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Procedure for the conduct of Domestic Homicide Reviews within Darlington

Version 4
Reviewed January 2020

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1 Background

The Home Office Multi-agency statutory guidance for domestic homicide reviews came into effect on 13th April 2011 and was updated in December 2016. The guidance is available at 2016 Home Office Guidance.

Domestic Homicide Reviews (DHR) were established on a statutory basis under section 9(3) of the Domestic Violence, Crime and Victims act (2004). Responsibility for establishing a DHR is clearly placed with the Chair of the local Community Safety Partnership (CSP) in consultation with multi agency partners. CSP's are viewed to be ideally placed to conduct DHRs because of their multi-agency design. Within Darlington this partnership is referred to as the Darlington Community Safety Partnership (CSP).

This procedure should be read in conjunction with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (DHRs), published in December 2016.

2 Definitions and Purpose of a DHR

2.1 Definitions

A DHR should be carried out to ensure that lessons are learnt when a person has been killed as a result of domestic violence. The guidance states:

'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:

- a person to whom he/she was related *or* with whom he/she had been in an intimate personal relationship, *or*
- a member of the same household

Where a victim took their own life and the circumstances give rise to concern (e.g. it emerges that there was coercive controlling behaviour in the relationship) a DHR should be undertaken, even if a subject is not charged with an offence or is tried and acquitted.

2.2 Purpose

The purpose of the DHR is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

- 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;
- contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice

The DHR should describe the history of abuse, identifying which agencies had contact with the victim, perpetrator and family and describing contact between agencies. The DHR should tell this story through the eyes of the victim and their children by talking to those around the victim including his or her family, friends, neighbours, community members and professionals. This will help the DHR panel understand the victim's reality, identifying any barriers the victim faced in reporting abuse and why interventions did not work. It will also help the DHR panel understand the context and environment in which professionals made decisions and acted.

The DHR should be inquisitive and professionally curious. It should not simply examine the conduct and actions of professionals and agencies but should consider organisational culture, training, supervision and leadership. The DHR should evaluate whether procedures and policies were sound, whether they supported the best interests of victims and whether changes to processes and policies could have secured a better outcome.

2.2.1 Situations preceding homicide to be considered

Situations preceding a homicide which will be of particular interest to the DHR panel include those where:

- 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. The evidence was either not shared with others, was not acted upon in accordance with recognised best professional practice or agencies or professionals felt that concerns were not taken sufficiently seriously.
- The victim had little or no known contact with any agencies. A DHR should probe why there was little or no contact with services. For example, were there barriers to accessing services and could more be done in the local area to raise awareness of services available to victims of domestic violence and abuse?
- The homicide indicates 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.
- The victim was being managed by, or should have been referred to a Multi-Agency Risk Assessment Conference (MARAC) or another multi agency forum.
- The homicide appears to have implications/reputational issues for a range of agencies and professionals.
- The homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed.
- The perpetrator holds a position of trust or authority e.g. police officer, social worker, health professional, and therefore the homicide is likely to have a significant impact on public confidence.

- There was a lack of local services to provide support or receive referrals for the victim or perpetrator.

2.2.2 Implementing immediate learning

An important purpose of the DHR is to establish what lessons can be learned from the domestic homicide and recommend changes to improve services. Lessons learnt and examples of good practice should be identified and communicated to relevant agencies as they are identified. Where appropriate, learning may be implemented as highlighted throughout the process, pending completion and approval of the DHR action plan.

2.2.3 Concurrent investigations and disciplinary action

DHRs are not specifically part of any disciplinary inquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separately to the DHR process. Alternatively, some DHRs may be conducted concurrently with (but separate to) disciplinary action.

The statutory guidance accepts that in a number of cases the DHR may be unable to commence until all criminal proceedings are complete. Where this is the case the DHR Panel should ensure that all the records and chronology of involvement are drawn up by each agency involved. As part of this process any lessons learned should be identified and brought to the attention of the relevant agency for action as soon as possible.

Dependent on the case, material gathered in the course of a DHR may be capable of assisting the defence case and would almost certainly be material that the defence would seek to obtain. If a DHR is being conducted parallel to a criminal investigation, documents and other information may all become disclosable. It is the responsibility of the disclosure officer to link with the panel chair and it is the responsibility of the Senior Investigating Officer (SIO) to keep the disclosure officer informed.

Where the evidence suggests that the suspect has killed themselves the case will be referred to the coroner and a file will be prepared. In these circumstances the DHR should be conducted without delay and the overview report and supporting documents should be submitted to the coroner to help inform the inquest. In cases where the suspect is arrested and charged, the commissioning of the overview report may be held until the conclusion of the criminal case, but this will be dependent on the individual circumstances of the case.

Other investigations and proceedings may also take place after a death, if this is the case the chair of the panel should discuss with the relevant criminal justice and other agencies such as HM Coroner, Independent Police Complaints Commission at an early stage how the DHR process should take these proceedings into account.

2.2.4 Information sharing and consent

The Data Protection Act (DPA) 2018 and General data Protection Regulations (GDPR) govern the protection of personal data of living persons and place obligations on public authorities. Problems with information sharing including access to records (e.g. medical records) and delays in receiving information have been reported in DHRs.

The Data Protection Act 2018 does not apply to deceased individuals and this applies to all records, including those held by solicitors and counsellors. Therefore, obtaining information about deceased victims of domestic abuse for a DHR should not normally present a difficulty. When considering disclosing information in relation to a deceased person the Common Law Duty of Confidentiality and the Human Rights Act 1998 must be considered.

The Data Protection Act 2018 applies to information about perpetrators. However, the DPA 2018 and GDPR are not barriers to collating and sharing information but provide a framework to ensure that personal information about living persons is shared appropriately. The Common Law Duty of Confidentiality and the Human Rights Act 1998 do not prevent the sharing of personal information. This can be because it is in the data subject's interests for the information to be disclosed or that public interest would justify the disclosure of the information.

