Gloucestershire Domestic Homicide Review (DHR) Protocol

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Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews referenced throughout:
https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

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1. Introduction

This document has been produced to:

- Outline how the statutory Domestic Homicide Review (DHR) guidance is applied in Gloucestershire.
- Provide guidance on best practice for establishing a DHR in Gloucestershire.
- Establish governance and accountability for DHRs locally.
- Answer key questions about the DHR process.

This guidance is designed to support community safety partnerships and agencies in establishing and participating in DHRs and should be read in conjunction with the Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[1].

1.1 Background to DHRs

Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence Crime and Victims Act 2004, with the provision coming into force in April 2011.

The Home Office published its Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews initially in 2011, with its latest refresh in December 2016.

1.2 Definition of a DHR[2]

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.

Throughout the guidance, where domestic homicide is referred to, it relates to this definition.

Where the definition set out has been met, then a DHR should be undertaken.

'Intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexual orientation.

Appendix 2 also outlines the national definition of domestic abuse to support in decision making as to whether a case meets the definition of a DHR.

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews
[2] Statutory guidance page 5

The statutory DHR guidance also outlines that where a victim takes 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 DHR should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.

1.3 Purpose of a DHR[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 inform national and local policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses for all the 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.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

Reviews are expected to not just simply examine the conduct of professionals and agencies, but should 'illuminate the past to make the future safer'; encourage professional curiosity, understanding the trail of abuse and seeing life through the eyes of the victim.

In addition, it is important to note that 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.

2. Establishing a DHR

2.1 The role of the Community Safety Partnership

The Home Office Statutory DHR guidance places responsibility for establishing a DHR with the local Community Safety Partnership (CSP).

The guidance states that where partner agencies operate in more than one local authority area, the responsibility for a DHR rests with the CSP area in which the victim was normally resident. In instances where there is no established address

[3] Statutory guidance page 6

prior to the incident, lead responsibility will rest with the area in which the victim was last known to have lived.

There may be some circumstances in which lead responsibility for conducting a DHR may not be easily determined. In these complex situations, local areas can make a decision as to how best a DHR can be established.

Within Gloucestershire, each District has its own CSP. A local decision has been made that the County-Wide CSP Safer Gloucestershire will work in partnership with districts and support the statutory function for establishing a DHR for the Districts of Gloucester, Stroud, Cotswolds, Tewksbury and Forest of Dean; with the District CSPs working with Safer Gloucestershire to progress the DHR.

Cheltenham CSP will retain its full statutory responsibility for DHRs, but will have the option of looking to Safer Gloucestershire for support at any stage if they feel this is necessary.

Throughout the rest of this guidance, CSP will refer to either Safer Gloucestershire in partnership with district CSPs or Cheltenham CSP, unless otherwise specified.

The chair of the CSP holds responsibility for establishing whether a death is to be subject of a DHR. In doing so consideration should be given to:

- The DHR definition set out in the statutory guidance.
- Partner agencies views on the death; particularly those who hold specialist knowledge in identifying and understanding the dynamics of domestic abuse.

In instances where the circumstances of the death are complex, it is advised that the CSP forms a small advisory group of key professionals to support decision making.

Appendix 3 sets out a summary of the key roles and responsibilities of CSPs in establishing DHRs.

2.2 Notification of a death for DHR consideration

Any professional or agency may refer a death to the CSP in writing for consideration for a DHR, if it is believed that there are important lessons for inter-agency working to be learned. In most circumstances however, the notification will be made by Gloucestershire Constabulary[4].

All notifications must be made in writing to the relevant District CSP and Safer Gloucestershire as soon as possible following the death. Ideally notifications should be made within a day or two after the death, there will however be some circumstances where notification is made slightly later to ensure details can be confirmed. Notifications must be sent securely via email to the chair of the relevant CSP and the DASV strategic Coordinator.

[4] Often by the Detective Superintendent from Public Protection/Crime Command

Appendix 4 provides key contact details for CSP members.

A template notification letter can be found in Appendix 5.

In addition to the formal notification letter, it is recommended that contact should be made via phone with a key lead from the District and Safer Gloucestershire.

The notification should include the details of the victim, alleged perpetrator and a summary of the circumstances surrounding the death (as agreed appropriate by the investigation team). The name and contact details of the County Domestic Abuse and Sexual Violence Coordinator should also be included to support the CSP in following the DHR process.

2.3 Process following notification

Once the CSP has received notification, the decision needs to be made as to whether the case meets the criteria for a DHR. In order to support the CSP decision making, it is advised that the CSP call on local expertise, and in particular, work with the County Domestic Abuse and Sexual Violence Strategic Coordinator.

Where the circumstances surrounding a death are particularly complex, and requires greater discussion, it is advised that the CSP work with the DASV Strategic Coordinator to bring together a small panel of local experts to support decision making. This panel should consist of the following agencies:

- CSP lead
- DASV Strategic Coordinator
- Police
- GDASS
- Health
- Social Care
- Other relevant agency based on circumstances of death

Where an expert panel is required to support the CSP in its decision making, the District CSP will take a lead in arranging[5].

