

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SAFEGUARDING ADULT REVIEW DOMESTIC HOMICIDE REVIEW

1.0 REVIEWS

1.1 Introduction

This procedure sets out the requirements for the Trust and staff to comply with the Safeguarding Adult Review Process of the Local Authority Safeguarding Adult Boards following Statutory Guidance from the Care Act 2014 and Home Office *Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews 2013*

1.2 Purpose

The Purpose of a Safeguarding Adult Review is to:

- Establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard adults
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and
- Improve inter-agency working and better safeguard and promote the welfare of adults at risk.
- Safeguarding Adult Reviews (SARs) are not inquiries into how an adult or who is culpable. These matters are for Coroners and Criminal Courts respectively.
- When there is a death or serious injury of an adult and abuse or neglect are suspected to be factors an assessment should be undertaken of whether there are other adults or children in the household/family who require safeguarding

1.3 Criteria

1.3.1 The responsible Local Authority Safeguarding Adult Board (LSAB) should always undertake a SAR whenever an adult dies (including by suicide) and abuse maltreatment or neglect is known or suspected to be a factor in the death.

1.3.2. The LSAB may also consider a SAR where a vulnerable adult has sustained a potentially life-threatening injury or serious, permanent impairment of physical, and/or mental health and development through abuse or neglect.

1.4 Process

- 1.4.1 Any agency or professional can refer a case for consideration for a SAR to the LSAB Safeguarding Manager via their own Safeguarding team

The LSAB Safeguarding Manager will consider if the circumstances of a case and make a recommendation to the LSAB SAR Panel

The Chair of the LSAB will decide if a case should be subject to a SAR within one month of notification and write to the Trust Chief Executive informing them of the decision, the scope and required timescales.

- 1.4.2 The Trust Executive Director for Clinical Governance & Quality will inform the Safeguarding Team who will immediately secure the service users and any other relevant records and inform the Trust Serious Incident Service Manager.

- 1.4.3 The Safeguarding Team in discussion with the Executive Director for Clinical Governance and Quality will:

- Appoint a Trust representative for the SAR Panel and
- Identify the most appropriate person to complete an Individual Management Review.

These two roles should remain separate

- 1.4.4 Where there is Trust Mental Health and Community Health involvement then the SAR Individual Management Review (IMR) will combine information to produce a single IMR

- 1.4.5 Where the Trust has instigated a Serious Incident Investigation then the SAR Panel should be informed to avoid duplicating the process. The Head of Safeguarding will be responsible for clarifying these processes with the Trust Head of Serious Incident service and the LSAB Panel.

1.5 Safeguarding Adult Review Panel

The role of the panel is to

- Agree the Terms of reference for the SAR
- Offer expert advice and information on services
- Gather and analyse all reports, information and agencies Individual Management Reviews
- Compile an Overview Report
- Make recommendations for implementation and monitor agencies compliance of those recommendations.
- Report progress, implications and recommendations to the Trust Safeguarding Group and Executive team as necessary

1.6 Individual Management Review (IMR)

1.6.1 The role of the IMR writer to complete an IMR within the timescales set in the Terms of Reference. The IMR writer should not have had any direct clinical involvement to ensure an objective analysis of the Trust involvement. An IMR will;

- Review all relevant case records on the vulnerable adult.
- Complete a comprehensive, factual chronology of involvement by the professionals in contact with the vulnerable adult
- Interview relevant staff and provide a summary to the interviewee
Compile a report which looks openly and critically at the involvement of professionals/services and contains analysis of the presenting facts
- Make recommendations and develop a SMART action plan.
- Identify any omissions in the Trust or LSAB Safeguarding procedures.
- Submit the IMR to the Trust Safeguarding Group and the Executive team for sign off prior to submitting the IMR to the LSAB

1.6.2 The Head of Safeguarding for Safeguarding will liaise with the Trust Communications department as necessary.

1.6.3 Any recommendations made in the IMR will be placed on the Trust Safeguarding Group action plan and can be implemented as soon as possible. Any subsequent recommendations made from the LSCB will also be placed on the action plan and monitored for compliance.

1.6.4 Once the Individual Management Report has been submitted to the LSAB a feedback process and debriefing for staff involved should take place.

1.6.5 A summary of the outcomes and recommendations of the LSAB Overview Report will be presented to the Trust Safeguarding Team and reported to the Executive Team as required.

