DOMESTIC HOMICIDE REVIEWS (DHRs)

1. Background

1.1 DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). The provision of DHRs came into force on 13th April 2011. Under the new arrangements DHRs should be carried out to ensure that lessons are learned when a person has been killed as a result of domestic violence.

1.2 Domestic violence includes physical violence, psychological, sexual, financial and emotional abuse which can involve partners, ex-partners, relatives or other members of the household. The current Stockton Partnership Strategic Assessment highlights that over the last 12 months Domestic Violence accounted 33% of all recorded violent crime. There has been one Domestic Homicide in Stockton in the last 5 years.

1.3 The provision allows the Secretary of State, in particular cases (e.g. when a local area fails to initiate a review itself) to direct that a specified person or body establishes or participates in a review. Section 9 also introduces a duty for every person or body establishing or participating in the review to have regard to the statutory guidance.

1.4 There is a requirement to contact the Home Office if a DHR is to be carried out. Enquiries should be sent to the following:

DHRENQUIRIES@homeoffice.gsi.gov.uk

1.5 To support frontline practitioners who will be taking part in domestic homicide reviews, the government has produced 38 pages of multi-agency statutory guidance for the Conduct of Domestic Violence Reviews and a supporting online training package for use by practitioners. Both can be found online at:

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

2. Statutory Guidance

The guidance issued under section 9 of the Domestic Violence, Crime and Victims Act (2004) states:

1. ‘domestic homicide review’ refers to 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 whom he/she was related or had been in an intimate personal relationship, or
(b) a member of the same household

2. The Secretary of State may in a particular case direct a person or body to establish or to participate in a DHR. Subsection 4 of the guidance provides the subsection of persons or bodies which includes:

In relation to England and Wales –

- chief officers of police for police areas in England and Wales
- local authorities
- Strategic Health Authorities
- Primary Care Trusts
- Providers of probation services
- Local Health Boards
- NHS trusts

3. It is the duty of any person or body establishing or participating in DHR to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews. If they decide to depart from this guidance they must have clear reasons for doing so.

3. The purpose of a DHR

3.1 The purpose of a DHR is to establish what lessons can be learned from the domestic homicide in relation to the way in which local professionals and organisations work individually and collaboratively to safeguard victims.

3.2 A DHR will identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and identify what is expected to change as a result.

3.3 The overarching aim of DHR is to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved organisational and partnership working.

3.4 It is important to note that DHRs are not inquiries into how the victim died or who is culpable and they are not specifically part of any disciplinary enquiry or process. Any issues which may emerge over the course of a DHR should be dealt with through the established disciplinary procedures of the relevant agency and applied separately to the DHR process.

3.5 The rationale for the review process is to ensure that agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide and violence. The review process will also assess whether

agencies have sufficient and robust procedures and protocols in place, which were fully understood and adhered to by staff.

4. The role of Community Safety Partnerships

4.1 Community Safety Partnerships have been identified as being best placed to carry out DHRs due to their multi-agency membership. A DHR should be carried out by the Community Safety Partnership (in our case SSP) in the area where the victim was normally a resident.

4.2 The guidance states that when a domestic homicide occurs the relevant police force is required to inform the SSP of the incident in writing. The overall responsibility for establishing a DHR is with the SSP and it is the Chair's responsibility to determine whether such a review should take place taking into account the definition of a DHR detailed within the statutory guidance. Any decision should be made in consultation with partners that have an understanding of the dynamics of domestic violence. This will also assist the chair in identifying those best placed to sit on the Review Panel.

4.3 Consultation with partners may also highlight any other ongoing reviews such as a child or adult Serious Case Review (SCR) or Mental Health Investigation (MHI). Any additional ongoing reviews will need to be considered as part of the decision. Where victims of domestic homicide are aged 16-18 child a SCR will take precedence over a DHR.

4.4 In all cases the Local Safeguarding Children Board (LSCB) should be notified of the intention to carry out a DHR. The LSCB document 'Working Together' point 8.11 highlights in such cases an SCR may be carried out where a parent has been murdered. Notification to the Stockton LSCB should be made via Pauline Beall, Stockton Local Safeguarding Children Business Manager.

5. Situations of concern

The guidance highlights a number of factors as examples of the types of situations preceding a homicide which will be of interest to review teams conducting a DHR:

5.1 Evidence of a risk of serious harm to the victim that was not recognised or identified by agencies in contact with the victim and/or the perpetrator, it was not shared with others and/or it was not acted upon in accordance with recognised best professional practice.

5.2 Any of the agencies or professionals involved considers that their concerns were not taken sufficiently or seriously or not acted on appropriately by others.

5.3 The homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or

other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.

5.4 The victim was being managed by, or should have been referred to a Multi-Agency Risk Assessment Conference (MARAC).

5.5 The homicide appears to have implications/reputational issues for a range of agencies and professionals.

5.6 The homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed.

5.7 The perpetrator holds a position of trust or authority e.g. police officer, social worker, health professional, and therefore the homicide is likely to have a significant impact on public confidence.

5.8 The victim had no known contact with any agencies. Could more be done in the local area to raise awareness of services available to victims of domestic violence?

