



Refuge's Response to 'Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004'

September 2006

Refuge

Founded in 1971, Refuge has grown from a small charity, pioneering the world's first refuge, to be the country's largest single provider of specialist accommodation and support for women and children escaping domestic violence. On any given day, we support over 900 women and children in our refuges and through our community based outreach services.

Refuge runs award winning media and advertising campaigns to raise public awareness of domestic violence nationally and internationally, whilst also campaigning and lobbying for better provision for women and children experiencing domestic violence.

Introduction

1.1 Refuge regards the government's intention to establish domestic homicide reviews across England and Wales as positive. Creating a forum through which agencies can learn lessons about domestic violence deaths and improve practice to prevent future tragedies, is an important element in any plan to combat domestic violence in our society.

1.2 Refuge believes that processes of investigation and of review in relation to unexpected deaths or homicides within a domestic violence context are vital if we are to properly understand the circumstances, as well as the causes of those deaths. Refuge anticipates that domestic homicide reviews will fulfil an important function by allowing agencies to analyse confidentially their involvement with these victims and their families and in so doing influence appropriate changes within and between local systems. It is hoped that the dissemination of aggregated review findings (national and regional) and the implementation of recommendations which follow, will lead to reductions in the numbers of domestic violence deaths and improved services for those who survive. Nevertheless, Refuge has some concerns about the process which are detailed within the body of this response.

Background

2.1 The system of strategic inquiry into deaths resulting from abuse within a domestic context developed in the 1970's following the inquiry, headed by Mr Field-Fisher QC, into the brutal killing of seven year old Maria Colwell in 1973 by her step-father. This inquiry shocked the nation, as have the other high profile inquiries into the deaths of vulnerable children that have followed. Yet what is perhaps more shocking, is the similarity of the findings and recommendations across these inquiries over time, despite significant changes in both legislation and systems of child protection; the implication seems to be that agencies are either failing to put recommendations into practice or lessons are not being learned.

2.2 Although the public inquiry process appears to have been successful in highlighting many practice errors, increasing the public's awareness of child protection and reforming legislation and practice, it has also been criticised for being particularly costly in terms of time and money. Concerns have also been levelled at its inherently legal bias and negative, judgemental approach, which are thought to result in defensiveness on the part of professionals¹ and mistrust on the part of the public.

2.3 In an attempt to improve this system of inquiry and to encourage agencies to openly express and learn from any failings, a confidential system of local review was developed; this was initially termed a Part 8 Review (established under the Children Act 1989) and is now known as a Serious Case Review. During the last 15 years, reviews of this type have tended to replace public inquiries into childhood deaths from abuse or neglect, with only a handful of instances continuing to reach the public domain, such as that of Victoria Climbié. Whilst the serious case review process has advantages in terms of confidentiality and openness for local agencies who might have been involved with the victim, there are disadvantages in terms of a lack of external scrutiny or objectivity, limited dissemination of review findings² and recommendations and therefore limited dissemination of lessons learned. Although government made a commitment to aggregate and report on serious case reviews every two years³, there has been only one report⁴ since that time which considered 40 serious case reviews, despite the fact that around 90 reviews are held annually. This and other research into the serious case review process indicates that similar problems consistently recur over time, such as weaknesses in terms of communication, assessments, resources, policies and procedures⁵ which leads one to wonder about the effectiveness of the process in promoting enduring and widespread change. In view of these short comings, Refuge is concerned that government proposes domestic homicide reviews should operate along the same lines as serious case reviews.

Domestic Homicide Reviews

3.1 As mentioned above, Refuge is supportive of a process for reviewing domestic homicides, but would like assurances that this process will not become a replacement for the more rigorous Article 2 compliant inquiries and/or inquests conducted by Coroners, thereby mirroring the way in which serious case reviews have tended to replace other forms of inquiry into child death from abuse or neglect. Furthermore, Refuge is concerned that both the process and the full findings of the domestic homicide review are intended to be confidential, believing this offers too much opportunity for cover-up, a lack of external scrutiny, limited involvement of families and insufficient opportunity for lessons to be widely disseminated to professionals and the public.