2.0 DOMESTIC HOMICIDE REVIEW (DHR)

2.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). Section 9 of the Act was brought into force on 13th April 2011.

The Government's current approach to tackling domestic violence is set out in the national Ending Violence Against Women and Girls strategy (2016-2020), which was published on 8th March 2016.

In April 2011 the Government issued national guidance to assist partnerships when conducting a Domestic Homicide Review: 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' (Home Office). This was reviewed in June 2013, with instructions that this guidance was to take

effect for any Domestic Homicide Review notified from 1st August 2013 onwards.

Following a review of the 2013 Guidance, the Government issued revised national guidance to assist partnerships when conducting a Domestic Homicide Review in December 2016.

3.0 DEFINITION

- 3.1 A Domestic Homicide Review, under the terms of the above Act, means ‘a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –
- A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or
 - A member of the same household as himself,
 - Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.

Held with a view to identifying the lessons to be learnt from the death.

- 3.2 When this definition has been met, a Domestic Homicide Review must be undertaken.

It should be noted that an ‘intimate personal relationship’ includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexual orientation.

- 3.3 In March 2013, the Government introduced a cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

“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

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of

the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

- 3.4 In December 2015, a new domestic abuse offence to tackle coercive and controlling behaviour was commenced in legislation. More information about controlling and coercive behaviour in an intimate or family relationship can be found in the statutory guidance:

<https://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship>

This definition includes so-called 'honour-based' violence and includes crimes such as female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

So-called 'honour-based' violence, sometimes referred to as "honour crimes" or "honour killings", encompasses crimes or incidents which are committed to protect or defend what is considered to be the 'honour' of the family or community. Victims may be 'punished' for not complying with what the family and/or community believe to be the 'correct' code of behaviour and therefore viewed as bringing 'shame' or 'dishonour' on the family or community. It is important to note that notions of 'honour' may not be obvious; victims may not identify or perceive what has happened as 'honour-based' violence.

Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. DHRs are not about who is culpable.

- 3.5 A member of the same household is defined in section 5 (4) of the Domestic Violence, Crime and Victims Act [2004] as:

a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it; where a victim lived in different households at different times, "the same household as victim" refers to the household in which victim was living at the time of the act that caused victim's death.

4.0 PURPOSE

4.1 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

4.2 It is, however, important to note that reviews should not simply examine the conduct of professionals and agencies. Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions.

4.3 The narrative of each review should articulate the life through the eyes of the victim (and their children) and talking to those around the victim including family, friends, neighbours, community members and professionals. This will help reviewers to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why any interventions did not work for them. The key is situating the review in the home, family and community of the victim and exploring everything with an open mind. It will also help understand the context and environment in which professionals made decisions and took (or did not take) actions. This would include, for example, the culture of the organisation, the training the professionals had, the supervision of these professionals, the leadership of agencies and so forth.

4.4 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action should be initiated, the established agency disciplinary

procedures should be undertaken separately to the DHR process. Alternatively, some DHRs may be conducted concurrently with (but separate to) disciplinary action.

- 4.5 The rationale for the review includes ensuring that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence. The review will also assess whether agencies have sufficient and robust procedures and protocols in place which were understood and adhered to by their staff

5.0 PROCESS

- 5.1 When a domestic homicide occurs, the relevant police force should inform the relevant Community Safety Partnership (CSP) in the Local Authority where the victim was normally resident.
- 5.2 The Local Authority CSP will contact statutory agencies, and request confirmation about whether the victim, the suspected perpetrator and wider family members are known to each organisation. Once this information is considered by the Local Authority CSP, organisations will be notified about whether criteria for a DHR are met, giving consideration to the definition set out in section 1 of the 2004 Act (see section 2). The Local Authority CSP will then arrange a Domestic Homicide Review Panel.
- 5.3 Agencies required under statute to participate under the above guidance in any future DHR are:
- Chief officers of police for police areas in England and Wales;
 - Local Authorities;
 - Providers of probation services;
 - Local Health Boards established under [section 11 of the National Health Service (Wales) Act 2006];
 - NHS trusts established under [section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006];

Other relevant agencies may be required to participate in the DHR at the request of the Review Panel.

- 5.4 When victims of domestic homicide are aged between 16 and 18, a child safeguarding practice reviews should take precedent over a DHR.

