SAFER BARNSLEY PARTNERSHIP

Barnsley Safeguarding Adults Board

Barnsley
PROCESS FOR REQUESTING A DOMESTIC HOMICIDE REVIEW
October 2017

Version	Author	Date	Details
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Contents

1 Introduction

This document provides guidance on the process for managing a Domestic Homicide Review (DHR) in Barnsley and has been ratified by the Safer Barnsley Partnership (SBP). The duty to undertake Domestic Homicide Reviews was established on a statutory basis by statutory guidance issued by the Home Office in April 2011 under the Domestic Violence, Crime and Victims Act 2004. The *'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* was revised in August 2013 and later in December 2016. A person establishing or participating in a Domestic Homicide Review must have regard to the statutory guidance and if they decide to depart from it, must have clear reasons for doing so.

This guidance complies with the Government's strategy to tackle domestic violence and abuse in all its forms entitled '*Ending Violence Against Women and Girls strategy (2016-2020)'.* The strategy makes prevention and early intervention the foundation of the Government's approach; DHRs therefore play a key role in the implementation of this strategy as their fundamental purpose is to prevent domestic violence and homicide by improving service responses and developing a coordinated multi-agency approach to ensure abuse is effectively identified and responded to at the earliest opportunity.

2 What is a Domestic Homicide Review?

A Domestic Homicide Review (DHR) is a process of investigation, re-evaluation, analysing, scrutinising and making recommendations, by reviewing the circumstances surrounding the death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom she/he was related or with whom she/he was or had been in an intimate personal relationship, or
- a member of the same household as her/himself, held with a view to identifying the lessons to be learnt from the death.

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

A domestic homicide review should also be conducted where the death occurred due to the victim taking their own life (suicide) and the circumstances surrounding the death give rise to concern, such as, where it emerges that there was coercive, controlling behaviour in the relationship. A review should be undertaken, even where a suspect is not charged with a criminal offence, or where they are charged and later acquitted. Where an agency suspects a suicide meets the criteria then they should follow the normal referral process, outlined below.

When the definition above has been satisfied then a DHR should be undertaken.

3 The purpose of a Domestic Homicide Review

A DHR is a review of the circumstances of a person's death, held with a view to identifying the lessons to be learnt from the death. DHRs are not inquiries into how the victim died or into who is culpable[1], nor are they specifically part of any disciplinary enquiry or process[2].

The purpose of a DHR is not to apportion blame BUT to:

- Review the circumstances.
- 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.
- Ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.
- Assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff.
- Identify clearly what those lessons were 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.
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice

4 DHR Approach/ Best Practice

In line with the statutory guidance issued by the Home Office, the Safer Barnsley Partnership (SBP) endeavours to focus the reviews on articulating what life was like for the victim by talking to those with close proximity to the victim including (where possible) the victim's family, friends, neighbours, relevant community members and relevant professionals. Our reviews will go beyond focussing on the conduct of individuals, professionals and agencies and evaluate whether the policies and procedures of each agency the victim or perpetrator had contact with (or should have had contact with) were sound. The reviews will establish whether the victim faced any barriers to reporting the abuse and consider what could be done to break

[1] A matter for Coroners and criminal courts, respectively, to determine as appropriate.

[2] 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.

down those barriers and whether any amendment to an agency's policies or procedures could have secured a better outcome for the victim.

Throughout the review process we will be professionally curious in order to find the trail of abuse and establish which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. The purpose of this approach is to find and recommend appropriate solutions to help recognise abuse and ensure victims are being signposted to the appropriate services. Likewise this approach will allow us to evaluate whether the interventions (or lack thereof) of those services are safe and effective by illuminating the past to make the future safer.

After the review process has concluded, the Safer Barnsley Partnership will ensure that the action plan produced is proactively managed to ensure that the lessons identified by the review are put into practice in a timely manner, and that agencies are accountable for their actions.

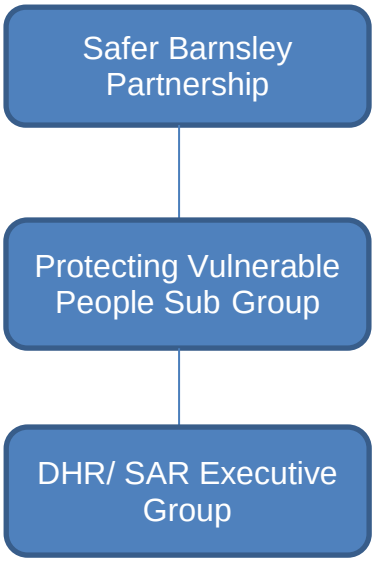
5 Responsibility for DHR's?

The overall responsibility for establishing and conducting a DHR rests with the Community Safety Partnership (CSP) of the Local Authority area in which the victim was normally resident at the time of the incident. This includes cases where a domestic homicide occurs outside of the U.K. In Barnsley, this is the Safer Barnsley Partnership (SBP).

If the victim had no established address prior to the incident, lead responsibility will rest with the area where the victim was last known to have frequented as a first option and then considered on a case by case basis.

In Barnsley the consideration of whether to undertake a DHR is delegated to an Executive Group of the SBP. Note, this is a joint group that consider safeguarding adult reviews (SAR) at the same time. Where appropriate, the executive group will recommend conducting a DHR and a SAR in parallel in order to avoid duplication of work and make the process more streamlined for staff and families affected. This will be established by considering whether the criteria for either of the above reviews have been satisfied.

The governance structure of the Safer Barnsley Partnership is such that the 'Protecting Vulnerable People (PVP) Sub-Group' will ultimately be responsible for ensuring compliance with the action plan produced upon conclusion of the DHR. This will be delegated to an appropriate officer within Healthier Communities who will be responsible for proactively managing the action plan. The officer will ensure the various agencies have complied with the identified actions and provided evidence of doing so. This will then be presented back to the PVP and once they are satisfied that the actions have been complied with, then the DHR can be formally closed.



