

Sheffield Safer and Sustainable Communities Partnership

Domestic Homicide Review Guidance

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| **Version date** | **Changes** |
| 19/08/11 | Version 1 |
| 25/03/14 | Version 2  |
| 6/12/17 | Version 3 – updated to include the 2016 DHR guidance |

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# About the Sheffield DHR Guidance

When a known domestic homicide, a suspected domestic homicide or suicides under some circumstances has happened, then the Community Safety Partnership in that area is required to undertake the statutory Domestic Homicide Review (DHR). Introduced in 2011, the Home Office has published a DHR guide <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews> for Community Safety Partnerships to ensure compliance with the process.

This local guide has been prepared on behalf of the Sheffield Safer and Sustainable Communities Partnership (SSCP[[1]](#footnote-1)), incorporating all requirements of the latest DHR (2016) guidance. The guide ensures that all those involved in the DHR locally, follow a single process when a Domestic Homicide Review (DHR) is required in the city.

The Sheffield guidance

* sets out the reasons for carrying out a DHR
* explains the criteria cases need to meet in order to qualify as a DHR,
* Explains the statutory nature of the process.
* Provides a brief description of the staged process when holding a DHR.

The detailed appendices contain templates for use by agencies involved in the DHR process. Note that all have been reviewed, as part of the revision process.

**A summary of the key changes**

The DHR guidance was updated in December 2016. The main changes include that DHRs should now be completed for suicides (where there is known coercive control), the purposes have been expanded to ensure DHRs highlight areas of best practice and contribute to building an increased understanding of the nature of domestic abuse and violence. The new guidance stresses that DHRs need to be written *‘through the eyes of the victim’*, taking a holistic approach to the review and being ‘professionally curious’.

It emphasises the need for the DHR Chair and Review panel to be and remain independent in the review process.

The scope of the reviews has been expanded to include (where appropriate) housing association and social housing tenancies, consideration of the support offered and received by the perpetrator, the use of police sanctions, the situation in relation to social housing, disclosures at work and immigration status.

The victim’s family should be considered as ‘key stakeholders’, with increased opportunities to be involved in the process, including contributing to the scope of the review, receiving regular updates, receiving copies of draft and final reports and offered the opportunity to choose a pseudonym. To assist the family member/s in the process, signposting to advocacy services should be offered.

Children involved in the case should be provided with specialist help and where appropriate be offered the opportunity to contribute[[2]](#footnote-2).

The review panel should invite the police Senior Investigating Officer to be involved in the first meeting as DHRs (where possible) should not be delayed until after the end of the criminal investigation. The aim is to drive change to local and national systems, as soon as issues are known.

There is a new Overview Report template and an Executive Summary template has been introduced. All recommended actions (where possible) should be tested, prior to adding to the action list, to ensure actions are SMARTER and are reasonable. A new data submission form for the Home Office has been introduced.

The guidance for Serious Incident reviews has been revised, there are now four criteria, adding *‘other circumstances that partners would consider will result in significant learning by more than one agency’*.

All templates have been reviewed and some new templates added to reflect the new guidance and local processes.

The opportunity to introduce practitioner meetings to the process on a case by case basis is now included.

There is more detailed guidance on parallel reviews, data protection and quality assurance to ensure the DHR meets the requirements of the process.

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, Strategic Commissioning Manager for Domestic and Sexual Abuse, Sheffield Drug and Alcohol / Domestic Abuse Co-ordination Team on 0114 205 3671 or 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.

## The definition of Domestic Violence and Abuse

In April 2014 the Government introduced a new cross-government definition of domestic violence and abuse, designed to ensure a common approach to tackling domestic abuse and violence 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
* female genital mutilation.

The domestic abuse 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.

**Suicide**

In some circumstances suicides would also meet the criteria to complete a DHR[[3]](#footnote-3). Particularly in cases where a long term history of coercive control is apparent. A DHR should be undertaken in such circumstances, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable – see page 17 for more detail on Suicide.

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

The government has expanded the section on the purpose of DHRs. Point D now includes effective multi-agency working to ensure disclosure and early intervention, and e and f are both new, adding DHRS should aid a better understanding of domestic abuse and the need to identify in reviews areas of best practice. The full list is as follows:-

a) 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[[4]](#footnote-4);

b) 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;

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) Contribute to a better understanding of the nature of domestic violence and abuse;

f) Highlight good practice.

The outcome of the DHR should be to have a thorough independent process in place, that produces an Overview report, with an executive Summary and a detailed action plan (Step 4, page 45) which has Home Office approval.

## What a DHR needs to include to satisfy the statutory guidance

To achieve the purposes the DHR process/ report needs to:-

* Be ‘professionally curious’, inquisitive and exploratory in its nature, learning lessons and action focused.
* have a narrative that articulates the life through the eyes of the victim (and their children), is should include talking to those around the victim including family, friends, neighbours, community members and professionals,
* keep an open mind
* Be situated in the victim’s home, the family and the community.
* Understand the history and trail of abuse, identifying which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other.
* Learn lessons and identify actions
* Understand the victim’s reality; identify any barriers the victim faced to reporting abuse and learn why any interventions did not work for them.
* Understand the context and environment in which professionals made decisions and took (or did not take) actions. This would include, for example, the culture of the organisation, the training the professionals had, the supervision of these professionals, the leadership of agencies, multi-agency working.
* Understand the conduct of individuals and whether procedures were followed.
* Evaluate whether the procedure / policy was sound and operated in the best interests of the victim.

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.

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.

# DHR 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.

A review should be opened promptly rather than waiting for the conclusion of criminal proceedings[[5]](#footnote-5). The aim is to ensure any early lessons can be identified and rapid action is taken to address them.

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:**

|  |  |  |
| --- | --- | --- |
| **Steps in the process** | **Time from homicide** | **Deadline** |
| **Step 1 - The decision making process** | ASAP | Notification of DHR can be given one of two ways :- |
| 1.    Police notify the Safer and Sustainable Communities Partnership (via the DACT) of a possible Domestic Homicide, verbally and confirmed in writing. |
| 2.    A professional or agency refers a homicide to the CSP in writing. |
| 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  |
| **Step 2 - DHR required. TOR & panel mtg** | 1 month | DACT lead officer to inform Home Office of intention regarding DHR. |
| Make contact with victim’s family |
| Invite the SIO to attend the first panel meeting. |
| 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. |
| **Step 3 - IMR** | 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.  |
| 3 months | Consider holding focus groups with practitioners |
| 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. |
| **Step 4 - Overview report** | 5 - 6 months | Review panel meets to discuss the first draft of overview report and its recommendations and agree any alterations. |
| Chair meets with the family and advocate to discuss the first draft of overview report and its recommendations and agree any alterations. |
| **Step 5 - Approval process** | 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.\* |
| **Step 6 - Publication** | 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). |
| **Step 7 - Actions audited** | 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 Template to the Overview Report.

# STEP 1 – Decision process for determining if a DHR is required

### Action after notification of a DHR

The police or any professional or agency may refer such a homicide to the CSP in writing if it is believed that there are important lessons for inter-agency working to be learned[[6]](#footnote-6).

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. The police should notify DACT as soon as possible, and confirm any details in a formal written notification.

Ideally, within five working days of the notification of the death (either from the police or professional or agency) 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 to the full list of agencies (Template 1)** as soon as possible 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** **(Template 2)** about their involvement with the individuals. This is 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 agencies to return initial information, **of five working days** as a standard to allow another one (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.

### Secure Email correspondence, passwords for notification and all case documents

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

Password protection - 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[[7]](#footnote-7):

*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 sexual orientation.

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 (**Template 3**) should be prepared by the DHR Co-ordinator 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 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 DHR Co-ordinator 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[[8]](#footnote-8) instead.

The level of DHR conducted should be ‘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 **Template 4**)

|  |  |
| --- | --- |
| **Organisation** | **Post** |
| South Yorkshire Police | District Commander |
| Sheffield City Council (Local Authority) | Executive Director, People’s Portfolio |
| 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.

### Overlap with other statutory duties

In some domestic homicide cases there may statutory requirements to hold another review, for example, a Safeguarding Adult Review or Mental Health Investigation. The new guidance in 40.c. explains what needs to be considered in such cases, recognising that the statutory requirements of a DHR overlap with these processes and that there are potential opportunities to remove duplication.

*40[[9]](#footnote-9). The chair and review panel should consider in each homicide the scope of the review process and draw up clear Terms of Reference which are proportionate to the nature of the homicide. Relevant issues to consider include the following:*

*c. How will the DHR process dovetail with other investigations that are running in parallel, such as an NHS investigation, a criminal investigatio2704n or an inquest?*

For example, *would running a DHR and Mental Health Investigation or Safeguarding Adults Review in parallel be more effective in addressing all the relevant questions that need to be asked, ensuring staff are not interviewed twice and that there are individuals who sit on both panels to ensure good cross communication?*

*It will be the initial responsibility of the DHR co-ordinator and then the responsibility of the review panel chair to ensure contact is made with the chair of any parallel process.*

### Victims aged between 16 and 18

In Sheffield it has been agreed that if a DHR is conducted when the victim is aged between 16 and 18, whether or not a child Serious Case Review is also being conducted, this would be led by Children Safeguarding service. Having one process which meets the two statutory criteria, would reduce the workload for all agencies involved and stress for the family.

The DHR Review Panel would need to agree this in the terms of reference, based on the evidence of the case presented. The panel will need to include specialist representatives to ensure the domestic abuse issues are adequately covered e.g. representation from the DACT.

### Victims who are adults with care and support needs

Consideration should also be given to whether either the victim or the perpetrator was an adult with care and support needs. An adult with care and support needs could also be involved as a perpetrator, witness or through loss of their carer.

It has been agreed locally that if the victim was an adult with care and support needs then it should be considered as to whether the DHR should be led by the Adult Safeguarding Service – depending on capacity, if this is not possible or desirable the coordination of the review will remain with the DACT in close consultation with the Adult Safeguarding Service. However in such cases, the DHR Panel has the opportunity to ‘dovetail’ the SAR review, and in effect remove any overlap between the two statutory requirements. Having one process which meets the two statutory criteria, would reduce workload for all agencies involved and stress for the family.

The DHR Review Panel would need to agree this in the terms of reference, based on the evidence of the case presented. They 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 a homicide which will be of interest to review teams when conducting a DHR. Point’s b, c, e and I have all been expanded upon in the 2016 guidance.

Point c - the review should explore and understand the reasons why there may have been no contact with support agencies. In these cases it is now important to understand the barriers to accessing support services and where more could have been done to address these.

Point I – the review should consider the availability of perpetrator services in addition to services for victims[[10]](#footnote-10)[[11]](#footnote-11):

The full list is as follows:-

a) 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.

b) Any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously.

c) The victim had little or no known contact with agencies. It is often incorrectly assumed by local areas that no contact with agencies indicates a DHR is not required. In fact, a DHR should probe why there was little or no contact with agencies. For example, were there any barriers to the victim accessing services, e.g. language, cultural, etc? Were the circumstances described in h) below a barrier? Were there particular reasons why local services were not appealing to a victim in these particular circumstances? Could more be done in the local area to raise awareness of services available to victims of domestic violence and abuse? Did contact diminish after initial engagement?

d) The homicide suggests that there have been failings in one or more aspects of the local operation of formal domestic violence and abuse procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.

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

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

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

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

i) Services were not available locally to refer/support the victim and/or the perpetrator.

### Death by Suicide

The 2016 guidance clarifies [[12]](#footnote-12) the position to take on suicides where coercive control is known. E.g. where a victim took their own life (suicide) and the circumstances give rise to concern, for example if it emerges that there was coercive and controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

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 to enable their views to be incorporated into the final draft, before the deadline for Overview Report.

There is a need to ensure that these parallel processes are run without compromising criminal proceedings OR delaying the remedial actions required as per the draft DHR.

*Supporting the criminal justice process*

*‘It is the Chair’s role to ensure the Review takes into account a coroner’s inquiry, and/or any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process*[[13]](#footnote-13)*’*

*There is a need to inform the SIO of any disclosures made during the course of the DHR process.* It is the Chair’s role therefore to ensure a robust disclosure process is in place with all agencies.

It is essential that the Chair and the SIO have good communication processes in place, to ensure the areas of the DHR that can continue, without compromising the case, are undertaken. Therefore the new guidance recommends (as local best practice in paragraph 41) that the Senior Investigating Officer for the case is invited to the Review Panel meetings and helps to set the Terms of Reference. If this is not possible, then they should receive regular updates from the DHR Co-ordinator[[14]](#footnote-14).

The guidance explains in paragraph 92 how the *‘review panel should ensure records are reviewed and a chronology drawn up to identify any immediate lessons to be learned (an immediate IMR). These should be brought to the attention of the relevant agency or agencies for action, secured for the subsequent overview report and forwarded to the disclosure officer for the criminal case. Any identified recommendations should be taken forward without delay[[15]](#footnote-15)’.*

*‘It is permissible for the review panel to conduct professional interviews, producing a draft overview report. However, any such work must take into account the views of the SIO to ensure that the criminal proceedings are not compromised[[16]](#footnote-16)’*.

