

Sheffield Safer and Sustainable Communities Partnership

Domestic Homicide Review Guidance

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# About the Sheffield DHR Guidance

This guidance has been prepared on behalf of the Sheffield Safer and Sustainable Communities Partnership (SSCP) in order that all partners can follow a single process when a Domestic Homicide Review (DHR) is required in the city.

All of the compulsory components of DHRs are set out in the Home Office Guidance (revised in 2013) which can be found at:

<https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews>

This guidance sets out the reasons for carrying out a DHR, the criteria cases need to meet in order to qualify as a DHR, and the statutory nature of the process in the initial part of the document. It also contains a brief description of the staged process of holding a DHR.

The appendices contain templates for use by agencies involved in the DHR process to use. In Sheffield, the Drug and Alcohol / Domestic Abuse Coordination Team (DACT) has been delegated responsibility to coordinate DHRs on behalf of the SSCP.

If you have any questions about the content of this guidance, please contact:

Alison Higgins, Domestic Abuse Strategy Manager, Sheffield Drug and Alcohol / Domestic Abuse Co-ordination Team on 0114 205 3671 or [Alison.Higgins@sheffield.gov.uk](mailto:Alison.Higgins@sheffield.gov.uk)

## What is a Domestic Homicide?

In summary, a domestic homicide is when someone has died as a result of domestic violence. This can include murder or manslaughter, causing death by neglect, and can include suicides in some circumstances. Very often a domestic homicide will have been preceded by a history of domestic abuse – physical, psychological, sexual, financial and/or emotional abuse involving partners, ex-partners, other relatives or household members. However this is not always the case.

### Revised definition of Domestic Violence and Abuse

Since the commencement of the statutory DHR process in 2011, the Government has introduced a new cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic abuse and violence is by different agencies. This definition states that domestic abuse and violence is:

*‘Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*

* *Psychological*
* *Physical*
* *Sexual*
* *Financial*
* *Emotional*

*Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

*Coercive behaviour is: an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.’*

The definition also includes ‘honour-based violence’, forced marriage and female genital mutilation.

The above revised definition should be borne in mind when assessing whether a case meets the criteria of a DHR, as well as in the process of assessing agency involvement with the individuals concerned when carrying out the DHR.

### What is the purpose of a Domestic Homicide Review (DHR)?

* 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
* Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.[[1]](#footnote-1)

It is clear from this that the main focus of a DHR is to learn lessons and to act upon identified actions, which suggests that at least as much effort should be made to implement the recommendations as is made in conducting the review process.

DHRs are NOT inquiries into how the victim died – this is a matter purely for the Coroner

and criminal courts, respectively, to determine as appropriate.

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DHRs are NOT designed to assign blame: the person or people directly responsible should be subject to criminal investigation and prosecution, and the DHR is conducted entirely separately from any criminal proceedings. If any individual professional is found to have fallen short of the standards expected of them, this is a matter for disciplinary or competency procedures within their own organisation.

### Timescales

The Home Office guidance provides a timetable for the DHR process in order to ensure all reviews are conducted within a set time period and lessons to be learnt are identified and addressed in a timely manner.

The DACT Officers supporting the DHR process will make sure that all agencies involved in the process are made aware of expected deadlines in the early stages of the DHR. Timescales may however be extended due to unavoidable delays e.g. in relation to the complex scope of the DHR or on-going criminal proceedings.

**Timescales are summarised below:**

|  |  |
| --- | --- |
| **Time from homicide** | **Deadline** |
| ASAP | Police notify Safer and Sustainable Communities Partnership (via the DACT) of a possible Domestic Homicide. |
| ASAP | The DACT issues a notification to all agencies (via a list of agency DHR leads) instructing them to secure their files, and fill out and return the SSCP template for initial information. |
| ASAP – no later than 5 working days after receiving notification | Agencies submit initial information about any contact with the subjects to the DACT in order that a Decision Report is prepared. |
| 10 working days | Decision Report circulated to DHR Consideration Panel.  This summarises the case, considers the eligibility in relation to the DHR criteria and makes a recommendation as to whether a DHR is undertaken or not. |
| Within 3 weeks | All DHR Consideration Panel Members to have received the Decision Report |
| 1 month | DACT lead officer to inform Home Office of intention regarding DHR.  Initial Terms of Reference drafted and circulated to panel members.  First meeting of the Review Panel to have been held.  Initial Terms of Reference agreed.  Independent Chair to have been appointed and notified. |
| 6 weeks | Independent Chair finalises the Terms of Reference.  Dates issued to agencies of schedule for DHR process.  Agencies submit their chronologies. |
| 8 weeks | IMR authors briefing meeting held |
| 3 months | Agencies submit their Individual Management Reviews (IMRs) N.B. these must be signed off by senior managers. |
| 4 months | IMR authors meet to consider the IMRs and other evidence and discuss issues arising from them – DACT provide a date for submission of second drafts. |
| 5 - 6 months | Review panel meets to discuss the first draft of overview report and its recommendations and agree any alterations. |
| 6 – 7 months | Further drafts of the overview report.  Review panel meets to sign off the final version of the overview report and finalise the Action Plan.  Final version signed off by SSCP Board. |
| 7 months | Final version of the overview report sent to Home Office.\* |
| Overview Report, and / or Executive Summary of report published after approval from the Home Office (how much is published depends on the wishes of family members or any other issues of sensitivity). | |
| Quarterly from submission date until completion | Audit progress on action plans. |

\*If the process is delayed for any reason, permission must be obtained for the delay from the Home Office and evidence of this included as an appendix to the overview report.

### Action after notification of a DHR

As soon as a suspected domestic homicide occurs, the South Yorkshire Police force will notify the Safer and Sustainable Communities Partnership (through the Domestic Abuse Strategy Manager based within the DACT Team), in order that the DACT can begin co-ordinating the DHR process.

Ideally, within five working days of the notification of the death the DHR Co-ordinator should be aware of/have ascertained the following:

* Cause of death of the victim
* If an alleged perpetrator has been identified and what charges are being brought against them (if they are living)
  + Dates of any planned court appearances
  + Remand status/location
* Status of the Coroner’s proceedings
* Details of the Senior Investigating Officer, Officer in Charge and Family Liaison Officer
* Information about any other significant family members/friends who may want to access in the course of the DHR.

The DHR Co-ordinator should circulate an urgent notification **letter (template – Appendix 1)** to the full contact list of agencies advising them to secure any records relating to the individuals involved in the suspected homicide, and to ensure any staff involved are aware of the death and can access support as appropriate.

The agencies should be asked to submit initial information about their involvement with the individuals **(template – Appendix 2)**, so that the DHR Co-ordinator can begin compiling a list of agencies that need to partake in the review process should it go ahead**.** All agencies will be sent this template and are required to submit information ONLY on this template to ensure that the information can be stored safely and that information is shared consistently.

A deadline will be set for returning the information, **of five working days** as a standard to allow another 1 week to prepare and circulate the Decision Report to the DHR Consideration Panel (see below), in order to notify the Home Office within one month of the death of the decision to conduct a DHR or not.

**Passwords for notification and all case documents**

All electronic correspondence must be sent either from and to secure email addresses OR sent as a password protected document.

The DHR Co-ordinator should select two appropriately neutral and respectful passwords for the case – one for opening documents, and one for modifying.

When notifying agencies with password protected documents, the recipients of the information should be asked to phone the DHR Co-ordinator for the password – it is not acceptable to send this in a further email due to information governance issues.

The DHR Co-ordinator should inform all of the Review Panel members of the passwords at the first panel meeting, and make them aware that they must phone to ask for reconfirmation if they have forgotten them, and that they will not be sent via e mail.

**Making the Decision**

If the following definition of the death is applicable, then a DHR MUST be conducted[[2]](#footnote-2):

*Domestic homicide review means 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-*

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

‘Intimate personal relationship’ includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

A member of the same household is defined as:

1. a person is to be regarded as a “member” of a particular household, even if s/he does not live in that household, if s/he visits it so often and for such periods of time that it is reasonable to regard him/her as a member of it;
2. where a victim lived in different households at different times, “the same household” refers to the household in which the victim was living at the time of the act that caused his/her death.

If the death can reasonably be judged to fit into the definition above, then there is no decision to be taken per se, rather, a Decision Report should be prepared by the Head of DACT to circulate to the DHR Consideration Panel setting out the circumstances surrounding the death, how it meets the criteria for a DHR, and the intention to conduct a DHR (**template – Appendix 3**). However where circumstances are more complicated and it is not clear that the death meets the criteria or it appears to have been a suicide the Head of DACT will prepare a briefing for the DHR Consideration Panel who will then consider and accept or reject the recommendation. NB in such circumstances the recommendation could be to conduct a Serious Incident Review[[3]](#footnote-3) instead.

The 2013 revised DHR guidance indicates that the level of DHR conducted is ‘proportionate’ to the case itself. This can be set out in the Terms of Reference at the inaugural Review Panel Meeting and will depend on the number of agencies that have been involved with the victim/perpetrator/other significant family.

### Membership of the DHR Consideration Panel

There is a standing membership for DHR Consideration Panels. See below. (For a table of current Consideration panel members, see **Appendix 4**)

|  |  |
| --- | --- |
| **Organisation** | Post |
| South Yorkshire Police | District Commander |
| Sheffield City Council (Local Authority) | Executive Director, Communities |
| Executive Director, Children and Families |
| National Probation Service | Head of Sheffield Probation |
| Clinical Commissioning Group | Chief Nurse |

### Terms of reference for the DHR Consideration Panel

The aim of the Consideration panel is to:

* Receive Decision Reports where the death meets the criteria for a DHR
* Receive briefings where a death or near miss may warrant a Serious Incident Review
* Consider all information that is currently known about the people involved in the death / near miss
* Consider any special circumstances
* Agree / disagree that the case presented reasonably meets the criteria for a Serious Incident Review being conducted.

The business of the group may be conducted by conference call or secure e mail to achieve the outcome within timescales.

### Victims aged between 16 and 18

It should be noted that, when victims of domestic homicide are aged between 16-18, there are separate requirements in statutory guidance for both a child Serious Case Review and a DHR. The SCR and DHR can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case – for example, considering whether some aspects of the reviews can be commissioned jointly so as to reduce the duplication of work for the organisations involved. In Sheffield it has been agreed that if a DHR is conducted whether or not a child Serious Case Review is also being conducted, this would be led by Children Safeguarding service.

Consideration should also be given to whether either the victim or the perpetrator was a ‘vulnerable adult’ – 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”. A vulnerable adult could also been involved as a witness or through loss of their carer.

The statutory guidance does not dictate when an adult SCR should take precedence over a DHR however it has been agreed locally that if the victim was a vulnerable adult then the DHR should be led by the Adult Safeguarding service. In either case, the Review Panel will need to include specialist representatives to ensure the domestic abuse issues are adequately covered e.g. representation from the DACT.

### Circumstances of particular concern

The following factors are just some examples of the types of situations preceding homicide which will be of interest to review teams when conducting a DHR[[4]](#footnote-4):

* There was evidence of a risk of serious harm to the victim that was not recognised or identified by the 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 their recognised best professional practice.
* Any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously or not acted on appropriately by other parties involved.
* 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.
* The victim was being managed by, or should have been referred to, a Multi-Agency Risk Assessment Conference (MARAC).
* The homicide appears to have implications/reputational issues for a range of agencies and professionals.
* The homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed.
* 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.
* The victim had no known contact with any agencies. For example, could more be done in the local area to raise awareness of services available to victims of domestic violence?

### Death by Suicide

Where a death has been by suicide within the context of a relationship where domestic abuse has been a feature, it is likely to be a more complex decision as to whether to conduct a DHR. South Yorkshire Police have a process in place whereby they are informed by the Coroner of all suicides in order that they can check if the suicide appears to be domestic abuse related. If indications have been given by the deceased prior, to their death, that the experience of domestic abuse has directly contributed to suicidal thoughts, this would indicate that a DHR should be carried out. This would be confirmed further if a suicide note has been left attributing the reason for the suicide to domestic abuse.

If this is not clear, then as much information should be sought by the DHR Co-ordinator as possible to include in the Briefing Report about the context of the relationship/s of the deceased, for the DHR Consideration Panel to comment on whether they feel this is significant enough to warrant a DHR. As per the revised guidance, the DHR can be proportionate with regard to the incident being reviewed.

### Circumstances where the perpetrator is arrested and charged

One of the following two outcomes may occur:

1. That the DHR be pended until the outcome of any criminal proceedings.
2. That the scope of the DHR is temporarily restricted until after the outcome of any criminal proceedings, such as consideration being given to not interviewing people who may be witnesses or defendants in criminal proceedings until the criminal justice needs have been satisfied. Where a restriction in scope is being considered, this should be for a defined need and/or applicable to named individuals.

The latter option is generally the preferred option for Sheffield DHRs. No individuals acting as witnesses or defendants would be interviewed as part of the DHR process until the criminal trial had finished, without agreement from South Yorkshire Police and the Crown Prosecution Service. Ordinarily, this occurs around mid-way through the DHR process allowing for involvement of those individuals and enable their views to be incorporated into the final before the deadline for Overview Report.

2013 revised National DHR Guidance is clear that all DHR processes should be aligned with police investigations, therefore it is recommended as local best practice that the Senior Investigating Officer for the case is invited to Review Panel meetings and helps to set the Terms of Reference, and that if this is not possible that they receive regular updates from the DHR Co-ordinator.

## Contra-indications for a Domestic Homicide Review

It may not be necessary to conduct a DHR if the following applies:

* The facts of the case do not fit the definition of a domestic homicide, as set out above.
* The victim and perpetrator were not ordinarily resident in Sheffield, and did not have contact with any agencies here – in other words, the homicide happened when they were visiting the area or had very recently moved here.
* One agency only had contact with the victim and/or perpetrator, and there is no indication that any other agency should have been involved. In this case there may not be a need for a partnership review.

Even under the circumstances outlined above, agencies that have had contact with the victim and/or perpetrator may wish to carry out an Individual Management Review to identify any issues for internal action.

### Circumstances where the perpetrator is deceased

In cases where the perpetrator is deceased (for example in cases of murder-suicide), the case will be referred to the Coroner and a file will be prepared. In these circumstances, it is appropriate for a DHR to be conducted without delay and the Overview Report and supporting documents should be submitted to the Coroner to help inform the Inquest.

### Final decision

The statutory guidance is clear that a DHR must be carried out where a death meets the criteria. If a decision is made not to carry out a DHR in any circumstances, and the Secretary of State disagrees, he/she can direct that a DHR is conducted.

### Notification process

When the decision has been made, the DHR Coordinator will take the following actions:

When it has agreed that a DHR **will be** undertaken:

* Notify the DHR team at the Home Office ([DHRENQUIRIES@homeoffice.gsi.gov.uk](mailto:DHRENQUIRIES@homeoffice.gsi.gov.uk))
* Notify all agencies, asking them to take the next step of nominating a Review Panel member and an Individual Management Review author
* Notify the coroner
* Notify the Council Communications Team
* Notify the lead Police Officer for any investigation and the Family Liaison Officer,
* Inform family and significant friends or colleagues of the DHR process, ask for consent to view their records as appropriate, and inform them that they will be invited to participate at a later stage (usually via the Family Liaison Officer)
* Co-ordinate the first meeting of the Review Panel to happen as soon as practicably possible – see below.
* Inform the Council Legal Department

When there **will not be** a DHR:

* Notify the DHR team at the Home Office ([DHRENQUIRIES@homeoffice.gsi.gov.uk](mailto:DHRENQUIRIES@homeoffice.gsi.gov.uk))
* Notify all agencies
* Notify the lead Police Officer for any investigation and the Family Liaison Officer
* Ensure that family, friends, colleagues etc. are aware of the decision or of any alternative processes to be conducted.

# The Review Panel

The Review Panel in Sheffield should be made up of a nominated representative of each agency involved in the DHR in question – this will have been ascertained when the agencies submitted initial information as to their involvement. This Review Panel member will not always be the Individual Management Review Author (each agency must nominate its own IMR author) but rather, be a senior representative of the agency who will attend all Review Panel meetings throughout the process. The Review Panel **must** include individuals from the statutory agencies listed under section 9 of the Domestic Violence, Crime and Victims Act 2004.[[5]](#footnote-5)

### Role of Review Panel Chair and Author

The statutory guidance states that:

* *The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on evidence the Review Panel decides is relevant. As local circumstances determine, the Chair may also be the author of the Overview Report.[[6]](#footnote-6)*

In Sheffield it is established practice that the Chair of the Review Panel will also author the Overview Report.

The Chair of the first meeting of the Review Panel will be the Director of DACT, as at this juncture an Independent Chair will not have been appointed. After the initial meeting and an appointment of the Chair /Author, this individual will go on to chair all meetings of the Review Panel and IMR author meetings and will also be the author of the Overview.

