SAFER CORNWALL

Kernow Salwa

Domestic Homicide Review

Toolkit

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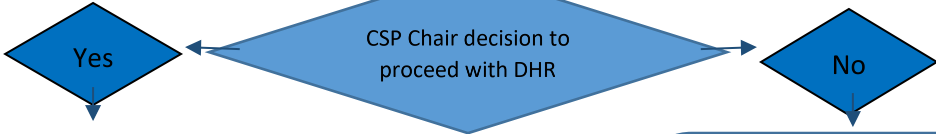
Domestic Homicide Review Process

Notification of a potential DHR

Information gathered from partner agencies and collated to prepare case for review by multi-agency DHR Commissioning Review Panel against the DHR statutory criteria

Case reviewed and recommendation made to CSP Chair
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/207602/criteria-DHR-web-v2.pdf

Within one month



Yes

No

Within 6 months (timescales may differ with agreement according to complexity and/or ongoing Criminal justice proceedings)

Criteria Met for DHR – CSP to:

Notify Home Office of decision: DHRENQUIRIES@homeoffice.gsi.gov.uk

Notify victim's family of decision in writing/ send out further information (HO and AAFDA leaflets)

Notification to coroner (invite to dovetail inquest) – include draft TOR and HO guidelines

Send letter to agencies to request chronologies and procure chair (contract)

Criteria not met

Notify Home Office of decision: DHRENQUIRIES@homeoffice.gsi.gov.uk

Notify victim's family of decision in writing

Notify referrer

Within one month

DHR Panel consider the scope, TOR including timescales

Agree agencies that need full IMRs (include Guidance to Doctors and GPs on the release of medical records if relevant)

Send TOR to family

Review undertaken

DHR Panel meets regularly to review progress and provide advice/support/challenge as required

Within 4 months

Chair integrates chronologies (chronolator programme), compiles and presents overview report and executive summary to DHR panel setting out findings

Action plan agreed

CSP agrees overview report, exec summary and action plan

Submit report and monitoring form to: DHRENQUIRIES@homeoffice.gsi.gov.uk

Agree communication strategy

Within one month

Home office clearance received (any changes necessary made)

Review shared with Agency leads

Agree Publication date (Safer Cornwall website)

Share with family

CSP monitors the submission of all DHR referrals/decisions and provides ongoing oversight of the implementation/impact of DHR recommendations

7. Introduction

The purpose of this document is to provide advice and guidance to those involved in undertaking Domestic Homicide Reviews (DHR). Included in the appendices are specimen templates which can be adapted for use during the DHR process. The guidance is accessible via the Community Safety Partnership website: Domestic Homicide Reviews (DHRs) - Safer Cornwall

DHRs were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004, which states:

(1) In this section "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) A person to whom he was related or with whom, he was or had been in an intimate personal relationship, or
(b) A member of the same household as himself.

And that reviews should be held with a view to identifying the lessons to be learnt from the death.

The agencies required to establish or participate in a DHR are:

- Chief officers of police for police areas in England and Wales;
- Local authorities;
- Strategic health authorities;
- Primary Care Trusts;
- Providers of Probation Services;

All professionals involved in a DHR should familiarise themselves with the statutory guidance contained in Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

2. Decision to hold a DHR

Referral for a DHR will normally come from the Police following a death, however any professional may refer a case for consideration for a DHR if they believe there are important lessons for inter-agency working to be learned. **The DHR referral form is at appendix 1.**

On receipt of a notification of a DHR the Community Safety Partnership (CSP) will prepare the case for consideration by the CSP Chair. Agencies will be contacted and asked to complete a form ahead of the meeting outlining their agency involvement (see appendix 5).

Consideration must be given as to whether the referral identifies serious safeguarding cases for any adults in the area that die as a result of abuse or neglect, whether known or suspected, and children under 18, in which case relevant referrals are made to the CIoS SAB Safeguarding Adult Review Subgroup and OSCP Rapid Review panel. CIoS SAB Safeguarding Adults Review referral form: Cornwall and the Isles of Scilly Safeguarding Adults Board - (ciossafeguarding.org.uk)

A joint DHR/ SAR protocol supports reviews where local referrals are made that are assessed to meet both the SAR and DHR criteria. The protocol (at Appendix 17) formalises the process for completing a joint review process (SAR/DHR). This will avoid replication, enhance the analysis and scrutiny of the information and circumstances to identify the themes, recommendations and learning, adding to the overall quality and outcomes of the review. The protocol sets out the process of how the CIoS SAB and SC CSP work effectively together where necessary to complete a joint SAR/DHR review that meets the core duties of both boards.

