Diogelu Gwent
Gwent Safeguarding

VAWDASV
Violence Against Women, Domestic Abuse and Sexual Violence
Trais Yn Erbyn Menywod, Cham-drin Domestig a Thrais Rhywiol

# Domestic Homicide Review using the Adult Practice Review (DAPR 2-2018) Methodology – Background and context Pilot 2

**Context**

This report describes the methodology used and some of the challenges identified. It is intended to be shared with the Safeguarding Board, the CSP and panel members' organisations but not for publication or sharing with the family. The reviewers will be sharing this report with the Home Office and Welsh Government.

Gwent established a Task and Finish Group to review the local arrangements for conducting DHRs. As a result a DHR was conducted using the APR Methodology. This was in agreement with Welsh Government and the Home Office. The report was presented to the Home Office in December 2017 and published in August 2018. Support was in place from the Public Service Board (PSB).

It was acknowledged that there was not a history of Domestic Abuse and it was agreed that a further pilot be conducted where Domestic Abuse was known and if possible that there was involvement from Probation.

Locally we were informed of a Case within Cwm Taf and it was suggested that the Reviewers undertake that review. A briefing paper was written (Appendix 1) and the Cwm Taf Regional Safeguarding Board Business Managers ensured that this was presented at the appropriate meetings to ensure the appropriate governance was in place.

**Governance**

The Police referred the case to the Cwm Taf Community Safety Partnership (CSP) who agreed that this case met the criteria for a DHR. The first panel meeting was held on 05/10/2017 where it was agreed that the DHR process would be suspended to allow the criminal process to be concluded. The panel reconvened in July 2018 and reviewers identified with further meetings held September 2018 and January 2019. Following the January meeting discussions were held with safeguarding and PSB partners in Gwent following the completion of the first D-APR in Gwent.

It was agreed that when reconvening the DHR it would be concluded using the APR methodology with the Reviewers from Gwent supporting. This was in partnership with the Home Office, Cwm Taf CSP and Welsh Government.

The first meeting of the reconvened process was on 10th June 2019 and the Learning Event held on 18th September 2019.

When the panel met in June they were mindful that there had already been considerable delay and were keen to conclude the process in a timely manner to ensure learning and set an ambitious target to have a report available to take to the Safeguarding Boards and CSP in December 2019.

Key dates were set but unfortunately one of the 2 dates to review the report were cancelled. A further date was made but not all panel members were able to attend. This and other commitments of the reviewers meant that the report was not agreed in time to be taken to the December Safeguarding Board in Cwm Taf.

Each partner agency had requested Individual Management Reports which had all been completed by September 2018.

The Reviewers sought to meet with Adult A but he declined but did agree for access to all of his records.

**Findings**

<u>Engagement from stakeholders</u>

The information from Mental Health services was incomplete and the Health Board panel member requested additional information on more than one occasion. The panel were not confident of the quality of the information provided. An example of incomplete information was that the Reviewers were not able to identify when Adult A had been admitted to hospital as a Mental Health patient and what his status was.

Mental Health Services did not seem to understand their role or importance of the information they provided as part of the learning and scrutiny by the panel. The Reviewers and panel did not have sufficient information and this necessitated the two reviewers undertaking a day's research within the mental health setting conducting their own review of the mental health records in relation to the perpetrator. This was unusual and not part of the expected reviewer role, but felt necessary to ensure detailed knowledge of key events and background was understood to inform the review.

Panel members had requested more detail about Adult A's mental health be included within the report. As Reviewers we were clear that the focus remain on the victim and other mechanisms would need to be used if there was more specific learning for Mental Health in relation to his care and treatment. The reviewers recognised that the Mental Health of Adult A was significant in this review and tried to ascertain what other reviews had taken place or were considered for example whether a Mental Health Review was considered.

A blended review that considered both the Domestic Abuse and the impact of Adult A's mental health would have been helpful and provided further learning for mental health services.

**Engagement with family and friends**

The Reviewers met with the victim's son and other family members. At the time of the meeting they were offered information regarding advocacy services specifically following a Domestic Homicide. They advised that they had ongoing contact with the Police Family Liaison Officer.

They had understood that the review was about practitioners learning from the events leading up to Rose's death. The family had understood that we would feedback the outcome of an investigation about Adults A's care and treatment, which we were unable to do. They had not been aware that this review was about Rose as a victim. We explained the purpose of a Domestic Homicide Review. The family continue to have unanswered questions in particular about the status of Adult A at the time of the assault.

The DH-APR gave the family an opportunity to be the voice of their loved one and ensure all aspects leading to her death are understood from the family's perspective. The family spoke at length about the relationship between the perpetrator and Rose and the events leading up to her death with compassion and thoughtful consideration of the details and wider influences on the whole family.

The specific question about the review of Adult A's care and treatment was fed back to the Chair of the DH-APR for further action.

**Learning Event**

All of the agencies who attended the learning event had prior knowledge and different levels of involvement with Rose and Adult A. All demonstrated a good knowledge of them and spoke of

their complex relationship. They brought Rose alive at the event, although it was clear that while all practitioners knew of Rose their professional role was with Adult A.

Feedback from participants was positive and the learning event provided an opportunity to discuss what had been a really traumatic event for them individually as practitioners and as a group. For many professionals it was an opportunity to discuss their understanding of what was meant by coercive control and raise awareness of how they can identify within their practice key issues and understand the wider VAWDASV agenda. Training requirements for individuals as well as teams and specific agencies were identified.

At panel meetings the status of Adult A's CTO particularly at the time of the assault was discussed at length. While it was acknowledged that the learning event focus was on Rose it was recognised that there would need to be some discussion about Adult A. To this end some of the key decision makers were invited. Unfortunately only Nursing staff attended with no decision makers or medical staff in attendance which others at the event noted and felt was a missed opportunity to understand the decision making for example ending the CTO. Panel members need the support of senior staff to ensure key professionals are supported to attend learning events.

**Other points for consideration**

The reviewers offered to support this review as they were keen to gain experience of DHRs in other settings and to consider whether this proposed DH-APR methodology works, and if this can be repeated. However although a tight timeframe for completion was set, not being there at the outset meant that as reviewers you were always trying to catch up with panel members about their knowledge of the case.

The delays meant that for the learning event some practitioners had already left their organisations. For others they described a traumatic event that they had been unable to gain closure on as there was always another review or action outstanding. This does not aid learning and for some it felt punitive. The methodology is aimed at a timely and responsive review to support learning and immediate improvements for practice. For this review the learning event was held more than 3 years following the assault, practitioners and practice had changed.

Prior to commencement of the first pilot, briefings had taken place at the Regional Safeguarding Board and each of the 5 Gwent Public Service Boards. This meant that receiving governance structures understood the aims and objectives of the pilot using this methodology. On presenting the report to the CSP there was a lack of understanding of the methodology used.