The Review Panel Chair and Overview Report author should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review. The role of the Review Panel Chair is to manage and co-ordinate the process of the DHR and write the overview report.

National guidance indicates that local partnerships may consider reciprocal chairing arrangements with other areas, however, at the time of this local guidance being updated the local preference is the appointment of an independent chair / author, usually an individual working as a private consultant, and not to chair DHR’s reciprocally with other areas conducting DHRs as backfilling posts would prove too onerous..

Due consideration should be given to the skills and expertise required to effectively chair a review, the following is provided as national guidance in making this selection:[[7]](#footnote-7)

* Relevant knowledge of domestic violence and abuse issues including ‘honour’ based violence, 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.
* Managerial experience.
* Strategic vision so that opportunities are identified to link in to and inform strategies such as the Government’s ‘Call to End Violence Against Women and Girls’.
* Good investigative, interviewing and communication skills.
* An understanding of the discipline regimes within participating agencies.
* The completion of the E-Learning Training Package on DHRs including the modules on chairing reviews and producing Overview Reports

(<http://www.homeoffice.gov.uk/publications/crime/domestic-homicide-review/>)

* Completion of Home Office DHR Chair’s training programmes (Sheffield considers that completion of this training is preferable however it has not been open to individuals working as private consultants thus far).

### Appointing an independent Review Panel chair / overview report writer in Sheffield

The preferred local process for DHRs in Sheffield is to contract an independent chair on a case by case basis. This provides truly disinterested independence and the opportunity to select the most appropriate candidate with the most appropriate skills and expertise for each review.

A ‘bank’ of CVs has been built up for individuals who may be able to act as DHR chairs. Candidates have been sought for this bank during each DHR in Sheffield and the Domestic Abuse Strategy Manager adds individuals to this as they express interest. When a DHR is needed, all of the individuals in the bank are to be contacted and sent an Expression of Interest form **(template – Appendix 5)**, asked if they are available for the period in question.

Out of those in the bank who submit an expression of interest, a minimum of 3 will be shortlisted by the DACT team based on experience, availability, references and cost) and presented to the first meeting of the Review Panel, and a preferred candidate will be chosen by consensus, and recorded in the formal minutes of the meeting. A reserve choice will also be selected at this meeting in case, for any reason the first choice for the role cannot then commit to this process.

The chosen chair must provide proof of appropriate public and professional insurance and a recent CRB/Disclosure and Barring check (in last 3 years). A contract is then signed with the SSCP (**template – Appendix 6).** This allows for an understanding of what work is to be done and how long it should take, and therefore the expected total fee; but also for some flexibility if more work is required.

**Role of the Review Panel**

The aim of the Review Panel is to work with the Chair / Author in order to:

* 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;
* 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;
* Improve intra and inter-agency working and provide a better service to victims of domestic abuse and violence;
* Ensure the review is conducted according to best practice with effective analysis and conclusions drawn on the information related to the case.

The Review Panel should bear in mind all equality and diversity issues at all times; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation and immigration status may all have a bearing on how the review is explained and conducted and the outcomes disseminated to local communities.

The panel member for the Police can advise the panel whether they can interview staff members about the case and notify the group of the trial date for any alleged perpetrator as soon as this is known. This is to allow any contact with family and friends or staff members of agencies who might be acting as witnesses to be interviewed as part of the DHR process without influencing the criminal proceedings in any way, as this is strictly prohibited.

### Role of Review Panel Member

This role is for a senior officer within an agency who will ensure the agencies effective participation in the Domestic Homicide Review process by:

* Representing their agency and ensuring that their agency’s views and opinions are represented;
* Supervising the Individual Management Review (IMR) author;
* Ensuring the IMR is signed off at an appropriate level;
* Implementing the recommendations and actions relevant to their agency.

The panel member needs to have sufficient authority within their agency to approve and take forward the recommendations of the Domestic Homicide Review.

The Review Panel member should not have direct line management responsibility for any staff member/s who worked with people involved in the case, and should not be the Individual Management Review author. This may be problematic for small organisations, such as those in the VCF sector, and in these cases the Chair may advise that a mentor from another agency is appointed to support the organisation and / or ensure that the IMR is produced with adequate independent scrutiny.

Panel members will also be expected to provide their expertise and knowledge of best practice in their field to ensure that the panel is well advised.

**Review Panel membership**

Current standing membership of the Sheffield DHR Review Panel are those occupying the roles below in the identified agencies; **(see Appendix 13 for current standing members)**

| **Organisation** | **Post** |
| --- | --- |
| SY Police | Head of Public Protection |
| Sheffield City Council | Head of Drug and Alcohol / Domestic Abuse Coordination Team (DACT) |
| Head of Safeguarding and Quality, Communities |
| Sheffield Safeguarding Children Board Manager |
| Assistant Director Legal Services |
| National Probation Service | Head of Sheffield Probation |
| Sheffield Clinical Commissioning Group | Chief Nurse |

Additional members, including representatives from the Voluntary Community and Faith Sector, will be co-opted on a case-by-case basis. Any agency that had significant involvement with the victim, perpetrator and/or household should have a representative on the Review Panel.

In addition, there are circumstances where people with specialist knowledge should be invited to sit on the Review Panel; for example, if the victim and/or perpetrator are from a BME background, if it was a same-sex partner relationship, if it is a male victim and female perpetrator, if the case involves complex issues such as immigration law etc.

Where a voluntary or private sector agency is required or invited to contribute to the Domestic Homicide Review, consideration should be given to the support they require in writing the IMR and sitting on the DHR panel to ensure effective contribution and learning and a mentor may be appointed as appropriate.

IMR authors may also be invited to attend one or more of the Review Panel meetings as observers.

# Notifying out of area agencies

Once the DHR Co-ordinator has been informed by agencies that the subjects have lived outside of the city, all efforts should be made to contact the Local Authority in which they lived through the equivalent DHR Leads in that area.

Once that person has been identified, they should be asked to send out notification to their local agencies as per their own DHR processes, including a tight deadline for response so the Sheffield DHR Co-ordinator and Chair can ascertain as early as possible whether an IMR will be needed from out of area agencies. (See **Appendix 28** for out of area letter and information submission template).

Once the information is received back from the out of area agencies, the Independent Chair will make the final decision as to whether this agency needs to submit an IMR as part of the DHR. If this is the case, see IMR section later in the guidance.

If it is decided they do not need to complete an IMR, this agency should be notified formally in writing by the DHR Co-ordinator that they will not be required to submit an IMR.

**Confidentiality**

Domestic Homicide Review cases can be subject to high levels of public interest and complex legal processes in the criminal and civil courts. IMR authors, panel members and any others involved with the review process need to be clear that the information they learn about the case and agency’s involvement is confidential. This means it should not be discussed with anyone apart from key officers within the agency who are responsible for either the current case management or the agencies former involvement with the subjects, or the senior managers in the agency who need to be kept informed in order to ensure the agency’s approval of the Overview Report.

It is vital that documents related to the Domestic Homicide Review are stored in a locked cupboard with restricted access. Electronic documents must be stored securely with restricted access and if necessary password protected. Once a DHR is completed the agency should securely archive all relevant documents but draft copies of overview reports and executive summaries should be shredded. The un-redacted Overview Report should be kept securely and access restricted.

A confidentiality agreement will be signed by all attendees at each meeting of the process (**see appendix 8**). Any breach in confidentiality will be discussed with relevant agencies.

# Case Anonymisations

For the purpose of the Terms of Reference, all chronologies, IMRs, and the final overview report, anonymisations for the subjects of the DHR must be chosen during the first meeting of the Review Panel. Where possible, these should be as simple as they can be in order to reduce confusion during the authoring of all reports.

The victim in a Sheffield DHR process is allocated a letter – for example, Adult X.

The anonymisations in this case would then be, as an example:

**Adult X - Victim**

**Adult XA - Adult X accused (alleged perpetrator)**

**Adult XM - Adult X’s mother**

**Adult XB - Adult X’s brother**

**Child XD - Adult X’s daughter (under 18)**

Where possible, this format should be used and all documents prepared throughout the process should adhere to these chosen name codes and not deviate from them, to avoid confusion.

# Meetings

A series of meeting must take place during the DHR process. The meetings are listed below along with the appendix number which provides a template for the agenda of these meetings.

|  |
| --- |
| 1. **Terms of Reference Meeting**   **(a ToR should be agreed and circulated to all agencies within 1 month of notification to the Home Office of a DHR)** |

The first Review Panel meeting should do the following:

* Establish the draft Terms of Reference (using the **template at Appendix 7**). All issues to be considered are included in this template.
* Establish initial timescales for the Review.
* Carry out selection process for Independent Chair and Overview Report author.
* Establish if any independent experts are required to join the Review Panel or assist the overview author.
* Discuss involvement of family members / friends etc.
* Consider legal proceedings and how this may impact on the interviewing of staff members.
* A template for this meeting is included in the guidance at **Appendix 9**.

After this initial meeting, the DHR co-ordinator will circulate the draft Terms of Reference via secure e mail for any amendments/comments. The Independent Chair / Author will review the Terms of Reference and make further changes as they see fit before a finalised version is emailed to the Home Office DHR team and all IMR authors and Panel Members. At this stage consideration should be given to whether the Clinical Commissioning Group should also prepare an IMR e.g. if there is significant or complex involvement from several health agencies.

At this meeting timescales will have been agreed for the Review and therefore Review Panel members need to ensure that their agency’s chronology and IMR will be completed within agreed timescales. They will also need to read all the circulated IMRs and chronologies prior to the next Review Panel meeting and consider what additional information may be required from their agency and / or what issues or inconsistencies they need to raise regarding other agency information.

|  |
| --- |
| 1. **Individual Management Review authors briefing** |

The merged chronology should be circulated at least a week before the meeting. IMR authors are invited to this meeting in order that the Chair can brief them on:

* The Terms of Reference.
* The process, timescale and requirements for the production of the IMR and the Overview Report
* To brief IMR authors regarding the specific issues pertinent to the case
* To discuss issues of concern that need exploring

A suggested agenda template is provided in this guidance – **Appendix 10**

The meeting will discuss the merged chronology in order to highlight any discrepancies or gaps.

|  |
| --- |
| 1. **Review Panel Meeting/s – to Review and discuss IMRs** |

The completed Individual Management Reviews (IMRs) and an (updated) merged chronology of agency interactions should be circulated at least a week before the meeting. Panel members are responsible for reading all papers before the meeting.

At this meeting, the panel should:

* Review and consider the individual management reports and chronology of the case in light of the terms of reference.
* Consider the inter-agency working evidenced in the case.
* Highlight the key issues emerging from the IMR findings so far, which should be addressed in the Overview Report.
* Identify if any agencies need to provide further information or consider issues / episodes of interaction further.

A suggested agenda template is provided in this guidance – **Appendix 11**

Following this meeting, panel members should ensure that any additional information requested from their agency is provided as soon as possible. They should also ascertain that any immediate actions arising from the IMR are being implemented.

If necessary, this meeting can be repeated one or more times, until the Review Panel is satisfied that enough information has been provided from all sources for a comprehensive overview report to be written. However, it is the responsibility of agencies to respond in a timely manner to all information requests/amendments to their IMRs, in order to avoid duplication of meetings.

|  |
| --- |
| 1. **Overview report review meeting(s)** |

The first draft of the overview report should be circulated at least a week before this meeting. Panel members are responsible for reading all papers before the meeting.

At this meeting, the panel should:

* Review any new information from the earlier panel meeting(s)
* Review the drat Overview Report and provide comment.
* Share and discuss agency recommendations.
* Consider the report author’s recommendations.
* Agree the Action Plan
* Agree the content of the Executive Summary
* A suggested agenda template is included in this guidance – **Appendix 12**

If necessary, this meeting can be repeated one or more times, until the Review Panel is satisfied with the Overview Report and recommendations documents. However, it is the responsibility of both the agencies and the Independent Chair to respond in a timely manner to all information requests/amendments to the Overview Report, in order to avoid duplication and meet the overall timescales.

Once the report is at a final stage, panel members must ensure the senior responsible manager from their agency, is satisfied that the agency’s involvement is accurately represented, the recommendations are achievable and there is commitment to implement them and that they will sign off the report.

## Consent

Consent of the victim of a Domestic Homicide Review is not an issue for the review process due to this individual being deceased.

However, it is necessary to attempt to offer involvement in the process and gain consent for their agency records to be reviewed from both the alleged perpetrator and other family members.

The DHR Co-ordinator should take the following steps when seeking consent from individuals involved in the case:

1. A letter should be prepared for the individual from whom consent is being sought to access their agency records.
2. Included with this should be a bespoke consent form prepared for the circumstances of the particular DHR for that individual to sign and return to the DHR Co-ordinator.
3. In situations where consent is refused, or no answer is given and all reasonable efforts have been made to obtain consent it may be appropriate to proceed without consent – a Public Interest Consideration document should be prepared, checked with Legal Services, and then circulated to the Independent Chair and Review Panel discussion and approval if deemed appropriate.

It is also useful at this stage to ascertain whether significant family members/friends wish to be involved in the DHR, and be interviewed by the Independent Chair, once the criminal proceedings are finished. Where possible, it is helpful to seek assistance from agencies that have a good relationship with these individuals to discuss the issue on the DHR chair’s behalf, or to liaise with the Family Liaison Officer (FLO) involved with the case who will be in close contact with the family during the criminal proceedings. The Police will be able to provide details of the FLO in each case.

Suggested templates for all of the above are included in this guidance in the following appendices;

**Appendix 14** – Template for consent letter to alleged perpetrator

**Appendix 15** – Template for consent letter to significant family member/other

**Appendix 16** – Template for consent form for alleged perpetrator

**Appendix 17** – Template for consent form for significant family member/other

**Appendix 18** – Template for letter inviting individuals to be involved in DHR process and consent form agreeing to this.

**Appendix 19** – Template for Public Interest Consideration Report

## Individual Management Reports

IMR authors should begin to draft their IMRs as soon as the terms of reference have been set and these should be completed within the deadline agreed at the initial Review Panel Meeting. 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
* Identify whether the homicide indicates that changes to practice could and should be made
* Identify how those changes will be brought about
* Identify examples of good practice within agencies
* Identify whether existing good practice is adequate or whether processes need reviewing in light of the case

The exact issues to be addressed in each IMR will be identified by the Terms of Reference provided by the Chair and Review Panel.

### The Chronology

The chronology assembles the records of agency involvement into a simplified format, ordered by date. The information should be brief and should not go into elaborate personal detail. This will guide the process of interviews, the drafting of the IMR, identify key episodes of agency involvement and will be merged with the chronologies of other agencies and will form an appendix of DHR Overview Report. The chronology should be forwarded to the DHR Coordinator as soon as it is complete, without waiting for the IMR report. A template is provided at **Appendix 20**.

### Genograms

A genogram will also be created and circulated to the agencies writing IMRs, for the agencies to include in the introductory section of their IMR.

### Out of area Individual Management Reports

If it has been established that an out of area agency needs to submit an individual management report, the DHR Co-ordinator should inform them of this after discussion with the Independent Chair.

The agency should be asked to nominate an IMR author as well as a senior officer who will sign off the IMR report and sit on the Review Panel going forwards.

The nominated individuals will then be included in all circulated emails on the DHR case and kept informed of progress.

Out of area agencies MUST use the templates provided by Sheffield’s DHR Co-ordinator and not their own area templates. The DHR Co-ordinator should provide these to the nominated individual as soon as they are informed they must complete an IMR – they should also be given a copy of the DHR timescales. Out of area agencies are, wherever possible, expected to attend IMR briefings and Review Panel meetings.

### Involvement of family and friends

A full and effective DHR process seeks the knowledge and views of the family and support networks of both the victim and the perpetrator. These are described as ‘family and friends’ but can include other people in their lives such as colleagues, neighbours, solicitors etc. These individuals are asked to share information that can give a fuller picture to the DHR Chair and Panel. They can offer their opinions of the services offered and received and may be able to offer an insight into the victim’s views.

Involvement in the process may also be of benefit to them – bereaved families and friends often express the need to prevent a similar tragedy occurring to someone else. They can also provide information on the wider lives of the people at the centre of the case, beyond domestic abuse. However it is also important the recognise the stress and upset that these individuals will be experiencing– as such it is important not to put pressure on them and to treat them with sensitivity. It is important to be mindful of possible sensitivity around certain dates / times of year that may cause extra stress e.g. the trial of the alleged perpetrator, the inquest, significant holidays and birthdays / anniversaries. If necessary the process may have to be delayed to enable the participation of family members at times that are suitable for their needs.

Where possible and appropriate, the Terms of Reference should be shared with the immediate family of the victim.

Once a decision has been made to conduct a DHR any significant family members or friends should be written to informing them of this decision, seeking their consent to access their records if they will be subject to the DHR, or simply asking them to participate if they are not. All invited should be asked to complete a consent/participation form so their intent is received formerly in writing (see **Appendices 14-18** for template letters and consent forms).