Where the referral identifies serious safeguarding cases for children under 18, a referral should be made for consideration by the OSCP Rapid Review panel (*see referral form appendix X*).

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed"

Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice. Issues might appear to be the same in some child safeguarding cases but reasons for actions and behaviours may be different and so there may be different learning to be gained from similar cases. Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families. [1]

Safeguarding partners must consider specific criteria and guidance (WT 2018) when determining whether to carry out a local child safeguarding practice review (LCSPR). (see Criteria for LCSPR appendix 16).

[1] Working Together to Safeguard Children 2018, Chapter 4

The Rapid Review Process will enable safeguarding partners to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps they should take next, including whether or not to undertake a child safeguarding practice review

The decision-making processes for DHR and LCSPR are separate and distinct; a Rapid Review Panel may decide that a single agency review, DHR or other form of review is most appropriate and request that the findings from such a parallel review be shared with them to inform learning and future practice. The National Child Safeguarding Practice Review Panel must be notified of the decision of the Rapid review Panel.

Once it is known that a case is being considered for a domestic homicide review, each organisation should secure its records relating to the case to guard against loss or interference

The Chair's decision should normally be made within one month of the CSP receiving the initial referral.

Once a CSP has made a decision on whether or not to initiate a DHR, the CSP will inform the Home Office of their decision, the CSP partners and the family of the victim.

The Home Office will circulate a decision not to undertake a review to the Quality Assurance panel for comment, who will feedback to the CSP. In some circumstances, the Secretary of State may direct a specified person or body to establish or participate in a DHR, where a person or body has declined involvement in a DHR.

The overview report should normally be completed within six months of the date of decision to proceed unless the review panel formally agrees an alternative timescale with the CSP. This will usually be in particularly complex cases and/or due to ongoing criminal justice or coroner proceedings. Further information around criminal proceedings and timing of the review can be found within the statutory guidance under sections 5 and 9.

3. Planning the DHR

Which CSP should take lead responsibility?

Where partner agencies of more than one CSP have known about or have had contact with the victim, the CSP for the area in which the victim was ordinarily resident should take lead responsibility for conducting the review. In circumstances were this is not easily determined, it is for local areas to come to an appropriate arrangement.

It should be noted that in some cases there may be other parallel processes in progress, for example an Adult, Child or MAPPA serious case review or health review. In such cases, consideration should be given to how these reviews can be managed in parallel in the most effective way. Considerations may include whether some or all aspects of the reviews could be jointly commissioned, subject to all final reports meeting the relevant statutory requirements.

Notifying partner agencies

Once the decision is made to proceed with a DHR, the CSP will write to the Chief Executives of the agencies involved in the case to request that records relating to the family are secured and where relevant that the agency identify a member of staff to form part of the Review Panel.

Notifying family members

The review panel should recognise that the quality and accuracy of the review is likely to be significantly enhanced by family, friends and wider community involvement. Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder. The chair/review panel should follow best practice when approaching and interacting with the family.

Further information about involvement of family, friends and other support network is available within Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews including links to leaflets which are available to download and use.

Appointment of an Independent Chair

The Independent Chair is appointed by the Community Safety Partnership and paid by the collective partnership DHR fund.

The chair may also be the author of the overview report, and accordingly should be an experienced individual who is not directly associated with any of the agencies involved in the review. In order to assure readers that the chair has no conflict of interest, an 'independence statement' should be included either in the body of the final report or as an appendix. This should also set out the chair's career history, relevant experience and independence (including length of time elapsed since leaving employment within any of the agencies involved).

The chair should have an enhanced knowledge of domestic violence and abuse issues, including specific types of violence such as 'honour-based' violence, and have a knowledge of relevant adult and child focused legislation and practice across the partner agencies. The chair should also have experience in the following:

- Managerial experience
- Strategic vision
- Good investigative, analytical, interviewing and communication skills
- Understanding of disciplinary regimes within participating agencies
- Understanding of wider statutory review frameworks
- Completed the Home Office online training, including the additional modules on chairing reviews and producing overview reports

It is recommended that all individuals participating in a DHR, including the Chair, complete the online Home Office training module Conducting a domestic homicide review: online learning

Appointment of a Review Panel

The review panel must include some or all individuals from the statutory agencies listed within Section 9 of the Domestic Violence, Crime and Victims Act 2004 and listed within the introduction to this toolkit. Consideration should also be given to including voluntary/community sector organisations who may have valuable information on the victim and/or perpetrator and may be able to represent the perspective of the victim and/or perpetrator. The panel should also include specialist or local domestic violence and abuse service representation.

