Leicestershire & Rutland Domestic Homicide Reviews: Local Procedures

This document outlines the procedures to be followed when considering and carrying out Domestic Homicide Reviews in accordance with the Home Office Guidance "Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)"

Authors: Chris Tew, Gary Watts, James Fox

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Introduction

Definition in the Home Office guidance:[1]

> "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" (p. 5, para 5).

On the 7th December 2016, the Home Office published the revised "*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews"*, which was created as part of the framework of the over-arching "Domestic Violence, Crime and Victims Act 2004" (section 9(3)).

The purpose for undertaking Domestic Homicide Reviews (DHRs) is to:

a. *Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;*
b. *Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;*
c. *Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;*
d. *Prevent domestic violence and homicide and improve service responses for all domestic violence victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;*
e. *Contribute to a better understanding of the nature of domestic violence and abuse; and*
f. *Highlight good practice.*

…Reviews should illuminate the past to make the future safer. Reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with

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1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

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 (para 8).

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… (Please see para's 9 & 10).

1. Background

The 8 Community Safety Partnerships (CSPs) in Leicestershire and Rutland have agreed, through the Leicestershire Safer Communities Strategy Board (LSCSB), to commission the Leicestershire & Rutland Safeguarding Boards to manage the review process through the joint Safeguarding Adults Board (SAB) & Local Safeguarding Children Board (LSCB) Safeguarding Case Review (SCR) Subgroup.

From the Home Office perspective, the CSP in the area where the homicide took place will remain the accountable body responsible for funding and commissioning the reviews; however, locally, all DHR activity is managed through the Safeguarding Boards Business Office (SBBO) which also acts as the single point of contact for the Home Office on DHRs.

The management of the multi-agency recommendations and the completion of actions, along with any resulting learning events, is the responsibility of the County Council Community Safety Team through the Domestic Abuse Partnership on behalf of the CSPs.

The Chair of the geographically relevant CSP will be responsible for individual DHR decisions including the need to hold a DHR, on the basis of recommendations from the LSCB/SAB conjoined SCR Subgroups meeting.

For updates from the Home Office, please visit their website:

https://www.gov.uk/government/collections/domestic-homicide-review

The following pages set out the local process for the completion of DHRs across Leicestershire & Rutland, which has been adapted from the revised statutory guidance published by the Home Office (December 2016).

2. Determining the need for a review

2.1. Notifications of deaths

When a domestic homicide occurs the police should inform the relevant Community Safety Partnership in writing of the incident. Where the deceased is aged 16 or 17 years, then the Child Death Overview Panel (CDOP) should also be made aware.

Any professional or agency/organisation may refer such a homicide to the CSP in writing.

In Leicestershire and Rutland the process is managed as follows:

- When the police or another agency/organisation are made aware of an adult death (this now includes 16 and 17 year olds) and where the circumstances may meet the criteria[2] for a DHR, there is an expectation that they will notify the SBBO manager or an officer within a reasonable time frame of the death occurring. The SBBO in turn notifies the head of the Leicestershire County Council Community Safety Team as soon as possible who will then liaise with the Chair of the relevant Community Safety Partnership (CSP)

- Although the initial information can be given verbally, a written report of the circumstances will be produced to comply with the national DHR procedures and to inform the relevant CSP Chair and SCR Subgroup

- Where a victim normally resides in Leicestershire or Rutland but their death occurs *outside* Leicestershire and Rutland and circumstances meet the criteria for a DHR, the responsibility for completing a DHR sits with the CSP where the victim's last known address was recorded.

- Where a victim normally resides outside of Leicestershire or Rutland but their death occurs *in* Leicestershire and Rutland and circumstances meet the criteria for a DHR, the responsibility for completing a DHR sits with the CSP where the victim's last known address was recorded.

2.2. Working with other areas

Where another CSP outside of Leicestershire and Rutland is completing a DHR within their area and they have reason to believe the individuals involved may be known to agencies within Leicestershire or Rutland, the CSP should write to the SBBO who will liaise with the Head of the Leicestershire County Council Community Safety Team. A trawl for information from local agencies/organisations will be conducted on behalf of the requesting CSP, and where possible, working to the requesting CSPs existing timescales.

2.3. Referring Cases for consideration

The case will be referred to the next planned Safeguarding Boards SCR Subgroup meeting unless the circumstances of the incident require a special meeting of the Subgroup to consider the case.

The SBBO will request an initial records check from members of the SCR Subgroup and domestic abuse specialist services. Agencies will share the outcome of their records check at the SCR Subgroup meeting where the case is considered.

Once it is known that a homicide is being considered for review, each agency with involvement with the victim, family or members of the household should promptly secure the agency's records relating to the case, to guard against loss or interference.

Following the meeting, a recommendation will be made by the group via the head of the County Council Community Safety Team to the Chair of the relevant CSP, stating if the

[2] The definition of the circumstances surrounding a death to meet DHR criteria can be found on page 2.

criteria for a DHR have been met and whether a DHR or other learning process should be conducted.