They should also be sent a copy of the most appropriate national DHR leaflet, which can be downloaded from:

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

Letters should explain the process and how they can contribute. They should be offered a choice as to how they contribute to the DHR. In the case of face-to-face interviews, these will be by two nominated professionals, one being the Independent DHR Chair. These individuals should not be IMR authors or have had direct or line management involvement in the case.

All meetings should be recorded and transcripts of the interview should be added to the DHR file held. The Review Panel will be responsible for deciding how the information is presented in the Overview Report and Executive Summary.

Where family and friends have refused to participate, this will be clearly recorded within the Overview Report. Please note that family and friends should be offered more than one opportunity to participate as their views re. participation may change overtime.

At the end of the process, but before publication, the Independent Chair will offer a meeting to those family members who have contributed. The full report should be provided to allow consideration of other findings and recommendations. Any areas of disagreement should be recorded. They should be informed of the likely publication date and informed of potential consequences of publication, i.e. media attention and renewed interest in the death.

The Review Panel should be mindful that the alleged perpetrator or members of the alleged perpetrator’s family might in some cases pose an on-going risk of violence to the victim’s family or friends or members of their own family. Any concerns of immediate risk that become evident should be communicated to the police. Particular consideration should be given to this issue in reviews where ‘honour’ based violence is suspected. Extra caution will be needed around confidentiality in relation to agency members and interpreters where there are possible links with the family, who may also be perpetrators. Extra caution will also be required when considering the level of participation from family members and should be carefully considered in consultation with a practitioner with expertise in this area, e.g. a specialist in immigration law / specialist BME women’s organisation.

### Involvement of staff members

During the process of the IMRs being written, staff members who have worked with the individuals in the case will need to be involved in the review. As this can cause stress for workers who knew the individuals well, it needs to be managed sensitively and the staff members need to be kept informed at all stages of the review process.

As soon as a DHR has been agreed, the nominated leads from all agencies involved will be notified and this person should then notify all of the staff members who have been involved in the case. The terms of reference of the review should be made clear at the earliest possible opportunity to staff and their line managers. A template letter is included in this guidance (**Appendix 24**) that can be used to inform staff members about the process.

If a member of staff is being asked to provide information or give an interview they should be given at least 2 weeks’ notice. It is important to give notice of this as soon as this is realised, in order to be able to meet the deadline for the IMR. They should be offered the opportunity to be accompanied by their trade union representative or other appropriate person in accordance with the usual policies of the organisation.

Once the Overview Report has been finalised, the Review Panel member from each agency should extract the sections of the report that directly concern individual staff and invite staff to read these extracts in conjunction with the Executive Summary. In order to ensure confidentiality, staff will not be permitted to retain these extracts. A manager should then discuss the implications for them of the review. This may include actions such as additional training but they should also consider if the staff member requires any further emotional support.

Prior to the publication of the Overview Report, a senior manager should also debrief the wider staff group on the findings of the DHR and the actions that the agency will be taking to address the recommendations through the agreed DHR action plan.

A domestic homicide can have an impact on entire teams, workplaces and organisations. Agencies are responsible for making sure staff are provided with and given access to emotional support. Measures being taken should be clearly identified and communicated widely. It is important that staff are made aware that the process is not to apportion blame, but rather to learn lessons in order to improve future practice.

Information should be provided about sources of independent support staff may wish to use in connection with their involvement in the review, e.g. employee assistance schemes, human resources, occupational health, trade unions or professional bodies.

On occasion information may be disclosed in the course of a DHR that indicates the need for disciplinary action against an individual member of staff. This would remain the responsibility of the employing agency, and the staff member should be supported through this process according to established procedures. Staff should be given the chance to share their views on the case, both about the individual’s practice and the multi-agency and/or organisational practice at the time. Professionals should be asked for their views about what could have made a difference for the victim/perpetrator. Staff should be allowed to view the relevant paperwork to aid their recall. Staff should feel that their views have been accurately represented, so it is appropriate to share the record of the interview with the staff member afterwards and to ask them to sign it.

Workers and their line managers should be interviewed separately, but a staff member can bring an appropriate supporter if they wish. Staff can be required to participate in a Review if it can be considered to be a reasonable adjunct to their normal duties and / or there is an “any other reasonable duty” clause in their Terms & Conditions.

If at any point during a staff interview new evidence comes to light that would assist either the prosecution or defence in any criminal case, this should be forwarded to the Senior Police Officer working on the case immediately.

### Agency Non-Engagement

Domestic Homicide Reviews are a statutory process implemented by the Home Office in 2011, agencies are therefore obliged to fully participate in the process. This means that agencies should communicate fully with the DHR Co-ordinator/Independent Chair, attending all relevant meetings and meet deadlines for submissions of chronologies and IMRs.

Lack of engagement in the process can be detrimental to all agencies involved as well as the progress of the case, as the agreed deadlines allow information to be shared and analysed in a timely manner in the panel environment. The following stages should be followed should problems be experienced with a particular agency;

* The Panel Member or IMR author should contact the DHR Co-ordinator or Chair to discuss any concerns they may have or difficulties with meeting deadlines, and agree a mutually agreeable outcome..
* If the Panel Member / IMR author is unable/unwilling to resolve the issue, then the DHR Co-ordinator and/or Independent Chair should contact the nominated senior manager that will sign off the work completed by the IMR author and discuss issues with them. A resolution should then be reached.
* If none of the above is possible it may be necessary to escalate the issue to a more senior agency representative and ask them to intervene on the behalf of the DHR Co-ordinator/Independent Chair. If this is necessary, a letter should be prepared presenting information on the previous unsuccessful attempts at communication. It should be made clear that the DHR is a statutory process and that for it to be most successful the agencies contributing should make best efforts to engage with the process.
* If the issue is not resolved through the above measures, then advice should be sought from more senior team members as to next steps.

## The DHR Overview Report

The overview report is written by the Independent DHR Chair in Sheffield DHR processes. It brings together the findings of agency IMRs, interviews with family/friends, outcomes of criminal investigations and court proceedings, and any other relevant information including reviews of local processes, legislation and national guidance. It also summarises the learning points to be taken from the case and makes recommendations which, once agreed are put into an action plan template (see **Appendix 25 – action plan**). An Executive Summary must also be produced by the author for submission to the Home Office along with the full report.

It is crucial that the report author has access to all relevant documentation and, where necessary, individual professionals, to enable them to effectively undertake their review functions. Updated 2013 guidance on DHRs indicates that the Independent Chair MUST discuss with other criminal justice agencies (Her Majesty’s Coroner, Senior Investigating Officer, Independent Police Complaints Commission) at an early stage, how the review should take account of such proceedings.

The Overview Report should also outline the independence of the chair in the introductory section.

See **Appendix 26** for key points from Domestic Homicide Review Toolkit’s ‘Guide to Writing an Overview Report’ (available in full at [www.gov.uk/government/uploads](http://www.gov.uk/government/uploads)).

### Analyses within the overview report

There are different models that can be used for analysis. DHRs have been in place for two years at the point at which this guidance is being refreshed. Therefore there are currently four fully completed DHR overview reports in existence for Sheffield which any appointed chair can use as a guide as long as they sign a confidentiality agreement when reading those that have not yet been made public. There are also a number of Serious Incident Review reports (see SIR section later in the report).

It may also be useful to look at some learning from Serious Case Reviews such as:

* SCIE: Learning together to safeguard children: a ‘systems’ model for case reviews

<http://www.scie.org.uk/publications/ataglance/ataglance01.asp>

* DCSF: Chapter 3 of *Understanding Serious Case Reviews and their Impact – A Biennial Analysis of Serious Case Reviews 2005-2007*

<https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RR129>

* Devaney et al (2011) ‘Inquiring into Non-Accidental Child Deaths: Reviewing the Review Process’, *British Journal of Social Work*, 41, pp242-260, DOI: 10.1093/bjsw/bcq069

### Formatting the overview report

There are templates for the Overview Report and Executive Summary plan in the appendices of the statutory guidance (available from <http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-homicide-reviews/>). Every area in the templates must be covered, but additional sections can be added on a case-by-case basis if appropriate.

Both the full report and executive summary must be completely anonymised. They should include the name of the Independent Chair and Review Panel members but the identities of the victim, alleged perpetrator, household members and any individual workers involved in the case must not be revealed.

All reports are regarded as Restricted as per the Government Protective Marking Scheme until the agreed date of publication, and should be clearly marked as such.

### Approval process

Once the Overview Report is drafted, there is a staged process to secure approval of the report. The stages are outlined below:

1. **Review Panel approval**

The first stage for securing approval of the report document is a meeting of the Review Panel (see **Appendix 12** for agenda template). This will have followed a process of amendment over more than one meeting depending on the complexity of the case. Throughout this process Review Panel members need to update their relevant Senior Manager re. any changes that impact on their agency.

1. **IMR author and responsible manager approval**

Once the report has been approved at Review Panel level, the Senior Manager for the agency must confirm back to the Chair and the DHR co-ordinator that they are content to sign off the report on behalf of their agency.

1. **Legal services approval**

The agreed Overview Report and the Executive Summary will be sent to Legal Services for consideration by the City Council insurers, to ensure the report will not present any liability issues for any agency referenced in the report or for the SSCP. If any significant changes are required at this stage, a further Review Panel meeting should be established to discuss the issues raised. If only minor changes are recommended (that do not impact on the recommendations of the report), agreement of these changes can be made by the Independent Chair.

1. **Community Safety Partnership approval**

The final approval of the overview report, executive summary and action plan lies with the SSCP (co-Chairs). If the co-Chairs are not satisfied they will feed back to the Review Panel, requesting further amendments and a further panel meeting as necessary.

It will not be possible to finalise the IMRs or the Overview Report until after the coronial/criminal justice proceedings, however, this should not prevent early lessons being shared within agencies and relevant recommendations acted on.

### Debriefing

Once the reports are agreed, but before publication, a debriefing should be arranged for family, friends, colleagues etc. explaining the findings of the DHR and what the next steps will be. The Independent Chair will normally lead this meeting/s.

Senior management in each agency that has carried out an Individual Management Review should feed back to their staff on the findings of the DHR and begin implementing the action plan. This is in addition to debriefing at the end of the IMR, as it will highlight any findings for inter-agency working.

The final draft reports could also be shared with key professionals who have not fed into an IMR e.g. the trial judge in any criminal proceedings, or the Coroner.

## Quality assurance by Home Office

Once they have been approved by the SSCP co-chairs, the DHR Co-ordinator will send the DHR documents to [DHRENQUIRIES@homeoffice.gsi.gov.uk](mailto:DHRENQUIRIES@homeoffice.gsi.gov.uk) for consideration by the Home Office Quality Assurance Group.

If the Quality Assurance Group finds the report to be inadequate, they will give a summary of their concerns to the SSCP co-Chairs, who will request amendments and may need to need to reconvene the Review Panel.

Once the Quality Assurance Group approves the DHR documents, they can be published publicly usually following a process of redaction. The Home Office website will also be updated with implications for national training and practice.

### Publication

The statutory guidance states that:

* In all cases, the Overview Report and Executive Summary should be suitably anonymised and made publicly available.
* All Overview Reports and Executive Summaries should be published unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen. The reasons for not publishing an Overview Report or Executive Summary should be communicated to the Quality Assurance Panel. [[8]](#footnote-8)

Before publication friends, family and other support networks should be debriefed about the findings. Along with any staff personally involved in the case, they should be informed of the proposed publication date and any objections they have should be taken into account. They should be offered extra support around the time of the publication.

Local elected members should be briefed in advance, especially in cases where they have given personal support to the family. This may include the Lord Mayor, Leader of the Council, cabinet members, local councillors and MPs, or the Police and Crime Commissioner.

Once the DHR Co-ordinator has been informed that the report has passed quality assurance and will be published, the wider list of agencies should also be informed of the publication date. The DHR Co-ordinator should ensure that the communications departments of the key organisations are aware and discuss any media arrangements.

In Sheffield the DHR reports will be published on the Sheffield First website.

### Media arrangements

All communication about the DHR needs to contain the clear message that its purpose is not to apportion blame, but to ensure improvements are made where necessary.

The lead communication service, which will be SCC Communications in the case of Sheffield DHRs (as identified in the Terms of Reference) should provide communications advice on the content of the DHR webpage, and, if deemed desirable, draw up a press release to announce the publication.

If there is likely to be considerable media interest, a communications strategy should be drawn up, involving the communications teams for the key agencies involved. In this case, the Chair’s contract will need to include time to prepare in collaboration with communications advisers, and to be available to the media around the time of publication.

### Publication day

The RESTRICTED marking and any draft numbering can now be removed from the documents. On the day of publication, the anonymised Overview Report and Executive Summary will be uploaded onto the Safer and Sustainable Communities Partnership website (<http://www.sheffieldfirst.net/the-partnership/safer-and-sustainable-communities>).

The Co-ordinator can then email a link to this webpage to the Review Panel, IMR authors and full contact list of agencies. In this they should be advised of where to direct any media enquiries.

## Action plans

The Domestic Abuse Strategic Board has the lead responsibility for implementing and monitoring action plans. Action plans are therefore monitored by a multi-agency group every 3 months, and agencies are to be asked to provide updates on the actions for which they are responsible.

The Domestic Abuse Strategic Board can escalate any ‘blocks’ to progress to the SSCP for resolution.

### Reporting back on action plans

The Domestic Abuse Strategic Board reports on progress to the SSCP. The same reports are also provided to the Safeguarding Children Board and Adult Safeguarding Partnership where relevant. These partnerships will include DHR action plans in their reports to Sheffield City Council Scrutiny committees, to increase public and democratic accountability (see **Appendix 26** for governance structure diagram for reporting back actions).

### Auditing action plans

A year after the publication of the DHR report, agencies should conduct an audit of progress against the action plan, ensuring that the recommended improvements have been implemented, that any new or revised processes or policies are working and checking that there have been no unintended consequences. Any issues should be reported to the DACT.

Once all actions in the action plan are assessed as being completed, and have been audited as such, then regular monitoring of that action plan can stop.

# Serious Incident Review Process

Sheffield has a local Serious Incident Review (SIR) process in place which can be implemented in the following circumstance:

* A near miss – a victim of domestic abuse who has been considered by the MARAC process within the last 12 months receives life threatening injuries.
* A charge of attempted murder is brought against the perpetrator of a domestic abuse incident.
* A victim that has been to MARAC within a twelve month period dies and the circumstances, while not meeting the DHR criteria, warrant consideration of agency involvement and response.

The latter circumstance would be particularly relevant in cases which have been deemed not to have met the threshold for full DHR but still pose learning opportunities, and deaths by suicide where there may have not been a direct enough link between the suicide and experience of domestic abuse, but where an individual has committed suicide who has been a victim of on-going domestic abuse and known to services.

See **Appendix 30** for the full Serious Incident Review Process including operational guidance.

The Serious Incident Review will take one of two forms:

* a full Serious Incident Review (similar to a DHR in terms of process but with a more limited scope e.g. re. time period covered) and without an independent chair / author
* a Light Touch Serious Incident Review

The decision as to whether to undertake a full review or a light touch review will be determined at the first SIR meeting on the basis of the following considerations:

1. the level of harm caused as a result of the incident – if it has long lasting consequences e.g. serious impairment or disability
2. the level of impact of the incident for the victim / their family other than in relation to health e.g. lack of confidence in services
3. the level of reputational risk for Sheffield agencies
4. the level of risk of further domestic abuse incidents

## Light Touch Review

If a full review is not necessary, as decided by the first SIR meeting, a meeting will be convened whereby the key issues arising from the case are discussed in order to identify lessons to be learned. The SIR Chair will facilitate the meeting so that lessons to be learned are agreed upon and agencies are tasked with drafting recommendations appropriate to their agencies. An Action Plan would then be developed and arrangements for auditing agreed by the Domestic Abuse Strategic Board.

Where a full SIR is to be undertaken, the process mirrors that of local DHR processes with appropriate amendments in place to reflect the non-statutory nature of the process and to account for the fact that the victim of the incident may be alive. In terms of all of the documents that may be submitted as part of a SIR, they are required to be thorough and to a similar quality of those submitted as part of a DHR, however, the scope may be more limited.

*All paperwork templates for a DHR can be adapted and used for SIR by changing the terms in the templates as necessary (see appendices to this guidance).*

## Consent issues in a SIR

Consent will need to be sought from all living parties that the review may wish to consider e.g. victim, alleged perpetrator, dependent children (via the parent/carer) or other significant adults. The DHR consideration panel will make a decision whether to proceed with a DHR based on whether consent is given or not.

In some cases, for example where consent is not given by either victim or alleged perpetrator, a single agency review may be appropriate and/or a review of the content of MARAC meetings that discussed the individuals in question, and the agreed MARAC action plan, as opposed to a full review – this decision will be made on a case by case basis.

