Domestic Homicide Reviews

Hammersmith & Fulham

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Background:

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). Section 9 of the Act was brought into force on13th April 2011. The objective of this protocol is to outline the approach being taken across Hammersmith & Fulham to meet this statutory requirement and ensure it delivers robust, effective and best practice reviews.

The revised multi agency statutory guidance for the conduct of DHRs, published in June 2013 and revised in 2016, issued under section 9(3) of the DV, Crime and Victims Act (2004), should be referred to alongside the detailed Home Office Guidance: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf**

Definitions

A Domestic Homicide Review, under the terms of the above Act, 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,
c) Suicide- that where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.
d) Held with a view to identifying the lessons to be learnt from the death.
e) When this definition has been met, a Domestic Homicide Review must be undertaken.

Purpose:

The purpose of a DHR is to:

a) 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;
b) 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;
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

The narrative of each review should articulate the life through the eyes of the victim (and their children) and talking to those around the victim including family, friends, neighbours, community members and professionals.

A successful DHR should go beyond focusing on the conduct of individuals and whether procedure was followed to evaluate whether the procedure/policy was sound.

The rationale for the review includes ensuring that agencies are responding appropriately to victims of domestic abuse 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. 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.

DHR Stages

The protocol outlines the key actions and accountabilities which need to be acted upon at each stage of the process.

There are five key stages:

1. **Commissioning the review**
2. **Conducting the review**
3. **Overview report and action plan**
4. **Completion and sign-off**
5. **Dissemination and learning**

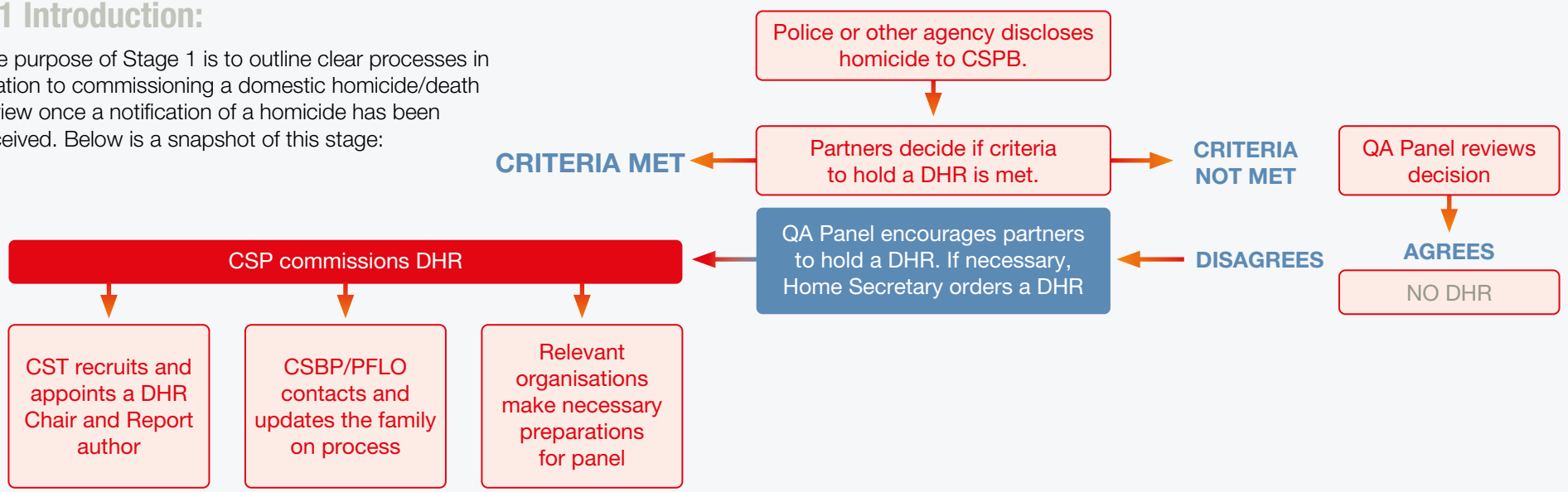
To ensure effective delivery and accountability at each stage, the protocol outlines:

- Roles and responsibilities for the:
  - Community Safety Partnership
  - DHR Panel
  - DHR Chair
- Involvement of family members
- Best practice
- How to overcome potential challenges and risks.

