



SINN FÉIN SUBMISSION TO THE DOJ CONSULTATION ON DOMESTIC HOMICIDE REVIEWS

Sinn Féin welcome the opportunity to respond to this consultation on Domestic Homicide Reviews (DHR's).

The North of Ireland has a human rights obligation to assess the risk factors in relation to domestic violence death and to shape policy and law based on empirical evidence. The obligations under human rights treaties require the collection and use of reliable data as an evidentiary basis for developing, funding and implementing death prevention and protection initiatives. A domestic homicide review function should fulfil our obligations under the following treaties: The Convention on the Rights of the Child; The Convention on the Elimination of Discrimination Against Women; The International Covenant on Civil and Political Rights; and The Convention on the rights of Persons with Disabilities.

As well as conducting case by case reviews, additional resources for research and evaluation would be valuable.

The Department of Justice should develop a database comprised of all domestic homicides, as well as death by suicide, that have occurred across the North of Ireland in order to enhance research by providing a comprehensive dataset to identify patterns or emerging trends among incidents, risk factors, service contact and strategies regarding domestic homicide prevention.

The process of analysing data and applying research to identify patterns, trends and risk factors relating to domestic and family violence deaths may inform policy change.

Much has been learned about domestic homicides from multidisciplinary death review committees in Canada and around the world. In Ontario, the Office of the Chief Coroner has had such a committee in operation since 2003. The motto of the Chief Coroner is “*We speak for the dead to protect the living*” which is a stark reminder of the important role that these reviews offer to the community.

Domestic Violence Fatality Review Teams are now widespread in the USA. They have proven invaluable in identifying common weaknesses in systems and protocols responding to domestic violence that have led to a fatality. They now exist in most Australian states.

Many victims of domestic violence encounter barriers or gaps in service particularly victims from more vulnerable communities (e.g., immigrant and refugee; rural). A Domestic Homicide Review can identify these barriers and gaps and form recommendations to address the issues, as well as strategies for perpetrator intervention that may have been overlooked.

In relation to the purpose of the review, which is outlined in the consultation document, it should also include speaking to family, friends, neighbours, community members and professionals which will contribute to a better understanding of any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

The review should be explorative and inquisitive which will help the panel better understand the trail of abuse.

It is understandable that DHR's are not specifically part of a disciplinary inquiry or process or not about attributing blame however organisations need to be open for criticism and not let this impede the process. It is not the place for them to become defensive. Openness and honesty is what is required.

The consultation document states that the final decision on whether there *shouldn't* be a DHR falls with the Department of Justice. Can the decision made by the Department be appealed/reviewed?

Paragraph 6.7 of the consultation document states ‘*There may also be instances where there is no scope for seeking out learning, for example, where*

there is a 'one off' incident, with no history of domestic violence and abuse and no contact with services. 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'.

Surely the senior oversight forum (SOF) can't be sure that the incident is a one off until a review is carried out. More information may come to light during the review after talking to family, friends etc. which would rebut the presumption that the incident was a one off. Reviews should be commissioned in all cases which meet the criteria.

Paragraph 6.10 states '*As the DHR process is in the early stages we do not consider that it should, at this stage, cover death by suicide.*'

The review of suicide deaths is valuable in terms of understanding the dynamic that domestic violence may play in those deaths and subsequently informing prevention strategies. Enabling the DHR panel to consider non-homicide cases that occur within a context of domestic and family violence may provide the opportunity to better identify trends and commonalities than would be possible if only homicide cases were considered.

Sinn Féin believe that the DHR process should cover death by suicide.

In relation to the terms of reference, they should include how schools and universities contribute to the review. The legislation covers the death of a person from age 16. It would therefore be important to include educational institutions in the terms of reference.

In relation to the Chair of the DHR panel, it is important that the chair is an experienced person who is not directly associated with any of the agencies involved in the review. The Chair should not be a member of SOF. There should be a clear and robust recruitment process for this role.