6.0 REVIEW PANEL

- 6.1 The Trust Head of Safeguarding is a Core Member of the DHR Core Group which is chaired by the SET DA team with local CSP representation. A member of the safeguarding team will be part of the review panel.
- 6.2 The Review Panel will establish the existence of any other ongoing reviews, such as a child practice reviews or safeguarding adult review (SAR) or Serious Incident (Serious Incident), which will need to be considered as part of the decision to undertake a DHR
- 6.3 It should be noted that Trust covers several local authority areas and as such DHR processes may differ slightly. For example the Review Panel may be a fixed, standing membership or be created on a bespoke basis for the purposes of undertaking a particular DHR.
- 6.4 Where the Trust has instigated a Serious Incident Investigation then the DHR Panel should be informed. The Executive Director for Clinical Governance & Quality will be responsible for clarifying these processes with the Trust Head of Serious Incident, Head of Safeguarding and the DHR Panel. These two processes should be coordinated and integrated in order to avoid unnecessary duplication (including interviewing staff more than once) and maintain the principles of good practice, wherever possible.
- 6.5 The role of the panel is to:
- Agree the Terms of reference for the DHR
 - Offer expert advice and information on services
 - Gather and analyse all reports, information and agencies Individual Management Reviews
 - Compile an Overview Report
 - Make recommendations for implementation and monitor agencies compliance of those recommendations.
 - Report progress, implications and recommendations to the Trust Safeguarding Group and Executive team as necessary

7.0 INDIVIDUAL MANAGEMENT REVIEW

- 7.1 The Executive Director for Clinical Governance & Quality in conjunction with the Head of Safeguarding or Relevant Director will be responsible for appointing an IMR writer. The IMR author should have experience and training in writing such reports e.g. Serious Incident Reports, Root Cause Analysis methodology etc. The IMR author should not have had any direct clinical involvement to ensure an objective analysis and should not be the direct line manager of the Trust representative on the Domestic Homicide Review Panel (DHRP).

- 7.2 Where the DHR involves a number of Trust service users from Mental Health and Community Health services the process will be combined to formulate one IMR report on behalf of the Trust.
- 7.3 Where there is a child involved, there may be a Safeguarding Children Practice Review. In these circumstances the SAR process for the child will take place separately to the DHR. However both IMR writers should meet to identify joint working and avoid duplication where possible.
- 7.4 The IMR writer should:
- Secure immediately all relevant records.
 - Review records and complete a comprehensive, factual chronology of involvement by the professionals in contact with the service users involved
 - Interview relevant staff and provide a summary to the interviewee
 - Compile a report which looks openly and critically at the involvement of professionals/services and contains analysis of the presenting facts
 - Develop a SMART action plan.
 - Identify any omissions in the Trust or DHR procedures.
 - Submit the IMR to the Trust Safeguarding Group and the Executive team for sign off prior to submitting the IMR to the DNR Panel
- 7.5 Where lessons are able to be drawn out they should be acted upon as quickly as possible without necessarily waiting for the DHR to be completed.
- 7.6 An IMR should be completed as per the terms of reference (usually within one month of notification) and make recommendations for an action plan.

8.0 OVERVIEW REPORT AND RECOMMENDATIONS

- 8.1 The Review Panel will combine relevant parts of IMR to formulate an Overview Report. This must be completed within six months from the time the Panel agreed the DHR. In some circumstances this timescale can be extended e.g. judicial proceedings
- 8.2 Once the Individual Management Report has been submitted to the DHR Panel, feedback process and debriefing for staff involved should take place.
- 8.3 Any recommendations made in the IMR will be placed on the Trust Safeguarding Group action plan and can be implemented as soon as possible. Any subsequent recommendations made from the DHR Panel will also be placed on the action plan and monitored monthly for compliance.
- 8.4 A summary of the outcomes and recommendations of the Overview Report will be presented to the Trust Safeguarding Team where necessary.

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- 8.5 DHR are not part of any disciplinary enquiry or process, but information that emerges from the Individual Management Review could indicate that actions may be required, including disciplinary action. In these circumstances the Executive Director for Clinical Governance & Quality should be informed.
- 8.6 The Head of Serious Incidents and Head of Safeguarding will inform the Executive Team in the Serious Incident Update Report of any new or existing DHR's where the Trust is involved. This will include any potential criticism of the Trust or its staff.
- 8.7 The Head of Serious Incidents and Head of Safeguarding will be responsible for timely sharing of information about potential criticism of the Trust or its staff with the Communications Team.

9.0 RESOURCES

- 9.0 [Southend Essex Thurrock Domestic Homicide Protocol. update August 2019](#)

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