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Analysis of statutory reviews of homicides and violent incidents

A report commissioned by the Mayor of London's Violence Reduction Unit

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About the Violence Reduction Unit

Announced by the Mayor in September 2018, the Violence Reduction Unit (VRU) is bringing together specialists from health, police, local government, probation and community organisations to tackle violent crime and the underlying causes of violent crime.

Supporting London to tackle violence at its roots

We believe that violence is preventable. The VRU is taking a fundamentally different approach to violence reduction – one where the public sector institutions and communities that make up London act together to help cut violence.

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Executive summary

This report summarises findings from research commissioned by the Violence Reduction Unit (VRU) with the aim of mapping and understanding violence in London. The VRU was established by the Mayor of London, Sadiq Khan in September 2018. It brings together specialists from health, police, local government, probation and community organisations to tackle violent crime and its underlying causes.

The aims of the VRU is to reduce violence in London, identify major causes of violence and to work in partnership to coordinate action to tackle them. The VRU aims to involve communities and build their capacity to help secure long-term reductions in crime and harm.

The VRU commissioned the Social Care Institute for Excellence (SCIE) to produce a thematic review of homicides across London, and a separate Strategic Needs Assessment, conducted by the Behavioural Insights Team (BIT). This was in order to establish key causation factors, common patterns and to help bring forward recommendations for the VRU and partners to consider in developing a longer-term approach to violence reduction.

It is important that both reports are read together, as the SCIE report is a deep dive into specific case reviews and the BIT report provides a holistic assessment of violence in London. The two reports combined provide a map of violence in London, thus providing an opportunity for developing an informed preventative approach to addressing violent crime in London.

Key findings and recommendations

The research indicates six main areas for the Violence Reduction Unit and its partners to consider in view of its goal to tackle violence in London at its roots.

The quality of learning from homicides and other violent incidents in London, particularly from incidents of youth violence is insufficient. Analysis of the four types of review considered in this report shows that there is not sufficient information or analysis to support a comprehensive understanding of the causes and patterns of violence, in particular in relation to serious youth violence.

Improving learning from research could ensure that the VRU's strategy to reduce violence identifies the full range of violence types and range of groups experiencing it; supporting a more informed and coordinated approach to tackling the causes of violence, and addressing them at scale.

Recommendation 1

The VRU should work with government and national partners including NHS England to review whether the content and quality of statutory reviews is adequate to enable learning. The VRU and partners need to be clear about what changes would be needed to support a public health informed and contextual approach to violence reduction.

Alongside this the VRU should work with government and national partners to explore whether additional learning processes are required for cases not currently covered by any statutory review processes.

Tackling all forms of violence. Violence is taking place beyond the street – it is happening in intimate and family relationships, between partners and adult family members, and parents and children. It is occurring between peers, both young people and adults, including people who are only loosely acquainted with each other.

Who is experiencing violence. Youth violence is not the full picture of violence in London – other groups at risk of experiencing violence include, children within their families, women, older people

and carers, vulnerable adults and adults living in supported or residential accommodation.

Recommendation 2

In fulfilling its commitment to tackling all forms of violence, the VRU should ensure that the full range of groups experiencing violence and the types of violence occurring are part of its strategy.

The VRU and other national and local organisations should also review the extent to which 'intimate partner violence' and 'adult family violence' are adequately distinguished within an overall approach to domestic abuse.

Recognising the range of circumstances and experiences in the approach to preventing and tackling violence. Adversity in childhood and adulthood is present in the lives of people experiencing violence. The findings indicate that experiences in adulthood – domestic abuse, mental health, substance misuse and stressors such as financial, housing and immigration problems may be important factors in tackling violence. The range of community and neighbourhood contexts in which violence is taking place needs to be a priority for reduction strategies. These include:

- schools
- places where gang activity is present and where there are risks of exploitation (for example, sex work)
- poor neighbourhoods where experiences like debt and insecure housing are common
- living in supported and residential accommodation.

Recommendation 3

The VRU should continue its approach of addressing adverse childhood experiences (ACEs), alongside a focus on contextual and resilience factors, as a means of tackling serious youth violence.

Recommendation 4

The VRU's approach should incorporate measures to address adverse experiences in adulthood, as a means for preventing and reducing serious violence.

Recommendation 5

Building on the focus of tackling violence at a community and neighbourhood level, and priority to support wellbeing in schools, the VRU should consider the full range of places and spaces in which violence may occur. These include:

- neighbourhoods where there is gang activity
- neighbourhoods and communities with increased risk of exploitation
- neighbourhoods with high levels of poverty, debt and insecure housing
- residential and supported accommodation for vulnerable adults, particularly where safeguarding arrangements are poor.

How violence escalates and can be prevented. The range of events leading up to violent incidents indicate opportunities to prevent the escalation of violence. For adults these include:

- adverse life events, such as losing employment
- break-up of relationships
- severe mental illness

- disengaging from mental health services
- destruction of property.

For young people, these include:

- going missing
- offending
- buying and carrying weapons.

There are gaps in the evidence about how violence escalates across the range of forms of violence, and therefore knowledge about how violent incidents can be reduced or prevented.

Multi-agency working. Across the cases reviewed it was evident that both victims and perpetrators came into contact with several services, indicating the range of agencies that need to be involved in addressing violence. This included: primary and acute health services, mental health services, children's social care, and housing services. Areas where multi-agency working could be strengthened were:

- understanding adolescent safeguarding issues, including criminal exploitation
- the role of schools in offering protection to children, including from exposure to gang-related activity
- responses to domestic abuse, including recognition and responses.

Recommendation 6

The VRU should review its strategy and objectives to assess whether the right balance has been struck between population-based primary prevention activities and action to identify and support those who may be at more immediate risk of serious violence. This will enable the VRU to continue building on its public health approach to violence reduction.

Recommendation 7

The VRU should commission research using a larger sample of cases to explore patterns of escalation relating to a range of forms of violence, aiming to develop the equivalent of the intimate partner violence 'Homicide Timeline' for other types of violence.

Recommendation 8

The VRU should continue to work with primary and acute health services, mental health services, the police, children's social care and others. Pan London forums should be engaged with to ensure agencies are working together for the purpose of learning and improvement.

Recommendation 9

In coordinating a multi-agency approach, key areas of practice for the VRU and its partners to consider are: adolescent safeguarding, the role of schools in relation to tackling youth violence, strengthening responses to domestic abuse, and recognition of domestic abuse in non-intimate partner family relationships.

Introduction

The VRU commissioned two research projects which aim to support the development of its long-term strategy to understand violence across London. These are:

- **A Strategic Needs Assessment** – To highlight key challenges around violence and associated impact across London. This takes an evidence-led and emerging trends approach, setting out the strategic needs, which will help focus the VRU's priorities.
- **An analysis of Homicides and Serious Case Reviews** – To establish key causation factors and common patterns in serious violence, to help inform recommendations for the VRU and its partners.

The research was delivered through a partnership between the VRU, Behavioural Insights Team (BIT) and the Social Care Institute for Excellence (SCIE) with expert advice from the University of Bedfordshire.

What is this research about?

This report sets out the findings from the analysis of Homicides and Serious Case Reviews. It looks at:

- patterns and characteristics of incidents of violence, including:
- the incident and escalation towards it
  - characteristics and behaviours of victims and perpetrators
  - the context of the incident
- how professionals responded in the run up to incidents.

For the first time, Domestic Homicide Reviews, Serious Case Reviews (now known as Child Safeguarding Practice Reviews), Safeguarding Adults Reviews, and Independent Investigation Reports (formerly known as Mental Health Homicide Reviews) are brought together to review learning across the statutory review process. A statutory review is a process with a basis in law or policy which is carried out after certain types of homicides or serious harmful incidents.

Reviews look at the circumstances of the individuals involved in an incident, what led up to it, and how well services worked with the individuals prior to and, where relevant, after the incident. They make recommendations for any changes that need to be made to local and national practice.

Statutory reviews provide a useful source of in-depth information about particular cases, the individuals involved and what happened. However, they do not cover all types of case. This research is therefore a 'deep dive' in to the circumstances of certain types of violence in London, rather than a comprehensive exploration of all types of violence. It is part of an ongoing research programme.

What types of incident are included?

We looked at all the cases of homicide and non-fatal violence in London, meeting the criteria for either a Domestic Homicide Review, Independent Investigation Report, Serious Case Review[1] or Safeguarding Adult Review. A brief description of the criteria for each of the types of review is shown in Figure 1 below. We also included a small number of cases meeting statutory review criteria in which people had taken their own lives following bullying or peer victimisation.

1 Under Working Together 2018, Serious Case Reviews are now termed 'Child Safeguarding Practice Reviews'. However, in the interests of accessibility across sectors we have used the more well-known term 'Serious Case Reviews' throughout this document.

FIGURE 1. Four types of included statutory review

Domestic Homicide Reviews (DHRs)
Conducted after the death of a person aged 16 or over from violence, abuse or neglect by someone to whom they are related, in an intimate relationship, or in the same household.

Independent Investigation Reports (IIRs)
Conducted when a homicide is committed by someone under the care of sepcialist mental health services in the six months prior to the event.

Serious Case Reviews (SCRs – now called Child Safeguarding Practice Reviews)
Conducted when abuse or neglect known or suspected, a child under 18 has died or been seriously harmed, and there is concern about safeguarding practice.

Safeguarding Adult Reviews (SARs)
Conducted when an adult dies as a result of abuse or neglect (known or suspected), and there is concern about how services worked with that person.

We included reviews published since January 2016, and grouped the incidents into different forms of violence, resulting in the following categories:

- Youth peer violence
- Adult peer violence
- Intimate partner violence
- Adult family violence (violence between family members who are not intimate partners)
- Within-family violence towards children
- Child sexual abuse.

