DOMESTIC HOMICIDE REVIEW (DHR)

LEARNING BRIEF - STEVE

Domestic Homicide Review (DHR)

The Domestic Violence, Crime and Victims Act (2004) defines a Domestic Homicide Review as 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. This multi-agency process seeks to identify lessons to be learnt from the death and prevent harm from happening in similar circumstances in the future.

More information on the DHR process can be found on the KBSP website.

Background information - Steve

The Keeping Bristol Safe Partnership commissioned this DHR following Steve taking his own life in April 2021.

Steve was aged 24 at the time of his death. In April 2021, police were called by the ambulance service to Steve's rented accommodation where he had been found hanging in his room by two housemates and Steve's mother.

The police conducted a comprehensive investigation and, as there was no third-party involvement, the matter was passed to the coroner and the inquest concluded death by suicide.

The review was commissioned based on the recorded events of domestic abuse by his father during the relevant period prior to Steve's death.

The facts - an overview

Steve was staying in lodgings with a couple at the time of his death, having lived in the family home with his father until a few months previously.

Steve had a disjointed upbringing, living with his father and grandmother for a period, during which he had been diagnosed with ADHD, possible low self-esteem and potential communication and learning needs. Aged 15, Steve moved back in with his mother following disruptive behaviour and two school moves.

Aged 17, following medical procedures and undiagnosed abdominal pains, Steve developed a dependency on medication.

As a young adult, Steve moved back in with his father and took up work as a scaffolder. He had a partner with whom he had a child but had restricted access following one reported incident of domestic abuse (August 2018).

During the relevant period, police attended seventeen incidents involving Steve (including the incident above). Most incidents were of a domestic nature between Steve and his father. On one occasion his father was arrested, charged, and convicted for an assault against Steve. His father was then supervised by the Community Rehabilitation Company prior to the re-integration into the Probation Service. Steve remained resident with his father in the same accommodation (Father's house) and when he sought housing he was not identified as having priority need (victim of DA).

The practical effect of COVID-19 at the time was also to isolate Steve and his father from others and require them to remain in the same household.

Other linked incidents also included attempts by Steve to take his own life (Overdose August 2018, and attempted hanging December 2020).

The review highlighted elements of controlling behaviour by Steve's father (reportedly having to seek permission to use the kitchen and bathroom) and potential financial abuse (in respect of rent paid to father) in addition to physical abuse.
Steve's drug habit also extended to illegal drugs, reportedly being in debt to drug dealers, and that with reported letters from HMRC proximate to his death added to Steve's worries.

Learning points

Vulnerabilities: The intersection of multiple vulnerabilities (substance misuse, mental health) and worries (child access, COVID-19) is apparent from this review.

Suicide Prevention: The review identified opportunities to strengthen the local strategic approach to suicide prevention by seeing it through the lens of domestic abuse and to consider the merits/practicalities of suicide safety planning.

Recognition & response (R&R): There remains a need for improved R&R of DA via professional curiosity, training, routine enquiry and recognising suicide/self-harming links to DA.

Unconscious bias: The risk of unconscious bias was apparent, not recognising familial abuse as DA, and thinking a young fit scaffolder could be at risk of such abuse.

Call Handling: Opportunities to seek assurance around police call handling to the same location and decisions to take no further action being in accordance with policy.

Partnership working: Steve's circumstances did not benefit from a multi-agency perspective of the relationship between father and son where escalating risk was not identified, with the case being heard only once at MARAC despite multiple domestic abuse related contacts.

Risk Management: An opportunity to strengthen the development of probation risk management regarding domestic abuse in the planned redesign of risk tools in the redesign of systems.

Good practice

GP: Communication between MARAC and GP

Children's Services: embedding of domestic abuse practitioners and use of 'signs of safety' model within the service.

Police: Significant cultural change programme together with performance and quality assurance regime plus DA procedural guidance.

Hospital: Mainstreaming of HEADSS (Home, Education/ Employment, Activities, Drugs, Sex and relationships, Self-harm and depression, Safety) initiative for patients plus IDVA provision.

Education services: Operation Encompass and use of an 'Alert Board' for supporting safe pick up and drop off for parents/carers.

Housing: Seeking DAHA accreditation plus a housing IDVA embedded into service.

Recommendations

Recommendation 1: Bristol City Council (Public Health) is to ensure that the link between all victims of domestic abuse and suicide is strengthened and plans to reduce suicide are embedded into partnership work on domestic abuse.

Recommendation 2: The ICB is to improve the ability of GPs to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse.

Recommendation 3: The GP practice seeks assurance that it has a system in place that demonstrates the recording of "suicidal ideation or thoughts of self-harm" using the codes as per the system of software in place for patient records.

Recommendation 4: Public health to explore the evidence-base for the routine use of 'safety planning' tools for those who express suicidal ideation and/or have attempted to take their own lives within the suicide prevention strategy.

Recommendation 5: A&S Police are to ensure that call handling policies and protocols ensure that all outstanding calls to a location are dealt with by the first attending police unit.

Recommendation 6: A&S Police should conduct assurance work around Domestic Abuse NFA authorisations to check for adherence to current policy. The audit should inform the next steps to be taken to address findings.

Recommendation 7: The Bristol MARAC steering group set a threshold for repeat domestic incidents that results in automatic referral to MARAC, reassures itself that there are no unnecessary delays in referral of cases to MARAC and makes necessary policy adjustments.

Recommendation 8: KBSP to coordinate a broad communication campaign targeting professionals and communities to raise awareness of domestic abuse and male victims, and to ensure male survivors know where to go for support.

Recommendation 9: UBHWT: Seek to improve the identification of domestic abuse victims by, - emending policy to incorporate self-harm/suicidal ideation as an indicator of abuse, - by adapting the self-harm template to incorporate enquiry about domestic abuse and deliver training on unconscious bias.

Recommendation 10: Victim support is to ensure that all MARAC actions mentioning VS are followed up.

Recommendation 11: The learning from this review is shared across the partnership to raise awareness of domestic abuse including interfamilial abuse, links to suicide and all the learning opportunities raised.

Support

Abuse and violence is not acceptable. If you or someone you know is a victim, report it and get help.

Call 999 if a crime is happening now or you're in immediate danger.

How to report it if you are not in immediate danger:

- call 101 or Crimestoppers on 0800 555 111
- fill in the online crime form (avonandsomerset.police.uk)
- visit your local police station

Domestic Abuse

Next Link Plus offers specialist domestic abuse support for women, men and children and young people from all communities (including LGBTQ+ and black and minority ethnic). Next Link Plus also offers support with any additional needs (for example substance use).

Call 0117 925 0680, text 07407 895620, email enquiries@nextlinkhousing.co.uk or online chat via the website.

If you, or someone you know, is experiencing thoughts of suicide, contact the National Suicide Prevention Helpline UK on 0800 689 5652, open 24/7.

ManKind Initiative

The ManKind Initiative is a specialist charity in the UK focusing on supporting male victims of domestic abuse. The service offers a confidential helpline, practical advice, emotional support, signposting to local services, and resources to help men escape abusive situations. They also work to raise awareness and improve policy responses to male domestic abuse.

Call the confidential helpline Monday – Friday 10am to 4pm (excluding bank holidays)
FREEPHONE 0808 800 1170
HELPLINE 01823 334 244

Where to find us:

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www.bristolsafeguarding.org