### The disclosure of sensitive material during the course of the DHR

The guidance is more explicit with regard the disclosure of sensitive material during the course of the DHR. Paragraph 94 explains that *‘All material generated or obtained in the DHR whilst the criminal case is ongoing must be made available to the SIO and disclosure officer to assess whether it is relevant to the criminal case. Where it is relevant, it will be for the CPS to decide whether it should be disclosed to the defence. Where the material is sensitive, the CPS or the SIO will consult with the chair before disclosure is made to the defence[[17]](#footnote-17).*

DHR interviews with witnesses in the criminal case:

*‘If there are family members, colleagues, friends or other individuals that a review chair wishes to speak to as part of the review and who are witnesses in the criminal case, the chair may be asked by the SIO not to contact them for interviews until after the conclusion of the criminal case. The SIO should consult with the CPS where the DHR panel proposes to speak to witnesses in an ongoing criminal case. Any representations to the DHR panel to delay contact with the witnesses will be informed by such liaison with the CPS[[18]](#footnote-18)’.*

*If at the end of the DHR process the criminal investigation is ongoing then the SIO needs to confirm whether a release of the draft report could be potentially misleading (as there may be more evidence to come)…*

*If the SIO confirms that the criminal investigation would be compromised then* the draft overview report cannot be shared until otherwise instructed from the SIO. The Review Panel needs to determine, working with the SIO, what actions can be taken forward without compromising the criminal proceedings, in order to ensure organisational intra and inter learning needs can be addressed.

*If the SIO confirms that the criminal investigation would NOT be compromised* then the overview report can be used in its draft form (until after the criminal trial) and actions can be taken to ensure organisational intra and inter learning needs are addressed, as long as it does not compromise the criminal investigation.

Following the conclusion of the criminal proceedings, the DHR should be concluded without delay.

### Disclosure and parallel criminal investigations

Proper and fair disclosure to the criminal justice system should be upheld during the DHR process.

All disclosure issues MUST be discussed with the police SIO, the CPS and the HM Coroner’s representative as appropriate[[19]](#footnote-19).

Further disclosure information can be found at: [*www.cps.gov.uk/legal/d\_to\_g/disclosure\_manual*](http://www.cps.gov.uk/legal/d_to_g/disclosure_manual)*.*

### 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.

The Overview Report and supporting documents should be submitted to the Coroner to help inform the Inquest; however this should only happen once the Home Office Quality Assurance Panel has reviewed them[[20]](#footnote-20).

### 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 Co-ordinator 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)
* 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 decision to complete the DHR process – see **Template 3a - Decision letter to the family - DHR criteria is met**.
* Ask Family and friends 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) – page 32.
* Co-ordinate the first meeting of the Review Panel to happen as soon as practicably possible
* Inform the Council Legal Department

**Go To Step 2**

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

* Notify the DHR team at the Home Office (DHRENQUIRIES@homeoffice.gsi.gov.uk)
* Notify all agencies
* Notify the lead Police Officer for any investigation and the Family Liaison Officer
* Notify the family - ‘The CSP should inform the victim's family, in writing (**Template 3b - Decision letter to the family – DHR criteria is NOT met.),** of its decision as well as send the family relevant correspondence from the Quality Assurance (QA) Panel regarding its position (see section 6 of this guidance on how to engage families). Where a decision is made not to inform the family, there is a requirement to advise the Home Office of its rationale in not doing so.
* Ensure family, friends, colleagues etc. are aware of the decision or of any alternative processes to be conducted.

**End DHR process**

# STEP 2 – DHR IS REQUIRED – Panel members, Chair and Terms of reference

### The Review Panel

The Review Panel **must** include individuals from the statutory agencies listed under section 9 of the Domestic Violence, Crime and Victims Act 2004[[21]](#footnote-21) and a specialist or local domestic abuse service must be included on the Panel[[22]](#footnote-22).

The aim is to have a review panel that is *‘sufficiently configured to bring relevant expertise in relation to the particular circumstances of the case as they will see the dynamics of the relationship through a different lens’.*

In Sheffield the approach is to have a review panel 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.

To ensure transparency, all names, roles and agencies represented on the Panel will be included in the DHR report[[23]](#footnote-23).

Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting. IMR authors normally present their IMRs to the panel and are often invited to meetings to discuss the draft overview report. Members of statutory agencies who have responsibilities for completing IMRs may also be members of the review panel but the panel should not consist solely of such people[[24]](#footnote-24).

The review Panel should meet an appropriate number of times to ensure there is robust oversight and rigorous challenge. The 2016 guidance explicitly states that meeting at the beginning and at the end of the process is not sufficient.

The Sheffield process is for at least three Review Panels to be undertaken (at one month, 5 to 6 months and 6 to 7 months after the initial notification), although this can change depending on the case.

### Role of Review Panel Chair and Author

The statutory guidance states: *‘As local circumstances determine, the CSP or 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. The chair may also be the author of the overview report. When appointing the chair, provision may be made for the chair to be made aware of the response from the Quality Assurance Panel and potentially to be involved in making any changes required as a result of this quality assurance’[[25]](#footnote-25).*

In Sheffield the following applies:-

* Where possible, the Chair of the Review Panel will also be the author of the Overview Report.
* The Chair of the first meeting of the Review Panel will be a manager in SCC, supported by the DACT strategic commissioning manager for domestic abuse, as at this juncture an Independent Chair will not have been appointed.
* The role of the Review Panel Chair is to manage and co-ordinate the process of the DHR and write the overview report.
* After the initial meeting and an appointment of the Chair /Author, the appointed Chair will then chair all meetings of the Review Panel and IMR author meetings.
* The Chair should be an experienced independent individual, who is not directly associated with any of the agencies involved in the review.
* The Chair should consider if the panel is becoming aware of any information that may be of interest to the judicial process, including for example an inquest[[26]](#footnote-26), to ensure that an inquest may be aware of any agency failings being revealed in the DHR process. It is the role of the Chair to contact the SIO accordingly.

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[[27]](#footnote-27).

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

In each DHR, it is imperative that the chair is independent. The chair should not be a member of the CSP. Where the Chair has worked for a CSP or an associated agency in the past, there needs to be a clear statement of the time elapsed. The final report needs to have an Independence statement[[28]](#footnote-28) which specifically states the Chair’s employment history, relevant experience and independence in relation to the report.

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 candidate with the most appropriate skills and expertise for each review.

### Recruitment of the chair

In Sheffield 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 Strategic Commissioning Manager for Domestic Abuse adds individuals to this as they express interest. When a DHR is needed, all of the individuals in the bank are contacted and sent an **Expression of Interest form** **(Template 5)**, and asked if they are available for the period in question.

The expression of interest form includes the statutory guidance recommendations re. skills and experience as follows:

1. Enhanced (previously relevant) knowledge of domestic violence and abuse issues including so-called ‘honour’-based violence, research, guidance and legislation relating to adults and children, including for example the Children’s Act 2004 (new in 2016), the Care Act 2014 (new in 2016) and the Equality Act 2010;
2. An understanding of the role and context of the main agencies likely to be involved in the review;
3. Managerial expertise; including dispute resolution.
4. Strategic vision so that opportunities are identified to link in and inform strategies such as the Government’s *Ending Violence against Women and Girls strategy: 2016 to 2020* [*https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020*](https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020)
5. Good investigative, analytical, interviewing and communication skills;
6. An understanding of the discipline regimes within participating agencies;
7. An understanding of wider statutory review frameworks such as child or adult reviews;
8. Completion of the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports.

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 Disclosure and Barring Scheme check (in last 3 years). A contract is then signed with the SSCP (**Template 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 the scope and Terms of Reference for the review (see template 7 for TOR).
* 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.
* Rigorously challenge the information presented[[29]](#footnote-29).
* Establish how to communicate with the family in each particular case (see more on family members on page 32).
* Receive the overview report and executive summary and ensure that
	+ all contributing organisations are satisfied with the information and fairly represented,
	+ the reports reflect the findings,
	+ reports are written in accordance with the guidance
	+ the reports are of a sufficient standard to send to the Home Office[[30]](#footnote-30).

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 it is best practice that they should not also be the Individual Management Review author. However members of statutory agencies who have responsibilities for completing IMRs may also be members of the review panel but the panel should not consist solely of such people.

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.

### Review Panel membership

The current standing membership of the Sheffield DHR Review Panel are the individuals in the following positions in the identified agencies; **(see Template 13 for the names of the current post holders).**

| **Organisation** | **Post** |
| --- | --- |
| SY Police  | Head of Public Protection Unit (PPU) |
| Sheffield City Council | Head of Commissioning, People Keeping Well |
| Head of Safeguarding and Quality, Communities  |
| Assistant Director with responsibility for Safeguarding and Quality Assurance |
| Assistant Director Legal Services  |
| National Probation Service  | Lead for Sheffield Probation  |
| Sheffield CCG (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 **Template 30** 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.

### Terms of Reference for the DHR

Refer to page 38 for details of the DHR meetings, the terms of reference is discussed at Meeting 1 and the TOR template can be found in Template 7.

# Factors to consider throughout the duration of the DHR

The following need to be undertaken and considered in the DHR and the subsequent steps taken:

* **Confidentiality**
* **Consent from the family of the victim and perpetrator**
* **Data protection**
* **Case anonymisation**
* **The involvement of family and friends**
* **The management of staff members involved in the case.**

### 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 Template 9**). Any breach in confidentiality will be discussed with relevant agencies.

A confidentiality statement **(Template 13a – Family confidentiality statement)** needsto be signed by all family members, involved in the DHR process. A decision should be made by the decision panel on a case by case basis regarding whether to send this out with the decision letter or with the consent letter **(templates 3a, 13b, 13c, 14 to 17).**

### Consent from family members and the perpetrator to access personal identifiable information

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.

### Children and consent to access personal identifiable information

In cases where there are children involved, there will be a need to review the agency information that is held by services supporting and in contact with the children, e.g. GP.

Consent is therefore required for all children involved in the case. The parent or the carer of the child/ren will need to be contacted to ask for their consent. However in some cases it may be determined that a child is of *‘sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision’*[[31]](#footnote-31), as per the Gillick competency test and therefore may be in a position to be able to provide their own consent.

There is for a need for the Review Panel to determine whether children can consent to sharing their information, using specialist advice.

### Requesting consent from the family to be involved in the DHR

It is important to know from the start of the DHR process, if possible, whether significant family members/friends wish to be involved in the DHR (see section on Family and how they can be involved). This includes an opportunity to 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 a letter requesting consent to share personal data and to be involved in the process, including for cases with children, are in the following appendices;

**Template 13b** – letter to the victim’s family asking for their contribution to the DHR (no children)

**Template 13c** - Letter to the victim’s family asking for their contribution to the DHR (with children)

**Template 14** – Consent letter for alleged perpetrator

**Template 15** - Consent form to alleged perpetrator

**Template 16** – Letter and Consent form for significant family member

Each letter should also include **template 18 – the FAQ questions for family members**.

### Data Protection and the professional sharing of information to the DHR process

The sharing of personal information is integral to the DHR process and needs to be in accordance with the DPA principles.

There are two sharing of information issues that the DHR process may experience:-.

1. the family and/or perpetrator refuse to share / consent cannot be sought
2. A lack of openness to sharing data of a personal level by agencies (when consent is and is not given).

The following outlines the DPA position:-

The Data Protection Act 1998 governs the personal data of all living individuals. Therefore following the death of the victim, the data protection principles do not normally apply and the full sharing of information (e.g. health, legal) is permissible.

If personal data/information is required of a living person, then the data protection principles need to be adhered to. This includes when to share and when not to share information, and with regard to what information to share. This is important for DHRs when living individuals do not consent to share their information, often in the case of the perpetrator.

There is a need to ensure all professionals, including clinicians and health professionals disclose information regarding all individuals identified in the DHR process, to cooperate with the DHR process, with or without that person’s consent.

In some situations a professional may not want to make a full disclosure (due to confidentiality obligations or other human right considerations). In such situations paragraph 99 explains that the following should be undertaken:-

*a) The* *review team should be informed about the existence of information relevant to an inquiry in all cases; and*

*b) The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content*[[32]](#footnote-32).

The Department of Health explains how information should be shared in such situations:-

* *‘where there is evidence to suggest that a person is responsible for the death of the victim, their confidentiality should be set aside in the greater public interest’.* This needs to be considered by the Review Panel when working with the professional who has raised the data protection issue.
* The DoH recognises the strong parallels between child Serious Case Reviews and DHRs. A child SCR explicitly states that *‘"When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent."* The DoH considers the same applies to health professionals sharing information to DHRs.
* The Striking the Balance DHR guidance explains about consent and the basis for sharing sensitive and personal information - *‘Even if the victims are asked explicitly for consent to have their information shared it is possible the full extent of the issues may not be understood or that the level of information already held by agencies is not appreciated and therefore the validity of the consent may be disputed. Furthermore, the alleged perpetrators are not asked for their consent or informed about the MARAC referral as to do so might jeopardise the victims safety. This provides a ground rule for Caldicott Guardians - all information shared about both victims and perpetrators must be in the context of the normal requirements of information sharing without consent, in this case on the basis of prevention and detection of crime or serious harm[[33]](#footnote-33)’.*

The Panel’s aim is therefore to ensure the principles of the data protection act are achieved, and that all professionals share sufficient information to meet the DHR objectives of reducing the risk of future harm.

Where there are issues with consent or agencies sharing information to the level required, then the Template for Public Interest Consideration Report (see **Template 19**) needs to be completed, and approved by Legal Services. The form presents a case to share personal level data factoring in the data protection principles, common law, and Human Rights Act.

