Proposed procedure for Domestic Homicide Reviews (DHR) in Stockton

Background

The purpose of this report is to present a procedure for conducting DHR's in Stockton. This procedure has been developed in consultation with DCI Peter McPhillips, Cleveland Police Vulnerability Unit and aims to incorporate the key elements of the Home Office guidance which was released in April 2011 and is available from: http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-homicide-reviews/.

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. 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 –

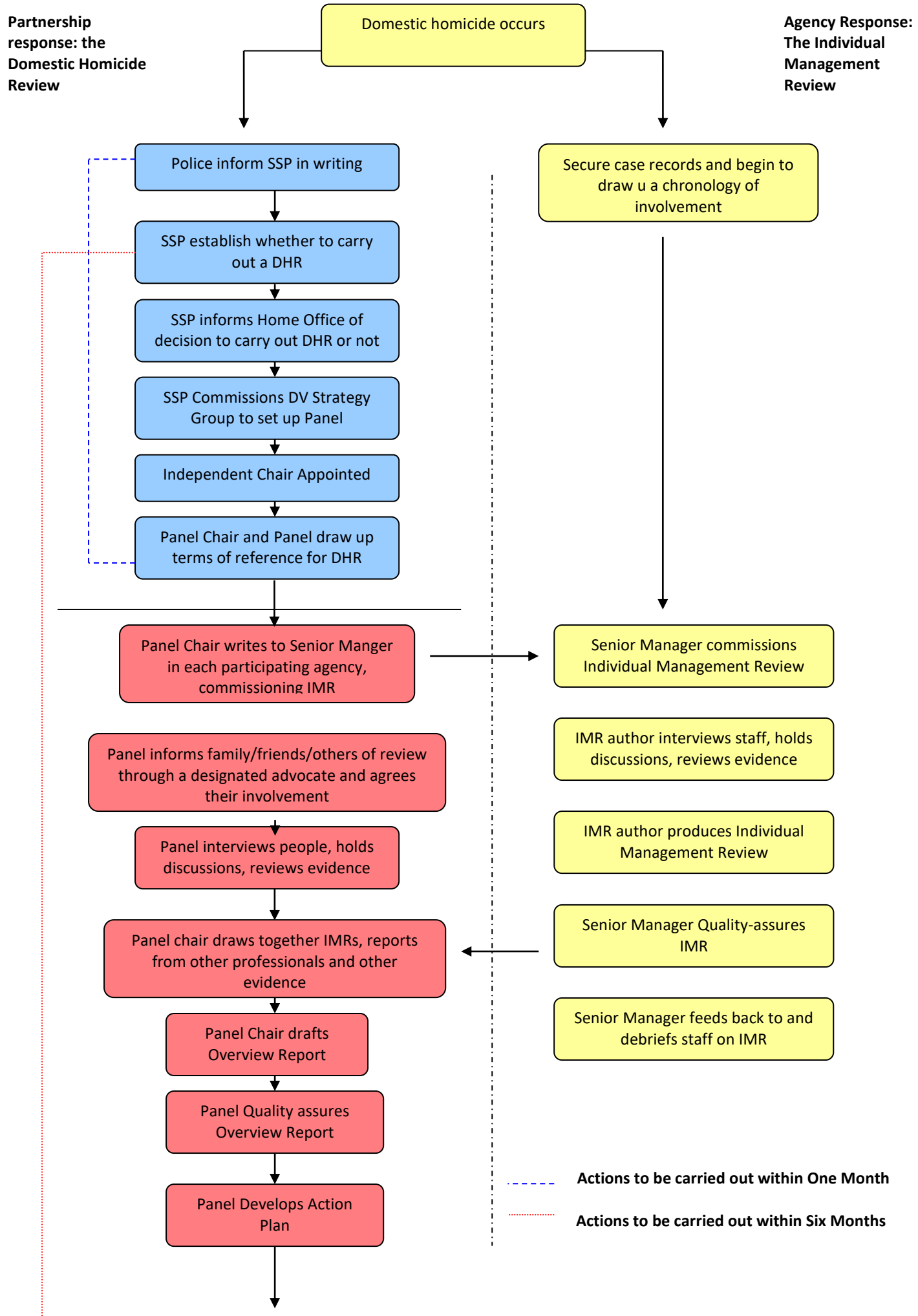
- chief officers of police for police areas in England and Wales
- local authorities
- Strategic Health Authorities
- Primary Care Trusts
- Providers of probation services
- Local Health Boards
- NHS trusts