On receipt of the notification, the CSP should write securely to nominated persons from core partner agencies[6]. This letter should inform them of the following:

- That there has been a death locally that requires consideration for a DHR.
- That they should secure and preserve any records held on individuals involved.
- That they should provide an update on whether they had any involvement with the individuals involved; informing them that they may be requested to attend a decision making meeting to support the CSP in making its decision.

[5] Until such a time when Safer Gloucestershire has staffing resources attached to support the process.
[6] The County DASV Strategic Coordinator will hold an up to date list of contacts.

Appendix 6 provides a template letter for informing agencies of a potential DHR and inviting them to attend an expert panel to support the CSP.

Appendix 7 provides a template letter for informing agencies that a DHR is being conducted and who the independent chair is.

Alongside the DHR statutory definition, the guidance also suggests considering the following when making a decision:

- 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 perpetrator; it was not shared with others; or was not acted upon in accordance with recognised best professional practice.
- Any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously.
- The victim had little or no known contact with agencies. In these circumstances, the DHR should explore why there was little or no contact.
- The death suggests that there have been failings in one of more aspects of the local operation of formal domestic abuse procedures or other procures for safeguarding adults, including homicides/deaths 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) or other multi-agency fora.
- The homicide/death appears to have implications/reputational issues for a range of agencies and professionals.
- The homicide/death suggests that national or local procedure 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 the homicide, therefore is likely to have significant impact on public confidence.
- Services were not available locally to refer/support the victim and/or perpetrator.

Once a decision has been reached by the CSP, they must inform the Home Office (within 1 month of the notification) of their decision via email: DHRENQUIRIES@homeoffice.gsi.gov.uk

The decision to conduct a DHR should also be shared with the wider Safer Gloucestershire Partnership and the other District CSPs. The Lead District for the current DHR should take the lead in this communication.

2.4 Overlaps with other review processes

There may be some circumstances surrounding the death which could require other multi-agency statutory reviews to be instigated, such as child safeguarding practice reviews and Safeguarding Adult Reviews. This may include circumstances such as (but not limited to):

- Domestic homicide victim is aged 16-17
- Domestic homicide also involves the death of a child aged under 18

- Domestic homicide victim is a vulnerable adult with care and support needs[7]
- Domestic homicide victim had significant mental health involvement

In these circumstances, the Gloucestershire's Children's Safeguarding Executive (GSCE), Gloucestershire Safeguarding Adults Board (GSAB) and mental health services, should be consulted to agree a joint review process where appropriate. This should occur as soon as possible after the notification has been received, and where necessary, involve members of the boards within any expert panel convened to support CSP decision making.

If a joint review is agreed, the relevant boards will need to work alongside the CSP in order to agree the chair appointment, funding and review terms of reference. The CSP and relevant board will also jointly hold the chair and review to account.

The Home Office actively encourages joint reviews to be conducted in these circumstances rather than two separate reviews. Where a joint review is conducted, final sign off and quality assurance of the review should come from the Home Office as well as the government department responsible for other statutory review processes.

In many cases, criminal proceedings will also be running alongside the DHR process. The Crown Prosecution Service (CPS) recommend that the DHR independent chair links with the police (senior investigating officer) and where appropriate the CPS to seek advice on whether the DHR should take account of any criminal investigation. This should include making enquiries as to what the potential impact a review may have upon such investigations or proceedings, including whether a review should not start until after the proceedings are completed or, if the DHR is already underway, whether it should be delayed until after the outcome of the criminal proceedings. The CPS is clear that once criminal proceedings are concluded, the DHR should proceed without delay[8].

In most cases, much of the preliminary work such as agreeing the scope of the review can be completed prior to criminal proceedings being finalised. The DHR is independent from the criminal justice process, so this is unlikely to have any influence on the scope and methodology.

2.5 Appointing a chair and role of chair

The CSP must appoint an independent chair who is responsible for managing and coordinating the review process and for producing the final overview report based on the evidence the review panel decides is relevant. The review chair and report author may be separate people working together or one person who completes both elements of the DHR.

[7] Deaths which occur within an institutional setting, such as a care home, will not be considered as a 'household' as determined by the DHR definition. These cases would therefore fall to the SAR process, not the DHR process.

[8] https://www.cps.gov.uk/legal-guidance/domestic-homicide-review

The Home Office Statutory Guidance outlines that the independent chair must:

- Not be directly associated with any agencies involved in the review.
- Not be a member of the CSP.
- Declare their independence within the overview report.
- Have enhanced knowledge of domestic abuse issues including 'honour' based violence, research, guidance and legislation relating to adults and children.
- Have an understanding of the role and context of the main agencies likely to be involved in the review.
- Have managerial expertise.
- Have strategic vision.
- Have good investigative, analytical, interviewing and communication skills.
- Have an understanding of wider statutory review frameworks, such as child/adult reviews.
- Have an understanding of the discipline regimes within participating agencies.
- Have completed the Home Office online training on DHRs, including the additional modules on chairing reviews and producing overview reports.