Below are the stages of a SIR process and how they differ from the DHR process – full details of each stage are available in **Appendix 28** – it is essential to note that the SIR is a non-statutory process and therefore is reliant on the co-operation and engagement of agencies that have been involved with the victim committing to learning lessons.

**Stage 1 – Police disclosure**

**Stage 2 – Notification –** will follow the same process as a DHR, only there will be a SIR Co-ordinator nominated rather than a DHR Co-ordinator, and agencies will be informed that a SIR is being considered rather than a DHR.

**Stage 3 – Consideration Panel –** a brief summary of case will be communicated to the standing DHR Consideration Panel with background information about considering a SIR rather than a DHR. The panel should consider if the case fits into the protocol’s criteria for a SIR and also take into account circumstances of particular concern as per the DHR process. If a decision is made NOT to hold a SIR, a summary report of reasons should be written within 7 days and the decision should be communicated to agencies. If a decision to proceed is taken, then it should be communicated to agencies whether the review will be a full review or a ‘light touch’ review dependent on the severity of the incident and the subsequent incidents.

**If a decision to proceed is made – the following stages should be followed**

**Stage 4 – Appointment of a SIR Chair**

Due to the non-statutory nature of a SIR, there would be no requirement to seek to employ an independent chair and a Chair will be identified from within partner agencies. The person identified will be an experienced individual who has undertaken the Home Office Domestic Homicide Review Chair’s training. At time of writing the individual who has completed this training in Sheffield is the Head of the DACT and they will therefore undertake the chairing of the SIR. The role of the SIR Chair is to manage and co-ordinate the process.

If there is any conflict of interest in using the Head of the DACT as chair, then alternative arrangements should be sought such as a senior representative from an alternative agency who had no contact with the victim and who has preferably completed the Home Office Domestic Homicide Review Chair’s training being asked to act as chair. In the case of an SIR – the chair will not be the author of the overview report. The overview report author will be identified within the Domestic Abuse Co-ordination Team.

The Chair of the SIR process should have the following relevant experience:

* Relevant knowledge of Domestic Abuse
* An understanding of the main agencies involved
* An understanding of operational regimes
* Managerial experience
* Have completed the Home Office DHR Chair’s training.

The report author should have the following relevant experience:

* Relevant knowledge of Domestic Abuse
* An understanding of the main agencies involved
* An understanding of operational regimes
* Experience of working on previous DHRs/SIRs and report writing experience.

**Stage 4 – First meeting of the SIR Panel –** terms of reference will be agreed in line with DHR processes to indicate the scope of the review.

During the SIR process, if the criminal proceedings are still underway it is not appropriate for the SIR Co-ordinator to be communicating about the issues arising from the review with the victim and/or alleged perpetrator. This should be made clear to these individuals when consent is sought, with assurances that the SIR Co-ordinator will arrange to meet with them as soon as the criminal proceedings are finished. If another agency is investigating the incident as well, then the SIR Co-ordinator must work with the lead on this investigation to ensure the reviews do not duplicate work. If a review such as a MAPPA review is taking place, this would take precedence over a SIR due to the non-statutory nature of the SIR. The terms of reference should be clear whether the SIR will be;

* A full Serious Incident Review (similar to a DHR in terms of process but with a more limited scope, e.g. re time period covered) and without an independent chair/author.
* A light touch SIR

The following should be considered when making the decision about depth of review;

* The level of harm caused as a result of the incident – if it has long lasting consequences e.g. serious impairment or disability.
* The level of impact of the incident for the victim/family other than in relation to health e.g. lack of confidence in services.
* The level of reputational risk for Sheffield agencies.
* The level of risk of further domestic abuse incidents.

**Stage 5 – Chronologies and IMRs –** IMRs and chronologies should be prepared using the DHR templates available in this guidance. They should be submitted to the SIR Co-ordinator in time for the agreed deadline.

**Stage 6 –Overview Report –** the SIR Co-ordinator will merge the chronologies in order to ascertain the order of events and to inform the writing of the Overview Report in a chronological fashion, agency by agency.

**Stage 7 – Panel meet to discuss Overview Report –** meet with first draft of report to discuss findings, actions and lessons learned. It is good practice for the author to circulate the report at least one week before the meeting to allow agencies to read their sections and note any questions or requested amendments.

**Stage 8 – Further drafts –** further drafts will then be completed and circulated via secure e mail until all members of the review panel are satisfied with the content and recommendations. A senior representative from each agency should email confirmation that they are happy to sign off the report as part of an audit trail.

**Stage 9 – Action plan –** all recommendations are made SMART and put into an action plan.

**Stage 10 – Sign off –** final document to be signed off by Chair of the SIR process.

**Stage 11 – Publication of findings –** A SIR is not a statutory process and therefore the final report will not be published or sent to the Home Office as is the procedure for DHRs. The final report into the incident will be shared among agencies as a guide for future operations and given to selected individuals such as the subjects of the SIR. It should be made clear by a water mark on all final report copies that this is a **restricted** document and should only be available to those who have been provided with copies.

# Appendix 1 – notification letter to agencies



Domestic Abuse Strategy Manager

Sheffield Domestic Abuse Co-ordination Team

Sheffield City Council

c/o Town Hall

Sheffield

S1 2HH

0114 20 53671

Date of letter

Dear Colleague

**URGENT: DOMESTIC HOMICIDE REVIEW**

As you may be aware, unfortunately there was an alleged domestic homicide in the city 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 Community Safety Partnership – in Sheffield this is the Safer and Sustainable Communities 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):

|  |  |
| --- | --- |
| Victim: | Insert names, dates of birth and addresses |
| Suspected perpetrator: | Insert names, dates of birth and addresses |
| Other members of household: | Insert names, dates of birth and addresses |

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 co-ordinator on the details below 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 review and if so, which agencies need to be involved. Please submit this information on the **template provided** along with this letter.

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

1. 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. Insert support options here

A decision will be taken within 4 weeks on whether to go ahead with a full Domestic Homicide Review. We will be in touch again following that decision.

Please send your response to co-ordinator name by secure email to: secure email address or password-protect it and send it to: email address. For any other queries please contact phone number.

Yours sincerely

Signatory



# Appendix 2 – Information Template

**Agency Synopsis for Sheffield Domestic Homicide Review:**

**Please return this to name here by date here, via secure e mail**

|  |  |  |
| --- | --- | --- |
| **Name of deceased** | **Date of Birth** | **Date of Death** |
|  |  |  |
| **Details of Agency Involvement** | | |
| **How long involved with the agency?**  **Identify any issues of particular note/concern, issues with engagement, need for escalation etc. with general dates.** | | |
| **Agency**: | | |
| **Date of Completion:** | | |
| **Completed by:** | | |

|  |  |  |
| --- | --- | --- |
| **Name and address of alleged suspect** | **Date of Birth** | **Relationship to deceased** |
|  |  |  |
| **Details of Agency Involvement** | | |
| **How long involved with the agency?**  **Identify any issues of particular note/concern, issues with engagement, need for escalation etc. with general dates.** | | |
| **Agency**: | | |
| **Date of Completion:** | | |
| **Completed by:** | | |

|  |  |  |
| --- | --- | --- |
| **Name and address of other relevant individuals** | **Date of Birth** | **Relationship to deceased** |
|  |  |  |
| **Details of Agency Involvement** | | |
| **How long involved with the agency?**  **Identify any issues of particular note/concern, issues with engagement, need for escalation etc. with general dates.** | | |
| **Agency**: | | |
| **Date of Completion:** | | |
| **Completed by:** | | |

# Appendix 3 – template for Decision Briefing

**Sheffield Safer and Sustainable Communities Partnership**

**Domestic Homicide Review– Case for Consideration**

Please review the following information that has been prepared to indicate that a death does/does not meet the criteria of a DHR to be undertaken by the Sheffield Safer and Sustainable Communities Partnership. There is a recommendation at the end; please indicate as soon as possible whether you agree or not that the case meets the criteria (the deadline for this is \_\_\_\_\_\_\_\_).

**Family details**

Insert details of victim, alleged perpetrator and relevant members of family / household

**Incident**

Insert summary of details of the incident causing death as known at this time.

**Background and agency involvement**

Insert summary of the individual’s background and the extent of agency involvement as know at this time.

**Criteria for a DHR**

The first factor to consider is whether the death meets the definition of a domestic homicide as set out in the Domestic Violence, Crime and Victims Act 2004:

|  |
| --- |
| The death of a person aged 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by –   1. A person to whom s/he was related or with whom s/he was or had been in an intimate personal relationship; or 2. a member of the same household as him/herself,   ‘Intimate personal relationship’ includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.  A member of the same household is defined as:   1. a person is to be regarded as a “member” of a particular household, even if s/he does not live in that household, if s/he visits it so often and for such periods of time that it is reasonable to regard him/her as a member of it; 2. where a victim lived in different households at different times, “the same household” refers to the household in which the victim was living at the time of the act that caused his/her death. |

Summarise which parts of this definition are met.

**Circumstances of concern**

Delete as appropriate from this list:

* There was evidence of a risk of serious harm to the victim that was not recognised or identified by the 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 their recognised best professional practice.
* Any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved.
* 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.
* The victim was being managed by, or should have been referred to, a Multi-Agency Risk Assessment Conference (MARAC).
* The homicide appears to have implications/reputational issues for a range of agencies and professionals.
* The homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed.
* 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.
* The victim had no known contact with any agencies. For example, could more be done in the local area to raise awareness of services available to victims of domestic violence?

**Contra-indications for a Domestic Homicide Review**

Delete as appropriate from this list:

* The facts of the case do not fit the definition of a domestic homicide, as set out above.
* The victim and perpetrator were not ordinarily resident in Sheffield, and did not have contact with any agencies here – in other words, the homicide happened when they were only visiting.
* A child or vulnerable adult Serious Case Review is to take precedence.
* One agency only had contact with the victim and/or perpetrator, and there is no indication that any other agency should have been involved. In this case there may not be a need for a partnership review.

Even under the circumstances outlined above, agencies that have had contact with the victim and/or perpetrator may wish to carry out an Individual Management Review to identify any points for internal action.

**Recommendation / grid**

In this case, the recommendation is that a DHR should / should not be undertaken, for the following reasons:

* The case clearly meets the criteria for a DHR as set out in this, and Home Office guidance
* Any other reason insert here.

Please indicate as soon as possible whether you support this recommendation.

Author

Date

# Appendix 4 – DHR Consideration Panel Members 2013/14

|  |  |  |
| --- | --- | --- |
| **Organisation** | **Post** |  |
| South Yorkshire Police | District Commander | David Hartley  [David.Hartley@southyorks.pnn.police.uk](mailto:David.Hartley@southyorks.pnn.police.uk) |
| Sheffield City Council (Local Authority) | Executive Director, Communities | Larraine Manley  [Larraine.Manley@sheffield.gov.uk](mailto:Larraine.Manley@sheffield.gov.uk) |
| Executive Director, Children and Families | Jayne Ludlam  [Jayne.ludlam@sheffield.gov.uk](mailto:Jayne.ludlam@sheffield.gov.uk) |
| National Probation Service | Head of Sheffield Probation | Dave Pidwell  [dave.pidwell@south-yorkshire.probation.gsi.gov.uk](mailto:dave.pidwell@south-yorkshire.probation.gsi.gov.uk) |
| Sheffield Clinical Commissioning Group | Chief Nurse | Kevin Clifford  [kevinclifford@nhs.net](mailto:kevinclifford@nhs.net) |

# Appendix 5: template for Expression of Interest re. Independent Chair / Author role



**Domestic Homicide Reviews Independent Chair and Overview Report Writer**

**Expressions of Interest**

Domestic Homicide Reviews are a statutory process established by the Home Office under section 9 of the Domestic Violence Crime and Victims Act 2004 which was implemented on 13th April 2011. In order to comply with Home Office guidance (revised 2013) Sheffield Domestic Abuse Co-ordination Team (DACT) is seeking a suitably qualified and experienced individual to undertake the role of Independent Chair and Overview Report author on behalf of Sheffield Safer and Sustainable Communities Partnership (SSCP).

This is a challenging role in a complex environment and as such, DACT is seeking expressions of interest from individuals with a strong commitment to improving practice across partner organisations.

**Contact**

Alison Higgins – Domestic Abuse Strategy Manager – [Alison.Higgins@sheffield.gov.uk](mailto:Alison.Higgins@sheffield.gov.uk)

Telephone number – 0114 205 3671

Work site address – Sheffield DACT, Ground Floor, New Bank House, 100 Queen Street, Sheffield, S1 2WA.

Postal address – Sheffield DACT, c/o Town Hall, Pinstone Street, Sheffield, S1 2HH

|  |  |
| --- | --- |
| **Key dates** |  |
| Expressions of interest start date |  |
| Expressions of interest end date |  |
| Estimated contract start date |  |
| Estimated contract end date |  |

**Summary**

Sheffield Safer and Sustainable Communities Partnership is currently looking to identify an Independent Chair and overview report author to lead a Domestic Homicide Review.

* **Work to be completed**
* Work with and report to Sheffield DACT and the Safer and Sustainable Communities Partnership including working with the review team based within the DACT.
* Work with the Review Panel to agree a Terms of Reference for the process.
* Liaise and consult with all agencies involved in the process as well as family members and support networks of the victim/perpetrator.
* Offer family, friends and support networks of the subjects of the review the opportunity to contribute towards the DHR process.
* Chair all Review Panel and other meetings relating to the particular DHR process.
* Support, and where appropriate challenge, Individual Management Review (IMR) authors.
* Provide quality assurance (assisted by the DACT team) for IMRs.
* Work with the Review Panel to ensure that the report accurately and comprehensively reflects the issues and themes relating to a particular case.
* Provide analysis of IMRs which will form the main body of the overview report, and ensure lessons to be learnt are identified and SMART recommendations made for improving practice, as well as recognising good practice.
* Meet statutory deadlines as provided in Home Office guidance on DHRs unless delays have been agreed as a result of the any criminal proceedings or other reason agreed by the Review Panel.
* Respond to any Home Office requirements of their scrutiny until the Overview Report is judged by the Home Office to be satisfactory and approved for publication.
* Make recommendations for the redaction of the final report prior to publication.

**Specifications for the Independent Chair and overview report writer**

* Management experience.
* Completion of online modules relating to conducting DHRs (and ideally having attended the Home Office training on chairing a DHR process).
* Proven ability to critically analyse information.
* Ability to extract key findings from a large and often complex set of information.
* Ability to author academic level reports.
* Ability to present findings in an articulate form to ensure report readers can understand the relevance and significance of the conclusions, particularly where remedial actions are required.
* Ability to present the findings of the report to the Review Panel, SSCP and Sheffield DACT.
* Ability to Chair meetings at an appropriate level.
* Experience of leading at least one other DHR OR Serious Case Review, which has been approved by either OFSTED or the Home Office or an appropriate body for Vulnerable Adults case reviews at an acceptable level. Or have experience of leading another type of high level review that demonstrates relevant transferable skills.
* Knowledge of or experience of working in the area of domestic abuse and / or safeguarding children or adults.
* References from two organisations for whom the candidate has worked in these capacities or similar.
* Hold an appropriate level qualification in a relevant field.

**Timescales**

The incident leading to this DHR occurred on (insert date here). The Home Office was notified on (insert date here) of the intention to carry out a DHR.

The Domestic Homicide Review overview report is therefore due to be submitted to the Home Office quality assurance panel on (insert date here) and the candidate must be available for all of the process leading up to this date and for a period of 4 months beyond this date in case of delays in criminal proceedings.

The contract will be deemed to be completed in all cases at the point when the Home Office grades the report as satisfactory and the author must be aware they would be required to implement all report changes/amendments/additions upon feedback from the Home Office.

The budget per Independent Chair, per case, cannot exceed £xxxx and a breakdown of costs is required before the role is allocated to an individual.

**All expressions of interest MUST include:**

* Name, address and contact details of the candidate.
* Information about previous experience and qualifications addressing all of the specification areas listed above, including previous DHRs/Serious Case Review processes chaired.
* Details of availability in general and/or during the review period identified as well as if the candidate will be able to meet the required timescales.
* An estimate of the proposed cost of the work and how the charge is structured.
* Details of two referees who may be approached for evidence of previous experience and satisfactory work (referees will only be approached if the candidate reaches the short list stage for working on a specific review).

All expressions of interest should be e mailed to Alison Higgins (contact details as above).

**Appendix - Financial Procedures Guidance**

* A commissioning template must be completed and sent to Commercial Services for clearance: http://intranet/managers/procurement-projects/policy/buying-consultancy.
* The financial procedures for engaging an individual on are on the Council intranet:http://intranet/managers/finance/financial-procedures/payments-to-individuals/engaging-an-individual.
* Support with drawing up a contract, insurance levels and other issues can be obtained from Sheffield City Council’s Commercial Services team.
* The Chair will need to be set up as a supplier on the Council’s finance system (OEO) if they are not already, this can take up to 2 months so should be done as soon as possible in the process. The chair can then invoice the SSCP to trigger payment.