For each category, we analysed the characteristics and contexts of the incident, and how services worked with those involved, to determine if there were any patterns or themes across the cases.

Using statutory reviews as the basis of the research means not all deaths and serious incidents are covered. Our research focused particularly on deaths and serious incidents involving young people, vulnerable adults, domestic homicide and homicides committed by people receiving mental health treatment. The reviews do not cover incidents such as homicide or violence between adults who were not related or in a relationship and were not vulnerable in any way. This is therefore a gap in the research.

What has the research found?

The quality of learning from homicides and other violent incidents, particularly incidents of youth peer violence is insufficient.

This research raised concerns in relation to both the quantity and quality of publicly available reviews conducted on homicides and other incidents involving youth peer violence. It also highlighted that there are some kinds of homicide from which no learning is currently required as standard.

It found a relatively small number of Serious Case Reviews of serious youth violence and homicide. We found just four Serious Case Reviews (plus one Independent Investigation report) of youth homicides published in London since 2016. This is

in the context of over 120 deaths of young people aged 16-24 during this time.[2] The extent of publicly available learning is small and sporadic, even taking into account that the duty to undertake a Serious Case Review stops at 18, and that some local areas are conducting good quality non-statutory reviews.[3] Given the longstanding practice of conducting Serious Case Reviews following the deaths of children and young people, it is notable that the review mechanism is not used more frequently after incidents of youth peer violence and homicide.

This research was unable to explore in detail why a relatively small number of Serious Case Reviews are conducted following youth homicides. Whether or not cases of youth peer violence meet the criteria for a Serious Case Review hinges on whether peer violence between young people is interpreted as a form of abuse in its own right. There is nothing in the government definition of abuse and neglect which excludes this, and increasingly views are shifting toward more recognition of peer violence between young people as a form of abuse.

To date there has been no national steer or discussion about the implications of recognising peer violence as abuse for Serious Case Reviews. It would be beneficial for the sector to review this, along with government departments responsible for multi-agency safeguarding policy.

The findings also highlighted inconsistencies in quality across all types of reviews. For example, key demographic information such as the ages and ethnicities of those involved was not always reported. Information that would have helped to understand the wider context surrounding violent incidents was often missing, such as about individuals involved and how professionals responded. This limited their usefulness in providing wider learning about patterns in violent incidents.

Finally, there are many kinds of incident that would not be covered by any statutory review process, for example homicides between adults who are not vulnerable, in a relationship or related. Again, this raises the question of whether any more should be done to learn systematically from these incidents.

Recommendation 1

For systematic and rigorous learning from homicides and other violent incidents

The VRU should work with the Department for Education, other government departments, NHS England and national and local partners to assess and identify review processes that would enable systematic learning about the nature or violence in London. This should include review of:

- the mechanisms for learning about youth violence
- the content and quality of statutory reviews
- changes needed to support a public health informed and contextual approach to violence reduction
- whether additional learning processes are required for cases not currently covered by any statutory review processes.

Consideration should be given to further research that would assist the VRU in gaining an in-depth understanding of the nature and patterns of violence in London.

2 Metropolitan Police Service Data, accessed September 2019. Although this time period does not exactly match the time period in which the reviewed incidents occurred, it does illustrate the significant mismatch between the number of incidents that are likely to have occurred, and the number of statutory reviews currently available.

3 These incidents would also have been reviewed under Child Death Overview Panel arrangements. However, this information is not currently available publicly.

A wide range of forms of violence and people experiencing violence needs attention.

The VRU is committed to tackling all forms of violence. This research underscored both the range of groups who may be vulnerable to violence, and the differences between various types of violence. These findings underline the nuance required to mirror these differences in preventative strategies, objectives and activities.[4]

There is considerable attention being given to understanding and tackling serious youth violence. But, the findings demonstrate that this is not the full picture of violence in London. The reviews spanned a range of types of violence, including violence affecting young people, and between intimate partners, adult family members, parents and children. The nature of incidents varied significantly in terms of the characteristics of those involved, how the incidents escalated, and the contexts in which they occurred. Within the sample of reviews analysed, examples were:

- Most victims of adult family homicide were older people (aged 65 and above), and they were often carers for the perpetrator of the incident. This group would require a very different type of response to people at risk of youth peer violence, or intimate partner violence.
- Perpetrators and victims in youth and adult peer violence often barely knew each other, if at all. This is compared to the longstanding patterns of abuse within a relationship that were often seen in intimate partner homicide.
- Gang-related activity was an important contextual factor for youth peer violence, but was not a significant factor in the other categories included.

The differences between different types of violent incident and those involved described in the remainder of this report, suggest that different approaches to preventing and tackling the range of forms of violence is needed.

Recommendation 2

Tackling all forms of violence affecting a range of groups

In fulfilling its commitment to tackling all forms of violence, the VRU should ensure that the full range of groups experiencing violence and the types of violence occurring are part of its strategy. This should include activities to address:

- children at risk of violence within their families
- women at risk of intimate partner violence, including those who are originally from outside the UK
- older people, particularly those who are carers, who may be at risk of violence from family members
- vulnerable adults, including those living in supported or residential accommodation.

The VRU and other national and local organisations should also review the extent to which 'intimate partner violence' and 'adult family violence' are adequately distinguished within an overall approach to domestic abuse.

Violence is occurring in the context of a wide range of circumstances and experiences.

The VRU is committed to taking a contextual violence reduction approach,[5] aiming to tackle a range of contexts and influences that impact on people's lives. This research supports this approach,

4 London Violence Reduction Unit Strategy(2019) Available at: www.london.gov.uk/moderngovmb/ieListDocuments.aspx?CId=443&MId=6342&Ver=4

5 Ibid.

finding that violence largely took place against a background of disadvantage and distress – often in multiple aspects of people's lives. This ranged from their own individual characteristics through to the influence of their neighbourhoods and wider society. Effectively preventing and tackling violence would require focus on this range of issues.

The findings suggest a number of additional areas for focus within a contextual violence reduction framework. These are:

- **Early disadvantage.** In many of the cases reviewed, people's disadvantage and distress did indeed appear to have started with early childhood disadvantage and adverse childhood experiences (ACEs), including domestic violence, abuse and neglect and the absence of a parent. In some cases, there was evidence of early adversities, as well as issues later on in individuals' lives, such as breakdown in family relationships, going missing or becoming homeless – experiences which exposed them to greater risks. It is important to note, however, that the relationship between childhood adversity and negative experiences and outcomes in adulthood is not simple. There is ongoing debate about this and on the challenge of establishing causation.[6]
- **Adversity experienced in adulthood.** In addition to adverse experiences in childhood, it was evident that the majority of adult victims and perpetrators were suffering ongoing adverse life circumstances and difficulties. This may or may not have been linked to earlier adversity. Difficulties frequently experienced included, mental health problems, domestic abuse and substance misuse problems; as well as stressors, such as immigration issues, lack of access to housing, and financial problems.

The influence of community and neighbourhood factors. Several cases highlighted these in exposing individuals to risk. In particular, the influence of:

- schools as a potential protective factor for young people, but also a space in which they can become exposed to others involved in criminal activities, and the risks associated with school exclusion
- neighbourhoods where there is gang activity as a factor in serious youth violence
- neighbourhoods and communities with increased risk of exploitation, for example through sex work
- neighbourhoods with high levels of poverty, debt and insecure housing
- residential and supported accommodation for vulnerable adults, particularly where safeguarding arrangements are poor.

Recommendation 3

The VRUs approach to tackling serious youth violence should continue to focus on contextual and resilience factors, as well as considering whether adverse childhood experiences (ACEs) are relevant.

Recommendation 4

The VRUs approach should incorporate measures to address 'adverse adult life circumstances', including adult experiences of domestic abuse, mental ill health, substance misuse and stressors such as financial and housing problems and immigration issues.

6 Edwards R, Gillies E, Lee E, Macvarish J, White S and Wastell D (2017) 'The Problem with ACEs'. *Submission to the House of Commons Science and Technology Select Committee Inquiry into the evidence-base for early years intervention (EY10039). 12 December 2017*.

Recommendation 5

Building on the focus on tackling violence at a community and neighbourhood level, and priority to support wellbeing in schools, the VRU should consider the full range of places and spaces in which violence may occur.

These include:

- neighbourhoods where there is gang activity
- neighbourhoods and communities with increased risk of exploitation
- neighbourhoods with high levels of poverty, debt and insecure housing
- residential and supported accommodation for vulnerable adults, particularly where safeguarding arrangements are poor.

The different events, warning signs or risk points associated with escalation towards different forms of serious violence and homicides should be used to prevent and tackle it effectively.

As part of this research, we looked at the events leading up to a violent incident. Events that were commonly seen in the leading up to violent incidents included, perpetrators experiencing adverse life events, such as losing employment or the break-up of a relationship;[7] perpetrators with severe mental illness or psychosis disengaging from mental health services, and threats to and destruction of property by the perpetrator.

Across the small number of cases of youth peer violence events included, young people going missing, becoming engaged in escalating levels of offending, and buying and carrying weapons. In cases of domestic abuse, the domestically abusive partner being released from prison or custody featured in the escalation of several incidents.

The VRU takes a public health approach to violence reduction.[8] But, the findings indicate that some individuals are likely to 'slip through the net', even with improved preventative activities. It is important that interventions not only take a 'primary prevention' approach, tackling the root causes of violence, but also intervene when someone is at more immediate risk of involvement in serious violence or homicide.

As this research was based on a very small sample of cases, the findings are only an indication of the types of events which could form part of a pattern of escalation towards serious violence or homicide. There are gaps in the evidence about how violence escalates across the range of forms of violence, and therefore knowledge about how violent incidents can be reduced or prevented. Further research is needed, building on examples, such as the 'Homicide Timeline'[9] of intimate partner homicides.

