Domestic Homicide Reviews

Interim Guidance

Please note that this is interim guidance with no statutory basis. However, it is expected to form the foundation for the statutory guidance which will be issued later this year.

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1. Introduction

1.1. Domestic Homicide reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act 2004. Section 9 is not yet in force - it is intended to bring it into effect later in 2010. At that stage the Home Secretary will issue statutory guidance to which agencies participating in DHRs will be required to have regard, in accordance with section 9(3). This interim guidance is designed to assist agencies in carrying out DHRs pending the implementation of section 9. Its operation will be monitored in order to inform the development of the statutory guidance.

1.2. The prime purpose of a domestic homicide review, carried out under this guidance, is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively, to improve their policies and practices in dealing with domestic abuse and to prevent homicides.

1.3. The lessons learned should be disseminated effectively, and the recommendations implemented in a timely manner so that the changes required result, wherever possible, in improved inter-agency working and better protection for domestic abuse victims.

1.4. Reducing the number of domestic violence-related homicides is a key national objective. *(Reference - National Indicator 34: DV Homicide)*

1.5. Domestic abuse is frequently repeated by the perpetrator and the abuse can escalate over time. This can sometimes make serious injury and homicides in domestic abuse cases preventable with early intervention. Therefore, it follows that local agencies should have adequate policies and procedures in place to instruct agency staff on how to intervene in domestic abuse cases. *(Reference - National Indicator 32: Repeat incidents of DV)*

2. Definitions

2.1. The Home Office is currently reviewing the age criteria within the domestic abuse definition with other Departments.

2.2. This guidance applies the definition of a DHR set out in section 9(1) of the Domestic Violence, Crime and Victims Act 2004:

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/she was related or with whom he/she was or had been in an intimate personal relationship; or

(b) a member of the same household as himself/herself,

held with a view to identifying the lessons to be learnt from the death.

3. Purpose of a Review

3.1. The purposes of domestic homicide reviews (DHRs) carried out under this guidance is to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- Improve intra and inter-agency working and so better protect and safeguard victims of domestic abuse.

3.2. DHRs are not inquiries into how the victim died or into who is culpable. That is a matter for Coroners and criminal courts, respectively, to determine as appropriate.

3.3. The aim should be to focus on agency and multi-agency accountability, intervention and expectations of good professional practice, rather than look at individual actions or any attribution of blame.

3.4. DHRs are also not a part of any disciplinary enquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action

should be initiated, the established disciplinary procedures should be undertaken separately to the DHR process. Alternatively, some DHRs may be conducted concurrently with (but separate to) disciplinary action.

3.5. The rationale for the review process is to make sure that agencies are responding appropriately to victims of domestic abuse by offering and/or putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidences of domestic homicide.

3.6. The review will also assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff.

4. Governing Body

4.1. Overall responsibility and ownership for establishing a review requires high level governance and must sit at the most senior level within the Basic Command Unit (BCU)/Local Authority area. It is suggested that the local Community Safety Partnership (CSP) take the lead and administration of the process.
Other options could involve:

- The Local Strategic Partnership (LSP)
- Local Strategic DA Multi-Agency Steering Group
- Local Safeguarding Adults Board

These remain as options for consideration within this interim guidance. A review of this guidance will be essential prior to statutory guidance coming into force.

4.2. Where partner agencies of more than one Local Authority area have known about or had contact with the victim, the Local Authority area in which the victim is/was normally resident should take lead responsibility for conducting any review. If there was no established address prior to the incident, lead responsibility will relate to the area where the victim was last known to have frequented as a first option and then considered on a case by

case basis.

4.3. Reviews should seek to establish whether any or all of the agencies involved responded correctly and in accordance with their own procedures and guidelines and where relevant, identify improved practice for the future.

5. Criteria for a DHR

5.1. The Governing Body should consider whether a case is to be subject of a DHR by applying the definition set out in paragraph 2.2 above. Any such homicide should immediately be referred to the Governing Body, which should consider whether a DHR is necessary.

5.2. **It is presumed that a DHR will take place in every case,** however the Chair of the Governing Body should make the final decision on whether a review should be conducted. The presence of any of the factors set out in paragraph 6.1 below will strengthen the presumption that a DHR should be held.