The Senior Investigating Officer from Leicestershire Police may be invited to attend or contribute to the meeting to offer the latest information in relation to ongoing investigations and to provide any feedback from their initial contact with the family.

2.4. Joint DHR with Serious Case Review (SCR) and/or Safeguarding Adult Review (SAR) processes

If it is established that the deceased was under the age of 18 or the family unit includes children/young people under the age of 18, the Safeguarding Boards Business Office will ensure that the information is considered by the SCR Subgroup to establish if the case also meets the criteria for a children's serious case review.[3]

Alternatively, if it is determined that the case involves an "adult at risk", the SBBO will ensure that the information is considered by the SCR Subgroup to establish if the case also meets the criteria for a Safeguarding Adult Review (SAR).

A link to the relevant section of the Care Act 2014 is shown below:

http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

If it is determined that the criteria is met for a Child SCR or an Adult SAR (in addition to a DHR), the joint SCR Subgroup will consider the case and make a recommendation to the Chairs of the LSCB or SAB and the CSP, stating that the Chairs agree to undertake a jointly commissioned process whereby the Child SCR or Adult SAR terms of reference incorporate the DHR elements. This should reduce duplication of work for the organisations involved and provide an improved experience for families.

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

2.5. Timescale

The decision on whether or not to hold a DHR should normally be taken by the Chair of the relevant CSP within 1 month of a homicide coming to the attention of the SCR Subgroup. There may be circumstances where more information is required to determine the appropriate type of review.

The Independent Chair of the Safeguarding Boards must be informed of the decision to conduct a DHR and will provide independent advice to the CSP Chair as necessary throughout the process.

2.6. Options available to the SCR Subgroup

[3] The criteria for a Children's Serious Case Review are defined by the Department of Education under the statutory framework of "Working Together". For more information on the LSCB, please visit http://www.lrsb.org.uk/

- To recommend that the CSP commission a DHR
- To recommend that the LSCB and CSP commission a joint DHR and child SCR
- To recommend that the SAB and CSP commission a joint DHR and adult SAR
- To recommend that a decision is put on hold until the criminal and coronial proceedings are completed
- To recommend that another type of review is commissioned (as defined in the Learning and Improvement Framework)
- To recommend that a review process is not undertaken.

2.7. SBBO Review Officer and Administration

When a decision has been made to undertake a DHR, the manager of the SBBO will appoint a SBBO Review Officer to the case and organise suitable administration support for the DHR process.

2.8. Notification of a decision to review (or not to review) a homicide

2.8.1. Home Office

The Chair of the relevant CSP, via the SBBO, will notify the Home Office of confirmation of either a decision to review or a decision not to review a homicide. This is placed in writing to:

The Home Office DHR enquiries: DHRENQUIRIES@homeoffice.gsi.gov.uk

A copy of this email will also be sent to the Independent Chair of the Safeguarding Board and the head of the County Council Community Safety Team by the SBBO.

As part of the Home Office internal processes the “decisions not to review” are reviewed by their Quality Assurance Group. This Group can request additional information about the case and also override the decision not to review. Whilst the Group meets quarterly, a response may not be received by the Group for some time after submission. During this time the SBBO will track the case until confirmation has been received by the Home Office that they are in agreement with that decision.

2.8.2. Coroner

The SBBO Review Officer will notify the coroner of the CSP’s intention to conduct a DHR or other review as a matter of courtesy.

2.8.3. Referrer

The SBBO Review Officer is responsible for providing feedback to the referrer of the decision made regarding a review.

2.9. Working with the criminal process and deciding when to suspend a review

Where there is an ongoing police investigation or an ongoing prosecution, the Police Detective Chief Inspector (DCI) responsible for Adult Safeguarding will inform the Senior

Investigating Officer (SIO), the Disclosure Officer, Family Liaison Officer (FLO) and where necessary the Crown Prosecutions Service of the CSP's intention to conduct a DHR or other review.

It may be appropriate to suspend a review due to ongoing criminal processes and investigations being undertaken. This is to ensure that the police are able to gather records and key witness information without interference from parallel legal processes. It is recognised that criminal proceedings take precedence and that, if the DCI for safeguarding wishes to make a recommendation to suspend the review, this should be done without delay and in writing with an explanation of their recommendation to the Chair of the SCR Subgroup.

It may be appropriate in some cases that portions of the review should be suspended: for example, internal agencies' reviews can be completed, but the bringing together of information into a multi-agency forum needs to be delayed. Alternatively the Review Panel may wish to delay contacting the family or interviewing key people as part of the review process. These decisions are taken in discussion with the Police DCI for adult Safeguarding.

In some instances processes are able to run parallel: for example, where the victim and the perpetrator are both deceased. This approach should always be cleared by the Police DCI for adult Safeguarding to ensure processes can run smoothly and without interference.

