations alongside the Police would be feasible.

5. Staffing Strategy and Supervision:
- Implement a staffing strategy to ensure those with multi-complex needs are allocated a permanent member of staff.
- Implement a regular supervisory procedure for both individual cases and members of staff for effective oversight of performance.

National Training Recommendations:

1. Structured Framework for Implementation:
- Advocate for a Home Office framework to ensure timely completion of DHR recommendations.

2. Safety Measures for High-Risk Individuals:

- Integrate safeguards to prevent leaving individuals alone in high-risk situations into the commissioning of homecare providers.

3. Research Database for Housing Decisions:
- Establish a national database for housing departments to assess accommodation suitability based on vulnerability and risk.

4. National Campaign on Familial Abuse:
- Launch a nationwide campaign to raise awareness of familial abuse among the public and employers.

5. Data Collection and Support:
- Victims and perpetrators should be asked directly to self-define their sexual orientation and how they identify themselves, for the purpose of signposting them to the appropriate additional support services, and this should be recorded appropriately and accurately.

Conclusions

Across Cambridgeshire and Peterborough, the increase in the number of DHRs is likely to be a result of greater identification and information sharing, rather than a real increase in homicide or suicide, however, this cannot be proven.

The DHR process is to identify lessons or opportunities where the "system" and organisations could have responded more effectively to a situation of domestic abuse. The above outcomes were all driven by findings from DHRs.

The response following a DHR is rarely a "one off" activity, but a system or organisation adapting to improve outcomes for those who come after those who have died.

DHRs are complex, expensive, and time-consuming processes, making it vitally important that lessons are learned, and changes are made.

There will be more recommendations from the DHRs of those who died in this period once these reports and recommendations are complete.