When sharing information with the DHR it is best practice to obtain consent from those involved, however, in many cases it will be lawful to share information without consent. Where it is deemed not appropriate to seek consent, the rationale for the decisions should be clearly recorded. Further information is contained in the Darlington Safeguarding Partnership Information Sharing Protocol 2019.

The Department of Health and Social Care encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and, where appropriate, the individual who caused their death. The General Medical Council (GMC) Confidentiality: good practice in handling patient information 2017 advises doctors to seriously consider requests for information for DHRs. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:

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

ii. 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

Information should be shared in accordance with the Data Protection Act 2018 and General Data Protection Regulations (GDPR) and the Darlington Safeguarding Partnership Information Sharing Protocol 2019. The Government published Information sharing advice for safeguarding practitioners in 2018 which may be helpful.

A process map is provided at **Appendix 1** which lists the required steps for carrying out a DHR. Further detailed information to support this chart is provided below.

3 Stages of a DHR and timescales

Specific timescales are included in national guidance
Steps 3.1.1 to 3.1.5 should be carried out within one month of the homicide.
Steps 3.1.6 to 3.4.4 should be carried out within six months of the homicide, where appropriate.

3.1 Initial report of a domestic homicide and immediate multi-agency response

3.1.1 A suspected domestic homicide occurs

A homicide occurs that appears to meet the DHR criteria in section 2. This includes relationships between adults who are or have been intimate partners or family members regardless of gender or sexuality and so called 'honour'-based violence.

3.1.2 The CSP is informed of the domestic homicide

When a domestic homicide occurs the Durham Constabulary Safeguarding Unit will inform the Darlington Community Safety Partnership (CSP) in writing of the incident. This notification should be sent via secure email to the Chair of the Darlington Community Safety Partnership and copied to the Head of Community Safety.

Any professional or agency may refer a homicide to the CSP in writing if it is believed that it might meet the criteria for a DHR or if there may be important lessons for inter-agency working.

3.1.3 A preliminary multi-agency group is established

The CSP Chair instructs the Domestic Abuse and Sexual Violence Executive Group (DASVEG) to establish a preliminary group.

On receipt of this instruction, the chair of DASVEG will contact key staff from the agencies identified in **Appendix 2** by email to request attendance at a preliminary meeting. The Senior Investigating Officer should be invited to brief the preliminary group about the homicide. The preliminary meeting will be chaired by the Chair of DASVEG.

The purpose of the preliminary meeting is to share initial information about the case including chronology and involvement of agencies in order to advise the Chair of the Community Safety Partnership whether the homicide meets the Home Office criteria for a DHR and identify agencies to sit on the DHR panel

The Chair of the CSP holds responsibility for establishing whether a homicide is to be subject to a DHR based on application of the Home Office criteria and the advice of the preliminary group.

The 2016 Home Office Guidance advises that a DHR should always be carried out where a homicide meets the definition identified above. However, the scale of the review will be proportionate to the existing intelligence / information and how this can be interpreted into lessons to be learned and actions to take forward.

3.1.4 A decision is made whether or not to proceed with a DHR and Home Office informed

On receipt of the recommendation from the preliminary group the Chair of the CSP will decide whether or not to proceed to a DHR based on whether the DHR criteria are met.

The Chair of the CSP will inform the Home Office of this decision by email, including brief anonymised details of the case, the date of death and a full justification for either holding a DHR or not proceeding with a DHR. The notification should be emailed to DHRENQUIRIES@homeoffice.gsi.gov.uk. The Head of Community Safety may notify the Home Office on behalf of the Chair of the CSP.

If it is decided to proceed with a DHR Details of the nominated chair of the Review Panel should be forwarded to the Home Office at the above email address.

3.1.5 Agencies secure records

Key agencies identified by the preliminary group should:
Implement standard procedures to ensure that all case records relating to the victim, perpetrator or and their families are secured and guarded against loss or interference.
Compile relevant chronologies of their involvement with the victim, perpetrator or their families (Appendix 3) which will form the basis of the Individual Management Review (IMR).

3.1.6 Informing the victim's family

The CSP should inform the victim's family, in writing, of its decision and send the family relevant correspondence from the Home Office Quality Assurance Panel. The CSP should inform the Home Office of the rationale for not informing the family.

3.1.7 Domestic Homicides where the victim is aged between 16 and 18 years or suspect / perpetrator was responsible for care of a child aged under 18 yrs.

The victim is aged between 16 and 18 years
It should be noted that, when victims of domestic homicide are aged between 16 and 18 years, there are separate requirements in statutory guidance for child Serious Case Reviews, Safeguarding Adults Review and a Domestic Homicide Review.

Consideration should be given to how these reviews can be managed in parallel with the DHR in the most effective manner possible so that organisations and professionals can learn from the case – for example, considering whether some or all aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved and provide an improved experience for families, subject to the final shape of the review meeting the requirements of both as set out in the statutory guidance.

The suspect / perpetrator was responsible for care of a child aged under 18 years
Where either the victim or the suspect/perpetrator was responsible for the care of a child under the age of 18, the Chair of the CSP should inform the Darlington Safeguarding Business Unit and Darlington Borough Council Children's Social Care of the homicide and these circumstances.

The Working Together to Safeguard Children (2018) statutory guidance (chapter 4 paragraph 29) requires safeguarding partners to have clear processes working collaboratively with other investigations, including Domestic Homicide Reviews, multi-agency public protection arrangements reviews or Safeguarding Adults Reviews in order to reduce burdens on and anxiety for the children and families concerned and to minimise duplication of effort.

In order to meet this requirement key safeguarding stakeholders identified in **Appendix 2** will be included in the preliminary group and, as required by the circumstances of the homicide, the DHR panel. Where there are possible grounds for both a Local Child Safeguarding Practice Review (LCSRP) and a Domestic Homicide Review (DHR) a decision should be made by the DHR and LSCRP chairs as to how they will coordinate the reviews, engagement and report(s). This may result in some parts being jointly commissioned and overseen, or one Board leading, with the same or different reports being taken to each commissioning body.