### Case Anonymisations and the use of pseudonyms

Anonymisations and pseudonyms should be agreed as soon as possible in to the process.

When to use a Pseudonym - family members can now ask for a suitable pseudonym to be used in the report rather than anonymisations[[34]](#footnote-34). The guidance states that choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative.

Ideally, pseudonym should be agreed at the first panel meeting or raised by the FLO, if the family decide not to attend the panel meeting, as soon as the family want to engage with the process.

Where the family members want this to happen, the process should allow this to happen. When discussing the case with the family and sharing any documentation with the family, agreed pseudonyms should be used.

The draft and final reports should all use these agreed pseudonyms. On occasions when the family decide not to use pseudonyms, the report needs to stipulate this[[35]](#footnote-35).

If the family do not wish to choose pseudonyms, anonymisation will be used.

Anonymisation should be used by all professionals involved with the case, when not in contact with family members.

Anonymisation should be used in the Terms of Reference, all chronologies, IMRs, and the final overview report.

How to anonymise – a simple process has been established and is as follows:-

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 XAP - 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)**

# Involvement of family, friends and other support networks

The participation of the family is ‘integral’ to the DHR process. They must be treated as a key stakeholder, and be offered clear communication from start to finish, offering them the opportunity to meet the review panel at the earliest opportunity, contributing to the terms of reference being offered specialist and expert advocacy support and offering the children an opportunity to contribute.

A full and effective DHR process seeks the inclusion, a thorough 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 contribute to the process, including sharing information that can give a fuller picture to the DHR Chair and Panel, and can help inform each part of the DHR process. They can offer their opinions of the services offered and received and may be able to offer an insight into the victim’s life and their views.

Family and friends 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.

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.

The review panel and Chair need to build up a positive experience for the family by offering clear communication about the process from the outset and throughout the review. It is likely that with each DHR, the communication with each family will be bespoke, based on the level of involvement the family want.

The family should be offered the opportunity to voluntarily participate in the process, and the opportunity will first be offered to them by a letter which is shared by the Family Liaison Officer, using the revised family and friend’s introductory letter.

The letter explains the process, how they can contribute and their choices available, contains a consent form and participation form and includes a copy of the most appropriate national DHR leaflet

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

Letters and the consent forms (templates 13b, 13c**,** 16)

Go to page 29 for details of consent from family members and the alleged perpetrator.

### Support to the family, the use of advocates and children involved in the case

There is a need to 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 has been agreed locally that the family will be signposted to specialist and expert advocates e.g. Victim Support Homicide Service[[36]](#footnote-36) and AAFDA[[37]](#footnote-37).

Children should be given specialist support and an opportunity to contribute as they may have important information to share. This will be arranged on a case by case basis in consultation with the local authorities Children, Young People and Families Service. See also page 29 for children and consent.

### Family engagement in the DHR process

Family members should be offered the opportunities to meet the review panel and to influence the scope, content and impact of the review. Their participation must be afforded the same status as other contributions. See page 29 on requesting family members to consent to be part of the process.

Family involvement humanises the deceased helping the process to focus on the victims and perpetrator’s perspectives rather than just agency views[[38]](#footnote-38).

The family should be offered a date to attend the first Panel meeting, where the terms of reference for the DHR are formulated. If the family decide not to meet the Panel or do not want to engage with the TOR process, where possible the TOR discussed at the first Panel meeting should still be shared with them via the FLO, offering them a second opportunity to engage with the TOR process.

The families should be offered the opportunity to choose, if they wish, a suitable pseudonym for the victim to be used in the report – See page 31.

### Interviews with the family

The family may provide ‘relevant information which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents[[39]](#footnote-39)’.

Face-to-face interviews should be conducted 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 with family, friends and others should be recorded and transcripts of any interviews should be added to the DHR file held.

Families can provide factual information as well as testimony to the emotional effect of the homicide. The review panel need to be aware of the risk of ascribing a ‘hierarchy of testimony’ regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

### The Chair’s role with family members

The Chair needs to meet the family in person[[40]](#footnote-40)[[41]](#footnote-41) at the earliest opportunity. The timing of the meeting needs to be after the FLO has met with and shared the family introduction letter, taking into consideration information from the advocate (if the family have taken up the offer) and any other ongoing processes, e.g. post mortems, criminal investigations.

The Chair should again offer signposting to advocacy support services. This may reiterate the information provided the FLO, but will provide a further opportunity for the family to consider using an advocate. The Chair cannot act as the advocate.

After meeting with the Chair, the family or via the advocate (if one is agreed) should understand:-

* how frequently they will be updated (as agreed with them),
* how their involvement and information will assist with the review
* how the information they disclose will be used in the review, whether it will be published and the benefits of being involved in the review e.g. how it may help other domestic abuse victims.
* when they will be involved in the process.
* the timeline for publication
* they will have an opportunity to be interviewed.
* they will be offered the opportunity to see the final report prior to publication.
* they will be offered the opportunity to choose a pseudonym.
* they have an opportunity to help *‘create the change after the review’*.

After the meeting with the family the Chair should be aware of:-

* any ethnic, cultural and linguistic needs for consideration.
* significant people in the victim’s life to consider being included in the review process (e.g. friends, colleagues etc).
* the families’ preferred method of communication (written, electronic, in person).
* all key dates - There is a need 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. This includes arranging dates to meet with family members or the date of the final published report. If necessary the process may have to be delayed to enable the participation of family members at times that are suitable for their needs.
* the amount of time the family may require to review all information received.

### The family and the Overview report – see Step 4 for the overview report

Adequate time should be given for the family to consider and absorb the information received. The amount of time determined should be discussed by the Chair with the family, and agreed on the basis of their particular dynamics and the deadlines required of the DHR process.

The family should have full sight of any media statements[[42]](#footnote-42) prior to their release.

### Action to take when the family refuse to participate

Where family and friends have refused to participate, this should be clearly recorded within the Overview Report.

When the family refuse to participate, there is a need to still share the final report with them, and make them aware of any media statements.

Family and friends should be offered more than one opportunity to participate as their views regarding participation may change overtime. There is a need to explain to the family, that late participation in the process could mean some limitations with regards to shaping the DHR process, as this is set out in the TOR at the start of the process.

### The Alleged Perpetrator and their family

The review should consider approaching the alleged perpetrator and the family of the alleged perpetrator[[43]](#footnote-43).

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[[44]](#footnote-44). 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[[45]](#footnote-45).

In such situations 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. In addition, the level of participation from family members. The decision to include 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 – Information for Panel members and IMR authors

During the process of the IMRs being written, staff members who have worked with the individuals in the case need to be involved. 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.
* Staff are required to participate 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.
* The terms of reference of the review should be made clear at the earliest possible opportunity to staff and their line managers, using the template letter (**Template 24**).

All members of staff asked to provide information or give an interview should be:-

* Given at least 2 weeks’ notice, as soon as it is realised, in order to be able to meet the IMR deadline.
* Offered the opportunity to be accompanied by their trade union representative or other appropriate person in accordance with the usual policies of the organisation.
* Provided with information about sources of independent support staff they 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.

In the interview all 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.
* allowed to view the relevant paperwork to aid their recall
* 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.
* Asked for their views about what could have made a difference for the victim/perpetrator.
* Be interviewed separately, but a staff member can bring an appropriate supporter if they wish.

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.

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.

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

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 debrief the wider staff group on the DHR findings and the actions that the agency will be taking to address the recommendations in the agreed DHR action plan.

# Overview of the DHR Meetings –Step 1 through to Step 5

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

### Meeting - Meet the SIO and Terms of Reference Meeting

**A ToR should be agreed and circulated to all agencies within one month of notification to the Home Office of a DHR.**

* The Agenda template for the initial Panel meeting is found in **Template 7**.
* The Chair’s briefing for the meeting is found in Template 8.

The first Review Panel meeting should do the following:

* Establish the draft Terms of Reference for the DHR, this where the scope of the whole review is identified **(Template 7**). All issues to be considered are included in this template.
* Meet the SIO of the investigation - The new guidance states it is good practice to invite the SIO to the first panel meeting, which is where the TOR is agreed. The SIO should present a briefing to the Panel on the investigation and so the SIO can be party to the TOR being agreed. On the basis of the information from the SIO, the Panel needs to determine if there a need to delay the DHR and at what stage/s it should be delayed[[46]](#footnote-46). The guidance explains how preliminary work, commissioning, analysing the IMRs and drafting the first version of the Chronology whilst not speaking to any potential witnesses can be undertaken before the criminal trial has taken place.
* 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.
* Consider legal proceedings and how this may impact on the interviewing of staff members.
* Discuss involvement of family members / friends etc.
* Meet the family members - the family should have an opportunity to meet with the Panel and they should be involved from the start. The decision on whether the family members attends the full, or part of the meeting should be based on information gathered by the DHR Co-ordinator with regard the contact with the family/ the advocate, the SIO, the FLO and the particular nature of the case.

After this initial Panel 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
	+ share with family members
	+ email the finalised version to the Home Office DHR team and all IMR authors and Panel Members.
* 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.
* The Review Panel members need to: -
	+ ensure that their agency’s chronology and IMR will be completed within agreed timescales.
	+ read all the circulated IMRs and chronologies prior to the next Review Panel meeting
	+ consider what additional information may be required from their agency
	+ Consider what issues or inconsistencies they need to raise regarding other agency information.

### Meeting - Individual Management Review - Authors briefing

One week prior to the meeting

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

**Template 10** is the suggested **agenda** **template to use for the IMR author’s briefing.**

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

Go to Overview of the DHR meetings - Step 3 for more details on IMRs.

### Meeting - Facilitated PractitionersEvents

In some DHR cases it may be agreed by the Review Panel that a facilitated practitioner’s event should be held. This is new to the DHR process in Sheffield; however such events have proven useful in Children’s Serious Case Reviews Sheffield and in other Local Authority areas.

This event would be organised to provide an opportunity for the front line practitioners who were involved with this individual / family to come together to look at what lessons can be learnt from this case. This would be conducted in a spirit of enquiry with the focus on learning and not in any way to attach blame to any single individual or agency. This would be an opportunity for practitioners to share their knowledge and experience of working with individuals and families who are living in situations of domestic abuse, explore areas of ‘good practice’ and identify the challenges and barriers to effective practice (these may be individual, organisational or systemic) with the aim of identifying ways of moving forward for the city. The learning from such an event would be shared with the DHR Review panel to inform the review outcomes.

### Meeting – IMR Review Panel Meeting/s – to Review and discuss IMRs

One week prior to the meeting

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 the 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.
* Offer challenge to agencies, and where issues cannot be resolved, the DHR report will need to record the areas of disagreement and actions taken towards a resolution. The Home Office will not arbitrate in such circumstances.

A suggested **IMR agenda review meeting template** is **Template 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.

### Meetings - Overview report and executive summary review meeting(s)

At least a week before the meeting

The first draft of the overview report and executive summary 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 draft Overview Report and executive summary 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 for the draft overview report meeting** is **Template 12**

If necessary, this meeting can be repeated one or more times, until the Review Panel is satisfied with the Overview Report and the recommendations documents, as per the guidance. The panel needs to:-

1. ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the reports;
2. be satisfied that the reports accurately reflect the review panel’s findings;
3. ensure that the reports have been written in accordance with this guidance; and
4. be satisfied that the reports are of a sufficiently high standard for them to be submitted to the Home Office.

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.

Go to Step 6, page 49, to find full details of the approval process.

# STEP 3 Individual Management Reports

### The IMR process

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 information from the IMR will form part of the overview report.

The three aims of the IMR are to:

* Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working (in terms of cultural, leadership, supervision, training)[[47]](#footnote-47) to see whether the homicide indicates that changes to practice could and should be made to support professionals to carry out their work to the highest standards.
* Identify how and when[[48]](#footnote-48) those changes or improvements will be brought about.
* Identify examples of good practice within agencies
* Identify whether existing 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 IMR should be requested as soon as the terms of reference are agreed and the decision to complete a DHR is decided, unless there is an issue with a particular agency and then it can be asked for sooner[[49]](#footnote-49).

The IMR author –this must be a staff member who had no direct involved with the victim, perpetrator or any family member and was not supervising any staff member involved in the IMR.

Where interviews with staff are undertaken by those preparing the DHR, written records should be taken and shared with the relevant interviewee. All such records should be retained for the purposes of disclosure to any criminal investigation should the need arise[[50]](#footnote-50).

All agencies’ required to submitted an IMR

* Need to adhere to the time frame provided by the requestor (DHR Co-ordinator or Chair).
* Should liaise with the requestor with issues of concern and raise queries as soon as they are known.

All agencies should be asked to secure their records, if they have not already done so.

Actions should be suggested by the agency, to address any areas of concern identified.

Debriefing staff involved – see section on staff members. Once the IMR is submitted and before the overview report is completed, senior staff at the agency should arrange time to feedback to staff any findings from the internal review.

A similar session should be arranged and completed after the overview report is signed off and before publication.

### The Chronology

It is important that any agency or employer that is approached to provide an IMR also provides the review panel with a comprehensive chronology of its involvement with the victim and others that may be the subject of the review. This will allow the review panel and chair to fully analyse events leading up to the homicide[[51]](#footnote-51).

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 Template of DHR Overview Report. The chronology should be forwarded to the DHR Co-ordinator as soon as it is complete, without waiting for the IMR report.

