**AGENDA ITEM 5**

**Strategic Policing and Crime Board**

**Tuesday 25th April 2023**

**Title:** Domestic Homicide Prevention

**Presented by:** Harjeet Chakira and Imogen Cheatham

# Domestic Homicide Prevention

## Introduction

This paper compiles various - but not exhaustive - streams of work being conducted by the Office of the West Midlands Police and Crime Commissioner (OPCC) and West Midlands Police (WMP) that relate to the prevention of domestic homicide and suicide.

The paper includes an exploration of:

a) The strategic direction of the OPCC in relation to domestic abuse perpetrator interventions;
b) The Management of Offenders & Suspects Investigative Toolkit;
c) The MARAC Review and Survivor Feedback Project;
d) Developments in respect of the national and local strategic oversight of Domestic Homicide Reviews (DHRs);
e) The suicide following domestic abuse research and conference.

## Domestic Abuse Perpetrator Interventions

During the course of 2021-2023 the OPCC has been working alongside partners towards the coordination of a regional domestic abuse perpetrator approach which is reflective of localised

nuances to reflect the variation in Local Authority areas including strategic structures, size and demographics which vary greatly for each area. What has become apparent throughout this work is that the response to domestic abuse perpetrators must sit alongside the regional MARAC Review which was commissioned by the VRP and carried out by Linxs consultancy. What has also become apparent is when considering any approaches to domestic abuse perpetrator interventions there is no one single intervention that will effectively meet the needs of all 7 Local Authority areas and indeed all domestic abuse perpetrators.

The OPCC has worked closely with the region to submit multiple partnership bids to the Home Office Perpetrator Intervention Fund 2023-25 based on the consultative work (described in the next paragraph). We will work with the region to effectively mobilise any successful projects and, should we not be successful through this competitive fund, we will seek solutions collectively.

Consultative work commenced at the Domestic Abuse (DA) Development Day held in November 2021 and the subsequent DA Perpetrator Partnership Workshop held on the 11th May 2022, a regional working group made up of key stakeholders was established by the OPCC to take forward learning in order to inform a West Midlands wide approach to tackling DA perpetration. Discussions at the working group were designed to delve deeper into the four key pillars of activity which were identified by partners. These four pillars effectively capture the areas of work which we as a region must consider if we are to effectively manage DA Perpetrators.

1. Systems readying
2. Behaviour Change Interventions
3. Strengthening the Criminal Justice System (CJS) Response
4. Prevention & Early Intervention with Children and Young People

What has been made clear to us throughout all discussions so far is that there is no one size that fits all when it comes to tackling DA Perpetrators. What is also clear is that we must adopt a short-term view in the first instance before we can progress onto longer term solutions. What is meant by this is that we have work to do in terms of readying our infrastructure and our systems in order to increase the chances of successfully embedding any behaviour change intervention.

Each local authority has differing approaches to tackling domestic abuse perpetrators. What our work with stakeholders has made clear is the need for a regional approach with local nuance to be led strategically by the OPCC. We have therefore worked closely with all 7 Local

Authority areas to understand what each area response could/should be based on what they currently commission and based on their local domestic abuse needs assessments.

This work has run alongside the MARAC review process. The MARAC review and subsequent MARAC re-design provides us with a unique opportunity to re-design our existing domestic abuse safeguarding systems to ensure they are better aligned with DA perpetrator management structures which will enable us to be in a good position for any forthcoming behaviour change intervention in the future. The working group raised the following points which have been taken into consideration by the OPCC;

**Repeats** - based on a comparison to 20/22 at a force level, DA crime has increased by 17.01% and the volume of positive outcomes reduced from 3,222 to 2,304. According to WMP current averages remain stable at 1,005 Repeat Victims, 1,079 Repeat Offenders. The group considered whether this information indicates we should be focussing our interventions at the high-end spectrum of risk or whether we should be looking at low/medium risk. Some Local Authorities stated that some offenders being managed in the offender management system for domestic abuse are not those that hitting the threshold for MARAC.

**High risk** – there is an ambiguity around how the term 'high risk' is being interpreted across systems and across safeguarding structures. For example, for the Birmingham/West Offender Management Teams, the criteria for high risk is *serial offenders*, which is two or more victims within a three-year period. Whereas for MARAC high risk is considered in line with the DASH Risk Assessment. The working group felt that risk can be a limiter as to what we do with a perpetrator, particularly if it is not being understood consistently. Another important point in relation to risk is the recognition/understanding of risk through the lens of coercive control and this being understood and applied consistently by the workforce.

**Sharing information** – information sharing was recognised as being an area which we need to give some thought to; how do we develop information sharing protocols locally/regionally which enable a multi-agency response between Health, WMP and Children's Services? Further consideration must be paid to how we overlay the data from each Local Authority. For example, Childrens Services may know of significant harm that may not cross into offender management due to criteria/risk. A place to overlay such data would be hugely beneficial.

