



Home Office

# Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

December 2016



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# Section 1 – Introduction

1. It is now over five years since Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004, and three years since the last review of the Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews. Much has advanced in our understanding of domestic violence and abuse which has helped shape the Government's response and it is timely, therefore, to update the guidance to take account of this changing landscape.
2. Since the guidance was last reviewed, the Government has introduced the Domestic Violence Disclosure Scheme so that an individual can check whether their partner has a violent past. Domestic Violence Protection Orders were created which allows authorities to take protective action in the immediate aftermath of a domestic violence incident. In the Serious Crime Act 2015, we introduced a new domestic abuse offence to target controlling and coercive behaviour, which is often harder to recognise than physical abuse but which has an equally devastating impact on a victim's life. But there is more to do and the new Ending Violence Against Women and Girls strategy (2016-2020), which was published on 8 March 2016, set out the Government's vision to tackle domestic violence and abuse in all its forms over the life of this Parliament.
3. The strategy makes prevention and early intervention the foundation of the Government's approach and recognises that responding to and raising awareness of domestic violence and abuse is 'everyone's business'. Everyone from health providers, law enforcement, support services, helplines, employers, and family and friends all need to play a part. Domestic Homicide Reviews have a key role in this as their main purpose is to prevent domestic violence and homicide and improve service responses for victims by developing a coordinated multi-agency approach to ensure that abuse is identified and responded to effectively at the earliest opportunity. The main changes within this document highlight the importance of taking a holistic approach when considering the facts presented during scrutiny of practice by agencies and professionals.
4. To complement this document, the Home Office has also published key findings from analysis of DHRs across England and Wales. The aim of this research is to update and extend the previous analysis – published in 2013 – by reviewing a larger sample of DHRs to capture common themes and trends. The key learning identified will help inform and shape local and national policy and practice.

## Section 2 – Status and purpose of this guidance

5. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act)<sup>1</sup>. 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 established under [section 13 of the National Health Service Act 2006];
- Primary Care Trusts established under [section 18] of that Act;
- Providers of probation services;
- Local Health Boards established under [section 11 of the National Health Service (Wales) Act 2006];
- NHS trusts established under [section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006];

(b) in relation to Northern Ireland—

- the Chief Constable of the Police Service of Northern Ireland;
- the Probation Board for Northern Ireland;

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<sup>1</sup>The Health and Social Care Act 2012 removed Strategic Health Authorities and Primary Care Trusts and inserted the NHS Commissioning Board (NHS England) and clinical commissioning group(s) into the list of organisations referenced in section 9(4) of the Domestic Violence, Crime and Victims Act 2004.

- Health and Social Services Boards established under Article 16 of the Health and Personal Social Services (Northern Ireland) Order 1972 (SI 1972/1265 (NI14));
- Health and Social Services Trusts established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 (SI 1991/194 (NI1)).

(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).

6. As statutory guidance issued under section 9(3) of the 2004 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 this guidance. This means that those persons involved in a DHR must take this guidance into account and, if they decide to depart from it, have clear reasons for doing so.

## The purpose of a Domestic Homicide Review

7. 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 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; and
  - highlight good practice.
8. It is, however, important to note that reviews should not simply examine the conduct of professionals and agencies. Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions.

9. 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. This will help reviewers to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why any interventions did not work for them. The key is situating the review in the home, family and community of the victim and exploring everything with an open mind. It will also help understand the context and environment in which professionals made decisions and took (or did not take) actions. This would include, for example, the culture of the organisation, the training the professionals had, the supervision of these professionals, the leadership of agencies and so forth.
10. 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. Does it operate in the best interests of victims? Could an adjustment in policy or procedure have secured a better outcome for the victim? This investigative technique is sometimes referred to as professional curiosity. It is a thoroughly inquisitive approach to a review and the impact on the tone of the report and the detail in the learning can be dramatically improved by adopting this mind-set.
11. 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. DHRs are not specifically part of any disciplinary inquiry 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.
12. 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.

## Definitions

13. Under section 9(1) of the 2004 Act, 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<sup>2</sup> 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.

Where the definition set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

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<sup>2</sup> Section 6 of the Interpretation Act 1978 - words importing the masculine gender includes the feminine.

14. 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 sexual orientation.
15. In March 2013, the Government introduced a cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

*“any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

*Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

*Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”*

In December 2015, a new domestic abuse offence to tackle coercive and controlling behaviour was commenced in legislation. More information about controlling and coercive behaviour in an intimate or family relationship can be found in the statutory guidance:

<https://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship>

16. This definition includes so-called 'honour-based' violence, and includes crimes such as female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.
17. So-called 'honour-based' violence, sometimes referred to as "honour crimes" or "honour killings", encompasses crimes or incidents which are committed to protect or defend what is considered to be the 'honour' of the family or community. Victims may be 'punished' for not complying with what the family and/or community believe to be the 'correct' code of behaviour and therefore viewed as bringing 'shame' or 'dishonour' on the family or community. It is important to note that notions of 'honour' may not be obvious; victims may not identify or perceive what has happened as 'honour-based' violence.
18. 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. Reviews are not about who is culpable.

