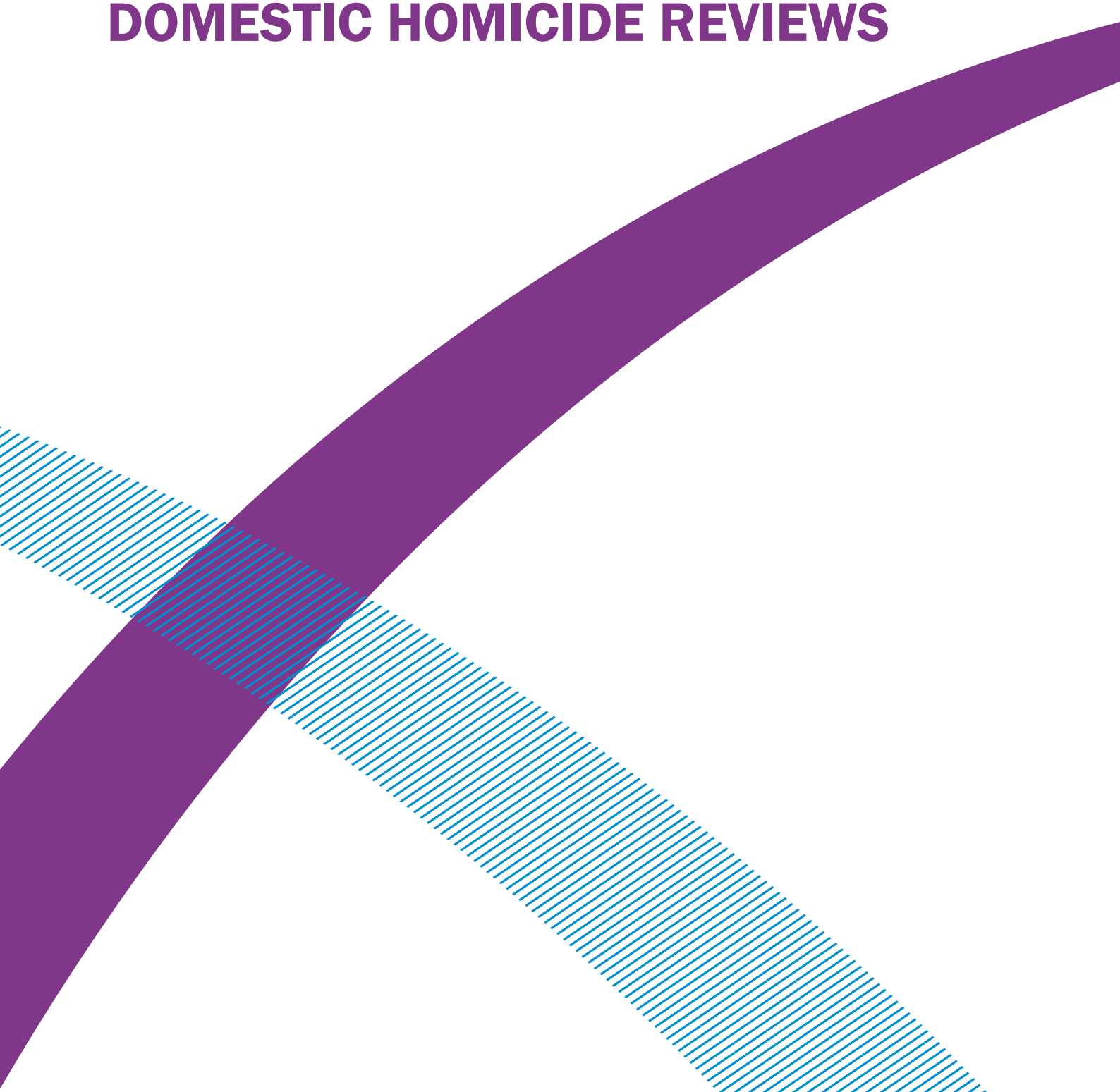
Home Office

# MULTI-AGENCY STATUTORY GUIDANCE FOR THE CONDUCT OF DOMESTIC HOMICIDE REVIEWS



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# 1. INTRODUCTION

1.1 The Government's current approach to tackling violence against women and girls including domestic violence is set out in the strategic narrative *Call to End Violence Against Women and Girls* (published on 25th November 2010) and the supporting Action Plan (published on 8th March 2011[1]). Preventing violence from happening in the first place is at the heart of this approach.