6 Notification of a Domestic Homicide

South Yorkshire Police, as the agency with lead responsibility for the investigation of domestic homicides in their force area, has a statutory duty to refer to the SBP all cases which appear to meet the criteria for a DHR.

Any other professional or agency may however make a referral in respect of a case which appears to meet the criteria for a DHR. For example, where Barnsley's specialist Domestic Abuse service, *Independent Domestic Abuse Services (IDAS),* are aware one of their clients has committed suicide, this should be referred for a DHR.

Where a domestic homicide of a person normally resident in the Barnsley area has occurred outside of the borough (including outside of the U.K.) referrals should always be made to South Yorkshire Police.

Appendix 1 shows a flowchart of stage 1 of the notification procedures.

Referrals should be by email to the DHR single point of contact (SPC) as soon as possible after the incident. Business Support will be the SPC. Notification must always be made via secure email at: DHR@barnsley.GCSX.gov.uk – Referrals should be made using the DHR Referral form see **Appendix 3.**

SPC to notify Barnsley's Healthier Communities Commissioner who will ensure that the Chair of the SBP is briefed on the circumstances.

7 Barnsley DHR/SAR Executive Group

As explained above, the decision to undertake a DHR and/ or an SAR is delegated to an executive group of the SBP. The executive group will consider whether the criteria for either (or both) reviews are satisfied and make a recommendation to the SBP Chair whether either (or both) of the reviews should be undertaken and whether this could be done in parallel.

Where a member of the executive group is unable to attend the meeting, they should ensure that a suitable deputy is sent in their place. If they fail to do this then it will be noted that they were absent from the meeting.

Aim of the Executive Group:

- To share historical and current agency information known about the victim / perpetrator / family / household members or known significant others.
- To share information about the events surrounding the death of the victim.
- To identify any parallel review processes that may be planned or underway in relation to the incident and the implications of these for DHR/SAR arrangements.
- To advise the SBP Chair on whether the statutory criteria for undertaking a DHR have been met and accordingly whether a DHR should be undertaken.
- To advise safeguarding adults on whether or not a case should be reviewed as a SAR.
- To identify those best placed to sit on the Domestic Homicide Review Panel where applicable and its draft terms of reference.

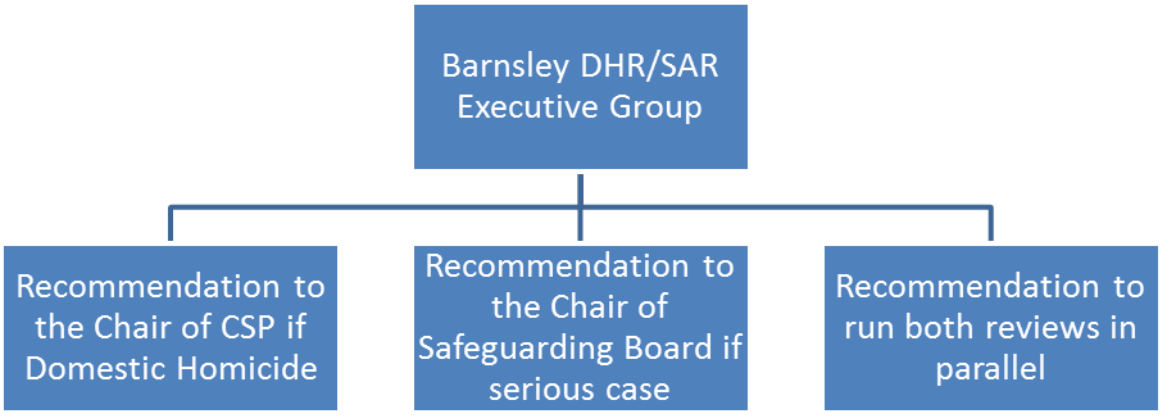
Membership

Core membership of the Executive Group comprises of:

- Barnsley Council services including Adult Services, Safer Communities, Healthier Communities, Safeguarding Adults and Children.
- South Yorkshire Police.
- Barnsley Clinical Commissioning Group.
- South West Yorkshire NHS Partnership Foundation Trust (SWYPFT).
- National Probation Service
- Barnsley Hospital Trust (BHNFT)

Any other local or national agency which had or may have had involvement with the victim, perpetrator or their families and households should also be invited to contribute to and attend the Executive Meeting. The following examples of those who should be considered are not exhaustive:

- Registered providers i.e. Housing Associations and Social Landlords
- HM Prison Service
- Independent Health professionals, e.g. GPs and Dentists
- Schools
- Crown Prosecution Service
- The Police Family Liaison Officer
- Representatives of the Voluntary and Community Sector (VCS) with expertise in domestic violence and abuse.



Servicing the meeting

The Executive Group meeting will be chaired by an independent suitably qualified person.

Executive Group meetings will be serviced by the Council's DHR business support officer. To enable members of the meeting to be fully prepared the officer will:

- Notify core members that the meeting date they have on hold in their calendars for DHR/SAR executive meetings will take place. Where there has been no notification then the business support officer must ensure the meeting is cancelled at least one week prior to the date held.
- Using the letter and information in Appendix 2 and 3 seek clarification from agencies on any information held about the victim. Agencies are expected to return the information within ***10 working days*** of receipt.
- Using the letter in Appendix 4 send invitations to executive group members and all other known agencies which had involvement with the victim, perpetrator or their families and households to attend the DHR/SAR Executive Group meeting.
- Using information provided, compile a summary for the Chair of each case in preparation for the meeting. Ensure that the Chair has hard copies.
- Prepare agenda as set out in Appendix 6.
- Attend the meeting and take action notes and record decisions.
- If a decision is taken to conduct a DHR then the SPC should send out the chronology in Appendix 3a to agencies identified as being involved. This is in preparation for the DHR.

Timescales

All requests will be submitted to the Executive Group with the authority to consider the referral. The Executive Group will be established within **15 working days** of the notification.

The Executive Group will consider the criteria for the undertaking of a DHR/SAR. The conclusions of the Executive Group and their recommendations should be provided in

writing **within 10 working** days of the meeting to the Chair of the SBP using the letter in Appendix 5 or the Chair of the Safeguarding Board, who will make the decision on whether there should be a review **within 15 working days.** Business support to send once authorised.