Locally a list of accredited chairs has been collated, with references from other areas where they have conducted DHRs. This list is held and maintained by the County DASV Strategic Coordinator, with the OPCC also retaining a copy.

Decisions on chairing arrangements will be made by key District Council leads from the CSP alongside the chair/vice chair of Safer Gloucestershire, representative from the OPCC and the DASV Strategic Coordinator. Where the review is a joint process with SCR/SAR process, members of these boards should also be consulted on chairing decisions.

Cheltenham CSP will lead in decision making for chairing of DHRs in their area, but have the option to seek support from Safer Gloucestershire at any time.

Gloucestershire OPCC will issue formal contracts with DHR chairs on behalf of Safer Gloucestershire. Cheltenham CSP will issue its own contract with the DHR chair.

Once the chair has been agreed, the lead district should inform the wider Safer Gloucestershire Partnership and the other district CSPs in the county.

Appendix 8 provides a template contract for CSPs to issue to DHR chairs at the point of commissioning them.

2.6 Informing the family

It is the responsibility of the CSP chair to ensure the family, where appropriate, are notified of the decision to conduct a DHR or not. In some circumstances it may not be appropriate for this notification to be made, for example, if it would pose a threat to other family members.

The CSP should therefore seek advice from the senior investigating officer, family liaison officer or other agency experts prior to officially informing them of the DHR.

Once the decision to conduct a DHR is made, decisions on when and how to contact the family can be made in conjunction with the independent chair.

The letter to the family should introduce the family to the DHR process and introduce them to the independent chair. Families should be made aware of their option to fully contribute to the review and be offered the support of specialist advocacy[9]; letters to families can also include an option for them to provide their consent for the advocacy service to make contact with them directly. They should also be asked how they wish future contact to be made with them and how frequently they wish for updates on the review to be given to them.

It is recommended where possible that the Family Liaison Officer (FLO) supports the delivery of the letter to the family and is fully briefed to answer any questions on the DHR process. The FLO is also requested to support the independent chair in making initial contact with the family to arrange their contribution to the review.

The chair is responsible for meeting family and friends at the earliest opportunity; taking in to account appropriate timing and other processes i.e. post mortems, criminal investigations etc.

The family will be informed of specialist advocacy as soon as they are informed of the DHR. It is important to note that the chair must not be the advocate for the family as this needs to be provided independently given the report may reach conclusions that the family disagrees with[10]. Once an advocate is in place, the chair should communicate with the family via the advocate where appropriate. Initial contact should be made in person and then agree with the family how they would like future contact to occur and how frequently.

The family should be provided with regular progress updates throughout the DHR and ensure the process and disclosure is explained to them fully. Families should also be informed of how their information has influenced the review.

The Home Office Statutory Guidance, Section 6 outlines the importance of involving the family in the DHR process. **This is summarised in Appendix 9.**

Appendix 10 provides a letter template for informing family members of the DHR.

The role of the family is important throughout the DHR and will be referenced throughout Section 3.

[9] Specialist Advocacy is provided by AAFDA: Advocacy After Fatal Domestic Abuse: https://aafda.org.uk/

[10] Should the family refuse the support of AAFDA, a local advocate can be decided upon, such as a representative from the local DA specialist service or someone who already has a working relationship with the family, to support the chair in remaining independent.

The review panel, once established, should consider if appropriate, approaching the family of the perpetrator who may also have relevant information to offer.

2.7 Administration

The District CSP is responsible for identifying an appropriate administrator to support the DHR process throughout. The administrator must be fully aware of the DHR statutory and local guidance and be given enhanced supervision to support them in responding to the DHR.

In some circumstances, the independent chair will provide their own administration for an additional fee.

The role of the administrator is:

- To be the first primary point of contact for queries via phone or email.
- Liaise with clients, statutory and voluntary agencies, to arrange meetings and chase for any outstanding material.
- Prepare and format various documents as required with the use of local templates. For example, Case Chronologies, Individual Management Reviews, formatting of the DHR report.
- Liaise with chair to monitor and update progress against review case.
- Support the chair in making contacts with agencies and where appropriate, the families involved, to set up meetings.
- Prepare meeting agendas in advance of DHR panel meetings.
- Arrange meeting facilities and distribute to attending agencies.
- Act as recording secretary and prepare action minutes for all meetings and interviews.
- Ensure that essential information of a sensitive and/or personal nature is not disclosed to, or discussed with, inappropriate persons and that all information is maintained in accordance with local standards and policies.
- Maintain records and information for the purpose of internal and external monitoring and evaluation of DHR records.
- Support the Community Safety Partnership in the running of the DHR.
- Link with the County DASV Strategic Coordinator in relation to progress with the DHR and queries linked to the process.