It is important to note that many of the issues outlined by the working group were also highlighted in the MARAC review findings and have been worked through on a local level through a dip sample exercise. Below we have summarised the current position across the four key areas of work outlined above.

1. Systems readying

Through discussions with partners we have been told that our systems and structures are not yet ready to embed a regional perpetrator programme. Partners emphasised the importance of joining up and ensuring a solid infrastructure between MASH, MARAC, ODOC and domestic abuse triage prior to any programme being embedded. It was stated that an effective infrastructure was an essential prerequisite to perpetrator resource being provided/implemented. It was recognised that this might be difficult with conflicting agendas between agencies and all partners including Community Safety Partnerships and Children Services needing to be part of the solution. An absolute joint commitment to a core structure needs to be agreed and then work around Local Authority or local needs should take place. Robust governance at a strategic and operation level is also essential.

The OPCC are planning how we can work with the region on readying our systems to make sure they can be fit for purpose. This will lead us to the development of a consistent infrastructure across the region to support the implementation of any behaviour change interventions which we later embed.

Alongside this there is also work taking place to embed the recommendations from the MARAC review carried out by Linxs consultancy. Linxs identified a duplication of safeguarding structures namely the MARAC, ODOC and MASH. They have put forward a number of different models for the West Midlands to consider which include discussing the perpetrator at the same time as discussing the victim/children. This approach would take a whole family approach and would mean the same family is not discussed separately at all 3 meetings. Part of the aforementioned dip sample work involves proposing a safeguarding structure which would work locally. This work is happening with OPCC oversight and it is envisaged will have the dual benefit of reducing MARAC demand as well as better alignment the management of high-risk offenders.

2. Behaviour Change Interventions

In terms of a behaviour change model, partners made clear the importance of transparency and multi-agency working, with a particular focus on the need for professional trust between perpetrator and victim services who must conduct jointly held risk assessments and would benefit from complex case meetings and regular communication between perpetrator facilitators and victim support services. Outcomes should be cross-referenced between agencies. A framework to ensure effective communication and joint-working is needed. The importance of working closely with victim services was emphasised by Victims Commissioner Nicky Brennan who strongly believes any intervention must priories the safety and wellbeing of victims.

Pre-motivational work is essential before perpetrators embark on a behaviour change intervention. The 6-week motivation to change pilot delivered by Richmond Fellowship and SafeLives' 'Engage' programme were given as examples of this. Addressing a perpetrator's wider needs such as drug and alcohol use and mental health can be useful in-roads to engagement and often needed to enable perpetrators to be in a position to meaningfully embark on a behaviour change intervention. Partners also highlighted the need for a sperate, specialist intervention for certain specific domestic abuse-related offending such as FGM, HBA, FM and Stalking.

What is clear through consultation so far is that we are not looking for a regional response that we roll out across the seven areas (at least not until the above systems work is done), however the following overarching principles have been identified;

- Joint risk assessments between the perps and the victim support service
- Where relevant complex case meetings between the two services
- Pre-motivational work is essential before perpetrator embark on a behaviour change intervention
- Addressing a perpetrator's wider needs such as drug and alcohol use and mental health
- Need for sperate, specialist intervention for certain specific DA-related offending such as FGM, HBA, FM and Stalking

In relation to Stalking, the OPCC has been commissioning the Early Awareness Stalking Intervention (EASI) since August 2021. EASI is an evidence-informed intervention for those who are known to have engaged in stalking, and is delivered at the earliest stage possible. EASI works with the ex-partner, rejected typology stalker who is not driven by serious mental illness. Those able to access the intervention are those who have made an admission of stalking and have cognitive functioning ability.

The intervention aims to increase, and develop hope, skills, and a commitment to change within participants with professional support, and is an intervention utilising the Focussed Acceptance and Commitment Therapy (FACT) treatment approach, which recommends 4-6 sessions. Anecdotal evidence suggests that FACT is a valid approach to use with perpetrators of stalking offences because it targets strong thoughts including the fixations and obsessions that are often associated with stalking. This intervention is being evaluated by the University of Derby and findings suggest significant perpetrator engagement and completion rates and relatively low repeat offences during and after participating in the intervention. The OPCC is working to ensure EASI becomes part of a wider multi-agency approach to stalking that

effectively responds to the recommendations of the National Stalking Consortium's super-complaint.

3. Strengthening the Criminal Justice System (CJS) Response

In terms of the CJS response to DA, partners consistently referred to this as 'broken'. The low number of cases which reach court were discussed as were the alarming 60% of domestic abuse police reports which are filed in the first 5 days. It goes without saying that the criminal justice response needs to improve its response to victims so they feel supported enough to continue with the case until it reaches court and there must be a continued effort to reduce attrition rates. There was an acknowledgement that there must also be an increase in the use of protection orders and civil interventions and a more robust response to breaches.