Panel members should disclose any personal interest, where there has been previous contact with either the victim or perpetrator in a professional or personal capacity. The panel and Independent Chair will then consider whether it is appropriate for the panel member to continue involvement or whether a replacement should be sought from that agency.

There are other agencies which may have a key role to play in the review process who may not be represented on the panel, but may be called upon to provide an analysis of their agency's involvement as part of the review. These might include (but not limited to):

- HM Prison Service
- HM Courts and Tribunals Service
- General Practitioners
- Dentists
- Teachers
- Crown Prosecution Service

It is important that any agency or employer that is approached to participate in the review does so in order to provide the review panel with a comprehensive chronology of its' involvement with the victim and others that may be the subject of the review.

In the interests of transparency, all members of the review panel should be named within the report, their respective roles set out and the agencies they represent.

The review panel should meet an appropriate number of times to ensure there is robust oversight and rigorous challenge.

4. Determining the Scope of the DHR

The chair, review panel and CSP should agree in each case the scope of the review process and draw up clear terms of reference which are proportionate to the nature of the homicide. The Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews contains helpful guidance on areas to consider within the review and should be considered in drawing up the terms of reference. (see appendix 2)

5. The Domestic Homicide Review report and publication

The overview report should bring together and draw overall conclusions from the information and analysis drawn from all the agencies involved in the review. Overview reports should be produced according to the outline format set out in appendix 10 in accordance with the features of the homicide.

The overview report should also make recommendations for further action which the review panel should translate into a SMART (specific, measurable, achievable, realistic and timely) action plan. (see appendix 12)

Further guidance on the format of agency reports, the overview report and action plan are contained within Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews and appendices to this toolkit.

On receipt of the completed report the CSP should:

- Agree the content of and sign off the report, executive summary and action plan
- Make arrangements to provide feedback and debriefing to staff, family and the media as appropriate

- Submit the report, executive summary and action using the required documentation to the Home Office

> Reports should not be published until clearance has been received from the Home Office Quality Assurance Panel

Once clearance has been received from the Home Office Quality Assurance Panel the CSP should:

- Provide a copy of the overview report, executive summary and action plan to the local Police Crime Commissioner and senior manager of each participating agency
- Ensure that any publication date takes into account any key dates, e.g. anniversary of the death, victim's birthday
- Publish suitably anonymised electronic copies of the overview report and executive summary on the appropriate website
- Notify the Home Office that the reports have been published and provide links to the reports
- Monitor the implementation of the actions set out in the action plan
- Formally conclude the review when the action plan has been completed and include an audit process

6. Media

It is essential to have a media strategy in place at the outset. Sometimes information may be given to the press before official publication, for example from family members or unwitting leaks from officers in any one of the participating agencies. Advice about specific media liaison and publicity will come from individual agency departments. The important points to consider are:

- Good communication between media / publicity departments across the partner agencies;
- Clear briefings for members of the CSP, review panel and appropriate officers within agencies and elected members, so that all concerned parties are fully aware of when to expect media coverage;
- Clarity about who will lead the media response and what the high level message will be;
- Thoughtfulness about the actual wording of reports that will be published – imagine seeing the lines that are written in a newspaper headline or article;
- Co-ordination with media releases from any other CSP or agencies involved;
- Training for relevant staff for high profile DHRs.

7. Embedding actions and wider learning

Whilst the ownership of action plans rests with the CSP, delivery of specific actions and ensuring that local and national learning influences service delivery, will often sit within other areas of partnership

working, e.g. Safeguarding Adult and Children Boards, the Health and Wellbeing Board and within partner agencies' practice and commissioning.