¹ Corby (2003) 'Towards a new means of inquiry into child abuse cases' *Journal of Social Welfare and Family Law* 25(3) 229-241

² This is generally an executive summary of findings disseminated locally with a copy of the full report sent to the department of health

³ Department of Health (1999) *Working Together to Safeguard Children: A guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children*.

⁴ Sinclair & Bullock (2002) '*Learning from Past Experience: A Review of Serious Case Reviews*' Department of Health.

⁵ Reder & Duncan (2004) Making the Most of the Victoria Climbié Inquiry Report. *Child Abuse Review Vol 13: 95-114*

3.2 Refuge believes an improved and enhanced approach to investigative Article 2 Inquiries⁶ could provide a more open form of review and that there is an opportunity to develop further this process via the current Coroner's Bill (2006)⁷ and allied proposals to reform this service. Refuge believes that an enhanced coronial inquiry has the potential to be superior to the serious case or domestic homicide review in that it would have powers to request records, to summon witnesses and to publicly hold systems to account where appropriate. In fact Harriet Harman (Minister of State for Constitutional Affairs) went so far as to state "*In the House we have recently legislated for homicide reviews in domestic violence cases, but, arguably, if the coroners system were working properly, we would not need homicide reviews, as all the relevant information would be brought to the coroner and proper lessons would be learned. The reviews have sprung up because the coroner system has not been dealing appropriately with these cases*"⁸.

3.3 Refuge is also aware of the considerable criticism both at home and abroad⁹ of the Inquiries Act 2005, with some suggesting this legislation undermines the open, transparent public system of inquiry¹⁰ for which the UK has become known and indeed respected. It would be an enormous shame if this prediction became reality and instead of open inquiries into deaths where the action of the state is in question, we have only confidential reviews or one sided coroner's inquiries in which state agencies are able to rely on legal representation funded by the tax payer and the families of victims are not.

3.4 With regard to the issue of private hearings and confidentiality, Refuge acknowledges that full public disclosure of all facts and individuals involved in inquiries can sometimes cause personal difficulty (or additional risk) and on occasion disclosure might even jeopardise national security. It is for this reason that Refuge accepts there might be exceptional circumstances where particular information should remain confidential.

3.5 Refuge also acknowledges that it could be difficult for agencies to engage in frank discussions, particularly where risk of litigation might result from sharing potentially incriminating information but would caution against establishing protocols (as some US States have done) which assure confidentiality and or prevent information discovered during the review process being used in any associated civil litigation.¹¹ Refuge also acknowledges that it could be difficult for reviews to strike a balance between creating a climate of confidentiality in which failings can be openly disclosed by professionals and conducting a thorough inquiry into what happened, with lessons learned shared fully between families and the wider public.

⁶ Article 2 of the European Convention on Human Rights imposes a positive obligation on States to protect by law the right to life and to conduct an effective investigation where an individual has been killed as a result of force by an agent of the State or where the death has been caused by the acts or omissions of a public authority.

⁷ For further details refer to Refuge's submission re the coroner's bill at www.refuge.org.uk.

⁸ Parliamentary debate: 6 February 2006.

⁹ The following agencies signed a joint letter opposing the bill, entitled '*The Inquiries Bill: The Wrong Answer*' (22 March 2005): Amnesty International, British Irish Rights Watch, The Committee on the Administration of Justice, Human Rights First, The Human Rights Institute of the International Bar Association, INQUEST, JUSTICE, Lawyers' Rights Watch Canada, The Law Society of England and Wales, Pat Finucane Centre, Scottish Human Rights Centre

¹⁰ Ibid

¹¹ Websdale, Sheeran & Johnson (forthcoming) '*Reviewing Domestic Violence Fatalities: Summarising National Developments*'

3.6 Refuge recommends that clear protocols are established to determine whether a domestic homicide review or an enhanced Article 2 compliant coroner's inquiry is most appropriate following a domestic violence fatality. Where there are early indications that a state agency has been negligent in its duty to prevent loss of life, Refuge would recommend that a public and open Article 2 compliant coroner's inquiry takes precedence. This course of action would not of course, preclude agencies from reviewing their own practice and or participating in a broader review of involvement with the deceased and their family/social networks in order to learn lessons and prevent future tragedies.