Recommendation 6

Building on its public health approach to violence reduction, the VRU should consider prevention strategies for when serious violence is an immediate risk, in addition to population-based primary prevention.

7 This is supported by other research, for example Monckton Smith (2019) Ibid.

8 London Violence Reduction Unit (2019) Available at: https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/violence-reduction-unit-vru/public-health-approach-reducing-violence

9 Monckton Smith, J. (2019) Intimate partner femicide: using Foucauldian analysis to track an eight-stage relationship progression to homicide. Violence Against Women. Available at: https://journals.sagepub.com/doi/full/10.1177/1077801219863876

Recommendation 7

The VRU should commission research using a larger sample of cases to explore patterns of escalation in a range of forms of violence, aiming to develop the equivalent of the intimate partner violence 'Homicide Timeline' for other types of violence

Victims and perpetrators of serious violence come into contact with a wide range of agencies making a multi-agency approach crucial.

While specific and targeted initiatives to tackle violence are important, the cases highlighted that addressing violence is, and should be, part of the 'core business' of a wide range of services. These include, primary and acute health services, mental health services, police, children's social care, housing and many others.

This research found that these services have an important role to play in tackling some of the contexts and causes of violence. They are in a position to spot signs that particular individuals or families are at increased risk. However, the analysis of the reviews suggested that a number of aspects of service delivery could be strengthened:

- Continuing to improve an understanding of adolescent safeguarding issues, for instance on issues such as child criminal exploitation; and how multi-agency partners can work effectively, such as by taking a contextual safeguarding approach.
- Maximising the role of schools as a protective factor to minimise risks resulting from children's exposure to gang activity and from exclusions.
- Responses to domestic abuse, particularly in relation to risk management of perpetrators, safeguarding children within domestic abuse environments and cultural sensitivity.
- Recognition and responses to domestic abuse in non-intimate partner family relationships.

Building on its existing commitment to working across institutions and systems, the VRU could catalyse improvements across a range of services, as well as putting in place its own initiatives.

Recommendation 8

The VRU should continue to work with a range of partners across the statutory and voluntary sector, including with:

- primary and acute health services
- mental health services
- police
- children's social care
- housing pan-London forums which bring some or all of these agencies together for the purpose of learning and improvement.

Recommendation 9

In coordinating a multi-agency approach, key areas of practice for the VRU and its partners to consider are:

- adolescent safeguarding issues and approaches, such as contextual safeguarding
- supporting schools to maximise their role in relation to youth violence
- strengthening responses to domestic abuse, particularly in relation to risk management of perpetrators, safeguarding children and cultural sensitivity
- improving recognition and responses to domestic abuse in non-intimate partner family relationships.

How the research was conducted

Sources of information

This research has analysed information about homicides and non-fatal violent incidents investigated in four types of publicly available statutory reviews. A statutory review is a process with a basis in law or policy which is carried out after certain types of homicides or serious harmful incidents.

We included all cases of homicide and non-fatal violence in London meeting the criteria for either a Domestic Homicide Review, Independent Investigation Report (formerly Mental Health Homicide Reviews), Serious Case Review or Safeguarding Adult Review published since 2016. The terms of reference for each of these types of review is shown in Table 1.

Broadly, statutory reviews look at the circumstances of the people involved in the incident, what led up to the incident, and how any services worked with people involved. As such, they provide a useful source of detailed learning about the involvement of vulnerable people in violent and fatal incidents.

We included reviews that looked at both fatal and non-fatal violent incidents involving both adults and children. We also included cases where people had taken their own lives, and there had been an element of bullying or victimisation in the run-up to this. We looked at a total of 64 reviews, published in the last three years in London. The reviews were grouped into six categories:

- Youth peer violence amongst 10–25-year-olds (including bullying-related suicide) (eight cases)
- Adult peer violence (violence between two adults over 26 who are not related or in a relationship – nine cases)
- Intimate partner violence (17 cases)
- Adult family violence (nine cases)
- Within-family violence towards children under 18 (18 cases)
- Child sexual abuse outside the family (three cases).

We started the research by speaking to a range of senior leaders in relevant services, community and voluntary organisations and in academia.

Table 1. Scope and purpose of included reviews

Review type	Legislation	Oversight	Scope and purpose
Domestic Homicide Review	Section 9(3) of the Domestic Violence, Crime and Victims Act 2004[10]	**Overseen by:** Home Office **Commissioned by:** Local Community Safety Partnerships and conducted by independent author(s)	**Scope and purpose:** '… a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by — (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.[11]
Independent Investigation Review	Article 2 of the European Convention on Human Rights and with guidance in the NHS Serious Incident Framework[12]	**Overseen by:** NHS England working via Regional Investigation Teams **Commissioned by:** NHS England and conducted by independent author(s)	**Scope and purpose:** Commissioned '… when a homicide has been committed by a person who is, or has been, subject to a care programme approach, or is under the care of specialist mental health services, in the past six months prior to the event… 'Investigations carried out under this framework are conducted for the purposes of learning to prevent recurrence. They are not inquiries into how a person died as this is a matter for coroners. Neither are they conducted to hold any individual or organisation to account.'[13]

10 Domestic Violence, Crime and Victims Act 2004, c.9:3. Available at: www.legislation.gov.uk/ukpga/2004/28/contents

11 Ibid.

12 NHS (2015) Serious incident framework: Supporting learning to prevent recurrence. London: NHS England.

13 Ibid.

Table 1. Scope and purpose of included reviews *(continued)*

Review type	Legislation	Oversight	
Serious Case Review now known as Child Safeguarding Practice Reviews[14]	Previously the Local Safeguarding Children Boards Regulations 2006[15] Working together to safeguard children 2018[16]	**Overseen by:** Department for Education **Commissioned by:** Local Safeguarding Children Boards* and conducted by author(s)	**Scope and purpose:** Undertaken where: (a) abuse or neglect of a child is known or suspected; and (b) either – (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard the child.[17]
Safeguarding Adult Review	Legislation: Care Act 2014, Section 44[18]	**Overseen by:** Department of Health and Social Care **Commissioned by:** Local Safeguarding Adult Boards and conducted by independent author(s)	**Scope and purpose:** Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.[19]

*Now known as Local Safeguarding Children's Partnerships.

14 Department for Education (2015) Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. London: HMSO. p. 81

15 Statutory guidance on Serious Case Reviews changed in July 2018. However, all of the included reviews had been carried out under the framework provided in Working Together 2015 or 2013 which is described below.

16 Local Safeguarding Children Boards Regulations (2006) Available at: www.legislation.gov.uk/uksi/2006/90/introduction/made

17 Department for Education (2015) Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. London: HMSO. p. 75

18 Care Act (2014) Available at: www.legislation.gov.uk/ukpga/2014/23/contents/enacted

19 Care Act (2014) statutory guidance for safeguarding. London: Department of Health and Social Care. Available from: www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

Research questions

The research looked at:

1. patterns in characteristics of the incidents, including:
   a) the incident and escalation towards it
   b) the characteristics and behaviours of victims and perpetrators
   c) the context for the incident.
2. patterns in how professionals responded in the run-up to the incidents.

A 'health warning' about the research

This research was a 'deep dive' in to a sample of cases of homicide and violence which resulted in a publicly available statutory review in one of the four categories listed above.[20]

The types of cases we have included is therefore dictated by the remit of the available statutory reviews (see Table 1). This means there is a focus on issues such as violence involving children, violence involving vulnerable adults, mental health and domestic abuse. This sample **does not** therefore include all types of violence and homicides, and it is important to consider the findings of this research alongside the overarching Strategic Needs Assessment conducted with this review.

It is difficult to compare the numbers of cases we have found here with the frequency of incidents overall, due to the way that data are gathered and reported. However, Table 2 below shows some of the ways that some types of incident are over- and under-represented in our data. Where available we have used data from London. Otherwise data has been taken from the Home Office Homicide Index.

This research was also dependent on the quality and quantity of information in the review reports. Whilst many of these are very comprehensive, there are often gaps in the reporting of:

- demographic information such as ethnicity (as has been noted elsewhere)[21] and ages of those involved
- information about the wider context which may have influenced individuals and events
- analysis about *why* any observed problems in practice occurred.

20 We have not included information from review processes that are not currently in the public domain such as the Child Death Overview Panel process.

21 Bernard, C and Harris, P. (2018) Serious Case Reviews: The lived experience of Black children. Family Social Work 24(2). Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/cfs.12610?af=R&

TABLE 2. Comparing reviews to overall numbers of homicides

Category	Our sample	Compared to…	Suggests…
Youth peer violence	…includes 4 homicides[22] of young people aged 16-24 (6% of our sample).	35% of homicides in London in 2018[23] involved this age group.	Under-represented in our data. 
Adult peer violence	… includes 13 cases in which the homicide was by a friend/ acquaintance or stranger (20% of our sample).	55% of homicides in England and Wales in 2018.[24]	Under-represented in our data. 
Intimate partner violence	…includes 17 cases of intimate partner homicides (26% of our sample).	20% of homicides in London in 2018.[25]	Over-represented in our data. 
Adult family violence	…includes 9 cases of homicides of people over 16 by a family member (14% of our sample).	5% of homicides of people over 16 in England and Wales in 2018.[26]	Over-represented in our data. 
Within-family violence towards children	…includes 14 cases of fatal incidents[27] of children aged under 16 by a family member (22% of our sample).	7% of homicides in London in 2018 were of children under 16.[28]	Over-represented in our data. 