It is therefore critical that action plans include the sharing of learning with other relevant partnerships, and identification of specific owners that can be asked to provide regular updates and assurance to the CSP. Action plans should also consider inclusion of quality assurance processes to assess impact. Examples are included below of audit activity that could be considered:

- Safeguarding Children Board Section 11 and 175 157 audits
- Safeguarding Children and Adult Board multi-agency case audits
- Single agency audits/quality assurance/management oversight activity
- Focused engagement with community groups such as survivors groups, children and young people forums (care leavers, young carers, children's council etc)
- Focused engagement with Practitioners forums

Reviews should also take account of wider learning from previous local and national DHRs and other relevant reviews such as adult and child serious case reviews, MAPPA serious case reviews and single agency review such as Probation Serious Further Offence reviews and Health reviews.

Learning from other processes should also be shared with CSPs where there is relevant learning for the partnership and should be reviewed by the CSP and associated subgroups on a regular basis to inform ongoing service improvements and commissioning.

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RESTRICTED

Referral to the Cornwall Community Safety Partnership regarding a potential Domestic Homicide Review

Criteria for Domestic Homicide Review:

"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) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

Referral regarding:

Person completing referral:

Designation:

Persons Involved:

Subject: **dob:** **dod:**

Address:

Suspect: **dob:**

Address:

Location of Incident:

Senior Investigating Officer:

Senior Officer representing for the DHR:

Serious Case Review officer:

Information

Background

History

Draft DHR Terms of Reference

Domestic Homicide review into the death of XX

1. Overall Aim of Domestic Homicide Review (DHR)

The purpose of a DHR is to:

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;

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; and

f) highlight good practice.

DHRs should be conducted in a way which:

- *Illuminates the past to make the future safer, be professionally curious and find the trail of abuse including which agencies had contact with the victim, perpetrator and family;*
- *The narrative of each review should articulate the life through the eyes of the victim (and their children) and talking to those around the victim, including family, friends, neighbours, community members and professionals. This will help reviewers understand the victim's reality, identify any barriers the victim faced to reporting and learning why any interventions didn't work for them;*
- *A DHR should go beyond focusing on the conduct of individuals and whether procedure was followed to evaluate whether the procedure/policy was sound and operating in the best interests of victims;*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research, local and national learning from previous reviews and case evidence to inform the findings*

2. The Management Review and Disciplinary Processes

DHRs are not inquiries into how the victim died or into who is culpable. DHRs are not specifically part of any disciplinary inquiry or process. Where information emerges in the course of a DHR which indicates that disciplinary action should be considered, this should be passed to the employing agency to undertake separately to the DHR process.

3. Other review/procedural processes

DHRs may be undertaken alongside other review processes, such as Adult Serious Case Reviews, Child Serious Case reviews, health organisation reviews and MAPPA Serious Case Reviews. In these circumstances, there is an expectation that contact will be made with the leads for these reviews, and agreements made regarding contact with families and the media.

Where a death has occurred, there may also be a Coronial review ongoing – in these circumstances, contact should be made with the Coroner to inform them of the review process, and agree what information should be shared and when to support both processes.

The DHR should also take account of any criminal investigation process in determining the timescale for the review to be completed, involvement of family members where they may be subject to investigation and also in respect of publication which may need to be delayed until conclusion of any investigation.

4. The Reason for the Domestic Homicide Review

4.1 To establish the facts about events leading up to and following the death of XX on XX.

4.2 To examine the roles of the organisations involved in the case, the extent to which XX had involvement with those agencies, and the appropriateness of single agency and partnership responses to the case.

4.3 To establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard XX wellbeing.

4.4 To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

4.5 To identify whether, as a result, there is a need for changes in organisational and/or partnership policy,

procedures or practice in Cornwall in order to improve our work to better safeguard victims of domestic abuse and their families.

5. The scope of the panel review:

5.1 To establish which agencies had contact with the family (chronology requests were sent to the following agencies: XXXXXX).

5.2 To produce a chronology of events and actions in relation to the case of the victim, from (date) to (date) seeking information from:

Organisations which had contact with the victim or the perpetrator: XXXXX

5.3 To review current roles, responsibilities, policies and practices in relation to victims, perpetrators and families of domestic abuse – to build up a picture of what should have happened.

5.4 To review this against what actually happened to draw out the strengths and weaknesses.

5.5 To review national best practice in respect of protecting victims and their families from domestic abuse.

5.6 To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

The review will also specifically consider:

5.7 An assessment of whether family, friends, key workers or colleagues (including employers) were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons).

5.8 A review of any barriers experienced by the family, friends, colleagues in reporting any abuse or concerns, including whether they (or the victim) knew how to report domestic abuse had they wanted to.