# Appendix 6: template contract for an Independent Chair / Author

**Contract for Consultancy Service – Domestic Homicide Review Independent Chair / Author**

This Contract is made the day of 20

**Between:** Sheffield Safer and Sustainable Communities Partnership of insert address

(Hereafter referred to as 'the SSCP')

**and:** Insert name of insert address

(Hereafter referred to as 'the Consultant')

(the ‘parties’)

**Recitals**

(A) The Consultant has certain skills, knowledge and experience of use to the SSCP.

(B) The Consultant is an independent contractor willing to provide services to the SSCP on the terms and conditions below (the ‘Contract’).

1. **Nature of the Work**

The Consultant, on behalf of the SSCP, will carry out the work set out in Schedule 1 of this Contract (‘the Work’).

2. **The Consultant**

The Work will be carried out by the Consultant, who may not sub-­ contract the Work to a third party without the prior written agreement of the SSCP, such agreement to be at the absolute discretion of the SSCP.

3. **Timetable**

3.1 This Contract shall commence on date and shall continue until the completion of the Work to the satisfaction of the SSCP unless terminated earlier under clause 5.

3.2 The Consultant shall inform the SSCP if the Work is going to take longer than the time specified within this Contract. The Consultant shall notify the SSCP in writing not later than two weeks prior to the expected end of the Contract should it consider that an extension is necessary. The SSCP shall then determine at its absolute discretion, acting reasonably, whether or not to allow an extension.

Should actions taken by the SSCP result in delay to the Work, the Consultant shall inform the SSCP of the likely delay and provide an estimate of the required extension of the Contract as soon as it becomes aware of a possible delay. The SSCP shall then determine at its absolute discretion, acting reasonably, whether or not to allow an extension of time.

3.4 If so required in writing by the SSCP, the Consultant shall undertake additional work to be paid for by the SSCP in accordance with clause 6.4 and to be treated for all purposes under the Contract as forming part of the Work.

4. **Monitoring and Review**

The Consultant shall have in place evidence demonstrating performance to date together with action being taken to rectify underperformance (‘the evidence’) and shall produce the evidence to the SSCP for each period of insert time period – suggested 75 hours i.e. 10 full days work completed by the Consultant. The evidence shall enable the Consultant and the SSCP to monitor the Work and compile a report forming the basis of a review of the Work involving both the Consultant and the SSCP.

5. **Termination**

5.1 Without limitation the SSCP may by notice in writing immediately terminate this Contract if the Consultant shall:

5.1.1 be in breach of any of the terms of this Contract which, in the case of a breach capable of remedy, shall not have been remedied by the Consultant within 21 days of receipt by the Consultant of a notice from the SSCP specifying the breach and requiring its remedy;

5.1.2 be incompetent, guilty of gross misconduct and/or any serious or persistent negligence in the provision of the Work hereunder;

5.1.3 fail or refuse after 21 day’s written warning to provide the Work reasonably and properly required hereunder.

6. **Fees**

6.1 In consideration of the provision of the Work, the SSCP shall pay the Consultant at the hourly rate detailed in Schedule 2 of this Contract in accordance with the provisions of clause 6.2 below. The amounts payable to the Consultant are exclusive of VAT and all expenses referred to in clause 7 below unless agreed otherwise in writing between the parties but are inclusive of income tax and national insurance (delete if not applicable).

6.2 All payments to the Consultant shall be made against the Consultant’s invoices within 30 days from receipt by the SSCP of such invoice. The invoices shall detail the Consultant's self-assessment tax number and tax office telephone number (if self-employed – delete if not applicable) / VAT registration number of the Consultant (if they have their own company to which we make payment – delete if not applicable) and the work completed and number of hours spent to which the invoice relates. Invoices shall be presented in arrears to the SSCP for not less than 30 hours unless with the prior written agreement of the SSCP / in the following sums at the completion of the following stages in the provision of the Work:

|  |  |
| --- | --- |
| Stage | Sum Payable upon Completion |
| e.g. Draft Report | e.g. 30 hours x hourly rate = £ |
|  |  |

6.3 Subject to clause 6.4, the SSCP shall in no circumstances be obliged to pay to the Consultant any monies other than those provided for in clause 6.1 above and clause 7 below, and VAT thereon where applicable.

6.4 In the event that the Consultant provides additional work under clause 3.4, the SSCP shall pay the Consultant for such additional work at a rate to be agreed in writing between the parties. Such rates shall exclude [and include] the matters referred to in clause 6.1.

6.5 Payment by the SSCP shall be without prejudice to any claims or rights which the SSCP may have against the Consultant and shall not constitute any admission by the SSCP as to the performance by the Consultant of its obligations hereunder. Prior to making any such payments, the SSCP shall be entitled to make deductions or deferments in respect of any disputes or claims whatsoever with or against the Consultant.

7. **Expenses**

The SSCP will pay reasonable properly recorded expenses accrued in the course of carrying out Work agreed in this Contract.

8. **Access to Documents**

8.1 The Consultant agrees to treat as secret and confidential and not at any time for any reason to disclose or permit to be disclosed to any person or otherwise make use of or permit to be made use of any unpublished information relating to the SSCP’s know-how, business plans, or finances or any information relating to the SSCP’s operations where the information is received during the period of this Contract and upon termination of this Contract for whatever reason the Consultant shall deliver up to the SSCP all working papers, computer disk and tapes or other materials and copies provided to or prepared by the Consultant pursuant either to this Contract or to any previous obligation owed to the SSCP.

8.2 Notwithstanding any other provision of this Contract:

8.2.1 in relation to all personal data, which shall have the meaning given to the phrase ‘personal data’ by the Data Protection Act 1998 (hereinafter referred to as DPA and as may be amended from time to time), which is acquired by or communicated to the Consultant in connection with the Work, the Consultant shall at all times comply with the DPA including without limitation as a data controller if necessary and shall ensure that any sub-consultant shall at all times comply with the DPA including without limitation as a data controller if necessary, and also shall maintain a valid and up to date registration or notification under the DPA covering the data processing to be performed in connection with the Work and shall ensure that any sub-consultant shall maintain a valid and up to date registration or notification under the DPA covering the data processing to be performed in connection with the Work;

8.2.2 the Consultant and any sub-consultant shall only undertake processing of personal data reasonably required in connection with the Work and shall not transfer any personal data to any country or territory outside the European Economic Area;

8.2.3 the Consultant shall bring into effect and maintain all technical and organizational measures to prevent unauthorized or unlawful processing of personal data and accidental loss or destruction of, damage to, personal data including but not limited to take reasonable steps to ensure the reliability of sub-consultants having access to the personal data;

8.2.4 the SSCP may, at reasonable intervals, request a written description of the technical and organizational methods employed by the Consultant and the sub-consultant referred to in Clause 8.2.3 and within 30 days of such a request, the Consultant shall supply written particulars of all such measures detailed to a reasonable level such that SSCP can determine whether or not, in connection with the personal data, it is compliant with the DPA;

8.2.5 the Consultant shall ensure that information held on behalf of the SSCP or otherwise in connection with this Contract or the Work provided hereunder is retained for disclosure and shall permit the SSCP to inspect such information from time to time;

8.2.6 the Consultant shall indemnify and keep indemnified the SSCP against all losses, claims, damages, liabilities, costs and expense (including reasonable legal costs) incurred by it in respect of any breach of Clause 8.2 by the Consultant.

8.3 All records and documents in connection with the Work shall be retained indefinitely upon the expiry or earlier termination of this Contract.

9. **Copyright**

The entire copyright in all material written by the Consultant in the course of carrying out this Work will be held by the SSCP who shall have exclusive right to publish any such material throughout the legal term of copyright.

10. **Contacts**

The SSCP contact person will be insert name and details

11. **Principles**

11.1 The Consultant shall conduct herself at all times considerately, respectfully and such as to enhance the image and reputation of the SSCP. In particular the Consultant shall ensure that she does not:

11.1.1 harm or expose to danger any person;

11.1.2 use abusive or insulting language or behaviour towards or in the presence of any such person or discriminate against or harass any such person by reason of or by reference to the colour, race, nationality or ethnic origin, age, sex, creed, disability or sexual orientation;

11.1.3 display any pornographic material;

11.1.4 create avoidable noise or other nuisance or disruption.

11.2 In connection with this Contract the Consultant shall not unlawfully discriminate against any disabled person contrary to Section 19 Disability Discrimination Act 1995.

11.3 The Consultant shall undertake the Work to the standard of reasonable care and skill to be expected of a consultant undertaking work similar to or the same as the Work provided by the Consultant under this Contract.

11.4 The Consultant shall not support any organisation or activity which is likely to bring the SSCP into disrepute.

11.5 Information gained as a result of carrying out the Work will be confidential.

11.6 The Consultant will act upon any legal advice provided to the SSCP in relation to the Work.

11.7 The Consultant shall not agree any further work with a member of the SSCP whilst this Contract is still in effect.

11.8 The Consultant shall not transfer, assign or sub-let the whole or any part of the Contract or the benefit thereof without the prior written approval of the SSCP.

11.9 The Consultant shall not engage in any activity during the period of this Contract and upon termination of this Contract which conflicts with or could potentially conflict with the Work (‘conflict of interests’). The Consultant shall notify the SSCP immediately of a conflict of interests and shall advise the SSCP of the course of action it intends to take to prevent such a conflict arising. The Consultant shall immediately carry out such course of action upon agreement between the parties.

12. **Tax and Insurance**

12.1 The Consultant will account to the appropriate authorities for any income tax and national insurance charges arising out of any payment made to the Consultant under this Contract.

12.2 The Consultant agrees to indemnify the SSCP against any income tax or national insurance due by him/her, which may be levied on the SSCP by the appropriate authorities.

12.3 The Consultant undertakes and agrees to take out adequate insurance cover with an insurance office of repute of not less than £5 million / £10 million public indemnity insurance and £2 million / £10 million professional indemnity insurance (check level with Council insurers) to cover the liability accepted by it under this Contract, including without limitation in relation to defamation and negligence. The Consultant agrees to produce at the SSCP's request a copy of the insurance policy or policies and relevant renewal receipts for inspection by the SSCP.

13. **Equal Opportunities**

The Consultant agrees to abide by the City Council's equal opportunities policy and ensure the Work is carried out within this context.

14. **Health and Safety**

The Consultant shall at all times comply with all legislation relating to health and safety at work together with all relevant codes of practice or other authoritative guidance and observe and apply the provisions of the health and safety documents, systems and controls relating to the Contract and shall ensure that any sub-consultant does so;

15. **Publicity**

The Consultant agrees to partake in agreed publicity activity related to the Work undertaken. The Consultant is entitled to mention the fact that consultancy work with the SSCP has taken place in future publicity material.

16. **Status**

16.1 This Contract does not form the basis of an employment relationship between the SSCP and the Consultant, and the Consultant is responsible for paying their own tax and National Insurance Contributions.

16.2 The Consultant is not an agent of the SSCP and cannot create any obligations for it.

17. **Alteration**

This Contract shall not be amended, modified, varied or supplemented except in writing signed by duly authorised representatives of the parties.

18. **Force Majeure**

Neither party shall be deemed in default of its obligations under this Contract nor shall be liable to the other to the extent that it is unable to perform any of its obligations by reason of any event or circumstance beyond its reasonable control.

19. **Governing law / jurisdiction**

This Contract shall be governed by and construed in accordance with English law and the parties herby submit to the exclusive jurisdiction of the English courts.

20. **Notice**

Any notice to be served under this Contract shall be served upon the recipient at its address set out herein either by hand or by first class post or otherwise by facsimile or e-mail transmission and shall be deemed served 48 hours after posting if sent by post or on delivery if it is delivered by hand and on completion of transmission if sent by facsimile or e-mail.

21. **Illegality**

If any provision or term of this Contract or any part thereof shall become or be declared illegal, invalid or unenforceable for any reason whatsoever (including but without limitation by reason of the provisions of any legislation or other provisions having the force of law or by reason of any decision of any Court or other body or authority having jurisdiction over the parties to this Contract including the EC Commission and the European Court of Justice) such provision or term shall be divisible from this Contract and shall be deemed to be deleted from this Contract. If the words omitted substantially affect or alter this Contract, the parties shall negotiate in good faith to amend and modify the provisions and terms of this Contract as may be necessary or desirable in the circumstances.

22. **Entire Agreement**

This Contract sets out the entire agreement of the parties and supersedes all prior agreements and understandings relating to its subject matter.

23. **Waiver**

No failure or delay on the part of either party hereto to exercise any right or remedy under this Contract shall be construed or operated as a waiver thereof nor shall any single or partial exercise of any right or remedy as the case may be. The rights and remedies provided in this Contract are cumulative and are not exclusive of any rights or remedies provided by law.

24. **Interpretation**

In this Contract the masculine shall include the feminine and vice versa.

25. **Contracts (Rights of Third Parties) Act 1999**

A person who is not a party to this Contract shall have no rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any of its terms.

Signed …………………………………………………………Date………………………….

On behalf of the SSCP

Signed …………………………………………………………Date………………………….

Consultant

## SCHEDULE 1

### The Work

Insert a schedule of work, setting out stages of work and how long each is expected to take e.g.:

|  |  |
| --- | --- |
| **Activity** | **Time allowed** |
| Stage 1: Information gathering |  |
| 1. IMR briefing meeting |  |
| 1. IMR reading time and feedback |  |
| 1. Review Panel meeting(s) – IMR discussion |  |
| 1. Undertake contact with family and friends as appropriate |  |
| Stage 2: Authoring overview report |  |
| 1. Draft overview report |  |
| 1. Review Panel meetings(s) – overview report discussion |  |
| 1. Re-drafting and producing Executive Summary |  |
| 1. Pre-publication briefings e.g. family and friends, SSCP |  |
| 1. Post-publication briefings e.g. media |  |
| Up to a total of |  |

## SCHEDULE 2

### Consultant’s Hourly Rate

Insert consultant’s hourly rate(s)

# Appendix 7: Terms of reference template

Provide a summary of the facts of the case (anonymised) and the extent of agency involvement as known at this time.

|  |  |
| --- | --- |
| 1. | Identifying issues and lessons to be learnt:   * What are the most important issues in this case that may lead to lessons to be learnt? What is the best way of analysing them? * Any obvious failings identified at this stage, whether in individual agencies or gaps in multi-agency/cross-authority working * Similarities with other domestic homicides – in Sheffield? Elsewhere that we know of? Can we draw on learning from those DHRs? * Are there any diversity or equalities issues that require additional consideration? Who can provide expert advice? |
|  | Complete here   * 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. * The review will consider any other information that is found to be relevant. |
| 2. | Time period   * Sufficient personal background before the homicide to get a picture of personalities and circumstances * Relevant family history/background * How far back to review agency involvement – state a start date * Are there further events to be reviewed after the homicide? State an end date * Give reasons for choosing the time period |
|  | Complete here |
| 3. | Review Panel Chair   * Reminder of the role and responsibility of chair * Background experience/knowledge/skills required * References/previous evaluations * Costs * Agreed by all agencies and the Safer and Sustainable Communities Partnership * Any assistance required because of complexity or volume * Any other ‘expert help’ required |
|  | Complete here |
| 4. | Overview report writer (if not the Review Panel Chair)   * Background experience/knowledge/skills required * References/previous evaluations * Costs * Agreed by all agencies and the Safer and Sustainable Communities Partnership * Any assistance required because of complexity or volume * Any other ‘expert help’ required |
|  | Complete here |
| 5. | Agencies required to contribute   * Agencies that had contact with the victim, perpetrator and/or members of their household(s) * Agencies that did not have contact but perhaps should have done * Any special requirements e.g. support, access to records? Will this impact on timescales? * Where the voluntary or private sector is involved consideration to be given to the support they require |
|  | Complete here |
| 6. | Process of review   * Timescales:   1. Dates for submission of chronology and Individual Management Reviews   2. Dates for Review Panel meetings   3. Date for ‘sign off’ by Safer and Sustainable Communities Partnership and report back to Home Office * Who will grant any extensions to deadlines? * How will any conflicts be resolved? |
|  | Complete here |
| 7. | Individual Management Reviews and chronologies   * Use of consistent templates (see guidance part 5) * Anonymisation – what initials or pseudonyms should be used for the people involved in the case? Workers should be referred to by (simplified) job titles, not names. * How widely should workers be interviewed e.g. only those with direct contact, their supervisors, their colleagues? * Will any extra resources be required by organisations e.g. workers interviewed by an independent party? * How will IMR authors access the records of multi-agency processes e.g. MARAC, MAPPA? |
|  | Complete here |
| 8. | Family members, friends, colleagues and employers   * Who should be invited to contribute – why? * Who should not be invited to contribute – why not? * Should the (alleged) perpetrator be interviewed? * Who will conduct the interviews? * Is there sufficient room in the timescale for interviews to take place? |
|  | It is very important to hear the voices of family and friends if this is possible and they are willing to participate.  Complete here |
| 9. | Parallel investigations   * Do we know of any parallel investigations, such as:   1. Coroner’s enquiry   2. Criminal investigation proceedings   3. Family or civil court proceedings   4. Mental health homicide investigation   5. Child or vulnerable adult serious case review   6. Investigations into practice / disciplinary proceedings * Who will act as the link between different investigations? * How can we ensure as little duplication of effort as possible? Especially with regard to avoiding repeated distress to the bereaved and to workers. * How may this impact on overall timescales? |
|  | Complete here |
| 10. | Publicity/media issues   * The balance between the public need to know and the private lives of the victims – striking a balance * Who will take the lead? * Individual/joint statements * Media/publicity planning meetings |
|  | Complete here |
| 11. | Other issues   * Is there a need for legal advice? Who will provide it? * Password for documents * Consistent anonymisation of names * Key contacts * Staff support |
|  | Complete here (don’t write down the password!) |

**Appendix 8: Confidentiality agreement**

**Meeting:**

**Date:**

The purpose of the Domestic Homicide Review Panel is to:

* 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.
* Improve intra- and inter-agency working and provide a better service to victims of domestic violence.
* Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

In order to assure a co-ordinated response that fully addresses all systematic concerns surrounding deaths as a result of domestic abuse, all relevant data should be shared and reviewed by the team, as permitted within the stipulations of the Data Protection Act, including historical information concerning the deceased, her or his family, the perpetrator and the circumstances surrounding the death. Much of this information is protected from public disclosure.