3. Initiating the review

3.1. Commissioning a Review Panel Chair/Overview Report Author

Once a decision to review has been made, the SBBO Review Officer will be responsible for securing the services of individuals to fill the roles of Review Panel Chair and an Overview Report Author (these are sometimes separate or dual roles). These persons should be independent of all the agencies/professionals directly involved in the particular case. A list of potential candidates will be drawn up and an individual chosen in conjunction with the SCR Subgroup Chair and a virtual panel of selectors.

When appropriate, the Chair of a DHR Panel may be a suitable employee of one of the local agencies not directly involved in the case.

Where an individual is externally commissioned, a legally binding contract will be put in place outlining their responsibilities in this role. The SBBO Business Manager will utilise Leicestershire County Council's legal services and comply with procurement rules when completing this task, due to the SBBO being hosted by Leicestershire County Council.

These appointments will be made with regard to their previous experience of such reviews and subject to satisfactory references from other Board Managers.

4. The Review Process

4.1. The agency information gathering process

After receiving agreement from the Chair of the CSP that they will conduct a DHR, the SBBO will issue a standard “Trawling letter” (Appendix 2) to an agreed list of agencies/organisations. This letter asks agencies/organisations if their services have a record of the deceased person, their current or previous partners or any members of the same household.

If services have been provided to the deceased person, their partner(s) or any members of the same household, agencies/organisations are asked to give a brief summary of the nature and dates of their involvement. If there has not been any involvement with the deceased person, their partner(s) or any members of the same household, a nil return response is required.

The timescale for replies to the trawling request is usually 10 working days (the return date will be specified on the trawl letter sent to agencies). If an employee has a pre-declared interest in the case (i.e. family member or associate) then this should be made known to the SBBO Business Manager.

Where records exist they must be secured as previously noted and an A4 summary of involvement submitted; where no record exists, a nil return is required.

4.2. Chronology

This process compiles a picture of agency involvement. The “Chronolator” software tool is used to collate information.

4.2.1. Compiling a chronology of events

The SBBO “Chronolator” is the main software package to compile agencies’ chronologies.

The chronology must be completed on the pro-forma provided and be a record of the information known and recorded at the time. Where an agency became aware of information relating to earlier events outside of the scoping period, this should be recorded in summary form for the Review Panel. Should the Review Panel wish to retrieve the details this can be requested at a later date.

The chronology is not designed to be an accurate chronology of the family history, but of the agency knowledge and action (e.g. where a family moved house in April but the Social Worker found out in June, the chronology should record the date the Social Worker was informed, not the date the family moved).

The letter will provide timescales and formats for the provision of an Agency Chronology and Individual Management Report, together with guidance on their completion. These must be returned to the SBBO by a given date.

The chronology will need to be returned to enable the merged chronology to be created and the Review Panel to start work.

On receipt of the information returned by partner agencies/organisations, the SBBO Review Officer will write a report outlining the circumstances of the case. This report will be considered by the Review Panel at its first meeting.

The report may contain details of the case, guidance from the Home Office on decision making around reviews, a tentative schedule for the scope of any review process and some draft terms of reference.

Where appropriate, the report will reflect relevant issues in any ongoing, parallel processes:

- Criminal
- Coronial (including Coroners regulation 28 letters)
- Court/care proceedings
- SCRs or SARs,
- Health agency Serious Incident reports (SI)
- Agency disciplinary proceedings.

4.3. Establishing the Review Panel

The purpose of the Review Panel is to offer expertise and independence rather than representation. Its task is to give an independent overview of how agencies work together. It is important that different professional disciplines are represented to ensure that the relevant advice and perspective are available to the panel. Where a small number of agencies are involved in the case, other agencies will be asked to provide a representative to ensure appropriate challenge.

The minimum panel size is 4 and standing panel members are to include the Domestic Abuse Reduction Coordinator of the local authority, local CSP representative and SBBO Review Officer. Following the revised guidance in December 2016, the panel must also include specialist or local domestic violence and abuse service representation.

Administration for the panels will be provided by the SBBO.

The Review Panel will include individuals from relevant statutory agencies listed under section 9 of the Domestic Violence, Crime and Victims Act 2004. Those with a duty to co-operate with the review include:

- Chief officers of police for police areas in England and Wales
- Local authorities
- Strategic health Authorities
- Primary Care Trusts
- Clinical Commissioning Groups (also representing NHS England according to local agreement)
- Providers of probation services
- NHS trusts

There are other agencies which may have a key role to play in the review process but are not named in legislation, including representatives from Health provider agencies, housing associations and social landlords, HMP Prison Service, general practitioners (GPs),

dentists, specialist domestic abuse services and teachers. Members from these agencies may be invited to join the panel.

The panel will produce draft terms of reference including the period of time the review will cover. These may be subject to change as the review progresses and further information becomes available.

Different services have different minimum and maximum adult record retention periods set against them: these can range from 2 years to 30 years, before they are destroyed. The Panel must bear this in mind when determining the length of the scoping period for the DHR and ensure this is proportionate.