5.9 A review of any previous concerning behaviour or history of abusive behaviour from the perpetrator and whether this was known to any agencies.

5.10 An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in Cornwall.

5.11 Whether family, friends, colleagues, employers, wanted to participate in the review. If so, ascertain if they were aware of any abusive behaviour by the perpetrator prior to her death.

5.12 Whether any organisational policy, training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

5.13 Whether the work undertaken by the services in this case are consistent with their own: professional standards, compliant with their own protocols, guidelines, policies and procedures.

6. Quality Assurance

The Independent Chair will be supported by the Review Panel throughout the course of the review who will assure the quality of the work.

The review and associated action plan will be impact assessed and quality assured by the Community Safety Partnerhip Board prior to final sign off.

7. Timeline

Attach as appendix

8. Review Panel

List names

9. Involvement of Family Members in the DHR

Outline plan for engagement with family/friends – who will do this? At what points?

Reference should also be made to the Multi-agency statutory guidance for the conduct of domestic homicide reviews December 2016 and the Guidance for domestic homicide review chairs on support for families https://www.gov.uk/government/publications/guidance-for-domestic-homicide-review-chairs-on-support-for-families in decision making.

10. **Outputs for the reviews**:

- A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care.

- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families.

- Meetings with the victim and perpetrator families to seek their involvement in influencing the terms of reference (where relevant).

Insert other outputs

11. Responding to Inquiries from the Media/ Communications Strategy

Insert agreed media strategy

12. Agreed Budget

Draft Letter to Chief Executives

Dear

Re: Domestic Homicide Review DHR...

Subject:<name> DOB:<insert> DOD:<insert> Address <insert>

Perpetrator <name> DOB <insert> Address <insert>

A decision has been made that the death of <insert> is to be made the subject of a Domestic Homicide Review.

As Chair of the Cornwall Community Safety Partnership I am writing to formally request that you take action to ensure that your agency files in respect of the above named persons are immediately secured to guard against potential loss or interference, and to enable the Domestic Homicide Review process to commence.

The purpose of this Domestic Homicide Review is to establish whether there are any issues in relation to multi-agency working and any lessons to be learned, and to achieve this, each agency that has had involvement with the subject or perpetrator is required to look openly and critically at their professional practice with the child/family. We will be convening a Review Panel to assist with the Domestic Homicide Review Process, and this may include a member of staff within your agency.

In preparation for the work to be undertaken by the Review Panel your agency is required to complete a chronology of your involvement with the following family members:

Deceased: DOB:

Address:

Perpetrator: DOB:

Address:

Child: DOB:

Address:

Child: **DOB:**

Address:

Please notify Safer Cornwall of the name of the person completing your Chronology by the <insert>. We will then contact the Chronology Writer directly and supply relevant documentation to them.

Completed chronologies will need to be submitted to Safer Cornwall no later than the <insert>**.**

The service area(s) for your agency that requires a chronology is:

<insert>

Thank you for your assistance in this important matter. If you would like to discuss the review further please contact <insert> at the above address who will be happy to respond to any queries you may have.

Yours sincerely

Chair, <insert> Cornwall Community Safety Partnership

Draft agency letter to request chronologies

Date

Private and Confidential
ORGANISATION

Dear (NAME)

REF: INDIVIDUAL AGENCY CHRONOLOGY OF CONTACT
I am writing to advise that Safer Cornwall has commissioned a Domestic Homicide Review (DHR) in relation to the death of (enter name) on (enter date).

On (enter date) (enter name of perpetrator) was convicted of (enter name of victim) murder at Truro Crown Court.

Safer Cornwall now has a statutory duty to commission a Domestic Homicide Review under Section 9 of the Domestic Violence, Crime and Victims Act 2004. This will commence immediately in line with Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016), of which a copy is attached.

The purpose of this letter is to request an **Individual Agency Chronology Summary** of any contact your organisation had with either of the subjects listed below. An Individual Agency Chronology Summary template has been provided for your completion. Please note, we are only requesting a summary of contact, not a formal Individual Management Review (IMR) or analysis at this stage.

The attached Information Sharing Framework outlines the special legal conditions satisfied to access personal information without explicit consent. Please use this to document to record a chain of evidence for your own decision-making and only include information that supports the purpose and aims of the Terms of Reference of this Review (also attached). **Do not** include any information that does not support the purpose of a Domestic Homicide Review or breaches the legal conditions ticked on the information Sharing Framework.