1.2 As part of the supporting Action Plan, the Government committed to the following action:

- Implement section 9 of the Domestic Violence, Crime and Victims Act (2004), putting in place statutory domestic violence homicide reviews.

1.3 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] Both documents are available download at www.homeoffice.gov.uk/vawg

# 2. BACKGROUND

2.1 Domestic violence includes physical violence, psychological, sexual, financial and emotional abuse involving partners, ex-partners, other relatives or household members. In 2009/10[2], domestic violence accounted for 14% of all violent incidents and affects both men and women.

2.2 Domestic violence is frequently repeated by the perpetrator and the violence can escalate over time. A domestic violence incident which results in the death of the victim is often not a first attack and is likely to have been preceded by psychological and emotional abuse. Many people and agencies may have known of these attacks – neighbours, for example, may have heard violence, a GP may have examined injuries, housing organisations may have been called repeatedly for repairs to homes, the police may have been called, there may have been previous prosecutions, or injunctions, and so on. This can sometimes make serious injury and homicide in domestic violence 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 violence cases. There should also be an emphasis on the need for specialist support for victims and their children as well as services for families, friends and others who may be affected by the homicide.

2.3 In June 2003, Safety and Justice: The previous Government's Proposals on Domestic Violence was published for consultation. The consultation ended in September 2003 and informed the development of the Domestic Violence, Crime and Victims Act, which received Royal Assent in November 2004.

[2] Edited by: Flatley J, Kershaw C, Smith K, Chaplin R and Moon D (2010) Crime in England and Wales 2009/10: Findings from the British Crime Survey and police recorded crime. London: Home office

# 3. STATUS AND PURPOSE OF THIS GUIDANCE

## THE STATUS OF THIS DOCUMENT AS STATUTORY GUIDANCE

3.1 This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The act states:

(1) In this section "domestic homicide review" means 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.

(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) to establish, or to participate in, a domestic homicide review.

(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.

(4) The persons and bodies within this subsection are—

(a) in relation to England and Wales—

- chief officers of police for police areas in England and Wales;
- local authorities;
- Strategic Health Authorities[3] established under [section 13 of the National Health Service Act 2006];
- Primary Care Trusts[4] established under [section 18] of that Act.
- Providers of probation services[5];
- 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];

(b) in relation to Northern Ireland—

- the Chief Constable of the Police Service of Northern Ireland;
- the Probation Board for Northern Ireland;
- Health and Social Services Boards established under Article 16 of the Health and Personal Social Services (Northern Ireland) Order 1972 (SI 1972/1265 (NI 14));
- Health and Social Services trusts established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 (SI 1991/194 (NI 1)).

(5) In subsection (4)(a) "local authority" means—

(a) in relation to England, the council of a district, county or London borough, the Common Council of the City of London and the Council of the Isles of Scilly;

(b) in relation to Wales, the council of a county or county borough.

(6) The Secretary of State may by order amend subsection (4) or (5).

3.2 As statutory guidance issued under section 9(3) of the Act, a person establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) must have regard to such guidance. This means that those persons involved in the establishment or participation of a DHR

[3] & [4] Subject to Parliamentary approval of the Health and Social Care Bill 2011, PCTs and SHAs will be replaced by the NHS Commissioning Board and Commissioning Consortia as bodies under section 9(3)(4) of the Domestic Violence, Crime and Victims act 2004;

[5] A provider of probation services in accordance with arrangements made under section 3 of the Offender Management Act 2007 (c.21)

must take the guidance into account and, if they decide to depart from it, have clear reasons for doing so.

## THE PURPOSE OF A DOMESTIC HOMICIDE REVIEW

3.3 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; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

3.4 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.

3.5 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.

3.6 The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

3.7 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.

## DEFINITIONS

3.8 **Domestic homicide review** means 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.