**Template 20** is the **Chronology** **template**.

### 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.

### How to work with staff members on a IMR

See page 36 on how to work with staff members during the IMR process and throughout the DHR process.

### 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.

See page 39 on DHR meetings to see more details of the IMR meeting.

# STEP 4 The DHR Overview Report, executive summary and action plan

# The Overview Report

The overview report is usually written by the Independent DHR Chair in the Sheffield DHR process.

**Template 27 is the** **Overview report template which** should be used for all DHR reports in Sheffield.

Each area in the templates must be covered, but additional sections can be added on a case-by-case basis if appropriate.

### The requirements of an Overview Report

The Chair’s independence must be stated explicitly in the report. The Chair must also keep an open mind during the process,

The Overview Report should achieve all the purposes of a DHR and the specific terms of reference.

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. 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 Chair needs to ensure that the report is **professionally curious, investigative, analytical, and exploratory**. Highlighting lessons to be learned and being action driven.

The report needs to:-

* Be written in way that articulates the life of the victim, which includes situating the report in the victim’s home, family and community. This will be done through using the information from the family, friends and community members engaged with the process and by using the IMR authors’ pen portraits of the victim.
* Fully understand and explain the history and trail of abuse, identifying which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other.
* Bring 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.
* Use any findings from supplementary reports (additional reports[[52]](#footnote-52) may be commissioned to supplement the information available in the IMRs to better support the conclusions and lessons to be learnt from the case).
* Recognise where processes and procedures failed and where individuals did not work in the best interests of the victim.
	+ Have understood the victim’s reality; identify any barriers the victim faced to reporting abuse and learn why any interventions did not work for them.
	+ Have understood the context and environment in which professionals made decisions and took (or did not take) actions. This would include, for example, the culture of the organisation, the training the professionals had, the supervision of these professionals, the leadership of agencies, multi-agency working.
	+ Have understood the conduct of individuals and whether procedures were followed.
	+ Evaluate whether the procedure / policy was sound and operated in the best interests of the victim.
* Identify lessons to be learnt and identify actions (see action plan on the next page).
* Highlight areas of good practice.

### Analysis within the overview report

The process of analysis is essential for the DHR, in order for all lessons to be identified and the objectives achieved.

The analysis section should address the terms of reference and the key lines of enquiry within them.

It should examine:-

* how and why events occurred,
* the information that was shared during the investigative process,
* the decisions that were made,
* the actions that were taken or not taken.
* highlight areas of good practice

It can consider whether different decisions or actions may have led to a different course of events.

There are a number of key documents that can be used by the Chair in this analytical process. These are as follows:-

* **The Home Office guide *‘Domestic Homicide Reviews – Key Findings from analyses of domestic homicide reviews’* (2016).** <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf>

This documents highlight key themes of DHRs are poor record keeping, risk assessment, communication, information sharing between agencies, domestic abuse not being recognised or explored further, organisational policy, worker competence, knowledge and skills, multi-agency working, training, and public awareness.

* **The Standing Together *‘Domestic Homicide Review – Case analysis’ (2016)*** [*www.standingtogether.org.uk/sites/default/files/docs/STADV\_DHR\_Report\_Final.pdf*](http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf)

This reports suggests recommendations for improved practice for a co-ordinated community response (no one agency knows everything), difference between intimate partner violence and adult family violence (e.g. the perp is the adult son), and the approaches required. There are recommendations for police, GP practices, social care, networks, risk, mental health services and schools.

Previous overview reports for Sheffield DHRs can also be used as a guide, including those yet to be public if the Chair signs a confidentiality agreement.

Learnings from Serious Case Reviews can also be referred to – see the following documents:-

* *SCIE: Learning together to safeguard children: a ‘systems’ model for case reviews* <http://www.scie.org.uk/publications/ataglance/ataglance01.asp>
* *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014*, May 2016<https://www.gov.uk/government/publications/analysis-of-serious-case-reviews-2011-to-2014>
* 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 [http://pure.qub.ac.uk/portal/en/publications/inquiring-into-nonaccidental-child-deaths-reviewing-the-review-process(00631cca-0f39-4674-8702-9b0409cbb7a7).html](http://pure.qub.ac.uk/portal/en/publications/inquiring-into-nonaccidental-child-deaths-reviewing-the-review-process%2800631cca-0f39-4674-8702-9b0409cbb7a7%29.html)

# Executive Summary

Template 28 should be used for the executive summary. The template is new to the national guidance and should be used for all DHRs in Sheffield.

The executive summary needs to be presented to and be approved by the review panel, via the approval process.

### Anonymisation in the overview report and executive summary

Both the Overview Report and the 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. The new 2016 guidance extends this anonymity beyond personal details but also to other identifying features, such as precise dates[[53]](#footnote-53).

### Mark reports as restricted

All reports should now be regarded and marked as ‘Official’[[54]](#footnote-54). This replaces the previously use d ‘Restricted’, required in the old guidance. ‘Official’ is to be used as per the Government Protective Marking Scheme until the agreed date of publication, and should be clearly marked as such on all documents.

# Action Plan

The overview report should have a detailed action plan which reflects the lessons learned in the body of the report. Recommendations should include:-

* Appropriate solutions to help recognise abuse and either signpost victims to suitable support or design safe interventions.
* Adjustments / amendments to policy or procedures to secure better outcomes, including the multi-agency approach, support services to victims and the family and agency working.
* all actions should be tested out by the agency, prior to the action being finalised, where possible[[55]](#footnote-55) and time frames agreed at the senior level by each agency.

**Action plans** should be written using the revised template in **Template 25.**

All actions should be SMARTER (see template 25).

**The Approval process**

Once agreed via the approval process (see next page for details), then the executive summary, the overview report and the action plan should be submitted to the CSP alongside the Executive Summary and the Overview report.

# STEP 5 The Approval process

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

### Review Panel approval

The approval of the overview report document needs to be FIRST approved by the Review Panel (see **Template 12** for the overview meeting 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 regarding any changes that impact on their agency.

The Review Panel need to scrutinise the overview report to:-

1. ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the reports;
2. be satisfied that the reports accurately reflect the review panel’s findings;
3. ensure that the reports have been written in accordance with this guidance; and
4. be satisfied that the reports are of a sufficiently high standard for them to be submitted to the Home Office. The Quality Assurance Panel[[56]](#footnote-56) will only sign off the report if it has:-
* established a full as picture as possible, speaking to the appropriate agencies, voluntary and community organisations, family and friends.
* demonstrated sufficient probing, analysis and has a balance narrative.
* Identified lessons to be learned and has plans in place to ensure this happens.
* minimised the likelihood of a repeat homicide.

### Family engagement and approval

The family need to be involved in the approval process. This process should be run in conjunction with the first meeting to discuss the overview report with the Review Panel.

The Sheffield offer is for the Chair and the advocate (if there is one) to meet with the family, provide a summary of the key findings, lessons learned and the actions.

There is an option to have sight of the complete overview report at the meeting, if the family wants this.

Sufficient time should be allowed at the meeting, to ensure the family has time to process all information provided, and for them to have sufficient opportunity to raise any concerns, points of clarification or amendments[[57]](#footnote-57).

Where further time is required for the family to review and process the information, further meeting dates or deadline dates of providing written feedback back to the Chair should be agreed, being mindful of the timescales involved and should run alongside the Review Panel meetings.

A confidentially agreement needs to be in place with the family to retain confidentially of all unpublished reports.

### IMR author and responsible manager approval

Once the report has been approved by the family and by the Review Panel, 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.

### 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.

### Safer and Sustainable Communities Partnership approval

The final approval of the overview report, executive summary and action plan lies with the SSCP (co-Chairs).

**Template 31 is a draft email to send to the SSCP with the overview report and executive summary for sign off.**

The SSCP needs to agree the content and ensure the report is fully anonymous apart from including the names of Review panel members and Chair and that it meets the four expectations required of the Quality Assurance Panel (see below).

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.

Once sign off is agreed by the SSCP, the **Home office Data Collection form (Template 29)** should be completed.

The Data Collection form should be submitted with the Overview Report, the Executive Summary and the Action Plan.

Note - 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.

### Debriefings after approval BUT before publication

Once the reports are approved, 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 / Sign Off 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 for consideration by the Home Office Quality Assurance Panel. The Panel currently meets on a monthly basis, therefore a response would be expected within one month.

The Quality Assurance Panel sign off DHRs based on four principles. These are[[58]](#footnote-58):-

1. Areas have spoken with the appropriate agencies, voluntary and community sector organisations, and family members and friends, to establish as full a picture as possible;
2. The report demonstrates sufficient probing and analysis and the narrative is balanced;
3. Lessons will be learnt and that areas have plans in place for ensuring this is the case;
4. The likelihood of a repeat homicide is minimised.

Point 2 is new to the principles, and therefore needs to be considered carefully in future DHRs.

Point 1 adds specific reference to community groups, therefore these need to be factored in.

IF the Home office Quality Assurance Group does not approve - the report is found to be inadequate, then the Panel 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. The new guidance explains how where significant changes are required the SSCP should agree with the Chair the changes required, and they will be listed on the revised report, as the author of the original report[[59]](#footnote-59).

**IF the Home office approves - Once the Quality Assurance Group approves the DHR documents, a letter is sent to the SSCP, confirming this, including any additional feedback. The letter[[60]](#footnote-60) is also automatically sent to the Police and Crime Commissioner.**

**Once approval is received by the area the report can be published, usually following a process of redaction.**

The agreed publication date (being mindful of key dates) should be agreed by the DHR Co-ordinator and shared with the Chair, the review panel, the family and staff members involved in the case.

Go to the next page where the Publication process is found.

# STEP 6 Approval given - actions to take before and during publication

Once the Home Office Quality Assurance Panel approves the report, it then needs to be published.

### Communication after the Home office Approval BUT before Publication

Family, friends and other support networks – All should be briefed before publication regarding the proposed publication date and any new objections should be taken into account. Extra support should be offered at this time.

Staff members – see section on involvement of staff members on page 36.

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.

The DHR Co-ordinator should also ensure that the communications departments of the key organisations are aware and discuss any media arrangements, and all involved should know where to refer any media requests/ enquiries.

### Amending the approval document into a document for publication.

The OFFICIAL marking and any draft numbering can now be removed from the documents.

The Overview Report and Executive Summary should be suitably anonymised (this may mean it is personified, as per the family request) and made publicly available.

### On the day of publication

The following is required:-

* The anonymised/ personified Overview Report and Executive Summary will be uploaded onto the Sheffield City Council website [www.sheffield.gov.uk](http://www.sheffield.gov.uk) 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[[61]](#footnote-61).
* Confirmation of publication should be emailed to the Home Office DHRENQUIRIES@homeoffice.gsi.gov.uk and include a link to the published documents.
* The Co-ordinator will email a link to this webpage to the Review Panel, IMR authors and full contact list of agencies. In this email they should be advised of where to direct any media enquiries.
* The family should be provided with the Home Office Quality Assurance Panel letter, a copy of the overview report and executive summary.
* An email containing the letter and a link to the report should be sent to the Police and Crime commissioner, elected members and senior managers of each participating agency.
* The Panel’s feedback should be made available to the Chair and author of the DHR, to help inform future DHRs they may be commissioned to undertake[[62]](#footnote-62).

### 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.

The family should be made aware of and have sight of any media statements and all should remain mindful of key dates, such as family birthdays and anniversaries.

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.

### The action by the Home Office

The Home Office website will be updated with implications for national training and practice.

# STEP 7 Action plan implementation

The guidance stipulates that action plans are the *‘beginning of the (change) process’* and that local governance structures should be in place to monitor the delivery against the HR action plans[[63]](#footnote-63).

There is a local governance structure in process to ensure all actions drive change and the action plan is completely delivered.

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

The Board also has the authority to escalate ‘blocks’ in 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 **Template 26** for the 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.

**End of DHR process**

# Serious Incident Review Process

### Circumstances for a SIR

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

* 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.
* Or other circumstances that partners consider will result in significant learning by more than one agency

See **Template 32** 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 SIR 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 **Template 30** – 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.

### The SIR Process

**Stage 1 – Police or other agency 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 with relevant skills as per the DHR Chair criteria. The role of the SIR Chair is to manage and co-ordinate the process.

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

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 / or 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 SMARTER 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.

**Sheffield**

**DHR Templates**

# Template 1 – Notification letter to agencies

Sheffield Domestic Abuse Co-ordination Team

Sheffield City Council

Floor 9

West Wing

Moorfoot Building

Sheffield

S1 4PL

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 insert 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 shown in the table below (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 |
| Children of the victim and of the suspect | Insert names, dates of birth and addresses |
| Other members of the household: | Insert names, dates of birth and addresses |

1. Action to take if you *do* hold records:-
	1. 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.
	2. Please then contact Alison Higgins 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 (revised in 2017)** along with this letter.
	3. 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.
2. Action to take if you *do not* hold records - Please also confirm if your organisation has had no involvement with the family on the same template.

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 note that information provided for the purpose of a Domestic Homicide or Serious Incident Review may be used as part of criminal proceedings and may become subject to disclosure to the defence, in accordance with the Criminal Procedure and Investigations Act 1996. Please note, sensitive material, such as witness personal information, will never be disclosed.

Please send your response to Alison Higgins by secure email to: Alison.higgins@sheffield.gcsx.gov.uk or password-protect it and send it to: Alison.higgins@sheffield.gov.uk. For any other queries please contact 0114 205 3671.