Stage 1: Commissioning a DHR

1.1 Introduction:

The purpose of Stage 1 is to outline clear processes in relation to commissioning a domestic homicide/death review once a notification of a homicide has been received. Below is a snapshot of this stage:



1.2 Roles and Responsibilities

Role of the Community Safety Programme Board (CSPB):

- Police notify CSPB chair of homicide/death.
- CSPB considers any parallel reviews and then decides to undertake a DHR
- CSPB notify Home Office of decision to undertake a DHR.
- CSPB notifies family of the decision to undertake a review (via a Police Family Liaison Officer) (Appendix 1: Family Template Letter)
- CSPB informs relevant organisations to identify a panel meeting representative and to secure records.

Community Safety Team Roles and Responsibilities:

- Community Safety Team (CST) sends letter to CSPB Chair to seek approve to undertake a DHR (Appendix 2: Notification Template letter)
- CST undertakes a call out for review chair and author (Appendix 3: Application Form)
- CST interviews and selects chair.
- CST draws up a contract with chair (Appendix 4: Contract)

Involvement of Family:

- Either the PFLO or an advocate contacts the family and provides an explanation of the DHR process with clear opportunities for contribution.
- Chair/Police works with the family to develop a genogram to identify key family members.
- In suicide cases, there will not be a FLO so the CST to directly contact family to notify and to offer support.

1.3 To consider:

Establishing timeframes:	• Consider realistic timeframes and approximate costs for the completion of the report.
Specialist services:	• Has a budget been set aside to ensure specialist/voluntary service input into the report?
Risk and Review Group:	• To ensure that the Risk and Review Group is kept up to date on decision and progress.
Securing records:	• CST to ensure agencies secure records relevant to the case.
Establishing Identity:	• All professionals to be mindful of any difference in name spellings etc.

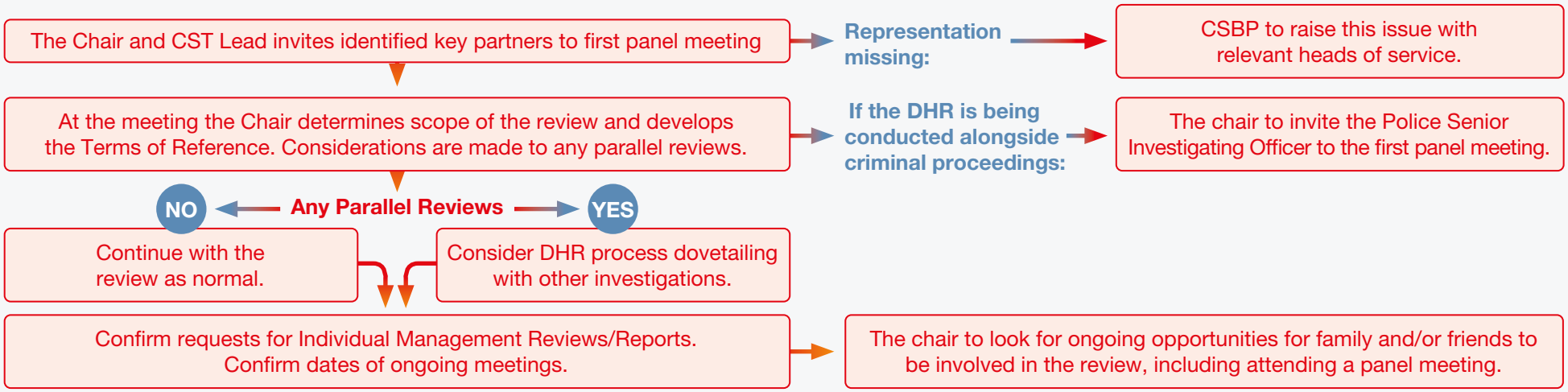
1.4 Best Practice:

Best Practice	What to do when problems arise:	
• Ensure transparency in recruitment of chair through a tender process. • Clear evidence which demonstrates the expertise of the chair. Chair application to be accompanied by previous Home Office letters from previously published DHRs and reference from previous borough. • Timely notifications to family and Home Office from CST & CSPB. • To benchmarking best practice against similar DHRs and learning highlighted by the Domestic Abuse Commissioner. • Roles and responsibilities are clearly understood by all involved. • All involved to consider any early issues equality, diversity and intersectionality.	**Finding a suitable chair:**	• Development of robust resources such as application forms. • Request for references • Adequate checks of previously reports and review of Home Office letters.
	Timeliness of process led by chair:	• Home Office Guidance to be used. • Contract to include estimated timeframes and managing slippage.
	Delay in start of DHR process due to Police processes:	• Clear communication with CSPB about any expected any delays • Consideration given to what can be started (securing records, any actions in light of immediate learning etc.)
	Lack of Family Involvement:	• Work closely with AAFDA • Clearly explain the DHR remit and process • Provide ongoing opportunities for input.

Stage 2: Conducting the Review

2.1 Introduction:

Stage 2 focuses on the processes and requirements in the initial set up and development of conducting the domestic homicide review. Below is a snapshot of this stage:



2.2 Roles and Responsibilities

Role of the CSPB:

- Oversee the quality of the review and ensure timeframes are observed.
- Ensure agencies are represented on the review panel and support the CST/Chair in following up with partners.
- To ask for updates on progress of the report and to have a standing item agenda on the CSPB agenda.

Roles and Responsibilities:

Chair: Clearly explain purpose and process of DHR to panel members through robust Terms of Reference. Ensure the high quality of Individual Management Reviews (IMRs) and provide support where needed.

CST: Arrange meeting dates, book rooms and support the chair in establishing first meeting. Ensure panel is diverse and fund additional representation where necessary.

Panel Members: Ensure senior representation at meetings who have not been involved in the case. Meaningfully contribute to the report through IMRs and panel meetings. Implement learning at the earliest opportunity.

Ensure the high quality of IMRs.

Involvement of Family/Friends:

- To be contacted by the chair who introduces themselves and explains the DHR process.
- To be asked by the chair if and how they want to contribute to the review.
- To be given the opportunity to understand and influence the scope of the review including the Terms of Reference.
- To be kept up to date on the progress off the report.

2.3 To consider:

IMRs or Report:	• Where there has not been agency involvement, the chair to consider if an IMR or a less detailed report is needed.
Specialist services:	• To ensure representation, and where possible, the CST fund attendance at meetings.
Parallel Processes:	• Consider managing the DHR in parallel to other reviews so that professionals can learn from the case. Consider whether some or all aspects of the reviews can be commissioned jointly so as to reduce duplication of work and an improved experience of families.
Criminal Proceedings:	• The chair to invite the Police Senior Investigating Officer to the first panel meeting to brief the panel of the investigation and be involved in developing the Terms of Reference.
Role of perpetrator:	• The chair to invite the perpetrator to participate in the review.