3.9 It should be noted that an 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

3.10 So called **'Honour'-Based Violence**, "honour crimes" and "honour killings" embrace a variety of crimes of violence (mainly but not exclusively against women), including assault, imprisonment and murder where the person is being punished by their family or their community. They are being punished for actually, or allegedly, undermining what the family or community believes to be the correct code of behaviour. In transgressing against this code of behaviour, the person shows that they have not been properly controlled to conform by their family and this is to the "shame" or "dishonour" of the family.

3.11 **A member of the same household** is defined in section 5 (4) of the Domestic Violence, Crime and Victims Act [2004] as:

> (a) a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
>
> (b) 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.

# 4. ESTABLISHING A DOMESTIC HOMICIDE REVIEW

## COMMUNITY SAFETY PARTNERSHIPS

4.1 When a domestic homicide occurs, the relevant police force should inform the relevant Community Safety Partnership (CSP) in writing of the incident. Overall responsibility for establishing a review should rest with the local CSP. CSPs are ideally placed to initiate a DHR and Review Panel due to their multi-agency design and locations across England and Wales.

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 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 Any professional or agency may refer such a homicide to the CSP in writing if it is believed that there are important lessons for inter-agency working to be learned.

4.4 The chair of the CSP holds responsibility for establishing whether a homicide is to be subject of a DHR by applying the definition set out in paragraph 3.8. This decision should be taken in consultation with local partners with an understanding of the dynamics of domestic violence. This will assist in identifying 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.

4.5 It should be noted that when victims of domestic homicide are aged between 16 and 18, a child SCR should take precedent over a DHR. However, it is vital that any elements of domestic violence relating to the homicide are addressed fully and the review includes representatives with a thorough understanding of domestic violence.

**4.6 Confirmation of a decision to review, as well as a decision not to review a homicide, should be sent in writing to the Home Office DHR enquiries inbox (DHRENQUIRIES@homeoffice.gsi.gov.uk).**

4.7 As stated at section 9(2) of the Act, the Secretary of State may in a particular homicide direct a specified person or body within subsection (4) to establish, or to participate in, a domestic homicide review. Such a direction is likely to be made where a person or body has declined involvement in a DHR. In such circumstances, the Quality Assurance Group[6] will liaise with the relevant person or body and ensure action is taken as directed.

## CIRCUMSTANCES OF PARTICULAR CONCERN

4.8 The following factors are just some examples of the types of situations preceding homicide which will be of interest to review teams when conducting a DHR:

- There was evidence of a risk of serious harm to the victim that was not recognised or 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 recognised best professional practice.
- Any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or

[6] An expert group made up of statutory and voluntary agencies and managed by the Home Office. Further information can be found at section 11.

not acted on appropriately by the other parties involved.

- The homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.
- The victim was being managed by, or should have been referred to a Multi-Agency Risk Assessment Conference (MARAC).
- The homicide appears to have implications/reputational issues for a range of agencies and professionals.
- The homicide suggests that national or 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 the homicide is likely to have a significant impact on public confidence.
- The victim had no known contact with any agencies. For example, could more be done in the local area to raise awareness of services available to victims of domestic violence?

# 5. CONDUCTING A DOMESTIC HOMICIDE REVIEW

## ESTABLISHING A REVIEW PANEL

5.1 Where the CSP considers that the criteria for a DHR at 3.8 are met and should be undertaken, they will utilise local contacts and request the establishment of a DHR Review Panel, involving representatives from the relevant agencies listed below at 5.3 in addition to representatives from the Voluntary and Community Sector (VCS) with expertise in domestic violence.

5.2 The Review Panel can either have a fixed, standing membership or be created on a bespoke basis for the purposes of undertaking a 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 and/or perpetrator and the importance of having agencies to represent the victim. Independent Domestic Violence Advisers (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 team.

5.3 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 (for England and Wales):

- chief officers of police for police areas in England and Wales;
- local authorities;
- Strategic Health Authorities[7] established under [section 13 of the National Health Service Act 2006];
- Primary Care Trusts[8] established under [section 18] of that Act.
- Providers of probation services[9];
- 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];

5.4 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, the HM Prison Service. Involvement with other agenices will need to be decided on a case by case basis and should be agreed by the Review Panel.