Yours sincerely

Signatory

Alison Higgins

Strategic Commissioning Manager for Domestic and Sexual Abuse

# Template 2 – Information Template



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

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

**Summary of Victim details**

|  |  |  |
| --- | --- | --- |
| **Name of deceased** | **Date of Birth** | **Date of Death** |
|  |  |  |
| **Details of Agency Involvement** |
| **Known to your agency? Yes / no****How long involved with the agency?****Identify any issues of particular note/concern, issues with engagement, need for escalation etc. with general dates.****Please mark from the following list below where there any specific considerations around equality and diversity issues that may require special consideration:-** * **age**
* **disability (including learning disabilities)**
* **gender reassignment**
* **marriage and civil partnership**
* **pregnancy and maternity**
* **race**
* **religion and belief**
* **sex and sexual orientation**
 |
| **Agency**: |
| **Date of Completion:** |
| **Completed by:** |

**Summary of alleged suspect details**

|  |  |  |
| --- | --- | --- |
| **Name and address of alleged suspect** | **Date of Birth** | **Relationship to deceased** |
|  |  |  |
| **Details of Agency Involvement** |
| **Known to your agency? Yes / no****How long involved with the agency?****Identify any issues of particular note/concern, issues with engagement, need for escalation etc. with general dates.****Please mark from the following list below where there any specific considerations around equality and diversity issues that may require special consideration:-** * **age**
* **disability (including learning disabilities)**
* **gender reassignment**
* **marriage and civil partnership**
* **pregnancy and maternity**
* **race**
* **religion and belief**
* **sex and sexual orientation**
 |
| **Agency**: |
| **Date of Completion:** |
| **Completed by:** |

**Summary of children**

Where the victim or the alleged suspect had children, list the children below and state whether you know if they are living or not living in the household.

|  |  |  |
| --- | --- | --- |
| **Name and address of children**  | **Date of Birth** | **Relationship to deceased** |
|  |  |  |
| **Details of Agency Involvement** |
| **Known to your agency? Yes / no****Were the children involved with the agency, if so for how long?****Living with the victim?****Living with the alleged suspect?** |
| **Agency**: |
| **Date of Completion:** |
| **Completed by:** |

**Summary of other relevant individuals living in the household**

List all other relevant individuals known to your service who were living in the household.

Where required, copy the box and add a new box for each individual

|  |  |  |
| --- | --- | --- |
| **Name and address of other relevant individuals** | **Date of Birth** | **Relationship to deceased** |
|  |  |  |
| **Details of Agency Involvement** |
| **Known to your agency? Yes / no****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:** |

# Template 3 – 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, children of the victim and or suspect 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:

1. 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.
2. Any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously.
3. The victim had little or no known contact with agencies. It is often incorrectly assumed by local areas that no contact with agencies indicates a DHR is not required. In fact, a DHR should probe why there was little or no contact with agencies. For example, were there any barriers to the victim accessing services, e.g. language, cultural, etc? Were the circumstances described in h) below a barrier? Were there particular reasons why local services were not appealing to a victim in these particular circumstances? Could more be done in the local area to raise awareness of services available to victims of domestic violence and abuse? Did contact diminish after initial engagement?
4. The homicide suggests that there have been failings in one or more aspects of the local operation of formal domestic violence and abuse procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.
5. The victim was being managed by, or should have been referred to, a Multi-Agency Risk Assessment Conference (MARAC) or other multi-agency fora.
6. The homicide appears to have implications/reputational issues for a range of agencies and professionals.
7. The homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed.
8. The perpetrator holds a position of trust or authority e.g. police officer, social worker, health professional, and the homicide, therefore, is likely to have a significant impact on public confidence.
9. Services were not available locally to refer/support the victim and/or the perpetrator.

**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

# Template 3a - Decision letter to family member informing them of the decision to hold a DHR

****Sheffield DACT

Sheffield City Council

Level 9 West

Moorfoot Building

Sheffield

S1 4PL

Insert Date

Dear

Please accept my condolences for the tragic loss of your xxxx.

I am writing to inform you that the Sheffield Safer Communities Partnership has made a decision to complete a Domestic Homicide Review / Safeguarding Adult review / Serious Incident Review into her death.

The decision to hold a review into XXX death was made because we have reason to believe that your XXXX experienced domestic abuse and neglect while s/he was alive.

The Sheffield Domestic Abuse Co-ordination Team will be carrying out the Review into her death.

The aim of this particular review is to complete a proportionate investigation into the contact local services had with xxxx, in order to find out whether they could have done anything differently or better for her. Ultimately, we want to learn lessons so that a future tragedy might be prevented.

It is not about assigning blame and is separate to the ongoing police investigation that is underway. I will be working closely with the police throughout the process, to ensure the criminal investigation is not jeopardised during our investigation.

There is further 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 need support, who should I contact?**

I understand this is a particularly distressing and emotional time for you. If you would like to speak to someone about the support available, you can contact Victim Support and/or AAFDA.

The contact details for these services are as follows:-

Victim Support

Website: <https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service>

Contact telephone number: 0300 303 1976

AADFA

Website: <https://aafda.org.uk/help-for-families/>

Contact telephone number: 07768 386922

I will write to you again in the next week to explain how you as a family member may want to/ can be involved in the review process.

Should you have any further questions please feel free to telephone me on 0114 205 3671.

Yours Sincerely

Alison Higgins

Strategic Commissioning Manager for Domestic and Sexual Abuse

Sheffield Domestic Abuse Coordination Team

Sheffield City Council

# Template 3b - Decision letter to family informing them of the decision to NOT hold a DHR

Sheffield DACT

Sheffield City Council

Level 9 West

Moorfoot Building

Sheffield

S1 4PL

Insert Date

Dear

Please accept my condolences for the tragic loss of your xxxx.

I am writing to inform you that the Sheffield Safer Communities Partnership has made the decision that there will not be a Domestic Homicide Review (DHR) completed in your XXXX death.

This decision was made following detailed consideration of the DHR criteria, which includes the definition of a Domestic homicide, the information received to the panel from a number of services and information provided by the police about the crime. The panel feel that the case does not meet the criteria required. I have notified the Home Office of this decision.

The case does however meet the criteria for a Safeguarding Adult Review. The review will be completed with the same professionalism taken with a DHR. The review is a requirement of The Care Act 2014 to *identify the lessons to be learnt from the case and to apply those lessons to future cases[[64]](#footnote-64)’*.

**Can I be involved in the review process?**

As a family member you will have an opportunity to be involved in this process. I will write to you again in the next week to explain how you as a family member may want to/ can be involved in the review process.

**I need support, who should I contact?**

I understand this is a particularly distressing and emotional time for you. If you would like to speak to someone about the support available, you can contact Victim Support and/or AAFDA.

The contact details for these services are as follows:-

Victim Support

Website: <https://www.victimsupport.org.uk/help-and-support/get-help/support-near-you/yorkshire-and-humber/humberside-and-south-yorkshire>

Contact telephone number: 0300 303 1976

AADFA

Website: <https://aafda.org.uk/help-for-families/>

Contact telephone number: 07768 386922

If you have any questions about the process please feel free to telephone me on 0114 2053671.

Yours Sincerely

Alison Higgins

Strategic Commissioning Manager for Domestic and Sexual Abuse

Sheffield Domestic Abuse Coordination Team

Sheffield City Council

# Template 4 – DHR Consideration Panel Members 2017/18

|  |  |  |
| --- | --- | --- |
| **Organisation** | **Post** |  |
| South Yorkshire Police  | District Commander | Shaun MorleyShaun.Morley2@southyorks.pnn.police.uk  |
| Sheffield City Council (Local Authority) | Executive Director, People’s Portfolio  | Jayne LudlamJayne.Ludlam@sheffield.gov.uk  |
| National Probation Service | Head of Sheffield Probation | Ann Powell Ann.powell@south-yorkshire.probation.gsi.gov.uk  |
| Sheffield Clinical Commissioning Group | Chief Nurse  | Penny Brooks Pennybrooks@nhs.net  |

# Template 5 - 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, implemented on 13th April 2011. In order to comply with Home Office guidance (revised 2016) the 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 – Strategic Commissioning Manager for Domestic and Sexual Abuse – Alison.Higgins@sheffield.gov.uk

Telephone number – 0114 205 3671

Work site address – Sheffield DACT, Floor 9, West Wing, Moorfoot Buildings, Sheffield, S1 4PL

|  |  |
| --- | --- |
| **Key dates** | **Date** |
| 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 SMARTER 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, challenge, good investigative, interviewing and communication skills.
* 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.
* Enhanced 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
* An Independence statement to this review in Sheffield.
* 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).

# Template 5a - Financial Procedures Guidance

Three or more written quotations should be requested and details recorded as an audit trail.

* 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.

# Template 6 - Contract for an Independent Chair / Author

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

This Contract is made the day of 20XX

**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) or fixed fee agreed £\_\_\_\_\_\_\_\_\_\_

# Template 7 - Terms of Reference

****

**DOMESTIC HOMICIDE REVIEW – ADULT XX**

**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** (Summary of the facts **or** 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, multi-agency working, and community engagement.
* Similarities with other domestic homicides – in Sheffield or elsewhere - can we draw on previous learning?
* Any diversity or equalities issues victim and perpetrator 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, immigration status, languages, disability, pregnancy and maternity, race, religion and belief, sex and sexual orientation.** Consider any other information that is found to be relevant, e.g
* *Perpetrator circumstances – e.g. MAPPA, DVPN/O, DVDS, police disclosure under right to know/right to ask, perpetrator support?*
* *Social housing tenants?*
* *Disclosure at work?*
* *Subject to MARAC and any other multi agency fora?*

**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, and other support networks (colleagues, employers, neighbours)**How will review: - * Provide clear communication - outlining the process from the start to the end of the process
* Offer the opportunity to meet the review panel.
* Share the TOR with the family to assist with the scope
* Offer dates for the Chair to meet family, friends and others (at the first opportunity)
* Ask if they want to choose a pseudonym.
* Be mindful of hierarchy of testimony
* Who should be invited to contribute and why? Children should be considered
* Who should not be invited to contribute and why not?
* involve the perpetrator’s family
* Should the alleged perpetrator be interviewed?
* How will interviews be conducted?
* Is there a need to facilitate involvement? By whom?
* Is there a need for a specialist advocate for the families? Whom?

Make sure there is sufficient room in the timescale for interviews to take place Ensure reference is made to agreeing an adequate time period for the family to review the draft report***It is very important to hear the voices of family and friends if possible and they are willing to participate****.***Parallel investigations**Criminal investigation proceedingsFamily or civil court proceedingsAny investigations of PracticeLink 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
* Requirement to provide the family with full media statements and mindful of key dates – birthdays etc.
 | **Agencies to bring information to inform the TOR discussion** |
| **5** | **Information Sharing** |  |
| **6** | **IMR Author Training** |  |
| **7** | **Any actions to be carried out as a matter of urgency** | **All agencies** |
| **8** | **Other issues*** Facilitated Practitioners event?
* Provision of legal advice
* Password for documents
* Consistent anonymisation of names
* Key contacts
* Staff support
 |  |
|  | **Next Meetings** * **IMR authors briefing:** Attendees anddate to be agreed
* Facilitated Practitioners event if required: Attendees anddate to be agreed
* **2nd Panel meeting:** date to be agreed
 |  |

# Template 8 - The Chair’s briefing for the Initial panel meeting / TOR

****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. Once confidentiality statement has been signed, a key explaining all the anonymised initials can be circulated
4. Background to case –Review the consideration briefing or summarise the facts of the case.
5. Hear from the SIO – if present in the meeting, an overview of the case should be presented by the SIO, raising any concerns about the criminal investigation. Decision needs to be made by the panel, to continue or delay the DHR.
6. Terms of reference
	1. Discussion of and gaining agreement for the draft ToR.
	2. Remind that the Review Chair, once appointed, may redraft again.
	3. Raise any concerns family members have raised, for consideration.
	4. The list of agencies to contribute to an IMR should be used to get the right agencies involved from the start, and all correct details for admin purposes. (see page 3)
7. 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.
8. Additional Review Panel members – consider whether any expert advisory members should be invited to join the panel.
9. 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.
10. Timescales for the process – outline expected milestones. These are fairly constrained, and will be finally set by the Review Chair.
11. 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.

