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CONSULTATION

ON

DOMESTIC HOMICIDE REVIEWS

NIPSA SUBMISSION
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INTRODUCTION

1. NIPSA is the largest trade union in Northern Ireland representing over 41,500 members employed across the whole of the public services in organisations such as the Northern Ireland Civil Service and its Agencies, Local Government, Education Authority, the Health Trusts, the NI Housing Executive as well as a host of Non-Departmental Public Bodies (NDPBs). NIPSA also represents a significant number of members in the Voluntary Sector.
2. NIPSA works to promote equality and human rights for all its members including civil society. We regularly represent workers suffering from the impact of violence and work with employers in raising awareness of domestic violence and abuse and developing related policies and practices. We have been working with organisations such as Women's Aid, Amnesty International, Northern Ireland Human Rights Commission, Equality Commission, International Labour Organisation, the Rainbow Project and others to ensure that all victims of domestic violence and abuse get both the services they need and an appropriate response from the civil and criminal justice systems.
3. We therefore welcome the opportunity to comment on this consultation and in doing so NIPSA endorses the submission made by the Women's Aid Federation for Northern Ireland and the Belfast Area Domestic Violence Partnership.

SECTION 5 – THE MAIN PURPOSE OF A DOMESTIC HOMICIDE REVIEW (DHR)

Q1. Do you have any comments to make about the purpose of a DHR?

4. NIPSA welcomes the fact that the primary purpose of a DHR is not about attributing blame or the conduct of a particular professional but is about illuminating the past to make the future safer. The purpose must be about being professionally curious, find the trail of abuse and taking a holistic approach when considering the facts presented during scrutiny of **practice** not **individuals** by agencies and professionals.
5. It is important that the purpose is to understand the context and environment in which professionals made decisions and took (or did not take) actions, for example, culture, training, supervision and leadership. It must go beyond focusing on the individual and whether procedure was followed to evaluate whether the procedure/policy was sound in the first place.

6. It is vital for the victim's voice to be central to the process. The report narrative should articulate the life through the eyes of the victim (and their children) and talking to those around the victim including family, friends, neighbours, community members and professionals. Situate the review in the home, family and community of the victim. Information from these sources can rebalance the forensic narrative. This will allow for a better understanding of what led to the death and how it could have been prevented.
7. The process must also be about 'enabling families to get answers to their questions'. We would therefore **recommend** this is added as a purpose under paragraph 5.1.

SECTION 6 – THE PROPOSED DHR PROCESS

Q2. Do you have anything to say about when a DHR will or will not be commissioned?

8. NIPSA notes in paragraph 6.7 that in cases where there is a 'one off' incident, with no history of domestic violence and abuse and no contact with services that in such cases, while the DHR criteria would be met, it may be unlikely that a DHR would be carried out or that there would be lessons to be learned. NIPSA would stress, even if there has been no contact with services, it is possible that there was abuse in the relationship and as such there is much learning to be gained from establishing how the abuse never reached any agencies or organisations and what can be done better to ensure abuse is tackled and addressed at the earliest possible stage. We therefore **recommend** the need for a DHR even if there has been no contact with agencies.
9. We further note in paragraph 6.10 that within the scope of DHR, it is not intended to cover cases of suicide but this will be the subject of review. NIPSA would **recommend**, in line with England, that following suicide and where the circumstances give rise to concern, for example, it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. It will especially be important to cover deaths by suicide given the commitment by the then Minister in October 2016 to introduce laws against coercive control in Northern Ireland and the fact coercive control is clearly recognised within the definition contained in the Domestic and Sexual Violence and Abuse Strategy. NIPSA would contend that it is critical that suicides with a history of domestic violence should be commissioned.

TERMS OF REFERENCE / SCOPE OF THE REVIEW

Q3. Do you have anything to say about what may 'typically' be outlined within the terms of reference?

10. NIPSA would **recommend** the following:
 - Consider the impact of a perpetrator's as well as a victim's immigration status on agency responses.