2.4 Best Practice:

Best Practice	**What to do when problems arise:**	
• The right people are on the review panel who are strategic in the role. The same person consistently attends meetings going forward. • Emerging learning is implemented at the earliest opportunities without needing to wait for the development of DHR or action. • All IMRs follow an agreed template which include meaningful recommendations for their own agency. • Family and friends are involved at the earliest stage of conducting the review. • An intersectional approach is adopted throughout the development of the DHR.	**Engagement of panel members:**	To raise any concerns with the CSPB who are to flag attendance with senior managers from the respective team.
	Timeframe delays due to Criminal Justice processes:	This is unavoidable and the CSP have no control over this but should keep the family and partners updated agreeing timeframes for further update in relation to the criminal case to manage expectations and plan next steps.
	Complaints from Family/friends:	Any complaints to be handled by the CSBP who investigate the issue, drawing on an independent mediator where necessary.
	Perpetrator involvement:	The perpetrator may be unwilling/unable to be involved in the review. Where appropriate, the chair to consider whether an appointed person could represent them.

Stage 3: The Overview Report

3.1 Introduction:

The purpose of Stage 3 is to outline what is required from the body of the overview report and the process towards making the report sign off ready.
Below are the key criteria that the report needs to meet:

- **Follows Home Office template**
- **Evidence based and well researched**
- **Addresses Intersectionality, Equality & Diversity**
- **Appropriate language and terminology**
- **SMART recommendations**

3.2 Roles and Responsibilities:

Role of the Community Safety Programme Board

- The CSBP is updated on progress of the DHR through quarterly monitoring reports provided by the DHR Chair (Appendix X Monitoring Report Template)
- The CSBP supports in addressing any emerging issues or problems.

Roles and Responsibilities:

Panel Members:

- Panel members are actively contributing to the Report and attending all necessary meetings.
- Comments and feedback are provided in a timely manner and to deadlines.
- Panel members jointly develop and own the action plan.
- Panel members keep their teams and managers up to date on all progress.

CST:

- Book rooms and send invitations for all meetings.
- Liaising with CSPB when needed or if problems arise.

Involvement of Family:

- Regular engagement and updates on progress are provided by the chair, including the timeline expected for publication.
- The family's comments are included in the report.
- Names are chosen by or with the agreement of family members
- Family are invited to attend a panel meeting.

3.3 To consider:

Who is on the panel:	• The right people on the panel. I.e Multi-agency and senior representation, diversity in experience
Specialist services:	• Is space being made to include the voice and insight of specialist services?
Voice of the victim:	• Is the report victim centred and including the victims voice through research and evidence?
Role of perpetrator:	• The perpetrator is visible and held to account in the report. The report does not include any form of collusion.
Risk and Review Group:	• To ensure that the Risk and Review Group is kept up to date on decision and progress.
Conducting Individual Management Reviews:	• 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.

3.4 Best Practice:

Best Practice	What to do when problems arise:	
• Ensuring timescales are met • The report includes robustly evidenced analysis • Strong SMART recommendations • Diverse contribution to the report. • Shared responsibility in action plan via a Coordinated Community Response Model. • Actions in the report are linked to wider VAWG strategic aims and objectives. • A post panel meeting is held to agree and/or co-produce the action plan.	**Language in the report:**	• The chair and the CST challenge any victim blaming language in the report.
	Unconscious biases:	• AADFA resource on Understanding Intersectionality: **https://aafda.org.uk/resource/understanding-intersectionality-domestic-homicide-reviews/**
	Time slippage:	• Chair sets clear timeframes. • Clear communication with CSPB about any expected any delays.
	Panel member involvement:	• Manager approval agreed. • CSBP to ensure the right representation.
	Family disagrees with the report:	• Family given sight of report throughout process to avoid any surprises. • Work closely with AAFDA
	Disagreements of recommendations or conclusions	• Agreed Terms of Reference and a group contract • Chair established fact from opinion and facilitates discussion.

Stage 4: Completion and Sign-Off

4.1 Introduction:

The purpose of Stage 3 is to outline what is required from the body of the overview report and the process towards making the report sign off ready. Below are the key criteria that the report needs to meet:

4.2 Roles and Responsibilities:

Role of the Community Safety Programme Board

The DHR report is sent to the CSPB in advance of the meeting to review.