2.8 Funding

Costs associated with DHRs are linked primarily with the independent chair, admin and advocacy services for families.

Locally, the OPCC has agreed to fund 50% of the chairing costs up to £5000. The remaining 50% of chairing costs will be shared equally between all of the District CSPs. This has been agreed in acknowledgement that the learning from DHRs is countywide rather than district based.

The OPCC will on behalf of Safer Gloucestershire, coordinate the joint funding model through the collection of shared costs from the districts and payments to the

independent chair. Cheltenham Borough Council will coordinate the funding for reviews in their area, but can look to Safer Gloucestershire for support where they have requested this support in the issuing of the contract to the independent chair.

Administration costs where possible will be borne locally, with the lead district for the DHR identifying administrative support internally for the duration of the DHR. If a local administrator cannot be identified, or the independent chair provides their own administration as part of their offer, the costs of administration will be shared across the 6 districts up to the value of £2000. Where administrative costs exceed this amount, the lead district for the DHR will fund any outstanding costs.

Where the DHR is joint with other review processes, the lead District for the DHR should liaise with either the GSAB or GSCB to agree a joint funding model for the review between these boards, the OPCC and district CSPs.

Specialist family advocacy will be provided by Advocacy After Fatal Domestic Abuse (AAFDA), a charitable organisation that provides support and advocacy to families to support and guide them through the DHR process and ensure they can influence the process and feed in to the review.

The majority of cases will require a fee from Gloucestershire to AAFDA of around £1500. Where DHRs are more complex and greater level of time and resource is required to support the family, costs may increase and reach a maximum of £2500. Any increased costs will be agreed with AAFDA on a needs basis. Costs for specialist advocacy will also be shared equally between the OPCC, Police and District CSPs[11]. A financial agreement for spot purchasing advocacy support has been developed between AAFDA, the OPCC, police and 6 district CSPs.

The lead district for the DHR should keep all other districts updated on the progress of the DHR and the agreed initial costs. District CSPs should also be kept updated on any changes to the costs throughout the DHR.

2.9 Media

In some cases it is likely that a domestic homicide will generate media attention. In these instances the communications/press team from OPCC should be the main contact for media enquiries for those districts signed up to Safer Gloucestershire leading on the DHR. Cheltenham Borough Council will be the main point of contact for media enquiries for DHRs running in the Cheltenham District.

It is recommended that the terms of reference for the DHR include a holding statement for the media and agreements on any specific media contact. Whilst the DHR is being conducted, it is recommended that media enquiries are responded to with a general statement confirming that the DHR is in progress and will be published in due course following quality assurance by the Home Office.

[11] Providing specialist advocacy is a statutory requirement under the Home Office DHR guidance.

Each agency involved in the DHR should also ensure their agency communications team are aware of the DHR, the agreed holding statement and communications lead for either the OPCC or Cheltenham Borough Council (CBC).

Prior to publication of the DHR, the communications/press lead from the OPCC or CBC should coordinate a meeting with DHR panel members and their media leads to set out the media approach upon publication. The response to the media will be dependent on the level of interest the case has generated and any likely fallout following agency recommendations.

It is recommended that prior to publication, the communications lead (OPCC/CBC) issue an agreed press release on the findings being published, and that each individual agency is also given the opportunity to issue statements. In high profile cases with a lot of media interest, senior members of organisations should be prepared to speak to the media if required regarding the findings for their agency.

The OPCC press team on issue of the press release will offer the PCC for media interviews as an independent party who can be critical of agencies where necessary and hold agencies to account based on the findings.

Any media response should also highlight agency best practice that has been identified in the DHR.

Whilst CBC will lead on communications for DHRs in their district, they can look towards Safer Gloucestershire for support where required; particularly if the DHR is high profile.

2.10 Complaints

2.10a Complaints against individual agencies

Where a complaint is made against an individual agency or an agencies member of staff in connection to the DHR, or as a result of their time on the DHR panel, the individual agency should respond via their own complaints procedures.

This should have no impact on the progress of the DHR, but may in some circumstances result in a change of representative on the DHR panel should that agency feel that is necessary.

2.10b Complaints against the Independent Chair

Any complaint against the DHR independent chair should be made in writing to the commissioning body for that DHR; OPCC on behalf of Safer Gloucestershire or Cheltenham Borough Council. The commissioning organisation will respond to the complaint directly with the independent chair and resolve as necessary following their complaints procedure. Where the chair has been commissioned from a wider organisation, complaints will be dealt with through liaison with the organisation rather than the chair directly.

In the unlikely event that the complaint cannot be resolved, or the independent chair is no longer able to fulfil the requirements set out in their contract, the commissioning agency can terminate the contract and commission a new independent chair to continue with the DHR.

2.10c Complaints against the DHR process or decision to conduct a DHR

In the event that a complaint is made about the decision to conduct a DHR, the District CSP should lead on the initial response.