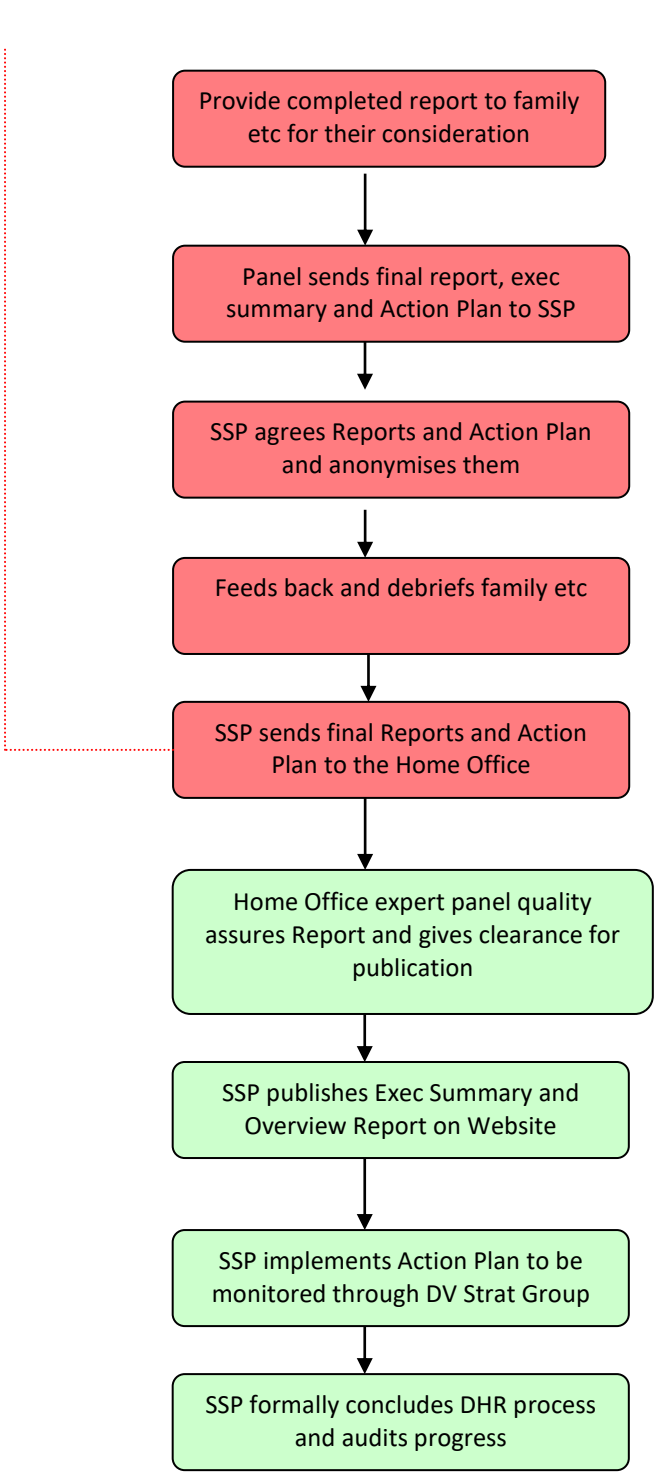
3. It is the duty of any person or body establishing or participating in DHR to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews. If they decide to depart from this guidance they must have clear reasons for doing so.

A number of meetings have taken place with representatives from the other three Tees Community Safety Partnerships and while the potential use of reciprocal arrangements to support DHR's has been explored there is a general consensus that each CSP would prefer to plan and conduct any subsequent DHR utilising their own resources.

Proposed approach for Stockton

It is proposed that in the first instance following notification of a domestic homicide, the SSP will decide whether a DHR needs to take place. This decision will take into account any other reviews or investigations which may be ongoing in respect of the homicide. Following agreement to conduct a DHR the Chair will instruct the Domestic Violence Strategy Group to begin the process of establishing a DHR steering group to progress the review. The existing Domestic Violence Strategy Group contains the relevant individuals with the necessary experience and expertise required to both identify the organisations and agencies required as well as appoint an independent chair to conduct a review. It is also likely that should a DHR be required that some if not all members of the existing group would play a key role. The flow chart below identifies the key stages involved in conducting a DHR within the 6 month timescale.


Partnership response: the Domestic Homicide Review
Domestic homicide occurs
Agency Response: The Individual Management Review
Police inform SSP in writing
SSP establish whether to carry out a DHR
SSP informs Home Office of decision to carry out DHR or not
SSP Commissions DV Strategy Group to set up Panel
Independent Chair Appointed
Panel Chair and Panel draw up terms of reference for DHR
Secure case records and begin to draw u a chronology of involvement
Panel Chair writes to Senior Manger in each participating agency, commissioning IMR
Senior Manager commissions Individual Management Review
Panel informs family/friends/others of review through a designated advocate and agrees their involvement
IMR author interviews staff, holds discussions, reviews evidence
Panel interviews people, holds discussions, reviews evidence
IMR author produces Individual Management Review
Panel chair draws together IMRs, reports from other professionals and other evidence
Senior Manager Quality-assures IMR
Panel Chair drafts Overview Report
Senior Manager feeds back to and debriefs staff on IMR
Panel Quality assures Overview Report
Panel Develops Action Plan
Actions to be carried out within One Month
Actions to be carried out within Six Months