The working group emphasised the need to increase the response to the vast amount of cases that do not make it into the CJS to ensure there is accountability for perpetrators and protection for victims. For this reason, the OPCC has been working with WMP on the development of an in-custody intervention which will engage domestic abuse perpetrators regardless of risk level. The intervention is based on the premise of a teachable moment, (which in education, is described as the time at which learning a particular topic or idea becomes possible or easiest). The aim is to apply this premise to domestic abuse offenders. The in-custody intervention is based on a model of navigators who would engage with perpetrators during these reachable teachable moments. They would work alongside the Adult Intervention Team (AIT) but be offender focussed and not part of the CJ process. It would be a voluntary (not mandatory) engagement with persons in custody and would engage with ALL domestic abuse offenders regardless of risk level. The ambition behind this service is that it would lead to an increase in engagement of offenders into criminal justice outcomes, including Out of Court Disposals and CPS Receipts.

It is important to point out that WMP have been offering CARA for a number of years. Project CARA is an out of court disposal for first time, standard or medium risk offenders of intimate domestic abuse. CARA sits within the criminal justice system and is part of a conditional caution. The ethos of CARA is that it is a positive opportunity to support offenders in addressing their actions and attitudes in order to prevent recidivism and repeat victimisation. The perpetrator must comply with attending a short rehabilitative domestic abuse awareness course (delivered as two workshops) which addresses abusive relationship behaviours. If the offender fails to comply, then they may face prosecution for the original offence. Acceptance to the Domestic Abuse Conditional Cautioning scheme must meet specific criteria as set by the Director of the Public Prosecution (DPP) and the Crown Prosecution Service (CPS).

4. Prevention & Early Intervention with Children and Young People

In society we unfortunately see the intergenerational normalisation of and desensitisation to violence and abuse from a young age. In tackling this, we need a whole-systems public heath approach that starts early in a child's life and looks at both the environment within and outside the home. Partners said this prevention and early intervention work should not be gender neutral but take a gendered lens and support in breaking these norms and barriers and helping children understand them. There needs to be a change in schools and RSE curriculum with materials and training available to teachers to have the confidence to deliver this work. It should look at misogyny and patriarchy and how it is present in popular culture as well as around healthy relationships and victim blaming. This needs to be delivered at a level suitable to the age of the child but delivered as soon as possible.

This work may sound ambitious however work has already across the region through our two recent successful rounds of Safer Streets 3 and 4 funding. Through these funds we have embarked on a journey of step change through the development of the Ending Male Violence Against Women and Girls Alliance and associated messaging around the VAWG agenda which is being communicated through various media platforms. Through this work the OPCC prioritised prevention work with children and young people which would address the structural context where institutional power imbalances and gender inequalities/norms exist which contribute to all forms of VAWG including domestic abuse. Below are two examples of the type of activity which is already taking place within this space;

- The VAWG Education Intervention Advisor (EIA) delivered by the West Midlands VRP is continuing to work with schools to develop VAWG training/resources for education professionals across different types of education settings, i.e. primary, secondary, universities including early years and delivering MVP training in schools.

- The Safer together (#timetotalk) programme was commissioned successfully in SSF3 to work specifically with boys exhibiting harmful sexual behaviours. The programme provides a safe space to explore their views, values and beliefs and was designed to align with the recommendations of Ofsted's Review of Sexual Abuse in Schools and Colleges (2021), Tackling Violence against Women and Girl's strategy (2021) and West Midlands Sexual Abuse and Assault Strategy (2020-2023).

- Op Encompass is a model used in the West Midlands, details of exactly how it functions varies slightly by Local Authority area. It is a partnership between WMP and the Local Authority to get notifications out to schools when there has been police call out to a domestic abuse incident where children were in the house. It has therefore been operating for different amounts of time in each borough, Birmingham only launching last September.

## Management of Offenders and Suspects Investigative Toolkit

- In 2021, an audit was conducted by the Office for Police and Crime Commissioner to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight into the West Midland Police overarching suspect management strategies, policies and practices. This audit revealed a number of key findings and an action plan, which has now been completed.

- The Force Criminal Investigation Department, Public Protection Unit and most recently (Feb 2022) Offender Management Unit have worked collaboratively to create the toolkit that will be used to house key messages and guidance on various aspects of offender and suspect management in one place and includes material that supports pillar two of Operation Soteria.