As information comes to light through the review, it may be appropriate for the Review Panel to trawl additional agencies to understand their involvement. The responsibility for contacting these additional agencies sits with the SBBO Review Officer and is undertaken at the discretion of the Review Panel Chair.

Subsequent Review Panels are held over the period of the review to pull out key practice episodes, through information provided in Independent Management Reviews (IMRs), to enable the panel to derive areas of learning from the case. This then culminates in the Overview Report, completed by the independent author to the agreed template, addressing all areas stipulated within the agreed terms of reference.

It is the responsibility of the DHR Review Panel to ensure any early lessons are disseminated in a timely manner through the agreed methods in place.

Legal advice will be provided to the panel by Leicestershire County Council Legal Services.

4.4. Arranging a briefing for Independent Management Review (IMR) Authors

In consultation with the Review Panel Chair and the DHR Author, a date will be set for a briefing for IMR Authors.

This briefing provides an overview of:

- What DHRs are
- How the process works
- What the purpose of IMRs and their role as author
- What is expected of them and what they can expect from the Board Office during the process

The case is discussed and draft terms of reference circulated on the agreed IMR template. This session allows IMR authors to understand more about their role in the process, ask any questions they may have and make appropriate links with other agencies.

4.5. Role of an IMR Author

The purpose of an IMR is to allow agencies to look openly and critically at individual and organisational practice, and the context within which people were working, to see whether the homicide indicates that changes could and should be made to procedures and practice.

IMR authors should identify how those changes will be brought about and highlight examples of good practice within agencies.

The IMR should begin once the terms of reference for the review have been set, and sooner if a homicide gives cause for concern within the individual agency. For those agencies with minimal involvement with the victim and their families, the panel may decide that a factual summary report of information is more appropriate than a full IMR report.

Those completing 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 case. It should be recognised by the Review Panel that this may not be possible in smaller organisations due to capacity and existing organisational structures. If this is the case, the Senior Manager representing that organisation should notify the Review Panel Chair.

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.

4.6. Securing Data

As noted previously, once it is known that a homicide is being considered for review, each agency with involvement with the victim, family or members of the household should secure the agency's records relating to the case, to guard against loss or interference.

4.7. Use of interviews

It will be necessary for IMR authors to decide which staff had involvement in the case and need to be interviewed. The staff list should be sent to the SBBO Review Officer, who will share this with the SIO and obtain permission to conduct interviews. Interviews should be recorded and the record agreed by the interviewee.

Where staff or others are interviewed by those preparing IMRs, a written record of such interviews should be made. This should be shared with the relevant interviewee, who will then check the record for accuracy and will amend as necessary before signing the document as an accurate record.

Staff should be reminded that the review does not form part of a disciplinary investigation. If the review finds that policies and procedures have not been followed, relevant staff or managers should be interviewed to understand the reasons for this in accordance with the relevant agency procedures.

The view of the SIO and subsequent CPS advice must be sought prior to interviewing witnesses involved in any criminal proceedings to ensure this is appropriate and timely with parallel processes. All IMR reports may be made available to the Disclosure Officer during the process should they wish to call upon any of the information.

4.8. Timescales and extension requests

IMR authors must be aware of the timescales for completing the chronology and the IMR. Any difficulties in meeting timescales should be raised as early as possible with their agency's designated Senior Manager who in turn will notify the Review Panel Chair of any delay. (IMR authors need to be aware how their work fits into the whole programme: e.g. the timescales for creating the merged chronology being dependent on each agency's chronology being available.)

4.9. Templates

The Individual Management Review report and chronology should be written using the templates provided by the SBBO Review Officer. These templates will be based upon those suggested within the national Home Office. The templates will be created and signed off by the Review Panel.

The terms of reference for the individual case will have been added to the template which will contain supporting notes for completion.

The report should be a "standalone" document encapsulating information from the chronology in summarised form and sufficient for the facts of the family history and agency involvement to be clear. Where this has not been demonstrated, the Review Panel may ask the IMR author to complete further work on the report.

4.10. Creation of an anonymisation key for IMR Authors

The Review Panel will agree with authors how the IMR's should be anonymised and will create an anonymisation key for partners to refer to individuals after a merged chronology and staff list has been provided. This process may not be completed until the conclusion of the Overview Report. This will be decided on a case by case basis by the DHR Panel.

4.11. Creation of single agency Action Plans

The IMR authors are requested to draw up a set of recommendations and Action plans as part of their role. These are scrutinised by the Review Panel and timescales set to them. It is expected that Senior Managers with the responsibility of signing off these IMRs, on behalf of their agency, initiate these actions without delay; this may mean that single agency actions are completed before the review is concluded.

4.12. Providing and receiving feedback

On completion of each IMR report, there will be a process of feedback and debriefing for the staff involved in the review prior to and post the publication of the Overview Report (i.e. those interviewed by IMR authors as part of the process). The management of these sessions are the responsibility of the senior manager in the relevant organisation on a single agency level.

