

SSP MULTI-AGENCY PROTOCOL FOR THE CONDUCT OF DOMESTIC HOMICIDE REVIEWS

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). This provision came into force on 13th April 2011.

1.2 This document provides advice to the Safer Southwark Partnership (SSP) Board on establishing DHRs in order to facilitate a consistent approach to the DHR process. It is based on Home Office statutory guidance (www.homeoffice.gov.uk/publications/crime/DHR-guidance?view=Binary) and council serious case reviews best practice.

1.3 All agencies that are members of the SSP are expected to adopt and adhere to this protocol.

2. Criteria

2.1 Consideration as to whether to conduct a DHR must take place when 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, including relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality, or

(b) a member of the same household as herself/himself. A member of the same household includes a person who visits it so often and for such periods of time that it is reasonable to regard him as a member of it, even if he does not live in that household. Where a victim (V) lived in different households at different times, “the same household as V” refers to the household in which V was living at the time of the act that caused V’s death.

3. Purpose

3.1 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding 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.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

3.2 It is acknowledged that agencies within the SSP have their own internal/statutory review processes to investigate serious incidents. DHRs are not specifically 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 agency disciplinary procedures should be undertaken separately to the DHR process. Alternatively, some DHRs may be conducted concurrently with (but separate to) disciplinary action.

3.3 In some instances there could be grounds for both a Serious Case Review (both children and/or vulnerable adults) and a DHR to take place. Some examples of possible scenarios and suggested courses of action are:

- Cases where the only victim is 18+ years old and he/she was not known to the mental health or vulnerable adults teams: a DHR will take place.

- Cases where the only victim is 18+ years old and he/she and/or the perpetrator was known to the mental health or vulnerable adults teams: a decision should be made at the outset by the two decision makers (SSP Board and Safeguarding Adults Partnership Board, SAPB) as to which process is to lead and who is to chair with a final report being taken to both commissioning bodies

- Cases where the only victim or perpetrator was <18 years old: only a serious case review takes place (according to the Home Office guidance SCRs should always take precedent) but it is vital that any elements of domestic violence relating to the homicide are addressed

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fully and the SCR includes representatives with a thorough understanding of domestic abuse.

- Cases where there are both 18+ and 18- years old victims: both DHR and SCR take place but in a coordinated way, for example the panel chairs will liaise when it comes to ordering the individual management reviews, in order to avoid duplication.

3.4 In addition to the above scenarios it is worth noting that Working Together to Safeguard Children, the Government guide to inter-agency working to safeguard and promote the welfare of children, stipulates that SCRs must be considered where a parent has been murdered and a DHR is being initiated. In essence this means that whenever a DHR is being carried out and the victim was a parent a SCR should also be considered.

3.5 The decision making bodies (Safeguarding Boards and SSP Board) will liaise on a case by case basis to decide the best course of action.

3.6 Reviews vary widely in their breadth and complexity but in all homicides, 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.

4. Process for carrying out a DHR

Initiating a review

4.1 When a domestic homicide, as defined above, occurs, Southwark Police should inform the SSP of the incident in writing. Overall responsibility for establishing a review rests with the SSP.

4.2 Where partner agencies of more than one Local Authority area have known about or had contact with the victim, the CSP of the Local Authority area in which the victim was normally resident takes 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 The chair of the SSP holds responsibility for establishing whether a homicide is to be subject of a DHR by applying the definition set out in paragraph 2.1. This decision should be

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taken in consultation with local partners with an understanding of the dynamics of domestic abuse, the Domestic Abuse Commissioning Group (DACG) will make recommendations to the SSP chair in relation to DHRs as well as linking in with existing safeguarding frameworks – including the Southwark adult and children safeguarding boards. The SSP chair will identify those best placed to sit on the Review Panel for that particular homicide. This may also establish the existence of any other ongoing reviews, such as a child or adult Serious Case Review (SCR) or Mental Health Investigation (MHI), which will need to be considered as part of the decision to undertake a DHR.