22 One young person was under 16.
23 Metropolitan Police data, accessed September 2019.
24 Office for National Statistics (2019) Homicide in England and Wales: year ending March 2018.
25 Metropolitan Police data, accessed September 2019.
26 Office for National Statistics (2019) Op. cit.
27 Note, not all of these would be categorised as homicide.
28 Metropolitan Police Service Data, accessed September 2019.

Summary of findings from the reviews

The following sections set out what the reviews told us about the characteristics and contexts of the incidents and how professionals responded in each of the categories we have looked at. For further information about the analysis of the reviews, see accompanying appendices (appendix 2–7).

Youth peer violence

We analysed eight cases of youth peer violence: five homicides, and three suicides by young people where peer violence or bullying had been present in the time before they took their own life.

Four of the homicide victims were young men aged 14 to 25, and one was a 17-year old young woman. All of the perpetrators were known or suspected to be young men. In three incidents the weapon used was a knife, one was a gun and for one incident the method of killing was not reported. Three of the incidents took place on the street/in a public place, one was at the perpetrator's home, and for one the location was not reported.

The three people who took their own life were all young women aged 12–18.

We chose to group the homicide and suicide cases together in order to highlight the similarities in the characteristics of the victims and the social contexts within which they were being exposed to risk and abuse.

Key findings

A lack of data about this group

Our research found that a relatively small number of statutory reviews of youth violence had been conducted – we found just five reviews of youth homicides published in London since January 2016.

CASE STUDY 1

Youth peer violence (homicide)

This case involved a 17-year-old young man who was killed in an altercation with three other young men outside his temporary accommodation. It was unclear if he knew the young men. However, there was some suggestion that the altercation was gang-related due to marks left on the body.

Leading up to incident the young person had been involved in increasingly serious offending, including robbery, sexual assault and suspected murder. He had also decided to leave his family home but had been evicted from his independent accommodation, and had since been living at multiple addresses.

The young person was brought up by his mother who was also caring for her disabled young brother and suffered depression and exhaustion.

Source: Serious Case Review

This is in the context of over 120 homicides of young people aged 15–25 occurring during this time.[29]

Several London boroughs have conducted non-statutory 'thematic' reviews into serious youth violence and we have looked at four of these as part of this research.[30] However, the small number of reviews raises important questions about how the system is learning from serious incidents involving adolescents, which the VRU and others will be exploring further.

29 Metropolitan Police Service Data, accessed September 2019.

30 Croydon Vulnerable Adolescents Thematic Review; Tower Hamlets – Troubled Lives, Tragic Consequences; Camden Youth Safety Taskforce; Southwark Extended Learning Review.

Experience of multiple risks

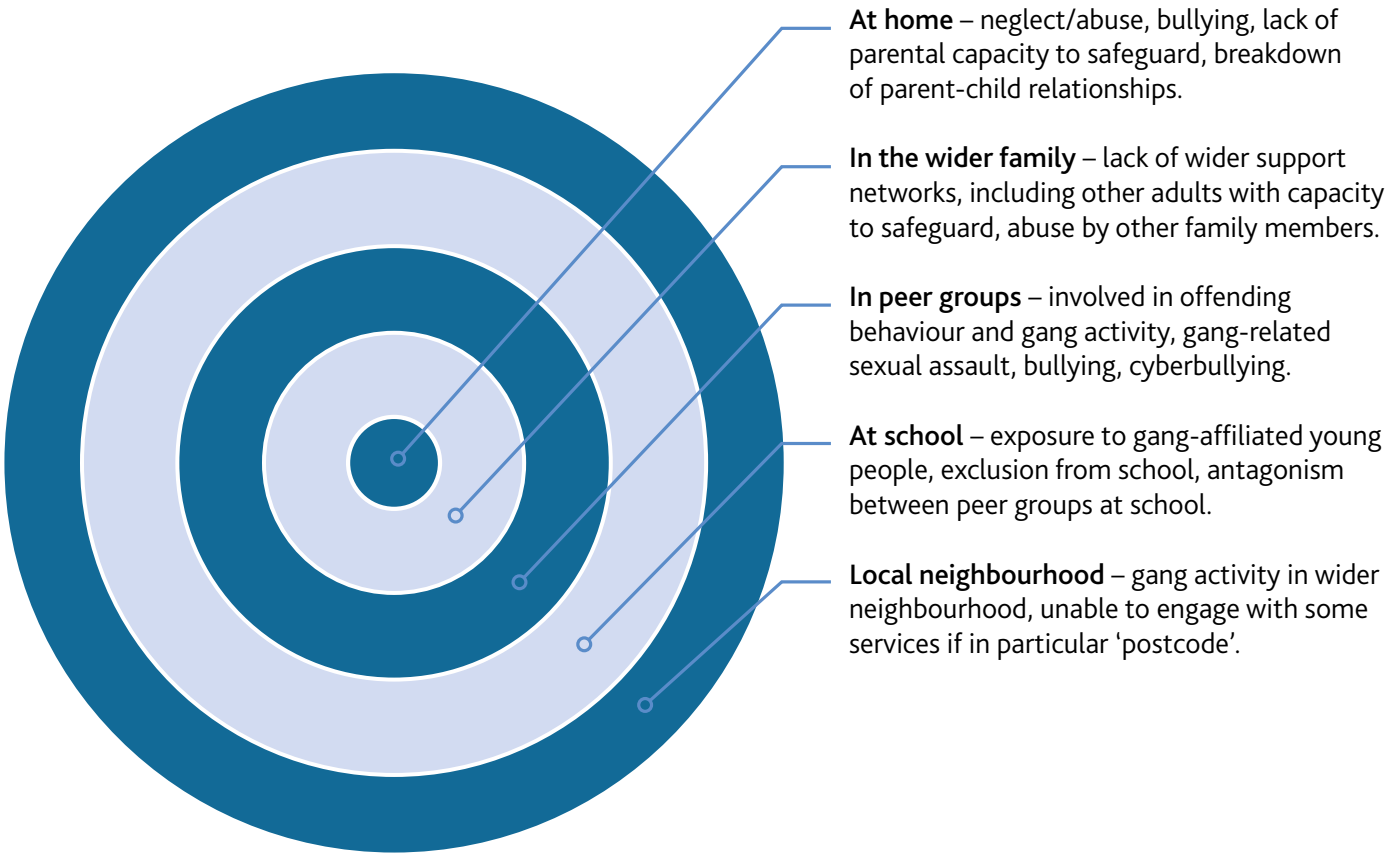
In most of the cases we looked at, both homicide and suicide victims were experiencing risk in many different parts of their lives, as illustrated in Figure 2 below.

For example, a young victim of homicide might be experiencing abuse or neglect within the home, exposure to other young people involved in criminality within their school, and grooming by gang members operating in their local neighbourhood. Or a young person who took their own life may have been abused within their family network, as well as being a victim of crime at the hands of peers and adults within their local area. Each of these factors has a varying influence on the safety of a young person at any given time – knowing which to prioritise to create safety is a complex process.

The reviews found that the multiple risks young people were exposed to were often exacerbated by:

- No single professional agency having an overview of risk in a young person's life – for example, a school might know about risks from a young person's immediate peer group but not gang activity in their local area, which would be dealt with by police, and vice versa.
- A tendency for professionals not to see adolescent risks within a safeguarding framework. For example, young people who had been groomed to sell drugs were largely dealt with via the criminal justice system, but did not receive a safeguarding response from children's social care.

FIGURE 2. Contextual factors experienced by victims of youth violence in eight cases



Escalation towards the incident

In the youth homicide cases, the escalation towards the incident often involved the young person being involved in increasingly risky contexts and situations, including:

- escalating patterns of offending, including violent offending
- going missing or choosing to move out of home
- buying or carrying weapons.

This was with the exception of one young woman who was killed by a male friend, who did not show any of the above behaviours. For the young people who took their own lives, all had self-harmed prior to the incident.

As noted above, professionals did not always note the safeguarding implications of these behaviours. For example, escalating patterns of offending often led to an increased involvement with police and youth offending services, but not involvement with children's social care from a safeguarding perspective.

Disproportionate representation of Black/ Black British young people in homicide cases

This was a very small sample of cases. However, within this small sample, young black men were over-represented as victims of peer homicide.[31] This fits with the broader data that suggests that young black men under 24 accounted for one in five victims of homicide.[32]

There is other research that examines the complexity of young people's ethnicity and relevance to their vulnerability.[33, 34] The reviews did not provide an exploration.

Adult peer violence

We looked at nine reviews of adult peer violence, eight of which were homicides and one serious violent incident involving a vulnerable adult. There were six male and three female victims, ranging in age from 25 to 74. There was one female and eight male perpetrators, aged 18 to 44. The relationship between the victims and perpetrators ranged from strangers to people who were friends/acquaintances

CASE STUDY 2

Adult peer violence – Mr X and Mr Y

The perpetrator and victim were both residents of a homeless hostel, which is where Mr Y was killed in a stabbing incident.

Prior to the incident they had been in dispute regarding a drug debt.

Mr X was of Eritrean origin and had come to the UK due to the risk of being enlisted in the army against his will. He had previous convictions for carrying a bladed article, but no recorded history of violence. He was a mental health service user who reported he had stopped taking his medication prior to incident.

Mr Y had a longstanding substance misuse problem and multiple physical health problems.

The review concluded that lack of clarity about safeguarding practices in the hostel was a contributory factor in the incident.

Source: Independent Investigation Report

31 The ethnicity of young people who took their own lives was not reported.

32 Homicide in London: Insights from exploring police data. Internal MOPAC document.

33 Bernard, C (2018) Serious case reviews: The lived experience of Black children. *Child and Family Social Work* 24(2) 256-263.