5.5 It is acknowledged that many CSP areas will already have established forums dealing with domestic violence and domestic homicide which hold a wealth of knowledge in understanding the complexities of such incidents and are often experienced in participating with DHRs and other review processes. Such forums should be fully included in the Review Panel and process. Where appropriate, the CSP may wish to refer the DHR for action to such a forum to lead on and manage the review.

5.6 Members of statutory agencies who have responsibilities for completing Individual Management Reviews (IMRs) may also be members of the Review Panel, but the Panel should not consist solely of such people.

5.7 The Review Panel should bear in mind all equality and diversity issues at all times; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation may all have a bearing on how the review is explained and conducted and the outcomes disseminated to local communities.

[7] & [8] subject to Parliamentary approval of the Health and Social Care Bill 2011, PCTs and SHAs will be replaced by the NHS Commissioning Board and Commissioning Consortia as bodies under section 9(3)(4) of the Domestic Violence, Crime and Victims act 2004;

[9] A provider of probation services in accordance with arrangements made under section 3 of the Offender Management Act 2007 (c.21)

## APPOINTING A CHAIR OF THE REVIEW PANEL

5.8 The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and co-ordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant.

5.9 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. Some areas may consider the development of a regional agreement where experienced individuals from neighbouring areas are exchanged or loaned to the Review Panel to help share good practice and promote dissemination of new information and learning.

5.10 Consideration should be given to the skills and expertise required to effectively chair a review. The following is a guide:

- Relevant knowledge of domestic violence issues including 'honour'-based violence, research, guidance and legislation relating to adults and children, including the Equality Act 2010.
- 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.
- The completion of the E-Learning Training Package on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing Overview Reports.

## DETERMINING THE SCOPE OF THE REVIEW

5.11 The Chair and Review Panel should consider in each homicide 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 homicide? 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? For example, victims may come from within hard to reach communities and consideration should be given to how the community can improve engagement and access to such groups.
- 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? Would a co-ordinated or jointly commissioned review process be more effective in addressing all the relevant questions that need to be asked, ensuring staff are not interviewed twice and that there are individuals who sit on both panels to ensure good cross communication? It will be the responsibility of the Review Panel Chair to ensure contact is made with the chair of any parallel process to consider combining the reviews.
- Should an outside 'expert' be consulted to help understand crucial aspects of the homicide? For example, a representative from a specialist BME women's organisation.

- Over what time period should events in the victim's and perpetrator's life be reviewed taking into account the circumstances of the homicide 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, age and disability that may require special consideration?
- Did the victim's immigration status have an impact on how agencies responded to their needs?
- Was the victim subject to a MARAC? If so, is there a need for a Memorandum of Understanding for the release of the minutes from the relevant meetings?
- Was the perpetrator subject to Multi Agency Public Protection Arrangements (MAPPA)? If so, is there a need for a Memorandum of Understanding for the release of the minutes from the relevant meetings?
- Was the perpetrator subject to a Domestic Violence Perpetrator Programme (DVPP)? If so, the professionals working with the perpetrator may know important information relating to the homicide as well as a key focus on the management of risk posed by the perpetrator.
- Did the victim have any contact with a domestic violence organisation or helpline? How will they be involved and contribute to the process?
- If appropriate, how will issues of 'honour'-based violence be covered and what processes will be put in place to ensure confidentiality?
- How should friends, family members and other support networks (for example, co-workers and employers, neighbours etc) 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? (Further information is available at section 7).
- How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for this?
- Consideration should also be given to whether either the victim or the perpetrator was a 'vulnerable adult' – a person "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation"[10]. If this is the case, the Review Panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act [2005].
- How will the Review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process? (See section 10 for further information)
- Is there a need to involve agencies/ professionals working in other Local Authority areas with an interest in the homicide, including members of the VCS and what should their roles and responsibilities be?