3.2 Establishing a DHR panel

3.2.1 Convening the DHR panel

The Chair of the CSP**,** informed by the recommendations of the preliminary group and the CSP, establishes a DHR panel. The membership of this panel will include relevant staff from Appendix 2 and representation from other organisations as appropriate. The Panel may include representatives from the Voluntary and Community Sector as well as those who have a duty to establish or participate in a DHR. A domestic abuse specialist should be invited to sit as a DHR panel member.

3.2.2 Appointing the DHR Panel Chair

The Chair of the CSP will appoint an Independent DHR Panel Chair (and author, if these are separate roles) through the regional **NEPO608 Domestic Homicide Review commissioning framework.**

The Chair of DASVEG will liaise with the Head of Community Safety at Darlington Borough Council to ensure that appropriate administrative support is provided for the DHR.

3.3 The DHR process – gathering information from agencies and families

3.3.1 Gathering information from agencies – Individual Management Reviews

The DHR Chair and Panel will identify those agencies required to complete an Individual Management Review (IMR). An IMR template is available at Appendix 5). Other key agencies that are required to participate in the DHR may be identified as the review progresses.

3.3.2 IMRs are requested

The DHR Review Panel Chair writes to Senior Managers in each participating agency to commission IMRs (Appendix 5). Members of the DHR Review Panel provide these contact details. The IMR request should include a copy of the DHR review terms of reference so that the Senior Manager has sufficient information to carry out the IMR. The IMRs will form part of the DHR Overview Report.

3.3.3 Agencies arrange IMRs

The Senior Manager commissions the IMR and appoints an IMR author. Those conducting IMRs will not have been directly involved with the victim, the perpetrator or their families and will not have been the immediate line manager of any staff involved in the IMR.

3.3.4 IMR authors complete investigations

Following completion of the chronology the IMR author clarifies information and identifies staff to participate in an interview.

The views of the SIO and subsequent CPS advice must be sought prior to interviewing witness involved in any criminal proceedings. The Chair of the DHR Panel will liaise with the Coroner about ongoing coronial proceedings.

Where staff or others are interviewed by those preparing IMRs, a written record of the interview should be made and shared with the interviewee. These records must be retained for the purposes of disclosure to a criminal investigation should the need arise. If the review finds that policies/procedures have not been followed, relevant staff or managers will be interviewed in accordance with the relevant agency procedures. DHRs do not form part of a disciplinary investigation but if information emerges during the review that suggests disciplinary action may be indicated then the relevant agency procedures should be followed.

The IMR author produces the IMR report and passes this to the Senior Manager in the organisation who commissioned the report for quality assurance. The Senior Manager is responsible for ensuring that any recommendations from both the IMR and, where appropriate, the Overview Report are acted on appropriately. On completion of each IMR report the Senior Manager should obtain approval through the relevant agency structures before submitting to the DHR Panel Chair. The Senior Managers should then feedback and de-brief the staff in their agency who were involved in the IMR, in advance of the Overview Report.

The DHR Panel Chair and Panel will review and add to the terms of reference developed by the preliminary group as appropriate.

The DHR Panel will continue to meet at the frequency agreed within the terms of reference, and will hold discussions and review evidence and will ensure that the IMRs meet the expected standards.

3.3.5 Involving families and friends in the DHR

The victim's family should be integral to the DHY and should be treated as a key stakeholder. The involvement of family, friends and wider community involvement is both necessary and complex because this can provide information about the nature and extent of the abuse which may not have been shared with agencies which enhances the quality and accuracy of the DHR. The DHR chair and panel should make every effort to include the family and ensure that best practice is followed in these interactions.

Participation of the victim's family and friends is voluntary. The chair and review panel can help ensure they have a positive experience by offering clear communication about the process from the outset and throughout the review. Those conducting the review should consider specialist and expert advocates for the families. Children should be given specialist help and an opportunity to contribute as they may have important information to offer.

The DHR Panel Chair will inform family/friends/others of the review through a designated advocate, usually the Police Family Liaison Officer (FLO), agrees their involvement, and requests completion of a consent form for the sharing of relevant information for both the victim and the perpetrator/suspect (Appendix 7). It may be appropriate for the Chair of the DHR Panel to accompany the FLO and meet key family members on commencement of the review. This will be dependent on the individual requirements of the family and discussions should take place between the DHR Panel Chair, the Family Liaison Officer and family members.

The DHR Panel should be aware of potential sensitivities and the need for confidentiality when meeting with members of informal support networks during the review. A record should be kept of all meetings.

Where family and friends are involved in the DHR they should be regularly updated on progress. If, at any time during the review, the process is interrupted pending criminal proceedings or other investigations then the family/friends should be notified of this immediately and informed once the process re-commences.

The Home Office has produced Guidance for domestic homicide review chairs on support for families and information leaflets for family, friends, employers and colleagues.

3.3.6 Compiling the DHR report and action plan

The DHR Panel Chair must have access to all relevant documentation and, where necessary, individual professionals to enable them to effectively undertake the review

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functions. The DHR Chair will liaise with the independent DHR author to draw together the IMRs, reports from other professionals and other evidence provided during the course of the DHR.

In addition to collating IMRs, the DHR Chair and Panel and may wish to consider holding practitioner event(s) using the Significant Incident Learning Process (SILP™) approach. This may give the Panel a deeper insight into contributory factors.

3.3.7 The DHR Panel Chair (or author if roles are separate) drafts the Overview Report and Executive Summary.

The Overview Report should bring together and draw conclusions from the information and analysis contained in the IMRs and report on information commissioned from any other relevant interests. The DHR Panel Chair and author will ensure that personal details are kept anonymous within the final report and Executive Summary**.**

The overview report should be completed **within six months** of the decision to proceed to DHR unless the review panel formally agrees an alternative timescale with the CSP. If the CSP believes a delay to the completion of the review to be unreasonable, they should contact the Home Office DHR Quality Assurance Panel for advice.