4.4 The SSP chair will then send confirmation of a decision to review as well as a decision not to review a homicide, **within one month of the incident taking place**, to the Home Office DHR enquiries inbox (DHRENQUIRIES@homeoffice.gsi.gov.uk)

Establishing a review panel

4.5 The panel will be created on a case by case basis. It will 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 and/ or perpetrator and the importance of having agencies to represent the victim. Independent Domestic Violence Advocates (IDVAs) and specialist domestic violence services, such as specialist Black and Minority Ethnic (BME) women's organisations, are key representatives to include on the review panel.

4.6 The persons and bodies that have a duty to establish or participate in a DHR if directed to do so by the Secretary of State include:

- Chief Officers of police for police areas in England and Wales.
- Local authorities.
- Strategic Health Authorities established under [section 13 of the National Health Service Act 2006].
- Primary Care Trusts established under [section 18] of that Act.
- Providers of probation services.
- Local Health Boards established under [section 11 of the National Health Service (Wales) Act 2006].
- NHS trusts established under [section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006].

4.7 There are other agencies which may have a key role to play in the review process but are not named in legislation, for example, representatives from the Crown Prosecution Service (CPS), housing associations and social landlords and the HM Prison Service. Involvement with other agencies will need to be decided on a case by case basis and should be agreed by the Review Panel.

Appointing a Chair of the review panel

4.8 The Review Panel will appoint an independent Chair of the Panel on a case by case basis, who is responsible for managing and coordinating the review process and for producing the final Overview Report based on individual management reviews (IMRs) and any other evidence the Review Panel decides is relevant.

4.9 The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review. The appointed Chair will have the skills and expertise required to effectively chair a review:

- The completion of the E-Learning Training Package on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing Overview Reports.
- Relevant knowledge of domestic violence issues.
- An understanding of the role and context of the main agencies likely to be involved in the review.
- Managerial expertise.
- Good investigative, interviewing and communication skills.
- An understanding of the discipline regimes within participating agencies.

Conducting the review

4.10 At the first meeting the Chair and Review Panel will agree the scope of the review process and draw up clear terms of reference. Relevant issues to consider include the following:

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- How will the DHR process dovetail with other investigations that are running parallel, for example a child or adult serious case review, a criminal investigation or an inquest, please refer to paragraph 3.3.
- Which agencies and professionals will be asked to submit reports and what other evidence and data required from each participant, this could include other local authorities.
- Support and other resources needed (any perceived deficits to be referred to Chair of the SSP)
- Specific considerations around equality and diversity
- Time scales within which the review process should be completed, this will be **no longer than six months since the date the Home Office was notified**¹.
- Dates, times and venues of meetings
- Nature and extent of legal advice required, in particular: how any pending criminal proceedings affect the timing and conduct of the review, how relevant personnel may be interviewed and at what stage
- Legal advice should be sought around Data Protection, Freedom of information and the Human Rights Act
- Whether insurance services for each agency need to be informed
- How matters concerning family and friends, the public and media will be managed before, during and after the review and who will take responsibility for this.

4.11 The Review Panel Chair makes the final decision on the suitability of the terms of reference for each DHR.

4.12 The Review Panel will carefully consider the potential benefits gained by including members of informal support networks, such as friends, family members and colleagues from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances, for example, where there are suspicions of 'honour'- based violence.

4.13 When meeting with friends, family members and others, the Review Panel will:

¹ As soon as it emerges that a DHR cannot be completed within the timescales above (perhaps because of judicial proceedings), the Review Panel should notify the SSP to renegotiate the timescale for completion. If the SSP believes that the delay to completion of the review is unreasonable they should refer the issue to the Home Office Quality Assurance Group for further advice.

