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Main differences in new DHR Statutory guidance published December 2016

Section 1 Introduction

The main changes within this document highlight the importance of taking a holistic approach when considering the facts presented during scrutiny of practice by agencies and professionals.

Section 2 Status and purpose of this guidance

The list of agencies expected to participate now includes the NHS Commissioning Board (NHS England) and Clinical Commissioning Groups.

The purpose of a Domestic Homicide Review

Two purposes added:

- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

Main new points summarised:

- Illuminate the past to make the future safer, that is, be professionally curious, find the trail of abuse and don't just examine the conduct of professionals and agencies.
- The report narrative should articulate the life through the eyes of the victim (and their children) and talking to those around the victim including family, friends, neighbours, community members and professionals.
- Situate the review in the home, family and community of the victim.
- Also understand the context and environment in which professionals made decisions and took (or did not take) actions, for example, culture, training, supervision and leadership.
- Go beyond focusing on the individual and whether procedure was followed to evaluate whether the procedure / policy was sound.

Definitions

One paragraph added (review suicides)

Following suicide and where the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.

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Section 3 Establishing a Domestic Homicide Review

Community Safety Partnerships

Main new points summarised:

- Safeguarding Adults Reviews are mentioned as an example of parallel reviews.
- Purpose of jointly commissioning reviews is not just to avoid duplication but to provide an improved experience for families.
- The CSP should advise the Home Office of its rationale if it does not inform the family of its decision regarding commissioning a DHR and does not send the family relevant correspondence from the Quality Assurance panel.

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Circumstances of a particular concern

Main new points summarised. Two circumstances extended (italics below):

- Stresses the need for a DHR even if there has been no contact with agencies.
- The victim was being managed by, or should have been referred to, a Multi-Agency Risk
- Assessment Conference (MARAC) *or other multi-agency fora.*
  Services were not available locally to refer/support the victim *and/or the perpetrator.*

Section 4 Conducting a Domestic Homicide Review

Establishing a Review Panel

Main new points summarised:

- The panel must also include specialist or local domestic violence and abuse service representation." Previous guidance said that 'consideration must also be given to including…'
- In essence, the review panel composition needs to be sufficiently configured to bring relevant expertise in relation to the particular circumstances of the case.
- Name the panel members in the report and state their role and the agency they represent.
- The panel should meet an appropriate number of times to ensure there is robust oversight and rigorous challenge. Meeting twice is ineffective.
- Disputes between panel members need to be resolved by the review panel and chair or the 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.
- It is important that any agency or employer that is approached to provide an IMR does so in order to provide the review panel with a comprehensive chronology.
- Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting……….

Appointing a Chair of the Review Panel

Main new points summarised:

- When appointing the chair, provision may be made for the chair to be made aware of the response from the Quality Assurance Panel and potentially to be involved in making any changes required as a result of this quality assurance.
- The chair should not be a member of the CSP.
- The report should clearly demonstrate the chair's independence from the CSP that commissioned the review and 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. If the chair previously came from the CSP or one of the agencies associated with the review, make clear in the independence statement how much time has elapsed since the person left that agency.
- There should be a clear and robust commissioning framework around recruiting a review panel chair that takes into account the skills and expertise required…..
- Enhanced knowledge of domestic violence and abuse issues (previous guidance said 'relevant knowledge').
- Analytical is added to the list of skills sought in Chairs.
- An understanding of wider statutory review frameworks such as child or adult reviews;

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Determining the Scope of the Review

Main new points summarised:

- Consider the impact of a perpetrator's as well as a victim's immigration status on agency responses.
- Check if the victim was subject to any multi agency fora not just the MARAC.
- 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"?
- Did the victim make a disclosure at work? Has the organisation a domestic violence policy?
- 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?

Section 5 Timescales for conducting a Domestic Homicide Review

Main new points summarised (AAFDA comment in italics):

- The chair of the review panel needs to consider if they are becoming aware of information that may be of interest to judicial processes including, for example, an inquest.

This point is to help ensure, for example, that an inquest is also aware of agency failures being revealed in the DHR process.