Template 8a – The contact list to complete for agencies completing an IMR

DHR XXXXX and Date XXXXXX

**Please complete if your agency is requested to do an IMR at this meeting**

**Please write clearly**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Agency *(add if your agency is not listed below)*** | **Is agency required to submit IMR?** | **Name of IMR author** | **Name of Senior Manager *(for sign off)*** | **Secure email** | **Telephone** |
| **Yes** | **No** | *Insert Contact details* |
| SY Police |   |   |   |   |   |   |
| IDVA service |   |   |   |   |   |   |
| Children’s NHS FT  |   |   |   |   |   |   |
| CCG |   |   |   |   |   |   |
| STH NHS FT |   |   |   |   |   |   |
| MAST |   |   |   |   |   |   |
| SCC CYPF Social Care |   |   |   |   |   |   |
| SCC Housing Services |   |   |   |   |   |   |
| SCC Housing Solutions |   |   |   |   |   |   |
| SCC Quality & Adult Safeguarding |   |   |   |   |   |   |
| Sheffield Futures |   |   |   |   |   |   |
| SHSC NHS FT |   |   |   |   |   |   |
| SARC |   |   |   |   |   |   |
| SY Probation Service |   |   |   |   |   |   |
| Victim Support |   |   |   |   |   |   |
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# Template 9 - 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.
* Acknowledge areas of best practice.
* Contribute to a better understanding of the nature of domestic violence and abuse.
* 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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# Template 10 - Agenda for the IMR author’s briefing



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

PURPOSE

* 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: (insert name) |   |
| **1** | Introduction, welcome and confidentiality | Chair |
| **2** | Apologies for absence | Chair |
| **3** | Review of Adult XXX DHR case |   |
| **4** | Terms of reference  | Chair  |
| **5** | Domestic Homicide Reviews process  |   |
| **6** | Guidance for producing an IMR, chronology and action plan – Discuss need for the pen portrait (new for 2016)  | Chair |
| **7** | Timetable and process of communication  |   |
| **8** | Any Other Business |   |
| **9** | Date, Time and Venue of Next Meeting (All Panel members) |   |

# Template 11 - Agenda for IMR review meeting(s)



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

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

|  |  |
| --- | --- |
| **Order** | **Agenda item** |
|  | 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 |
|  | Update to timetable andDate of Next Meeting |

# Template 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** | **Order** | **Agenda Item** |
|  |  | 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 |

# Template 13 – Standing Review Panel Membership 2017/18

| **Organisation** | **Post** | **Current post holder** |
| --- | --- | --- |
| SY Police  | Head of Public Protection Unit (PPU) | Pete Horner |
| Sheffield City Council | Head of Commissioning, People Keeping Well | Lorraine Jubb  |
| Head of Safeguarding and Quality, Communities  | Simon Richards  |
| Assistant Director with responsibility for Safeguarding and Quality Assurance | Victoria Horsefield |
| Assistant Director Legal Services  | Steve Eccleston |
| National Probation Service  | Lead for Sheffield Probation  | Ann Powell  |
| Sheffield CCG (Clinical Commissioning Group) | Chief Nurse  | Penny Brooks  |

# Template 13a - Family confidentiality form

**Instruction to the sender - This form needs to be sent with the letter to the family member and returned by the family member.**

**Family confidentiality form**

The Domestic Homicide Review will be conducted in line with the Data Protection Act.

The Sheffield Safer and Sustainable Communities Partnership procedures for Domestic Homicide Reviews stipulate that no family member involved in the review will discuss, share or disclose any details of the review with anyone other than the chosen advocate (if applicable), the Chair of the Review, the DACT representative and the police.

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

| **Name** |  | **Relationship to the victim** |  | **Signature** |  | **Date** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

# Template 13b – Letter to the victim’s family asking for their contribution to the DHR – NO children



Sheffield DACT

Sheffield City Council

Level 9 West

Moorfoot Building

Sheffield

S1 4PL

Insert Date

Dear XXXX

Please accept my condolences for the tragic loss of your xxxx.

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 that considers the contact local services had with xxxx, in order to find out whether they could have done anything differently or better for her. 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.

Involving family members is particularly important to the process because you can influence the content and impact of the review and you can increase our understanding of what XXX was like as a person.

We would like to discuss the full opportunities available, however we would like to highlight the following:-

1. We would like to offer you the opportunity to meet with the Chair of the review and the Review Panel, at the earliest opportunity.
2. We would like to share the terms of reference with you, this is a document which outlines the content of the review. We welcome any comments from you, because in this way you can help shape the review.
3. We would like to regularly update you with progress.
4. We would like to hear what you can tell us about xxx **and what you know about their life and the sort of person they were**. What you share with us will add to the information we gather from local services, to help us fully understand what happened.

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 xxx personally.

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.

If you are willing to make a contribution after the trial, we can arrange for you to do. This can be completed in a number of ways and together we can use the most appropriate method for you. For example, we can do this in writing or in a recording, by phone or in person with the Chair of the Domestic Homicide Review process.

**What do I need to do next?**

To start your participation in this review, you will need to complete, sign and return to me, the consent and confidentially forms attached.

1. The consent form - You can say yes or no to each of the questions on the consent form. If you answer yes, to all or some of the questions, this gives your consent to that question and informs me about how you want to be part of the process.

One of the questions asks for your permission for services you have been involved in to share personal information that is relevant to the DHR.

1. The confidentiality form – this is an extremely important form and needs to be completed, if you wish to participate in the process in any way. This form is to ensure any information you hear or receive while being involved in this review process is kept confidential and is not shared verbally or physically with anyone else.

**What if I don’t want to be involved and do not give my consent?**

If you say no, please complete the consent form, responding with a ‘no’ to the questions. You can change your mind at any time, although the further into the process we are when this happens may limit your options.

**I’m unsure, what should I do?**

If you are not sure what to do or you have further questions please contact me by telephone or email to discuss.

**I want to know more, where can I get more information?**

There is further 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 need support, who should I contact?**

I understand this is a particularly distressing and emotional time for you. If you would like to speak to someone about the support available, you can contact Victim Support and/or AAFDA.

The contact details for these services are as follows:-

Victim Support

Website: <https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service>

Contact telephone number: 0300 303 1976

AADFA

Website: <https://aafda.org.uk/help-for-families/>

Contact telephone number: 07768 386922

It is important you are involved from the start and therefore we ask that you respond promptly, with the consent and confidentiality agreements in this letter. If you are returning these by post please send to the Strategic Commissioning Manager for Domestic and Sexual Abuse, Sheffield DACT at the address above.

If you have any questions about the process please feel free to telephone me on 0114 205 3671.

Yours Sincerely

Alison Higgins

Strategic Commissioning Manager for Domestic and Sexual Abuse

Sheffield Domestic abuse Coordination Team

Sheffield City Council

# The Family participation & consent response form – no children

**Participation and consent to share information in a Domestic Homicide Review (DHR) – Response form**

|  |  |
| --- | --- |
| Name – (insert)Date of Birth – (insert)Address – (insert) | Please mark |
| **Participation in the Domestic Homicide Review** |
| I would like to speak to the DHR independent Chair and the Sheffield Domestic Abuse Co-ordination Team about xxxx, and the support she received from agencies, once the criminal proceedings are finished. | Yes / No |
| I would like to participate in the DHR process and I want to discuss what I can do to help. | Yes / No |
| I would like to meet with the review panel at the earliest opportunity. | Yes / No |
| **Consent to share information held in the agencies involved in the DHR** |
| I give my consent for services involved in the DHR review to share details of my involvement with their service. List the agencies involved | Yes / No |

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 provide further information and to arrange a meeting:

**The Family confidentiality form**

The Domestic Homicide Review will be conducted in line with the Data Protection Act.

The Sheffield Safer and Sustainable Communities Partnership procedures for Domestic Homicide Reviews stipulate that no family member involved in the review will discuss, share or disclose any details of the review with anyone other than the chosen advocate (if applicable), the Chair of the Review, the DACT representative and the police.

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

| **Name** | **Relationship to the victim** | **Signature** | **Date** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

If you are returning these by post please send to the Strategic Commissioning Manager for Domestic and Sexual Abuse, Sheffield DACT at Sheffield DACT, Sheffield City Council, Level 9 West, Moorfoot Building, Sheffield, S1 4PL.

# Template 13c – Letter to the victim’s family asking for their contribution to the DHR – with children



Sheffield DACT

Sheffield City Council

Level 9 West

Moorfoot Building

Sheffield

S1 4PL

Insert Date

Dear XXXX

Please accept my condolences for the tragic loss of your xxxx.

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 that considers the contact local services had with xxxx, in order to find out whether they could have done anything differently or better for her. 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.

Involving family members is particularly important to the process because you can influence the content and impact of the review and you can increase our understanding of what XXX was like as a person.

We would like to discuss the full opportunities available, however we would like to highlight the following:-

1. We would like to offer you the opportunity to meet with the Chair of the review and the Review Panel, at the earliest opportunity.
2. We would like to share the terms of reference with you, this is a document which outlines the content of the review. We welcome any comments from you, because in this way you can help shape the review.
3. We would like to regularly update you with progress.
4. We would like to hear what you and if possible your children/ grandchildren / relative to the recipient can tell us about xxx. So we can understand **what you and the children know about their life and the sort of person they were**. What you and the children share with us will add to the information we gather from local services, to help us fully understand what happened.

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 xxx personally.

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.

If you are willing to make a contribution after the trial, we can arrange for you to do. This can be completed in a number of ways and together we can use the most appropriate method for you. For example, we can do this in writing or in a recording, by phone or in person with the Chair of the Domestic Homicide Review process.

**What do I need to do next?**

To start your and the children’s participation in this review, you will need to complete, sign and return to me, the consent and confidentially forms attached.

1. The consent form - You can say yes or no to each of the questions on the consent form. If you answer yes, to all or some of the questions, this gives your consent to that question and informs me about how you want to be part of the process.

One of the questions ask for your permission for services you have been involved in to share personal information that is relevant to the DHR.

A second asks for your consent for agencies to share personal information on behalf of the children.

1. The confidentiality form – this is an extremely important form and needs to be completed, if you wish to participate in the process in any way. This form is to ensure any information you hear or receive while being involved in this review process is kept confidential and is not shared verbally or physically with anyone else.

**What if I don’t want to be involved and do not give my consent?**

If you say no, please complete the consent form, responding with a ‘no’ to the questions. You can change your mind at any time, although the further into the process we are when this happens may limit your options.

**I’m unsure, what should I do?**

If you are not sure what to do or you have further questions please contact me by telephone or email to discuss.

**I want to know more, where can I get more information?**

There is further 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 need support, who should I contact?**

I understand this is a particularly distressing and emotional time for you. If you would like to speak to someone about the support available, you can contact Victim Support and/or AAFDA.

The contact details for these services are as follows:-

Victim Support

Website: <https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service>

Contact telephone number: 0300 303 1976

AADFA

Website: <https://aafda.org.uk/help-for-families/>

Contact telephone number: 07768 386922.

Specialist help for the children is also available, please contact me so I can arrange.

It is important you are involved from the start and therefore we ask that you respond promptly, with the consent and confidentiality agreements in this letter. If you are returning these by post please send to the Strategic Commissioning Manager for Domestic and Sexual Abuse, Sheffield DACT at the address above.

If you have any questions about the process please feel free to telephone me on 0114 205 3671.

Yours Sincerely

Alison Higgins

Strategic Commissioning Manager for Domestic and Sexual Abuse

Sheffield Domestic abuse Coordination Team

Sheffield City Council

**Participation and consent to share information in a Domestic Homicide Review (DHR) – Response form**

|  |  |
| --- | --- |
| Name – (insert)Date of Birth – (insert)Address – (insert) | Please mark |
| **Participation in the Domestic Homicide Review** |
| I would like to speak to the DHR independent Chair and the Sheffield Domestic Abuse Co-ordination Team about xxxx, and the support she received from agencies, once the criminal proceedings are finished. | Yes / No |
| I would like to participate in the DHR process and I want to discuss what I can do to help. | Yes / No |
| I would like to meet with the review panel at the earliest opportunity. | Yes / No |
| **Consent to share information held in the agencies involved in the DHR** |
| I give my consent for services involved in the DHR review to share details of my involvement with their service. List the agencies involved | Yes / No |
| I give my consent for services listed below who were involved (insert names of children) with the children in my care to share details of their involvement with their service. List the agencies involved  | Yes / No |

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 provide further information and to arrange a meeting:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family confidentiality form**

The Domestic Homicide Review will be conducted in line with the Data Protection Act.

The Sheffield Safer and Sustainable Communities Partnership procedures for Domestic Homicide Reviews stipulate that no family member involved in the review will discuss, share or disclose any details of the review with anyone other than the chosen advocate (if applicable), the Chair of the Review, the DACT representative and the police.

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

| **Name** | **Relationship to the victim** | **Signature** | **Date** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

If you are returning these by post please send to the Strategic Commissioning Manager for Domestic and Sexual Abuse, Sheffield DACT at Sheffield DACT, Sheffield City Council, Level 9 West, Moorfoot Building, Sheffield, S1 4PL.

# Template 14 – Consent letter to alleged perpetrator



DACT

Sheffield City Council

Level 9 West

Moorfoot Building

Sheffield

S1 4PL

Insert date here

Dear insert name here,

I am writing to you as the Council’s Domestic Abuse Strategic Commissioning Manager. Sheffield Domestic Abuse Co-ordination Team has commissioned a Domestic Homicide Review into the death of insert name of victim here.

The Domestic Homicide Review Process we would like consider the full information held by all agency’s in Sheffield you have had contact with. The aim is 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.

Please be aware that 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. Therefore I will not be speaking to any of the individuals involved in the case until the proceedings are finished.

In order to proceed we would like to have your permission:

1. To access full 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, They will be using this information about you to look into the support you received by agencies in Sheffield to identify if there are any lessons to be learnt. Agencies will then discuss and agree recommendations that need to be put into practice.

1. To meet with you to hear your views about the support you received and any issues you wish to raise or concerns you may have.

This is a voluntary offer, and you do not have to give permission to meet with me, but if you do meet with me, then information you can provide, may help others in the future.

Again, we would not be able to do this, until after the criminal proceedings are finished.

I have included a section on the consent form (sent with this letter) 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.

It is best practice to ask you for your consent, however if you do not give your consent, then it may be in the public interest for agencies to share relevant information.