5.3. At this stage the Governing Body should also consider how the process will fit in with those for other types of review, e.g. MAPPA, Child or Vulnerable Adult Serious Case Reviews, and whether a joint review should be undertaken. It will be the responsibility of the Governing Body chair to make contact with the chair of any parallel process to collaborate the reviews.

5.4. Any professional or agency may refer such a case to the Governing Body if it is believed that there are important lessons for inter-agency working to be learned from the case.

6. Circumstances of Particular Concern

6.1. When deciding whether or not a case should be subject of a domestic homicide review the Panel should consider the following factors as indicators that the review will yield useful lessons:

- There was evidence of a risk of serious harm to the victim that was not recognised/identified by the agencies in contact with the victim and/or the perpetrator, it was not shared with others and/or it was not acted upon in accordance with their usual/acceptable practice.
- Any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved.
- The case indicates that there have been failings in one or more aspects of the local operation of formal domestic abuse procedures or other procedures for safeguarding adults, including cases where it is believed that there was no contact with any agency.
- The victim was being managed by a MARAC.
- The case appears to have implications/reputation issues for a range of agencies and professionals.
- The case suggests that local procedures or protocols may need to change or are not adequately understood or followed.
- The perpetrator holds a position of trust or authority e.g. police officer, social worker, health professional, and therefore likely to have a significant impact on public confidence.

6.2. In some cases that do not meet the criteria for a full DHR but give rise to concern, it may be valuable to conduct a single agency individual management review or a smaller-scale audit. For example where there are lessons to be learnt about the way staff worked within one agency rather than about how agencies worked together.

7. Relevant Agencies

7.1. The persons and bodies that are likely to establish or participate in a DHR include (for England and Wales):

- Chief Officers of police
- Local Authorities (includes education, housing and social services)
- Local probation boards or trusts

- Strategic Health Authorities
- Primary Care Trusts
- NHS trusts/local health boards in Wales

8. Establishing a Review Panel

8.1. Where the Governing Body considers that the criteria for a DHR are met, the Governing Body should request that a DHR Panel is set up, involving representatives from the above listed statutory authorities to consider questions such as whether a DHR should take place and the scope and terms of reference for the review.

8.2. The DHR Panel can either have a fixed, standing membership or be created on a bespoke basis for the purposes of undertaking this particular DHR. It should involve individuals across a broad spectrum of both statutory and voluntary agencies, taking into account that the voluntary sector may have valuable information on the victim or perpetrator and the importance of having agencies to represent the victim. One such example is established MARAC members. However, if the MARAC member has been directly involved in the case another representative from the same agency will be required. Consideration could be given to MARACs as the appropriate and effective body to form the membership of the DHR panel given the specialist skills of the multi-agency partners present.

8.3. Members of agencies who have responsibilities for completing individual management reviews may also be members of the Panel, but the Panel should not consist solely of such people.

8.4. The review panel should bear in mind equality and diversity issues at all times, as language, culture, family ties and kinship, sexual orientation and disability will all have a bearing on how the review is explained and conducted and the outcomes disseminated to local communities.

8.5. Particular consideration should be given to cases of Honour Based Violence (HBV). HBV is a crime which has or may have been committed to protect or defend the so-called ‘honour’ of the family and/or community. Extra

caution will need to be taken around confidentiality in relation to agency members and interpreters where there is possible links with the family, which often includes the perpetrators.

9. Appointing a Chair for the Review Panel

9.1. The Chair of the Governing Body should appoint an independent chair to take responsibility for managing and co-ordinating the review process and for producing the final report based on individual management reviews (IMRs) and any other evidence the review panel decides is relevant. Some forces may consider employing an independent consultant for this role, resources and finance permitting. There is no central funding available in relation to this interim guidance.

9.2. The chair should be an experienced person who is neither a member of the Governing Body nor an employee of any of the agencies involved in this case. For example the Chair could be someone from another police service/County area which is not involved in the DHR or part of a Regional agreement in exchanging professionals in neighbouring areas to reduce costs and promote dissemination of new information and learning.

9.3. Consideration will need to be given to the skills and expertise needed by the chair, the following list is a guide:

- Relevant knowledge of domestic abuse issues, research, guidance and legislation relating to adults and children.
- Understanding of the role and context of the main agencies likely to be involved in the review.
- Managerial expertise.
- Investigative, interviewing and communication skills.
- Understanding of the discipline regimes within participating agencies.

