GUIDANCE OVERVIEW FOR UNDERTAKING DOMESTIC HOMICIDE REVIEWS IN HERTFORDSHIRE

1. Introduction

A Domestic Homicide Review (DHR) is a multi-agency 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 either:

a) A person to whom they were related
b) A person with whom they were, or had been, in an intimate personal relationship
c) A member of the same household as themselves.

Or:

Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship.

Since 13 April 2011, there has been a statutory requirement for local areas (i.e. Community Safety Partnerships) to conduct a DHR following a domestic homicide that meets the above criteria. The purpose of a DHR is not to reinvestigate the death or apportion blame, but to:

- Fully illuminate the life of the victim and the events that lead to their death
- Establish lessons to be learnt from the homicide regarding how local professionals and organisations work both individually and together to safeguard victims
- Identify clearly how, and within what timescales, lessons will be acted upon and what is thus expected to change
- Apply these lessons to service responses, including changes to policies and procedures
- Prevent future domestic homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

The Home Office statutory guidance for the conduct of DHRs can be found here. Notes on good practice, as outlined by experts at Advocacy After Fatal Domestic Abuse (AAFDA), can be found here.

2. Process Overview

An overview of the DHR process in Hertfordshire is outlined in the table below.

STAGE 1	Timescale
1. Notification of Death Received from Police (or other agency)	Within 28 Days of Notification
2. Initial information request sent to all DHR sub-group members plus any other relevant agencies	
3. Notification circulated to DHR substantive members & CSP Chair to agree whether DHR criteria is met	
4. If agreed, Initial Panel meeting to be arranged	
5. Partnerships Manager in the Strategic Partnerships Team to notify:	
i. Home Office	
ii. Coroner	
iii. Safeguarding Boards Manager	
6. Chronologies to be requested from the following in the first instance and representative invited to be on Panel	
i. Adult Care Services, HCC	
ii. Children's Services, HCC	
iii. CCGs (via Tracey Cooper)	
iv. GP (contact details from Stephenie Evis)	
v. HPFT	
vi. HCT	
vii. BeNCH	
viii. NPS	
ix. Refuge	
x. Herts Constabulary	
xi. Any others known to be involved	
7. Once received, chronologies to be merged into one document for Initial Panel meeting	
8. Initial Panel meeting takes place to appoint	
i. DHR Panel Chair	
ii. Overview Report Writer	
iii. Agree Terms of Reference and Scope	
iv. Decide on Panel membership	
9. Agree letter to be sent to family and friends	
STAGE 2	
10. DHR Panel meetings to be arranged as agreed	6 months
11. Additional agencies to be asked to provide chronologies and Panel members, if appropriate	
12. IMRs to be requested from agreed agencies and signed	
13. IMR authors briefing session to take place	
14. DHR panel chairs to complete IMR section (Section 1.1) of Quality Assurance checklist	
15. Family members to be invited to meet the Panel	
16. Overview Report Writer to compile report	
17. DHR Panel to agree Recommendations	
18. DHR Panel chair to complete Overview Report section (Section 1.2) of Quality Assurance Checklist and send form on to DHR sub-group chair	
STAGE 3	
19. Final report to be shared with family members and consideration given to how and when to share with perpetrator.	3 weeks
STAGE 4	
20. Overview Report Writer, DHR Panel Chair, CSP Chair to attend DHR sub group meeting to review Recommendations to ensure they are SMART	
21. Final draft report to be reviewed by DHR sub group	
22. DHR sub-group chair to complete their section (Section 2) of the Quality Assurance checklist and return to the Strategic Partnerships team	
23. Action Plan to be sent to agencies to add their actions under the Recommendations	
STAGE 5	
24. Report, Executive Summary, action plan and Quality Assurance checklist to be presented to CSP for approval, sign off and for them to progress the action plan	
25. Sarah Taylor to send final report, Executive Summary and Action Plan to Home Office for their QA Panel to review	

22. CSP to provide quarterly updates for DHR sub group on progress of action plan	
STAGE 6	
23. Learning Event to be organised for agencies	3 months after report submitted to CSP
STAGE 7	
24. CSP to publish report once received back from Home Office, if appropriate	

3. Roles and Responsibilities

3.1 Community Safety Partnership

When a domestic homicide happens, the police (or other relevant agency) should inform the relevant Community Safety Partnership (CSP). It is the responsibility of the Community Safety Partnership where the victim was last, or most frequently, resident to decide whether the case is to be subject of a domestic homicide review by applying the definition set out in the guidance.

The CSP chair is responsible for:

- Appointing and commissioning the DHR panel chair and Overview Report Writer (ORW), ensuring that they are suitably independent from any responsible authority within the CSP[1]
- Final approval, and sign off, of: Overview Report, Executive Summary, action plan and Quality Assurance Checklist
- Monitoring progress against any actions that agencies have because of the Overview Report
- Updating Hertfordshire's Domestic Abuse Partnership Board, via the DHR sub-group, on a quarterly basis on progress against the overall action plan
- Highlighting any delays in progress in the DHR process to the DHR sub-group.