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- Communicate through a designated advocate who has, where possible, an existing working relationship with the family i.e. a VCS representative.
- Make a decision regarding the timing of contact with the family based on information from the advocate and taking account of other ongoing processes i.e. post mortems, criminal investigations.
- Ensure initial contact is made in person and deliver the relevant information leaflet (see appendix Home Office website).
- Ensure regular engagement and updates on progress through the advocate, including the timeline expected for publication.
- Explain clearly how the information disclosed will be used and whether this information will be published.
- Explain how their information has assisted the review and how it may help other domestic violence victims.
- Prior to sending the final review to the Home Office, a completed version of the review should be provided to the family. This will allow consideration of the other findings and recommendations. It is then possible to record any areas of disagreement.
- Maintain reasonable contact with the family, even if they decline involvement in the review process; it will be important to communicate through the designated advocate when the review is completed and when the review has been assessed and is ready for publication. They should also be informed about the potential consequences of publication i.e. media attention and renewed interest in the homicide.

4.14 The Review Panel should be aware of the potential sensitivities and need for confidentiality when meeting with members of informal support networks during the review and all such meetings should be recorded. Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.

Receipt of evidence

4.15 Agencies and interested parties will be notified by the Chair of the requirement to conduct a review and be obliged to secure any records pertaining to the case against loss and interference. In these circumstances, the Review Panel will ensure records are reviewed and a chronology drawn up to identify any immediate lessons to be learned (an immediate

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IMR). These should be brought to the attention of the relevant agency or agencies for action, secured for the subsequent Overview Report and forwarded to the disclosure officer for the criminal case. Any identified recommendations should be taken forward without delay.

4.16 The Chair of the Review Panel will write to the senior manager in each of the participating agencies to commission the IMRs. The aim of the IMR is 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 homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples
- Each agency involved will be asked to:
 - Present and examine the chronology of events, and highlight any discrepancies
 - Present a comprehensive report of the actions by their agencies
 - Ensure any other management reports and other relevant information is made available

4.17 Those conducting IMRs should not have been directly involved with the victim, the perpetrator or either of their families and should not have been the immediate line manager of any staff involved in the IMR. The IMR reports should be quality assured by the senior manager in the organisation who has commissioned the report.

4.18 As instructed by the Chair, each agency will then carry out an IMR of its involvement with the victim or perpetrator. 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.

4.19 The views of the senior investigating officer and subsequent SSP advice must be sought prior to interviewing witnesses involved any criminal proceedings. 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 homicide gives cause for concern within the

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individual agency. Professionals outside of the IMR process (such as GPs) should contribute reports of their involvement with the victim(s) and/or perpetrator(s).

4.20 A template for writing IMR can be found in appendix 2. IMRs will not be made publicly available

Once IMRs have been completed, each agency involved will be asked by the panel to:

- Present and examine the chronology of events, and highlight any discrepancies
- Explain in detail the actions by their agencies
- Ensure any other management reports and other relevant information is made available

Discussion of Evidence/ Adjudication

4.21 This stage of the review is where the assessment of alternative courses of action takes place. The review panel will:

- Cross-reference all agency management reports and reports commissioned from any other source
- Examine and identify relevant action points
- Form a view on practice and procedural issues
- Agree the key points to be included in the report and the proposals for action

Disclosure and criminal Proceedings

4.22 Dependent on the case, material gathered in the course of a DHR may be capable of assisting the defence case (as well as the prosecution) and would almost certainly be material that the defence would seek to gain access to. If a DHR is being conducted parallel to a criminal investigation the disclosure officer will be obliged to inform the Prosecutor and any interviews with other agency staff, documents, case conferences, etc. may all become discloseable. It is the responsibility of disclosure officer to link in with panel chair. Further information about disclosure can be found at www.cps.gov.uk/legal/d_to_g/disclosure_manual.

The Overview Report

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4.23 The review panel will complete the review of IMRs as above and those commissioned from any other source and advise the Chair on the production of an Overview Report, which brings together information, analyses it and makes recommendations. The Chair will ensure that the Overview Report is written and delivered within agreed timescales.

4.24 Overview Reports should be produced according to the outline format and template (see appendix 3) and as with IMRs, the precise format depends on the features of the homicide. The Review Panel will keep personal details anonymous within the final report and Executive Summary.