10. Determining the Scope of the Review

10.1. The DHR Panel should consider, in the light of each case, the scope of the review process, and draw up clear terms of reference. Relevant issues to

consider include the following:

- What appear to be the most important issues to address in identifying the learning from this specific case? How can the relevant information best be obtained and analysed?

- Which agencies and professionals should be asked to submit reports or otherwise contribute to the review including, where appropriate, agencies that have not come into contact with the victim or perpetrator but might have been expected to do so?

- Assisting the DHR Panel by bringing in an outside expert at any stage, to help understand crucial aspects of the case.

- Over what time period should events in the victim's and perpetrator's life be reviewed taking into account the circumstances of the case i.e. how far back should enquiries cover and what is the cut-off point? What history/background information will help better to understand the events leading to the death.

- Are there any specific considerations around equality and diversity issues such as ethnicity and disability that may require special consideration?

- How should the family members, other significant people and where appropriate the perpetrator contribute to the review, and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process taking account of possible conflicting views within the family.

- How should matters concerning the family, public and media interest be managed before, during and after the review?

- How the DHR process will dovetail with other investigations that are running parallel, for example a child or adult SCR, a criminal investigation or an inquest. How a co-ordinated or jointly commissioned review process will address all the relevant questions that need to be

asked, in the most effective way, ensuring that staff are not interviewed twice and that there are people who sit on both panels to ensure good cross communication.

- The communication and liaison process with the coroner and/or CPS to take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the case to ensure that relevant information can be shared without incurring significant delay in the review process.

- Whether any MARAC or MAPPA processes contributed to the case and the need for a Memorandum of Understanding for the release of the minutes from the relevant meetings.

- Is there a need to involve agencies/professionals working in other Local Authority areas with an interest in the case, including voluntary sector and what should their roles and responsibilities be?

- Who will make the link with relevant interests outside the main statutory agencies, for example independent professionals and voluntary organisations?

- How should the review process take account of previous lessons learned from research and previous DHRs.

- When should the review process start, and by what date should it be completed. Are there any parallel court cases pending which could influence progress or the timing of the publication of the executive summary?

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review.

- Consideration for disclosure in criminal proceedings.

- Cost implications in relation to independent chairs and staff time in preparing the IMRs and attending the panel meetings, taking into account the lack of central funding during this interim period.

10.2. Some of the above issues may need to be revisited as the review progresses and new information emerges. This reconsideration of the issues may in turn mean that the terms of reference will need to be revised and agreed by the DHR Panel Chair.

10.3. The DHR panel should carefully consider family involvement and the potential benefits gained by including both the victim and perpetrator's families. The families should be given every opportunity to contribute unless there are exceptional circumstances. The benefits include:

- It may assist the family with the healing process which links in with the objectives of the new 'National Victims Service' supporting victims for as long as they need after homicide.
- Obtaining of relevant information held by the families which was unavailable in official records.
- It may reveal useful insights enabling agencies to view the tragedy through the victims' and perpetrator's eyes, to improve service design.

10.4. The DHR Panel need to be aware of the potential sensitivity and confidentiality of any meeting with any of the agencies involved prior to or during the review and all such meetings should be recorded.

10.5. The DHR panel should have a broad outlook to allow the review to access other networks to which victims may have disclosed to, for example, employers, Citizen Advice Bureaux and other non statutory agencies.
10.6. The Review Panel Chair should make the final decision on the suitability of the terms of reference for each DHR.

11. Time-Scales

11.1. Reviews vary widely in their breadth and complexity but, in all cases, **where lessons are able to be drawn out they should be acted upon as quickly as possible without necessarily waiting for the DHR to be completed.**

11.2. The decision on whether or not to hold a review should be taken by the

Chair of the Governing Body within **one month** of a case coming to their attention.

11.3. The terms of reference for the review will also need to be drawn up and agreed within this timescale.

11.4. Individual agencies should secure case records promptly and begin to work quickly to draw up a chronology of involvement with the victim, perpetrator and their families as outlined in the terms of reference.

11.5. Reviews, including the overview report, should be completed within a further **four** months, from the date of the decision to proceed, unless an alternative timescale is formally agreed with the relevant Governing Body. Sometimes the complexity of a case does not become apparent until the review is in progress. As soon as it emerges that a DHR cannot be completed within the four months (perhaps because of judicial proceedings), the Review Panel should notify the Governing Body to renegotiate the timescale for completion.