34 Croydon Safeguarding Children's Board (2019) Vulnerable adolescents thematic review. London: Croydon LCSB. Available at: https://croydonlcsb.org.uk/wp-content/uploads/2019/02/CSCB-Vulnerable-Adolescent-Thematic-Review-PUBLISHED-Feb-2019.pdf

or flat/housemates. In seven of the homicides, a knife was used as the weapon and for one the method of killing was not reported.

Key findings

Vulnerable victims and perpetrators

All of the perpetrators, and most of the victims of the incidents of adult peer violence we looked at were vulnerable adults. This included:

- people with mental ill health
- people with chronic illness
- disabled people
- people without employment and/or who were homeless.

Those involved often had a lack of family contact of wider social support/networks, for example people who had become estranged from their families and children. The exception to this was victims of stranger violence – often these individuals had been targeted at random and did not appear to have any pre-disposing vulnerabilities.

The high levels of vulnerability that we saw in this sample are likely to be due to using statutory reviews as our source data, and may not be representative of the wider population who commit, or are subject to, peer violence.

Role of supported and residential accommodation

In several cases, the victim and perpetrator knew each other because they lived together in supported or residential accommodation. Again, this may a particular factor in the cases we looked at because incidents occurring in these settings should trigger a review. However, it is important to think about the risks involved where a number of vulnerable adults are brought together, often in environments which the reviews found had poor safeguarding arrangements or security measures such as locks on doors.

Lack of prior violence within the relationship

The majority of perpetrators had a history of violence such as assaults on their family members or on professionals. However, in most of the cases we looked at, there was no history of physical conflict or violence between the victim and perpetrator.

Intimate partner violence

We analysed 17 cases of intimate partner violence, all of which were homicides. There were 15 female and two male victims aged between 18 and 44. The perpetrators were 15 men and two women, also aged between 18 and 44. In most cases, the victim and perpetrator were in an intimate relationship at the time of the incident (married, partners) although of these, four couples were separated. Information about weapons used was given in twelve of the reviews.

CASE STUDY 3

Intimate partner violence – Nargiza

Nargiza was originally from a Central Asian Republic, and most of her family still lived there. She and her husband had three children, two of whom lived overseas with her family.

Nargiza was killed by her husband at their home. This followed a pattern of abuse within the marriage, including physical abuse, coercive control, financial abuse, emotional abuse and isolation, sexual violence and using her children to control her behaviour. Her husband's alcohol use was also a factor in some of the abuse.

Nargiza had insecure immigration status, which her husband used as part of coercive control, for example threatening to cancel her visa after a visit home so that she would not be able to return to the UK.

Source: Domestic Homicide Review

Nine of the homicides were committed with knives, one was committed with multiple weapons including a knife and an iron, one with a firearm, and from being pushed from a high building.

Key findings

Nationality, ethnicity and gender

Women from backgrounds other than White British were disproportionately represented amongst these cases (10 of 19 cases; ethnicity not reported for six cases). This appeared to contribute to women's vulnerability in terms of:

- For women who had been born outside the UK, there was a lack of family support networks to whom they could turn for help, or who may have been able to notice that there were difficulties in the relationship. In some cases, women's isolation was compounded by having married outside of their own culture or religion against their family's wishes.
- Being more reluctant to engage with services. In some cases, concerns about immigration status or being drawn in to illegal activities such as sex work or suspected sex work (for example through licensed massage parlours) may have played a role on this.
- Where women spoke English as an additional language, there was sometimes a language barrier to engaging with services.
- In some cases, having insecure immigration status formed part of the coercive control in the person's relationship.

Our analysis suggested that services were not always well equipped to understand the intersecting issues of ethnicity, nationality and gender. For example, abusive behaviours between partners were sometimes ascribed to 'cultural issues' – for example, that it was appropriate within that person's culture that the woman in a relationship should 'obey' the man. In other cases, background factors such as the vulnerability of women of some nationalities to being exploited through, for example, involvement in sex work were not well understood by practitioners.

Alcohol and substance misuse

A significant proportion of perpetrators, and a smaller number of victims, in the cases we reviewed had alcohol and substance misuse problems. In many cases, alcohol and substance misuse were one of the features of the domestic abuse between the perpetrator and victim, and in several cases, this was a factor in the escalation towards the incident.

Despite this, only a small number of perpetrators had contact with specialist substance misuse services. In some cases, this was because the perpetrator refused to engage with services or seek help. In some cases, recommended referrals to substance misuse services were not made or followed up.

Prior domestic abuse within the relationship

In the majority of incidents of intimate partner homicide, there had been known prior domestic abuse within the relationship, including physical abuse (in over half of cases), emotional abuse, coercive control, financial abuse and stalking. This coincides with findings of other research which shows that intimate partner homicides often show a predictable pattern of escalation.[35]

Many of the reviews highlighted issues relating to the professional response to domestic abuse. In a number of cases, perpetrators were not arrested for domestic abuse offences prior to the homicide, despite there being sufficient grounds for arrest. Whilst in a number of cases this was because victims did not want to press charges, the reviews note that alternative routes to prosecution (for example evidence-based prosecution) were not pursued. In some cases, this appears to have led to a lack of

35 Monckton Smith, J. (2019) Intimate partner femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide. Violence Against Women, e-publication.

trust in the police by the victim. In several cases, the reviews found that services did not adequately register escalating patterns of frequency and seriousness of abusive incidents.

Adult family violence

We reviewed nine cases of adult family violence (violence between family members who were not in an intimate partner relationship), all of which were homicides. There were five female and four male victims, the majority of whom were aged over 65. There were eight male perpetrators and one female, aged between 25 and 54.

In all but two cases, the relationship between victim and perpetrator was that of parent-child. Four were mothers killed by sons, two were fathers killed by sons, and one father was killed by his daughter. The remaining two cases were of siblings.

Information about weapons used were given in six of the reviews. Five of the homicides were committed with knives, or a bladed object, and one via asphyxiation.

Key findings

Older age profile of victims

It was notable that victims in this category had a considerably higher average age than any of the other categories, with the majority being over 65. This reflects the fact that most victims were elderly parents of adult children. The older age of the victims also meant that they experienced vulnerabilities such as chronic health problems.

Perpetrator mental ill health

Nearly all the perpetrators in the cases of adult family violence we reviewed had serious mental health problems, and in one case the perpetrator also had a learning disability. However, this may partly be because our principal source of data was Independent Investigation Reports of homicides committed by people in receipt of mental health services.

CASE STUDY 4

Adult family violence – Delphine

Delphine was 81 at the time of the incident and of Mauritian heritage. She had multiple health conditions related to her age. She was the main carer for Julien who had an autism spectrum disorder and diabetes and was later diagnosed with psychosis.

Delphine had not received a carer's assessment or been identified as a vulnerable adult. Julien had not been violent to her before the incident, but had destroyed her property on occasions, which meets the definition of domestic abuse.

Julien was admitted to an inpatient mental health unit when he started refusing to eat, drink or take his medication. Once he had improved slightly he was allowed to take unescorted leave from the ward. Julien killed his mother while taking authorised unescorted leave from the unit.

Source: Domestic Homicide Review

A worsening of perpetrators' mental health problems; disengaging, or being discharged, from mental health services, or ceasing to take prescribed medication was therefore a common feature in the escalation towards the incidents in these cases. In a small number of cases it appeared that risk assessment processes relating to mental health problems tended to focus on the person's risk to themselves, with less of a focus on any risk they might pose to others.

Caring relationships between victims and perpetrators

In six of the cases reviewed, there was a caring relationship between the victim and perpetrator. In five cases the victim was the main carer for the perpetrator, and in one case the perpetrator was the

carer for the victim. There was an additional case in which victim and perpetrator were siblings who were both carers for their seriously ill mother.

The reviews highlighted the significant strain that caring placed on individuals and relationships. There appeared to be a lack of consideration of the carer's ability to care – particularly given that many of them had chronic health problems themselves.

In many of the reviews we considered, those in caring roles had never been offered a formal carer's assessment, despite meeting statutory definitions, and being treated as the main carer in other ways (for example, attending care review meetings). This resulted in a lack of support for both the carers and the cared-for person, meaning that neither person's needs were adequately met.

Recognising domestic abuse between family members

The cases of adult family violence often featured behaviours meeting the definition of domestic abuse, including destruction of property, emotional and physical abuse, and financial abuse. However, these were rarely recognised by practitioners as such, and specialist domestic abuse support was not involved in any of the cases we reviewed.

This appeared in part to be because the forms of abuse that were occurring – including financial abuse and destruction of property – were less readily recognised as 'domestic abuse'. There was also some evidence that professionals less readily recognised domestic abuse within the context of a parent-child relationship, or in one case within relationships across a wider family.

Within-family violence towards children

We analysed 18 cases of violence towards children aged under 18 which occurred within a family context. Fourteen were reviews following fatal physical abuse or deliberate homicide, four were reviews of serious non-fatal harm due to intentional physical injury or assault.[36]

These cases included 23 child victims (five incidents included two child victims), including nine female and 10 male victims (gender was unknown in six cases). In two of the incidents, an adult was also killed within the same incident and three also involved the suicide of the perpetrator. In the cases we looked at, most children who had been killed or seriously harmed were under the age of five – this pattern has also been seen at a national level.[37]

We took a wide definition of 'family', to include step-parents, partners, grandparents and so on. Within this definition the perpetrator or suspected perpetrator in 17 cases was the child's biological parent or parents. In one case the perpetrator was the partner of the child's mother. There were roughly equal numbers of female and male perpetrators (12 and 11 respectively). The majority of incidents did not report use of a weapon.

Key findings

Prior abuse and neglect of children, and involvement of children's social care services

Similar to the findings of other research,[38] over half of the victims in this sample had not, on the basis of the information in the reviews, been subject to known abuse or neglect prior to the incident. Similarly, the majority were not known to children's social care services before the incident.