- Good practice is to invite the SIO to attend the first panel meeting to brief the panel on the investigation and for the SIO to be party to the setting of the terms of reference.
- Some local areas are waiting until the conclusion of criminal proceedings before commencing a review. It is important that a review is opened promptly so that early lessons can be identified and rapid action taken to address them.
- Preliminary work, such as commissioning and analysing IMRs and drafting a first iteration of a chronology, whilst avoiding speaking to potential witnesses can be undertaken before a criminal trial has taken place.
- Any appeals lodged following the conclusion of criminal proceedings should not delay the submission of a DHR to the Home Office for quality assurance.

Section 6 – Involvement of Family, Friends and Other Support Networks

Main new points summarised:

- Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder.
- The chair and review panel can help establish a positive experience for family and friends by offering clear communication about the process from the outset and throughout the review.
- Those conducting the review should consider specialist and expert advocates for the families.
- Children should also be given specialist help and an opportunity to contribute as they may have important information to offer.

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- Give family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review.
- Their contributions, whenever given in the review journey, must be afforded the same status as other contributions.
- Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents.
- Families should be able to provide factual information as well as testimony to the emotional effect of the homicide.
- The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.
- Enabling families to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative.
- It would be helpful if reports could outline where families have declined the use of a pseudonym.
- When meeting with family members, friends and others, the chair should:
  - Meet at the earliest opportunity
  - Offer signposting to specialist and expert advocacy support services to those who do not have a designated advocate.
- The chair cannot be the advocate for the family as they need to be fully independent and may reach conclusions that the family disagrees with;
- Share completed and full versions of the review reports with the family prior to sending them to the Home Office.
- CSPs should ensure that adequate time is given to the family to consider and absorb the report, identify if any information has been incorrectly captured and record any areas of disagreement. In some cases, this may involve drawing up a legal form of undertaking to maintain confidentiality of an unpublished review.
- The CSP should ensure the family are fully sighted on any media statements and be mindful of the need to consider key dates, such as birthdays, anniversaries, etc.
- Invite the family to help create the change after the review.
- The review panel should consider approaching the family of the perpetrator who may also have relevant information to offer.

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Section 7 – Content of the Individual Management Reviews and the Overview Report

Individual Management Reviews

Main new points summarised:

- As regards professional context the guidance provides the following examples: culture, leadership, supervision, training, etc.
- Extends 'how changes…will be brought' about to include 'when'.

The Overview Report

Main new points summarised:

- Where necessary, further studies may be commissioned to supplement the information available from the IMRs to enable better supported conclusions about the lessons to be learnt from the case.
- Extends anonymity of personal details to include avoiding other identifying features e.g. precise dates, within the final overview report and executive summary.
- Previously, the review findings were 'Restricted'. Now, they should be regarded as 'Official' as per the Government Security Classification Scheme until the agreed date of publication.
- Regarding the review panel's obligations:
  - Be satisfied that the reports accurately reflect the review panel's findings.
  - Be satisfied that the reports are of a sufficiently high standard for them to be submitted to the Home Office.

The Action Plan

Main new points summarised:

- Actions should, as far as possible, be tested with the agency before the action is finalised and timeframes should also be agreed at a senior level by each of the participating agencies.
- Completing the action plan and publishing the DHR is only the beginning of the process. To derive value from the DHR process and prevent further abuse and homicide, CSPs should satisfy themselves that there are appropriate governance mechanisms in place for monitoring delivery against DHR action plans.

Community Safety Partnership action on receiving the Overview Report, Executive Summary and Action Plan

Main new points summarised:

- Complete the form on page 41 which is not for publication and will be used by the Home Office only for data collection purposes;
- Ensure the chair, review panel and family members are involved in the publication date to consider key dates, e.g. the anniversary of the homicide or the birthday of the victim;
- Provide a copy of the overview report and supporting documents, including the letter from the Home Office Quality Assurance Panel, to the family;
- Notify the Home Office using the email address in paragraph 77(d) that the reports have been published and provide links to the reports;

Section 8 – Publication of the Overview Report

No major changes

Section 9 – Disclosure and Criminal Proceedings

General Principles

Main new points summarised:

- It is incumbent on the chair to ensure that there is a robust process in place for the purpose of disclosure to the disclosure officer responsible for the criminal investigation.