3.7 Refuge prefers the term **domestic fatality review**, as this includes those who commit suicide as a result of domestic violence and unborn children who die during assaults upon their mother. Refuge also believes it is important for the review process to include those who die prematurely from other, yet associated causes (such as HIV or substance abuse) which have developed as a consequence of domestic abuse.

STYLE AND DEFINITION OF REVIEWS

Q1 – What format do you think would be appropriate for domestic homicide reviews? Though they have commonality with the SCRs, are there any issues that may arise if this process and style is adopted?

1.1.1 Yes, as mentioned above Refuge has grave concerns about the confidential nature of serious case reviews, the limited dissemination of findings, limited involvement of families, limited face to face contact with professionals involved with the victim, lack of legal powers to compel professionals and others to provide information and the lack of external scrutiny or objectivity.

1.1.2 Refuge is also concerned that despite 15 years of reviews of childhood death and serious injury, similar failings consistently emerge. Refuge fears a similar picture could develop following the development of domestic fatality reviews, where common risk factors or trends are found time and again. This is not to suggest either process is futile, rather that it is essential to ensure information gleaned from reviews results in appropriate changes in legislation, policy and practice; this however, will require considerable co-ordination and effort at both local and national levels. It will also require secure and consistent funding for specialist domestic violence services and mandatory training for professionals across the board.

1.1.3 Research into the serious case review process indicates that there has been a tendency to over emphasise procedural and bureaucratic recommendations, with less attention given to professional training and improved support/working conditions for staff.¹² This focus might go some way to explaining why past failings continue to re-appear in the present.

1.1.4 Refuge recommends the development of regional teams who carry out reviews across localities and who report to a national domestic fatality expert panel. This system could be advantageous in terms of promoting

- independence and objectivity of local reviews
- effective and consistent approaches to reviews

¹² Reder & Duncan (2004) *ibid*

- increased credibility with the public
- aggregation and dissemination of national findings
- national strategies for improved practice, including an appropriately resourced programme of training

TIMING AND PROPORTIONALITY

Q2 – A process for deciding when a review should take place is needed. What procedure can be used to ensure that the process is effective, and who should take that decision?

2.1.1 Refuge would recommend carrying out either a domestic fatality review or an enhanced coroner's Article 2 compliant inquiry in all circumstances where domestic violence is a factor in the death. The decision as to which process is most appropriate would depend on whether there are any early indications that a state agency has been negligent in its duty to prevent the death.

2.1.2 Refuge is pleased to see that the government has commented on the need to consider carrying out domestic homicide reviews where a suicide has occurred or an unborn child has been killed as a result of domestic violence.

2.1.3 Research undertaken both in the UK¹³ and abroad¹⁴ suggests that there is a causal link between attempted or completed suicide and concurrent experiences of domestic violence. In 2000, UK statistics reveal that around 34% (n= 509) female suicides were committed by domestic violence victims, a number which is almost 5 times greater than that for women who die at the hands of their partner or ex-partner¹⁵.

2.1.4 We have also known for some time that domestic violence assaults on pregnant women represent a significant and lethal risk for their unborn children, with research now highlighting domestic violence as the leading cause of foetal death.¹⁶

2.1.5 Refuge believes it is important that domestic fatality reviews include any children who have also died in such circumstances. In addition, Refuge would recommend holding a serious case review for any surviving children of parents and or siblings who have died. Combining these reviews, rather than operating in parallel would be cost effective in terms of money, time and in promoting multi and cross-disciplinary learning about adults and children at risk from domestic violence.

2.1.6 Refuge also believes it is appropriate to undertake reviews in instances where individuals have been very seriously harmed during domestic violence incidents. This would mirror the practice of serious case reviews where there is a brief to consider agency involvement in cases where children have suffered serious harm or neglect.