It is recommended that complaints of this nature are followed up initially through stating the Home Office Statutory Guidance outlining the statutory duty placed on the CSP to conduct such a review by the Government.

Should the complaint continue the complaints process of the local authority for the lead District should be followed, with advice sought from the Home Office as to how to proceed. In some circumstances, permission may need to be sought from the Home Office to not publish such a review should it cause distress to the family or complainant.

Should a complaint be made about how the DHR process is being run, complaints should in the first instance be made to Safer Gloucestershire via the OPCC. It is then recommended that the OPCC establish with the complainant if the complaint relates to the conduct of an agency or the independent chair and follow the processes outlined above as necessary. Should the complaint be more general about the DHR process, it is recommended that the OPCC/DASV Strategic Coordinator liaise with the complainant, DHR panel and independent chair to resolve.

2.11 Data Protection

Section 10 of the Home Office Multi-Agency Guidance for the Conduct of DHRs 2016 outlines the data protection principles for the DHR to consider.

Should any data protection issues arise throughout the DHR, it is recommended that the Home Office be contacted for initial advice, or local data protection officers be consulted.

As with other multi-agency processes, it is the individual participating agencies responsibility to ensure they operate under data protection principles.

The independent chair and panel members should consider and include in the terms of reference for the review, the necessary details on data protection as outlined in the Home Office statutory guidance.

3. Conducting a DHR

3.1 Establishing a review panel

Once the criteria for a DHR have been met and a chair has been commissioned, the CSP, alongside the chair, is then required to utilise local contacts to establish a DHR review panel.

Locally, review panels will be constructed on a bespoke basis, dependant on the case and those agencies involved. As detailed under section 2.3, a range of agencies should be written to at the initial stages of scoping a DHR to identify those agencies that hold records on the case in question.

Review panels must however always include some or all of the organisations listed under Section 9 of the Domestic Violence Crime and Victims Act 2004 (local level applied):

- Gloucestershire Constabulary
- Gloucestershire County Council (inc. children and adult social care/safeguarding)
- Gloucestershire Clinical Commissioning Group
- 2gether NHS Foundation Trust
- Gloucestershire Care Services NHS Trust
- Gloucestershire Hospitals NHS Foundation Trust
- National Probation Service

DHR review panels must also ensure representatives from specialist domestic abuse organisations, locally, Gloucestershire Domestic Abuse Support Service (GDASS).

The DHR review panel must include representation from all agencies involved in the case, as well as any necessary expert organisations to provide guidance and oversight for particular case circumstance or relationship dynamics.

DHR review panels will not have representation from local political members, including local authority councillors so as not to influence the independence of the review. Where political members have dual roles, perhaps as a political member as well as staff within a core agency, they must represent their organisation not their political party. Roles of this nature should be politically restricted, and if not, the professionals must declare their interests. In these circumstances, it is advised that the CSP and chair agree the appropriateness of such panel members and ensure the independence of the review is not impacted.

3.1a The role of the panel members

When agencies and organisations in the county are requested to identify a staff member to be a DHR review panel member, they must consider the following requirements:

- Panel members must be independent of any line management of staff involved in the case.

- Panel members must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during the panel meeting.
- Panel members must be aware of and bear in mind at all times equality and diversity issues and comply with the requirements of the Public Sector Equality Act duties.
- Panel members must be responsible for working with the Independent Management Review (IMR) author (where different, see3.4) to ensure lessons learned are disseminated appropriately throughout organisations.
- Panel members need to be mindful of their role in working with the independent chair whilst also holding them to account. The DHR overview report is a collective piece of work and all panel members must be satisfied that it accurately represents the discussions held and actions agreed.
- Panel members should appropriately and professionally challenge one another to ensure the identification of lessons to be learnt and the development of SMART action plans.

Panel members will also be expected to support the development of the terms of reference and agree these prior to the start of the review. Panel members will also be asked to consider if additional expertise is required to support the review process.

Given the enhanced role of the family within the statutory DHR guidelines, panel members should be prepared to meet with the family and answer their questions if the family wishes to do so. This will usually be arranged for one of the final panel meetings, after the family have been given time to read the overview report.

3.2 Forming the review terms of reference

It is the role of the review panel, led by the independent chair, to agree the terms of reference and scope of the review. The scope of the review should ne proportionate to the nature of the homicide.

This activity should be a priority for the first panel meeting.

The statutory DHR guidance provides a non-exhaustive list of considerations when developing the scope of the review:

- 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 perpetrators but might have been expected to do so?
- How will the DHR process dovetail with other investigations that are running in parallel, such as an NHS, criminal investigation or inquest?
- Should an expert be consulted to help understand crucial aspects of the homicide? For example, a representative from a specialist BME, LGBT or disability organisations.

