Sefton
Domestic Abuse
Partnership Board

Domestic Homicide Reviews (DHRs)

1 What is it?

A Domestic Homicide Review (DHR) is an independent learning review carried out when a person aged 16+ dies, or is suspected to have died, as a result of violence, abuse or neglect by a partner or family member.

This can include cases where a victim died by suicide.

2 Purpose

The aim of a DHR is to:

- Identify lessons that can be learned to help prevent future deaths related to domestic abuse.
- Improve service responses to victims and their children.
- Highlight good practice.

DHRs are NOT:

- Inquiries into how the victim died.
- Designed to assign blame; a DHR is conducted entirely separately from any criminal proceedings.

3 Legislation and Governance

Safer Sefton Together is responsible for DHRs in Sefton. They were made a statutory requirement in April 2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

Statutory Guidance is provided by the Home Office as to how DHRs should be conducted.

The Statutory Guidance is currently being reviewed by the Home Office and a public consultation on the draft ended in Summer 2024. As part of this review, the name of DHRs will change to Domestic Abuse Related Death Reviews (DARDR) when the revised Statutory Guidance is released. Until then, reviews will continue to be known as DHRs.

4 Sefton DHRs

To date, 16 DHRs have been completed in Sefton involving the death of 18 victims.

15 victims were female, 3 were male.

All victims were White British.

14 individuals were victims of homicide, 3 victims died by suicide, 1 died by accidental death.

Of the 14 homicide victims, 6 involved family violence, 7 involved a partner/ex-partner.

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5 Common themes

Lack of understanding and awareness of domestic abuse – including types of abuse (particularly family violence and coercive control) and the barriers victims can face.

Lack of consistency in providing an appropriate response – risk recognition, understanding of support services available, not following organisational procedures, management oversight on cases involving domestic abuse.

Complex Lives

- Victims of domestic abuse with substance misuse and/or mental health issues face additional vulnerabilities and barriers to accessing support.
- The risk of suicide for victims of domestic abuse is increased but often not properly considered or understood.

Lack of professional curiosity

- Lack of further querying by practitioners of issues presented – both in terms of issues faced by victims and what is presented by perpetrators.
- A need for more routine enquiry of domestic abuse indicators.

Impact of trauma

- Lack of consistent understanding of the additional trauma impact on victims of domestic abuse who have children removed from their care.
- Victims with complex lives often have a significant history of trauma.

The risk of suicide for victims of domestic abuse is increased but often not properly considered or understood

6 Implementing learning and recommendations

All DHRs have an action plan which seek to address the recommendations put forward. Individual agencies are responsible for completing their own single agency action plans.

Wider learning and DHR panel recommendations are taken forward into Sefton's Domestic Abuse Partnership Board. Key themes identified to date have been incorporated within Sefton's Domestic and Sexual Violence Strategy and Action Plan.

7 Further information

https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

www.sefton.gov.uk/safer-sefton-together

www.sefton.gov.uk/domestic-abuse