36 We did not include deaths related to, but not directly caused by maltreatment such as deaths resulting from poor supervision. See Appendix 1 Methods section for more detail.

37 Brandon M, Bailey S., Belderson P et al. (2009) *Understanding Serious Case Reviews and their Impact. A Biennial Analysis of Serious Case Reviews 2005-07*. London: DSCF

38 Brandon M, Belderson, P, Warren C et al. (2008) *Analysing child deaths and serious injury through abuse and neglect: What can we learn? Biennial analysis of Serious Case Reviews 2003-2005.* London: DCSF.

CASE STUDY 5

Family violence towards children under 18 – Family W

Ms W was a white British woman and had lived in southeast London all her life. She appeared to come from a close-knit family who were supportive of one another.

Ms W was experiencing a range of stress factors in the months leading up to the incident including homelessness, debt and suffering a miscarriage. Ms W also suffered from depression.

Ms W killed her two children, aged nine and three, using methadone before taking her own life. She had not been prescribed methadone or had known substance misuse problems.

Source: Serious Case Review

In several cases the family had been known to mental health services, due to parental mental ill health (see below). However, worsening parental mental health did not always lead to a consideration of safeguarding issues for any children, or a referral to children's social care. This highlights the importance of taking a 'Think Family' approach to parental mental health, and considering any risks to children arising from parental mental health problems.

In many cases, the families had been known only to universal services such as their GP and health visitor prior to the incident. This reinforces the key roles these services play in safeguarding, and in being alert to known risk factors such as domestic abuse and parental mental ill health.

Parental mental health problems

Whilst the vast majority of parents with mental health problems do not pose any risk to their children, parental mental ill health is a known feature of cases where children are killed or injured by parents.[39]

We took a wide definition of 'family', to include step-parents, partners, grandparents and so on. Within this definition the perpetrator or suspected perpetrator in 17 cases was the child's biological parent or parents. In one case the perpetrator was the partner of the child's mother. There were roughly equal numbers of female and male perpetrators (12 and 11 respectively). The majority of incidents did not include use of a weapon.

Domestic abuse

Domestic abuse also featured in a high proportion of the included reviews. Exposure to domestic abuse is recognised as a form of abuse itself. There also appeared to be two key ways that domestic abuse was linked to incidents of violence towards children:

- Domestically, and often physically, abusive partners (often men) directing violent behaviour towards their children. For example, in one case following the breakdown of a relationship which had featured domestic abuse including threats to kill, one man killed his youngest child and ex-partner.
- Domestic abuse forming part of a range of stressors and other risk factors such as substance misuse and involvement in offending behaviour, which formed the backdrop to a violent incident towards a child.

Housing, financial and immigration issues

In many of the cases, families were under multiple stresses including issues with housing, money and immigration status. In most cases, there did not appear to be a direct causal relationship between these stressors and the incident. However, they further contributed to the pressures on family relationships and mental health.

39 Brandon M, Belderson, P, Warren C et al. (2008) *Analysing child deaths and serious injury through abuse and neglect: What can we learn? Biennial analysis of Serious Case Reviews 2003-2005*. London: DCSF

Issues in relation to housing occurred frequently, in terms of families living in accommodation that was inadequate, families living in temporary accommodation, experiencing frequent housing moves and homelessness. In a number of cases this placed a strain on parents and their ability to care for their children, as well as their ability to engage with services – and for services to locate and engage with them.

Financial difficulties, including debt arising from rent arrears, lack of financial support from estranged partners, and problems with benefit payments were also a feature in a number of cases.

Finally, difficulties faced by people originally from outside the UK also featured in a number of cases. For some people, this meant that they had no support networks or family within this country who might have been alert to risk factors or changes in their behaviour. In some cases, difficulties in relation to obtaining secure immigration status represented another stress factor on parents.

Child sexual abuse

We analysed three cases of sexual abuse of children. It is relatively unusual for these cases to be subject to statutory review. However, these cases had been reviewed because one was sexual abuse perpetrated by a young person (aged 17) towards a young child, one was a young child who was abused by their foster carers, and one was a nine-year old who had had indecent images made of her.

Key findings

It was difficult to draw thematic conclusions from such a small number of cases, which were quite different from each other. One key finding related to **links between other prior abuse and neglect and child sexual abuse outside the family**. As has been found elsewhere, the young people in these cases who were sexually abused outside their family had experienced prior forms of abuse – such as sexual abuse or neglect – within their family.[40] In one case neglect appeared to also be linked to the parent not safeguarding the child from extrafamilial sexual abuse. Again, this is similar to the findings of other research.[41]

CASE STUDY 6

Sexual abuse – Kesandu

Kesandu was nine years old and lived with her mother. Her parents were separated. A number of concerns had been raised about Kesandu at school in relation to suspected neglect – for example being overweight, having inappropriately sized clothing and not having underwear. The school provided support through an early help/Team Around the Family process.

The Child Exploitation Online Protection (CEOP) Service received an anonymous referral in relation to indecent images of a young girl being shown in a YouTube video. Following investigation, which took several months, the girl was identified as Kesandu.

The local police and children's social care worked together with school to do a joint home visit. The home conditions were found to be unsuitable for a child. Kesandu was taken in to the care of the local authority.

Source: Serious Case Review

40 Flood, S and Holmes D. (eds) (2016) Child neglect and its relationship to other forms of harm – responding effectively to children's needs: Executive summary, Totnes: RIP, NSPCC, Action for Children. Available at: www.nspcc.org.uk/globalassets/documents/research-reports/child-neglect-an-evidence-scope-executive-summary.pdf

41 Berelowitz, S., Clifton, J., Firimin, F. C., Gulyurtlu, S and Edwards, G. (2013) "If only someone had listened" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report. London: Office of the Children's Commissioner.

Implications for the VRU and partners

This section sets out what the findings of the research might mean for the work of the VRU and other local and national partners.

Is the whole system learning in the right way?

This research reviewed learning from across four publicly available statutory review processes: Domestic Homicide Reviews, Independent Investigation Reports, Safeguarding Adult Reviews and Serious Case Reviews. The research raised concerns in relation to both the quantity and quality of reviews conducted on homicides and other incidents involving youth peer violence. It also highlighted that there are some kinds of homicide from which no learning is currently required as standard.

Learning following serious youth violence

This research found a relatively small number of Serious Case Reviews of serious youth violence and homicide – we found just four Serious Case Reviews (plus one Independent Investigation report) of youth homicides published in London since 2016, in the context of in the context of over 120 deaths of young people aged 16–24 during this time.[42] Even taking into account the fact that the duty to undertake SCRs stops at 18, and the good quality non-statutory reviews that some local areas are conducting, this suggests the extent of publicly available learning is small and sporadic.[43] Given the longstanding practice of conducting Serious Case Reviews following the deaths of children and young people as a result of, for example, abuse and neglect within the family, this raises questions about why this review mechanism is not used more frequently after incidents of youth peer violence and homicide.

This research was unable to explore in detail why a relatively small number of Serious Case Reviews are conducted following youth homicides. What is clear is that whether or not cases of youth peer violence meet the criteria for a Serious Case Review hinges on whether peer violence between young people is interpreted as a form of abuse in its own right. Views about this seem to be shifting toward increasing recognition of peer violence between young people as abuse. However, to date there has been no national steer on the implications of this for Serious Case Reviews from the government departments responsible for multi-agency safeguarding policy. Further discussion within the sector about this would be beneficial.

Quality of reviews

This research also highlighted inconsistencies in quality across all types of reviews. The reports often had gaps in the information provided terms of:

- information about victim and perpetrator, such as age and ethnicity. The reasons for this (for example, whether this information was not known or not reported for a particular reason) were unclear
- a lack of thorough exploration of contextual factors relevant to the incident,[44] for example relating to people's families, peer groups and communities. Whilst this could be considered not to strictly be within the remit of statutory review processes, inclusion of this information would

42 Metropolitan Police Service Data, accessed September 2019. Although this time period does not exactly match the time period in which the reviewed incidents occurred, it does illustrate the significant mismatch between the number of incidents that are likely to have occurred, and the number of statutory reviews currently available.

43 These incidents would also have been reviewed under Child Death Overview Panel arrangements. However, this information is not currently available publicly.

44 Similar to Firmin C (2017) Contextualising case reviews: a methodology for developing systemic safeguarding practices, *Child and Family Social Work* 23 (1) 45-52

significantly assist organisations such as the VRU and others who are seeking to take contextual approaches to violence reduction

- a lack of clear analysis of reasons underlying some poor professional practice observed in the cases which could in turn better inform activities to improve practice (as has been noted elsewhere[45]). In a number of the reports, descriptions were given of aspects of professional practice that could have been improved, without consideration of *why* this practice was observed, and the blocks and barriers that professionals may have been experiencing.

Statutory reviews are potentially useful sources of learning to a wide range of stakeholders – not just the immediate 'commissioners' of the reviews. As such, it may be helpful to consider in a more holistic way how the methods used in the reviews can be better aligned to the kind of learning that is needed by a range of organisations to improve services, drawing on approaches such as contextual case review[46] and systems approaches to case review, which aim to understand more about the factors underlying and poor practice observed in a review.[47]

Incidents not covered by any statutory review process

Finally, as noted in the 'Health warning' at the start of this document, there are many kinds of incident that are not covered by any statutory review process. For example, homicides between adults who are not vulnerable, in a relationship or related, and not committed by someone in receipt of mental health services are not routinely subject to statutory review processes. This potentially leaves a gap in our knowledge about the characteristics and circumstances of these incidents, which could be used to inform preventative strategies and activities.