# Section 3 – Establishing a Domestic Homicide Review

## Community Safety Partnerships

19. 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 rests with the local CSP as they are ideally placed to initiate a DHR and review panel due to their multi-agency design and locations across England and Wales. CSPs are made up of representatives from the 'responsible authorities' (police, local authorities, fire and rescue authorities, probation service and health) who work together to protect their local communities from crime and help people feel safer.
20. 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. There may be circumstances in which lead responsibility for conducting a review may not be easily determined due to the complex nature of the case. It is for local areas to come to an appropriate arrangement in such circumstances.
21. 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.
22. The chair of the CSP holds responsibility for establishing whether a homicide is to be the subject of a DHR by giving consideration to the definition set out in section 1 of the 2004 Act – see section 2. This decision should be taken in consultation with local partners with an understanding of the dynamics of domestic violence and abuse. This will assist in identifying those best placed to sit on the review panel for that particular homicide. CSPs will wish to contact relevant bodies to establish the existence of any other ongoing reviews, such as a child Serious Case Review (SCR) (Child Practice Review in Wales), Safeguarding Adults Review (SAR) or Mental Health Investigation (MHI), which will need to be considered as part of the decision to undertake a DHR.
23. It should be noted that, when victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for child Serious Case Reviews, Safeguarding Adults Review and a Domestic Homicide Review. Consideration should be given to how these reviews can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case – for example, considering whether some or all aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved and provide an improved experience for families, subject to the final shape of the review meeting the requirements of both as set out in the statutory guidance.
24. The CSP should send in writing its confirmation of a decision to review, as well as a decision not to review a homicide, to the Home Office DHR enquiries inbox: [DHRENQUIRIES@homeoffice.gsi.gov.uk](mailto:DHRENQUIRIES@homeoffice.gsi.gov.uk).
25. The CSP should at the same time also inform the victim's family, in writing, of its decision as well as send the family relevant correspondence from the Quality Assurance (QA)

Panel<sup>3</sup> regarding its position (see section 6 of this guidance on how to engage families) or advise the Home Office of its rationale in not doing so.

26. The Home Office will circulate a decision not to review to the QA Panel for comment and appropriate feedback will be given to the CSP. 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 QA Panel will liaise with the relevant person or body and ensure action is taken as directed.

## Circumstances of a Particular Concern

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

- a) 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.
- b) Any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously.
- c) The victim had little or no known contact with agencies. It is often incorrectly assumed by local areas that no contact with agencies indicates a DHR is not required. In fact, a DHR should probe why there was little or no contact with agencies. For example, were there any barriers to the victim accessing services, e.g. language, cultural, etc? Were the circumstances described in h) below a barrier? Were there particular reasons why local services were not appealing to a victim in these particular circumstances? Could more be done in the local area to raise awareness of services available to victims of domestic violence and abuse? Did contact diminish after initial engagement?
- d) The homicide 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, including homicides where it is believed that there was no contact with any agency.
- e) The victim was being managed by, or should have been referred to, a Multi-Agency Risk Assessment Conference (MARAC) or other multi-agency fora.
- f) The homicide appears to have implications/reputational issues for a range of agencies and professionals.
- g) The homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed.
- h) 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.
- i) Services were not available locally to refer/support the victim and/or the perpetrator.

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<sup>3</sup> See Section 11 for more information about the role of the Quality Assurance Panel.

# Section 4 – Conducting a Domestic Homicide Review

## Establishing a Review Panel

28. Where the CSP considers that the criteria for a DHR at paragraph 13 of this guidance are met and a review should be undertaken, they will utilise local contacts and request the establishment of a DHR review panel.
29. 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. The review panel must include some or all individuals from the statutory agencies listed under section 9 of the 2004 Act. Consideration must also be given to including voluntary and community sector organisations who may have valuable information on the victim and/or perpetrator and, as circumstances determine, may be able to represent the perspective of the victim and/or perpetrator. The review panel must also include specialist or local domestic violence and abuse service representation. In essence, the review panel composition needs to be sufficiently configured to bring relevant expertise in relation to the particular circumstances of the case as they will see the dynamics of the relationship through a different lens.
30. In the interests of transparency, all members of the review panel should be named in the report, their respective roles set out and the agencies which they represent.
31. The review panel should meet an appropriate number of times to ensure there is robust oversight and rigorous challenge. For example, a review panel that only met at the beginning and end of the review would imply a limited and arguably ineffective role in the DHR process. Although disputes between review panel members can be healthy and form the basis of rigorous challenge, they need to be resolved by the review panel and chair. If they cannot be resolved, the DHR report will need to record the areas of disagreement and actions taken towards a resolution. The Home Office will not arbitrate in such circumstances.
32. 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 housing associations and social landlords, HM Prison Service, HM Courts and Tribunals Service, General Practitioners (GPs), dentists and teachers. The Crown Prosecution Service (CPS) will not normally be part of the review panel, however, the CPS and agencies not named in legislation may be called upon to provide an Individual Management Review (IMR) as required (section 7 sets out the content of IMRs). It is important that any agency or employer that is approached to provide an IMR does so in order to provide the review panel with a comprehensive chronology of its involvement with the victim and others that may be the subject of the review. This will allow the review panel and chair to fully analyse events leading up to the homicide.
33. It is acknowledged that many CSP areas will already have established forums dealing with domestic violence and abuse 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 but responsibility remains with the CSP.

34. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting. IMR authors normally present their IMRs to the panel and are often invited to meetings to discuss the draft overview report. Members of statutory agencies who have responsibilities for completing IMRs may also be members of the review panel but the panel should not consist solely of such people.
35. The review panel should bear in mind equality and diversity issues at all times and comply with the requirements of the Public Sector Equality Act duties. Age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, ethnicity, sex and sexual orientation may all have a bearing on how the review is explained and conducted, and how the outcomes are disseminated to local communities.