4.25 The findings of the review should be regarded as 'Restricted' as per the Government Protective Marking Scheme (GPMS) until the agreed date of publication. Prior to this, information should be made available only to participating professionals and their line managers 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 Chair, taking into account ongoing criminal proceedings

4.26 On being presented with the Overview Report the Review Panel will ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented and will ensure that the Report is of a high standard and is written according with this protocol.

Overview Report Action Plan

4.27 The Overview Report will also make recommendations for future action which the Review Panel should translate into a specific, measurable, achievable, realistic and timely (SMART) Action Plan. The Action Plan will be agreed at senior level by each of the participating organisations and should set out how improvements in practice and systems will be monitored and reviewed. Once agreed, the Review Panel should provide a copy of the Overview Report, Executive Summary and the Action Plan (hereafter referred to as 'supporting documents') to the Chair of the SSP.

SSP on receiving the Overview Report

4.28 On receiving the Overview Report and supporting documents, the SSP should:

- Agree the content for publication, ensuring that it is fully anonymous apart from including the names of the Review Panel Chair and members.
- Make arrangements to provide feedback and debriefing to staff, family members and media as appropriate (i.e. the media won't be briefed until the report has been cleared by the Home Office).
- Sign off the Overview Report and supporting documents.
- Provide a copy of the Overview Report and supporting documents to the Home Office Quality Assurance Group. This should be via email to DHRENQUIRIES@homeoffice.gsi.gov.uk.
- The document should not be published until clearance has been received from the Home Office Quality Assurance Group (for example if there is an ongoing court case).

4.29 On receiving clearance from the Home Office Quality Assurance Group, the SSP will:

- Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency.
- Provide an electronic copy of the Overview Report and Executive Summary on the local SSP web page.
- Monitor the implementation of the Action Plan.
- Formally conclude the review when the Action Plan has been implemented and include an audit process.

Quality Assurance

4.30 Quality assurance for completed DHRs rests with Office. Once Overview Reports and supporting documents are sent to the Home Office, they will be assessed. The group meet on a quarterly basis to assess report standards as well as identifying good and poor practice and training needs.

4.31 Following the quality assurance process, the Home Office Quality Assurance Group will inform the SSP of any outstanding issues and information on when the review can be published. Completed reviews should be published at a local level on the local SSP website.