The CSPB sign off the report and accompanying action plan.

Once the report has been signed off by the Home Office Quality Assurance Panel, the CSPB to send the DHR to all panel members who are to forward onto their teams.

Roles and Responsibilities:

Chair: The Chair to get sign off from the panel before submitting to the CSPB.

If required, the chair to present the report to the CSPB and make necessary changes.

To make any changes requested by the Home Office.

Panel Members: To sign off the report and action plan from their respective teams.

Observe timelines to ensure the report can be completed in a timely fashion

Involvement of Family:

The family should be included throughout the process and updated of any changes to the report or to timelines.

The family's comments should be included in the final version.

The family should have oversight of the report before it is submitted to the CSPB

1. The Chair to liaise with family to determine appropriate publication date.

4.3 To consider:

Senior sign off:	• Sign off is needed not just from CSPB and panel, but from managers/senior leads of panel representatives.
Distribution of the report:	• A robust list to be drawn up of where the report needs to be circulated and through which platforms.
Publication of report:	• This should be on a date discussed with family/friends to avoid anniversaries or other significant dates.

4.4 Best Practice:

Best Practice	What to do when problems arise:	
• The report, executive summary and action plan should be completed within six months of the CSPB signing off the DHR – unless an alternative timescale was formally agreed. • Any delays should be communicated to the Home Office Quality Assurance Panel and the CSPB. • The family should be updated at every stage and consulted throughout. • The final report should be re-submitted to the home office and sent to MOPAC.	**If the CSBP disagrees with the report:**	• The DHR Chair to provide clarification on disputed element of the report. • Any feedback provided by the CSPB panel will be considered by the independent chair and the report to be reviewed and changes to be made where necessary. • A suitable timeframe for changes and re-submission of the report to be agreed.
	If the Home Office QA Panel disagrees:	• Any feedback provided by the QA panel should be considered by the Chair who may where appropriate challenge their decision or make the necessary amendments. • Agree final changes and re-submit on a timely fashion.