## Appointing a Chair of the Review Panel

36. As local circumstances determine, the CSP or the review panel should appoint an independent chair of the panel who is responsible for managing and coordinating the review process and for producing the final overview report based on evidence the review panel decides is relevant. The chair may also be the author of the overview report. When appointing the chair, provision may be made for the chair to be made aware of the response from the Quality Assurance Panel and potentially to be involved in making any changes required as a result of this quality assurance.
37. The review panel chair (and author, if separate roles) should, where possible, be an experienced individual who is not 'directly associated' with any of the agencies involved in the review. The chair should not be a member of the CSP. The report should clearly demonstrate the chair's independence from the CSP that commissioned the review and the agencies involved in the review. In order to assure readers that the chair has no conflict of interest, an 'independence statement' should be included either in the body of the report or as an appendix which sets out the chair's career history, relevant experience and independence. If a chair was previously a member of one of the agencies associated with the review or on one of the agencies on the relevant CSP, make clear in the independence statement how much time has elapsed since the person left that agency.
38. CSPs may wish to 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.
39. There should be a clear and robust commissioning framework around recruiting a review panel chair that takes into account the skills and expertise required to effectively chair a review. The following is a guide:
- a) Enhanced knowledge of domestic violence and abuse issues including so-called 'honour'-based violence, research, guidance and legislation relating to adults and children, including for example the Children's Act 2004, the Care Act 2014 and the Equality Act 2010;
  - b) An understanding of the role and context of the main agencies likely to be involved in the review;
  - c) Managerial expertise;

- d) Strategic vision so that opportunities are identified to link in and inform strategies such as the Government's *Ending Violence against Women and Girls strategy: 2016 to 2020* available here: <https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020>
- e) Good investigative, analytical, interviewing and communication skills;
- f) An understanding of the discipline regimes within participating agencies;
- g) An understanding of wider statutory review frameworks such as child or adult reviews;
- h) Completion of the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports.

## Determining the Scope of the Review

40. The chair and review panel should consider in each homicide the scope of the review process and draw up clear terms of reference which are proportionate to the nature of the homicide. Relevant issues to consider include the following:

This is not an exhaustive list:-

- a) 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?
- b) 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 communities who may find it difficult to engage in services, e.g. refugees, the disabled, etc. and consideration should be given on how lessons arising from the DHR can improve the engagement with those communities.
- c) How will the DHR process dovetail with other investigations that are running in parallel, such as an NHS investigation, a criminal investigation or an inquest? For example, would running a DHR and Mental Health Investigation or Safeguarding Adults Review in parallel 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? Is the duty of candour principle relevant? How will the Review take account of a coroner's inquiry, and/or 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 9 for further information). It will be the responsibility of the review panel chair to ensure contact is made with the chair of any parallel process.
- d) Should an expert be consulted to help understand crucial aspects of the homicide? For example, a representative from a specialist BME, LGBT or disability organisation.
- e) 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 to better understand the events leading to the death?

- f) Are there any specific considerations around equality and diversity issues such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?
- g) Did the victim's or perpetrator's immigration status have an impact on how agencies responded to their needs?
- h) Was the victim subject to a Multi-agency Risk Assessment Conference (MARAC) or other multi-agency fora? If so, is there a need for a Memorandum of Understanding for the release of any minutes from the relevant meetings?
- i) Was the perpetrator subject to Multi Agency Public Protection Arrangements (MAPPA)? If so, should a request be made for the release of an executive summary of any minutes (subject to relevant legal considerations) and does this need to be accompanied by a Memorandum of Understanding?
- j) Was the perpetrator subject to a domestic violence perpetrator programme? 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 (subject to relevant legal considerations).
- k) Was the perpetrator the subject of a Domestic Violence Protection Notice or Domestic Violence Protection Order? Did the victim seek information about the perpetrator's criminal history under the Domestic Violence Disclosure Scheme? Did the police make a disclosure under "Right to Ask" or "Right to Know"? More information on the operation of these schemes can be found here:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/97864/DV-protection-orders.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97864/DV-protection-orders.pdf)  
  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/224877/DV\\_Disclosure\\_Scheme\\_Guidance\\_-\\_REVISED\\_W.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224877/DV_Disclosure_Scheme_Guidance_-_REVISED_W.pdf)
- l) Did the victim have any contact with a domestic violence and abuse organisation, charity or helpline? How will they be involved and contribute to the process? Helplines, charities and local specialist domestic abuse services, including refuges, can be a useful source of information, although the disclosure of information about perpetrators may be subject to legal considerations.
- m) If relevant, how will issues of so-called 'honour'-based violence be covered and what processes will be put in place to ensure confidentiality?
- n) How should family members, friends and other support networks (for example, co-workers and employers, neighbours etc) and, where appropriate, the perpetrator contribute to the review (including influencing the terms of reference), 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 (see paragraphs 56-57)? Further information on the involvement of these groups is available at section 6.
- o) 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?

- p) Did the victim make a disclosure at work? Has the organisation a domestic violence policy?
  - q) Consideration should also be given to whether either the victim or the perpetrator was an 'Adult at Risk' – 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”.<sup>4</sup> 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.
  - r) How will agencies/professionals working in other local authority areas with an interest in the homicide be involved, including members of local domestic abuse services and what should their roles and responsibilities be?
  - s) Were the victim (and/or perpetrator) social housing tenants? If so was there rent arrears or frequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? These could be indicators of a potential domestic abuse situation. Does the social Housing Landlord carry out routine screening for domestic abuse? Are there policies in place which support and allow staff to identify and report suspected domestic abuse? Have the processes in place been reviewed to ensure that they remain effective?
  - t) Who will make the link with relevant interested parties outside the main statutory agencies, for example independent professionals and voluntary organisations?
  - u) How should the review process take account of previous lessons learned i.e. from research and recommendations made from previous DHRs in the same local authority area?
  - v) Does the review panel need to obtain independent legal advice about any aspect of the proposed review?
41. Where there is an on-going criminal investigation it is the responsibility of the review panel chair to ensure that early contact is made with the Senior Investigating Officer (SIO) accomplished first by the CSP at the time of notification of a homicide and subsequently by the chair to ensure no conflict exists between the two processes.
42. The review panel chair should make the final decision on the suitability of the terms of reference for each DHR so that the terms of reference are proportionate to the nature of the homicide. 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 as the DHR progresses.