[10] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4074540.pdf

- Who will make the link with relevant interested parties outside the main statutory agencies, for example independent professionals and voluntary organisations?
- How should the review process take account of previous lessons learned i.e. from research and previous DHRs?
- Does the Review Panel need to obtain independent legal advice about any aspect of the proposed review?

5.12 In some homicides that do not meet the criteria for a 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.

5.13 The Review Panel Chair should make the final decision on the suitability of the terms of reference for each DHR. 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 Review Panel.

# 6. TIME-SCALES FOR CONDUCTING DOMESTIC HOMICIDE REVIEWS

6.1 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. The timescales for DHRs are based on those used in Serious Case Reviews.[11]

6.2 The decision on whether or not to hold a review should be taken by the Chair of the CSP within **one month** of a homicide coming to their attention. The terms of reference for the review will also need to be drafted and agreed within this timescale.

6.3 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.

6.4 The Overview Report should be completed within a further **six months** of the date of the decision to proceed unless an alternative timescale is formally agreed with the relevant CSP. 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 timescales above (perhaps because of judicial proceedings), the Review Panel should notify the CSP to renegotiate the timescale for completion. If the CSP believes that the delay to completion of the review is unreasonable they should refer the issue to the Quality Assurance Group for further advice.

6.5 In some cases, mental health investigations, criminal investigations or other legal proceedings may be carried out after a death. The Chair of the Review Panel should discuss with the relevant criminal justice and/or other agencies (e.g. HM Coroner, Senior Investigating Officer, 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?

6.6 It may be necessary to agree that the review will be pended until after the outcome of any criminal proceedings. However, this should not mean that learning arising from the homicide should not be taken forward. It is essential that necessary learning is not delayed to prevent the same mistakes being replicated in other cases.

6.7 Agencies and interested parties should be notified 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 should ensure records are reviewed and a chronology drawn up to identify any immediate lessons to be learned (an immediate 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.

6.8 Following the criminal proceedings the DHR should be concluded without delay. Further information on disclosure and criminal proceedings is at section 10.

[11] Chapter 8, Serious Case Reviews, Working Together to Safeguard Children, 2010

# 7. INVOLVEMENT WITH FRIENDS, FAMILY MEMBERS AND OTHER SUPPORT NETWORKS

7.1 In domestic violence homicides, members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals 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. The benefits include:

- Assisting the family with the healing process which links in with the objectives of the new 'National Homicide Service' supporting victims for as long as they need after homicide. For example, a review may allow them to disclose information in private which may not be published. A family would not be able to achieve this in an inquest which is in the public domain.
- Helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.
- Obtaining relevant information held by family members, friends and colleagues which is not recorded in official records.
- Revealing different perspectives of the case, enabling agencies to improve service design and processes.
- Allowing the Review Panel to get a more complete view of the victim's life and see the homicide through the eyes of the victim. This approach can help the panel understand the decisions and choices the victim made.

7.2 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.

7.3 When meeting with friends, family members and others, the Review Panel should:

- 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 7.5 below).
- 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.

7.4 The Review Panel should also access other networks which victims and perpetrators may have disclosed to, for example, employers, health professionals, local professionals involved in Domestic Violence Perpetrator Programmes (DVPPs) or their local VCS agencies. Information leaflets explaining the DHR process for the following support networks can be found at www.homeoffice.gov.uk/vawg

- Friends
- Family members
- Employers and colleagues

7.5 The Review Panel should also be mindful that the perpetrator or members of the perpetrator's family might in some cases pose an ongoing risk of violence to the victim's family or friends. If the Review Panel is concerned that there may be a risk of imminent physical harm to any known individual(s), they should contact the police immediately so that steps can be taken to secure protection.

7.6 Particular consideration should be given to reviews where 'honour'-based violence is suspected. Extra caution will need to be taken around confidentiality in relation to agency members and interpreters where there are possible links with the family, who may be the perpetrators. Extra caution will also be required when considering the level of participation from family members and should be carefully considered in consultation with a practitioner with expertise in this area, for example, a specialist BME women's organisation.