DHRs are not part of any disciplinary inquiries, but information that emerges during the course of a review may indicate that disciplinary action should be taken under agencies' internal procedures.

4.13. Interaction with the family, friends and associated persons

It is a vital part of the DHR process to involve key individuals that the deceased interacted with leading up to the event, such as friends, family and other informal support networks. This will enable the panel to gather rich data and first-hand information on the deceased from these people. As part of the Review Process, the panel members and chair must decide how best to interact with the family and who and how to involve other key people who would have formed part of the deceased's life.

This will be done in collaboration with the Police Family Liaison Officer (FLO) and Police Senior Investigating Officer (SIO) to utilise existing advocacy services that the family may be accessing as part of police support and ongoing investigations. Timing is important when approaching the family; the panel will be guided by the FLO with this, bearing in mind ongoing parallel processes.

The panel Chair or the Overview Report author will make initial contact with the family members through the FLO, explaining to the family the DHR process and how they are able to be involved. During this engagement, the relevant Home Office information leaflet will be provided to the family.[4]

The panel Chair or the Overview Report author will then ensure there is regular engagement and updates on progress from the panel (through an advocate if appropriate), including the timeline expected for publication. This will explain clearly how the information disclosed will be used and whether this information will be published.

If the family decline involvement in the Review Process, the Chair or the Overview Report author will maintain links and notify when the review is completed and ready for publication. The panel Chair will also highlight any potential consequences of publication: for example, media attention and renewed interest in the homicide.

The Review Officer will assist with the process of contact with families on behalf of the panel if agreed by the panel Chair and Overview Report author.

4.14. Sharing information

4.14.1. Seeking Consent

During the DHR process, agencies are required to check their records for information they hold on the adults and children within the family unit. They may also be required to "trawl" for information on the perpetrator's previous partners. It is the "trawling" agencies' responsibility to ensure the relevant information sharing agreements are in place, and that their agency seeks relevant consent for the information that they are sharing with the Review Panel.

Agencies may wish to refer to the information sharing principles and exemptions as outlined by the Information Commissioner's Office, the Data Protection Act (1998) the "Caldicott guidance" (DH 1997), and case law in relation to Human Rights

[4] Information Leaflet compiled by the Home Office for Family members: http://www.homeoffice.gov.uk/publications/crime/DHR-leaflet2?view=Binary

legislation. Where in doubt, agencies are requested to refer to the Board's procedures and their internal information governance teams for advice.

4.14.2. Disclosure

The Review Panel will work closely with the nominated Disclosure Officer responsible for the case within Leicestershire Police. The panel will ensure that all IMR reports are made available during the process should the police wish to call upon any of the documentation to support their investigations.

4.14.3. Anonymisation

The content of the Overview Report and Executive Summary will be suitably anonymised in accordance with the key created by the SBBO Review Officer in order to protect the identity of the victim, perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998. This means preparing Overview Reports in a form suitable for publication, or redacting them appropriately before publication.

Only the Review Panel members and the panel Chair's name will be provided on the report, along with the contact details of the SBBO.

4.14.4. Freedom of Information Act Requests (FOIA)

The CSP will utilise the relevant Information Governance team to process any FOIA requests received regarding the DHR.

4.14.5. Accessibility

If the Review Panel is working with a family or organisation which would benefit from documents being translated or meetings and telephone calls being interpreted, this will be arranged by the SBBO Review Officer through the Leicestershire County Council Interpreting and Translation Services.

Where appropriate, the CSP will consider translating the executive summary in readiness for publication into different languages and other formats, such as Braille or British Sign Language, for the benefit of those involved in the review. This will be reviewed on a case by case basis.

4.14.6. Media Inquiries

Within the review process, the SBBO Review Officer will coordinate a multi-agency media planning group to coordinate the publication of the final Overview Report and executive summary.

During the review, especially at times of criminal trial and Coroner's inquests, there may be media inquiries to agencies about the case. If such an inquiry comes through to agencies, it is the receiving agency's responsibility to bring this to the attention of the Review Panel Chair and SBBO Review Officer.

If the inquiry is specifically about the DHR process or published report, this needs to be forwarded to the SBBO who will liaise with the Leicestershire County Council Community Safety Team Manager, who will, in turn, coordinate responses on behalf of the partnership. No comments about the DHR should be made without agreed partnership consent.

4.15. Drawing up the Overview Report, Executive Summary, Recommendations and Action Plans

The purpose of a DHR Overview Report is to bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports and associated documentation submitted to the review.

The Overview Report is completed by the independent author and will be anonymised in regard to any person identifiable information, with the agreed anonymisation key.

An Executive Summary will also be produced by the author designed as an “easy reference” version of the Overview Report.

The Overview Report will be written in line with Home Office guidance and to a high standard.

4.16. Action planning

The Overview Report will outline a set of recommendations for action which the Review Panel and CSP should translate into a specific, measurable, achievable, realistic and timely (SMART) Action Plan, which will be provided on the agreed template.