- T/Sergeant Vanessa Nelson is the guardian and lead developer for the overall product, who saw opportunities to make this a comprehensive 'toolkit' which would drive home not just how WMP can manage offenders but a wider overarching aim of supporting the ever-changing workforce, prevent homicide and do the utmost to minimise repeated offending with the tools already at their disposal. The toolkit will also form part of the Initial Induction training programme, currently under development. The toolkit focuses on key messages, directions and reminders. Some examples include the THRIVE risk assessment, bail legislation and guidance, victims code compliance and appropriate recording through CONNECT**,** guidance on how investigators can better work with offender managers, a reminder of Stalking Clinics and the EASI project and input from the PPU standards officer with direction to sergeants on the quality of their investigative reviews. This has recently been shared with the HMIC inspectors at a focus group on Homicide Prevention in early March 2023.

## Regional MARAC Review

- Multi-Agency Risk Assessment Conferences (MARACs) were established in response to the lack of systematic risk assessment among agencies responding to domestic abuse, and the need for a local forum for agencies to share information in order to produce a coordinated action plan to increase victim safety. This function is however, not statutory.

- In 2022, Linxs Consultancy were commissioned by the Office of the Police and Crime Commissioner (West Midlands) to undertake a review of MARACs operating across the West Midlands.
- The review was triggered by concerns relating to the continued increase of regional MARAC demand, and the pressure this was having on the MARAC administrative function, partners and on the quality of outcomes for victims and their families.
- The increasing number of 'high-risk' domestic abuse incidents reported to West Midlands Police resulted in rapid rises in MARAC caseloads, in addition, complex needs being identified in referrals made into MARAC namely, substance misuse and mental health issues further exacerbating potential risk and harm to victims.
- On commissioning the research into the function of MARAC, the high volume of cases was demonstrated through an overall increase in accepted referrals of 44.8%.
- Birmingham had the highest number of referrals which doubled in the three-year period (91.6% increase from 2019/20) resulting in the introduction of two daily MARACs split between the East and West of the city to cope with demand, stakeholders expressing this temporary measure as being inefficient in the long-run.
- The review concluded that the current MARAC process was "built for a different era", identifying that the current volume and increasing complexity of cases was problematic and unsustainable. This finding was echoed across the regional partnership and there is a universal drive for change and improvement.
- On publishing their findings, Linxs included a synopsis of comparative practice examination to ascertain how other Local Authority and/or Force areas have reframed their MARAC process to address similar challenges faced as the West Midlands. Whilst there is some variation, most are utilising a form of triage, which is being shown to improve timeliness of safeguarding and ultimately reduce the numbers who progress to full multiagency discussions.
- To examine challenges which had been identified through the initial review, each of the seven local authorities agreed to complete a dip sample of local MARAC cases.
- The dip sample sought to understand whether a MARAC referral and discussion was necessary to achieve the appropriate safeguarding outcome for individual cases, and whether the MARAC process caused any delays in actioning support and intervention.

- Findings of the dip sample entirely supported the conclusions of the review, emphasising the need to overhaul the existing MARAC process.

- Linxs concluded, “The MARAC process does clearly have a value in some cases, including the provision of new information and/or further disclosures of risk, however, it is clear that a significant proportion of cases do not need a full hearing. Safeguarding can be provided outside of the meeting and necessary actions set via triage.”

- Key recommendations from the review included:

    - Developing a screening (pre-MARAC triage) approach to ensure, rapid safeguarding and reduced duplication; reducing the MARAC caseload; freeing up MARAC capacity to focus on complex case; and consistency of threshold application.
    - Introduction of a new case management system to enhance tracking and promote accountability and ownership.
    - A clear working protocol for the use of multiagency meetings outside of MARAC (professional meetings) for repeat cases is required.
    - Providing greater focus on risk assessment and MARAC training, chair training and recruitment.
    - Determine relationships and ownership between other multiagency forums, such as ODOC (One day one conversation), where cases overlap.

- Following the review, the MARAC Sub-group which is chaired and coordinated by the OPCC and is made up of all 7 Local Authority Domestic Abuse leads, MARAC Coordinators and the WMP MARAC Lead meets monthly to work through recommendations and any matters arising especially those pertaining to the administrative function of MARAC and ongoing demand.

- Coventry has since piloted the triage process as recommended by Linxs, triages have been taking place weekly since late 2022.

- This process, once agreed by partners on the group would be the preferred risk-assessment and decision-making framework intended for use in the region as it aids in ensuring individual high-risk cases of domestic abuse are safely managed and safeguarded.

- The process will identify, through a series of tiered referral options, the most appropriate intervention for cases based on the information available to assessing panels.

- Further areas of improvement identified through the group/ review include:
  - Improved offer for robust training programmes to cover; triage and MARAC processes
  - Rebooting the roles and responsibilities of all agencies concerning the domestic abuse agenda
  - Professionals meetings - understanding the expectations of involvement not necessarily a one-off meeting but a process that will be reconvened until risk is effectively managed.