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

Alison Higgins

Strategic Commissioning Manager for Domestic and Sexual Abuse

Sheffield Domestic Abuse Co-ordination Team

# Template 15 – 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Template 16 – Consent letter to other (e.g. perpetrator’s family, friend / colleague / community member)

NOTE - Update accordingly with regard the relationship to the victim or the perpetrator



DACT

Sheffield City Council

Level 9 West

Moorfoot Building

Sheffield

S1 4PL

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, friend, colleague…)

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 have the opportunity to speak to you in person and hear what you would like to tell us both about insert victim’s name and 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.

We appreciate that discussing this might be an upsetting prospect for you but we hope you will agree that it is really important that we hear from people who knew xxx personally.

There is an information leaflet on Domestic Homicide reviews for family and friends 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 and participation 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 DACT, Sheffield City Council, Level 9 West, Moorfoot Building, Sheffield, S1 4PL.

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

Alison Higgins

Strategic Commissioning Manager for Domestic and Sexual Abuse

Sheffield Domestic Abuse Co-ordination Team

Sheffield City Council

# Template 17 - Consent form for ’Other’

****

**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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Template 18 – Frequently asked Questions form to be sent with letters to the family and others.



**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 came 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**

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

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

# Template 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.

# Template 20 – Chronology

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.

# Template 21 - IMR

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 job title is, what you 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**

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.

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.

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

Copy in terms of reference here

**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 ongoing, 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). Provide details of their relationship to the victim, ethnic origin and address (if different). Use the agreed initial or alternative names.

Insert a family tree or genogram if one is available.

Provide a pen portrait of the victim. This is a description of the victim - this may cover age, and other physical characteristics but will focus on softer dimensions your service has observed in terms of attitude, appearance and lifestyle.

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.

The chronology will identify the names of professionals involved with the victim, perpetrator and family members at each stage of the contact with your service. State whether they have been interviewed as part of the IMR.

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?
* Did staff make use of the available training?
* Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

Policies, procedures and risk assessment:

* Did the agency have policies and procedures in place for dealing with concerns about, or disclosure of, domestic violence? Had the victim disclosed to any practitioners, their employer or professionals and if, so was the response appropriate? Was this information shared, where appropriate?
* 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? Were these 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? Or were relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time? – ‘professionally curious’
* Were appropriate statutory actions taken in line with the relevant time frames (reviews, re-assessments, visits)?
* For housing services - Were the victim (and/or perpetrator) social housing tenants? If so was there rent arrears or frequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? Did the social Housing Landlord carry out routine screening for domestic abuse? Are there policies in place which support and allow staff to identify and report suspected domestic abuse? Have the processes in place been reviewed to ensure that they remain effective?

Client focus:

* When and in what way were the client’s wishes and feelings ascertained and considered?
* Is it reasonable to assume that the wishes of the victim should have been known?
* 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? Were any of the other protected characteristics relevant in this case? E.g. Did the victim’s immigration status have an impact on how agency responded to their needs?
* How accessible were the services to the client? e.g. time to start treatment/support following referral? How effectively did the victim engage with your service? How effectively did you work with the victim to engage with the support/ service?
* Was the victim subject to a MARAC or other multi-agency fora?

Perpetrator focus

* What was known about the perpetrator in your service?
* Were they being managed under MAPPA?
* Were there any injunctions of protection orders in place, e.g. DVPO, DVPN? Or had been in place previously?

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?
* How effective was information sharing between agencies?
* What evidence was there of good inter-agency activity?
* Did anything adversely affect the inter-agency activity?

Other

* Are there any other questions that may be appropriate and could add content to the case?

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 and beyond 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).

# Template 22 – Checklist for an excellent IMR

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |   | Yes | No | N/A |
| 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 Template |   |   |   |
| 5 | The Terms of Reference are clearly set out and each Term of Reference subject answered, if applicable to the agency |   |   |   |
| 6 | The IMR sets out which records were accessed |   |   |   |
| 7 | All relevant staff have been interviewed, a transcript of the interview is available, has been shared with the interviewee and has been retained for the purposes of disclosure to a criminal investigation should the need arise. Where it has not been possible to interview relevant staff, 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 SMARTER (specific, measurable, achievable, realistic and timely with evaluation and review built in). 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.  |   |   |   |

# Template 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 Template 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 DHR 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 **Template 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 Template 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 **Template 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**:



# Template 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.

# Template 25 - Action plan for the overview report



# Template 26 - Governance structure for action reporting

Domestic and Sexual 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

# Template 27 - Overview Report Template

**INSERT SSCP LOGO**

SHEFFIELD SAFER AND SUSTAINABLE

COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

ADULT (INSERT INITIAL OR PSEUDONYM)

Insert DATE

Insert Author details

**TITLE PAGE OF OVERVIEW REPORT**

|  |  |
| --- | --- |
| Name of the Community Safety Partnership  |   |
| Victim’s pseudonym and month and year of death *(note do not use the precise date)*  |   |
| Author’s name  |   |
| Date the review report was completed  |   |

**LIST OF CONTENTS PAGE**

This report of a domestic homicide review examines agency responses and support given to (pseudonym used for victim’s name), a resident of (area name) prior to the point of (his/her) death on (date of death).

In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

Summarise the circumstances that led to a review being undertaken in this case.

The review will consider agencies contact/involvement with (victim’s and perpetrator’s pseudonym) from (indicate date/s/period that the scope of the review will be examining and the reason this has been chosen).

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

**TIMESCALES**

This review began on (date) and was concluded on (date).

Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review.

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

**CONFIDENTIALITY**

The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. Include pseudonym/s agreed with the family and used in the report to protect the identity of the individual(s) involved.

State the age of the victim and perpetrator at the time of the fatal incident, and their ethnicity.

**TERMS OF REFERENCE**

**METHODOLOGY**

Record details of the decision to undertake a DHR and who was involved in that decision.

Describe the methodology used, what documents were used, whether interviews undertaken.

**INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY**

Include when people were contacted and by whom; the nature of their involvement and whether they have been provided with the relevant Home Office DHR leaflet. Include whether:

* The family had the help of a specialist and expert advocate
* The terms of reference were shared with them to assist with the scope of the review
* The family met the review panel
* The family have been updated regularly
* Reviewed the draft report in private with plenty of time to do so, and have the opportunity to comment and make amendments if required.
* All those contributing were able to do so using the medium they prefer

**CONTRIBUTORS TO THE REVIEW**

List the agencies and other contributors to the review and the nature of their contribution i.e. IMR, report, or information.

Confirm the independence of IMR authors and how they are independent.

**THE REVIEW PANEL MEMBERS**

List the names of DHR panel members, their role and job title and the agency they represent.

Include number of times the Panel met, and confirm independence of Panel members.

**AUTHOR OF THE OVERVIEW REPORT**

Explain the independence of the chair (and author if separate roles) and give details of their career history and relevant experience.

Confirm that the chair/author have had no connection with the Community Safety Partnership. If they have worked for any agency in the area previously state how long ago that employment ended.

**PARALLEL REVIEWS**

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

**EQUALITY AND DIVERSITY**

Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted.

**DISSEMINATION**

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

*Insert the names of family members, elected Members, the Police and Crime Commissioner and the heads of all the services involved in the review.*

**BACKGROUND INFORMATION (THE FACTS)**

* Where the victim lived and where the homicide took place.
* A synopsis of the homicide (what actually happened and how the victim was killed).
* Details of the Post Mortem and inquest and/or Coroner’s inquiry if already held. State the cause of death.
* Members of the family and the household. Who else lived at the address and, if children were living there, what their ages were at the time (to enhance anonymity, the children’s genders should not be given).
* How long the victim had been living with the perpetrator(s). If a partner/ex-partner, how long they had been together as a couple.
* Who has been charged with the homicide, the date and outcome of the trial, and sentence given.
* If the review is being undertaken into a victim who took their own life (suicide) state on what basis this was considered to meet the criteria to undertake the review.

**CHRONOLOGY**

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

Provide a combined narrative chronology charting relevant key events/contact/involvement with the victim, the perpetrator and their families by agencies, professionals and others who have contributed to the review process.

Note the time and date of each occasion when the victim, perpetrator or child(ren) was seen and the views and wishes that were sought or expressed.

*(If the family structure is extensive or complex consider including an anonymised genogram at the start of the chronology)*

**OVERVIEW**

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

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

**ANALYSIS**

The analysis section should address the terms of reference and the key lines of enquiry within them.

This part of the overview should examine:-

* how and why events occurred,
* the information that was shared *during the investigative process*,
* the decisions that were made,
* The actions that were taken or not taken.
* Highlight areas of good practice

It can consider whether different decisions or actions may have led to a different course of events.

**CONCLUSIONS**

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

**LESSONS TO BE LEARNT**

This part of the report should:-

* summarise what lessons are to be drawn from the case
* summarise how those lessons should be translated into recommendations for action.
* State any early learning identified during the review process and whether this has already been acted upon.

**RECOMMENDATIONS**

Recommendations should include, but not be limited to,

* those made in individual management reports
* Recommendations of national impact made for national level bodies or organisations.

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

# Template 28 - Executive Summary Template

**TITLE PAGE OF EXECUTIVE SUMMARY**

|  |  |
| --- | --- |
| Name of the Community Safety Partnership  |   |
| Victim’s pseudonym and month and year of death *(note do not use the precise date)*  |   |
| Author’s name  |   |
| Date the review report was completed  |   |

**LIST OF CONTENTS PAGE**

**THE REVIEW PROCESS**

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

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

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

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

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

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

**CONTRIBUTORS TO THE REVIEW**

List the agencies and other contributors to the review and the nature of their contribution i.e. IMR, report, or information.

Confirm the independence of IMR authors and how they are independent.

**THE REVIEW PANEL MEMBERS**

List the names of DHR panel members, their role/job title and the agency they represent.

Include number of times the Panel met, and confirm independence of Panel members.

**AUTHOR OF THE OVERVIEW REPORT**

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

**TERMS OF REFERENCE FOR THE REVIEW**

**SUMMARY CHRONOLOGY**

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

**KEY ISSUES ARISING FROM THE REVIEW**

(Add issues as required)

**CONCLUSIONS**

**LESSONS TO BE LEARNED**

**RECOMMENDATIONS FROM THE REVIEW**

(Add recommendations as required)

# Template 29 – Home Office DHR Data Collection Form

**This form is not for publication – for home office data collection only.**

**The form needs to be completed by the CSP and sent with the overview report and the Executive Summary to the Home Office.**

**DOMESTIC HOMICIDE REVIEW**

|  |  |
| --- | --- |
| Community Safety Partnership |   |
| Local DHR Reference |   |
| Police Force |   |
| Date first notified to Home Office |   |
| Name of Review Panel Chair |   |
| Name of Report Author |   |
| Date report completed |   |
| Date submitted to Home Office |   |
|  |  |
| (Please include information for all victims) | **Victim** |
| Victim Gender |   |
| Age at time of incident |   |
| Relationship to perpetrator |   |
| Ethnicity (ONS) |   |
| Nationality |   |
| Religion |   |
| Sexual Orientation |   |
| Disability |   |
|  |  |
| Gender | **Perpetrator** |
| Age at time of incident |   |
| Relationship to victim |   |
| Ethnicity (ONS) |   |
| Nationality |   |
| Religion |   |
| Sexual Orientation |   |
| Disability |   |
| Details of verdict |   |
|  |  |
| Date of homicide | **General** |
| Place of murder |   |
| Method of killing |   |
| Number of Children in Household |   |

# Template 30 – Out of area letter template and information submission template



Domestic Abuse Coordination Team

Sheffield City Council

Level 9 East

Moorfoot Building

Sheffield

S1 4PL

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 (insert date) 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** |

1. If you ***do*** hold records, please then contact Alison Higgins, 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.

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.
2. If you do **not** hold records please confirm this to Alison Higgins as well.
3. 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.

For any other queries please contact 0114 20 53671.

Yours sincerely

Alison Higgins

Strategic Commissioning Manager for Domestic and Sexual Abuse

Domestic Abuse Coordination Team

Sheffield City Council

# Template 31 – Email template to send the final draft report to the SSCP for sign off

Draft email for DHR sign off by SSCP

Dear (insert names) and Chief Superintendent XXX

Please find attached the final draft of the Adult XXX Domestic Homicide Review Overview Report which is being sent to you for sign off on behalf of the Safer and Sustainable Communities Partnership. Please note that due to the confidential nature of this document it is password protected and passwords will be sent in a separate email.

The final draft has been prepared by the Independent Chair XXXX, following the XXX Adult XXX DHR Review Panel meeting yesterday. The date for submission to the Home Office is **(insert date)**. I would therefore request that you give the Overview Report your urgent attention.

If you need any clarification please contact Alison Higgins, the Domestic Abuse Partnership Manager on 07792 336148 or 20 53671 or by email alison.higgins@sheffield.gov.uk or if you are using secure email alison.higgins@sheffield.gcsx.gov.uk Or you can send queries to me and I will forward them on.

We look forward to hearing your responses to the Review

Yours sincerely

*Alison Higgins*Strategic Commissioning Manager for Domestic and Sexual Abuse

Domestic Abuse Coordination Team

Sheffield City Council

*Tel: 0114 296 4987*
*Mobile: 07792 336148*

# Template 32 - Serious Incident Review Process

**Domestic Abuse Serious Incident Review Process**

**Definition**

Serious Incidents Reviews (SIR) should be carried out where one or more of the following circumstances occur;

* 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.
* Or other circumstances that partners consider will result in significant learning by more than one agency

The process will mirror that of local Domestic Homicide Review processes existing in Sheffield 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.