- Over what time period should events in the victims and perpetrators 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 to better understand the events leading to the death?
- Are there any specific considerations around equality and diversity issues that may require special consideration?
- Did the victims or perpetrators immigration status have an impact on how agencies responded to their needs?
- Was the victim subject to a multi-agency risk assessment conference (MARAC) or other multi-agency fora?
- Was the perpetrator subject to multi-agency public protection arrangements (MAPPA)?
- Was the perpetrator subject to a DA perpetrator programme?
- Was the perpetrator subject of a domestic violence protection notice or order (DVPN/DVPO)? Did the victim seek information about the history of the perpetrators criminal history under the Domestic Violence Disclosure Scheme? Did the police make a disclosure under 'right to ask' or 'right to know'?
- Did the victim have any contact with a DA organisations, charity of helpline?
- If relevant, how will issues of so-called 'honour'-based violence be covered and what processes will be out in place to ensure confidentiality?
- How should family members, friends and other support networks, 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 the possible conflicting views within the family?
- 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?
- Did the victim make a disclosure at work? Has the organisation a DA policy?
- Consideration should also be given to whether either the victim or the perpetrator was an 'adult at risk'; if this is the case, the review panel may require the assistance or advice of additional appropriate agencies.
- How will agencies/professionals working in other local authority areas with an interest in the homicide be involved, including members of the local DA services and what should their roles and responsibilities be?
- Were the victim (and/or perpetrator) social housing tenants? If so was there rent arears or frequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? Does the social housing landlord carry out routine screening for DA? Are there policies in place which support staff to identify and report suspected DA? Have the processes on place been reviewed to ensure that they remain effective?
- Who will make the link with relevant interested parties outside the main statutory agencies?
- How should the review process take account of previous lessons learned?

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

The review panel chair is responsible for the final decision on the terms of reference and ensuring they are suitable and proportionate.

3.3 Review Panel meeting structure and timescales

As soon as the need for a DHR is established by the CSP, the review must be conducted expeditiously so that lessons are able to be drawn out which can be then be acted upon as quickly as possible.

The decision to conduct a DHR must be made within one month of the homicide/death coming to the attention of the CSP.

Following the decision, the DHR should then be completed within six months. It is accepted that some reviews will go beyond the six month timescale in circumstances of complex scope for the review or delayed and ongoing criminal proceedings. Extending the timescale for completing a DHR must be agreed by the CSP and should also be referred to the Home Office Quality Assurance panel for further advice and notification.

The review itself will vary on a case by case basis, but will roughly follow the below structure in relation to panel meetings:

Stage 1:

- Introductions and a summary of the DHR process.
- Agencies will be asked to provide a short summary of their involvement in the case to provide context to the review and support the development of the terms of reference.
- The panel will discuss and agree the scope of the review and terms of reference; this will include agreeing the role of family and friends in feeding in to the review.
- Discuss and agree support for panel members.
- Discuss and agree with the chair the timescales for the next stages of the review.

Stage 2:

The next stage of the review process will vary in length dependant on the scale and scope of the review.

This stage is where the panel will review the agency-wide chronology and Individual Management Reviews (IMRs). The panel will have the IMRs presented by their authors and will discuss the key findings and agree the recommendations/lessons learnt for each agency.

The number of panel meetings will vary dependant on the number of IMRs commissioned for the review.

The views of the family and friends will be included in this section to support the panels' analysis of key findings.

Stage 3:
The independent chair will present the draft overview report to the panel for full discussion and suggest amendments.

The number of panel meetings will vary dependant on the number of amendments required of the report, but should be completed in no more than 3 panel meetings where possible.

The panel will then agree the final draft report and executive summary.

Stage 4:
The family will be given the opportunity to read the final overview report and if they wish to do so, meet the panel to share their thoughts and views.

Once the family have provided their feedback, the report will be finalised with agreement of the panel and submitted to the CSP for final sign off and submission to the Home Office.

The number of meetings in this stage will again vary dependant on the level of family involvement. The panel should be flexible and supportive in allowing the family adequate time to read the report and provide their thoughts and feedback on the review.

Appendix 11 provides a summary overview of the whole Gloucestershire 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.

3.4 Chronology and Individual Management Reviews (IMRs)

Those agencies identified as having involvement in the case will be required to complete an IMR for the review and a full chronology of their involvement in line with the terms of reference for the review.

When agencies are written to requesting their membership on the panel, agencies should also be requested to identify someone to produce the IMR and chronology. This can be the same representative as the panel member, but agencies may decide to identify a different person to complete this detail.

The independent chair may commission additional IMRs from agencies who are not required as panel members. In these circumstances, the chair will write to senior managers of organisations to commission the IMR.

The chronology from each agency will be merged in to a master chronology for the panel to consider the sequence of events and agency contact and identify key events in the life of the victim and perpetrator.

Appendix 12 provides a template chronology

The aim of the IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standards.
- Identify how and when those changes or improvement will be brought about.
- Identify examples of good practice within agencies.

IMRs should be completed by someone who had no direct involvement with the victim, perpetrator or either families and should also not have been the immediate line manager of any staff involved.

All IMRs should be quality assured by the senior manager in the organisation who commissioned the report. This senior manager will be responsible for ensuring any recommendations in the IMR are appropriate and later acted upon appropriately.