The overview report should be based on the outline format and template provided at Appendix 8 but the precise format depends on the features of the homicide. The template should be amended/re-structured as required. The chair/ author must ensure that the content of the overview report and executive summary is suitably anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others. These reports will be submitted to the Home Office and published when approved.

The findings of the report are marked as Restricted as per the Government Protective Marking Scheme until the agreed date of publication. Once drafted the writers group share the Overview Report and Executive Summary with the Review Panel.

3.3.8 The DHR Panel Quality Assures the Overview Report and Executive Summary

The DHR Panel should quality assure the Overview Report and Executive Summary by ensuring that:

- Contributing organisations and individuals are satisfied that their information is fully and fairly represented in the reports
- The reports accurately reflect the review panel's findings
- The reports have been written in in accordance with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Review (Appendix 9).
- The reports are of a sufficiently high standard to be submitted to the Home Office
- Any action and learning from concurrent reviews undertaken by the Darlington Safeguarding Partnership Board is taken into consideration.

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3.3.9 The DHR Panel produces an action plan

The DHR Panel will develop the Overview Report Action Plan based on the recommendations for future action identified within the Overview Report. The resulting actions will be specific, measurable, achievable, realistic and timely (SMART) and these actions will be agreed at a senior level by each of the participating organisations. A template is provided at Appendix 10. The Review Panel will identify a Lead Officer for actions and will ensure that the Lead begins to progress the action as soon as it is identified.

3.4 Approval of the DHR report and action plan

3.4.1 The DHR Overview Report, executive summary and action plan are submitted to DASVEG

Once agreed, the review panel chair will provide a copy of the overview report, executive summary and action plan to DASVEG.

DASVEG will consider the reports prior to final presentation to the Darlington CSP Board. The DASVEG Chair will ensure that the Overview Report is tabled at the next available DASVEG meeting and the DHR review panel chair and report author will present the findings at this meeting.

3.4.2 The DHR reports are submitted to the CSP

Once DASVEG has received the **Overview Report** the DHR Chair will forward the Overview Report, executive summary and Action Plan to **the Chair of the CSP** by secure email. Where additional agency action plans exist, developed by the Senior Managers through the IMR process, these should also be forwarded to the Chair of the CSP.

3.4.3 The CSP Board agree the reports and action plan

On receipt of the Overview Report, executive summary and Action Plan, the Chair of the CSP will raise this with the **CSP Board** who will:

- Agree the content of the reports, executive summary and action plan, ensuring they are fully anonymised apart from including the names of the Review Panel Chair and members;
- Approve the overview report, executive summary and action plan
- Ensure that the DHR report and action plan are tabled for discussion at the next CSP meeting.

3.4.4 The CSP submits the reports and action plan to the Home Office for approval

The CSP will ensure that a copy of the anonymised Executive Summary, Overview report and action plan, are submitted to the Home Office Quality Assurance group. A Home Office data collection form available at [CSP DHR monitoring form] which is not for publication should also be submitted. These documents should be sent via email:

DHRENQUIRIES@homeoffice.gsi.gov.uk. The CSP chair may delegate this action to the Head of Community Safety

3.4.5 The Home Office approves the DHR reports and action plan

The Home Office expert panel quality assures the report and provides an 'adequate' or 'inadequate' verdict. If 'adequate' the Home Office gives clearance for publication and may provide recommendations for amendments to the overview report prior to publication.

If 'inadequate' the review panel will reconvene and a conference call with the Chair of the Home Office Quality Assurance Panel will take place. Appropriate amendments will be made, and the report will be resubmitted to the next available quality assurance (QA) Panel. This will be coordinated by the Chair of the CSP who may delegate this to the Head of Community Safety.

3.5 Communication with key agencies and implementation of the DHR Action plan

The CSP instructs the DASVEG to implement and monitor the Overview Report Action Plan and any Senior Manager Action Plans on a quarterly basis. Updates are captured and fed back by the managers who commissioned the IMRs.

The CSP should arrange for copies of the overview report, executive summary and action plan to be forwarded to the Senior Managers that participated in the IMRs. The Senior Managers are responsible for carrying out a follow up feedback session with the staff members who participated in the IMR once the overview report has been completed, prior to its publication and ensuring that any appropriate recommendations from the Overview Report are acted upon within their own agency.

3.6 Communication with the family and other agencies and publication of the DHR report

3.6.1 Communication with the family

Once the Overview report and action plan have been deemed adequate by the Home Office QA Group the Review Panel Chair should provide a copy of both the overview report and action plan to the family via the nominated advocate.

If it is likely the report may be leaked due to media interest the document should be shared with the family as soon as possible.

If deemed appropriate by the Chair of the Review Panel, a media strategy meeting should be held prior to publication, led by DBC Communication Team.

3.6.2 Communication with other agencies

Once the Home Office have given clearance for publication the Chair of the CSP shares the overview report and action plan with relevant statutory organisations involved with investigating the homicide such as the Coroner and the Independent Police Complaints Commission to confirm that the information contained within the review can be shared

publicly. An update on feedback from the Home Office is provided to the DASVEG and the CSP Board by the Chair of the CSP.

Details of the proposed publication and timescales should be shared with:

- DHR Panel members
- Senior Managers participating in the IMR process
- The Office of Police, Crime and Victims Commissioner
- Children's services if involved
- Any other relevant agencies e.g. County Coroner, Independent Police Complaints Commission, etc.

3.6.3 Publication of the DHR report and executive summary

The DHR chair and panel and family members of the victim should be involved in the publication date to consider key dates (e.g. the birthday of the victim or anniversary of the homicide).