# 8. CONTENT OF THE INDIVIDUAL MANAGEMENT REVIEWS AND THE OVERVIEW REPORT

## INDIVIDUAL MANAGEMENT REVIEWS

8.1 The Chair of the Review Panel should write to the senior manager in each of the participating agencies to commission the IMRs. The IMRs will form part of the Overview Report.

8.2 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 of good practice within agencies.

8.3 DHRs are not part of any disciplinary inquiries, 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.

8.4 Once it is known that a homicide 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 records promptly, work quickly to draw up a chronology of their involvement with the victim, perpetrator or their families. Each agency should then carry out an IMR of its involvement with the victim or perpetrator, unless it had no involvement (see Appendix one).

8.5 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 involved any criminal proceedings.

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

8.7 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.

8.8 The IMR reports should be quality assured by the senior manager in the organisation who has commissioned the report. This senior manager will be responsible for ensuring that any recommendations from both the IMR and, where appropriate, the Overview Report are acted on appropriately.

8.9 On completion of each IMR report, there should be a process of feedback and debriefing for the staff involved in the review, in advance of completion of the Overview Report. There should also be a follow-up feedback session with these staff members once the Overview Report has been completed and prior to its publication. The management of these sessions are the responsibility of the senior manager in the relevant organisation.

## THE OVERVIEW REPORT

8.10 The Overview Report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports or information commissioned from any other relevant interests.

8.11 Overview Reports should be produced according to the outline format and template (see appendices 3 and 4) and as with IMRs, the precise format depends on the features of the homicide. The Review Panel will need to bear in mind the importance of keeping personal details anonymous within the final report and Executive Summary.

8.12 It is crucial the Chair has access to all relevant documentation and, where necessary, individual professionals to enable them to effectively undertake their review functions.

8.13 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.

8.14 As part of the terms of reference, the Chair should appoint lead individuals or agencies to take responsibility for engaging with family members and friends, and for responding to media interest about the review, in liaison with contributing agencies and professionals.

## REVIEW PANEL ACTION ON RECEIVING AN OVERVIEW REPORT

8.15 On being presented with the Overview Report the Review 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.

## OVERVIEW REPORT ACTION PLAN

8.16 The Overview Report should also make recommendations for future action which the Review Panel should translate into a specific, measurable, achievable, realistic and timely (SMART) Action Plan (see appendix 5). The Action Plan should be agreed at senior level by each of the participating organisations.

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

8.18 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 CSP.

## COMMUNITY SAFETY PARTNERSHIP ACTION ON RECEIVING THE OVERVIEW REPORT

8.19 On receiving the Overview Report and supporting documents, the CSP should:

- Agree the content of the Overview Report and Executive Summary for publication, ensuring that it is fully anonymised apart from including the names of the Review Panel Chair and members;
- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate;

- 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 (see section 9).

8.20 On receiving clearance from the Home Office Quality Assurance Group, the CSP should:

- 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 CSP web page;
- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan;
- Formally conclude the review when the Action Plan has been implemented and include an audit process.

# 9. PUBLICATION OF THE OVERVIEW REPORT

9.1 In all cases, the Overview Report and Executive Summary, should be suitably anonymised and made publicly available. IMRs should not be made publicly available. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The aim in publishing these reviews is to restore public confidence and improve transparency of the processes in place, across all agencies, to protect victims.

9.2 All Overview Reports and Executive Summaries should be published unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen. The publication of the documents needs to be timed in accordance with the conclusion of any related court proceedings and other review processes. The content of the Overview Report and Executive Summary must 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. This means preparing Overview Reports in a form suitable for publication, or redacting them appropriately before publication.

9.3 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.

9.4 Where appropriate, consideration should also be given to translating the executive summary into different languages and other formats, such as Braille or British Sign Language.

9.5 Publication of Overview Reports and the Executive Summary will take place following agreement from the Quality Assurance Group at the Home Office and should be published on the local CSP web page.

# 10. DISCLOSURE AND CRIMINAL PROCEEDINGS

10.1 Disclosure is one of the most important issues in the criminal justice system and the application of proper and fair disclosure is a vital component of a fair criminal justice system. All disclosure issues must be discussed with the police SIO, the CPS and the HM Coroner's representative as appropriate.