8 Decision to Conduct a Domestic Homicide Review

The decision on whether to hold a DHR should be taken by the chair of the SBP. This will be done after consultation with the executive group.

Barnsley's Commissioner for Healthier Communities must, on behalf of the SBP Chair, send written confirmation of the decision on whether or not to undertake a DHR to the Home Office DHR enquiry box at: DHREnquiries@homeoffice.gsi.gov.uk (See Appendix 7 letter) Business support will send on behalf of the Commissioner for Healthier Communities.

Barnsley's Commissioner for Healthier Communities on behalf of the SBP Chair must, at the same time also inform the victim's family, in writing, of the SBP's position regarding whether a DHR will be conducted; as well as any subsequent correspondence from the Home Office regarding this position. (See Appendix 8 letter)

9 Conducting the review

Once a decision has been taken to conduct a review the following must be put into place:

1) Invite applications from the approved Chair list
2) Appointment of Review Panel Chair
3) Establish a Review Panel
4) Determine the scope of the review
5) Agree local terms of reference
6) Instruct the appropriate agencies and request the relevant IMRs

9a. Appointment and Role of the Review Panel Chair & Report Author

The Review Panel Chair/Author who is the same person should be an experienced individual who is not directly associated with any of the agencies involved in the Review. An 'independence statement' should be included in the report which sets out the chair's career history, relevant experience and independence. Where the Chair has previously worked within the SBP or one of the agencies involved in the review, the 'independence statement' should clarify how much time has elapsed since the person left the agency. The Chair will be appointed by Commissioners in Healthier Communities.

The Review Panel Chair will be responsible for effectively leading and coordinating the Review Panel and for quality assurance of the final Report based on the Individual Management Review (IMR – see below) and any other evidence the DHR Panel decides

is relevant. This will include full administration of the process. The Review Panel Chair will also be expected to make any necessary amendments to the report following feedback from the Home Office.

Consideration should be given to the skills and expertise required to effectively Chair a DHR and to write an analytical Report (see **Appendix 10** checklist). The following is a guide:

- Advanced knowledge of domestic violence and abuse issues, research, guidance and legislation relating to adults and children, including the Equality Act [2010].
- An understanding of the role and context of the main agencies likely to be involved in the Review, including disclosure processes associated with the Criminal Procedure and Investigations Act [1996].
- Managerial expertise.
- 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*.
- Good investigative, analytical, interviewing and communication skills.
- An understanding of the discipline regimes within participating agencies.
- An understanding of wider statutory review frameworks such as child or adult reviews
- Completion of the Home Office E-Learning Training Package on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing Overview Reports.
- Attendance at the DHR Chair's Training events run by the Home Office.

The Review Panel Chair is responsible for the final decision on the suitability of the draft DHR Terms of Reference and should agree these at the first meeting of the Panel. The Terms of Reference may however need to be revisited as the Review progresses and as new information is identified. Any amendments to the Terms of Reference will be agreed with the Review Panel by the Review Panel Chair.

The Review Panel Chair will establish an agreed timetable of Review Panel meetings in accordance with the required timescales of the Review and set specific parameters, including timescales, for the completion of IMRs.

As part of the terms of reference, the Chair should appoint lead individuals or agencies who will act as a:

- Designated advocate for engaging with family members and friends.
- Contact point for responding to media interest about the Review in conjunction with Barnsley Council's corporate communications team.

The Review Panel Chair (RPC) should as far as possible, ensure that the review process is a learning exercise in itself for all those involved in the case.

The RPC will:

- Be responsible for engaging with family members and ensuring they have the opportunity to be integral to the review process. Where the family wish to be involved the RPC will treat them as a key stakeholder and will signpost them to specialist advocacy services (such as AAFDA) where appropriate.
- Regularly update the Lead Officer in Communities and the Chair of the SBP on progress with the DHR along with providing the victim's family with regular updates (where appropriate).
- Maintain contact with the Chair / Lead Professional of any parallel reviews or investigation processes and to ensure that any coordination and joint commissioning arrangements are effective.

The Chair of the Review Panel should ensure that regular updates are obtained regarding services being provided by any agency to meet the safeguarding or other needs of individuals who are subject of the Review.

Where there is an on-going criminal investigation the Review Panel Chair will ensure that early and regular contact is made with the Senior Investigating Officer to ensure no conflict exists between the two processes. This relates particularly to any planned interviews with family members, practitioners and managers and must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial.

9b Establish a Review Panel

A review panel must be established for the purposes of undertaking a DHR. This panel can have a fixed, standing membership or can be created on a bespoke basis for the purposes of undertaking a particular DHR. The review panel should consist of some or all of the individuals from the statutory agencies listed under section 9 of the 2004 Act, including:

- Chief Officers of Police
- Local Authorities
- NHS Commissioning Board (NHS England)
- Clinical Commissioning Group(s)
- Providers of Probation Services

The review panel must also include specialist or local domestic violence and abuse service representation (IDAS) as well as any other specialist service e.g. substance misuse where applicable (Recovery Steps Barnsley/ DISC).
The composition of the review panel must be sufficiently configured to provide various perspectives and expertise surrounding the circumstances of the case. The panel members must be of sufficient seniority to commit on behalf of their agency to the decisions made during panel meetings however, they must be independent of any line management of staff directly involved in the case. The panel members, their role, and the agency they represent will be specified in the report.
Where there is a dispute between members of the panel, these should be resolved by the panel and the panel chair. Where disputes cannot be mediated, the DHR

report needs to record the areas of disagreement and actions taken towards a resolution. The Home Office will not arbitrate in such circumstances.

In establishing the members to sit on the review panel it should also be considered whether any specialist advisors should be consulted in relation to equality and diversity issues, in order to comply with the Public Sector Equality Act duties. For example, where appropriate, the review panel chair should consider consulting with advocates from BME communities or the LGBT community.