The CSP will ensure that the overview report and executive summary are published on the Darlington CSP website. The Home Office should be notified by email that the reports have been published, including links to these.

3.7 Audit of the action plan and conclusion of the DHR

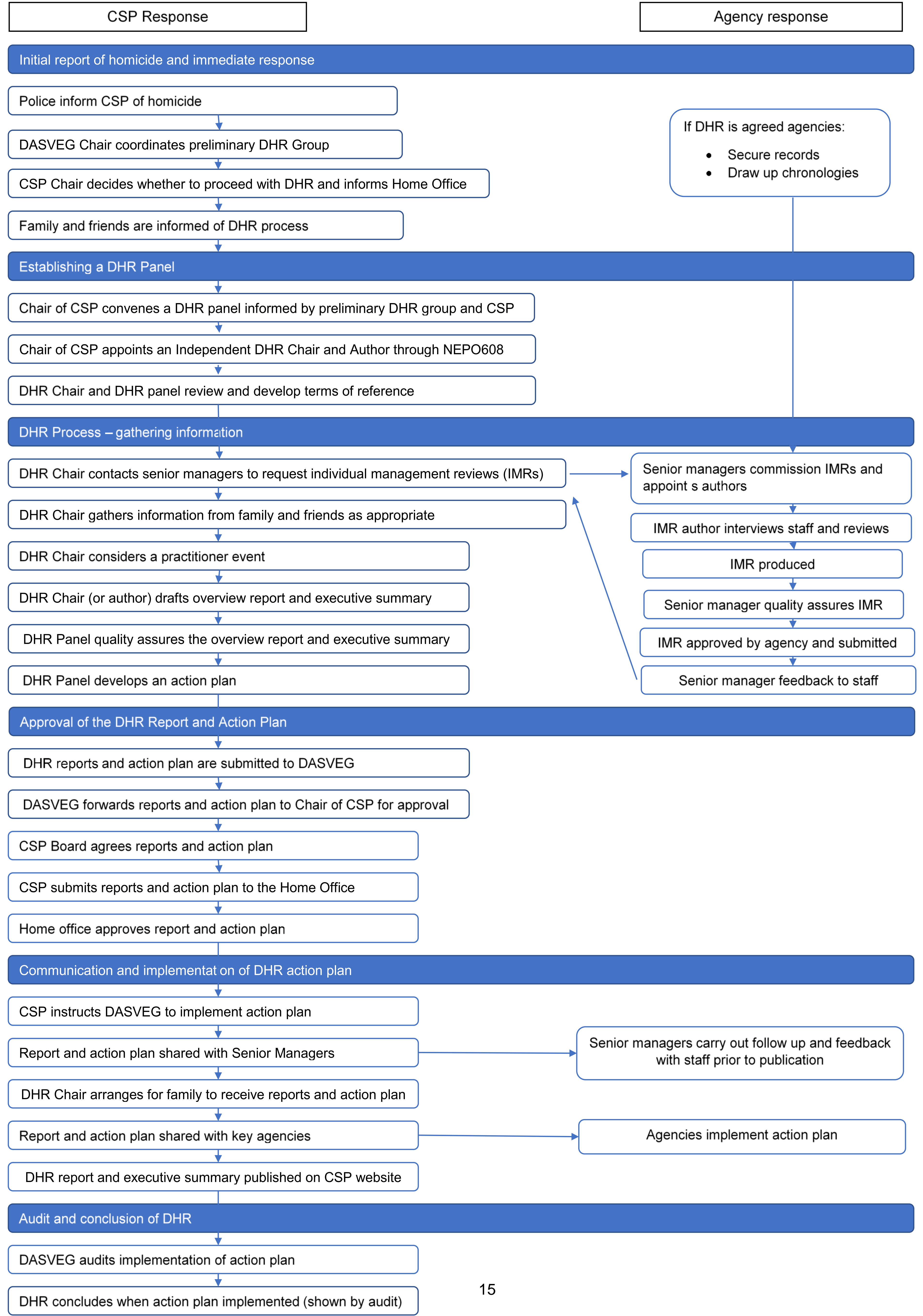
The Chair of DASVEG will lead an audit of the process and compiles a lessons-learned and good practice document on an annual basis that can be shared as appropriate. This should then be published alongside the DHR on the CSP website.

The CSP should monitor the implementation of the actions set out in the action plan. This is undertaken by DASVEG on behalf of the CSP.

DASVEG will implement an audit of the action plan. **The DHR is formally concluded when the action plan has been implemented and evidence provided by the audit.**

4 Appendices

4.1 Appendix 1: Process Map of a DHR



4.2 Appendix 2: Preliminary Group Membership and agenda

Post	Current Post Holder (November 2019)
Chair of Domestic Abuse and Sexual Violence Executive Group	Jeanne Trotter (OPCVC)
Head of Community Safety DBC	Graham Hall
Chair of the Community Safety Partnership	Adrian Green
Head of Safeguarding and Major Crime Team, Durham Constabulary	Dave Ashton
County Durham & Darlington Foundation Trust, Associate Director of Nursing (Patient Experience and Safeguarding)	Jason Cram
North Durham, Durham Dales, Easington and Sedgefield, and Darlington Clinical Commissioning Groups, Designated Nurse Safeguarding Children and Looked After Children	Heather McFarlane
Head of Safeguarding (Lead Nurse for Public Health and Quality) Harrogate and District NHS Foundation Trust	Suzanne Lamb
Harbour Support Services, Business Manager	Caren Barnfather
Tees Esk and Wear Valley NHS Foundation Trust, Head of Adult Safeguarding	Lesley Harrison Nicki Smith
Head of Durham National Probation Service	Maureen Gavin
Deputy Director of Operations, Community Rehabilitation Company (CRC)	Kay Nicholson
Head of Service, Adult Social Care (DBC)	Kevin Kelly
Head of Service, Locality Services and First Contact (DBC)	Chris Bell