11.6. In some cases, mental health reviews, criminal investigations or other legal proceedings may be carried out after death. The Chair of the DHR Panel should discuss with the relevant criminal justice and/or other agencies (e.g. HM Coroner, SIO, Independent Police Complaints Commission), at an early stage, how the review process should take account of such proceedings. For example, how does this affect timing, the way in which the review is conducted (including interviews of relevant personnel), its potential impact on criminal investigations, and who should contribute at what stage?

11.7. DHRs should not be delayed as a matter of course because of outstanding criminal proceedings, or an outstanding decision on whether or not to prosecute. These decisions will need to be made on a case by case basis.

11.8. It may be necessary to agree that the executive summary will not be published until after the outcome of any criminal proceedings, unless new evidence comes to light that may have a bearing on those proceedings.

However, this should not mean that the recommendations arising from the review should not be taken forward.

11.9. It is essential that the necessary learning or local issues are not delayed so that the same mistakes are not replicated in other cases. The review panel would need to consider whether any of the recommendations identified would, if they were acted on, jeopardise the criminal proceedings.

12. Individual Management Reviews

12.1. The chair of the review panel should write to the senior manager in each of the participating agencies to commission the individual management reviews (IMRs).

12.2. The IMRs form part of the main domestic homicide review.

12.3. Domestic homicide reviews are not part of any disciplinary inquires, but information that emerges in the course of a review may indicate that disciplinary action should be taken under established procedures. Alternatively, reviews may be conducted concurrently with disciplinary action. This is a matter for agencies to decide in accordance with their disciplinary procedures. The same consideration should be taken in relation to complaint procedures underway against any single agency.

12.4. Once it is known that a case is being considered for review, each agency should secure its records relating to the case to guard against loss or interference and having secured their case records promptly, then begin to work quickly to draw up a chronology of their involvement with the victim. Each agency should then carry out an IMR of its involvement with the victim or perpetrator, unless it had no involvement.

12.5. The IMR should begin as soon as a decision is taken to proceed with a review and once the terms of reference have been set, and sooner if a case gives cause for concern within the individual agency. Independent professionals (including GPs) should contribute reports of their involvement.

12.6. The aim of management reviews should be to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the case indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

12.7. Those conducting IMRs and those producing the overview report ideally should not have been directly involved with the victim, the perpetrator or their families and should not have been the immediate line manger of the practioner involved.

12.8. The individual management review reports should be quality assured by the senior manager in the organisation who has commissioned the report. This senior manager will be responsible also for ensuring that the recommendations of both the individual management review and where appropriate the overview report are acted on.

12.9. On completion of each individual management review report, there should be a process of feedback and debriefing for the staff involved in the case, in advance of completion of the overview report. There should also be a follow-up feedback session with these staff once the overview report has been completed if it raises new issues which should be discussed before the executive summary is published.

Appendix One

Appendix one is an outline format to assist in the preparation of individual management reviews, to ensure that the relevant questions are addressed, and that the information is provided in a consistent format for the overview report.

The questions listed do not comprise a comprehensive checklist relevant to all situations. Each case may have specific issues that need to be explored and each review should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

Where staff or others are interviewed by those preparing IMRs, a written record of such interviews should be made and this should be shared with the relevant interviewee. Staff should be reminded that the review does not form part of a disciplinary investigation. If the review finds that policies and procedures have not been followed, relevant staff or managers should be interviewed to understand the reasons for this in accordance with the relevant agency procedures. The views of the SIO and subsequent CPS advice must be sought prior to interviewing witnesses in any criminal proceedings.

Appendix Two

Appendix two is an IMR template.

13. The Overview Report

13.1. It is suggested that the independent author and review panel chair is the same person due to financial constraints.

13.2. The overview report should bring together, and draw overall conclusions from the information and analysis contained in the individual management reviews and reports commissioned from any other relevant interests.

13.3. Overview reports should be produced according to the template (appendix 4), as with IMR, the precise format depends on the features of the case.

13.4. The overview report should also make recommendations for future action.

13.5. It is crucial the overview authors have access to all relevant documentation and where necessary individual professionals to enable them to effectively undertake their review functions.

13.6. The findings of the review should be regarded as ‘Restricted’ as per the Government Protective Marking Scheme (GPMS).Information should be made available only to participating officers/professionals and their line mangers who have a pre-declared interest in the review. It may also be appropriate to

share these findings with family members as directed by the DHR panel chair, taking into account ongoing criminal proceedings.