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Circumstances where the perpetrator is arrested and charged

Main new points summarised:

Regarding where criminal proceedings have restricted progress of the DHR:

- The overview report could be considered in draft form until after the criminal trial as organisational intra and inter learning needs to take place. However, consideration should be given before releasing an early draft on whether it could be potentially misleading if there is more evidence/information to come.
- The previous guidance discussed the CSP or SIO deciding if sensitive material would be disclosed to the defence. The new guidance defines sensitive material in this context as "any material the disclosure of which he or she believes would give rise to a real risk of serious prejudice to an important public interest and the reason for that belief." (Para 96, Ch 8, CPS Guidance).

Circumstances where the Perpetrator is deceased

Main new points summarised:

Regarding when there is also an Inquest

- DHR reports should be shared with the Coroner **once** they have been reviewed by the Quality Assurance Panel.

Section 10 – Data Protection

Data Protection Act 1998 considerations

This is a new section the main points of which are:

- Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
  - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
  - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.

  The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest.
- The Department of Health recognises that DHRs have a strong parallel with child Serious Case Reviews. Guidance advises doctors that they should participate fully in these reviews. It goes on to say "When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent." The Department of Health believes it is reasonable that this should be the principle that doctors should follow in cooperating with DHR's. This action was further supported by recommendations in the Department of Health document 'Striking the Balance' (2012) available here:

https://www.gov.uk/government/publications/striking-the-balance-practical-guidance-on-the-application-of-caldicott-guardian-principles-to-domestic-violence-and-maracs-multi-agency-risk-assessment-conferences

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Section 11 – Quality Assurance and dissemination of lessons learned

Quality Assurance

Main new points summarised:

- A fourth key issue for the Quality Assurance Panel is added, that the report demonstrates sufficient probing and analysis and the narrative is balanced;
- The letter from the quality assurance panel, following its assessment of the report will be shared with the Police and Crime Commissioner.
- Areas are encouraged to communicate the Panel's feedback to authors and chairs of DHRs to help inform future DHRs which they may be commissioned to undertake.
- If a DHR report requires a significant number of changes, the CSP should agree the adjustments with the original chair/author who will be named on the report having written the original version.

APPENDIX ONE - OUTLINE FORMAT FOR INDIVIDUAL MANAGEMENT REVIEWS

AGENCY INVOLVEMENT WITH THE VICTIM, THE PERPETRATOR AND THEIR FAMILIES

ANALYSIS OF INVOLVEMENT

Main new points summarised:

- The guidance no longer includes a requirement to make a statement about predictability and preventability.

Consider if:

- There were an injunctions or protection orders that were, or previously had been, in place
- Any staff made use of available training
- If any restructuring during the period under review had an impact on the quality of the service delivered?

APPENDIX TWO - INDIVIDUAL MANAGEMENT REVIEW TEMPLATE

INTRODUCTION

Main new points summarised:

- Provide a pen portrait of the victim

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APPENDIX THREE - OVERVIEW REPORT TEMPLATE

The entire template is shown here as there are so many new points because the previous templates were incomplete.

Combines the old Appendix Three (Outline Format for Overview Report) with the old Appendix Four (Domestic Homicide Overview Report Template) and includes new information.

TITLE PAGE OF OVERVIEW REPORT

- Name of the Community Safety Partnership
- Victim's pseudonym and month and year of death
- Author's name
- Date the review report was completed

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Note that paragraph 70 requires that precise dates are not used. This section appears to define identifying the month and year as not precise.

LIST OF CONTENTS PAGE

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.

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

CONFIDENTIALITY
The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. Include pseudonym/s 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 perpetrator at the time of the fatal incident, and their ethnicity.

TERMS OF REFERENCE

METHODOLOGY
Record details of the decision to undertake a DHR and who was involved in that decision. Describe the methodology used, what documents were used, whether interviews undertaken.

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY
Include when people were contacted and by whom; the nature of their involvement and whether

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they have been provided with the relevant 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 of the review
- The family met the review panel
- The family have been updated regularly
- Reviewed the draft report in private with plenty of time to do so, and have the opportunity to comment and make amendments if required.
- All those contributing were able to do so using the medium they prefer

CONTRIBUTORS TO THE REVIEW
List the agencies and other contributors to the review and the nature of their contribution i.e. IMR, report, or information.
Confirm the independence of IMR authors and how they are independent.

THE REVIEW PANEL MEMBERS
List the names of DHR panel members, their role and job title and the agency they represent (Section 4 paragraph 29).
Include number of times the Panel met, and confirm independence of Panel members.