Agenda- Preliminary DHR Meeting
Date and time
Location

The preliminary meeting will recommend to the chair of the safeguarding partnership whether the domestic homicide in question meets the requirements for a full domestic homicide review. In so doing the meeting will 'review the circumstances in which the death of a person aged 16 or over has, or appears to have resulted from violence, abuse or neglect by;

A person whom he/she was related or had been in an intimate partner relationship

A member of the same household

1	Welcome and Introductions	Chair
2	Background to the case *[SIO to give appropriate level of background to the case]*	SIO
3	Updates from all agencies with regard to their knowledge of the case	All attendees
4	Identification of any ongoing proceedings *[Any other proceedings that may be taking place, i.e. criminal proceedings, coroner, IPCC, etc. Implications of this i.e. hold review until proceedings complete, etc]*	All attendees
5	Decision and recommendation	Chair
Depending on above decision:		
6	Identification of potential members to be part of the review	All attendees
7	Initial development of terms of reference	All attendees
8	Any other business	Chair

4.3 Appendix 3: Chronology of involvement template

Darlington CSP Domestic Homicide Review

Chronology of Involvement
Period of Review

VICTIM'S INITIALS: ________ **AGE** ____________________ **AGENCY:** ______________________________

Guidance Notes	Use font Arial 11 throughout the chronology, abbreviations for anonymity as agreed at Panel meeting and dates should be shown as dd/mm/yyyy.

Date (dd/mm/yy)	Family Members	Information	Source - Agency	Action / Outcome	Victim seen ✓	IMR & Panel Members Initials & Comment	

Guidance

Date: *The entry on file.*
Family Member: *The victim, the family member or any other person on whom the entry on the record is related to.*
Information: *The significant piece of information e.g. police log of reported incidence of domestic violence; or other organisational involvement.*
Agency *– Source: The agency or individual sharing the information that records refer to.*
Action: *Action taken by agency, individual (only initials of individuals not full names). The information should inform the reader of any action taken in response to the event or episode*
Management Review Officer's comment: *Any issues the officer has identified that need to be brought to the attention of the Domestic Homicide Review Panel.*
Panel Notes: *Any issues the Panel require further information or clarification on*

4.4 Appendix 4: DHR Panel Terms of Reference template

RESTRICTED

MAKING DARLINGTON SAFER
Safer People, Safer Places

Domestic Homicide Review

Terms of Reference

DHR Case Ref: [Insert case reference]

[Insert date here]

DRAFT

Report of [Insert Name], Chair of the Review Panel

1. Introduction

This Domestic Homicide Review is commissioned by the Darlington Community Safety Partnership (CSP) in response to the death(s) of [*victim]* on *[Date]*.

This Domestic Homicide Review (DHR) was commissioned because under the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (3.1) (a) the incident involved 'a person to whom he was related or with whom he was or had been in an intimate personal relationship' (Home Office 2016).

[Name of independent Chair and Job Title] has been appointed as Chair of the review panel at the DHR Panel meeting held on *[date]*.

The Chair of the DHR panel has been selected after careful consideration by both the DHR Preliminary Group and the Chair of the Darlington Community Safety Partnership. The partnership is clear that the independence of the chair from direct line management of those involved in the DHR is essential in order to ensure effective and objective challenge to individual agencies and enable appropriate independent analysis of relevant information.

2. Purpose of the Domestic Homicide Review

The purpose of the DHR is to:

- Establish the facts that led to the incident on [date] and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on *[date]*.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the DHR process. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the DHR

The DHR will:

- Seek to establish whether the events of *[date]* could have been predicted or prevented.
- Consider the period of *[insert timescale]* prior to the events, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the DHR.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.
- Take account of the coroners' inquest in terms of timing and contact with the family.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Aim to produce the report by the end of *[date]* subject to any criminal proceedings, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

[insert relevant issues for consideration specific to this case e.g.

- *Was the victim known to local domestic abuse services, was this an isolated incident and were there any previous concerns or warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?*
- *Are family, friends, and colleagues participating in the DHR, were they aware of any abuse that may have been taking place?*
- *Were there any barriers experienced by the victim or family, friends and colleagues in reporting the abuse?*
- *Was abuse present in any previous relationships, did this affect the victim's decision on whether to access support?*
- *Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?*
- *Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?*

This document was classified as: OFFICIAL

- *Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children.]*

4. Family involvement

The DHR will seek to involve the family of both the victim and the perpetrator in the DHR process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the DHR process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process of the coroner's inquest and ensure that the family are able to respond to the DHR and the inquest avoiding duplication of effort and without undue pressure.

5. Legal advice and costs

Each statutory agency will be expected and reminded to inform their legal departments that the DHR is taking place. Each statutory agency may seek their own legal advice at their own discretion and cost. There may be a requirement to access independent legal advice on the part of the DHR panel, in which case the DHR panel will liaise with the CSP statutory partners to agree funding and the source this advice. Should the scope of the review extend beyond the anticipated internal review, the DHR panel will raise this through the CSP for further guidance.

6. Panel members, expert witnesses and advisors

The following agencies and individuals are suggested to participate in the DHR panel:

[insert as appropriate].

It is intended to consider consulting with the following agencies and individuals to provide a view of the findings and recommendations arising from the report:

[insert as appropriate].

Other appropriate agencies and people may be identified through the course of the review.

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7. Media and communication

The management of all media and communication will be through a joint team drawn from the statutory partners involved. There will be no presumption to inform the public via the media that a DHR is being held in order to protect the family from any unwanted media attention. However, a reactive press statement regarding the DHR will be developed to respond to any enquiries to explain the basis for the review, why and who commissioned the review, the basic methodology and that the DHR panel is working closely with the family throughout the process. An executive summary of the DHR will be published on the Darlington Partnership website, as requested within the Home Office guidance, with an appropriate press statement available to respond to any enquiries. The recommendations of the DHR Panel will be distributed through the Darlington Partnership website, the Domestic Abuse & Sexual Violence Forum Executive Group (DASVEG) and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

All written communication from the DHR panel will be sent using the Darlington CSP logo and including business addresses for the DHR panel members.