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<sup>4</sup>See:

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4074540.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4074540.pdf)

## Section 5 – Timescales for conducting a Domestic Homicide Review

43. As soon as the need for a Domestic Homicide Review is established by the CSP the review must be conducted expeditiously so that lessons are able to be drawn out which can then be acted upon as quickly as possible.
44. The decision on whether or not to proceed with a review should be taken by the chair of the CSP **within one month** of a homicide coming to their attention.
45. 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. Agencies should also begin to work quickly to draw up a chronology of involvement with the victim, perpetrator and their families to help inform the terms of reference.
46. The overview report should be completed **within a further six months** of the date of the decision to proceed unless the review panel formally agrees an alternative timescale with the CSP. It is acknowledged that some DHRs will necessarily go beyond this further six month timescale due to the complex scope of the DHR and/or due to on-going criminal justice proceedings. If the CSP believes that the delay to completion of the review is unreasonable, they should refer the issue to the Quality Assurance Panel for further advice.
47. 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 must discuss with the relevant criminal justice and/or other agencies (e.g. HM Coroner, SIO, Independent Police Complaints Commission), at an early stage, how the review process should take account of such proceedings. For example, how does this affect timing, the way in which the review is conducted (including interviews of relevant personnel), its potential impact on criminal investigations, and who should contribute at what stage? The chair of the review panel needs to consider if they are becoming aware of information that may be of interest to judicial processes including, for example, an inquest.
48. Where a criminal investigation/prosecution is anticipated to run parallel to a DHR, the review panel chair should inform the SIO of the Terms of Reference of the review – this is so that the SIO can have an opportunity to express any views on the content before the terms of reference are finalised. Good practice is to invite the SIO to attend the first panel meeting to brief the panel on the investigation and for the SIO to be party to the setting of the terms of reference.
49. Some local areas are waiting until the conclusion of criminal proceedings before commencing a review. It is important that a review is opened promptly so that early lessons can be identified and rapid action taken to address them. Preliminary work, such as commissioning and analysing IMRs and drafting a first iteration of a chronology, whilst avoiding speaking to potential witnesses can be undertaken before a criminal trial has taken place.
50. If, following representation from the SIO, it is agreed by the panel to delay progressing the DHR at any stage, then following the criminal proceedings, the review should be concluded without delay. Further information on disclosure and criminal proceedings is at section 9 of this guidance. Any appeals lodged following the conclusion of criminal proceedings should not delay the submission of a DHR to the Home Office for quality assurance.

# Section 6 – Involvement of Family, Friends and Other Support Networks

51. The review panel should recognise that the quality and accuracy of the review is likely to be significantly enhanced by family, friends and wider community involvement. Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder. The chair/review panel should make every effort to include the family and ensure that when approaching and interacting with the family the Panel follows best practice.
52. The involvement of family, friends and others is both necessary and complex as they can have important information about the nature and extent of the abuse which may not have been shared with agencies. Participation is voluntary. The chair and review panel can help establish a positive experience for family and friends by offering clear communication about the process from the outset and throughout the review. Those conducting the review should consider specialist and expert advocates for the families. Children should also be given specialist help and an opportunity to contribute as they may have important information to offer.
53. The benefits of involving family, friends and other support networks include:
- a) assisting the victim's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide;
  - b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on the victim's and perpetrator's perspectives rather than just agency views.
  - c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.
  - d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of the victim and/or perpetrator in order to see the homicide through the eyes of the victim and/or perpetrator. This approach can help the panel understand the decisions and choices the victim and/or perpetrator made.
  - e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.
  - f) revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) enabling families to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

54. The review panel should be aware of the potential sensitivities and need for confidentiality when meeting friends, neighbours, work colleagues, etc. 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 (FLOs) and SIOs involved in any related police investigation to identify any existing advocates and the respective positions of the family, friends and other support networks with regards to the homicide.

55. When considering whether to interview family members, friends and other support networks, the review panel must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial. The chair will need to discuss the timescales for interviews with the SIO and take guidance from the SIO in relation to any ongoing criminal proceedings.

56. When meeting with family members, friends and others, the chair should:

- a) meet with family members and others at the earliest opportunity and offer signposting to specialist and expert advocacy support services to those who do not have a designated advocate. The chair cannot be the advocate for the family as they need to be fully independent and may reach conclusions that the family disagrees with;
- b) communicate, where appropriate, directly or, if preferred by the family, through a designated advocate, where one has been assigned, who has, where possible, an existing working relationship with the family, for example a local domestic abuse service representative.
- c) take into account their ethnic, cultural and linguistic needs.
- d) 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.
- e) ensure initial contact is made in person (but make clear there are different ways in which friends, family members and others can contribute to the review e.g. in writing, via electronic communication) and deliver the relevant information leaflet (see paragraph 58 below).
- f) ensure regular engagement and updates on progress through the advocate, including the timeline expected for publication.
- g) explain clearly how the information disclosed will be used and whether this information will be published.
- h) explain how their information has assisted the review and how it may help other domestic violence and abuse victims.
- i) share completed and full versions of the review reports with the family prior to sending them to the Home Office. CSPs should ensure that adequate time is given to the family

to consider and absorb the report, identify if any information has been incorrectly captured and record any areas of disagreement. In some cases, this may involve drawing up a legal form of undertaking to maintain confidentiality of an unpublished review.

- j) maintain reasonable contact with the family, through a designated advocate if appropriate, even if they decline involvement in the review process. This is particularly important when the review is completed, 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. The CSP should ensure the family are fully sighted on any media statements and be mindful of the need to consider key dates, such as birthdays, anniversaries, etc.
- k) invite the family to help create the change after the review.

57. The review panel should consider approaching the family of the perpetrator who may also have relevant information to offer. The chair 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, or vice versa. If the chair 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.

58. The review panel should also access other networks which victims and perpetrators may have disclosed to, for example, employers, health professionals, local professionals in domestic violence prevention work, or local domestic abuse service agencies. Information leaflets (available in English and other languages) explaining the DHR process are available for the following:

- Family members
- Friends
- Employers and colleagues

The leaflets can be found at:

<https://www.gov.uk/government/organisations/home-office/series/domestic-homicide-review>

59. Particular consideration should be given to reviews where so-called '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 organisation.