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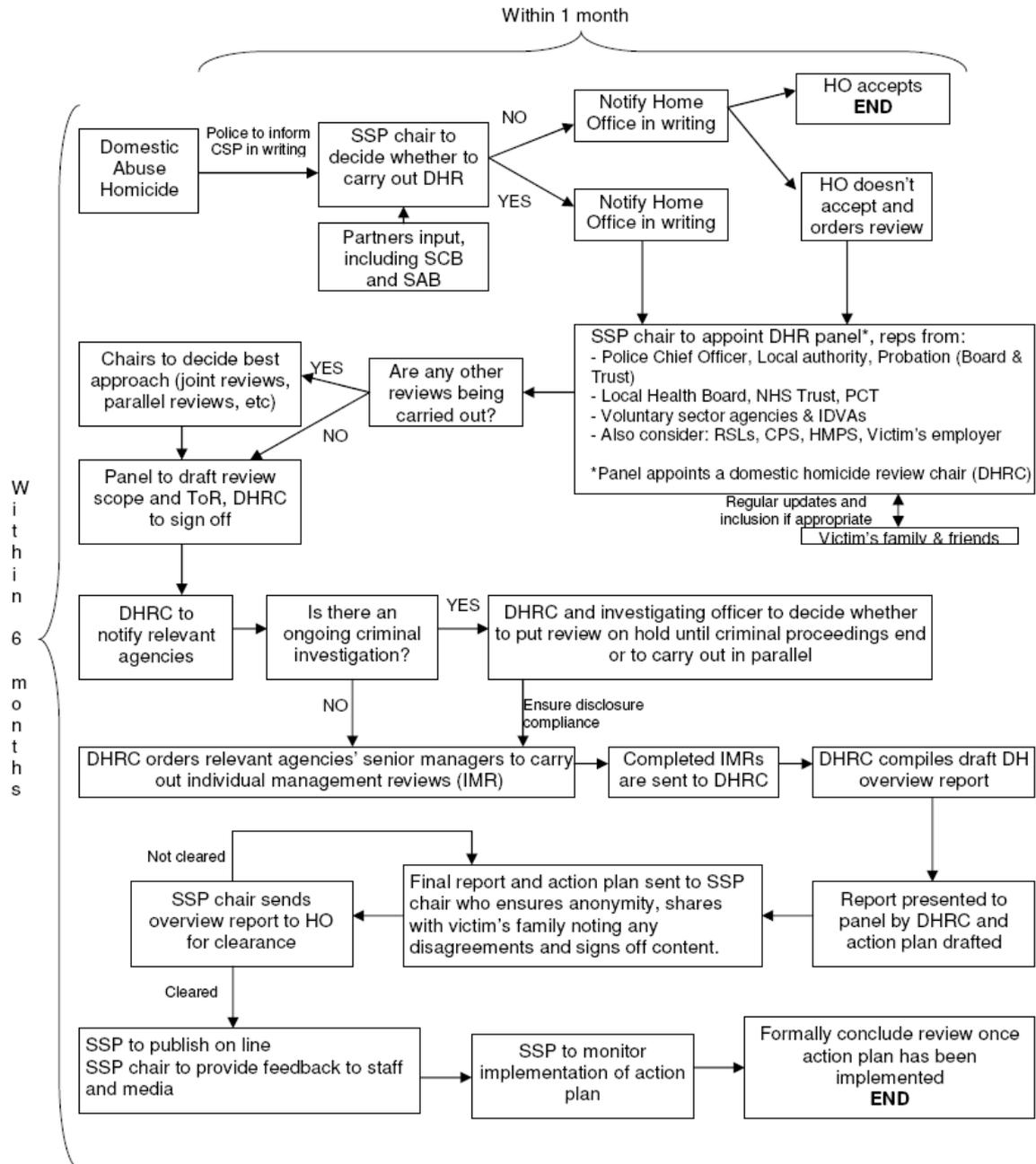
Dissemination of Lessons Learnt

4.32 DHRs are a vital source of information to improve national and local policy and practice. All agencies involved have a responsibility to identify and disseminate common themes and trends across review reports, and act on any lessons identified to improve practice and safeguard victims.

4.33 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. The SSP Chair will consider what type and level of information needs to be disseminated, how and to whom, in the light of the review. This should include communication of both examples of good practice and areas where change is required.

4.34 Subsequent learning will be disseminated to the local MARAC, DACG, the SSCB and the SAPB. Learning will be incorporated into SSP, SSCB, and SAPB training programmes. The SSP will put in place a means of monitoring and auditing the actions against recommendations and intended outcomes.

Appendix 1 Domestic Homicide Review Process Flowchart



Appendix 2

INDIVIDUAL MANAGEMENT REVIEW TEMPLATE

1. INTRODUCTION

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

- Identification of person subject to review
- Date of Birth:
- Date of death /date of serious injury/offence
- 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 IF RELEVANT

Name	Date of birth	Relationship	Ethnic origin	Address

Include family tree or genogram if relevant.

2. TERMS OF REFERENCE

3. METHODOLOGY

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

4. DETAILS OF PARELLEL REVIEWS/PROCESSES

5. 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/child/family/perpetrator was seen including antecedent history where relevant

Identify the details of the professionals from within your agency who were involved with the victim, family, perpetrator and whether they were interviewed or not for the purposes of this IMR.

6. ANALYSIS OF INVOLVEMENT

Consider the events that occurred, the decisions made, and the actions taken or not. Assess practice against guidance and relevant legislation.

ADDRESSING TERMS OF REFERENCE

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

7. EFFECTIVE PRACTICE/LESSONS LEARNT

8. RECOMMENDATIONS

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

Appendix 3

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 and/or Coroner's inquiry 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 the perpetrator(s). If a partner/ex-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.