Throughout the review, the panel should meet an 'appropriate' number of times to ensure there is robust scrutiny. It will not be adequate for the review panel to only meet twice (once at the beginning and once at the end of the review).

The review panel should endeavour to conduct the review in line with the best practice identified within Section 4 of this document. This includes being professionally curious to establish the trail of abuse and considering what barriers the victim faced to accessing services.

9c Determining the Scope of the Review

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.

Where the family wish to partake in the review process, they should be invited to contribute to determining the scope of the review.

A non-exhaustive list of the issues that should be considered when determining the scope of the review is included at **Appendix 8a**.
A draft 'terms of reference' is included within **Appendix 9**.

10 Individual Management Reviews (IMRs)

Individual Management Reviews (IMRs) should be commissioned by, or on behalf of, the Chief Officers of all agencies who have provided services to the victim, perpetrator and family members or significant others identified in the Term of Reference within the time period specified there.

The IMR should begin as soon as an agency is advised by the SBP Chair of a decision to proceed with a DHR, and sooner if a homicide gives cause for concern within the individual agency.

The aim of the IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that changes could and should be made.

- To identify how and when those changes will be brought about.
- To identify examples of good practice within agencies.

A format for IMRs and a standard IMR Template is provided at **Appendix 9** together with draft terms of reference.

Full names and designations of individuals will be used in reports submitted to the Review Panel. Any material from them included in the Report will be anonymised towards the end of the DHR process and prior to wider dissemination. Every IMR should be accompanied by a detailed chronology of agency involvement with the individuals subject to the DHR.

The professional commissioned to conduct an Individual Management Review 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.

Chief Officers must ensure that the senior manager identified to complete the IMR is given sufficient time and any required resources to do so within the agreed timescales.

Those conducting Individual Management Reviews should consider carefully which staff and managers should be interviewed to inform the Review. The views of the Police Senior Investigating Officer and, where applicable, the Crown Prosecution Service must be sought prior to interviewing individuals who may be witnesses in criminal proceedings.

Staff should be reminded that the Review does not form part of a disciplinary investigation. The individual should be given the opportunity to have a supporter in attendance at interview and it is for the individual to decide who that should be. The role however is to support and not to represent the interviewee.

A written record of such interviews should be made. This should be agreed and signed by both the interviewee and the interviewer, with any areas of disagreement noted. The record should be shared with the interviewee and securely stored in case it is needed as part of any criminal proceedings.

The IMR reports should be quality assured by a senior manager in the organisation on behalf of the Chief Officer.

11 Timescales for Conducting a Domestic Homicide Review

The Report should be completed within six months of the decision to hold a DHR unless an alternative timescale is formally agreed with the SBP. (see flowchart **Appendix 1**).

To meet this timescale it is essential that senior managers identified to complete IMRs are given sufficient time and any resources required resources to do so.

The complexity of the DHR, as well as ongoing criminal justice or other legal proceedings, may prevent the DHR being completed within the above timescale. This may not become apparent until the Review is in progress.

As soon as it emerges that a DHR cannot be completed within the timescales above the Review Panel Chair should discuss this with the Chair of the SBP. If the SBP believes that the delay to completion of the Review is unreasonable they should refer the issue to the Home Office for further advice.

Where an extension beyond the six month timescale is agreed by the SBP, the Council lead in Healthier Communities should update the Home Office accordingly.

Members of the Review Panel should be aware that the review process takes time and even after the initial 6 month period has passed, the SBP has to await feedback from the Home Office before the Report can be published.

In all cases the aim should be to draw out lessons and act upon them without delay and without necessarily waiting for the DHR to be completed. This is particularly important where an extended timescale for the DHR is required and in such cases all identified recommendations should be implemented as soon as possible.

Where completion of the DHR is delayed by criminal justice or other legal proceedings it should be completed without delay once those proceedings are concluded.

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 Report. There should also be a follow-up feedback session with these staff members once the Report has been completed and prior to its publication. The management of these sessions is the responsibility of the senior manager in the relevant organisation.

12 Disclosure and Criminal Proceedings

Disclosure is one of the most important issues in the criminal justice system and the application of proper and fair processes is a vital component of a fair system. The Criminal Procedure and Investigations Act [1996] provides the legislative framework for disclosure in criminal proceedings.

Material generated or obtained in the course of a DHR may be capable of undermining the prosecution case or assisting the defence and if a criminal prosecution is ongoing all such material must be made available to the Police Senior Investigating Officer and Disclosure Officer to assess whether it is relevant. Those officers will liaise with the Crown Prosecution Service as appropriate. Where material is held by a third party, prosecutors must take any steps they regard as appropriate to obtain it. This may

include applying for a witness summons causing a representative of the third party to produce the material to the Court.

It is the responsibility of the Disclosure Officer to liaise with the Review Panel Chair regarding the disclosure of Review material, particularly where potentially disclosable material from the DHR is sensitive; although in most cases applications for access to material should be directed to the organisation which owns it.

13 Involvement of Family Members, Friends, and other Support Networks

In domestic homicides family members, friends, colleagues and members of informal support networks may have detailed knowledge that will enhance the quality and accuracy of the Review. The DHR Panel should recognise the benefits to be gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances, for example, where there are suspicions of 'honour'-based violence. The benefits include:

- Assisting the family with the healing process. Participation by the family also humanizes the deceased, helping the process to focus on the victims and perpetrator's perspectives rather than agency views.
- Helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.
- Allowing the Review Panel to get a more complete view of the victim's life and see the homicide through the eyes of the victim. This approach can help the panel understand the decisions and choices the victim made.
- Obtaining relevant information held by family members, friends and colleagues which is not recorded in official records.
- Revealing different perspectives of the case, enabling agencies to improve service design and processes.

The Review Panel should also access other networks which victims and perpetrators may have disclosed to, for example, employers, health professionals, professionals involved in Domestic Violence Perpetrator Programmes (DVPPs) or local VCS organisations.