10.2 There may be homicides where the investigator believes that a third party (for example, a local authority or social care) has material or information which might be relevant to the prosecution case. In such cases, if the material or information might reasonably be considered capable of undermining the prosecution case or of assisting the case for the accused, prosecutors are asked to take steps they regard as appropriate to obtain it. This may include applying for a witness summons causing a representative of the 'third party' to produce the material to the Court.

10.3 Dependent on the case, material gathered in the course of a DHR may be capable of assisting the defence case 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.

10.4 Below is a suggested process for managing issues of disclosure within a DHR:

- In all cases of domestic homicide, even when the suspect subsequently commits suicide, a criminal investigation will be commenced.
- Once an investigation has been commenced, the relevant CSP should be informed in order that they may consider commissioning a DHR.
- Where the evidence indicates that the suspect has killed themselves the case will be referred to the Coroner and a file will be prepared. In these circumstances it is appropriate for a DHR to be conducted without delay and the Overview Report and supporting documents should be submitted to the Coroner to help inform the Inquest.
- In cases where the suspect is arrested and charged, the commissioning of the Overview Report should be held temporarily until the conclusion of the criminal case but agencies and interested parties should be notified of the requirement and be obliged to secure any records pertaining to the homicide against loss and interference. In these circumstances, the Review Panel should ensure records are reviewed and a chronology drawn up to identify any immediate lessons to be learned (an immediate 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.
- Following the criminal proceedings the DHR should be concluded without delay.

10.5 Further information about disclosure can be found at www.cps.gov.uk/legal/d_to_g/disclosure_manual.

# 11. QUALITY ASSURANCE AND DISSEMINATION OF LESSONS LEARNED

## QUALITY ASSURANCE

11.1 Quality assurance for completed DHRs rests with an expert group made up of statutory and voluntary agencies and managed by the Home Office. All completed Overview Reports and supporting documents should be sent to the Home Office (DHRENQUIRIES@homeoffice.gsi.gov.uk) and will be assessed against this guidance. The group meet on a quarterly basis to assess report standards as well as identifying good and poor practice and training needs. Further information about this group can be found at www.homeoffice.gov.uk.

11.2 Where reviews are assessed as inadequate, a summary of findings is sent to the CSP Chair who is responsible for ensuring the areas of concern are revisited and amended. The Home Office Quality Assurance Group will be responsible for assessing progress identified at a national level.

11.3 Following the quality assurance process, the Quality Assurance Group will inform the CSP 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 CSP website. The Home Office page will also include examples of effective practice and updates on national learning and training.

11.4 The Home Office Quality Assurance Group is also responsible for:

- Disseminating lessons learned at a national level and effective practice.
- Identifying serious failings and common themes.
- Communicating with the media to raise awareness of the positive work of the statutory and voluntary agencies with domestic violence victims and perpetrators so that attention is not focused disproportionately on tragedies.
- Communicating and liaising with other government departments to ensure appropriate engagement from all relevant agencies.
- Providing central storage for DHRs to allow for clear auditing of review documentation and quick retrieval if required.
- Requesting updates from local areas on actions taken following a review
- Reviewing decisions by CSPs not to undertake a DHR
- Recommending national training needs and working across government to ensure existing training is highlighted
- Recommending service needs to commissioners

## LEARNING LESSONS AND EFFECTIVE PRACTICE

11.5 DHRs are a vital source of information to inform 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.

11.6 It is important to draw out key findings of DHRs and their implications for policy and practice. The following may assist in achieving maximum benefit from the DHR 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.

- Subsequent learning should be disseminated to the local MARAC, any local Domestic Violence Forums or similar, the Local Safeguarding Children Board and commissioners of services.
- Incorporate the learning into local and regional training programmes.
- The CSP should put in place a means of monitoring and auditing the actions against recommendations and intended outcomes.
- Establish a culture of learning lessons by having a standing agenda item for DHRs on the meetings of CSP and Domestic Violence Forums and similar groups.