Any “early learning” lessons identified by individual agencies should be actioned promptly by the relevant agency and their progress and outcomes should be recorded as part of their IMR and the Overview Report.

Single agency Action plans must be agreed at senior level by each of the participating organisations. They should set out who will do what, by when, with what intended outcome, setting out how improvements in practice and systems will be monitored and reviewed.

The multi-agency Action plan is completed following the recommendations arising from the Overview Report. These actions are drawn up by the Review Panel with input from the relevant partnership (e.g. CSP, Safeguarding Board, or Domestic Abuse Partnership), reviewed by the SCR Subgroup and finalised by the relevant community safety partnership.

4.17. Consultation and re-drafts

Until publication any version of the Overview Report should only be circulated to:

- Those agencies participating in the review
- Members of the SCR Subgroup
- Members of the Leicestershire Safer Communities Strategy Board
- The Chair and members of the relevant CSP
- The Independent Chair of the Safeguarding Board

- Any other agencies agreed by the panel Chair.

The report will also be shared with family members through the panel Chair. The timing of this will take account of any ongoing criminal or coronial proceedings.

Any disputes with the contents of the review or factual inaccuracies should be raised in the DHR panel or SCR Subgroup meetings and formally minuted. This will enable the Overview report Author to make any necessary re-drafts and provide an audit trail of amendments.

For example:

If contributing agencies or individuals are not satisfied that their information is fully and fairly represented in the Overview Report

or

If they wish to bring context to a particular action or provide the Chair with missing information.

It will also allow the panel and the SCR Subgroup to ensure that the terms of reference have been addressed fully.

If re-drafts are necessary these will be noted through version control of the Overview Report. Once the Overview Report is agreed, the Review Panel should provide a copy of the Overview Report, Executive Summary and the Action plan to the Chair of the relevant CSP and the Independent Chair of the Safeguarding Board.

Following the agreement of the contents by the CSP Chair, this will then be submitted to the Home Office Quality Assurance Panel by the SBBO Review Officer.

This will be submitted via secure email to:

The Home Office DHR enquiries: DHRENQUIRIES@homeoffice.gsi.gov.uk

5. Concluding the Review

5.1. Publication Arrangements

There is an expectation that all Overview Reports and Executive Summaries compiled through the DHR process will be published. (Exceptions to publication can be explored in para 81 page 24). These will be uploaded onto the Leicestershire and Rutland Domestic Homicide Review website:

www.LRDHR.org.uk/

The purpose of publishing the reports is for the lessons learnt within the case to be shared widely. The aim in publishing these reviews is to ensure public confidence, and to improve transparency of the processes across all agencies and to protect potential future victims.

In certain circumstances, there may be reasons relating to the welfare of any children or other persons directly concerned in the review which mean it is not appropriate to publish the reports or that partial redaction of the report is necessary. The panel Chair will present these potential issues to the SCR Subgroup for consideration.

Where reports are to be published, this will be planned after any criminal or coronial processes have been completed and the Home Office Quality Assurance Panel has given approval of the documents. This will be planned and coordinated by a “small publication” meeting that will be attended by relevant media and safeguarding leads.

The small publication meeting will determine the lead agency for publication and media enquiries.

Where relevant Leicester City Safeguarding Boards Business Offices should also be informed of potential publication dates.

This process will ensure that agencies are fully prepared for the issues associated with the publication of the case and relevant Chief Officers are briefed and available to comment on the day of publication.

Domestic Homicide Reviews will normally remain on the DHR website for one year, before being removed, and are only available by direct request to the CSP or County Council Community Safety Team.

5.2. Supporting the family

The DHR panel will ensure that relevant family members are fully briefed on the report and understand its potential impact on them (e.g. media interest). They should be provided with the opportunity to ask any questions. Where appropriate, the media planning group will provide relevant media support for the families involved during this process.

The family will also be asked for any feedback on their experience of the process; this will be arranged by the Review Panel Chair. The DHR Panel Chair will signpost families to the National Homicide Service[5] and other specific charities set up to support families through incidents of domestic homicide.

5.3. Dissemination of the learning

After the document has been published, the Community Safety Partnership may organise the dissemination of multi-agency learning. This can be done through a variety of methods available:

- Publicising the report through the newsletters
- Utilising existing distribution networks amongst partners to notify agencies
- Utilising intra and internets/news-feeds amongst partners
- Incorporating learning into training sessions as case examples
- Publicising the review through conferences and display stands
- Holding learning workshops for practitioners

[5] https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service

- Providing “stock” presentations for safeguarding leads to utilise in internal training sessions
- Sharing at regional/local safeguarding and domestic violence forums
- Providing a presentation to the Leicestershire Safer Communities Strategy Board and local Community Safety Partnerships.

5.4. Monitoring the Action Plan/Audit processes

The monitoring and audit of Action plans is the responsibility of the Community Safety Team on behalf of the Community Safety Partnership.