¹³ Walby S (2004) The Cost of Domestic Violence DTI

¹⁴ Stark & Flitcraft (1995) 'Killing the beast within: Woman battering and female suicidality', *International Journal of Health Services*, 25, 1, 43-64. Counts, (1987) Female Suicide and Wife Abuse in Cross Cultural Perspective. *Suicide and Life Threatening Behavior* 17(3):194-204

¹⁵ Home Office statistics indicate that around 115 women are killed annually by a current or former partner. In Flood-Page & Taylor (2003) Crime in England and Wales 2001/2002: Supplementary Volume

¹⁶ Friend (1998). Responding to violence against women: a specialist's role. Editorial, *Hospital Medicine*, 59(9), 98-99

2.1.7 Learning lessons about women who ultimately kill their abusive partners and the responses of relevant agencies prior to the death, is as critical as learning about the many women and children who are killed in such circumstances.

2.1.8 Refuge is keen to ensure that reviews are also conducted in relation to domestic fatalities that occur abroad. There may be instances for example, where there was prior concern that enforced removal of the victim was likely and where steps could possibly have been taken to prevent the death.

Q3 – What are your views on the possibility of holding reviews before the outcome of any legal proceedings or investigations? Do we adopt the same procedures as the SCRs and decide on a case-by-case basis?

3.1.1 Reviews could run concurrently with coroner's investigations and or criminal proceedings, provided clear agreements were reached regarding disclosure of information. Review teams should have a clear and irrefutable duty to share any information which comes to light that may further the investigations of either the criminal or coroner's court.

WHICH BODY SHOULD TAKE THE LEAD RESPONSIBILITY FOR INSTIGATING THE REVIEW?

Q5 – How effective would CDRPs or equivalents be in taking the lead responsibility for reviews, and are there any other agencies/partnerships that could do this?

5.1.1 Refuge agrees that many of the usual members found in CDRPs would be suitable for the purpose of reviewing domestic fatalities. It is important however, that members also include those from the domestic violence sector, the voluntary sector and where possible, relatives of other domestic homicide victims; insight into the experiences of victims could otherwise be rather limited if all the members were exclusively local authority or PCT employees. The local domestic violence forum might be an alternative group to lead the reviews, but again it would be important to ensure comprehensive membership from all local agencies, including education and GPs who are generally poorly represented at such fora.

5.1.2 As previously mentioned, if the domestic fatality review is the only investigation taking place, then the lack of external scrutiny and/or independence of the review team has the potential to undermine seriously the credibility and effectiveness of the process. Creating teams of local authority/PCT professionals to oversee their own practice in circumstances where disclosure of error might result in judicial review seems naïve. Refuge suggests that the establishment of regional domestic fatality review teams, who report to a central/national panel, might go some way to partially resolving this problem.

5.1.3 Refuge further recommends that an independent, external chair (a person without any local connections either personal or professional) is appointed to review the homicide. The individual appointed to write the report should be similarly independent.

Q6 – Are CDRPs or equivalent in two-tier authority areas with responsibility for education and social services the only bodies that could conduct reviews?

See response to Q5 above.

Q7 – How can local areas incorporate quality assurance steps into the review process, and who should advise on quality assurance assessment of reviews?

7.1.1 One risk to the quality and accuracy of reviews is the requirement that agencies should carry out their own internal review and submit a written report to the review panel/team (para 3.6). Refuge believes it is crucial that the review process is not simply a confidential paper exercise. The review team should have the powers to require individuals to disclose records and to present verbal information to the panel. Face to face interactions are crucial in any process of investigation. A widely available published report of the full review findings is also important in ensuring the process of investigation, analysis and interpretation is open to critical evaluation. As previously indicated a central team could be appointed to provide training, guidance and protocols to regional domestic fatality review teams, as well as oversee their progress and ensure quality assurance measures are in place. The creation of a national quality assurance process would also ensure consistency of reviews, help aggregate findings and allow for external monitoring.

Q8 – What are the equality and diversity impact issues that should be considered under this section?

8.1.1 Refuge believes it is crucial that review teams are conversant with and able to demonstrate sensitivity in relation to issues of diversity and equality as they impact on all clients throughout the review process.

DETERMINING THE SCOPE OF THE REVIEW

Q9 – What other factors need to be considered?

9.1.1 Issues of confidentiality and dissemination of the findings are both important in terms of changing practice within a locality. Whilst full information about failings within and between systems is crucial to effect positive change, wide dissemination of review findings will almost inevitably result in loss of anonymity for individual professionals known to be involved with the victim, even if their identify has not been formally disclosed. An emphasis on recommendations which address system failings rather than individual errors is very important, as is the provision of appropriate support for professionals who might be particularly vulnerable as a result of the review process.