# Section 7 – Content of the Individual Management Reviews and the Overview Report

## Individual Management Reviews

60. The review panel chair should write to the senior manager in each of the agencies, bodies or organisations identified as part of the scope of the review to commission the IMRs. The IMRs will form part of the overview report.

61. The aim of the IMR is to:

- a) 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.
- b) identify how and when those changes or improvements will be brought about.
- c) identify examples of good practice within agencies.

62. 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.

63. 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 (see Appendix two).

64. 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. Such records should be retained for the purposes of disclosure to a criminal investigation should the need arise. 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 as they may be involved in any linked criminal proceedings.

65. 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.

66. 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.
67. 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.
68. 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

69. 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. Where necessary, further studies may be commissioned to supplement the information available from the IMRs to enable better supported conclusions about the lessons to be learnt from the case. The overview report and executive summary are drafted by the review panel chair or author if the roles are separate.
70. Overview reports should be produced according to the outline format and template (in the appendices) and, as with IMRs, the precise format depends on the features of the homicide. The chair / author must keep personal details anonymous and other identifying features e.g. precise dates, within the final overview report and executive summary that are sent to the CSP.
71. 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.
72. The findings of the review 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. It may also be appropriate to share these findings with family members as directed by the chair, taking into account ongoing criminal proceedings and any possible civil action.
73. As part of the terms of reference, the chair should appoint a lead individual or agency who, in liaison with contributing agencies and professionals, should act as a:
  - a) designated advocate for engaging with family members and friends;
  - b) contact point for responding to media interest about the review.

## Review Panel action on receiving Overview Report and Executive Summary

74. On being presented with the overview report and executive summary the review panel should:

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

## The Action Plan

75. 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). All DHRs should include a targeted and achievable action plan to help achieve the purposes of DHRs as described in paragraph 7. Actions should, as far as possible, be tested with the agency before the action is finalised and timeframes should also be agreed at a senior level by each of the participating agencies. In other words, the action plan should set out who will do what, by when, with what intended outcome and clearly describe how improvements in practice and systems will be monitored and reviewed.
76. Completing the action plan and publishing the DHR is only the beginning of the process. To derive value from the DHR process and prevent further abuse and homicide, CSPs should satisfy themselves that there are appropriate governance mechanisms in place for monitoring delivery against DHR action plans.
77. Once agreed, the review panel should provide a copy of the overview report, executive summary and the action plan to the CSP.

## Community Safety Partnership action on receiving the Overview Report, Executive Summary and Action Plan

78. On receiving the documents the CSP should:
- a) 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 members;
  - b) make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate;
  - c) sign off the overview report, executive summary and action plan;
  - d) complete the form on page 41 which is not for publication and will be used by the Home Office only for data collection purposes;
  - e) submit a copy of the overview report, executive summary, action plan and data collection form to the Home Office via a secure email to: [DHREnquiries@homeoffice.gsi.gov.uk](mailto:DHREnquiries@homeoffice.gsi.gov.uk). The CSP should also confirm a secure contact email address which the Home Office (on behalf of the Quality Assurance Panel) can use for correspondence with the CSP.

- f) ensure that the documents are not published until clearance has been received from the Home Office Quality Assurance Panel (see section 8).

79. On receiving clearance from the Home Office Quality Assurance Panel, the CSP should:

- a) provide a copy of the overview report, executive summary and action plan to the local Police and Crime Commissioner and senior manager of each participating agency;
- b) ensure the chair, review panel and family members are involved in the publication date to consider key dates, e.g. the anniversary of the homicide or the birthday of the victim;
- c) publish suitably anonymised electronic copies of the overview report and executive summary on the local CSP website;
- d) provide a copy of the overview report and supporting documents, including the letter from the Home Office Quality Assurance Panel, to the family;
- e) notify the Home Office using the email address in paragraph 77(d) that the reports have been published and provide links to the reports;
- f) monitor the implementation of the actions set out in the action plan;
- g) formally conclude the review when the action plan has been implemented and include an audit process.

## Section 8 – Publication of the Overview Report

80. 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 and abuse. 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.
81. 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 reasons for not publishing an overview report and executive summary should be communicated to the Quality Assurance Panel. 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 reports in a form suitable for publication, or redacting them appropriately before publication.
82. Information holders who receive requests to release information under the Freedom of Information Act 2000 will need to refer to their own internal procedures for dealing with these types of applications.
83. Where appropriate, consideration should also be given to translating the overview report and executive summary into different languages and other formats, such as Braille or British Sign Language.
84. Publication of overview reports and executive summaries will take place following agreement from the Home Office Quality Assurance Panel and should be published on the local CSP website.
85. In some cases, it may not be possible to finalise the IMRs and the overview report or to finalise and publish an executive summary until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons learned from being acted upon.
86. The report author should, in their final reports, make reference to any requests to delay the planned work of the DHR panel, and include a copy of the written request as an appendix so that it can clearly be understood why the request was made, taking into account any data protection restrictions.

# Section 9 – Disclosure and Criminal Proceedings

## General Principles

87. 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. Regard must also be given to the Criminal Procedure and Investigations Act 1996.
88. There may be homicides where the investigator believes that a third party (for example, a local authority or social care organisation) has relevant material or information. 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 and review to decide whether it has to be disclosed to the defence. This may include applying for a witness summons requiring a representative of the 'third party' to produce the material to the court.
89. 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 in parallel to a criminal investigation, the disclosure officer will be obliged to inform the prosecutor. Any interviews with other agency staff, documents, case conferences etc may all become disclosable. It is the responsibility of a disclosure officer to link in with the review panel chair. It is incumbent on the chair to ensure that there is a robust process in place for the purpose of disclosure to the disclosure officer responsible for the criminal investigation.