The Sheffield Safer and Sustainable Communities Partnership procedures for Domestic Homicide Reviews stipulate that in no case will any team member disclose any information regarding team discussion outside the meeting other than pursuant to the mandated agency responsibilities of that individual. Public statements about the general purpose of the Domestic Homicide Review process may be made, as long as they are not identified with any specific case.

The undersigned agrees to abide by the terms of this confidentiality policy.

| **Name** |  | **Agency** |  | **Signature** |  | **Date** |
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**Appendix 9: Agenda for initial Review Panel - Terms of Reference meeting**

|  |  |
| --- | --- |
| **Date of Meeting:** |  |
| **Time:** |  |
| **Venue:** |  |

|  |  |  |
| --- | --- | --- |
| **No.** | **Item** | |
| **1** | **Welcome, Introductions and Apologies** | **Chair** |
| **2** | **Confidentiality statement** | **Chair** |
| **3** | **Background to case** (see Consideration Briefing attached) | **Alison Higgins** |
| **4** | **Draft Terms of Reference**  **Identify issues and lessons to be learnt**   * Most important issues that may lead to lessons, best way to analysis them, any unusual issues. * Any obvious failings identified - individual agencies, or in multi-agency working. * Similarities with other domestic homicides – in Sheffield or elsewhere - can we draw on learning * Any diversity or equalities issues that require additional / special consideration.   *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.*   * Consider any other information that is found to be relevant.   **Time period**   * Sufficient personal background before the homicide to get a picture of personalities and circumstances * Relevant family history/background * How far back to review agency involvement – state a start date * Are there further events to be reviewed after the homicide? State an end date/ cut off point * Reasons for choosing the time period   **Appointment of Chair / Author**   * The role and responsibility of chair * Background experience/knowledge/skills required * References/previous evaluations * Costs * To be agreed by all agencies and the Safer and Sustainable Communities Partnership * Any assistance required because of complexity or volume * Any other ‘expert help’ required   **Agencies required to contribute**   * Agencies that had contact with the victim, perpetrator and/or members of their household(s) * Agencies that did not have contact but perhaps should have done * Any special requirements e.g. support, access to records? Will this impact on timescales? * Where the voluntary or private sector is involved consideration to be given to the support they require.   **Processes and timescales**   * Consideration of Criminal Procedures timescales * Dates for submission of chronology and Individual Management Reviews * Dates for Review Panel meetings * Date for ‘sign off’ by Safer and Sustainable Communities Partnership and report back to Home Office   Who will grant any extensions to deadlines?  How will any conflicts be resolved?  **Individual Management Reviews and chronologies**   * Use of consistent templates * Anonymisation – Initials or pseudonyms must be used for the people involved in the case * Workers should be referred to by (simplified) job titles, not names. * How widely should workers be interviewed e.g. only those with direct contact, their supervisors, their colleagues? * Any extra resources be required by organisations.   **Family members, friends, colleagues and employers**   * Who should be invited to contribute and why. * Who should not be invited to contribute and why not. * Should the alleged perpetrator be interviewed. * Who will conduct the interviews.   Make sure there is sufficient room in the timescale for interviews to take place  ***It is very important to hear the voices of family and friends if possible and they are willing to participate****.*  **Parallel investigations**  Criminal investigation proceedings  Family or civil court proceedings  Any investigations of Practice  Link persons between different investigations  *How can we ensure as little duplication of effort as possible, especially with regard to avoiding repeated distress to the bereaved and to workers.*  *If this case raises questions about practice who will take issues forward.*  How may this impact on overall timescales  **Communications and Media**  The balance between the public need to know and the private lives of the victims – striking a balance   * Communications Lead * Any media/publicity planning meetings needed. * Individual/joint statements | Agencies to bring information to inform the TOR discussion |
| **5** | **Information Sharing** |  |
| **6** | **IMR Author Training** |  |
| **7** | **Other issues**   * Provision of legal advice * Password for documents * Consistent anonymisation of names * Key contacts * Staff support |  |
|  | **Date of Next Meeting** To be agreed |  |

Chair’s briefing:

1. Purpose of meeting – to agree how the DHR process will be conducted. Remind that DHRs are about learning lessons and improving practice.
2. Introductions – ask that everyone states their role in the process e.g. review panel member, IMR author, observer, and explain different responsibilities.
3. Confidentiality – draw attention to confidentiality statement. Circulate copy for everyone to sign.
4. Background to case – once confidentiality statement has been signed a key explaining all the anonymised initials can be circulated.
5. Terms of reference – discussion of and gaining agreement for the draft ToR. Remind that the Review Chair, once appointed, may redraft again.
6. Appointment of Review Chair – at least 3 CVs (possibly with covering letters) need to be thoroughly discussed. Clearly sum up reasons for choosing preferred candidate and a reserve candidate to be recorded in the minutes.
7. Additional Review Panel members – consider whether any expert advisory members should be invited to join the panel.
8. Information sharing and consent – check that all necessary information sharing agreements are in place, and that agencies are clear on when and how to gain consent to use client information for an IMR.
9. Timescales for the process – outline expected milestones. These are fairly constrained, and will be finally set by the Review Chair.
10. Parallel investigations – briefly establish position of any parallel investigations e.g.
    1. Coroner’s enquiry
    2. Criminal investigation proceedings
    3. Family or civil court proceedings
    4. Mental health homicide investigation
    5. Child or vulnerable adult serious case review
    6. Investigations into practice / disciplinary proceedings

If there are parallel investigations, discuss whether it is suitable for the Individual Management Review authors to interview staff members involved; and whether it is appropriate to interview family members; and how disclosure of new evidence should be managed.

1. Communications and media – these needs will be concentrated around the publication of the review. Clarify who will be the key contact.
2. Date of next meeting – will be set in collaboration with the Review Chair, likely to be in around 2 months’ time.

# Appendix 10: Agenda for IMR author’s briefing

|  |  |
| --- | --- |
| **Date of Meeting:** |  |
| **Time:** |  |
| **Venue:** |  |

**Agenda**

Purpose of this meeting will be :-

* Presentation of terms of reference.
* To brief the IMR authors by discussion of the process, timescale and requirements for the production of the IMR and the Overview Report
* To brief IMR authors regarding the immigration issues pertinent to the case

|  |  |  |
| --- | --- | --- |
| **Item** | **Agenda Item** | **By Whom** |
|  | Chair for meeting: |  |
|  | Introduction, welcome and confidentiality | Chair |
|  | Apologies for absence | Chair |
|  | Review of Adult D DHR case |  |
|  | Terms of reference | Chair |
|  | Domestic Homicide Reviews process |  |
|  | Guidance for producing an IMR, chronology and action plan | Chair |
|  | Timetable and process of communication |  |
|  | Any Other Business |  |
|  | Date, Time and Venue of Next Meeting (All Panel members) |  |

# Appendix 11: Agenda for IMR review meeting(s)



*(Title of meeting)* **Domestic Homicide Review Adult x - IMR Review Meeting**

|  |  |
| --- | --- |
| **Date of Meeting:** |  |
| **Time:** |  |
| **Venue:** |  |

|  |  |  |
| --- | --- | --- |
| Time |  |  |
|  |  | Chair: Purpose of Meeting and intended outcomes |
|  |  | Introductions |
|  |  | Confidentiality |
|  |  | Merged chronology |
|  |  | Review IMRs:   * + Agency A   + Agency B, etc. |
|  |  | Review any other contributions |
|  |  | Inter-agency working in this case |
|  |  | Key issues emerging so far |
|  |  | IMR action plans |
|  |  | Date of Next Meeting |

# Appendix 12: Agenda for draft Overview Report Review meeting(s)



(*title of meeting)* **Domestic Homicide Review Panel Meeting - Adult x**

|  |  |
| --- | --- |
| **Date of Meeting:** |  |
| **Time:** |  |
| **Venue:** |  |

|  |  |  |
| --- | --- | --- |
| Time |  |  |
|  |  | Chair: Purpose of Meeting and intended outcomes |
|  |  | Introductions |
|  |  | Confidentiality |
|  |  | Overview report |
|  |  | Executive summary |
|  |  | Recommendations   * + - Agency A     - Agency B etc. |
|  |  | Action plan |
|  |  | Debriefing in agencies |
|  |  | Next steps in approval process |
|  |  | Communications and media around publication |
|  |  | Date of Next Meeting |

# Appendix 13 – Standing Review Panel Membership 2013/14

| **Organisation** | **Post** | **Current potholder** |
| --- | --- | --- |
| SY Police | Head of Public Protection Unit (PPU) | Pete Horner |
| Sheffield City Council | Head of Domestic Abuse Coordination Team | Jo Daykin-Goodall |
| Head of Safeguarding and Quality, Communities | Simon Richards |
| Safeguarding Children Board Manager | Victoria Horsefield |
| Assistant Director Legal Services | Steve Eccleston |
| National Probation Service | Lead for Sheffield Probation | Dave Pidwell |
| Sheffield CCG (Clinical Commissioning Group) | Chief Nurse | Kevin Clifford |

# Appendix 14 – Consent letter to alleged perpetrator



Domestic Abuse Manager

Sheffield City Council

Town Hall

Sheffield

S1 2HH

0114 2053671

Insert date here

Dear insert name here

I am writing to you as the Council’s Domestic Abuse Manager. Sheffield Domestic Abuse Co-ordination Team have commissioned a Domestic Homicide Review into the death of insert name of victim here. I would like to ask your permission to review the contact local services had with you in the lead up to the incident and find out whether services could have done anything differently for you.

Therefore I would like your permission to access information held by Sheffield agencies on you. If you do consent, the agencies concerned will identify a representative, who has not been involved in supporting you, to look at the information they hold about you and identify any lessons to be learnt. Agencies will discuss and agree recommendations to be put into practice.

This investigation is separate from the criminal proceedings that are underway, the aim being to learn lessons so that in the future domestic homicides might be prevented. We will not be speaking to any of the individuals involved in the case until the proceedings are finished.

The review would involve looking at the support you and received by agencies in Sheffield. I would also like to hear your views as to the support you received and any issues you wish to raise or concerns you may have. We would not be able to do this, however, until after the criminal proceedings are finished. I have included a section on the consent form for you to complete if you would like to speak with us once these proceedings are finished.

I enclose a consent form and a stamped addressed envelope for you to sign and return giving consent for us to access your records.

If you have any questions or queries about this process please write to me at the above address of phone me on the above telephone number.

I look forward to hearing from you.

Yours Sincerely

Domestic Abuse Manager

Sheffield Domestic Abuse Co-ordination Team

# Appendix 15 – Consent letter to other



Domestic Abuse Manager

Sheffield DACT

c/o Town Hall

Pinstone Street

Sheffield

S1 2HH

Insert date here

Dear Insert name here

Please accept my condolences for the tragic loss of insert name and describe relationship the person you’re writing to had with the victim (e.g. your daughter, X)

I am writing to inform you that Sheffield Domestic Abuse Co-ordination Team will be carrying out a Domestic Homicide Review into her/his death.

A Domestic Homicide Review (DHR) is a formal process for a wide range of organisations to look at the contact local services had with both name of the victim and the person accused of her murder, and find out whether they could have done anything differently or better for them. It is not about assigning blame, and it is separate from the criminal proceedings that are underway. We want to learn lessons so that a future tragedy might be prevented.

We would like to ask your permission to look at information held about you by Sheffield agencies. This is because describe reason why they are significant person in the case e.g. you were living in the same house as X at the time and there were come incidents which involved you directly.

We would also like to the opportunity to speak to you in person and hear what you would like to tell us both about insert victim’s name as a person, and about the support she/he received from services. We are not allowed to do this until after the criminal proceedings so if you consent, we will be in touch with you when these have concluded.

There is information on Domestic Homicide Reviews for family members at the following link on the Home Office website:

<https://www.gov.uk/government/publications/domestic-homicide-review-leaflet-for-family> .

I enclose a consent form so that you can let us know if you are willing to give us consent. If you are returning this by post please send to Domestic Abuse Strategy Manager, Sheffield DACT, c/o Town Hall, Pinstone Street, Sheffield, S1 2HH. If you have any questions about the process please feel free to telephone name, numbers, and e mail addresses of those working on this particular DHR.

Yours Sincerely

Domestic Abuse Strategy Manager

Sheffield Domestic Abuse Co-ordination Team

# Appendix 16 – Consent form for alleged perpetrator



**Form of Consent**

I, name of alleged perpetrator (date of birth in brackets), give consent for the Domestic Homicide Review Panel to access the information held about me by the following agencies in Sheffield;

* List all agencies wishing to get info from in bullet point form

I understand that this will be used to inform the Domestic Homicide Review being conducted into the death of name of victim.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Involvement in Domestic Homicide Review**

I would like to be involved in contributing to the Domestic Homicide Review into the death of name of victim and agree to be contacted after the criminal proceedings are complete to arrange this.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Appendix 17 – Consent form other significant individuals



**Form of consent**

I, name of involved person (date of birth in brackets), currently residing at address, give the Domestic Homicide Review Panel permission to access information held about me by the following Sheffield agencies;

* List all agencies seeking info from in bullet point form

I understand that this will be used to inform the Domestic Homicide Review into the death of name of victim.

I understand that my identity will be anonymised and that the final report will be published.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participation in Domestic Homicide Review**

I, name of individual (date of birth in brackets), would like to speak to the Domestic Homicide Review Independent Chair about name of victim once the criminal proceedings are finished.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact details to arrange meeting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Frequently Asked Questions**

**What is a Domestic Homicide Review (DHR)?**

Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act 2004. This creates a requirement for local areas to undertake a multi-agency review following a domestic violence homicide. This provision will come into force on 13th April 2011.

The reviews are very similar to reviews into child murders (Serious Case Reviews) and the process is the same: all relevant agencies contribute an Independent Management Review (IMR) and an independent author then drafts the review based on these.

Relevant family members are entitled to take part and most reviews benefit significantly when they do.

The point of the review is to learn lessons to prevent such deaths in the future. They do not allocate blame. That is the purpose of the courts.

**Why are you being asked for information?**

The best reviews have access to the fullest possible information to understand what led to the incident and what can be done to prevent it in the future. The reviews are a government requirement and providing information for them is clearly in the public interest.

**What will happen to the information I provide?**

Information provided goes to the relevant agency Independent Management Review author only. They will keep it secure and use it to inform their report to the independent author. Records will be either destroyed or returned to you at the end.

**Can you provide information without the data subjects consent?**

Yes. Best practice is always to ask for permission to share information first e.g. a health visitor about a mother or a GP about a patient, but if consent is refused then it is usually in the public interest to share relevant information with the IMR author. It is usually possible to reach agreement with the author as to what information is actually needed and you don’t have to provide information beyond this.

**Guidance**

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

<http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp>

# Appendix 18 – Letter re involvement in DHR and response form



Domestic Abuse Manager

Sheffield DACT

c/o Town Hall

Pinstone Street

Sheffield

S1 2HH

Insert date here

Dear insert name here

**Re: Domestic Homicide Review**

Please accept my condolences for the tragic loss of name of victim and relation to person letter is to (e.g. the loss of your sister, X)

I am writing to inform you that Sheffield Domestic Abuse Co-ordination Team will be carrying out a Domestic Homicide Review into her death.

A Domestic Homicide Review (DHR) is a formal process for a wide range of

organisations to look at the contact local services had with both victim’s name and the person accused of her murder, and find out whether they could have done anything differently or better for them. It is not about assigning blame, and is separate from the criminal proceedings that are underway. We want to learn lessons so that a future tragedy might be prevented.