Clearly introducing statutory review processes for additional types of incidents would have a resource implication, and it may simply not be feasible to conduct review processes after all homicides. However, this research does raise the question of whether any more should be done to learn systematically from incidents not currently subject to statutory review processes.

Taking a differentiated approach to violence

The VRU is committed to tackling a range of forms of violence, within a broad World Health Organization definition.[48] This research underscored both the range of groups who may be vulnerable to violence, and the differences between various types of violence. These findings underline the nuance required to mirror these differences in preventative strategies, objectives and activities.

With the exception of violence by parents towards children under 18, the overwhelming majority of cases in our sample were incidents involving knives. However, many did not fit the typical media portrayal of 'knife crime' as street-based crime between young people. Instead the cases reviewed spanned a range of other forms of violence, including intimate partner violence, violence between adult family members and violence between parents and children.

This research provides a useful reminder that incidents of violence can look and 'feel' very different in terms of:

- the characteristics of the individuals involved
- the relationships and dynamics between victim and perpetrator
- patterns of escalation towards the incident
- the contexts which give rise to violence.

45 Similar to Fish S, Munro E, Bairstow S (2008) Learning together to safeguard children: developing a multi-agency systems approach for case reviews. London: Social Care Institute for Excellence.

46 Firmin (2017) Op. cit.

47 Fish et al. (2008) Op. cit.

48 World Health Organization. Definition and typology of violence. [online] Available at: www.who.int/violenceprevention/approach/definition/en/

TABLE 3. Victim characteristics[49]

	Youth peer violence 8 reviews	Intimate partner violence 17 reviews	Adult family violence 9 reviews	Adult peer violence 9 reviews	Within-family violence towards children 18 reviews	Child sexual abuse 3 reviews
Gender	Homicide: 4 male, 1 female; Suicide: 3 female	15 female, 2 male	5 female, 4 male	6 male, 3 female	10 male, 9 female, 4 not reported[50]	2 female, 1 case with multiple victims, genders not reported
Age range	13–25	18–44	35–85+, majority over 65	25–74	0–18, majority aged 5 or under	Not reported (2), 8–9 (1)
Ethnicity	Not reported (5), Black/Black British (3)	White (5), Asian/Asian British (3), Black/ Black British (2), Mixed (1), Other (1), Not reported (5)	White (3), Asian/Asian British (3), Black/ Black British (2), Not reported (1)	Not reported (8), White (1)	Not reported (9), Mixed (7), Black/Black British (6), Asian/Asian British (1)	Not reported
Most commonly occurring victim characteristics in this sample[51]	**Absent parent(s) (5)** **Abuse or neglect (as a child) (5)** **Experiencing domestic abuse (5)** Mental health difficulties (5) Substance misuse problems (5)	**Experiencing domestic abuse (12)** **Alcohol misuse (5)** Domestic abuse during pregnancy (4) **Substance misuse (4)** **English as a second or additional language (4)** Born outside UK (4)	Caring responsibilities (6) Chronic illness or long-term condition (6) **Experiencing domestic abuse (4)** **English as a second or additional language (4)** Abuse or neglect (as an adult) (3)	Chronic illness or long-term condition (3) Disability (2) Unemployment (2)	**Experiencing domestic violence (9)** **Abuse or neglect (as a child) (8)** Parent with a mental health condition (8) **Growing up in a household in which there are adults experiencing alcohol and drug use problems (7)** **Absent parent(s) (3)**	**Absent parent(s) (2)** **Abuse or neglect (as a child) (2)** Care-experienced child (2)

49 See Appendices 2-7 for further detail.
50 Five cases had two child victims
51 Shows the top five most common characteristics in each category. Bold text denotes characteristic that appears in two or more categories.

For example, the differing characteristics of victims and perpetrators across different types of incident are illustrated in Tables 3 and 4. Comparing across the categories, we see that whilst some characteristics of the people involved in homicides and violent incidents recurred, there were also significant differences between the categories. Key findings included:

- Nearly all perpetrators in all categories were men, with the exception of within-family violence towards children where there was a roughly even gender split between the perpetrators.
- For most categories of violence towards adults, the majority of victims were in middle age. However, for adult family violence, victims tended to be aged 65 or older – reflecting the fact that most of the victims in this category were older parents of adult children.
- Compared to other categories, both intimate partner violence and adult family violence categories included a relatively high number of people who had been born outside the UK and/or for whom English was a second or other language. This appeared to relate to having limited family support in this country, and also difficulties in engaging with services that could provide support.
- Victim characteristics which recurred across categories included experiencing domestic violence prior to the incident, having experienced abuse or neglect as a child, having one or more absent parents, and alcohol or substance misuse either by the victim or within their family.
- However, there were also key differences between victims of different types of incident. For example, victims of adult family violence tended to have different characteristics including being in a caring role for the perpetrator, and experiencing chronic health conditions – often linked to their older age. Victims of adult peer violence in the cases reviewed here were often marginalised individuals, for example people who were homeless or living in supported accommodation.
- Perpetrator characteristics which recurred across categories included mental health problems, substance misuse problems, and unemployment. However, there were also some distinctive features between categories. For example, perpetrators of intimate partner violence appeared to have a greater frequency of alcohol misuse problems than in other categories.

This research also highlights the importance of taking a nuanced approach to ethnicity, and to consider: how ethnicity interacts with other forms of vulnerability; what it means in terms of the day-to-day realities of individuals,[52] and how it affects their capacity and willingness to engage with services that may support them.

Whilst minority ethnic groups were over-represented in most categories of violence, based on this small sample, the specific groups involved and how ethnicity interacted with other factors was different for different categories. For example, the experience of a black British young man born in the UK, trying to negotiate gang affiliations in their school and neighbourhood whilst becoming increasingly involved with the criminal justice system is of course very different to a woman from Central Asia, speaking English as an additional language, living in a domestically abusive relationship and afraid to seek help in case it draws attention to her immigration status. Again, this suggests that approaches to violence prevention will need to be tailored to different groups and their particular vulnerabilities.

Relationships between victims and perpetrators

The dynamics of the relationships between victim and perpetrator also differed between categories, as illustrated in Table 5. For example, in the cases of youth and adult peer violence we reviewed, the victim and perpetrator were often not personally known to each other. When they were, the reviews did not report a pattern of behaviour within the relationship that might have predicted a violent incident or homicide. This suggests contextual risk factors, such

52 Bernard, C (2018) Serious case reviews: The lived experience of Black children. *Child and Family Social Work* 24(2) 256-263.

TABLE 4. Perpetrator characteristics[53]

	Youth peer violence 8 reviews	Intimate partner violence 17 reviews	Adult family violence 9 reviews	Adult peer violence 9 reviews	Within-family violence towards children 18 reviews[54]	Child sexual abuse 3 reviews
Gender	Homicide: 1 male, 4 unknown; Suicide: Not applicable	15 female, 2 male	8 male, 1 female	6 male, 3 female	12 female, 11 male	2 male, 1 not reported
Age range	Age not known/ reported for majority of perpetrators	18–44	25–54	25–44	25–54	Age not known/ reported for majority of perpetrators
Ethnicity	Ethnicity not known/ reported for majority of perpetrators	White (3), Asian/Asian British (4), Black/Black British (4), Other (2), Not reported (4)	White (4), Asian/Asian British (3), Black/Black British (2)	Not reported (8), White (1)	Not reported (14), White (2), Black/Black British (3), Mixed (1), Asian/Asian British (1), Other (1)	Not reported
Most commonly occurring perpetrator characteristics in this sample[55]	Not known/reported	Alcohol misuse (10), **Unemployment (8)** History of violence (7) **Substance misuse (6)** **Mental health problems (6)**	**Mental health problems (8)** Caring responsibilities (5) **Substance misuse (5)** Failure to comply with medication (5) Alcohol misuse (4) Social isolation (4)	Chronic illness or long-term condition (3) Disability (2) **Unemployment (1)**	**Mental health problems (10)** Domestic abuse (9) History of offending (9) **Substance misuse (6)** Originally from outside UK (5)	Not reported

53 See Appendices 2–7 for further detail.

54 23 perpetrators in total as more than one perpetrator in 5 cases.

55 Shows the top five most common characteristics in each category. Bold text denotes characteristic that appears in two or more categories.

as gang-related activity and social exclusion, may have been more important in leading to these types of violence and would therefore be a key focus of intervention in order to prevent future incidents.

In contrast, in the cases of intimate partner homicide there had often been a history of escalating domestic abuse within the relationship, including physical violence, emotional abuse and coercive control. For parental violence towards children, many (although not all) cases had included some prior indicators of risk such as prior physical abuse. This suggests that a different approach, focusing on the specific dynamics of the affected relationship would be appropriate, as well addressing the wider stressors and risk factors.

The cases of adult family homicide frequently took place within the context of a 'carer' relationship between the victim and perpetrator, with lack of support for the caring role identified in the reviews as a contributory factor to relationship strain and eventual violence. Again, this suggests a different approach focusing on supporting this caring relationship could be an appropriate preventative measure.

Additional areas of focus within a contextual violence reduction approach, including adverse adult life circumstances

The VRU is committed to taking a contextual violence reduction approach, aiming to tackle a range of contexts and influences that impact on people's lives. This research supports this approach, finding that violence in the cases reviewed largely took place against a background of disadvantage and distress – often in multiple aspects of people's lives, ranging from their own individual characteristics through to the influence of their neighbourhoods and wider society. The research suggests some additional areas that may be worthy of focus within a contextual violence reduction framework.