The Review Panel should be aware of the potential sensitivities and need for confidentiality when meeting with members of informal support networks during the Review and all such meetings should be recorded. Consideration should also be given at an early stage to working with the Police Family Liaison Officer and Senior Investigating Officer involved in the related police investigation to identify any existing advocates and the respective positions of family members, friends and other support networks with regard to the homicide.

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 Review Panel Chair will need to discuss the timescales for interviews with the Senior Investigating

Officer (SIO) and take guidance from the SIO in relation to any ongoing criminal proceedings.

14 The Overview Report

The Overview Report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and other reports together with information obtained from other sources.

It is crucial that the Review Panel Chair and, if applicable, the Report Author have access to all relevant documentation and, where necessary, individual professionals.

An Executive Summary of the Overview Report should be prepared by the Report Author.

An Outline Format for the Overview Report is provided at **Appendix 9a**, although the precise format of these reports will depend on the features of the case.

The Report Author should, in their final Report, make reference to any requests to extend the timescale for completing the Review and include a copy of the written request as an appendix so that it can be clearly understood why the request was made.

On completion of the Overview Report members of the Review Panel should:

- Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Report.
- Ensure that the Report is produced to a high standard and is written in accordance with the 'Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' (Home Office, 2013).
- Translate recommendations from the Report into an outline Action Plan (see **Appendix 9**) and agree this on behalf of their respective agencies. The Action Plan should set out who will do what, by when, with what intended outcome and how improvements in practice and systems will be monitored and reviewed; it should be coordinated with current and relevant action plans from any previous DHR processes
- Once agreed, provide the anonymised Overview Report, Executive Summary and the Action Plan to the Chair of Barnsley's SBP.
- The Lead Officer for Communities will provide a copy of the Report and Action Plan to the Home Office. This should be via email to DHREnquiries@homeoffice.gsi.gov.uk The SBP should also confirm a secure contact email address which the Home Office (on behalf of the Quality Assurance Panel) can use for correspondence.
- Once agreed by the SBP the action plan will be managed by Barnsley's Protecting Vulnerable People Sub-Group. They will report delivery against actions into the SBP.

15 Media and Communications

- Communication and media protocols will be needed at various stages of the DHR process to manage media interest and to keep the local community informed. This would be from initial incident development to the instigation of the DHR and then to publication of the reports.
- Prior to the publication of a DHR report it will be agreed who is the key spokesperson.
- Liaison between the communication officers of the key partner agencies will be needed to form a consistent message from the partnership with Barnsley Council Communications and Marketing team will be lead press office contact.
- Any response to the media from partners involved in the process should be sent to the lead press office contact for approval.

Appendix 1 – Flow Chart

Step 1 - Initial Notification

Notification to Single Point of Contact (SPC) in Business Support at: DHR@barnsley.GCSX.gov.uk

Step 2 – Informing Key

SPC Notifies:
CSP Chair
Executive Director Communities
Services Director Communities
Services Director People (Adults) DHR lead

SPC Notifies Key External Stakeholders: Relevant Senior Police Officer
NHS Commissioning Board (NHS England)
CCG
Probation Services
BMBC Commissioned Services: DISC/ Recovery Steps Barnsley
IDAS
Barnsley Futures

Key stakeholders inform appropriate others on a need to know basis.
Within 2 Working Days

Step 3 – Coordination of Intelligence

3a. SPC sends password protected letter & overview report template to key agencies to coordinate intelligence relating to the case – ***within 48 hours***

3b. SPC collates intelligence into a summary report – sends to members of executive meeting at least one week prior.

3c. SPC advises members of DHR/SAR executive meeting; these are planned monthly. Where no notification received SPC should cancel meeting

NO

SPC informs Home Office and the family of victim on behalf of CSP Chair, outlining reasons.
CSP await feedback from the Quality Assurance Panel. Once feedback received this is shared to

Step 4 – Executive Group Meeting

Executive group meet to determine whether a DHR/SAR should be held.

YES

Chair of Executive Group informs (via DHR Lead Officer) Chair of CSP/ Safeguarding within ***10 working days***
Chair of CSP makes decision whether or not to proceed with DHR
SPC informs Home Office on behalf of the Chair of the CSP. SPC will also make initial contact with family members by letter to explain the process.

Stage 2

Step 1
- Establish Review Panel
- The executive group should decide the agencies that should sit on the review panel.

Step 2
- Appoint Review Panel Chair
- Healthier Communities will commission a RPC from the list of approved chairs.

Step 3
- Arrange Review Panel Meetings
- Determine scope of review at first meeting and approve terms of reference.

Step 4
- Review Conducted, Relevant IMRs Commissioned and Review Panel meetings Conducted.
- Report written by RPC and agreed by Panel.

Step 5
- Substantive Review Complete. Overview Report is scrutinised by Panel and submitted to Home Office with Executive Summary, Action Plan and Data Collection Form.
- Clearance given from Home Office - Anonymised Reports published on website and distributed to other agencies and the PCC

Stage 3 – Learning the Lessons

Step 1
- DHR lead ensures action plan is distributed to all relevant agencies, with explanation that they must inform DHR lead when actions completed and provide tangible evidence of this.

Step 2
- DHR lead in Healthier Communities will be responsible for proactively managing the action plan, by making regular contact with Agencies and pursuing outstanding actions.

Step 3
- DHR lead will present evidence and data from DHR Action Plan to members of the PVP sub-group on a quarterly basis.
- Where agencies have failed to implement the changes (and/or provide evidence) this will be noted by PVP and escalated to senior managers within the relevant organisation.

Step 4
- Once PVP sub-group are satisfied that the action plan has been fully implemented they can officially sign off the review.

Appendix 2 – Letter requesting information

Dear Colleague

URGENT: DOMESTIC HOMICIDE REVIEW

As you may be aware, unfortunately there was an alleged domestic homicide in Barnsley on date. Under the Domestic Violence, Crime and Victims Act 2004, this means that the need for a Domestic Homicide Review has to be considered by the Safer Barnsley Partnership.