For this reason we would like to hear from you, to find out what you are able to tell us about victim’s name. We appreciate that discussing this might be an upsetting prospect, but we hope you will agree that it is really important that we hear from people who knew victim’s name personally so that we can understand the full picture of what happened.

If you are willing to make a contribution, we can arrange for you to do so however would be best for you: in writing or in a recording, by phone or in person with the Chair of the Domestic Homicide Review process.

We will not be speaking to any individual involved in the case until the criminal proceedings are finished, so as not to interfere with this process.

However, we would like to know if you would be willing to contribute to the review so that we can contact you when the criminal proceedings are over. I have enclosed a consent form for you to sign and return to us if you are willing to be involved. You can return this to name, e mail addresses and phone numbers of who needs the form back.

Full information on Domestic Homicide Reviews for family members are available on the Home Office web site at;

<https://www.gov.uk/government/publications/domestic-homicide-review-leaflet-for-family>

Yours Sincerely

Domestic Abuse Strategy Manager

Sheffield Domestic Abuse Co-ordination Team



**Participation in Domestic Homicide Review – Response form**

I, name of family member/friend, would like to speak to the DHR independent Chair Sheffield Domestic Abuse Co-ordination Team about name of victim and their relation to them and the support she/he received from agencies, once the criminal proceedings are finished.

I understand that this information will be used to inform the DHR report and that any contribution I make will be anonymised, but may be published in the final report.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact details to arrange meeting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Appendix 19 – Public Interest Consideration template

**Public Interest Consideration Document**

**What is a Domestic Homicide Review (DHR)?**

A DHR is a multi agency review aimed at learning lessons from the way agencies and individuals worked together in cases where someone dies in circumstances of domestic abuse.

They are undertaken pursuant to 9(3) of the Domestic Violence, Crime and Victims Act (2004) and subsequent guidance. There is a requirement that agencies work together to produce a meaningful review. They are not “fault finding” exercises. That is the function of the Criminal and Coroners Courts. They are an enquiry into how people worked together in order to try and avoid such incidents arising in the future.

**How is a DHR conducted?**

Experienced and senior officers from each professional discipline e.g. police, GP’s, social workers are appointed to review their relevant agencies records, interview staff and prepare a report. This is called an Independent Management Review (IMR). They won’t have had previous involvement with the case.

They then pass those reviews onto an independent person who will author a report bringing all the information together. The process is very similar to a Serious Case Review which follows when a child dies in circumstances of neglect or violence.

**Why is access to records required?**

The records kept by any agency, including GP’s and medics, form an important contemporaneous record of events which, when reviewed, can help tell the true story of how professionals were responding to the circumstances they were in and establish whether different ways of working could produce better outcomes in the future.

**Whose records might be required?**

The records of the victim, his or her children and the alleged perpetrator may all be relevant to the review. Not all the records will need to be accessed. Only records identified as relevant to the issues under review will need to be considered.

The relevant agencies regarding the alleged perpetrator in the Adult insert letter of case here DHR are:

* **List all agencies information will be sought from on the individual here**

**Adult insert letter here DHR – Terms of Reference**

**INSERT TERMS OF REFERENCE FOR THE DHR HERE**

**Legal and legislative framework for accessing records vs. maintaining confidentiality (amend table below as to how it applies to individual concerned)**

|  |  |
| --- | --- |
| **Argument for public access** | **Argument for maintaining confidentiality** |
| **Data Protection Act 1988 (DPA)**  The DPA explicitly allows the release of confidential personal information, even where consent is refused, for ‘… the prevention…of crime’. (S29). DHRs are explicitly intended to learn lessons to prevent future homicides and would fit appropriately into this category.  In reaching a decision to release information under the DPA, the principles under the Act need to be applied. These are very similar to ‘Caldicott’ principles. Only relevant and accurate information will be shared for a specific and legitimate reason. The processes used in a DHR ensure this is achieved.  **The Human Rights Act 1998 (HRA)**  *‘Right to respect for private and family life’ (Article 8)*  This is NOT an absolute right. Information and records can be shared without consent under Article and if doing so is lawful and necessary. The ‘prevention of crime’ is explicitly included as a legitimate ground for interfering with a right to respect for private life.  Information will only be considered that is relevant to the DHR. Providing information that answers the terms of reference is clearly lawful. Non-relevant information will not be disclosed.  **The Common Law**  The Common Law of England is Judge made law in court cases. GMC Guidance states: ‘36. *Confidential medical care is recognised in Common Law as being in the public interest.* ***However****, there can also be a public interest in disclosing information: to protect individuals or society from risks of serious harm.’*  Agencies sometimes think that only a real risk of physical harm justifies disclosure but this is not what the law states – protecting society from harm is also a legitimate reason to share information and this is just what a DHR sets out to do. The GMC go on to say:  ’*37. Personal information may, therefore, be disclosed in the public interest, without patients’ consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient’s interest in keeping the information confidential.’*  The GMC wrote to the Chair of Sheffield’s first DHR as follows:  *‘We… feel that there is a strong parallel with Serious Case Reviews. Our 0-18 years guidance for doctors (paragraph 62) says that doctors ‘should participate fully’ in Serious Case Reviews; it goes on to say ‘When the overall purpose of a review is to protect other children or young people from risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent. We think it is reasonable that this should be the principle that doctors should follow in co-operating with DHRs as well’.* | **Inability to ask Adult letter for consent/refusal of consent**  Add any relevant detail of how consent has been sought/refused – why it cannot be sought.  **The Data Protection Act 1998 (DPA)**  Data must not be disclosed to other parties without the consent of the individual whom it is about, unless there is legislation or other overriding legitimate reason to share the information (for example, the prevention or detection of crime). It is an offence for Other Parties to obtain this personal data without authorisation.  **The Human Rights Act 1998 (HRA)**  The HRA provides that individuals have a “*Right to respect for private and family life*” (Article 8).  **The Common Law**  Confidential medical care is recognised in Common Law as being in the public interest. |

**Decision**

Give information here as to why in the balance of the above the decision is taken to proceed accessing their records e.g. Adult X has been arrested and charged with murder/manslaughter, indicating that the records will have some information about the agencies involved with leading up to the incident.

On the grounds of Public Interest records relevant to the Terms of Reference of Adult X DHR will be reviewed by the IMR authors appointed by the agencies concerned. This decision has been made as it is hoped that the Adult X DHR process will lead to lessons being learnt by agencies that may help prevent domestic homicides in the future.

Accessing the records on this proposed basis balances Adult X’s right to respect for his/her privacy and private life whilst properly seeking the information which will allow lessons to be learned as required in this review by law.

Agencies need to review their records and identify anything relevant to the Terms of Reference, or any other information provided. Agencies should be aware that in the case of the alleged perpetrator, former presentations may be key to future recognition and early intervention. The records should only be disclosed to the IMR author. They will be kept securely. The IMR author will review them as part of their report writing process. The records will then be destroyed or returned to the agency if they wish. The actual DHR report will be based on the IMR reports prepared by each agency’s author.

**A court order will not be required.** There are no court proceedings associated with a DHR so there is nothing for the court to make an Order for. The responsibility for reviewing and disclosing records lies with each agency that holds them.

Professional identities should be anonymised e.g. HV1 for a Health Visitor or GP 2 for a GP. Sensitivities around these issues can be communicated via the IMR author.

The DHR will be made public is as this is a Government requirement. Publication will be following the Quality Assurance Process undertaken by the Home Office and will also wait until after any criminal process has concluded in order that any information that emerges through the trial process can be incorporated.

# Appendix 20 – Chronology template

Use the embedded spreadsheet template to complete the chronology. Guidance on completing each section is included as a comment in the column heading – hover over it with the mouse to display it.



Return the completed chronology to the DACT Review Team as soon as it is completed – do not wait until the IMR report is completed.

# Appendix 21 – Individual Management Review Template

STRICTLY CONFIDENTIAL

**Individual Management Review report from (insert agency name and logo)**

DHR CASE: Insert agreed initials / alternative name and year

|  |
| --- |
| Author: (please insert name and designation of report author here. State what your role is and how this equips you to undertake the review. State you are independent of any operational involvement in the case)  Signed:  Date: |
| Countersigned: (please insert name and designation of person signing off the report on behalf of the agency)  Signed:  Date: |

Version: xx

**Table of contents**

|  |  |
| --- | --- |
| Section | Page |
| 1. Introduction | Insert page no |
| 1. Family and household composition | Insert page no |
| 1. Chronology of service provision and involvement | Insert page no |
| 1. Analysis of involvement | Insert page no |
| 1. Conclusions | Insert page no |
| 1. Recommendations | Insert page no |

**Section 1: Introduction**

Below is the wording for the introduction of the report. In most cases it is advisable to follow this wording.

In cases where you choose to use an alternative introduction then please ensure the content below is adhered to.

Throughout the report please ensure that your report is fully anonymised including names, addresses, professional names and identifiable locations e.g. names of nurseries, schools, GP surgeries. A full list of those professionals identified in the report should be kept securely by your agency.

This individual management review report of (insert name of organisation here) is produced in accordance with Sheffield Safer and Sustainable Communities Partnership’s procedure for conducting a Domestic Homicide Review. It will form part of a multi-agency Domestic Homicide Review overview report.

This report has been prepared following a review of the care/services provided to the homicide victim, perpetrator, and/or members of their family(ies) or household(s). Its purpose is to look openly and critically at individual and organisational practice to see whether the case indicates changes could and should be made, and if so, to identify how those changes will be brought about.

**About the organisation**

Include here a brief description of your organisation.

**Terms of reference**

The specific terms of reference considered in undertaking this Domestic Homicide Review have been agreed as:

Copy in terms of reference here (**not** the whole document – the specific issues are to be explored in relation to the case, usually the first section after the details of the subjects)

**Methodology**

The following sources of information have been used to inform the review:

Insert the sources of information your agency has used, e.g. file reports, supervision records, training documents, policies and procedures, management information, interviews with staff (state job title only). Where unable to interview staff please state the reason for this.

**Details of parallel reviews and processes**

If any parallel reviews (i.e. serious case review, mental health investigation) are on-going, make a note here. **Section 2: Family and household composition**

Insert a description of the victim, suspected perpetrator and other close members of their family(ies) or household(s). Use the agreed initial or alternative names and state their relationship to each other. Insert a genogram if one is available.

Highlight the people that your agency had contact with and briefly explain the nature of your agency’s involvement with them.

**Section 3: Chronology of service provision and involvement**

You should already have assembled a comprehensive chronology that charts the involvement of the agency with the victim, the perpetrator and their families over the period of time set out in the review’s terms of reference. It should summarise the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to the victim, the perpetrator and their families; and any other action taken.

This section of the report is the accompanying narrative and should draw on information contained in the chronology, bringing the chronology to life. From a review of your chronology highlight the significant episodes of involvement your agency had with the subjects of this review. Describe in more detail the reason for your agency’s involvement and what you actually did.

Episodes of service provision may be broken down as appropriate e.g. by periods of the case being ‘open’ with your agency, by change of keyworker, by school years for children.

**Section 4: Analysis of involvement**

The analysis should consider the events that occurred, the decisions made and the actions taken or not taken; consider not only what happened but why. Assess actual practice against policies, guidance and legislation.

The following are examples of the areas that will need to be considered for all reviews:

Service and practitioner standards:

* Was the agency’s involvement in line with organisational expectation of services and/or national expectation of this service?
* Were practitioners sensitive to the needs of the victim and/or the perpetrator, knowledgeable about potential indicators of domestic violence 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?
* Was the level of staff supervision appropriate and did it address the issues for this client?
* Were senior managers involved at the appropriate points?

**Policies, procedures and risk assessment:**

* Did the agency have policies and procedures in place for dealing with concerns about, or disclosure of, domestic violence? Were these procedures and policies effective, and agreed by practitioners to be effective and worth using?
* Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator?
* What assessment was undertaken by the agency? Were any opportunities to undertake assessment missed? Do assessments and decisions appear to have been reached in an informed professional way?
* Was any threshold applied for accessing the service appropriate and in line with agency thresholds?
* Did actions or risk management plans accord with assessments and decisions made? Were appropriate services then offered or provided?
* Were appropriate statutory actions taken in line with the relevant time frames (reviews, re-assessments, visits)?

**Client focus:**

* When and in what way were the client’s wishes and feelings ascertained and considered? Were they given enough information, options and time to make informed decisions?
* Was the client signposted or referred to other agencies that they might prefer to work with?
* Was the practice sensitive to the racial/ethnic, cultural, linguistic, and religious identity of the people concerned? Was any disability or vulnerability considered and allowed for?
* How accessible were the services to the client?

**Inter-agency working:**

* Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?
* Was the client signposted or referred to other agencies?
* Was disclosure of or concern about domestic abuse shared between agencies?
* What evidence was there of good inter-agency activity?
* Did anything adversely affect the inter-agency activity?

**Good practice:**

* Are there ways of working effectively that could be passed on to other organisations or individuals?
* What evidence was there of good inter-agency activity?
* Was any additional support or service provided above what would normally be offered? Were there any examples of good practice over and above that which would be routinely provided?

**Lessons to be learned:**

* 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?
* What contributed to services being below expectations – individual workers’ situations, the organisational situation, the political context?
* Did anything or anyone appear to interrupt or overly influence the decision making process?
* Did anything adversely affect inter-agency activity?
* Have any previous Domestic Homicide Reviews made recommendations about similar concerns and why weren’t the lessons embedded from these previous DHRs?

**Terms of reference**

In addition to the questions above, address any specific issues in the terms of reference.

**Section 5: Conclusions**

Pull together the findings and analysis in order to comment on:

* Service provided, quality of practice and adherence to procedures
* Appropriateness of procedure
* Decision making
* Action taken in respect of decisions made
* Shortfall in resources, where it appears directly relevant

**Section 6: Recommendations**

Individual agency recommendations for action contained in the report will be considered by the Review Panel for inclusion in the overview report. The Review Panel may also recommend further actions for your agency to be included in the overview report.

Any individual agency recommendations not included in the overview report are expected to be acted on within individual agency governance arrangements.

Recommendations for action must flow from the conclusions. Recommendations can include changes for your agency procedure, practice, or deployment of resources. In addition you may make recommendations that may have an impact on other agencies as well as your own.

Any recommendation that suggest immediate action is required should be reported to your senior manager and the Chair of the Review Panel and should not wait until the completion of the report.

In most cases recommendations should follow a SMARTER framework (see briefing note for further details).

# Appendix 22 – checklist for an excellent IMR

|  |  |  |
| --- | --- | --- |
| 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 SSCP 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 23 – Key IMR Guidance Notes

**Desk- based review**

Before investigating the agency’s involvement any further, the IMR author should assure him/herself that they are familiar with:

* The agency’s policies and procedures
* Any relevant partnership / multi-agency policies and protocols (e.g. those of the Sheffield Domestic Abuse Partnership)
* Professional standards and good practice
* National and local research and evidence-based practice

**Interview staff**

The IMR author should then arrange to interview the staff members who had contact with the victim, perpetrator and/or other members of the household. The interview should cover the staff member’s involvement, how they arrived at any decisions regarding the client(s) and whether the agency’s policies and procedures were followed.

Staff members may well be witnesses in criminal proceedings. In this case the view of the police’s Senior Investigating Officer should be sought on the protocol for interviewing them. If the staff member discloses anything new that would be relevant to the criminal case, it must be forwarded to the disclosure officer at the police without delay.

The IMR author should be sensitive to the fact that the interview may be difficult or distressing for the staff member. The staff member may wish to be accompanied by an appropriate supporter.

A written record should be made of each interview and shared with the interviewee and any other people present.

**Disciplinary and complaint investigations**

The overall Domestic Homicide Review is not part of any disciplinary inquiry, but information that emerges in the course of an IMR may indicate that disciplinary action should be taken under established procedures.

Alternatively, reviews may be conducted concurrently with disciplinary action. This is a matter for agencies to decide in accordance with their disciplinary procedures. The same consideration should be taken in relation to complaint procedures underway against any single agency.

**Write the IMR report and recommendations**

The IMR author must then analyse the information gathered through the desk-based review and the interviews and produce a report and recommendations. A template for the report is provided at appendix 2; see also the section on recommendations below.

The crucial part of the IMR is the *analysis.* It needs to move beyond a description of interactions to comparing the organisation’s actual practice against best practice. Did the organisation live up to the standards it has set for itself? Are those standards up-to-date and rigorous?

If the analysis indicates that policies and procedures have not been followed, relevant staff or managers should be re-interviewed to understand the reasons for this.

If the CCG are writing an IMR, commissioning within the health service should be considered as part of the analysis and recommendations. Recommendations should be clearly directed to one or more parts of the health service.

**Quality assurance**

The senior manager responsible for domestic abuse (and the Review Panel member if this is someone different) should quality-assure the IMR report and recommendations – see the section below on ‘minimum’ content and good practice.