TIMEFRAME FOR CONDUCTING THE REVIEW

Q11 – Do you have any views on the proposal of a maximum duration of three months for a review?

11.1.1 There is some evidence from serious case review research¹⁷ to suggest that this time frame is insufficient. Given that domestic fatality reviews are likely to necessitate analysis of

¹⁷ Sinclair & Bullock (2002) *Learning from Past Experience. A Review of Serious Case Reviews*, Department of Health.

records and information about the victim, the perpetrator and any surviving children, the task has the potential to be even more time consuming than that of serious case reviews.

Q12 – What are the equality and diversity impact issues that should be considered under this section?

12.1.2 The timing of the review should take into account factors such as the bereaved family's culture as well as normal grieving and burial rights.

INDIVIDUAL AGENCIES' MANAGEMENT REVIEWS

Q13 – Are there any other areas that could be included here, and are the questions that are outlined relevant?

13.1.1 Refuge is concerned about the lack of transparency inherent within the proposed review process. Reducing the review to an internal paper exercise whereby agencies investigate and produce a report detailing their own involvement with the victim is inappropriate. Refuge recommends that reviews are conducted by regional domestic fatality review teams with the powers to compel professionals to attend, to produce records and to commission independently written reports. Refuge also recommends including face to face interviews with professionals and others who were in direct contact with the victim and or perpetrator.

13.1.2 Refuge also recommends the involvement of agencies that could have been reasonably expected to have contact with the victim but did not. This could further our understanding of the barriers to help seeking faced by some victims, as well as illustrate the degree to which domestic violence remains undetected and therefore unaddressed.

Q14 – What are the equality and diversity impact issues that should be considered under this section?

14.1.1 Refuge suggests that close examination of equality and diversity issues in relation to service provision should be embedded within every agency's process of review. Appropriate engagement with a service can mean the difference between life and death for some domestic violence victims. Awareness of the barriers to both help seeking and appropriate service provision for particular communities is essential.

FAMILY INVOLVEMENT

Q15 – Are there any areas not covered that you think would be helpful?

15.1.1 Refuge believes that there are likely to be tensions between what the families of victims want from the review process such as openness, accountability, information, justice; what agencies want, such as confidentially learning lessons and improving practice and what a domestic fatality review is set up to provide. Offering support to families as well as clarity about the process and what they can expect from the review, is crucial.

15.1.2 Families need to be aware that the process of a domestic fatality review is different and separate from any parallel processes of criminal investigation, formal complaints procedure against an individual agency or a public inquiry. Families need to acknowledge and accept that their role is to offer information to the review team and that they are not equal partners in the process of review with rights of access to other information submitted about the death of their relative. The family of the perpetrator should also be involved where possible.

15.1.3 Refuge is concerned about the proposal that agencies should seek consent from the victim's family (and possibly the perpetrator's family) before information is shared between agencies,¹⁸ believing this represents a serious stumbling block to the process of review.

15.1.4 Some families might not want to be involved in the process and this is, of course, their right. And whilst this should not prevent local agencies from reviewing their own involvement, it is likely to result in a rather one-sided, professionally biased review.

15.1.5 Domestic fatality review teams should be alert to the possibility that others in the family or social network might also have been involved in the death and there could be a risk of further victims. Particular sensitivity should be given to children whose parent(s) and or sibling(s) have died, especially with regard to obtaining their views; additional specialist professional support might be of value to children engaged in the review process.

15.1.6 It is also important for domestic fatality review teams to consider the involvement of the victim's social networks/work colleagues, particularly in urban contexts where people often reside many miles from their nearest family member, or where their family live abroad.

15.1.7 Families should always have the option of pursuing a public, rigorous Article 2 compliant investigation into the acts or omissions of a state agency, where this is thought to have contributed to the death. Such families should be provided with the same level of legal representation as the state agencies they seek to hold to account.

15.1.8 Refuge strongly believes that appropriate support should be available for the families of victims and perpetrators throughout the process of review.