- Lastly, a new model will be most effective alongside a new IT system that would provide live information sharing and tracking (allowing progress to be updated by all partners) and dynamic minutes' creation. This will enhance ownership and peer scrutiny.
- The system would cover all cases whether at triage, full MARAC or Professionals Meetings. Changes thus allowing for greater capacity to review cases and ensure that actions are completed.
- The introduction of an IT System inevitably presents a resource saving due to the high volume of manual processing involved in the current MARAC process. Its introduction will additionally create improved case management and greater duty of care for victims and their families.
- Most significantly, an IT system provides a single space for the sharing and recording of information relating to high-risk cases, enabling enquiring professionals to promptly make informed decisions relating to safeguarding, saving on the time and resource which is currently spent gathering information from third parties.
- In conclusion, whilst significant issues exist within the current MARAC process, we have identified the key issues and set out a pathway to success which partners are seeking to implement. Implementing these changes will take dedicated time and resource from across the partnership and we will report further to board as this work develops.

## West Midlands MARAC Survivor Feedback Project

- The Survivor Feedback Project was completed in April 2022, exploring the MARAC experience of victims of high-risk Domestic Abuse who were referred to a West Midlands MARAC in 2021. Overarchingly, MARAC sought to establish an

understanding of the front-line impact of the MARAC process and the services utilising it, and how much safer it actually makes survivors of high-risk domestic abuse in the West Midlands.

- The project spoke to 52 participants from across the region and the findings were published in a report, along with a list of safeguarding recommendations, in January 2023. The feedback was collected via a survey with participation both in person and over the telephone, all of which was robustly risk assessed. A demographic breakdown of those that participated includes;
    - Survivor (male): 8% (4)
    - Survivor (female): 92% (48)
    - Survivor (LGBT+): 6% (3)
    - Survivor (ethnic minority): 30% (16)
    - Survivor (living with a disability): 9% (5)

- Over 70% of participants told us they were safer today than they were when they were first referred to MARAC. Intervention is successful in reducing risk, enabling survivors to leave abusive relationships and giving them access to tailored support.
- the full report is embedded below to be read and understood by our partner agencies.


West Midlands
MARAC Survivor Feec

- It was acknowledged that by the very nature of being safe enough to participate, the vast majority of survey participants presented with an increased likelihood of having experienced a positive outcome.
- MARAC were not able to capture the voice of those who are not safe today or who did not wish to share their feelings with them we must therefore remain mindful as we consider the findings, that they may well have told a different story which sadly cannot be heard through this report.

## Domestic Homicide Reviews

- Sadly, despite the continued efforts of all those involved, domestic homicides can and do occur.
- This section summarises the current local arrangements pertaining to DHRs and provides a summary of the Home Office's current proposal for change.

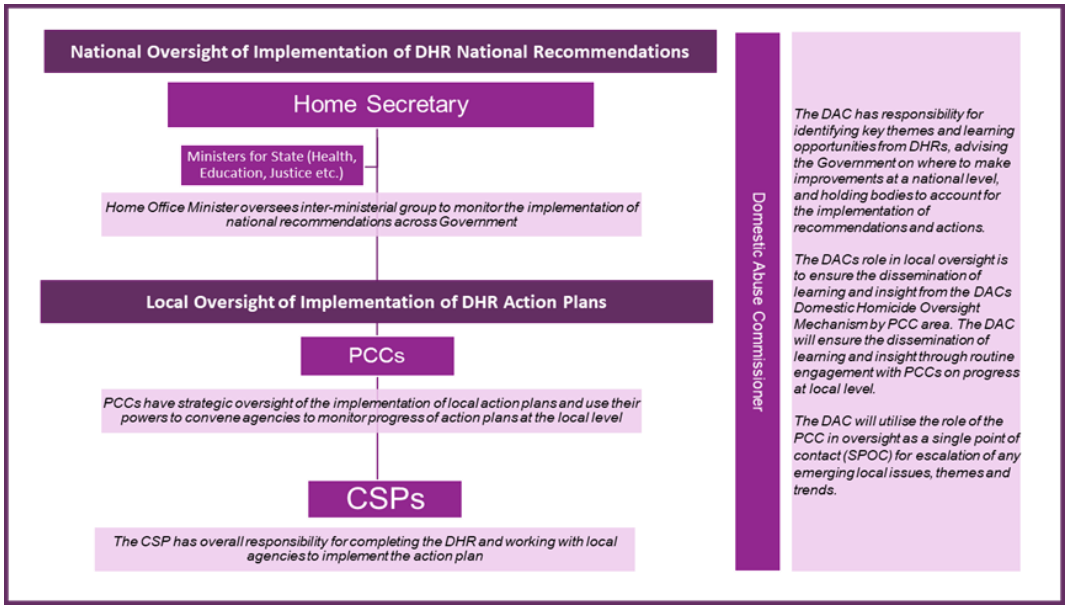
- DHRs are a statutory requirement under section 9 of the Domestic Violence, Crime and Adults Act (2004) and are carried out where a person has died as a result of abuse, violence or neglect by a relative, intimate partner or member of the same household.The current process for a DHR is initiated when the relevant police force informs the relevant Community Safety Partnership (CSP) of the incident.Overall responsibility for establishing a review, rests with the local CSP as they are ideally placed to initiate a DHR and review panel due to their multi-agency design and locations.CSPs are made up of representatives from the 'responsible authorities' (i.e. police, local authorities, fire and rescue authorities, probation service and health) who work together to protect their local communities from crime and help people feel safer.
- The PCC holds the West Midlands Community Safety Partnership (CSP) budget. Each year the PCC provides a budget allocation from the CSP Budget to support the DHR process. The allocation for 2022-2023 was £235k.
- A summary of 22/23 DHRs;