At this point the IMR report should be forwarded to the DHR co-ordinator. The co-ordinator has an overview of the IMR reports from various agencies, and so may be able to point out discrepancies to be checked, or missed avenues of investigation.

The aim of the various iterations of quality assurance and re-drafting is to produce a thorough analysis, so that the Chair does not have to perform the analysis him/herself whilst writing the overview report.

Once the IMR report is deemed satisfactory by all, both the IMR author and the senior manager should ‘sign off’ on the cover sheet.

**Feedback**

Once the report and recommendations are finalised, the senior manager should debrief the staff who have been involved in the review. There should also be a second feedback session after the DHR Overview report is completed.

**Implement recommendations**

The senior manager must then take forward the actions recommended as a result of the IMR. The IMR recommendations should be implemented immediately, and not wait for the conclusion of the overall DHR process.

**Confidentiality**

These cases can be subject to high levels of public interest and complex legal processes in the criminal and civil courts. IMR authors, panel members and any others involved with the review process need to be clear that the information they learn about the case and agency’s involvement is confidential. This means it should not be discussed with anyone apart from key agency officers within the agency who are responsible for either the current case management, where information is required to manage the case, or the senior managers in the agency who need to be kept informed in order to achieve the agency’s approval.

It is vital that documents related to the Domestic Homicide Review are stored in a locked cupboard with restricted access. Electronic documents must be password protected and access restricted. Once a DHR is completed the agency should securely archive all relevant documents but draft copies of overview reports and executive summaries should be shredded. The Overview Report should be kept securely and access restricted.

All IMR authors will be expected to sign a confidentiality agreement and any breach will be discussed with relevant agencies. An example confidentiality agreement is included at **appendix 7**.

**Roles in the IMR process**

**Senior manager**

A senior manager in each agency is responsible for commissioning the IMR process. Often this person will also be the Review Panel member from that agency, but not necessarily.

To summarise, their responsibilities are:

* Ensure case records are secured immediately
* Appoint a person to produce the IMR, and ensure they have adequate capacity and resources to complete the report
* Quality-assure the IMR, paying particular attention to the strength of the analysis
* Feedback and debrief staff on completion of IMR
* Further feedback and debrief on completion of overview report, prior to publication
* Agree and implement IMR recommendations and relevant parts of DHR action plan

**IMR author**

The IMR author should not have had any direct involvement with the victim, the perpetrator or their families; and should not be the immediate line manager of any staff involved in the IMR.

To summarise, their responsibilities are:

* Draw up a chronology
* Review records relating to the case, policies and procedures, and relevant research
* Interview staff involved with case. Make a written record and share it back
* Forward relevant evidence to the disclosure officer for the criminal case
* Draw together and analyse information and produce IMR report and recommendations

**Content**

The minimum content is set out in the template at appendix 2. Briefly, it comprises an introduction, a comprehensive chronology, analysis of the agency’s involvement, a conclusion and recommendations.

However, the overall aim is to find existing good practice and points for improvement, which will ultimately reduce domestic violence and perhaps save lives. It is therefore worth expending as much effort as reasonably possible to produce an excellent IMR.

Since they are a new requirement, good practice in writing domestic homicide IMRs will develop over the coming years, and will be co-ordinated nationally by the Home Office. However, we can learn from the Ofsted guidance on how to produce an ‘outstanding’ IMR for a child Serious Case Review:

* All relevant agencies produce a comprehensive and well-structured management review of their full involvement with the child(ren) and family.
* The review takes full account of the outcomes for the child(ren) concerned in light of their individual needs and their racial, cultural, linguistic and religious identity.
* Practice at individual and organisational levels is analysed openly, thoroughly and critically against national and local statutory requirements, professional standards and current procedural guidance. The information provided is comprehensive and fully addresses the terms of reference.
* Good practice is highlighted with appropriate consideration of its potential for wider implementation. Areas for changes in practice are clearly identified and supported with measurable and specific recommendations for improvement.

See also the checklist for an excellent IMR at **Appendix 20**.

**Recommendations**

The recommendations are the result of the analysis of the agency’s involvement and seek to address any failings identified, or extend any good practice more widely. They should be few in number and **SMARTER**:

|  |  |
| --- | --- |
| **Specific** | Limited to a single action per recommendation, stating who should do it. |
| **Measurable** | This relates to measuring whether the recommendation has been met or not, so we can say it has been done *x* many times or improved by *y*%. |
| **Achievable** | The recommendation needs to be a concrete action to be carried out, not just an aspiration. It needs to be within the remit of the person/people or agency identified. |
| **Realistic** | It needs to be achievable in the real world, taking account of the financial and other resources available. |
| **Timely** | A realistic timescale should be included. |
| **Evaluation** | Include a recommendation about how the agency will understand the impact the recommended changes have had. |
| **Review** | Include a recommendation about how the agency will know it has improved its service or practice as a result of learning from this IMR, and the changes are fully embedded. |

# Appendix 24 – Example letter to send to staff

Dear colleague

The Sheffield Safer and Sustainable Communities Partnership has started the process of a Domestic Homicide Review into the death of name, and has asked our agency to undertake an Individual Management Review of our involvement.

This is a confidential process which aims to establish what services we offered to the victim, perpetrator and/or members of their household(s), how effective these services were, and whether we missed any opportunities to intervene. The aim is to learn lessons about how to improve our services and the way we work with other agencies; we will not use this process to assign blame to anyone.

**What’s involved in a Domestic Homicide Review?**

Each agency that had involvement with the victim, perpetrator and/or members of their household(s) will appoint a manager who has not been involved in the case to carry out an Individual Management Review (IMR). This involves using records and case files to complete a chronology of its involvement with the family, and interviewing key staff.

You may be invited to participate in one of these interviews. If so, you will be given plenty of notice, will be able to review case records to help you recall the facts, and be able to bring a supporter if you want. Interviews will be recorded in writing, and you will be able to see the record of the interview. The interview will focus not only on your involvement with the client, but that of all the agencies involved and ask what, in your opinion, may have made a difference. This is *not* a disciplinary or competency process; should this be necessary, we will use our existing procedures.

If possible, the family and friends of the victim, and possibly the perpetrator, will also be asked to contribute their views and opinions to the Domestic Homicide Review.

A Review Panel, with representatives from all the agencies involved, and an independent chair, read all the IMRs and any other contributions. These are then drawn together into an anonymised Overview Report which analyses the situation and makes recommendations about how services could improve or work together better. You will be briefed about the findings of the report, and what actions we are going to take as a result.

The Overview Report and its Executive Summary are public documents and will normally be published on the Safer and Sustainable Communities Partnership website. They are fully anonymised to ensure confidentiality for both the family and practitioners.

**Useful contacts**

* Our member on the Review Panel is name. He/she is responsible for co-ordinating all our involvement in the Domestic Homicide Review process.
* Name will be writing our Individual Management Review. He/she will be identifying the staff members he/she needs to talk to and contacting them as soon as possible.
* To read more about the Domestic Homicide Review process, visit the Safer and Sustainable Communities Partnership website (link) or the Home Office website (<http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-homicide-reviews/>). The co-ordinator for this DHR is name at organisation.

**Support for you**

We recognise that this is a distressing time for those involved with the family. Please do seek support from your colleagues and line manager. Provide details of any employee assistance programme, HR, occupational health etc.

# Appendix 25: action plan template for overview report



# Appendix 26 - Governance structure for action reporting

Domestic Abuse Strategic Board

Safer and Sustainable Communities Partnership Board

DHR action plans

Safer and Stronger Communities Scrutiny Board

Children, Young People and Family Support Scrutiny Board

Healthier Communities and Adult Social Care Scrutiny Board

Adult Safeguarding Partnership

Safeguarding Children Board

Domestic Homicide / Serious Incident Review Sub Group

# Appendix 27 – Key points from ‘Guide to Writing an Overview Report’

**Starting Point**

* The author will need to have been present at all Review Panel meetings other than the inaugural meeting in which the author was selected.
* The author needs a clear understanding of the terms of reference.
* The author should have access to all of the information needed to write the Overview report and to have read this information personally.
* The author should be satisfied there is no legal barrier to seeing any relevant material or to including any of it in the overview report.
* Ensure the family are informed at the stage the author is drafting the report.

**Required specialist knowledge from an overview author**

* **Domestic Violence and Stalking:** Knowledge of domestic abuse will be key in all DHRs. Note especially that exertion of power and coercive control by the abuser over the victim is a key dynamic feature of the domestic abuse. Issues for the author may be whether staff and professionals fully understand the impact of coercive control on the victim’s behaviour. An understanding of the legal framework for protection of victims will also be necessary. Stalking often co-occurs with domestic abuse and expertise in this area, including an understanding of recent legislation, should be sought if it is relevant to a particular review.
* **Honour-based violence:** An honour crime is a crime that is, or has been explained by the perpetrator as, committed as a consequence of the need to protect or defend the honour of the family. There is no culture or religion that condones this practice and it affects many communities. An apparent reluctance to access support and services may be evidence of a victim’s fear and shame brought about by the family’s intimidating behaviour in the name of family ‘honour’. The report may need to address the issue of whether services were sufficiently proactive, sensitive and supportive.

**Additional knowledge** that could be helpful for an overview author:

* **Individuals experiencing problems with mental health, drugs or alcohol:**
* **Vulnerable individuals and children.**
* **Other specialist areas** including race/gender/sexual orientation, and any differences in treatment by agencies. All the grounds for discrimination or ‘protected characteristics’ in the Equality Act 2010 i.e. age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, religion/belief will need to be considered.

**Legal Considerations**

* That the criminal proceedings do not prevent your use of any information. Communication with the Senior Investigating Officer is essential to ensure any disclosure issues are addressed.
* That all confidential information concerning the perpetrator or other surviving members of the family have either been disclosed with their consent or with the authority of each agency in the public interest.
* All providing information in writing or at interview have been informed the material may be mentioned in the Overview Report and they will have the chance to comment on this.
* Any information in Children’s Act 1989 proceedings has been disclosed with the consent of the court.
* That if the victim was subject to a MARAC procedure (Multi-Agency Risk Assessment Conference), or the perpetrator to a MAPPA (Multi-Agency Public Protection Arrangement) – a Memorandum of Understanding has been provided for the release of the Minutes.
* Any omissions of information due to legal prevention should be stated at the beginning of the report.
* Where there is any doubt on a legal matter, the Chair should ensure that legal advice is obtained (either specialist if necessary or from Local Authority lawyers).

**Creating an authoritative report**

* Above all, show that the review has been fearless, impartial, fair, balanced and thorough in its approach, challenging where necessary but also compassionate in the face of tragedy which led to the review.
* You are entrusted with a weighty task. Put yourself in the position of each reader of the report and check whether you have explained every procedural aspect and accounted for all conclusions reached.
* Your report is the culmination of the review panel’s work. Use a language and style which is understandable by the victim’s family, friends, the perpetrator and public as well as agencies and individuals who have contributed to the review.

**Suggestions to assist with drafting**

* Using the Guidance ‘Outline Format for Overview Report’ as a skeleton, add material gradually to each sub-section, cross-referencing by page number as you go to reports, policy documents and other material. As an aide memoire this will prove invaluable.
* Flesh out the chronology. Avoid paraphrasing and let the contemporaneous records speak for themselves. Original wording can be contrasted with commentary from interviews and reports in your analysis section (triangulation).
* Avoid premature findings. If discrepancies occur, make a note for now. Include your thoughts in the analysis section as they occur to you and they can be developed later.
* As you draft the report be aware of expressing your opinions. Keep focussed on those who have contributed to the review. Quote from them rather than paraphrase. Produce an evidence- based report.
* Where possible, include commentary not only from those who provided services but also from those who received services. Their words should be heard through the report.

**Avoiding hindsight bias and outcome bias**

**Hindsight bias** is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This tends towards a focus upon blaming staff and professionals closest in time to the incident.

**Outcome bias** is when the outcome of the incident influences the way it is analysed, for example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability becomes inconsistent and unfair.

**Preventability – potential difficulties**

* Human action is complex and the effect of decisions on subsequent actions of others is best seen in terms of the likelihood of particular outcomes.
* A narrative explanation based on the likelihood of events occurring and the likelihood that a homicide could have been prevent if certain services had been effective, will be much more accurate and helpful when drafting recommendations for improvement.
* The conclusions about likelihood should always be evidence-based.
* From your accumulated evidence you may be able to conclude events were ‘very unlikely’ or ‘highly unlikely’ however, you should also be prepared to state that there is insufficient evidence to reach any conclusion.
* Evidence based views should be included on ‘missed opportunities’.
* Take care with the words you use and anticipate their possible interpretation when the report is published.
* A narrative approach can be usefully constructive.

**Conclusions have three purposes**

* Making a public statement concerning learning of lessons and confidence in services.
* Presenting findings for dissemination and learning.
* Commenting on services as a basis for recommendations.

**Appendix 28 – Out of area letter template and information submission template**



Domestic Abuse Coordination Team

Community Services

Sheffield City Council

Town Hall

Sheffield

S1 2HH

0114 20 53671

Insert date here

**URGENT: DOMESTIC HOMICIDE REVIEW – Response required by insert date here (maximum of 2 weeks from the letter date)**

Dear Colleague

A Domestic Homicide occurred in Sheffield on insert date of incident. Under the Domestic Violence, Crime and Victims Act 2004, this means that the need for a DHR has been considered and approved, and the Domestic Abuse Co-ordination Team is currently running this process.

The alleged perpetrator and/or victim in this case is believed to have lived at some point in area being sent to inserted here– this would have been during 2010/2011 period.

As such, we need to ascertain which agencies had contact with him/her in location so that we can ask these agencies to provide information to inform the Sheffield DHR.

If you could please do the following;

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

**Alleged perpetrator: Insert name**

**Insert DOB**

**Insert address in that area if known**

**Victim**: **Insert name**

**Insert DOB**

**Insert address in that area if known**

If you ***do*** hold records, please then contact name of person, on the details below as soon as possible, and let us know what the nature of your agency’s involvement with the family was. Please submit any information on the template included in this letter and do not send it as part of an e mail. 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 for you to do so, and which agencies need to be involved.

If you do **not** hold records please confirm this to name as well..

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.

Please send your response by **secure** email to: name and e mail addresses of people here to submit to.

1. 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.

For any other queries please contact 0114 20 53671.

Yours sincerely

Alison Higgins

Sheffield Domestic Abuse Strategy Manager

Domestic Abuse Coordination Team

Community Services

Sheffield City Council

# Appendix 29 – Agency Synopsis for Sheffield Domestic Homicide Review

**Agency Synopsis for Sheffield Domestic Homicide Review: insert date of incident here**

|  |  |  |
| --- | --- | --- |
| **Name of deceased** | **Date of Birth** | **Date of Death** |
| Complete name of deceased | DOB of deceased | Date of death |
| **Details of Agency Involvement** | | |
| **How long involved with the agency?**  **Identify any issues of particular note/concern, issues with engagement, need for escalation etc. with general dates.** | | |
| **Agency**: | | |
| **Date of Completion:** | | |
| **Completed by:** | | |

|  |  |  |
| --- | --- | --- |
| **Name and address of alleged suspect** | **Date of Birth** | **Relationship to deceased** |
| Insert name | Insert DOB | Insert info |
| **Details of Agency Involvement** | | |
| **How long involved with the agency?**  **Identify any issues of particular note/concern, issues with engagement, need for escalation etc. with general dates.** | | |
| **Agency**: | | |
| **Date of Completion:** | | |
| **Completed by:** | | |

|  |  |  |
| --- | --- | --- |
| **Name and address of other relevant individuals** | **Date of Birth** | **Relationship to deceased** |
|  |  |  |
| **Details of Agency Involvement** | | |
| **How long involved with the agency?**  **Identify any issues of particular note/concern, issues with engagement, need for escalation etc. with general dates.** | | |
| **Agency**: | | |
| **Date of Completion:** | | |
| **Completed by:** | | |

1. Page 6, point 7 **Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews**

   Revised – applicable to all notifications made from and including 1 August 2013 [↑](#footnote-ref-1)
2. Page 7 point 12 **Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews**

   Revised – applicable to all notifications made from and including 1 August 2013 [↑](#footnote-ref-2)
3. Ibid Page 14 point 37 *‘In some homicides that do not meet the criteria for a DHR or where a victim committed suicide and the circumstances give rise to concern, the CSP should consider conducting a single agency individual management review or a smaller-scale audit; for example, where there are lessons to be learnt or on how staff worked within one agency rather than about how agencies worked together.’* [↑](#footnote-ref-3)
4. Ibid page 10 point 25 [↑](#footnote-ref-4)
5. Ibid page 11 point 27 [↑](#footnote-ref-5)
6. Ibid page 11 point 32 [↑](#footnote-ref-6)
7. Ibid page 12 point 34 [↑](#footnote-ref-7)
8. Ibid page 21 points 74 and 75 [↑](#footnote-ref-8)