Provide completed report to family etc for their consideration
Panel sends final report, exec summary and Action Plan to SSP
SSP agrees Reports and Action Plan and anonymises them
Feeds back and debriefs family etc
SSP sends final Reports and Action Plan to the Home Office
Home Office expert panel quality assures Report and gives clearance for publication
SSP publishes Exec Summary and Overview Report on Website
SSP implements Action Plan to be monitored through DV Strat Group
SSP formally concludes DHR process and audits progress

Timescales

There should be a maximum of one month between the SSP being notified of a domestic homicide and the Review panel agreeing its terms of reference. The guidance suggests a maximum of 6 months between the decision to carry out a DHR and the final report being submitted to the Home Office for quality assurance. The Home Office Quality Assurance group will only meet quarterly and as such this will impose a further delay before the final publication of the review.

Points to consider

Appointing an independent chair: The main issue in relation to adequately resourcing a DHR is the appointment of an independent chair, suitably experienced and with the necessary capacity and expertise to lead a review. Reciprocal arrangements with other authorities have been explored and do not appear to be feasible. The other option of utilising existing senior officers/directors within existing organisations within the partnership area is an option. However, this may not be practical considering the large time commitment required as well as the possible/likely involvement of partner organisations in the review process. Research into other CSP areas suggests that other partnerships appear to be looking to appoint an external chair and requesting additional resource from partners involved to cover this cost (estimated to be in the region of £10,000 to £20,000 per review) Other areas are also exploring the possibility of setting aside an annual resource to be used should a DHR occur. The SSP may want to consider ringfencing some of the annual contribution it receives from partners which currently stands at £5,000.

Conducting Individual Management Reviews (IMR's): 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. While organisations such as the Police and the Local Authority will have existing IMR authors that can be used as part of this process, some smaller or voluntary organisations required to be involved may not. This may also have additional resource and cost implications which will need to be considered as part of the initial setting up of the panel. In addition to this it is also proposed that an IMR report template is produced to provide consistency.

History of involvement: As part of the terms of reference it is important to agree how far back an organisation needs to go in relation to their involvement with the victim/perpetrator. For example if an agency has not been involved for over 7 years it is likely that their procedures and personnel have changed significantly during this time and as such may not be relevant.

Involvement of the family and communication throughout a review: The flow chart outlines a number of actions in relation to adequately informing and involving the family of the victim. Due to the sensitive nature of a review it is important to agree a consistent and appropriate format for regularly liaising with the family. It is recommended that a leaflet/handout is produced in consultation with DV practitioners which can be provided at the start of a DHR. This leaflet should explain the DHR process, the key timescales and elements of a review and what the family can expect at the end and what support will be available throughout the process. It is also recommended that along with this leaflet an individual involved with the review is identified to act as the single point of contact for the family.

Consideration of existing reviews, hearings and completion of criminal proceedings: The statutory guidance accepts that in the majority of cases the DHR will be not be able to start until all criminal proceedings are complete. Where this is the case the DHR panel should ensure that the records and chronology of involvement are drawn up for each organisation involved. As part of this process any immediate lessons to be learned should be identified and brought to the attention of the relevant organisation for action. Other investigations such

as mental health investigations and other legal proceedings may take place after a death. As such the chair of the panel should discuss with the relevant criminal justice and other relevant agencies such as HM Coroner, Independent Police Complaints Commission at an early stage how the review process should take these proceedings into account. In some cases a Serious Case Review (SCR) may be ongoing which will take priority over a DHR. If this is the case it may be possible to specifically reference the domestic homicide issues as part of this review rather than conduct a separate review at a later date.

Training and support: To support frontline practitioners who will be taking part in domestic homicide reviews, the government has produced a 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/ It is expected that the first Domestic Homicide Reviews will be completed from October/November 2011 and as such there may be opportunities for peer support and further guidance from the Home Office. Any additional information will be highlighted to the SSP.

Recommendation

In summary it is recommended that the Safer Stockton Partnership:

1. Agrees that the Domestic Violence Strategy Group should take the lead on the setting up of a panel and the appointment of an independent chair to conduct a DHR

2. Agrees to the proposed procedure for conducting a DHR within Stockton

3. Acknowledges the potential resource implications for conducting a DHR and agree to either:

    a. Identify an annual budget to cover the costs of any potential review

    b. Explore the resource issue on a case by case basis

Steven Hume
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