Signed by Review Panel

……………………………

……………………………

……………………………

……………………………

……………………………

……………………………

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This document was classified as: OFFICIAL

4.5 Appendix 5: Individual Management Review template

[Insert Logo of your Agency here]

Individual Management Review

MANAGEMENT REVIEW REPORT OF:

[Insert Name of Agency]

MANAGEMENT REVIEW ON:

[insert names and dob on victim, perpetrator, family members if relevant]

e.g. Joseph Bloggs 31.09.1975
Jane Bloggs 31.11.1977

DATE OF DEATH
[insert date of Homicide under review]

THE CONTENTS OF THIS REPORT ARE STRICTLY CONFIDENTIAL AND SHOULD NOT BE SHARED WITHOUT THE CONSENT OF THE AUTHOR

IMR Author: ______________________
Designation: ______________________
Date: ______________________

Signed off by: ______________________
Designation: ______________________
Date: ______________________

This Management Review has been signed off confirming satisfaction with the findings and the quality of the review.

DRAFT

Contents

1. Introduction
2. Family information and genogram
3. Involvement with victims / perpetrator
4. Terms of reference
5. Methodology
6. Details of parallel reviews/ processes
7. Chronology of agency involvement
8. Analysis of agency involvement
9. Effective practice / lessons learned
10. Recommendations by this agency
11. Glossary and references
12. Appendices

DRAFT

INDIVIDUAL MANAGEMENT REVIEW REPORT FORMAT

1. Introduction

Brief factual/contextual summary of the situation leading to the IMR including an outline of the terms of reference and date for completion:

- Identification of person subject to review
- Date of Birth
- Date of death / offence
- Name, job title and contact details of person completing this IMR (include confirmation regarding independence from the line management of the case).

2. Family information and genogram

Genogram as at * [please complete to demonstrate detailed relationship of the family known to your agency]

Family Name ______________________________ Period of Review ______________________________

DRAFT

A Genogram is a way of representing a family tree and relationships within the family.

Key:

			X					______	Enduring Relationship
								- - - -	Transitory relationship
Female	Male	Pregnancy	Abortion or Miscarriage	Deceased – Cross is placed inside gender symbol		Subject		/	Separation
								//	Divorce

Where there are a number of children from a relationship the eldest child is placed on the furthest left, followed by the second eldest and so on, with the youngest child appearing on the right. Dates should be shown as dd/mm/yyyy.

Family Composition

[Include family composition, summary of family background and circumstances past and present that might help understand issues, family relationships and actions or inactions. Consider diversity, cultural or ethnic issues in relation to the family]

3. Involvement with Victims/ Perpetrator

[Construct a comprehensive chronology of involvement by the organisation and / or professional(s) in contact with the victims/ perpetrator over the period of time set out in the review's terms of reference, using the template provided at Appendix 2 of the DHR procedure. The completed chronology template should be attached as a separate document at the end of the report.

Within this section of the report, refer to the attached chronology and briefly summarise decisions reached, the services offered and / or provided to the individuals and other action taken].

4. Terms of Reference (TOR)

This section should refer to and detail the TOR developed by the DHR Panel

5. Methodology

Record the methodology used including extent of document review and interviews undertaken.

6. Details of Parallel Reviews/Processes

7. Chronology of Agency Involvement

8. Analysis of Agency involvement

Consider the events which occurred, the decision made, and any action taken. Were judgements made, or actions taken, which indicate that practice or management could be improved? It is important to identify what happened and why. Consider the following issues which relate directly to the DHR Terms of Reference:

- The DHR will identify the most important issues to address in identifying learning from this case.
- Examine the agencies knowledge/contact with the victims/ perpetrator, the assessments made, actions taken, and decisions reached.
- Was everything done which might reasonably have been expected to understand and manage effectively any risk of harm? What were the key points/opportunities for assessment and decision making in relation to those identified? Do assessments and decisions appear to have been reached in an informed and professional manner?
- Examine whether there were any issues in communication or information sharing including whether managers were appropriately consulted and involved.

DRAFT

- Describe why actions/decisions did or did not happen, including the influence of any organisational/capacity issues.
- Were the services provided timely, appropriate and proportionate to their needs?
- What considerations were made regarding ethnicity, religion, diversity and equality and how did these impact on those involved?

[Insert additional recommendations specific to the circumstances of this case]

Other considerations

- Relevant research should be used to assist the Domestic Homicide Review Panel.

Please note the scope of the DHR may be amended as the review progresses and new information emerges.

9. Effective Practice/Lessons Learnt

Does a picture emerge from the IMR investigation that provides an understanding of the lived experience of the victim(s)/ perpetrator, what might have helped, whether they were the main focus of activity and whether staff fulfil their safeguarding responsibility?

Are there lessons from this case for the way in which this organisation works to ensure agencies are responding appropriately to victims of domestic violence?

Is there good practice to highlight as well as ways in which practice can be improved?

Are there implications for ways of working; training (single and inter agency); management and supervision; working in partnership with other organisations; resources?

10. Recommendations by this agency

Recommendations should be Specific, Measurable, Achievable, Realistic and Timely (SMART)

Action Plan

[The agency should complete an action plan using the Appendix 4 of the IMR. (NB: actions should be relevant to specific recommendations. Person responsible should be clearly stated and deadline dates realistic and achievable].

11. Glossary and References

12. Appendices – include the following as appendices (templates below):

- Chronology of events
- Profile of staff interviewed
- Profile of interviewee
- Action Plan
- Guidance on the disclosure of personal information

DRAFT

DRAFT

IMR: Chronology of Involvement

Period of Review ____________________

VICTIM'S INITIALS: ______ **AGE** ______ **AGENCY:** ______

Guidance Notes	Use font Arial 11 throughout the chronology, abbreviations for anonymity as agreed at Panel meeting and dates should be shown as dd/mm/yyyy.