# GLOSSARY

| | |
|---|---|
| **DHR** | Domestic Homicide Review |
| **CSP** | Community Safety Partnership |
| **MARAC** | Multi-Agency Risk Assessment Conference |
| **MAPPA** | Multi-Agency Public Protection Arrangements |
| **IDVA** | Independent Domestic Violence Adviser |
| **SCR** | Serious Case Review |
| **MHI** | Mental Health Investigation |
| **VCS** | Voluntary and Community Sector |
| **SIO** | Senior Investigating Officer |
| **FLO** | Family Liaison Officer |
| **IMR** | Individual Management Reviews |
| **DASH** | Domestic Abuse, Stalking and 'Honour'-Based Violence Risk Identification Checklist |
| **TOR** | Terms of Reference |
| **PCT** | Primary care Trust |
| **SHA** | Strategic Health Authorities |
| **CPS** | Crown Prosecution Service |
| **SMART** | Specific, Measurable, Achievable, Realistic and Timely |
| **DVPP** | Domestic Violence Perpetrator Programme |
| **GMPS** | Government Protective Marking Scheme |
| **FOIA** | Freedom of Information Act |
| **BME** | Black and Minority Ethnic |

# 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. Each homicide 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. The following are examples of 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 violence 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 violence 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 violence? 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 violence 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?
- 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?
- To what degree could the homicide have been accurately predicted and prevented?

# APPENDIX TWO

## 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 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 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.

# APPENDIX FOUR

## DOMESTIC HOMICIDE OVERVIEW REPORT TEMPLATE

TO BE ANONYMISED FOR PUBLICATION AND DISSEMINATION

REPORT INTO THE DEATH OF

(add victim's name/reference)

Report produced by .....

Date .....

## 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).

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

## TIMESCALES

This review began on (date) and was concluded on (date). Reviews, including the overview report, should be completed, where possible, within six 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 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 / Criminal proceedings have been completed. (Details of outcome)

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:

(This will vary for every homicide)

- (Area) Local Authority
- (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) Local Probation Board
- (Area) Strategic Health Authority
- (Area) Primary Care Trust
- (Area) Local Health Board
- (Area) NHS Trusts
- (Area) Mental Health Team
- (Area) Victim Support Services
- (Area) IDVA
- (Area) Local Refuge
- (Area) Community Police Consultative Group
- (Area) Friends / Family / Employer
- other

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 PANEL CONCLUDING 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 violence 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)

To note: It will not always be possible to arrive at a definitive judgement about what intervention could have or would not have prevented the death.

### RECOMMENDATIONS

- (Add recommendation(s))

(Name of author of report)

(Position in agency)

(Date)

## HOUSING REPORT

MURDER OF (VICTIM)

Of (address)

(age and ethnicity)

(name and address of Housing Office)

(details of housing provider if victim was supported by UK Border Agency

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 TEMPLATE

| 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?<br>(N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for national level) | How exactly is the relevant agency going to make this recommendation happen?<br>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 recommendation be completed by? | When is the recommendation actually completed?<br>What does outcome look like? |
| Fictional examples; | | | | | | |
| All coroner's should receive training on domestic violence | National | - Review current coroner's training and identify gaps<br>- Develop training module.<br>- Roll-out revised training package as follows:<br>June-July – Coroners in region X<br>Aug-Sept –Coroners in region Y | Ministry of Justice<br>Coroner's team | - Review completed in January 09<br>- Training package agreed April 09<br>- 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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Educate the community on the risk factors around domestic abuse | Local and national | - Identify mediums to advertise these risk factors by July 2012 and how and if it should be done in a targeted way so they are accessible to all, i.e. Local authority web-site, GP surgeries, Accident and emergency clinics, Dentist surgeries, Job Centres etc<br>- Circulate briefing and hold meetings to discuss<br>- Get leaflet printed nationally advising family, friends and community on how to help victims of domestic violence and distribute by December 2012 | CSPs and<br>Home Office | Plan agreed July 2012<br>Mediums told of information and are advertising it by Sept 2012<br>Leaflet distributed nationally December 2012 | Dec 2012 | The community is much more aware of the risk factors and reports are being heard of the community making safe and early interventions to avert domestic violence.<br>More questions are being received from the community on how to help victims of domestic violence. |

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