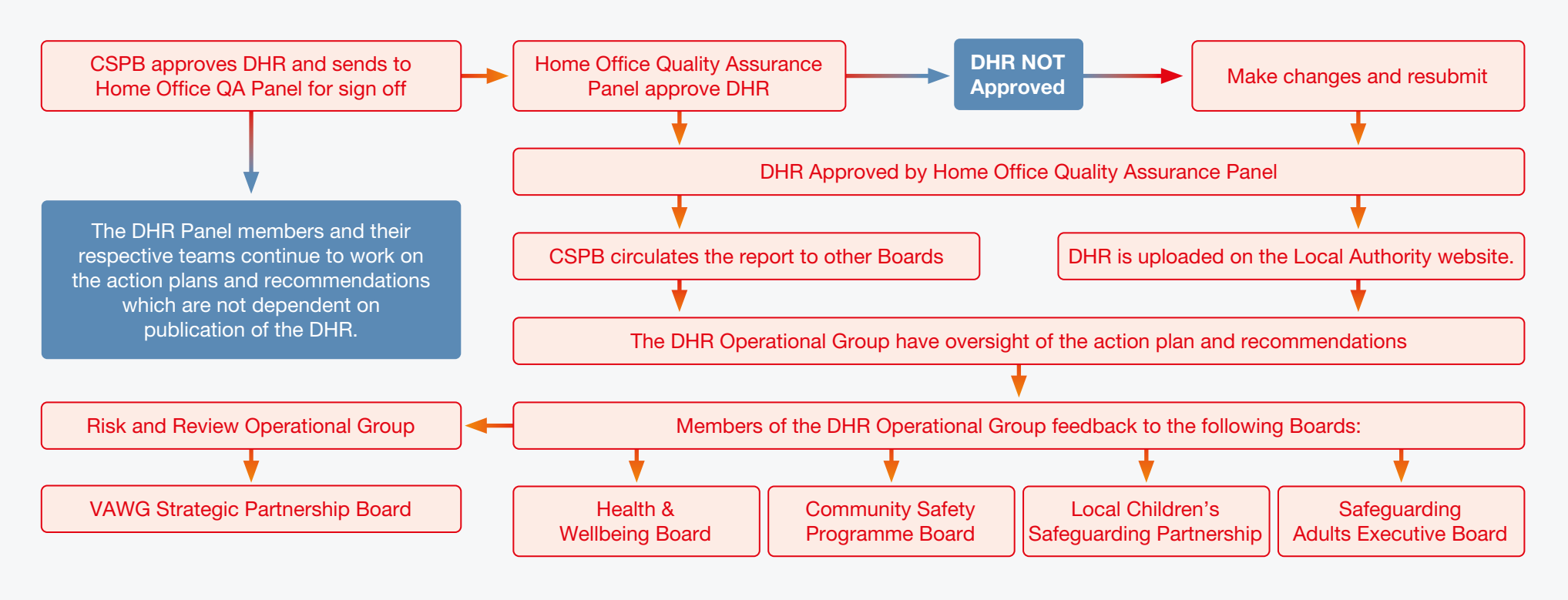
Stage 5: Dissemination and Learning

5.1 Introduction:

The purpose of this stage is to outline what is required to ensure that the lessons and learning from Domestic Homicide Reports are embedded into practice and the action plan is effectively implemented and monitored. Below are the key actions that need to be undertaken for dissemination of learning:

- **A learning event is held for professionals**
- **One-page summaries of reports are distributed**
- **The report goes to all Statutory Boards**
- **Actions are held by all partners and overseen by the DHR Task Group**
- **Impact Measurement in place**

5.2 Governance Process and Structure:



5.3 Roles and Responsibilities:

Domestic Homicide Review Operational Group	Roles and Responsibilities:
• The DHROG to have oversight of the action plan and requests updates on a quarterly basis from action holders. • The DHROG to update the CSPB, the Risk and Review Operational Group and the VAWG Strategic Board on progress and to seek support if challenges occur. • To focus on themes from DHRs and coordinate an improved wider operational response. • To organise a wider leaning event for professionals to embed learning • To update the DA Commissioner on local learning and challenges.	**Action holders:** • Named individuals/agencies on action plan to feed into the DHR T&FG with updates on their action on a quarterly basis (Appendix X Quarterly Reporting Template) **CST:** • The CST Team to develop a media plan prior to publishing the DHR Report • The CST to upload the DHR Overview Report, Action Plan and Executive Summary onto the Local Authority website, avoiding any important dates such as the anniversary of the death and the victim's birthday. • The CST to develop and distribute a one-page summary of the report. **Chair:** • The Chair of the DHR Panel to meet with agreed family members prior to publication and go through the version to be published. **Community Safety Programme Board:** • The CSPB shares the DHR and action plan with statutory boards including the SAEB, LSCP, and the HWB **VAWG Strategic Board and Risk and Review Operational Group:** • To ask for quarterly updates from the DHR T&FG and to support the implementation of learning and recommendations.

5.4 Best Practice

Best Practice	What to do when problems arise:	
• DHR to be a standing item agenda at the CSPB • Shared ownership of report and actions • Actions are completed to deadlines • Learning targeted at both strategic and operational levels • DA Commissioner is kept up to date on local learning.	Completion of actions	• The ownership of actions will be clearly stated on the action plan. These will be incorporated into the wider Strategic VAWG action plan.
	Measuring Impact	• Action plans to be SMART with clear deadlines and lines of accountability.
	Resourcing	• Agencies to have ownership of the actions and to be supported by the VAWG Strategic board as part of the Coordinated Community Response
	Challenges in implementing national recommendations	• National recommendations to be adapted to a local setting and the National Domestic Abuse Commissioner to be consulted on additional challenges.

For further information please contact:

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