## Circumstances where the perpetrator is arrested and charged

90. In cases where the perpetrator is arrested and charged, one of the following two outcomes may occur:
- a) that the DHR be pended until after the outcome of any criminal proceedings;
  - b) that the scope of the DHR is temporarily restricted until after the outcome of any criminal proceedings, such as consideration being given to not interviewing people who may be witnesses or defendants in criminal proceedings until the criminal justice need has been satisfied. Where a restriction in scope is being considered, this should be for a defined need and/or applicable to named individuals.
91. In either outcome, the overview report could be considered in draft form until after the criminal trial as organisational intra and inter learning needs to take place. However, consideration should be given before releasing an early draft on whether it could be potentially misleading if there is more evidence/information to come.
92. Regardless of the outcome, every effort should be taken to ensure that learning arising from the homicide is taken forward where this does not compromise the integrity of relevant criminal proceedings. It is essential that necessary learning is not delayed to prevent the same mistakes being replicated in other cases. 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.

93. It is permissible for the review panel to carry out further work in relation to the review in tandem during ongoing criminal proceedings, for example, conducting professional interviews, producing a draft overview report. However, any such work must take into account the views of the SIO to ensure that the criminal proceedings are not compromised.
94. All material generated or obtained in the DHR whilst the criminal case is ongoing must be made available to the SIO and disclosure officer to assess whether it is relevant to the criminal case. Where it is relevant, it will be for the CPS to decide whether it should be disclosed to the defence. Where the material is sensitive, the CPS or the SIO will consult with the chair before disclosure is made to the defence. Sensitive material in this context can be “any material the disclosure of which he or she believes would give rise to a real risk of serious prejudice to an important public interest and the reason for that belief.”<sup>5</sup>
95. If there are family members, colleagues, friends or other individuals that a review chair wishes to speak to as part of the review and who are witnesses in the criminal case, the chair may be asked by the SIO not to contact them for interviews until after the conclusion of the criminal case. The SIO should consult with the CPS where the DHR panel proposes to speak to witnesses in an ongoing criminal case. Any representations to the DHR panel to delay contact with the witnesses will be informed by such liaison with the CPS.
96. Following the conclusion of the criminal proceedings, the DHR should be concluded without delay. Further information about disclosure can be found at:  
[www.cps.gov.uk/legal/d\\_to\\_g/disclosure\\_manual](http://www.cps.gov.uk/legal/d_to_g/disclosure_manual).

## Circumstances where the Perpetrator is deceased

97. Where evidence indicates that the perpetrator is deceased and either:
- a) the cause of death is unknown;
  - b) the death was violent or unnatural;
  - c) the death was sudden and unexplained;
  - d) the person who died was not visited by a medical practitioner during their final illness;
  - e) the medical certificate is not available;
  - f) the person who died was not seen by the doctor who signed the medical certificate within 14 days before death or after they died;
  - g) the death occurred during an operation or before the person came out of anaesthetic;
  - h) the medical certificate suggests the death may have been caused by an industrial disease or industrial poisoning;

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 once they have been reviewed by the Quality Assurance Panel should be submitted to the Coroner to help inform the Inquest.

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<sup>5</sup> Taken from chapter 8 of the CPS guidance set out in paragraph 96.

# Section 10 – Data Protection

## Data Protection Act 1998 considerations

98. The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles'. Data protection issues in relation to DHRs tend to emerge in relation to access to records, for example medical records. Data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors. In the case of a living person, for example the perpetrator, the obligations do apply. It is recognised that some local areas have faced resistance from clinicians and health professionals when seeking release of medical records on perpetrators.
99. The Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and, where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
- a) The review team should be informed about the existence of information relevant to an inquiry in all cases; and
  - b) The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.

The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest.

100. The Department of Health recognises that DHRs have a strong parallel with child Serious Case Reviews. Guidance advises doctors that they should participate fully in these reviews. It goes on to say "When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent." The Department of Health believes it is reasonable that this should be the principle that doctors should follow in cooperating with DHR's. This action was further supported by recommendations in the Department of Health document '*Striking the Balance*' (2012) available here:

<https://www.gov.uk/government/publications/striking-the-balance-practical-guidance-on-the-application-of-caldicott-guardian-principles-to-domestic-violence-and-maracs-multi-agency-risk-assessment-conferences>

# Section 11 – Quality Assurance and dissemination of lessons learned

## Quality Assurance

101. Quality assurance for completed DHRs rests with an expert panel made up of statutory and voluntary sector agencies and managed by the Home Office. All completed overview reports and supporting documents should be sent to the Home Office using the secure email address: [DHRENQUIRIES@homeoffice.gsi.gov.uk](mailto:DHRENQUIRIES@homeoffice.gsi.gov.uk) and will be assessed against this guidance. The Panel meets on a regular basis (monthly at present) to assess report standards as well as identifying good practice and training needs. Further information about the panel, including its terms of reference, can be found at: <https://www.gov.uk/domestic-violence-and-abuse>.
102. The key issue for the Quality Assurance Panel is to ensure that:
- areas have spoken with the appropriate agencies, voluntary and community sector organisations, and family members and friends, to establish a 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.
103. The Quality Assurance Panel will review the DHR and will write back to the area making recommendations for change or agreeing that the report is fit for publication. This letter will also be copied to the Police and Crime Commissioner for the area concerned (or to the Mayor's Office for Policing and Crime in relation to DHRs undertaken by London Boroughs) so they are routinely sighted on DHRs undertaken in their local area.
104. Areas are encouraged to communicate the Panel's feedback to authors and chairs of DHRs to help inform future DHRs which they may be commissioned to undertake.
105. On receipt of the letter from the Quality Assurance Panel, the area should make any necessary changes and publish the report and letter from the Panel on its Community Safety website. If a DHR report requires a significant number of changes, the CSP should agree the adjustments with the original chair/author who will be named on the report having written the original version.
106. Only in exceptional circumstances should publication of the report be withheld - for example, child safeguarding reasons (see section 8 for further information).
107. 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.
108. The Home Office Quality Assurance Panel is also responsible for:
- disseminating lessons learned at a national level and effective practice;
  - assessing progress identified at a national level;

- c) identifying serious failings and common themes;
- d) communicating with the media to raise awareness of the positive work of statutory and voluntary sector agencies with domestic violence and abuse victims and perpetrators so that attention is not focused disproportionately on tragedies;
- e) communicating and liaising with other government departments to ensure appropriate engagement from all relevant agencies;
- f) providing central storage for DHRs to allow for clear auditing of review documentation and quick retrieval if required;
- g) reviewing decisions by CSPs not to undertake a DHR;
- h) recommending national training needs and working across government to ensure existing training is highlighted;
- i) recommending service needs to commissioners.