**Consent**

Consent should be sought from all living parties that the review may wish to consider: e.g. victim, perpetrator, dependent children (via the parent / carer), or other significant adults. If consent is withheld, the right to withhold consent will be balanced on a case by case basis against the public interest of learning the lessons of the case. The DHR Consideration Panel will make the final decision as to whether to proceed where consent is withheld. Levels of involvement and engagement of the victim are at their own discretion.

**Note –** in some cases, for example where consent is not given by either victim or 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 investigation. This decision will be made on a case by case basis.

**Process**

The following process should be observed in carrying out a Serious Incident Review;

***1. Police or other agency disclosure***

The investigating police force or another agency inform the Domestic Abuse Coordination Team (DACT) of any domestic abuse incident or crime that has resulted in a near miss, life threatening injuries, an initial arrest for attempted murder within a domestic incident, or any other circumstance whereby death or serious injury appears to have resulted from domestic abuse or neglect .

***2. Notification***

The appointed DHR/SIR co-ordinator (this individual will be chosen by Sheffield DACT as the SIR co-ordinator and will organise the progress of the SIR from this point) circulates urgent notification to the full contact list of agencies, password protected and via secure email, requesting information they have regarding the victim and/or perpetrator of the incident. This should take place as soon as possible after police disclosure of a crime taking place.

***3. Consideration Panel***

A brief summary of the case should be communicated to the Consideration Panel in order that they can make a decision to proceed with a Serious Incident Review, or not.

The Sheffield membership of the consideration panel for SIRs should mirror that of the panel currently in place for Domestic Homicide Reviews.

The consideration panel should decide whether a SIR should commence based on the nature of the incident and how well it fits within the definition of a SIR appropriate incident, and should also take into account **circumstances of particular concern** as considered in the Domestic Homicide Review process as follows;

* Evidence of a risk of serious harm to the victim that was not recognised or identified by agencies in contact with the victim/perpetrator; it wasn’t shared, and/or it was not acted upon in accordance with recognised best professional practice.
* Agencies/professionals involved consider their concerns were not taken sufficiently seriously or not acted on appropriately by agencies involved.
* The serious incident indicates there have been failings in one or more aspects of local operation of formal domestic violence or other procedures, or Safeguarding Adults.
* The victim was being managed by, or should have been referred to Multi Agency Risk Assessment Conference (MARAC).
* The serious incident appears to have implications/reputational issues for a range of agencies/professionals.
* The serious incident suggests national or local procedures or protocols may need to change or are not adequately understood or followed.
* Victim had no known contact with any agencies, e.g. could awareness have been raised.

If a decision is made to NOT hold a SIR, a summary report of reasons for this decision should be written within **7 days** of the decision being made and circulated to members of the consideration panel for approval – this decision should then be communicated to relevant agencies aware of the serious incident.

As referenced at the beginning of the procedural document, a ‘light touch’ review may be carried out if this is deemed the most appropriate response to some incidents.

If a decision is made to proceed with a SIR, the process should continue as follows;

***4. Appoint a Serious Incident Panel Chair***

Any individual acting as a chair for a SIR should be objective and not connected to any of the agencies or victim/perpetrator of the serious incident; in the case of Serious Incident Reviews the chair of the panel will be an experienced individual from a partner agency.

The Chair of the SIR will meet the following criteria;

* Relevant knowledge of Domestic Abuse
* An understanding of the main agencies involved
* An understanding of operational regimes
* Managerial experience
* No conflict of interest

***5. First meeting of the Serious Incident Panel***

Terms of reference should be agreed by the Serious Incident Review panel as a priority agenda item. The TOR should take into consideration the following issues and both the issues and the planned approach to dealing with them should be stated clearly; (template available as an Template to the SIR process documents); Dependent on the nature of the incident, some of the stages may not be included however, this will be agreed in full at this meeting.

1. Identification of issues and lessons to be learnt.
2. Scope of the Serious Incident Review (specific concerns to be investigated).
3. Scale of the review e.g. full or ‘light touch’
4. Timetable for the process.
5. Terms of Reference
6. Confirmation of review panel chair.
7. Confirmation of overview report author.
8. Agencies required to contribute to the SIR.
9. Process for the specific SIR.
10. Individual Management Reviews and chronology as necessary
11. Family friends, colleagues and employers.[[65]](#footnote-65)
12. **Parallel investigations (if any) \***
13. Publicity/media issues.
14. Other issues (for example, need for legal advice, confidentiality and security of information, staff support)

\***Parallel criminal proceedings/agency investigations**

During the process of a Serious Incident Review, if the criminal proceedings are still underway, it is not appropriate for the SIR co-ordinator to be communicating with the victim and/or perpetrator about the details of the incident itself until the criminal proceedings are finished. This should be made clear to the victim/perpetrator in the letter sent to them seeking their consent to review their case, and they should be advised to make a note of any details about the incident they wish to discuss as a part of the SIR once the criminal proceedings are finished. These individuals do, however, have a right to remain informed about the progress of the review and should be kept updated as the review progresses.

Additionally, if there is another agency investigation on-going into any incident that has led to a Serious Incident Review, a priority for both the lead of this investigation and the SIR co-ordinator should be ensuring these investigations complement one another and do not either duplicate work or contradict one another in conclusion. If a statutory process is triggered e.g. a MAPPA Review, this process will take precedence over a SIR.

***6. Scale of the Review***

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.

***7. Review Panel***

The review panel for the SIR should be made up of relevant professionals in the city. Members will be decided upon on a case by case basis but these are likely to include South Yorkshire Police, representatives of Health Trusts and Commissioners, and Council representatives (Children’s and Adult’s Services or Safeguarding) and representatives from Probation and the Voluntary Sector as necessary.

***Full Serious Incident Reviews Process***

***8. Individual Management Review reports***

IMRs from agencies involved with the victim/perpetrator should be submitted to the SIR co-ordinator at the 12 week point in the procedure to enable the co-ordinator to collate responses and begin compiling the overview report. The IMRs and overview report should follow a specific structure (template will be available).

***9. Chronology and writing of overview report***

The SIR co-ordinator will compile the chronology of events to ascertain the order of events and to inform the overview report, along with the individual management reports from agencies involved with the victim/perpetrator.

This should then inform the writing of the overview report in a chronological fashion.

***10. Review Panel meet to discuss the overview report***

Review panel meet with a first draft of the report to discuss the findings, actions and lessons learned recommendations from the report.

***11. Further drafts of overview report***

Further drafts of the overview report to be completed until all members of review panel are satisfied with the content and action plan.

Action plan to be agreed and disseminated to agencies involved with the victim/perpetrator.

***12. Actions from Serious Incident Review overview report to be audited***

The Domestic Abuse Strategic Board will ensure that the Action Plan is audited and actions are implemented.

***13. Publication of findings***

A Serious Incident Review is not a statutory process and therefore the final report will not be published or sent to the Home Office as is procedure for Domestic Homicide Review reports. The final report into the incident will be shared among agencies as a guide for future operations, and given to select individuals such as the subjects of the SIR. The sharing of the final report will be discussed and agreed during review panel meetings before the final version of the SIR report is complete.

1. This is hereon in, the reference used when referring to the Safer Communities Partnership in Sheffield [↑](#footnote-ref-1)
2. E.g. taking into accounts the age and the "parental right yields to the child’s right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision." [↑](#footnote-ref-2)
3. Ibid, page 8, section 18 [↑](#footnote-ref-3)
4. *DHR Multiagency statutory guidance for the conduct of Domestic Homicide Reviews*, December 2016, page 10 [↑](#footnote-ref-4)
5. Section 5, point 48, page 16 [↑](#footnote-ref-5)
6. Ibid, page 9, point 21 [↑](#footnote-ref-6)
7. 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-7)
8. 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-8)
9. DHR 2016, Section 4, point 40 [↑](#footnote-ref-9)
10. Ibid, page 10, section 27 [↑](#footnote-ref-10)
11. Ibid [↑](#footnote-ref-11)
12. Ibid, page 8, section 18 [↑](#footnote-ref-12)
13. DHR 2016, Section 3, point 35 c, page 12 [↑](#footnote-ref-13)
14. DHR 2016, Section 4, point 41, page 15 [↑](#footnote-ref-14)
15. DHR 2016, Section 9, point 92, page 25 [↑](#footnote-ref-15)
16. DHR 2016, Section 9, point 92, page 25 [↑](#footnote-ref-16)
17. Section 9, point 94, page 26 [↑](#footnote-ref-17)
18. Section 9, point 95, page 26 [↑](#footnote-ref-18)
19. Section 9, point 81, page 25 [↑](#footnote-ref-19)
20. Section 9, point 97, page 26 [↑](#footnote-ref-20)
21. Ibid page 11 point 27 [↑](#footnote-ref-21)
22. Ibid page 11, section 29. [↑](#footnote-ref-22)
23. 2016, page 11, section 30 [↑](#footnote-ref-23)
24. 2016, page 11, section 34 [↑](#footnote-ref-24)
25. 2016, page 11 point 36 [↑](#footnote-ref-25)
26. Section 5, 47, page 16 [↑](#footnote-ref-26)
27. 2016 page 12, section 38 [↑](#footnote-ref-27)
28. 2016, page 12, section 37 [↑](#footnote-ref-28)
29. Ibid. Page 11, section 31 [↑](#footnote-ref-29)
30. Section 7, point 74, page 21 [↑](#footnote-ref-30)
31. ##  How is Gillick competency assessed? Lord Scarman’s comments in his judgment of the Gillick case in the House of Lords [(Gillick v West Norfolk, 1985)](https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/#pageref11214) are often referred to as the test of "Gillick competency": ".*..it is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved."* He also commented more generally on parents’ versus children’s rights: *"parental right yields to the child’s right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."*

<https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/> [↑](#footnote-ref-31)
32. Section 10, point 99, page 27. [↑](#footnote-ref-32)
33. [*https://www.gov.uk/government/publications/striking-the-balance-practical-guidance-on-the-application-of-caldicott-guardian-principles-to-domestic-violence-and-maracs-multi-agency-risk-assessment-conferences*](https://www.gov.uk/government/publications/striking-the-balance-practical-guidance-on-the-application-of-caldicott-guardian-principles-to-domestic-violence-and-maracs-multi-agency-risk-assessment-conferences) [↑](#footnote-ref-33)
34. DHR guidance 2016, Section 6, 51.g page 18 [↑](#footnote-ref-34)
35. 2016 guidance, Section 6, point 53.g, page 17 [↑](#footnote-ref-35)
36. <https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service> [↑](#footnote-ref-36)
37. <https://aafda.org.uk/help-for-families/domestic-homicide-reviews-for-families/> [↑](#footnote-ref-37)
38. 2016 guidance, Section 6, point 53.b, page 17 [↑](#footnote-ref-38)
39. 2016 guidance, Section 6, point 53.e, page 17 [↑](#footnote-ref-39)
40. 2016, Section 6, point 56 [↑](#footnote-ref-40)
41. Working with the family and friends information is found in Section 6 of the DHR 2016 guidance. [↑](#footnote-ref-41)
42. 2016 guidance, Section 6, point 56.j, page 19 [↑](#footnote-ref-42)
43. 2016 guidance, Section 6, point 57, page 19 [↑](#footnote-ref-43)
44. 2016 guidance, Section 6, point 58, page 19 [↑](#footnote-ref-44)
45. 2016 guidance, Section 6, point 59, page 19 [↑](#footnote-ref-45)
46. Section 5, point 50, page 16. [↑](#footnote-ref-46)
47. Section 7, point 61, page 20 [↑](#footnote-ref-47)
48. Section 7, point 61, page 20 [↑](#footnote-ref-48)
49. Section 7, point 65, page 20. [↑](#footnote-ref-49)
50. Section 7, point 64, page 20 [↑](#footnote-ref-50)
51. Ibid, page 11 section 32 [↑](#footnote-ref-51)
52. DHR 2016, Section 7, point 69, page 21 [↑](#footnote-ref-52)
53. DHR 2016, Section 7, point 70, Page 21 [↑](#footnote-ref-53)
54. DHR 2016, Section 7, point 72, Page 21 [↑](#footnote-ref-54)
55. DHR 2016, Section 7, point 75, page 22 [↑](#footnote-ref-55)
56. [↑](#footnote-ref-56)
57. Section 6, point 56.j, page 19. [↑](#footnote-ref-57)
58. Section 11, point 102, page 28 [↑](#footnote-ref-58)
59. Section 11, point 105, page 28 [↑](#footnote-ref-59)
60. Section 11, point 103, page 28 [↑](#footnote-ref-60)
61. Ibid page 21 points 74 and 75 [↑](#footnote-ref-61)
62. Section 11, point 105, page 28 [↑](#footnote-ref-62)
63. DHR 2016, Section 11, point 109, page 29 [↑](#footnote-ref-63)
64. The Care Act (2014) Part 1, 44 (5) [↑](#footnote-ref-64)
65. Family members can be offered support by the local Victim Support Service if necessary <https://humbersouthyorks.victimsupport.org.uk/> [↑](#footnote-ref-65)