AUTHOR OF THE OVERVIEW REPORT
Explain the independence of the chair (and author if separate roles) and give details of their career history and relevant experience (Section 4 paragraph 36). Confirm that the chair/author have had no connection with the Community Safety Partnership. If they have worked for any agency in the area previously state how long ago that employment ended.

PARALLEL REVIEWS
State if an inquest or any other reviews or inquiries have been conducted and whether they have been used to inform this review.

EQUALITY AND DIVERSITY
Address the nine 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.

DISSEMINATION
List of recipients who will receive copies of the review report.

BACKGROUND INFORMATION (THE FACTS)

- Where the victim lived and where the homicide took place. A synopsis of the homicide (what actually happened and how the victim was killed).
- Details of the Post Mortem and inquest and/or Coroner's inquiry if already held. State the cause of death.
- 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, the children's genders should not be given).
- 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.

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- Who has been charged with the homicide, the date and outcome of the trial, and sentence given.
- 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.

CHRONOLOGY

Explain the background history of the victim and the perpetrator prior to the timescales under review stated in the terms of reference to give context to their story.

Provide a 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).

OVERVIEW

An overview that summarises what information was known to the agencies and professionals involved about the victim, the perpetrator and their families.

Any other relevant facts or information about the victim and perpetrator.

ANALYSIS

This part of the overview 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. The analysis 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.

CONCLUSIONS

Bring together an overview of main issues identified and conclusions drawn from them which will translate into the detailing of lessons learnt in the next section.

LESSONS TO BE LEARNT

This part of the report should summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action.

State any early learning identified during the review process and whether this has already been acted upon.

RECOMMENDATIONS

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.

Recommendations should be focused and specific, and capable of being implemented.

APPENDIX FOUR - EXECUTIVE SUMMARY TEMPLATE

The entire template is shown here as there are so many new points because the previous templates were incomplete.

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TITLE PAGE OF EXECUTIVE SUMMARY

- Name of the Community Safety Partnership
- Victim's pseudonym and month and year of death
- Author's name
- Date report completed

LIST OF CONTENTS PAGE

THE REVIEW PROCESS

This summary outlines the process undertaken by (local Community Safety Partnership area) domestic homicide review panel in reviewing the homicide of (victim's pseudonym) who was a resident in their area.

The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

(add victim and perpetrator's pseudonyms, age at time of the fatal incident, ethnicity and add pseudonyms of any other relevant parties and their relationship to the victim and/or perpetrator)

Criminal proceedings were completed on (date) and the perpetrator was (give verdict, sentence and tariff where relevant). If DHR is as a result of a suicide give coroner's verdict.

The process began with an initial meeting of the Community Safety Partnership on (date) when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with (victim/perpetrator) prior to the point of death were contacted and asked to confirm whether they had involvement with them.

(Number) of the (total number) agencies contacted confirmed contact with the victim and/or perpetrator and children involved (if relevant) and were asked to secure their files.

CONTRIBUTORS TO THE REVIEW

List the agencies and other contributors to the review and the nature of their contribution i.e.
IMR, report, or information.
Confirm the independence of IMR authors and how they are independent.

THE REVIEW PANEL MEMBERS

List the names of DHR panel members, their role/job title and the agency they represent (Section 4 paragraph 29).
Include number of times the Panel met, and confirm independence of Panel members.

AUTHOR OF THE OVERVIEW REPORT

Explain the independence of the chair (and author if separate roles) and give details of their career history and relevant experience (Section 4 paragraph 36). Confirm that the chair/author have had no connection with the Community Safety Partnership. If they have worked for any agency in the area previously state how long ago that employment ended.

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TERMS OF REFERENCE FOR THE REVIEW

SUMMARY CHRONOLOGY
A summary of the key facts from the background and combined chronology of agency interaction with the victim and perpetrator and their family; what was done or agreed. The summary should provide sufficient facts to give context for the key issues arising from the review. Background information which also gives context to the victim's and perpetrator's story.

KEY ISSUES ARISING FROM THE REVIEW
(Add issues as required)

CONCLUSIONS

LESSONS TO BE LEARNED

RECOMMENDATIONS FROM THE REVIEW
(Add recommendations as required)

NEW FORM TO BE COMPLETED
Page 41

There is a new form to be completed on page 41 of the guidance. It will facilitate the gathering of key data on victims and perpetrators.

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