## Lessons learned and effective practice

109. 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. Publishing the DHR and completing the action plan is only the beginning of the process. To derive value from the DHR process and prevent further abuse and homicide, local areas should have governance mechanisms in place for monitoring delivery against DHR action plans. CSPs should satisfy themselves that an appropriate framework is in place.
110. It is important to draw out key findings of DHRs and their implications for policy and practice. The following may assist the CSP, which has a leading role, in achieving maximum benefit from the DHR process:
- a) 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.
  - b) 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.
  - c) Subsequent learning should be disseminated to the local MARAC, other multi-agency fora, the Safeguarding Adult Board, the Local Safeguarding Children Board and commissioners of services.
  - d) Share and incorporate the learning (including any national lessons learnt) across the strands of adult and children safeguarding and utilise into local and regional training programmes for frontline staff.
  - e) The CSP should put in place a means of monitoring and auditing the actions against recommendations and intended outcomes.
  - f) 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.



# 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 and any items of specific interest outside those parameters. 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 abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?
- Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

- Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?
- Had the victim disclosed to any practitioners or professionals 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 any of the other protected characteristics relevant in this case?
- 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?
- Did any staff make use of available training?
- Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?
- How accessible were the services for the victim and perpetrator?

# APPENDIX TWO

## INDIVIDUAL MANAGEMENT REVIEW TEMPLATE

### INTRODUCTION

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

- Identification of person subject to review
- Date of Birth:
- Date of death / 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 a family tree or genogram if relevant.

Pen portrait of the victim.

### TERMS OF REFERENCE

### METHODOLOGY

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

### DETAILS OF PARALLEL REVIEWS/PROCESSES

### 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.

## **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.

## **EFFECTIVE PRACTICE/LESSONS LEARNT**

## **RECOMMENDATIONS**

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

# APPENDIX THREE

## OVERVIEW REPORT TEMPLATE

### TITLE PAGE OF OVERVIEW REPORT

- Name of the Community Safety Partnership
- Victim's pseudonym and month and year of death
- Author's name
- Date the review report was completed

### LIST OF CONTENTS PAGE

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

In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

Summarise the circumstances that led to a review being undertaken in this case.

The review will consider agencies contact/involvement with (victim's and perpetrator's pseudonym) from (indicate date/s/period that the scope of the review will be examining and the reason this has been chosen).

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 and abuse. 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. Explain any reasons for delay in completion (this should include any additional delays other than due to the criminal trial).

### CONFIDENTIALITY

The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. Include pseudonym/s agreed with the family and used in the report to protect the identity of the individual(s) involved.

State the age of the victim and perpetrator at the time of the fatal incident, and their ethnicity.

## **TERMS OF REFERENCE**

### **METHODOLOGY**

Record details of the decision to undertake a DHR and who was involved in that decision.

Describe the methodology used, what documents were used, whether interviews undertaken.

### **INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY**

Include when people were contacted and by whom; the nature of their involvement and whether they have been provided with the relevant Home Office DHR leaflet. Include whether:

- The family had the help of a specialist and expert advocate
- The terms of reference were shared with them to assist with the scope of the review
- The family met the review panel
- The family have been updated regularly
- Reviewed the draft report in private with plenty of time to do so, and have the opportunity to comment and make amendments if required.
- All those contributing were able to do so using the medium they prefer

### **CONTRIBUTORS TO THE REVIEW**

List the agencies and other contributors to the review and the nature of their contribution i.e. IMR, report, or information.

Confirm the independence of IMR authors and how they are independent.

### **THE REVIEW PANEL MEMBERS**

List the names of DHR panel members, their role and job title and the agency they represent (Section 4 paragraph 29).

Include number of times the Panel met, and confirm independence of Panel members.

### **AUTHOR OF THE OVERVIEW REPORT**

Explain the independence of the chair (and author if separate roles) and give details of their career history and relevant experience (Section 4 paragraph 36). Confirm that the chair/author have had no connection with the Community Safety Partnership. If they have worked for any agency in the area previously state how long ago that employment ended.

### **PARALLEL REVIEWS**

State if an inquest or any other reviews or inquiries have been conducted and whether they have been used to inform this review.

### **EQUALITY AND DIVERSITY**

Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted.

## DISSEMINATION

List of recipients who will receive copies of the review report.

## BACKGROUND INFORMATION (THE FACTS)

- Where the victim lived and where the homicide took place. A synopsis of the homicide (what actually happened and how the victim was killed).
- Details of the Post Mortem and inquest and/or Coroner's inquiry if already held. State the cause of death.
- 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 (to enhance anonymity, the children's genders should not be given).
- 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 homicide, the date and outcome of the trial, and sentence given.
- If the review is being undertaken into a victim who took their own life (suicide) state on what basis this was considered to meet the criteria to undertake the review.

## CHRONOLOGY

Explain the background history of the victim and the perpetrator prior to the timescales under review stated in the terms of reference to give context to their story.

Provide a combined narrative chronology charting relevant key events/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.

*(If the family structure is extensive or complex consider including an anonymised genogram at the start of the chronology)*

## OVERVIEW

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 about the victim and perpetrator.