6. Version control and summary of amendments

Date	No	Consultation Method
16.10.14	0.01	First draft: Gary and Chris from City procedures
04.02.15	0.02	Second draft: Gary and Chris
04.02.15	0.03	Transferred to new template
06.02.15	0.04	Part reviewed by Gary with tracking
09.02.15	0.05	Fully reviewed by Gary with tracking
31.03.15	0.06	Further review to James for consultation
21.05.15	0.07	Reviewed by James Fox
27.05.15	0.08	Revisions and further comments: Gary/Chris
28.05.15	0.09	Responses and minor revisions by James
03.12.15	1.0	Finalised
15.04.17	2.0	Reviewed and updated following revised DHR guidance published December 2016
28.6.17	2.0 FINAL	Published on www.lrsb.org.uk following CSP consultation May/June 2017

7. Signatory

Role	Name	Signature
Community Safety Officer on behalf of Leicestershire & Rutland CSPs	Rik Basra	via email 19.6.17

8. Review Periods

Procedures:
6 months after publication, then 3 yearly unless changes are made at a government level.
Templates:
6 months after publication, then 3 yearly unless changes are made at a government level.
Funding Arrangements:
To be reviewed annually between the LSCSB and the Safeguarding Boards.

9. Acronyms list

DHR	Domestic Homicide Review
DV/DA	Domestic Violence/Domestic Abuse
SCR	Serious Case Review
SAB	Safeguarding Adults Board
LSCB	Local Safeguarding Children Board
CSP	Community Safety Partnership
LSCSB	Leicestershire Safer Communities Strategy Board
HO	Home Office
IMR	Individual Management Report
FLO	Family Liaison Officer
SIO	Senior Investigating Officer (police)
SEG	Safeguarding Effectiveness Group
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
ToR	Terms of Reference
SMART	Specific, Measurable, Achievable, Realistic, Timely
CPS	Crown Prosecution Service
BME/BAME	Black and Minority Ethnic or Black, Asian and Minority Ethnic are the terminology normally used in the UK to describe people of non-white descent (Institute of Race Relations).
FOIA	Freedom of Information Act
FGM	Female Genital Mutilation
VCS	Voluntary and Community Sector
IDVA	Independent Domestic Violence Advocate/Adviser – Specialist support for those at high risk from harm from domestic abuse
CAADA	Coordinated Action Against Domestic Abuse – Now Safe Lives
DASH	Domestic Abuse Stalking and Harassment (Common Risk Indicator Tool for DA)
MHI	Mental Health Investigation
CCG	Clinical Commissioning Groups
LCC	Leicestershire County Council
ACPO	Association of Chief Police Officers replaced in April 2015 by NPCC National Police Chiefs Council
SBBO	Safeguarding Boards Business Office

10. Definition of Terms

- **Domestic Violence/Abuse (terms used interchangeably)**: 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: an 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. (This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.)[6] 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

- This definition, which is not a legal definition, includes so called 'honour' based violence, **female genital mutilation (FGM)** and **forced marriage**, and is clear that victims are not confined to one gender or ethnic group

- So called **"Honour" Based Violence**: "honour crimes" and "honour killings" encompasses crimes or incidents which are committed to protect or defend what is considered to be an '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.

- **Suicide** – 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.

- **Intimate personal relationship** includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

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

[6] http://www.homeoffice.gov.uk/media-centre/news/domestic-violence-definition

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

- where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

- **Victim:** a person harmed, injured or killed as a result of crime, accident or other event or action.

11. Contacts and further information

For more information on this local process, please contact the SBBO Business Manager on:

SBBO@leics.gov.uk or securely on SBBO@leics.gcsx.gov.uk
Telephone: 0116 305 7130.

For more information on the Leicestershire Safer Communities Strategy Board and local Community Safety Partnerships, please contact the Leicestershire County Council Community Safety Team on:

Telephone: 0116 305 8077.

For more information on the Leicestershire and Rutland Safeguarding Adults and Children's Board, please visit:

http://www.lrsb.org.uk/
Or contact the Boards Business Manager on 0116 305 7130.

For up to date information on the national DHR guidance and national domestic violence strategies, please visit:

http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-violence/domestic-homicide-reviews/

For more information on local domestic abuse services and to seek support if you are experiencing domestic abuse, please visit:

http://lrsb.org.uk/domestic-abuse

Domestic Abuse Helplines in Leicester, Leicestershire and Rutland:

Domestic Abuse & Sexual Violence in Leicestershire and Rutland - Advice and Services

Single public helpline number: 0808 802 0028
Single business line for professionals: 0116 255 0004

Helplines are open to both **men** and **women** affected and provide information, emotional support and signposting to local face to face support.

Remember, in an emergency you should always dial 999.