Date (dd/mm/yy)	**Family Members**	**Information**	**Source - Agency**	**Action / Outcome**	**Victim seen ✓**	**IMR & Panel Members Initials & Comment**	

Guidance

Date: *The entry on file.*

Family Member: *The victim, the family member or any other person on whom the entry on the record is related to.*

Information: *The significant piece of information e.g. police log of reported incidence of domestic violence; or other organisational involvement.*

Agency *– Source: The agency or individual sharing the information that records refer to.*

Action: *Action taken by agency, individual (only initials of individuals not full names). The information should inform the reader of any action taken in response to the event or episode*

Management Review Officer's comment: *Any issues the officer has identified that need to be brought to the attention of the Domestic Homicide Review Panel.*

Panel Notes: *Any issues the Panel require further information or clarification on*

IMR: Profile of Staff Involved in the Review

Name	Designation	Interviewed Yes/No	Interview Date	Any Other Comments

DRAFT

IMR: Profile of interviewee

<table>
<tr><td>Full name:</td><td colspan="2"></td></tr>
<tr><td>Qualifications:</td><td colspan="2"></td></tr>
<tr><td>Designation:</td><td colspan="2"></td></tr>
<tr><td>Time in post:</td><td colspan="2"></td></tr>
<tr><td>Employing body:</td><td colspan="2"></td></tr>
<tr><td>Employing address:</td><td colspan="2"></td></tr>
<tr><td>Previous employment:</td><td colspan="2"></td></tr>
<tr><td>Employer</td><td>Dates</td><td>Posts Held</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Description of role in relation to this particular case:</td><td colspan="2"></td></tr>
</table>

List any domestic violence awareness training or related training received both within and outside the agency in the last 3 years.	

DRAFT

IMR: Domestic Homicide Review Action Plan

Action Plan of

RECOMMENDATIONS	DESIRED OUTCOME / LESSONS LEARNED	ACTIONS	TIMESCALE	LEAD OFFICER	PROGRESS

4.6 Appendix 6: Template family member consent form

MAKING DARLINGTON SAFER
Safer People, Safer Places

Contact:
Direct
Tel:
Fax:
email:
Ref:

[Insert contact address]

8 April 2020

Consent to access and share information held by agencies involved with [name]

I understand that the public sector agencies are required to undertake a domestic homicide review which will examine the way in which agencies provided support services to [name].

I understand that the review will lead to a report being prepared that highlights good practice and lessons that can be learnt to improve the practice of agencies working together to support individuals experiencing domestic abuse.

I understand the report will detail recommendations for agencies in order to develop and improve practice. The summary of the lessons learnt from the report will be shared with agencies, though this report will not identify individuals.

I give consent for information to be shared with professionals conducting the review and that this information will be destroyed after the report is completed.

Signed: …………………………………..

Print name: ………………………………

Please sign and return to:

[Insert name & address of review panel chair]

4.7 DHR Appendix 7: Overview Report Template

Darlington Community Safety Partnership Domestic Homicide Overview Report

[Insert victim's pseudonym, month and year of death*]*

[*insert* Author's Name]

[*insert* Date review report completed]

List of contents page

- Executive summary
- Introduction and background to domestic homicide review
- Domestic homicide review panel concluding report
- Conclusions and lessons learned
- Appendices including chronology

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.

1. 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).

2. 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.

3. Terms of reference

4. 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.

5. 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

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. Dissemination

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

12. Background information

- 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 was charged with the homicide, the date and outcome of the trial, and sentence.
- 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.

13. 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 children 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)*

14. Overview

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

15. Analysis

This should examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It can consider whether different decisions or actions may have led to a different course of events. The analysis section should address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice should be highlighted.

16. 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.

17. Lessons to be learnt

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

18. Recommendations

Recommendations should include, but not be limited to, those made in individual management reports and can include recommendations of national impact made for national level bodies or organisations.
Recommendations should be focused and specific, and capable of being implemented.

4.8 DHR Appendix 8: Executive Summary Template

Darlington Community Safety Partnership
Domestic Homicide Review
Executive Summary

[Insert victim's pseudonym, month and year of death*]*

[*insert* Author's Name]

[*insert* Date review report completed]

1. List of contents page

2. The review process

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

The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members: (add victim and perpetrator's pseudonyms, age at time of the fatal incident, ethnicity and add pseudonyms of any other relevant parties and their relationship to the victim and/or perpetrator).

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

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

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

3. 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.

4. 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. 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.

5. Terms of reference for the review

6. 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.

7. Key issues arising from the review

(Add issues as required)

8. Conclusions

9. Lessons to be learned

10. Recommendations from the review

(Add recommendations as required)

4.9 DHR Appendix 9: Overview Report Action Plan

Darlington
Domestic Homicide Review
Action Plan

DHR reference: [insert reference]

Updated [Insert Date]

Action Plan following the death of: [add victim's name/reference]

Action Plan produced by [insert name]

Date [date]

RECOMMENDATIONS	Scope of the recommendation i.e. local or regional	ACTIONs to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date
What is the over-arching recommendation?	Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the Home Office Quality Assurance Panel, however the review panel can suggest recommendations for national level)	How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?	Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?	Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved	When should this recommendation be completed by?	When is the recommendation actually completed? What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?

4.10 DHR Appendix 10: Additional information

Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Review, Home Office revised December 2016

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

Statutory guidance framework: controlling or coercive behaviour in an intimate or family relationship

https://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship

Domestic Homicide Reviews: key findings from research December 2016

https://www.gov.uk/government/publications/domestic-homicide-review-lessons-learned

Criteria for considering a Domestic Homicide Review, Home Office June 2013

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207602/criteria-DHR-web-v2.pdf