Please do the following **immediately**:

1. **Check to see if you hold records for the following people (please treat this information as sensitive and restricted):**

Name of victim:
Address
Date of Birth
Date of Death
Name of alleged Perpetrator
Address
Date of Birth

Other household members: Insert name, address, DOB

Please complete the information requested in Appendix 3 attached to this letter. This is required to identify which agencies should attend the Executive Group meeting and which hold relevant information that would inform a Domestic Homicide Review in the event of one being commissioned.

If you do hold records, secure them immediately by copying and/or restricting electronic access. To be completely clear, only staff who will be involved in the DHR process (should it proceed), should have access to the file from now on.

Please then contact DHR@barnsley.GCSX.gov.uk as soon as possible and let us know what the nature of your agency's involvement with family was. This information is only required in brief at present – i.e. we are not asking you to write a full Internal Management Review of your agency's involvement at this stage. We are asking for this information in order to determine whether it is necessary to conduct a full Domestic Homicide review and if so, which agencies need to be involved.

Please also confirm if your organisation has had no involvement with the family on the same template.

2. **Ensure any staff or volunteers who had contact with the people involved in the case are aware of the death, and that they have access to appropriate support.**

A decision will be taken on whether to go ahead with a full Domestic Homicide Review. We will be in touch again following that decision.

Please send your (password protected) response within 10 working days to DHR@barnsley.GCSX.gov.uk and of course a separate password to enable access to the documents.

Yours sincerely

Chair of the DHR/SAR Executive Group

Appendix 3 – Referral Form

This form should be completed when notifying Barnsley's DHR Single Point of Contact and the Chair of the Safer Barnsley Partnership (SBP) that a suspected Domestic Homicide has occurred. This form should be submitted within **48 hours** of a verbal referral to request that a DHR Executive Group is convened under the Domestic Violence, Crime and Victims Act (2004, section 9 (3)), and in accordance with the Home Office *'Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'*.

This form should be sent **by password protected e-mail (*marked confidential*)** to Barnsley's DHR Single Point of Contact via e-mail to DHR@barnsley.GCSX.gov.uk

Notifier's details	
Name of person notifying	
Name of agency (if applicable)	
Designation (if applicable)	
Address of person notifying	
Telephone number of notifying person	
Email of notifying person	
Date of notification	
Victims details	
Victim's last name(s)	
Victim's first name(s)	
Other names used	
Victim's date of birth	
Age (if DoB not known)	
Date of death	
Home address	
Any other known addresses (please list):	
Ethnicity	
Preferred language	
Any disability	
Religion	
Are or were there any legal orders in place?	
Is the victim or has the victim ever been the subject of a Multi-agency Risk Assessment Conference (MARAC)?	

Brief summary of contact with the agency i.e. date span of contact/number of contacts and result of contact (NFA/Prosecution/Risk assessment not resulting in MARAC etc.)	
Alleged perpetrators details	
Perpetrators last name (s)	
Perpetrators first name(s)	
Other name(s) used	
Perpetrators date of birth	
Age (if DOB unknown)	
Home address	
Any other known addresses (please list):	
Ethnicity	
Preferred language	
Any disability	
Religion	
Are or were there any legal orders in place?	
Please state the current status of the police investigation if known. (Has the alleged perpetrator been arrested, place on bail or charged)?	
Is or has the alleged perpetrator ever been the subject of Multi-Agency Public Protection Arrangements (MAPPA)?	
Brief summary of contact with the agency i.e. date span of contact/number of contacts and result of contact (NFA/Prosecution/Risk assessment not resulting in MARAC etc.)	

Other members of the victims household – please provide details of any other members of the victims household?			
Name	**Date of birth**	**Address**	**Relationship to victim**

Details of incident	
Date of incident	
Address where incident occurred	
Please provide a brief overview of the circumstances of the case in the space below	

DHR criteria	
Please highlight which of the criteria below has been met in order to convene a DHR Executive Group meeting? (Please put a cross in any applicable section)	
There has been a death of a person aged 16 or over which appears to be a result of violence, abuse of neglect?	
The alleged perpetrator was, or has been in an intimate personal relationship with the victim.	
The alleged perpetrator is a member of the same household as the victim	
The victim took their own life and you suspect there may have been an abusive and/ or controlling relationship.	

Details of any agency known to or working with the victim			
Name	**Designation**	**Agency**	**Contact details**

Details of any agency known to or working with the alleged perpetrator			
Name	**Designation**	**Agency**	**Contact details**

Please return this form to DHR@barnsley.GCSX.gov.uk 48 hours of notification.

Appendix 3a – Chronology Form

Chronology - confidential
Name of victim:

Has your Agency/ Organisation previously had contact with any of the people

Please list the dates the victim and/or perpetrator were in contact with your agency (either in person through another source such as GP notes, files etc), the source of information, details about the nature of the contact and any comments.

Please ensure this is in date order without acronyms.

Victim chronology			
Dates	**Source**	**Nature**	**Comments**

Alleged perpetrator chronology			
Dates	**Source**	**Nature**	**Comments**

Appendix 4 – Invite letter to Executive Group

Dear colleague,

Re: Invitation to attend a Domestic Homicide Review Executive Group Meeting in relation to (Insert name, date of birth and address of victim).

I am writing to inform you that an Executive Group meeting regarding the above named individual has been scheduled for (Insert time and date). The meeting will be held at (Insert location). **Please make a note of this date.**

Case Background:
(Insert brief summary from DHR Notification form).

Please bring along to the meeting any information you have in relation to this case. Note that a chronology of events has been compiled and will be used to inform the meeting.

Please confirm that you are able to attend.

Yours sincerely

Chair of the DHR/SAR Executive Group

Appendix 5 – Notifying SBP Chair letter

RESTRICTED

Chair Safer Barnsley Partnership

South Yorkshire Police Barnsley

My Ref:
Your Ref:
Date:
Enquiries to:
Direct Dial:
E-Mail:

Dear

Re: Domestic Homicide Referral: Insert victims name and Date of Birth

I am writing to advise you that a multi-agency Executive Group Meeting regarding the above named individual was held on **insert date** at Barnsley Council offices.