Firstly, this research supported a focus on adverse childhood experiences – but also indicated that adversity experienced in adulthood was also important. In many of the cases reviewed in this research, people's disadvantage and distress did indeed appear to have started with early childhood disadvantage and adverse childhood experiences. A substantial number of both victims and perpetrators across the different categories of violence had experienced adverse childhood experiences including domestic violence, abuse and neglect and the absence of a parent. In some cases, a clear progression was seen from these early adversities through to issues such as breakdown in family relationships and young people going missing or becoming homeless, and thereby being exposed to greater risks.

However, it was also evident that the majority of adult victims and perpetrators were suffering ongoing adverse life circumstances and difficulties – which may or may not have been linked to earlier adversity. The adverse life circumstances reported in the reviews we considered included:

- **Mental health problems** – serious mental health issues such as psychosis were a direct contributory factor in some of the incidents. In other cases, mental health problems were part of a wider pattern of difficulties such as domestic abuse, family conflict and substance misuse. In some cases, people with poor mental health struggled to engage with services for themselves or others in their families.
- **Experience of domestic abuse** was an issue not just in the cases where this was a part of the escalation towards the incident itself but was in the backgrounds of many of the victims and perpetrators of violence.
- **Substance misuse issue**s again were both a direct contributory factor in some incidents, as well as forming part of the background in a larger number of cases.
- **Issues relating to migration** – people who had been born outside the UK may be particularly vulnerable to social isolation and lack of support from wider friends and family, and less able to approach services for help. This may be particularly the case for people who:

TABLE 5. Relationship between victim and perpetrator[56]

	Youth peer violence 8 reviews	Intimate partner violence 17 reviews	Adult family violence 9 reviews	Adult peer violence 9 reviews	Within-family violence towards children 18 reviews	Child sexual abuse 3 reviews
Relationship of perpetrator to victim	Homicide: Unclear or unknown (3), friends/ acquaintances (2)	Married or partner (13), separated (4)	Adult child (7), sibling (2)	Acquaintance, including neighbour or co-resident (7), stranger (2)	Parent (17), partner of parent (1)	Foster carer (1), stranger (1), multiple not reported (1)
Characteristics of the relationship	No information	Domestic abuse (15); Physical abuse (9) Emotional abuse (8) Coercive control (6) History of relationship strain/separation (6) Financial abuse (4) Stalking (3) Other (3) Sexual abuse (2) Not known (1)	Carer (6) Domestic abuse (3) Emotional abuse (2) Financial abuse (2) History of relationship strain/separation (2) Coercive control (1) Neglect (1) Physical abuse (1)	Not known (6) Emotional abuse (1) Financial abuse (1) Physical abuse (1) Conflict over debt (1)	Physical abuse (11) Not known (6) Emotional abuse (5) Neglect (3) Domestic abuse (2) Financial abuse (2) Coercive control (1) None (1)	No information

56 See Appendices 2-7 for further detail.

  - **have insecure immigration status** and so are fearful about becoming involved with services
  - **speak English as a second or additional language** and are less able to communicate with services
  - **have been drawn in to illegal activities such as prostitution,** and so are reluctant to approach services.
- **Unsupported caring relationships** – people who were carers and were not being adequately supported were strongly represented within adult family violence cases.

Wider social factors were also a key contextual factor in a range of cases, including: problems with housing or a lack of housing options, meaning that people were unable to move away from homes or areas where they were at risk; financial difficulties and debt placing a strain on individuals and families; gang activity and other forms of criminality, and sex work occurring in particular neighbourhoods and communities.

This research supports the VRU's contextual approach of addressing social contexts conducive to violence, as well as individual risk factors. This research suggests that social contexts requiring additional consideration may include:

- neighbourhoods where there is gang activity
- neighbourhoods and communities with increased risk of exploitation, for example through sex work
- neighbourhoods with high levels of poverty, debt and insecure housing
- schools and Pupil Referral Units where young people are involved in criminality or gang activity, and where vulnerable young people are frequently excluded
- residential and supported accommodation for adults, particularly where safeguarding arrangements are poor.

Recognising warning signs or risk points associated with escalation towards violent incidents and homicides

Even with improved approaches to tackling the risk factors and contexts for violence, some individuals are likely to 'slip through the net'. It is therefore important that interventions not only take a 'primary prevention' approach, tackling the root causes of violence, but can also intervene when someone is at more immediate risk of involvement in serious violence or homicide.

As part of this research, we looked at the events leading up to a violent incident. These are summarised in Table 6. Clearly, this research was based on a very small sample of cases. The below findings are therefore an indication of the types of events which could form part of a pattern of escalation towards serious violence or homicide. Further research, building on existing approaches such as the intimate partner violence 'Homicide Timeline'[57] would be beneficial in this area.

Our research found that the different events were associated with the lead-up to different types of incident. The differing patterns of escalation were partly linked to whether the incident arose from a pattern of existing abuse within a relationship or took place between individuals who were relatively unknown to each other.

In the small number of cases of youth peer violence we looked at, common events occurring leading up to a serious incident included young people going missing, becoming engaged in escalating levels of offending, and buying and carrying weapons.

For intimate partner violence, the cases reviewed here more often included a pattern of abusive incidents between the perpetrator and victim, including physical abuse, threats and destruction of property.

57 Monckton Smith, J. (2019) Intimate partner femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide. Violence Against Women, e-publication.

TABLE 6. Events occurring in progression towards incidents[58]

Feature of escalation towards incident[59]	Youth peer violence 8 reviews	Intimate partner violence 17 reviews	Adult family violence 9 reviews	Adult peer violence 9 reviews	Within-family violence towards children 18 reviews[59]	Child sexual abuse 3 reviews
Pattern of escalating frequency and/or seriousness of offending by the victim	✔					No information
Victim leaving home and/or frequently going missing	✔					No information
Victim purchasing or carrying weapons	✔					No information
Victim self-harm	✔					No information
Perpetrator stopping mental health medication or being discharged from services		✔	✔	✔		No information
Police or ambulance call-outs		✔				No information
Perpetrator released from police custody or prison		✔				No information
Perpetrator experienced adverse life event		✔	✔		✔	No information
Threats, conflict or destruction of property by perpetrator		✔	✔			No information
Alcohol or drug use by perpetrator immediately prior to incident		✔	✔		✔	No information
Perpetrator pattern of physical violence towards victim		✔				No information
Perpetrator was abusive or violent to other individuals				✔		No information

58 Indicative data only – dependent on information included in the review reports.

59 Appeared in at least two cases in a category.

The incidents we looked at could be precipitated by the perpetrator experiencing an adverse life event such as losing a job,[60] and may be immediately preceded by alcohol or drug use. The perpetrator being released from custody or prison was also a feature of leading up to a number of incidents.

For cases where the perpetrator had a serious mental illness or was experiencing psychosis, individuals ceasing to engage with mental health services, or being discharged from community or inpatient services also featured as a risk point in a number of cases.

Gaining an improved understanding of the equivalent of the intimate partner violence 'Homicide Timeline' for a range of other forms of violence could help to support risk assessment and prevention across a range of services.

Continuing to take a multi-agency approach

Across the cases, both victims and perpetrators came into contact with a wide range of services. Whilst specific targeted initiatives and interventions to tackle violence are important, the cases also highlighted that addressing violence is, and should be, part of the 'core business' of a wide range of services including health, mental health, police, children's social care, housing and many others.

These services have an important role to play in tackling some of the contexts and causes of violence, as well as being equipped to spot signs that particular individuals or families are at increased risk. However, the reviews suggest that a number of aspects of service delivery could be strengthened. The VRU could have a potential role in catalysing improvements across a range of services.

Some of the key areas for improvement identified included:

- **Adolescent safeguarding** – continuing to improve understanding of adolescent safeguarding issues and how they are tackled by a range of multi-agency partners through approaches such as contextual safeguarding. The reviews we looked at highlighted that risks to older children, such as criminal exploitation, were not always viewed as safeguarding issues. This mirrors findings from other research which suggests that safeguarding issues faced by older children can present distinct challenges, which need a particular type of professional response.[61]
- **The role of schools** – supporting schools to maximise their role as a protective factor, and minimise risks resulting from children's exposure to gang activity in school, and from exclusions. Many of the reviews highlighted excellent practice by schools, particularly primary schools, in terms of providing behavioural support, emotional support and mentoring. Many schools showed good knowledge of safeguarding procedures, and appropriately made onward referrals to children's social care as necessary. However, schools could also be a source of risk, including in terms of providing a context in which young people met others who were involved in criminality and gang-related behaviour.
- **Strengthening responses to domestic abuse** – particularly in relation to risk management of perpetrators, including use of arrest for domestic violence offences and safeguarding children within domestic abuse environments.
- **Recognising and responding to risk and domestic abuse in non-intimate partner family relationships** – several reviews noted that, although behaviours meeting the definition of domestic abuse were present cases of adult family homicide, these were not identified by professionals working with the families concerned. Risks arising from unsupported caring relationships were also noted in several reviews.

60 This is supported by other research, for example Monckton Smith (2019) Op. cit.

61 Firmin C, Horan J, Holmes D et al. (undated) Safeguarding during adolescence – the relationship between Contextual Safeguarding, Complex Safeguarding and Transitional Safeguarding. Research in Practice.

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Analysis of statutory reviews of homicides and violent incidents

A report commissioned by the Mayor of London's Violence Reduction Unit

This report summarises findings from research commissioned by the Violence Reduction Unit (VRU) with the aim of mapping and understanding violence in London. The VRU was established by the Mayor of London, Sadiq Khan in September 2018. It brings together specialists from health, police, local government, probation and community organisations to tackle violent crime and its underlying causes.

The aims of the VRU is to reduce violence in London, identify major causes of violence and to work in partnership to coordinate action to tackle them. The VRU aims to involve communities and build their capacity to help secure long-term reductions in crime and harm.

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