Sinn Féin agree that there is a need to ensure that there is contingency and capacity should the Chair be absent or should there be an increased level of DHR's in a year. Therefore, it makes sense to have more than one Chair with cases allocated appropriately.

Sinn Féin also agree that there should be a core panel membership to ensure continuity and consistency.

We also concur that the voluntary and community sector would be vital to the core membership of the panel. They may have valuable information on the victim and/or perpetrator.

Panel members should be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

The panel must bear in mind equality and diversity issues at all times and comply with the requirements of s75. Consideration should be given to having a panel member who has expertise in this area and who will make sure that equality and diversity issues are considered throughout the process.

Family involvement in the process is extremely important. The quality and accuracy of the review is likely to be significantly enhanced by family. They can provide important information about the nature and extent of the abuse which agencies may not be aware of. Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder. Families may have someone who is willing to advocate on their behalf who should be listened to. Families contributions must be afforded the same status as other contributions.

The involvement of other individuals is necessary to obtain relevant information held by them which statutory agencies may not know or may not be recorded in official records. Victims and perpetrators may have disclosed information to employers, colleagues, health professionals, etc. The process should involve all those who played a key role in the life of the victim and/or perpetrator. The review panel should access these networks.

The DHR must be conducted expeditiously so that lessons are able to be drawn out which can be acted upon as quickly as possible. It is important that a review is opened promptly so that early lessons can be identified and action taken to address them. If there are ongoing criminal proceedings preliminary work should be carried out in the meantime and the review should be concluded without delay at the end of the criminal proceedings.

The process should allow organisations to look openly and critically at individual and organisational practice. This will indicate whether practice needs to be changed or improved and how and when the changes/improvement will be brought about. Senior managers of the organisations need to sign off on

this as it should be them who are responsible for ensuring that any recommendations are acted on appropriately.

In relation to the approach proposed regarding the gathering of information, those gathering the information should not have been directly involved with the victim, the perpetrator or the families and should not have been the immediate line manager of any staff involved in the case.

The proposals do not provide information on what powers the panel will have to deal with those who refuse to participate or provide the information required.

The panel need the appropriate powers to access information. The Department needs to consider whether enabling legislation would be required to give the DHR panel access to the information that they need.

In relation to the publication of the DHR report, the report should be suitably anonymised and made publically available. Publishing reports will improve transparency in the process and restore public confidence. Publicising will also highlight the lessons to be learnt, what needs to change as well as good practice. Sinn Féin believe that the report should be publicised after each individual DHR as well as thematic reports at the end of the year to reflect what has been learned.

The panel should translate the actions contained in the final report into a specific, measurable, achievable, realistic and timely action plan. This would help achieve the purposes of DHR's. There needs to be appropriate governance mechanisms in place for monitoring delivery against the action plan.

Sinn Féin agree that the overall responsibility for establishing a review should rest with SOF as they should be ideally placed to initiate a DHR and review panel due to their multi-agency design.

Consideration should be given to the Fire and Rescue Service being included in the membership and also a legal professional. There should also be organisations at the table who represent rural areas.

It should be the responsibility of SOF to ensure that the correct organisations are participating in the review panel particularly those who deal with domestic violence and abuse and domestic homicide. This should be kept under review throughout the process. SOF need to make sure that families are treated as key stakeholders and that reasonable contact is maintained with the family. SOF

should ensure that adequate time is given to the family to consider and absorb the report and identify if any information has been incorrectly captured.

SOF should also communicate and liaise with other Departments to ensure appropriate engagement from all relevant agencies and to ensure existing training is highlighted.

Sinn Féin would like more information on who Chairs SOF and what powers the chair will have if for example there is unreasonable delay in the completion of the review. Does SOF refer the matter to DOJ and if so what powers will DOJ have to deal with the matter?

Sinn Féin assert that there needs to be an evaluation of the DHR model which should be conducted in 3 years from when the DHR process began.