| **Local Authority** | Number of DHRs (year 22-23) | Comments |
|---|---|---|
| Birmingham | 18 | 18 panels live at the moment with 3 to be published shortly. |
| Dudley | 4 | 1 complete, 1 part complete (on hold), 2 x part payment for work undertaken this year |
| Walsall | 0 | No new DHRs in the current financial year |
| Sandwell | 3 | Sandwell MBC have been managing 4* DHR notifications.<br>3 of which progressed to full DHR and 1 of which did not meet threshold for DHR although it progressed as a Learning Review via the DHR Standing Panel. |
| Solihull | 3 | Three new cases in 2022/23 but in total, managing seven DHRs at different stages. Four progressing from previous years into 2022. See attached email for details. |
| Coventry | 3 | Currently running 3 DHR's in 2022 – 23 |
| Wolverhampton | 3 | Currently running |

| | | |
|---|---|---|
| **Total** | **13** | |

## Home Office DHR Review – Proposals for Change

- The APCC and Home Office have been consulting with PCCs on the local oversight arrangements and mechanisms of the Domestic Homicide Reviews (DHR) process.
- It has been suggested that as PCCs also have responsibility for a) commissioning services to support victims of crime, b) working with other organisations, including criminal justice partners, to deliver a joined-up approach to local priorities, and c) improving community safety. Together, these functions place them in an ideal position to have local oversight of DHR action plans that are seeking to improve local responses to preventing domestic abuse and homicide.
- Under the proposed changes, the Community Safety Partnership will decide if the criteria for a DHR has been met and if so will conduct a rapid evidence review (even if the DHR will not be going ahead) which will be sent to the Home Office and PCC.
- At this stage the PCC will be able to comment on the decision taken by the CSP.
- Once the review is completed the PCC will maintain strategic oversight of DHR recommendations (mechanism to be determined).
- There is no additional resource being offered by the Home Office for this increased level of PCC oversight.
- On a national level there is inconsistency between PCC offices in their local arrangements around DHRs at present. Some already operate bi-annual DHR clinics (Norfolk) and are very much involved in the oversight of recommendations while others maintain oversight through their regional domestic abuse partnerships, integrated Care Boards or Health and Wellbeing boards.
- It may also be the case that collaboration via a number of different partnership structures already in existence is preferred depending on the local context such as local boards who may have an interest in DHRs.
- Ultimately, the PCC needs to be satisfied that appropriate oversight and governance is in place to implement DHR action plans in their area and that they have the mechanisms to hold partners to account to implement action plans, when necessary.
- The Home Office proposal for oversight can be shown below;




## Emerging issues in relation to DHRs

- In response to the Covid 19 pandemic the NPCC and College of Policing working with the national policing Vulnerability Knowledge and Practice Programme (VKPP), developed the concept of tracking all deaths within a domestic setting to learn any potential lessons rapidly as England and Wales moved through various stages of lockdown.
- In 2020 the Domestic Homicide Project was established to collect, review, and share quick-time learning from all police recorded domestic homicides and also from suspected suicides of individuals with a history of domestic abuse victimisation in the wake of the Covid-19 pandemic and restrictions.
- As well as domestic homicide by a (current or ex) partner or family member, the Project also counted child deaths in a domestic setting, unexplained or suspicious deaths, and suspected suicides of individuals with a known history of domestic abuse victimisation.
- Below is a summary of some of their year 2 findings;
    - Domestic abuse affects 2.3 million adults every year, while **one in five homicides is a domestic homicide**[1].
    - Around 24% of all domestic homicides are suicides
    - There was a rise of 28% (n = +14) in the number of submissions for suspected victim suicide in Year 2.

