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To: **Kent Community Safety Partnership – 18th March 2014**

Classification: **For Information**

Subject: **Lessons Learned from Domestic Homicide Reviews (DHRs)**

Summary: This paper provides a summary of the key lessons identified locally and nationally from completed Domestic Homicide Reviews and explains how these will be cascaded to practitioners across Kent and Medway.

1.0 Background

1.1 The Home Office's Domestic Homicide Review Guidance states that, "All agencies involved in DHRs have a responsibility to identify and disseminate common themes and trends across review reports, and act on any lesson identified to improve practice and safeguard victims".

1.2 In November 2013 the Home Office issued a report outlining the common themes it had identified from the DHRs submitted to them for quality assurance. The majority of these themes have also been identified as issues within our Kent and Medway DHRs.

2.0 Common Lessons Learned from Completed Domestic Homicide Reviews

2.1 **Awareness Raising and Communication** – There is a lack of understanding by practitioners about what types of behaviour constitute domestic abuse, with some agencies only seeming to recognise physical abuse and not the danger posed to victims through power and control based abusive behaviours.

2.2 **Awareness and Training for Healthcare Professionals** – GPs responses in particular to domestic abuse has been highlighted nationally, and within the majority of the Kent and Medway DHRs, as being inadequate. Disclosures to healthcare professionals (domestic abuse and other safeguarding issues) are not always followed up and there is a lack of knowledge about how to respond to domestic abuse.

2.3 **Risk Assessment** – Agencies need to ensure that there is a consistent approach to the implementation of risk assessment and safety planning. Risk assessments should be reviewed to capture any changes in risk and further training in risk assessment and management is needed by some agencies.

2.4 **Information Sharing and Multi Agency Working** – In some cases there has been inadequate information sharing and a lack of interagency referrals which could have led to additional support being provided to victims. Several of our Kent and Medway DHRs have involved families moving around from area to area and the difficulties of

accessing /transferring agency records when moving areas was also found to be a barrier to timely information sharing.

2.5 **Complex Needs** – In some DHRs those involved had a variety of different needs e.g. domestic abuse, sexual abuse, alcohol misuse, drug misuse and mental health illness. Often agencies were still silo working, dealing with their own specialist area of expertise and were not considering a multi-agency response to help with the other issues individuals were experiencing.

2.6 **Perpetrators and Bail** – Inadequate information sharing about releases on bail or from prison and a lack of compliance with procedures following breach of bail conditions has been found in some cases nationally, along with a lack of suitable accommodation on prison release, meaning that domestic abuse perpetrators have returned home to continue the abuse.

2.7 **Safeguarding Children** – When children have been in the families involved in DHRs on some occasions there have been missed opportunities to refer them to Children's Services and some agencies when working with the adults in the family do not seem to have considered the children's needs.

3.0 Implementing Kent and Medway's Lessons Learned

3.1 It is up to each local area to consider what type and level of information needs to be disseminated for each DHR to ensure that learning is disseminated to the local MARAC (Multi Agency Risk Assessment Conference) partners, local Domestic Abuse Forums or similar, Local Safeguarding Children Boards and commissioners of services.

3.2 To meet this responsibility the Kent and Medway DHR Steering Group have organised three Lessons Learned Seminars to disseminate the key lessons and themes identified from our completed DHRs to front line practitioners. Additionally all completed DHRs are published on both the Kent and Medway CSP pages on both councils' websites.

3.3 The Lessons Learned Seminars are being held in different locations across Kent and Medway, during January, February and March 2014, and it is anticipated that in total approximately 360 practitioners will attend. The Independent Chairs will present each case and its findings and the key agencies involved in the reviews will also be present to discuss the changes that they have made as a result of their involvement in the DHRs.

3.4 All delegates will receive a follow up questionnaire asking for feedback on whether the seminars have assisted them to develop/adapt their practice once they have had the opportunity to reflect on the themes and issues presented and discussed these within their own teams and/or organisations.

3.5 Further Lessons Learned Seminars will be arranged during 2014 to disseminate the key lessons and themes identified in the other DHRs we will have completed.

Further reading:

Home Office Lessons Learned Report:
www.gov.uk/government/publications/domestic-homicide-review-lessons-learned

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