6. Conducting a DHR

6.1 In order to conduct a DHR a review panel needs to be established involving representatives from the relevant agencies (detailed within section 2 of the *statutory guidance)* in addition to representatives from the VCS who have an expertise in domestic violence. The review panel should consist of individuals from a broad spectrum of statutory and voluntary agencies to ensure that there is a high level of information about the victim and/or the perpetrator. It is also important to ensure that there are agencies/individuals on the review panel representing the victim.

6.2 Within the guidance there is an acknowledgement that there may already be established forums dealing with domestic violence and domestic homicide within the SSP area. As such existing established forums need to be fully included in the review and panel process and where appropriate the SSP may refer the DHR for action to a forum to lead on and manage the review.

6.3 *Appointment of a chair*

The review panel needs to appoint an independent Chair of the Panel who will be responsible for managing and co-ordinating the review process and the production of the final Overview Report. The guidance highlights some possible criteria which can be used to ensure that the panel recruits a suitably experienced and skilled chair (section 5, point 5.10)

6.4 *Determining the scope of the review*

In each case the Chair and the review panel need to agree the scope of the review process and agree upon clear terms of reference. The guidance identifies a range of relevant issues to consider (section 5, point 5.11) although this is not an exhaustive list. The final decision on the suitability of the terms of reference resides with the review panel Chair.

6.5 *Timescales*

The timescales for carrying out a DHR are based on those used in Serious Case Reviews. Within one month of a homicide coming to the attention of the SSP, the decision needs to be taken as to whether or not to hold a review by the Chair. There is also a requirement to draft and agree the terms of reference within this timescale.

6.6 Once this has been agreed individual agencies are required to secure case records promptly and work to draw up a chronological account of involvement with the victim, perpetrator and their families.

6.7 There is a requirement to complete the final Overview Report within a further 6 months unless an alternative timescale has been formally agreed with the SSP. This may be necessary in more complex cases which may materialise following further investigation and may include other elements such as judicial proceedings which would prevent the conclusion of a DHR in the desired timescale. Detailed information is provided in section 6 of the statutory guidance.

6.8 *Involving family members and support networks*

The guidance highlights the potential benefits of involving individuals from the both the victims and in some cases the perpetrators networks in the overall review process. However, this may not be possible in exceptional cases such as incidents where is there is suspected 'honour' based violence. All meetings should be recorded and confidential. As part of the process the support of family liaison officers and senior investigating officers (SIOs) should be considered especially in relation to determining the position of the family in coming to terms with the homicide. Further information can be found in section 7 of the guidance.

6.9 *The completion of Individual Management Reviews (IMRs) and The Overview Report*

As part of the review process each of the participating agencies/organisations is required commission an IMR. Completed IMRs will form part of the overview report. Each IMR should detail the agencies involvement with the victim or perpetrator and should look openly and critically at individual and organisational practices. Guidance states that the IMR should start as soon as a decision is taken to proceed with a review. Individuals conducting IMRs should not have

been directly involved with the victim, the perpetrator or either family and should not have immediately line managed any staff involved in the IMR. There is a requirement for a feedback session for all staff involved in the IMR prior to its inclusion in the final Overview Report. The Final Overview report should include a final action plan with clear timescales and responsibilities. Once the final report has been signed off by the SSP Chair a copy should be provided to the Home Office Quality Assurance Group. Only following approval from the Home Office can the document be published. Following approval a copy should be provided to the senior manager of each participating organisation. A copy of the report and action plan should also be available on the SSP website. The review will be formally concluded following implementation of the action plan; an audit process must be included. Further information including guidance on final publication, quality assurance can be found in section 8 of the guidance.

7. Issues to consider

7.1 The new requirement places increased scrutiny on the work of agencies and organisations in Stockton at a time when the level of funding available to support domestic violence prevention is reducing. Stockton was recently unsuccessful in securing MARAC and IDVA funding which will have an impact on the level of support available to victims. There is a risk that this may lead to victims losing confidence and withdrawing from court proceedings. This in turn places a greater risk on a possible Domestic Homicide in the future.

7.2 The guidance highlights that DHRs are to be used to explore processes and learn lessons for the future. However, due to the sensitive and emotive nature of such a review, similar to Serious Case Reviews, there is a risk that these reviews will be seen as an opportunity to blame/expose individuals and organisations failings and the final publication of the review may lead to an increase in media scrutiny which may have a negative impact on the take up/confidence of domestic violence services and support in the future.

7.3 The completion of IMRs is a specialist area of work which is not readily available to all organisations and as such often needs to be commissioned out at a cost. In the current economic climate this will prove difficult for many organisations. DCI Peter McPhillips from Public Protection (HQ) is leading on the implementation of DHRs on behalf of Cleveland Police. It is envisaged that a support facility will be available through the Police to complete IMRs as there are a number of individuals experienced in this process through involvement in Serious Case Reviews. At this stage it is unclear the full level of support available and whether or not there will be a cost implication. Another option may be to work with other Community Safety Partnerships to train a number of IMR authors to mutually support reviews in other areas.

8. Next steps

8.1 It is proposed that the SSP considers responding directly to the Home Office outlining the above concerns particularly in relation to the reduction in funding/support for domestic violence prevention work.

8.2 DCI Peter McPhillips is in the process of organising a meeting with Tees Valley Community Safety Managers to discuss DHRs further and how they will be progressed. Further updates will be provided to SSP and DV Strategy Group and to other Partnerships which may have an interest in this issue (e.g. Local Safeguarding Children Board, Safeguarding Adults Committee).