DOMESTIC HOMICIDE REVIEW (DHR)

LEARNING BRIEF - CHARLOTTE

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 - Charlotte

Charlotte (pseudonym) was in her 20s when she died by suicide in March 2022. Her previous partner, Darren (pseudonym), had completed suicide months earlier.

Charlotte, around the time of her death, was being supported by services after disclosing that she had experienced domestic abuse committed by Darren. Charlotte and Darren had been in a relationship for many years and had a child together.

Key themes: mental health, suicide, and domestic abuse.

Key Learning

Understanding the Links Between Suicide and Domestic Abuse

The review indicated that links between domestic abuse and suicide were not understood by those working with Charlotte. Charlotte had first disclosed thoughts of suicide and had explained that these feelings had resulted from the domestic abuse committed by Darren. Research on intimate partner violence, suicidality and self-harm shows that past-year suicide attempts were two to three times more common in victims of intimate partner violence than non-victims. The recent 5-year cross-sector strategy for suicide prevention in England recognises domestic abuse as a risk factor for suicide. In Bristol, the suicide prevention strategy is currently being reviewed and will include the recognition of the links between domestic abuse and suicide.

Perpetrator Management and Prevention Strategies

Darren had a significant offending history, including being the perpetrator of domestic abuse in two previous relationships. The review highlighted that Domestic Violence Protection Notices and the Domestic Violence Disclosure Scheme provide opportunities for multi-agency coordination where domestic abuse is present in relationships. The review also highlighted the importance of the DRIVE Project which is a multi-agency collaboration to tackle domestic abuse by working directly with those presenting abusive behaviour, as well as the Building Better Relationships programme which Darren was required to attend after being convicted of an assault on an ex-partner.

Child Protection Meetings and Multi-Agency Involvement

The review highlighted a lack of wider agency involvement in child protection strategy meetings which prevented Charlotte's needs from being fully considered. As only a limited number of agencies were invited to the strategy meeting, which did not include domestic abuse services, this prevented the development of a comprehensive multi-agency plan and limited the ability to gain a holistic picture of the family's circumstances. The review has recommended that a wide range of agencies are included within strategy discussions, such as including domestic abuse services for all domestic abuse related cases, regardless of involvement with the victim, and perpetrator intervention services, if they are working with the perpetrator.

Good Practice

Rapport and Relationships

Support workers from Elim Housing and Places for People showcased good practice in regularly assessing Charlotte, sharing information with partners in response to domestic abuse, and carrying out consistent submissions of information for child safeguarding referrals.

Service Engagement with Darren

The family nurse partnership and midwifery services showed proactive engagement with Darren to help them understand the male figures in the child's life, and to manage any risk which he posed. Both services consistently shared information, and were involved in child protection arrangements.

Responses to Risk and Referrals

The review highlighted examples of good practice from the Next Link support worker in responding to referrals from the family nurse, and completing a Domestic Abuse, Stalking, Harassment, and Honour-Based Violence (DASH) risk assessment when appropriate. Following the DASH risk assessment, a support plan was agreed and put into place with Charlotte's needs at the forefront, such as support for a housing move request, legal advice about Darren's conduct, and support to manage abusive relationships. Next Link also shared necessary information to the Police following the implementation of the safety plan which led to referrals to other agencies for further support.

Recommendations

- **Recommendation 1:** Each organisation that uses the DASH risk assessment tool should review its policy and guidance.
- **Recommendation 2:** Each organisation should review its policy for the third party reporting of crimes to the police.
- **Recommendation 3:** The Bristol Multi-Agency Risk Assessment Conference should review the current published arrangements and referral criteria, ensuring that the arrangements are clear and widely promoted within Bristol.
- **Recommendation 4:** The Avon and Somerset Constabulary should present its plans to manage serial perpetrators of domestic abuse to the KBSP, outlining how this will be achieved and how it will measure ongoing performance.
- **Recommendation 5:** MARAC Chairs should receive training in the management of serial perpetrators of domestic abuse, to provide the confidence to challenge and hold agencies to account.
- **Recommendation 6:** The KBSP Safeguarding Children's Partnership should seek assurances from Bristol Children's Services about the application of its multi-agency strategy discussion protocol and should consider how agency involvement is regularly monitored.
- **Recommendation 7:** When cases involve domestic abuse, the domestic abuse services should be included within strategy discussions and consideration always given to being included in core groups. Perpetrator intervention services should be included in cases where they are working with the perpetrator.
- **Recommendation 8:** Bristol Children's Services should consider the training requirement of its managers who chair child protection processes, in addition to the independent chairs of child protection conferences.

- **Recommendation 9:** The KBSP should consider the development of a comprehensive multi-agency training package, to develop a consistent understanding of domestic abuse and suicide, enabling professionals to develop multi-agency support plans. This should also consider how the learning identified in this DHR may contribute to the Bristol Suicide Prevention Strategy 2025-2028.
- **Recommendation 10:** The Bristol, North Somerset and South Gloucestershire Integrated Care Board, should consider the learning from this DHR, as to how babies and young children should not be seen as protective factors in parental suicide, and liaise with the appropriate body to consider the development of national guidance.

Support

Next Link

The Next Link Plus service offers specialist domestic abuse support. Call 0117 925 0680, text 07407 895620, email enquiries@nextlinkhousing.co.uk or online chat via the Next Link website

Women's Aid Survivor's Handbook

Women's Aid have published a survivor's handbook which provides practical support and information for women experiencing domestic abuse. Women's Aid also has a live chat service.

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

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.

Where to find us:

KBSP@bristol.gov.uk

@KBSPartnership

www.bristolsafeguarding.org