The Executive Meeting considered information from a number of agencies and concluded that the case meets the criteria for a statutory Domestic Homicide Review on the basis that:

The death of **insert victims name** has, **insert criteria – met the criteria to conduct a domestic homicide review**

The meeting therefore recommended that you commission a Domestic Homicide Review in this case.

Subject to your approval this review process will be conducted in accordance with the Barnsley's Guidance for the Conduct of Domestic Homicide Reviews. The Review Report will be completed within 6 months of your decision to proceed, and will be presented to the Safer Barnsley Partnership for approval, sign off and dissemination.

Should you require any further information please do not hesitate to contact me?

Yours sincerely

Appendix 6 – Agenda template Executive Group

BARNSLEY DHR/SAR EXECUTIVE GROUP MEETING

(Day and Date)
(Time)
(Venue and Room)

Chair: Bob Dyson **Minute Taker: (Name)**

A G E N D A

		Papers	Lead
1.	Welcome, Introductions and Apologies for Absence	Verbal	Chair
2.	Case for consideration **Victim:** **Date of Birth;** Overview of the circumstances which led to an agency referring this case for consideration of undertaking a Domestic Homicide Review/SAR. Information known to agencies. Identification of any investigations. Has the criteria for conducting a Domestic Homicide Review/SAR been met?	**Appendix 3** **Chronology**	Chair
3.	Any Other business	Verbal	Chair
	Date and Time of the next meeting		

	(Day and Date) **(Time)** **(Venue and Room)**		

Appendix 7 – Notifying Home Office letter

RESTRICTED

Home Office

My Ref:
Your Ref:
Date:
Enquiries to:
Direct Dial:
E-Mail:

Dear Sir or Madam

Re: Domestic Homicide Notification: Insert victims name

I am writing to advise you that a multi-agency Executive Group Meeting regarding the above named individual was held on **insert date** at Barnsley Council offices.

The Executive Meeting considered information from a number of agencies and concluded that the case meets/ does not meet[3] the criteria for a statutory Domestic Homicide Review on the basis that:

The death of **insert victims name** has, **insert criteria**

The Executive Group passed the recommendation to the Chair of Safer Barnsley Partnership who has recommended that we commission a Domestic Homicide Review in this case.

The review will be undertaken and a copy of the review sent to you for quality assurance.

Should you require any further information please do not hesitate to contact me?

Yours faithfully

[3] Delete as appropriate

Appendix 8 – Notifying family letter

Dear

Re:

I am writing to advise you that following on from (**Insert nature of incident**) a number of agencies in Barnsley will be taking part in a review of their involvement in the case in accordance with their duties under Section 9 of the Domestic Violence, Crime and Victims Act 2004.

The purpose of such a Review is to establish whether there are lessons to be learned from the way in which local professionals and organisations worked together, with a view to improving service responses and inter-agency working in future.

I would very much like you to contribute to the Review and ask whether you would be willing to meet with me at a convenient local venue. This will be your opportunity to share your views on the way that agencies worked and the services that they provided.

If you would like to contribute to the review may I ask that you make contact with (**Insert contact**) on the above telephone number and the appropriate arrangements will be made?

As part of the review process your GP will be contacted and I also am seeking your agreement for any relevant information to be released and shared as part of the Review. Please note that any information provided will be treated with sensitivity.

If you are agreeable to this information being shared would you please sign the attached form and arrange for it to be returned to the address given below. A copy of this letter and a leaflet explaining the process are provided for your records.

If you have any queries please do not hesitate to contact (**Insert contact**) who I working with me on the review.

Yours sincerely

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? 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/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?

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". 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?

Appendix 9 – Individual Management Review Report Template

Barnsley Safeguarding Adults Board

Strictly Confidential
Please note Individual Management Reviews (IMRs) are confidential documents, which belong to the individual organisations and should not be shared with anybody outside of the DHR Review Panel.

Individual Management Review
For inclusion in
Barnsley Safer Communities Partnership
Domestic Homicide Review Report

Relating to: Insert name of victim

Author:

Contact details:

Date:

Contents **Page No.**

1. Introduction

Brief factual/ contextual summary of the situation leading to the DHR including an outline of the terms of reference and date for completion. Identify the person subject to this review, their date of birth, date of death (or offence where perpetrator). Include the name, job title and contact details of the person completing the IMR (including confirmation of independence from 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. Include a pen portrait of the victim.

2. Terms of reference

In line with the statutory guidance, these terms of reference are subject to review and updating as the DHR progresses.

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Reduce the risk of domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

The Terms of Reference that will be addressed in the Individual Management Reviews are:

a. To review each agency's involvement with the following people between from **INSERT DATE** to **INSERT DATE** the date of **INSERT VICTIMS NAME** death:

- Deceased (Date of birth; Date of death)
- Address
- Suspect (Date of birth)
- Address

- Children
- Address
- Further address identified

Agencies with relevant knowledge of the victim or perpetrator before this time are asked to provide a brief synopsis of their involvement.

b. The review will address whether the incident in which **deceased** died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic violence.
c. Whether there were any barriers experienced by **deceased** or family / friends / colleagues in reporting any abuse in Bradford or elsewhere, including whether they knew how to report domestic abuse should s/he have wanted to.
d. Whether **deceased** had experienced abuse in previous relationships in Barnsley or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before s/he died.
e. Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by **deceased** that were missed.
f. Whether the **suspect** had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.
g. Whether there were opportunities for agency intervention in relation to domestic abuse regarding **deceased**, the **suspect** or the dependent children (if they had any) that were missed.
h. The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the borough.
i. The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Questions to be covered in the IMR

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 (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?
- 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?
- Had the victim disclosed to anyone and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?

3. Family Profile

Provide details of the family profile.