- Did the victim seek information about the perpetrator's criminal history under the Domestic Violence Disclosure Scheme? Did the police make a disclosure under "Right to Ask" or "Right to Know"?
- Were the victim (and/or perpetrator) social housing tenants? If so was there rent arrears or frequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? These could be indicators of a potential domestic abuse situation. Does the social housing landlord carry out routine screening for domestic abuse? Are there policies in place which support and allow staff to identify and report suspected domestic abuse? Have the processes in place been reviewed to ensure that they remain effective?

THE APPOINTMENT OF A CHAIR

Q4. Do you have anything to say about:

- the knowledge and skills of the Chair
 - the recruitment and contingency for the role of the Chair?
11. In paragraph 6.16 it states the Chair should *ideally* be independent from all agencies involved in the process. NIPSA would **recommend** the Chair *must* be independent of the agencies contributing to the review.
 12. The report should clearly demonstrate the Chair's independence from the referral body/agency and all other agencies involved in the review.
 13. An 'independence statement' should be included in the report which sets out the Chair's career history, relevant experience and independence.
 14. There should be a clear and robust commissioning framework around recruiting a review panel Chair or Chairpersons that takes into account the skills and expertise required. We would **recommend** the criteria for appointment should be strengthened to ensure the person appointed has *enhanced/advance knowledge of domestic and sexual violence and abuse issues and analytical is added to the list of skills sought*.
 15. The Chair *must* have an understanding of wider statutory review frameworks such as child or adult reviews.
 16. NIPSA would **recommend** the need to appoint at a minimum two Chairs but ideally 3 or 4 Chairs to conduct DHRs on a rotational basis and avoid pressure being put on to one or two Chairpersons. This will ensure proper and adequate time is provided for the DHRs and a thorough process is conducted without undue pressure being imposed.

DHR PANEL MEMBERSHIP

Q5. Do you have any comments to make about DHR panel membership?

17. In paragraph 6.22 it states the panel *must* include individuals from organisations as set out in the 2004 Act. However in paragraph 6.23 it states “*there would be considerable merit in the panel having members from groups representing both male and female victims of domestic violence and abuse*”. **NIPSA would contend that it is essential and the panel must also include specialist or local domestic violence and abuse service representation.**
18. Panel members must also be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to comment on behalf of their agency to decisions made during a panel meeting.
19. It would be important to include other relevant voluntary sector organisations such as those working in the areas of mental health, substance misuse, BME in cases where the perpetrator or victim's background suggests that these agencies may have relevant knowledge or challenge function to contribute.

Q6. Do you have any comments to make about the consideration of equality and diversity issues by the Panel?

20. NIPSA contends that all protected characteristics under the equality legislation, including rural needs, *must* be taken into consideration as part of the DHR. It will be important for the Chair and Panel to examine not only barriers that may be posed by agencies policies and procedures, but also how a person's characteristic or status might have influenced on how either the perpetrator or victim acted in the lead up to the homicide.
21. We also **recommend** that in cases where victims are foreign nationals or not for ‘indigenous’ communities, their cultural context should also be examined. For instance, if the victim was a BME woman whose country of origin or community had different cultural norms around domestic violence, this might be useful information in unpicking whether the victim believed she was a victim of abuse, or felt that the abuse merited reporting to police or a support service. Such considerations would aid in the Panel's understanding of the victim's motivation for actions taken or not taken, and provide an insight into how policies and procedures need to be changed to intervene earlier in such cases.

HOW WILL FAMILIES BE INVOLVED IN THE DHR PROCESS

Q7. Do you have anything to say about family involvement in the process?

22. As previously stated family and friends make an empirical contribution to the review and therefore must be given the opportunity to be integral to reviews and should be treated as a key stakeholder.
23. The Chair and review panel can help establish a positive experience for family and friends by offering clear communication about the process from the outset

and throughout the review. Those conducting the review should consider specialist and expert advocates for the families.

24. Children should also be given specialist help and an opportunity to contribute as they may have important information to offer.
25. Give family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions.
26. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents.
27. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide.
28. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.
29. Enabling families to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.
30. When meeting with family members, friends and others, the Chair should:
 - Meet at the earliest opportunity.
 - Offer signposting to specialist and expert advocacy support services to those who do not have a designated advocate.

The Chair cannot be the advocate for the family as they need to be fully independent and may reach conclusions that the family disagrees with.