13.7. The DHR Panel chair should appoint a lead agency to take responsibility for debriefing family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals.

Appendix Three

Appendix three is an outline format to assist in the preparation of the overview report, although as with the IMRs, the precise format will depend on the individual features of the case.

The review panel will need to bear in mind the importance of keeping personal details anonymous within the final report.

Appendix Four is an overview report template.

14. DHR Panel Action on Receiving an Overview Report

14.1. On being presented with the overview report the DHR Panel should:

- Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report;
- Ensure that the overview report is of a high standard and is written in accordance with this guidance;

15. DHR action plan

15.1. The DHR review panel should translate recommendations into an action plan that should be signed up to at a senior level by each of the organisations that needs to be involved.

15.2. The plan should set out who will do what, by when, with what intended outcome. The plan should set out how improvements in practice and systems will be monitored and reviewed

15.3. Provide a copy of the overview report, executive summary and the action plan to the chair of the Governing Body.

Appendix 5 is an Action Plan template.

16. Governing Body Action on Receiving the Overview Report

16.1. The Governing Body should:

- Commission and agree the content of the executive summary for publication, ensuring that it accurately represents the full DHR, includes the action plan in full and is fully anonymised apart from including the names of the DHR Panel chair and members;

- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate, following completion of the executive summary;

- Sign off the final DHR, i.e. the overview report, the executive summary and the action plan;

- Decide to whom the overview report, or any part of it, should be made available in order to support implementation of the recommendations and the learning lessons, taking into account any legal obligations in relation to the sharing and protection of information, including those under the Freedom of Information Act 2000 and the Data Protection Act 1998;

- Provide a copy of the overview report, executive summary and the action plan to the senior manager of each agency;

- Disseminate report or key findings to other interested parties as agreed.

- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) DHR action plan;

- Formally conclude the review when the action plan has been implemented, to include an audit process.

17. Accountability and Disclosure

17.1. All disclosure issues must be discussed with the police Senior Investigating Officer, the Crown Prosecution Service and the HM Coroner's representative as appropriate.

17.2. Any material generated during a review will be treated as Third Party material, the ownership being retained by the relevant agency.

17.3. Where information is sought using the Freedom of Information Act (FOIA), it is important to refer to sections 30 and 31 which identify key exemptions.

17.4. The review panel should consider carefully who might have an interest in the review and what information should be made publicly available. Disclosure of personal confidential information without consent – particularly from medical records – will require a public interest justification, and the disclosure must be necessary and proportionate having regard to the purposes of the review. Where organisations conclude that the need to preserve confidentiality outweighs the public interest in disclosure, they should record their reasons.

There are difficult interests to balance, including:

- the need to maintain confidentiality of personal information relating to the victim, the perpetrator, their families and others;
- the accountability of public services and the importance of maintaining public confidence in the review process;
- the need to secure full and open participation from the different agencies and professionals involved;
- the responsibility to provide relevant information to those with a legitimate interest;

- The constraints on sharing or publishing information which could undermine an ongoing criminal investigation, or prejudice the course of justice where criminal proceedings have already begun.

17.5. It is important to anticipate requests for information and plan in advance how they should be met. For example, a specific agency may have been given responsibility by the DHR Panel for debriefing family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals.

17.6. In all cases, the overview report should contain an executive summary that should be made public and include, as a minimum, information about the review process, key issues arising from the case and the recommendations that have been made. The full overview report should not be made publicly available.

17.7. The publication of the executive summary needs to be timed in accordance with the conclusion of any related court proceedings. The content of the executive summary needs to be suitably anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the Data Protection Act 1998.

17.8. Where appropriate, consideration should also be given to translating the executive summary into different languages and other formats, such as Braille.

18. Learning Lessons Locally

18.1. As the purpose of DHRs is to learn lessons for improving both individual agency and inter-agency working, they will be of little value unless the lessons are learnt and acted upon. This means that at least as much effort should be spent on implementing the recommendations as on conducting the review.