MEDIA INVOLVEMENT

16.1.1. The media have an important function in sharing important lessons learned from the review with a wider professional and public audience. It seems important that review members adhere to clear protocols regarding 'what' is shared with the media, 'why' and 'by whom'. Protecting the identities of individuals in any dealings with the media is likely to be crucial in terms of ensuring full participation of families and professionals in the review process.

Q17 – What are the equality and diversity impact issues that should be considered under this section?

¹⁸ Paragraph 3.6

17.1.1 Refuge believes it will be important to ensure that the findings of domestic fatality reviews are reported to the media accurately and in a manner which is sensitive to and respectful of issues of equality and diversity.

EXPERT ADVISERS/WITNESSES

Q18 – Do you have any views or comments on the appointment and use of expert advisers/witnesses?

18.1.1 Ideally, domestic fatality review teams should contain their own 'experts' in domestic violence, including those from the voluntary sector. There is a danger however, that without explicit guidance on review team membership this might not occur. It is particularly worrying that some CRDP's do not include any members from either the statutory or voluntary domestic violence sector.

18.1.2 Other independent expert advisors or witnesses are also likely to be necessary when undertaking a full review into the circumstances of the death and Refuge recommends that funding is made available to facilitate this process when appropriate.

Q19 – What are the equality and diversity impact issues that should be considered under this section?

19.1.1 It might also be necessary to use experts who have knowledge and experience with abused minorities, the elderly, disabled, those from rural areas and or lesbian and gay communities.

COSTS

Q22 – What are the issues that may arise from following this protocol, and do you have any suggestions on how costs may be met?

22.2.1 Refuge is concerned that the domestic fatality review process is expected to operate using existing funds. Refuge recommends instead that central government invests in a system of regional and national teams with a clear brief to review all domestic violence fatalities (including suicides and unborn children) to aggregate findings, to monitor the effectiveness of changes to practice, policy and legislation and to provide a central system of training for review team members across the country. Refuge also suggests that these teams should also integrate closely (at local and national levels) with serious case reviews teams, the reformed coronial service and child death review teams. All of this will cost money, but it might save lives.

22.2.2 Refuge is also concerned about additional costs to the voluntary sector from involvement in this process.

PRODUCING THE FINAL REPORT

Q23 – Do you have any views on how the report should be made available? Full report or executive summary and recommendations etc.?

23.1.1 Refuge recommends that a full report should be made widely available.

Q24 – What are the equality and diversity impact issues that should be considered under this section?

24.1.1 Creating a report in languages additional to English will also be important in some areas. Again, this will have cost implications.

Q25 – Are there any other questions that arise from this guidance?

25.1.1 Refuge is concerned about the number of routes available for investigating and or reviewing deaths within England and Wales and the consequent potential for confusion and fragmentation. In brief, we appear to have options for:

1. Public inquiries
2. Coroner's inquiries
3. Domestic homicide reviews
4. Serious case reviews
5. Child death reviews.

25.1.2 It seems crucial that there is clarity about which is the most appropriate route to take and why, particularly in relation to children who have died within a context of domestic violence. It also seems important that we do not reduce the numbers of public coroner's inquiries, as other commonwealth countries have done¹⁹ and downgrade our investigative response to sudden or suspicious deaths to a process of local, confidential review, instead of a rigorous appropriately resourced public investigation.

25.1.3 Moreover, unless the government addresses the inadequacies of the death certification process and its dislocation from the coronial service, the possibility that some domestic fatalities will go unrecognised, remains.

25.1.4 Finally, Refuge wonders how the domestic fatality review process will intersect with the broader Violence Against Women (VAW) agenda. Homicides and fatalities under this heading would include other forms of death such as killings by strangers, killings of sex workers and deaths resulting from infection and or complications following FGM²⁰. Refuge believes it is crucial that we explicitly acknowledge that lethal violence affects both the private and public spheres of women's lives and that we create structures and narratives to describe and monitor these violations, with a view to reducing suffering and bringing perpetrators to justice.

[Ends]

¹⁹ Tom Luce, Chair of the Review of the Coroners' Service, in giving evidence to the Coroner's Bill Select Committee (25th April 2006)

²⁰ Also described as 'Female Genital Cutting'