4. Methodology

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

5. Chronology

Construct a comprehensive chronology of involvement by agencies over the period of time set out in the Terms of Reference. State when the victim/perpetrator/family member was

seen including antecedent history where relevant. ***Please do not include full names or addresses in this section.*** Identify the details of the professionals from within your agency who were involved with the victim, perpetrator, family and whether they were interviewed or not for the purposes of this IMR. **Please do not refer to workers by name. For clarity use SW1, SW2 for social workers and HV1, HV2 for health visitors etc. For confidentiality reasons there is a table in the appendices for codes used which will be removed prior to circulation.**

Source of information: State whether information from interview with staff, case notes, supervision notes etc.
Subject of recording: Using initials only state who the entry relates to i.e. deceased, suspect, parent, sibling, child etc.

6. Analysis

Consider the events that occurred, the decisions made and the actions taken or not. Assess practice against guidance and relevant legislation. Please consider further analysis in respect of key critical factors, which are not otherwise covered by the sections above, using the Terms of Reference headings.

7. Lessons Learnt

Consider both the practice that occurred, including any good practice and areas for improvement.

8. Recommendation

Recommendations should be focussed on the key findings of the IMR and be specific about the outcome which they are seeking. These will be used to develop the action plan.

9. Action Plan

Actions should be Specific, Measurable, Achievable, Realistic, Timely, Evaluation, Review (SMARTER)

Appendix 9a – Overview Report Template

1) Title Page
    a. Name of Community Safety Partnership
    b. Victim's pseudonym and month and year of death
    c. Author's name
    d. Date the review report was completed
2) List of Contents Page

3) Introduction

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.

4) 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 the delay in completion (this should include any additional delays other than due to the criminal trial).

5) Confidentiality

The findings of each IMR are confidential. Information is only available to participating officers/ professionals and their line managers. Include pseudonyms 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 perpreator at the time of the fatal incident, and their ethnicity.

6) Terms of reference
7) Methodology
    a. Include details of the decision to undertake a DHR and who was involved in that decision.
    b. Describe the methodology used, what documents were used, whether interviews were undertaken.
8) Invovlvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

Include when people were contacted and bu whom, the nature of their involvement and whether they have been provided with the relebvant 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.
- The family met the review panel.
- The family have been updated regularly.
- The family reviewed the draft report in private with plenty of time to do so and whether they had the opportunity to comment and make amendments if required.
- All those contributing were able to do so using their preferred medium.

9) Contributors to the Review
    a. List the agencies and other contributors and the nature of their contribution. I.e IMR, Report, Information
    b. Confirm the independence of the IMR authors and how they are independent.
10) The Review Panel Members
    a. List names of DHR Panel members, their role, job title and the agency they represent.
    b. Include number of times panel met and confirm independence of panel members.
11) Author of Overview Report
    a. Explain independence of Chair, details of career history and relevant experience. Confirm they had no connection with the CSP. If they previously worked for any of the agencies within the review, state how long ago that employment ended.
12) Parallel Reviews
    a. State if an inquest or any other review or inquiries have been conducted and whether they have been used to inform this review.
13) Equality and Diversity
    a. Address the 9 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.
14) Dissemination
    a. List of recipients who will receive copies of the review report.
15) Background Information (The Facts)
    a. Where the victim lived and where the homicide took place. A synopisis of the homicide (what happened and how the victim was killed).
    b. Details of the Post Mortem and inquest and/or Coroner's inquiry if already held. State the cause of death.
    c. 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 do not give genders of children).
    d. 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.
    e. Who has been charged with the homicide, the date and outcome of the trial, and sentence given.

f. 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.

16) Chronology
    a. Background history of the victim and perpetrator prior to the timescales under review, to give context.
    b. 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.
17) Overview
    a. An overview that summarises what information was known to the agencies and professionals involved about the victim, perpetrator and their families.
    b. Any other relevant facts about the victim and perpetrator.
18) Analysis
    a. This part of the Overview Report 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. This 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.
19) Conclusions
    a. Bring together an overview of the main issues identified and the conclusions drawn from them which will translate into the detailing of lessons learnt in the next section.
20) Lessons to be learnt
    a. Summarise lessons to be drawn from the case and how those lessons should be translated into recommendations for action.
    b. State any early learning identified during the review process and whether this has already been acted upon.
21) Recommendations
    a. 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.
    b. Recommendations should be focussed and specific and capable of being implemented.

Appendix 10 – Checklist for an excellent IMR

Barnsley
Checklist for an excellent IMR
January 2016

1	The agency identified a suitably independent author to complete the IMR and this is clearly stated in the IMR	
2	The IMR author has provided an overview of the role of the agency	
3	The IMR author has provided a brief summary of their background and suitability to complete this IMR	
4	The IMR follows the template provided by Safer Barnsley Partnership and is fully anonymised using the codes provided. Professionals should be identified by their job title and a list provided as a separate appendix	
5	The Terms of Reference are clearly set out and each Term of Reference answered if applicable to the agency	
6	The IMR sets out which records were accessed	
7	All relevant staff have been interviewed and where this has not been possible this has been fully explained in the IMR	
8	The IMR has retained a focus on the people concerned and the victim's voice comes through in the IMR	
9	The IMR has addressed issues of race, culture, language, religion and disability	
10	The IMR is well structured, comprehensive, and analytical and looks openly and critically at practice, decisions made, and services offered to the homicide victim, perpetrator, and/or members of their family(ies) or household(s. Good practice is identified	
11	The IMR reaches well founded conclusions and identifies the key lessons to be learnt	
12	The recommendations flow from the lessons learnt and are SMART (specific, measurable, achievable, realistic and timely). There are recommendations on how to evaluate the impact and review the implementation.	
13	The IMR has been signed off by a Senior Manager in the agency	
14	There is a clear plan of how the findings will be fed back to the staff members involved.	

Appendix 11 – Home Office Data Collection Form

THIS IS NOT FOR PUBLICATION – FOR HOME OFFICE DATA COLLECTION ONLY

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[4]	
Nationality	
Religion	
Sexual Orientation	
Disability	

	Perpetrator
Gender	
Age at time of incident	
Relationship to victim	
Ethnicity	
Nationality	
Religion	
Sexual Orientation	
Disability	
Details of verdict	

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

4

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