The following may assist in getting maximum benefit from the review process:

- As far as possible, the review should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.
- Consider what type and level of information needs to be disseminated, how and to whom, in the light of the review. Be prepared to communicate both examples of good practice and areas where change is required.
- It is recommended that the subsequent learning could be disseminated to the local MARAC and the local Domestic Violence Forum or similar.
- Incorporate the learning into local/regional/national training programmes.
- Focus recommendations on key areas, with specific, measurable and achievable proposals for change and intended outcomes.
- The local review panel should put in place a means of monitoring and auditing the actions against recommendations and intended outcomes.

19. Good Practice

19.1. Establish a culture of learning lessons and review. In order to support this, consideration for the MARAC, Community Safety Partnership meeting, Domestic Violence Forum or a similar forum to have a standing agenda item for DHRs.

19.2. The Governing Bodies need to have in place clear, systematic case-recording and record-keeping systems.

- Develop good communication and understanding between different disciplines and members of the review panel.
- Communicate with the local community and media to raise awareness of the positive work of the statutory and voluntary agencies with domestic abuse victims and perpetrators, so that attention is not focused disproportionately on tragedies.

- Make sure staff and their representatives understand what can be expected in the event of a domestic homicide review.
- Central storage to allow for clear auditing of review documentation and quick retrieval if required.

20. Learning Lessons Nationally

20.1. DHRs should be an important source of information to inform national policy and practice. Agencies are responsible for identifying and disseminating common themes and trends across review reports, and acting on lessons for policy and practice.

20.2. It is important to draw out key findings of Domestic Homicide Reviews and their implications for policy and practice. The National Police Improvement Agency (NPIA) will be assisting with the dissemination of learning across the police service.

Appendix One

OUTLINE FORMAT FOR INDIVIDUAL MANAGEMENT REVIEWS

Agency involvement with the victim, the perpetrator and their families

The review should include a comprehensive chronology that charts the involvement of the agency with the victim, the perpetrator and their families over the period of time set out in the review's terms of reference. It should summarise the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to the victim, the perpetrator and their families; and any other action taken.

Analysis of involvement

The review should consider the events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why. The following are the areas that will need to be considered:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

- Did the agency comply with domestic abuse protocols agreed with other agencies, including any information-sharing protocols?

- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

- Was anything known about the perpetrator? For example, were they being managed under MAPPA?

- Had the victim disclosed to anyone and if so, was the response appropriate?

- Was this information recorded and shared, where appropriate?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary.

- Were senior managers or other agencies and professionals involved at the appropriate points?

- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

- Good practice

- Are there ways of working effectively that could be passed on to other organisations or individuals?

- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

- How accessible were the services for the victim and perpetrator?

Appendix Two

IMR TEMPLATE

1. INTRODUCTION

Brief factual/contextual summary of the situation leading to the DHR including an outline of the TOR and date for completion:

- *NAME OF VICTIM:*
- *Date of Birth:*
- *Date of death*
- *Name, job title and contact details of person completing this IMR (include confirmation regarding independence from the line management of the case*).

Victim, perpetrator, family Details

Name	Date of birth	Relationship	Ethnic origin	Address

Include family tree or genogram if relevant.

2. METHODOLOGY

Record the methodology used including extent of document review and interviews undertaken.

3. TERMS OF REFERENCE

4. CHRONOLOGY OF AGENCY INVOLVEMENT

What was your Agency's involvement with the victim?

Construct a comprehensive chronology of involvement by your agency over the period of time set out in the review's terms of reference. State when the victim was seen.

Would you also please identify the details of the professionals from within your agency who were involved with the victim and whether they were interviewed or not for the purposes of this IMR.

5. ANALYSIS OF INVOLVEMENT

Consider the events that occurred, the decisions made, and the actions taken or not. It is also important to reflect on where good practice and the strengths of professional support existed.

Addressing terms of reference

Consider further analysis in respect of key critical factors, which are not otherwise covered by the sections above.

6. GOOD PRACTICE/LESSONS LEARNT

7. RECOMMENDATIONS

Recommendations should be focussed on the key findings of the IMR and be specific about the outcome which they are seeking.

Appendix Three

OUTLINE FORMAT FOR OVERVIEW REPORT

Introduction

- Summarise the circumstances that led to a review being undertaken in this case.
- State the terms of reference of the review and record the methodology used, what documents were used, whether interviews undertaken.
- List the contributors to the review and the nature of their contribution.
- List the DHR panel members and the author of the overview report.