When conducting an IMR, the IMR author may choose to interview staff members who had involvement in the case to support their assessment of agency involvement. Where interviews are conducted, this should be formally recorded and shared with the interviewee. These records should be retained for the purpose of disclosure to a criminal investigation should the need arise. Further detail on disclosure and criminal investigations can be found in **section 9 of the Home Office statutory DHR guidance.**

Once an IMR has been completed, agencies should develop an internal process for feeding back to any staff involved.

It is important to note that the DHR plays no role in disciplinary or complaints processes, although in some cases information may emerge that indicates that disciplinary action should be taken under that agencies established processes. Some DHRs may run alongside disciplinary or complaints processes for some agencies; this is a matter for individual agencies to manage within their own processes.

IMRs are presented to the DHR panel and will be discussed to agree on the final key findings, lessons learnt and recommendations.

Appendix 13 provides an IMR template

3.5 Overview report

The overview report will be completed by the independent chair, or report author where this is a separate individual. The report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and other reports that have fed in to the review. Where necessary, further studies may be commissioned to supplement the information available from the IMRs to better support conclusion and lessons learnt from the case.

The overview report should be produced in accordance with the format outlined in appendix 3 of the Home Office statutory DHR guidance.

The overview report should be regarded as 'Official' as per the Government Security Classification Scheme 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.

The review panel will have the overview report presented to them by the independent chair. On being presented with the report and its executive summary the review panel should:

- Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the reports.
- Be satisfied that the reports accurately reflect the review panel's findings.
- Ensure that the reports have been written in accordance with the guidance.
- Be satisfied that the reports are of a sufficiently high standard for them to be submitted to the Home Office.

The final draft of the overview report should be provided to the family, giving them adequate time to consider and absorb the report, identify if any information has been incorrectly captured and record any areas of disagreement. It is recommended that the family are then given the opportunity to meet the review panel to discuss their thoughts on the report, and that the panel then consider the family input prior to agreeing the final version and submitting to the CSP.

3.6 Action Plan

Within the overview report, recommendations for future actions will be made and agencies are required to translate these into specific measurable, achievable, realistic and timely (SMART) actions.

All DHRs must include a targeted and achievable action plan in which actions have been tested with the agency before the action plan is finalised and timeframes for completion should also be agreed at a senior level by each participating agency.

4. Process following completion

4.1 Role of CSP following completion of overview report, executive summary and action plan

Upon receipt of the final documentation the CSP[12] should:

- Agree the content of the overview report, executive summary and action plan, ensuring that they are fully anonymised apart from including the names of the review panel chair and panel members.
- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.
- Sign off the overview report, executive summary and action plan.
- Complete the form on page 41 of the Home Office DHR statutory guidance to assist in national data collection.
- Submit to entire DHR to the Home Office via secure email to: DHREnquiries@homeoffice.gsi.gov.uk
- Ensure that the documented are not published until clearance has been received by the Home Office Quality Assurance Panel.

In instances where the CSP wishes to make changes to the report, including the action plan, these should be referred back to the independent chair and review panel for consideration. The CSP should not look to influence the independence of the report by making its own recommendations without consultation with the review panel and chair; and as mentioned within 3.6 all agency actions must be approved by senior level staff in each organisation.

4.2 Quality Assurance

The Home Office Quality Assurance (QA) panel is made up of various experts from the statutory and voluntary sector who will assess all DHRs on a monthly basis for their compliance with the statutory guidance and assess report standards. The panel will also look to identify good practice and training needs.

The QA panel will look to ensure that the DHR demonstrates that:

- Areas have spoken with the appropriate agencies, voluntary and community sector organisations and family members and friends, to establish as full a picture as possible.
- The report demonstrates sufficient probing and analysis and the narrative is balanced.
- Lessons will be learnt and that areas have plans in place for ensuring this is the case.
- The likelihood of a repeat homicide is minimised.

Once the QA panel have reviewed the DHR, they will then write back to the CSP either making recommendations for change, or agreeing that the report is fit for publication.

[12] Safer Gloucestershire (in partnership with District leads) or Cheltenham CSP

If the QA panel requests changes to the report, the original panel should be made aware prior to publication. In circumstances where significant changes have been requested, it is advised that the panel be reconvened with the independent chair in order to review the changes requested.

The QA panel is also responsible for:

- Disseminating lesson learned and effective practice at a national level.
- Assessing progress at national level
- Identifying serious failings and common themes
- Communicating with media to raise awareness of the positive work of statutory and voluntary sector agencies.
- Communicating and liaising with other government departments to ensure appropriate engagement from all relevant agencies.
- Providing central storage of all DHRs to allow for clear auditing and quick retrieval.
- Reviewing decision by CSPs not to undertake a DHR.
- Recommending national training needs
- Recommending service needs to commissioners.