31. Share completed and full versions of the review reports with the family prior to sending them to the Senior Oversight Forum.
32. The Chair and Panel should ensure that adequate time is given to the family to consider and absorb the report, identify if any information has been incorrectly captured and record any areas of disagreement. In some cases, this may involve drawing up a legal form of undertaking to maintain confidentiality of an unpublished review.
33. The Chair and Panel should ensure the family are fully sighted on any media statements and be mindful of the need to consider key dates, such as birthdays, anniversaries, etc.

34. Invite the family to help create the change after the review.

INVOLVEMENT OF OTHER INDIVIDUALS IN THE DHR PROCESS

Q8. Do you have anything to say about the involvement of other individuals in the process?

35. NIPSA supports the need to involve a wider network of friends, work colleagues, employers etc., where relevant, as they could bring some valuable information and insight to the review process.

36. We acknowledge that involving perpetrators can be useful and approaching the family of the perpetrator who may also have relevant information to offer is also useful. However it is important that the Chair and Panel understand the capacity of perpetrators for manipulation and a knowledge and understanding of grooming and the potential for a perpetrator's family to be complicit in abuse is vital.

PROGRESS OF THE DHR AND REPORTS

Q.9 Do you have any comments about the two key elements of the DHR process:

- (i) Initial findings, learning and identification of actions needed; and
- (ii) Identification of key findings, learning, actions and longer terms change?

37. NIPSA supports the two-stage process.

Q.10 Do you have any comment on the approach proposed regarding gathering information, or any suggestions as to how best this could be undertaken?

38. The Chair of the review panel needs to consider if they are becoming aware of information that may be of interest to judicial processes including, for example, an inquest. *This point is to help ensure, for example, that an inquest is also aware of agency failures being revealed in the DHR process.*

39. Good practice is to invite the Senior Investigating Officer to attend the first panel meeting to brief the panel on the investigation.

40. It is important that a review is opened promptly so that early lessons can be identified and rapid action taken to address them.

41. Preliminary work, such as commissioning and analysing IMRs and drafting a first iteration of a chronology, whilst avoiding speaking to potential witnesses can be undertaken before a criminal trial has taken place.

42. Any appeals lodged following the conclusion of criminal proceedings should not delay the submission of a DHR to the Senior Oversight Forum for quality assurance.

Q11. Do you have any comment on the suggested approach around publication of the DHR report and do you have any views on the frequency of report publication?

43. NIPSA supports the proposal to produce a full report as outlined. We also recommend in addition to a full report an Executive Summary should be produced.

44. It is important that publishing the DHR report is seen as only the beginning of the process. To derive value from the DHR process and prevent further abuse and homicide there must be appropriate governance mechanisms in place for monitoring delivery against the DHR action plans. Action Plans must include timeframes agreed at a senior level by each of the participating agencies.

45. Where necessary, further studies could be commissioned to supplement the information available from the IMRs to enable better supported conclusions about the lessons to be learnt from the case.

Q12. Do you have any comment on the potential outcome of the reviews through the development of reports?

46. We agree that the outcome of the review process should focus very much on tangible results. However we have some concerns about the enforceability of recommendations. To this end we would recommend the Department examine enforcement models used in different jurisdictions.

QUALITY ASSURANCE IN THE DHR PROCESS

Q13. Do you have any comment on the role and scope of the Senior Oversight Forum (SOF)?

47. The quality assurance function is vital to the whole DHR process. The role of the SOF should include receiving updates on the progress of DHRs and the effective implementation of recommendations.

48. In line with our comment at point 46 above we would like to see the SOF having more of an enforcement function to ensure compliance with the recommendations.

49. We would recommend the SOF's follow up function to review how findings of review are being implemented should be written into the process in detail.

Q14. Do you have any comment on the organisations that would make up the Senior Oversight Forum, particularly the additional bodies that could be considered, or others that should be considered?

50. It will be important that organisations such as Women's Aid, Men's Advisory Project, NEXUS, are standing members of the SOF as the lead domestic and sexual violence and abuse organisations in Northern Ireland. It will also be important that organisations such as The Rainbow Project, CaraFriend, Sail who represent the LGBT community are also represented.