The Facts

- Where the victim lived and where the victim was murdered. A synopsis of the murder (what actually happened and how the victim was killed).
- Details of the Post Mortem and inquest if already held.
- Members of the family and the household. Who else lived at the address and, if children were living there, what their ages were at the time.
- How long the victim had been living with their partner. How long they had been together as a couple.
- Who has been charged with the murder and the date of the trial (if known).
- A chronology charting contact/involvement with the victim, the perpetrator and their families by agencies, professionals and others who have contributed to the review process. Note the time and date of each occasion when the victim, perpetrator or child(ren) was seen and the views and wishes that were sought or expressed.
- An overview that summarises what information was known to the agencies and professionals involved about the victim, the perpetrator and their families.
- Any other relevant facts or information.

Analysis

This part of the overview should examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It can consider whether different decisions or actions may have led to a different course of events. The analysis section is also where any examples of good practice should be highlighted.

Conclusions and recommendations

This part of the report should summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action. Recommendations should include, but not be limited to those made in individual management reports and may include recommendations of national impact. Recommendations should be relatively few in number, focused and specific, and capable of being implemented.

Appendix Four

Domestic Homicide Overview Template

REPORT INTO THE DEATH OF

(add victim's name)

Report produced by …..
Date ……

Content

Introduction Page

Executive summary Page

Concluding report Page

Housing report Page

Police report Page

IDVA/VSS/Other victim representation report Page

Other relevant agencies' reports Page

Appendix Page

Introduction

This report of a domestic homicide review examines agency responses and support given to (victim's name), a resident of (area name) prior to the point of (his/her) death on (date of death).

The review will consider agencies contact/involvement with (victim's and perpetrator's name) from (indicate date/s/ period that the scope of the review will be examining).

Essentially this review is to establish whether any or all the agencies involved responded correctly and within their set procedures and guidelines.

The rationale for the review process is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and/or putting in place appropriate support mechanisms that can avert future incidences of domestic homicide.

Timescales

This review began on (date) and was concluded on (date). Reviews, including the overview report, should be completed within four months of the commencement of the review.

Confidentiality

The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

Dissemination

(List of recipients) have received copies of this report.

Executive Summary **To be suitably anonymised for publication and dissemination**

1. The review process

This summary outlines the process undertaken by (local area) domestic homicide review panel in reviewing the murder of (victim).

(Suspect) is currently awaiting trial for (victim)'s murder.

The process began with an initial meeting on (date) of all agencies that potentially had contact with (victim) prior to the point of death.

Agencies participating in this case review are:

- (Area) Housing
- (Area) Education (Access and Inclusion Services)
- (Area) Social Care (Adult and Children's Social Care Services)
- (Area) Police Domestic Abuse Unit/Child Abuse Investigation Unit
- (Area) Victim Support Services
- (Area) IDVA
- (Area) Local Refuge
- (Area) Community Police Consultative Group
- (Area) Probation
- (Area) Health
- (etc)

Agencies were asked to give chronological accounts of their contact with the victim prior to his/her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

A chronology of interaction with the victim and/or their family;

what was done or agreed;

whether internal procedures were followed; and

conclusions and recommendations from the agency's point of view.

The accounts of involvement with this victim cover different periods of time prior to their death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

(Number) of the (total number) agencies responded. In total, (number) agencies have responded as having had no contact with either the victim or the suspect or with any children involved: (name agencies).

(Number) have responded with information indicating some level of involvement with the victim: (name agencies).

(Indicate here if an agency's contact is of no relevance to the events that led to the death of the victim, state their last record of contact and detail)

The police report shows that on (number) occasions between (date) and (date) the police had contact with (victim) in relation to allegations of (name allegations and who the alleged offences were committed by). (State what the victim's wishes were at the time in terms of proceeding or withdrawing)

(Agencies) responded as having no trace of the victim, the suspect or any children on their database or general registry. (State here if information has come to light showing the contrary)

(State here any agencies showing contact or interaction with the victim or their family)

2. Key issues arising from the review

(Add issues as required)

3. Conclusions and recommendations from the review

(Add conclusions and recommendations as required)

(AREA) DOMESTIC HOMICIDE REVIEW PANELCONCLUDING REPORT

Introduction

This review report is an anthology of information and facts from (number) agencies, all of which were potential support agencies for (victim). Essentially, only (number) agencies had records of contact with (victim) prior to their death. They are:

- (agency)
- (agency)