4.3 Publication

Once clearance has been received from the Home Office QA panel, the CSP must publish the overview report and executive summary on the local CSP website[13].

Section 2.9 provides guidance on the approach for media enquiries.

The chair of the review should also be made aware of the publication plans, and again, in high profile cases, be involved in the planning meeting.

The family should be provided with a copy of the overview report and letter from the Home Office QA panel. They should also be consulted to agree a publication date in order to avoid any significant dates for their family, and also to agree the approach with the media given they may also be approached for a statement.

Each participating agency should be provided with a copy of the report and action plan.

Once the report is published, the Home Office must be notified and provided with a link to the report via secure email: DHREnquiries@homeoffice.gsi.gov.uk

4.4 Implementing the action plan

It is the role of agencies to implement their actions within the deadline stated in the action plan.

[13] At district level.

The CSP is responsible for monitoring action plan completion and for holding agencies to account for actions that are either not completed or making limited progress.

DHR action plans will be monitored regularly at Safer Gloucestershire or Cheltenham CSP, and where possible (and when wanted by the family), updates on action progress will be given to the family to improve agency accountability.

The DHR cannot be formally concluded until the action plan has been fully implemented and audited by the CSP.

5. Local Domestic Abuse Learning Reviews

Where the death of a person does not meet this criteria, but where there is significant history of domestic abuse, CSPs can take the local decision to hold a learning review with the aim of:

- Establishing what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse including their dependent children.
- Identifying 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.
- Applying these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic abuse and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

The learning review will differ from a DHR in that it will aim to be conducted in a workshop style; allowing agencies to share information relating to their involvement in the case, hold discussions and develop lessons learnt and action plans. The aim of this workshop is to ensure learning from cases where a review would otherwise not be conducted, but where it is felt significant learning can be found that will improve service responses to victims of domestic abuse.

This approach can also be adopted for local 'near miss reviews' in which '*a domestic homicide was avoided through incident circumstance rather than through agency intervention to protect those involved*'. This will often involve a significant violent incident in which the victim has survived and where learning can be gained by agencies that were involved or should have been involved in the safeguarding of the victim.

5.1 Criteria for a Domestic Abuse Learning Review

The death of a person does not meet the criteria for a DHR on the basis that their death is not linked to their experience of violence, abuse or neglect, but where there

is significant domestic abuse history[14] that had a substantial and detrimental impact on their life and/or;

- 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 considers that their concerns were not taken sufficiently seriously.
- The victim had little or no known contact with agencies but should have been known and supported.
- The death suggests that there have been failings in one or more aspects of the local operation of formal domestic violence and abuse procedures or other procedures for safeguarding adults.
- The victim was being managed by, or should have been referred to, a Multi-Agency Risk Assessment Conference (MARAC) or other multi-agency fora.
- The death appears to have implications/reputational issues for a range of agencies and professionals.
- The death 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 the homicide, therefore, is likely to have a significant impact on public confidence.
- Services were not available locally to refer/support the victim and/or the perpetrator.

5.2 Establishing a DA learning Review

Any agency can identify a case to be considered for a learning review. Cases should be sent to the County Domestic Abuse and Sexual Violence Strategic Coordinator, who will then make contact with the relevant CSP to consider the case for review. A pool of local experts can be called upon to support decision making if required, as per local DHR guidance.

5.3 Chairing arrangements

As this process is not statutory, there is no need to commission an independent chair, unless considered necessary by the CSP. As such, a local decision can be taken as to who is best placed to chair the learning review.

5.4 Agency involvement

Agencies will be invited to attend a 1 day learning review workshop and bring with them to the meeting;

A summary of their involvement with the victim, perpetrator and any children; recommended that they complete a short chronology that also considers;

[14] Long term DA, with multiple reports to any agency, including periods of high risk abuse or multiple perpetrators. This may include any medical conditions or complex needs the victim has, being linked to the DA they experienced.

- The events that occurred, the decisions made, and the actions taken or not. Assess practice against guidance and relevant legislation; see appendix A to support.
- Examples of effective and/or best practice
- Recommendations for improving future practice and how this can be actioned.

Agencies are also asked to be prepared to discuss and challenge one another and consider the voice of the victim.

5.5 Accountability

The review will be accountable to the CSP and any action to be taken following this review will be monitored by this group.

Appendices

The following appendices have been developed in a separate document:

1. DHR checklist
2. Domestic Abuse definition
3. Summary of the role of CSPs
4. Key contacts for CSPs
5. Template DHR Notification Letter
6. Template letter to inform agencies of the potential DHR
7. Template letter to inform agencies of the confirmed DHR and commissioned chair
8. Template contract for the independent chair
9. Importance of family involvement summary
10. Template letter to family members
11. Summary DHR process flowchart
12. Chronology template
13. IMR template
14. Family Advocacy Funding Agreement with AAFDA
15. DHR funding Agreement

All up to date templates and key agency contacts will be held by the County DASV Strategic Coordinator and Office for the Police and Crime Commissioner and will be available on request.