3.2 DHR Panel

Where the Hertfordshire Domestic Abuse Partnership and CSP chair consider that the criteria for a DHR have been met, a review panel will be established. In Hertfordshire, review panel membership is tailored to each DHR. However, there are some fixed members, including representatives from: the police, County council, Clinical commissioning groups, the Chair of the DHR subgroup, a representative from a domestic abuse specialist organisation and a suitable independent. Individuals from other statutory and voluntary agencies will be asked to join the panel if they have valuable information on the victim or perpetrator or where they have specialist knowledge that may aid the DHR.

In Hertfordshire, the Chief Executive from a neighbouring local authority to the district/borough in which the homicide occurred will typically act as the DHR panel chair, unless otherwise agreed by panel members at the initial panel meeting. Any costs associated with the commissioning of the DHR panel chair and ORW will be met by the budget provided by the Office of the Police and Crime Commissioned (OPCC).

The DHR panel must:

- Meet an appropriate number of times to ensure that there is robust oversight and rigorous challenge
- Carefully consider the potential benefits of including members of the victim's friends, family and other support networks in the review process[2].

[1] Those previously affiliated with any of the responsible authorities within the CSP area must have been disassociated from said authority for a minimum of 2 years before the date of the homicide

[2] More information and guidance on involving friends, family and other support networks can be found here.

- Ensure all IMRs, and final Overview Report, are of a high standard and all associated recommendations are SMART, as per the guidance in the DHR Panel Toolkit. The Chair must sign the Quality Assurance checklist once satisfied with the quality of IMRs and the Overview Report.
- Ensure relevant recommendations in the overview report are put into an action plan, which is agreed at a senior level by each of the participating organisations
- Provide a copy of the overview report, executive summary and action plan to the chair of the CSP

The DHR Panel Chair has overall responsibility for all the above, as well as:

- Appointing communications and family liaison leads, with the support and advice of the panel
- Ensuring IMR authors have not been directly involved with the victim, the perpetrator or either of their families and have not line managed any staff involved in the case
- Ensuring that all IMRs have been fully quality assured by relevant agencies, and have requested any necessary changes
- Present the Overview Report alongside the ORW to the DHR sub-group and CSP
- Work with the ORW to review the Overview Report and agree actions with the CSP and substantive DHR Panel Members.

The Home Office have also created an overview document which outlines the chair person's role and responsibilities, and all review panel chairpersons should review this before undertaking the role.

3.3 DHR subgroup

The DHR subgroup quality assure the recommendations in the final overview report, and the resulting action plan, to ensure that they are SMART. They must sign the Quality Assurance Checklist, which will have been sent on to them by the DHR Panel Chair, once they are satisfied this is the case.

3.4 Strategic Partnerships Team

The Strategic Partnerships Team for Domestic Abuse is located within Hertfordshire County Council's Adult Care Services department. They are responsible for the general management of Hertfordshire's DHR process on behalf of the Hertfordshire Domestic Abuse Partnership. Their role involves:

- Making relevant toolkits available to: DHR Panel Chairs, ORWs and agencies producing IMRs.
- Managing requests for, and the submissions of, chronologies and IMRs.
- Providing administrative and business support to DHR panel chairs (via the team's Business Support Officer)
- Sharing relevant guidance to all those involved in the DHR process
- Managing inward and outward communication between the Home Office, local Safeguarding Boards and Coroner's Office (via the Partnerships Manager). This includes submission of the Overview Report to the Home Office for quality assurance.

4. The Overview Report

The multi-agency statutory guidance for the conduct of DHRs states that the chair of the review panel is responsible for producing the final Overview Report. In Hertfordshire, a separate Overview Report Writer (ORW) is usually appointed, with the panel chair retaining final responsibility for the report and its overall quality. However, there can be occasions where the DHR Panel Chair and ORW are the same person.

The overview report must:

- Be completed within **six months** from the date of decision to proceed with the DHR (unless otherwise agreed by the DHR panel and CSP)
- Bring together and draw conclusions from the information and analysis contained in IMRs.
- Be shared with any participating family members, friends or other support networks (if this is appropriate and agreed by the Chair), especially where they have contributed to the review.

- Make SMART recommendations for future action (see materials in ORW Toolkit)
- Be produced according to the outline format and template (see ORW Toolkit)
- Be marked as “official” until the agreed date of publication
- Fully anonymise all personal data and be redacted where necessary
- Be published by the CSP following approval from the Home Office Quality Assurance Panel.

The ORW must:

- Have been present at all review panel meetings from the outset, if possible.
- Have read all relevant quality guidance, as provided in the ORW’s Toolkit, and ensure that their report is of high quality with SMART recommendations.
- Investigate any inconsistencies in IMRs, seeking clarification and extra documentation from IMR authors where necessary.
- Have a clear understanding of: the Terms of Reference of the Domestic Homicide Review, membership of the review panel, the role of the ORW and lines of communication with the Chair and senior managers commissioning IMRs