(State whether any of the accounts bear any direct relation to the victim's murder)

The Facts

Analysis

(State any agency involvement)

(State whether the review panel is of the opinion that all agency intervention was appropriate and that agencies acted in accordance with their set procedures and guidelines)

Conclusion/Lessons Learnt

(State whether the review panel, after thorough consideration, believes that under the circumstances agency intervention potentially could have or would not have prevented the victim's death, given the information that has come to light through the review)

(State whether the information available to the review panel suggests that there were/were no recorded incidences of domestic abuse between the victim and the suspect and whether this is/is not conclusive)

(State anything else that is relevant to the conclusions resulting from the review)

Recommendations

- (Add recommendation)
- (Add recommendation)
- (Add recommendation)
- (Add recommendation)

(Name of author of report)
(Position in agency)
(Date)

HOUSING REPORT

MURDER OF (VICTIM)

Of (address)

(age and ethnic appearance)

(name and address of Housing Office)

Tenancy reference: (reference)

Tenancy commenced (date). Tenancy ended/was due to end (date).

Other occupants: (name, date of birth and relationship)

History of involvement:

- (When the victim applied for housing and any other housing applications listed in chronological order)
- (Whether the victim was on the at-risk house file)
- (Details of any medical problems)
- (Details of relationships and children)
- (Details of repairs undertaken in terms of locks being changed, for example)
- (Anything else that suggests that the victim may have been at risk)

.

(Name of officer completing report)
(Position in agency)
(Date)

POLICE REPORT

Introduction

Methodology

Terms of Reference

Chronology

(Describe the events in a chronological order)

CALL (number) and CRIME (number) on (date)
For example: Police were called to 25 Reinmouth Close, Birmingham by Mrs Bernays, who wished to report an assault. The police attended and reported an allegation of common assault on Mrs Bernays – CRIS (number) refers. The circumstances were ….

CRIME (number) on (date)
For example: The above crime report refers to a (non-crime-book domestic incident) whereby Mrs Bernays called the police to report the fact that her husband, Mr Bernays, had been verbally abusive towards her. ….

INTELLIGENCE (log number) on (date)
For example: Intelligence shows that Mr Bernays has a history of violence against an ex-partner and has previously used a weapon.

The murder investigation

CRIME (number) Report dealing with the murder of (victim).

INTELLIGENCE (reference number)
Police intelligence record regarding the murder investigation.

(State: what occurred prior to the murder (events and sequence); whether there was an argument and what it was about; whether there was alcohol or drugs involved; brief details of the murder in terms of:

- **how the victim was found;**
- **where the victim was found;**
- **how the victim was killed (modus operandi and weapons); and injuries sustained by the victim, etc;**
- **any other relevant details about the history of police involvement with the victim and/or the family, i.e. if the suspect had assaulted anyone else.**
- **the court result, if there is one, and when and where the suspect is appearing for trial)**

(Name of officer completing report)
(Area)
(Date)

APPENDIX

Confirmation of no record of contact from:

- **(Agency 1)**
- **(Agency 2)**
- **(Agency 3)**
- **(Agency 4)**
- **(Agency 5)**
- **(Agency 6)**

Appendix Five

Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
What is the over-arching recommendation?	Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the analyst, however the review panel can suggest a rec. for national level)	How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?	Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?	Have there been key steps that have allowed the recommendation to be enacted?	When should this rec. be completed by?	When is the rec. actually completed? What does outcome look like?
Fictional examples;						
1. All coroner's should receive training on domestic violence	National	-Review current coroner's training and identify gaps -Develop training module. -Roll-out revised training package as follows: June-July – Coroners in region X Aug-Sept –Coroners in region Y	Ministry of Justice Coroner's team	- Review completed in January 09 - Training package agreed April 09 - Roll-out begins June 2009	All coroners to be trained by September 2009	All coroners received training by December 2009 and their narrative verdicts are beginning to reflect that this training has been effective.

2. All staff in Woodley office to receive training on Honour Based Violence and Forced Marriage	Local	- Commission expert to train all staff on HBV and FM - Allocate specific training days	Head of Woodley office	- Commission expert by January 2010 - Deliver training by end February 2010	All staff to be trained on HBV and FM by end February 2010	All staff received training by end February 2010 Those suffering HBV are always received in an effective way having regard to sensitivity and security issues. Customer feedback and reduced complaints may indicate the staff are applying this training.