[1] NPCC VKPP Domestic homicides and suspected victim suicides y2 report.pdf

- The increase in suspected victim suicides is likely to be reflective of better awareness and identification by police of these cases, as a result of this Project.
- Whilst numbers are small, the full two-year dataset appears to include a lower proportion of victims and suspects of white ethnicities and a higher proportion of victims and suspects of minority ethnic heritages compared to the general population as measured by the 2011 Census (22% of victims and 20% of suspects were of minority ethnic heritages, compared to 14% in the Census). This was particularly true of victims and suspects of black ethnicities (8% compared with 3% in the Census).
- Comparing the two years, there was a rise in male victims of suspected victim suicide, from 10% (n = 5) in Year 1 to 19% (n = 12) in Year 2, although the great majority of victims were still female (n = 45 (90%) in Year 1, n = 52 (81%) in Year 2). Within these 12 cases in Year 2, the majority (n = 10) had experienced prior abuse from an intimate partner. In two cases this abuse was from a male partner and in eight cases from a female partner. There is perhaps an interesting dynamic in these eight cases involving prior female-to-male abuse: in all eight, the male victim was previously known to police as both a victim and as a perpetrator of abuse.

- The charity, Advocacy After Fatal Domestic Abuse (AAFDA) held its annual conference in March 2023 which sought to help raise the status of victims of domestic abuse and bereaved families.
- The programme comprised of accounts from families bereaved by fatal domestic abuse sharing their experiences of seeking to obtain justice and a range of speakers from the public sector, academia and the third sector supporting victims and families affected by domestic abuse.
- Some topics explored and recommendations made at the conference include:

  - Involving Children in the DHR process and criminal justice journey, although it takes a great amount of support from professionals (acknowledging the trauma caused and supporting appropriately), children and young people often have a lot to contribute to reviews.
  - Children and young people can help determine the facts, and help professionals see through the victim's eyes, which helps them to produce a review that is accurate and meaningful. A compassionate review can thus be a testimonial for children and young people of the events that led up to the death, and dispel myths and victim blaming. If professionals continue to frame only

the adult as the only victim, this omits the fact that domestic abuse affects all members of the family, harming those that witness acts of abuse.

- An example given by an academic researcher on the day referenced the Arizona Child and Adolescent Survivor Initiative (ACASI, *American-based*) which is commissioned to foster the healing of intimate partner violence survivors. ACASI provides free, state-wide services to caregivers and parents of children and adolescents who have been impacted by intimate partner violence.
- Support services such as ACASI are limited in the UK, there is even greater need for services offering bespoke support to bereaved children whose parent/s, caregivers or family members from the same household die as a result of domestic abuse.
- Specialised support for children and young people could include, trauma therapy, intensive multi-agency case management, advocacy and mentoring programmes.
- There was recognition of DA-related suicides that go 'unrecognised' or are overlooked by some professionals for reasons including, stakeholders and family members highlighting the lack of adequacy of existing statutory guidelines to ensure a consistent and robust approach.
- Challenges with determining the role domestic abuse may have played in a death by suicide, acknowledging that although there are established links between domestic abuse and suicidality, a direct causal effect could be challenging to establish.
- Additionally, barriers are faced by families in seeking justice if a victim of domestic homicide had challenges with their mental health, particularly suicidal ideation. Such history could therefore be taken as sufficient explanation for a death.
- AAFDA recommends professionals scrutinising whether cases of suicide where domestic abuse was present are identified and referred as appropriate, it was unclear whether those on DHR panels are advised of all cases where suicide was present.
- AAFDA's findings reiterated the continued dominant focus of DHR commissioning being on cases where perpetrators directly inflict fatal violence despite the 2016 reform to include suicide in its remit.
- The Home Office shared its plans to develop an online DHR library which could be accessed centrally by members of the public, hosted and managed by the Home Office.

- Some bereaved families emphasised the importance of dissemination with aims to improve policy, legislation, and awareness raising. It was acknowledged that for those where a perpetrator is not convicted, publishing reports could cause further psychological harm to those bereaved, especially children who may readily access reports without mechanisms for support having been put in place – safeguarding is therefore key.
- Finally, practice recommendations from the conference included, ensuring skills and knowledge of the independent chair and review panel were tailored to each case including expertise from specialist DA services (particularly by and for services due to cultural nuances that are often missed in such cases).
- It is imperative that families have equal status during this process, with opportunities given to identify and address specific issues and support needs that may arise in decision-making relating to their participation, and support whether or not there is a criminal justice outcome.