12. Summary of the DHR process

1	The police should inform the relevant Community Safety Partnership in writing of the incident The SBBO is notified of a death where circumstances suggest it could meet the criteria for a DHR It is determined whether this could also meet the criteria for a child SCR. If so a joint approach is agreed with the SBBO Business Manager
2	SBBO initiates initial information gathering from agencies
3	The initial case detail is presented by the police to the Leicestershire & Rutland Joint Adults and Children's Safeguarding Case Review Subgroup and a recommendation is made by the Subgroup to the relevant Community Safety Partnership via the Community Safety Team
4	Within a month of being informed, the relevant CSP has to decide on whether to carry out a DHR. The Home Office is notified and the timeframe for the process agreed
5	Further information gathering carried out if required
6	An Independent Chair is identified and an independent Overview Report writer is commissioned. Agencies are invited to participate in the review Templates for the chronology are circulated with return date
7	DHR Panels are convened and timescales to obtain information agreed – taking into account other parallel processes (criminal/coronial) The perpetrator/victim/families/employers and friends of the family are invited to participate in the review by the panel Chair
8	IMR Briefings are provided and templates for the report are circulated. A return date is communicated to IMR authors

9	An Overview Report is completed using information from agency IMRs and recommendations drawn up An Executive Summary is produced Subsequent SMART Action plans are drawn up (single agency and multi-agency)
10	Publication of the report is planned for a date agreed following completion of all legal processes
11	The report is submitted to the Home Office for quality assurance Following feedback the report is published if appropriate
12	The Leicestershire Safer Communities Strategy Board ensures that Action plans are monitored until completed, then actions are tested for effectiveness

Appendix 1: Template letter requesting a trawl of information held by agencies

Dear Safeguarding lead,

RE: Serious Incident Trawling Request

Background and Request

The Leicestershire & Rutland Safeguarding Boards Serious Case Review Subgroup has been informed of a death concerning an individual who may be known to your agency.

This initial information trawling exercise will enable the Board to make an informed decision on the best course of action to take, following the death of this adult. This could result in the undertaking of a Domestic Homicide Review (DHR). The Board recognise that gathering information from records can be a time consuming task. To ensure we identify agencies that have had involvement and relevant facts quickly, the following guidance is recommended:

Check all known records including electronic and paper based, including historical records. If the person is known to your agency then records and access must be secured.

Use a combination of names/spellings, any known aliases, dates of birth and addresses to ensure all records are searched.

An initial A4 side summary of your agency's contact/involvement with the individuals needs to be provided at this stage however your agency may be requested to provide a more in-depth chronology at a later stage, if a DHR is initiated.

If there are no records of any contact then this confirmation is also required by providing a nil or negative response.

The deadline for you providing the Leicestershire and Rutland Safeguarding Boards Business Office with the A4 page summary, outlining your agency's involvement with this person OR a nil return, is DD/MM/YYYY (10 working days).

Legislation

A Domestic Homicide Review (DHR) is a statutory review of the circumstances in which the death of a person 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.

The Reviews are carried out in accordance with Home Office statutory guidance.

The purpose of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

It is the duty of any of the bodies specified below to have regard to the Guidance issued by the Secretary of State as to the establishment and conduct of Domestic Homicide Reviews:

- Chief Officers of Police
- Local Authorities
- NHS Commissioning Board (NHS England)
- Clinical Commissioning Groups
- Providers of Probation Services
- NHS Trusts.

Information sharing guidance

As stated above, one of the purposes of the Domestic Homicide Review is the prevention of domestic violence homicide and it is considered that the sharing of information in connection with a Review is exempt from the non-disclosure provisions of the Data Protection Act. In addition there is an overriding public interest in disclosing the information requested and justification for doing so, although it is appreciated that you will wish to satisfy yourself that the disclosure is necessary, proportionate and restricted to material that is relevant to the purposes referred to above.

Any material that is disclosed pursuant to this request will (if referred to in the Review) be anonymised to protect the identity of any third party. The panel has considered whether there is any other effective means of obtaining this information and is satisfied that there are no other means available.

If you have any concerns about the contents of this letter can I suggest that you discuss these with your Information Management Compliance Officer and/or your legal advisers?

For more information on the DHR process and your agencies responsibilities, guidance can be found on the following webpage:

https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

Please see overleaf for information trawl details. If you have any questions at this stage, please contact me using the details below.

Yours sincerely

(Name and contact details of SBBO leading).

Details of deceased:

Name:

DOB:

Deceased's address at time of death:

Period of involvement to initially scope:

Other significant individuals for scoping:

Name:

DOB:

Address:

Relationship to deceased:

Period of involvement to initially scope:

Name:

DOB:

Address:

Relationship to deceased:

Period of involvement to initially scope:

Name:

DOB:

Address:

Relationship to deceased:

Period of involvement to initially scope:

PLEASE ENSURE WHEN YOU SEARCH AGENCY RECORDS THAT YOU SEARCH USING ALTERNATIVE SPELLINGS OF FIRST NAMES AND SURNAMES FOR ALL FAMILY MEMBERS.

Known spellings for the family:

Known previous addresses of family members:

If you find you had contact with these individuals outside of the scoping period, please note this in your response.