## 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 should address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice should be highlighted.

## **CONCLUSIONS**

Bring together an overview of main issues identified and conclusions drawn from them which will translate into the detailing of lessons learnt in the next section.

## **LESSONS TO BE LEARNT**

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.

State any early learning identified during the review process and whether this has already been acted upon.

## **RECOMMENDATIONS**

Recommendations should include, but not be limited to, those made in individual management reports and can include recommendations of national impact made for national level bodies or organisations.

Recommendations should be focused and specific, and capable of being implemented.

# APPENDIX FOUR

## EXECUTIVE SUMMARY TEMPLATE

### TITLE PAGE OF EXECUTIVE SUMMARY

- Name of the Community Safety Partnership
- Victim's pseudonym and month and year of death
- Author's name
- Date report completed

### LIST OF CONTENTS PAGE

#### THE REVIEW PROCESS

This summary outlines the process undertaken by (local Community Safety Partnership area) domestic homicide review panel in reviewing the homicide of (victim's pseudonym) who was a resident in their area.

The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

*(add victim and perpetrator's pseudonyms, age at time of the fatal incident, ethnicity and add pseudonyms of any other relevant parties and their relationship to the victim and/or perpetrator)*

Criminal proceedings were completed on (date) and the perpetrator was (give verdict, sentence and tariff where relevant). *If DHR is as a result of a suicide give coroner's verdict.*

The process began with an initial meeting of the Community Safety Partnership on (date) when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with (victim/perpetrator) prior to the point of death were contacted and asked to confirm whether they had involvement with them.

(Number) of the (total number) agencies contacted confirmed contact with the victim and/or perpetrator and children involved (if relevant) and were asked to secure their files.

#### CONTRIBUTORS TO THE REVIEW

List the agencies and other contributors to the review and the nature of their contribution i.e. IMR, report, or information.

Confirm the independence of IMR authors and how they are independent.

#### THE REVIEW PANEL MEMBERS

List the names of DHR panel members, their role/job title and the agency they represent (Section 4 paragraph 29).

Include number of times the Panel met, and confirm independence of Panel members.

## **AUTHOR OF THE OVERVIEW REPORT**

Explain the independence of the chair (and author if separate roles) and give details of their career history and relevant experience (Section 4 paragraph 36). Confirm that the chair/author have had no connection with the Community Safety Partnership. If they have worked for any agency in the area previously state how long ago that employment ended.

## **TERMS OF REFERENCE FOR THE REVIEW**

### **SUMMARY CHRONOLOGY**

*A summary of the key facts from the background and combined chronology of agency interaction with the victim and perpetrator and their family; what was done or agreed. The summary should provide sufficient facts to give context for the key issues arising from the review. Background information which also gives context to the victim's and perpetrator's story.*

### **KEY ISSUES ARISING FROM THE REVIEW**

(Add issues as required)

### **CONCLUSIONS**

### **LESSONS TO BE LEARNED**

### **RECOMMENDATIONS FROM THE REVIEW**

(Add recommendations as required)

## DOMESTIC HOMICIDE REVIEW

Community Safety Partnership	
Local DHR Reference	
Police Force	
Date first notified to Home Office	
Name of Review Panel Chair	
Name of Report Author	
Date report completed	
Date submitted to Home Office	

(Please include information for all victims)	Victim
Gender	
Age at time of incident	
Relationship to perpetrator	
Ethnicity <sup>6</sup>	
Nationality	
Religion	
Sexual Orientation	
Disability	

	Perpetrator
Gender	
Age at time of incident	
Relationship to victim	
Ethnicity <sup>1</sup>	
Nationality	
Religion	
Sexual Orientation	
Disability	
Details of verdict	

	General
Date of homicide	
Place of murder	
Method of killing	
Number of Children in Household	

<sup>1</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/2011censusanalysisethnicityandreligionofthenonukbornpopulationinenglandandwales/2015-06-18>

# APPENDIX FIVE

## ACTION PLAN EXAMPLE

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
What is the over-arching recommendation?	Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the Home Office Quality Assurance Panel, however the review panel can suggest recommendations for national level)	How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?	Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation ?	Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved	When should this recommendation be completed by?	When is the recommendation actually completed? What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?
Fictional examples;						
All coroners are fully trained in identifying domestic violence and abuse	National	<ul style="list-style-type: none"> <li>- Review current coroners' training and identify gaps</li> <li>- Develop training module.</li> <li>- Roll-out revised training package as follows: June-July – Coroners in region X Aug-Sept –Coroners in region Y</li> </ul>	Ministry of Justice Coroner's team	<ul style="list-style-type: none"> <li>- Review completed in January 2017</li> <li>- Training package agreed April 2017</li> <li>- Roll-out begins June 2017</li> </ul>	All coroners to be trained by September 2017	All coroners received training by December 2017 and their narrative verdicts are beginning to reflect that this training has been effective.
Community educated on the risk factors around domestic violence and abuse	Local and national	<ul style="list-style-type: none"> <li>- Identify mediums to advertise these risk factors by July 2017 and how and if it should be done in a targeted way so they are</li> </ul>	CSPs and Home Office	Plan agreed July 2017 Mediums told of information and are advertising it	Dec 2017	The community is much more aware of the risk factors and reports are being heard of the

		<p>accessible to all, i.e. Local Authority web-site, GP surgeries, Accident and Emergency clinics, dentist surgeries, Job Centres etc</p> <ul style="list-style-type: none"> <li>- Circulate briefing and hold meetings to discuss</li> <li>- Get leaflet printed nationally advising family, friends and community on how to help victims of domestic violence and abuse and distribute by December 2017</li> </ul>		<p>by Sept 2017</p> <p>Leaflet distributed nationally December 2017</p>		<p>community making safe and early interventions to avert domestic violence and abuse.</p> <p>More questions are being received from the community on how to help victims of domestic violence and abuse.</p>
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