## Suicide following Domestic Abuse

- As mentioned above suicide following domestic abuse and 'hidden homicide' has, until very recently, been relatively under-examined. This is despite the fact that Domestic Homicide Review (DHR) data and emerging DHR trends shown above indicate that domestic abuse has been increasingly identified as a casual factor related to deaths caused by suicide.
- Suicide following domestic abuse featured within the Government's Tackling Domestic Abuse Plan and the Police and Crime Commissioner for the West Midlands, Simon Foster, committed to highlighting the risk and prevalence of suicide following domestic abuse in his Police and Crime Plan 2021-2025.
- In 2021, the Office of the West Midlands Police and Crime Commissioner was successful in its application to the Home Office Domestic Abuse Perpetrator Research Fund to commission the University of Birmingham to undertake their research 'Domestic Abuse Links to Suicide'. The full report is available is available here.
- The research makes the following recommendations:

1. Develop and pilot an assessment tool which aims to identify the predictors of suicide by gathering information from the survivor; taking into account information outside of survivors' awareness as well as information they are conscious of:

a) Information survivors would be aware of might include: in relation to abuses; whether they had experienced life-threatening abuse; sexual assault/rape, coercion and control; multiple abuses and repetition of abuse. In relation to feeling states –despair, hopelessness and burdensomeness/ isolation/self-hatred. The number of relationships which have been disrupted or terminated. This should also elicit information about a survivor's perceptions of/relationship with the police (and health services) and may assist in building trust and any previous or childhood experiences which were trauma or terror-inducing, such as, some form of abuse, disaster (e.g., house fire), accident or medical procedure. In relation to coping strategies –whether they are using self-harm and/or alcohol and drugs to cope. A challenge will be to elicit an honest answer from the survivors who fear police action in response to admission of using illegal substances.

b) Information survivors would not be aware might include their own emotional and psychological state, such as whether they have depression or PTSD. Some of this information would be available from the CORE-10 questionnaire.

2. Develop and require commissioning/delivery by police forces and health services of training to ensure that police officers and health staff can:
   a) apply the newly developed assessment
   b) elicit information from survivors about sexual assault/rape without raising the risk of harm for the survivor (key contributors to survivor silence are shame and fear of police action against the perpetrator on the basis of a rape allegation, which will both prompt retribution from the perpetrator and subject the survivor to the intrusion experienced by victim-witnesses in rape cases)
   c) elicit information from survivors about the abuse of children in the context of support for them as the protective parent (a key contributor to survivor silence is fear of being accused of not protecting the children and the children being removed by social services)
   d) understand the key role services have in supporting survivors' self-identity and can act in a supportive way regardless of the constraints they operate under in terms of organisational process and procedure.
3. Develop guidance for police forces and health services to introduce and maintain a domestic abuse survivor suicide prevention/welfare pathway, with local statutory and VCS partners. The framework should contain the information in this report, and any other/up-dated information about how domestic abuse dismantles the

survivor's identity and the link with suicide translated into operational understanding and practice.

4. A small amount of additional funding is made available to explore the information collected in this research about the contact survivors had with services other than the police and health services i.e., children's social care, schools, housing, immigration services, the Family courts and voluntary and community sector services (community and residential domestic abuse services and the Samaritans).
5. More, and more nuanced research is commissioned to track the trajectory from abuse to suicidality and, in the process, to differentiate suicide ideation from suicidality. The research should incorporate evaluation of any of the above pilot activities.
6. More quantitative and qualitative research is undertaken to understand the high incidence of suicide amongst male perpetrators (and victims) of domestic violence. It would be valuable for this research to seek to understand the dynamic relationship between socio-economic status, substance abuse, domestic violence, and potential suicide."[2]

- This research will be presented by Professor Flowe on 26th April 2023 at the Suicide following Domestic Abuse Conference, a joint OPCC and West Midlands Police event with local, regional and national partners. This event intends to shine a much-needed spotlight on suicidality and suicide following domestic abuse and the whole systems approach that is critical to prevent future domestic abuse survivor suicides. This conference is designed to raise greater awareness of the link between domestic abuse and suicide through presenting both research and the voices of bereaved families. By doing so event hopes to drive discussion around policy and practice development that improves the way agencies and systems coordinate to prevent future deaths and effectively identify, investigate and respond where domestic abuse is a causal factor of suicide, whilst supporting those bereaved. Throughout the day, delegates will have the opportunity to explore:
    - The potential for prosecutions in cases of suicide following domestic abuse. A four-part case study and presentation will be delivered by the Crown Prosecution Service;
    - Changes to policy and practice that are taking place across the vulnerability space at a national, regional and local level;

[2] Christie, C., Rockey, J. C., Bradbury-Jones, C., Bandyopadhyay, S., & Flowe, H. D. (2023). Domestic Abuse links to Suicide: Rapid Review, Fieldwork, and Quantitative Analysis Report. https://doi.org/10.31219/osf.io/4t9ab

- The current local and national research in this area, including learning from the University of Birmingham's Domestic Abuse links to Suicide research and the Vulnerability Knowledge and Practice Programme;
- The support services that exist to support the families and friends affected by suicide following, suspected victim suicide/ suicide following domestic abuse;
- The critical issues in relation to suicide following domestic abuse through the voices of bereaved family members;
- The impact on children;

  Prevention, Intervention and the coordinated community response in the context of suicide following domestic abuse, including DHRs.