SUBJECTS

Victim:
Date of Birth:
Address:

Offender:

Date of Birth
Address:

TIMESCALES
Please provide a chronology of contact for **(enter victim's name)** from **(enter dates as prescribed by the DHR Chair)** unless you hold relevant information to support the aims of the Terms of Reference.

Please provide a chronology of contact for **(enter perpetrator's name)** from **(enter dates as prescribed by the DHR Chair)** unless you hold relevant personal information which supports the purpose of a DHR and/or the Terms of Reference of the Review.

This includes;

a) Any previous concerning behaviour or history of abusive behaviour from **(enter perpetrator's name)** towards other ex-partners/family members/dependents/professionals, or;

b) Information (such as medical issues or escalating behaviour) which would assist in examining if the homicide was predictable, and therefore preventable;

c) Information or a chain of events which would have (or should have) triggered a professional response, leading to a direct or indirect link to the behaviour of **(enter perpetrator's name)** leading up to the death of **(enter victim's name)**.

Please do not include information that predates (enter date to be provided by DHR Chair) for either subject.

NEXT STEPS

After you submit your **Individual Agency Chronology Summary**, the Review Panel will contact you to request a formal analysis of your involvement with either or both of the subjects via an Individual Management Review (IMR) – or to notify you that an IMR will not be required.

Please ensure that your chronology is completed and returned to the DHR Support Officer via dhr@cornwall.gov.uk by (enter date to be provided by Chair).

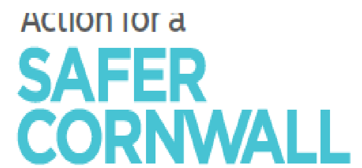
The attached documents have been provided to assist you. Please contact the DHR Support Officer on the above email address if you experience problems opening the documents;

- Home Office Guidance for DHRs (2016)
- Terms of Reference for (enter DHR No).
- Individual Agency Chronology Summary Template

If you have any queries, please do not hesitate to contact me via the DHR Support Officer and I will endeavour to answer any questions you may have regarding the Review.

Yours sincerely,
Name of chair
Independent Chair
Domestic Homicide Reviews

Enc.



Individual Agency Chronology Summary

You have been identified as an agency that may have had contact with a person whose case has been referred for a domestic homicide review. Please check your agency's records to see if you have had contact with the victim (Adult A) or perpetrator (Adult B) – details included within the accompanying letter - and complete the Individual Agency Chronology Summary below.

IF YOUR AGENCY HAS HAD CONTACT WITH ADULT A AND ADULT B PLEASE COMPLETE TWO SEPARATE CHRONOLOGY SUMMARIES

Your Details					
Name		Agency Name & Address			
Email		Tel No			
Signed				Date	

Declaration of Contact	
Has your agency had contact with Adult A or Adult B?	Yes/No (delete as appropriate)
If you have answered No, you do not need to complete further sections and should return the form to the DHR Support Officer at dhr@cornwall.gov.uk *If you have answered Yes, please continue to the table below*	

Summary of Agency Key Events		
TIMELINE: **Adult A:** date range supplied, unless you hold relevant information to support the aims of the Terms of Reference. **Adult B:** *date range supplied unless you hold relevant personal information which supports the purpose of a DHR and/or the Terms of Reference of the Review.*		
Date (Please give date(s) of key event between the stipulated dates listed in the timeline):	Description of key incidents/interventions starting with initial referral/contact/involvement with your agency/service: Please include a summary of your agency's involvement between the dates stipulated in the timeline above.	Comments:

Returning your Individual Agency Chronology Summary

All Individual Agency Chronology Summaries should be sent to dhr@cornwall.gov.uk no later than --- on the -------- by secure email or password protected

Appendix 6- Draft letter to request IMR

Date

Private and Confidential

To:

Dear

I am writing to advise that Safer Cornwall is undertaking a Domestic Homicide Review (DHR) in relation to the death of ……..reported on ……

The DHR has been commissioned by the Safer Cornwall Community Safety Partnership under Section 9 of the Domestic Violence, Crime and Victims Act 2004. The Government published updated guidance on DHRs on 07 December 2016 and a copy is enclosed.

The purpose of this letter is to ask that you arrange for any records pertaining to the victim (below) be secured in order that they can form part of an Individual Management Report (IMR) required from each agency. If you *do* hold records, you can secure them by copying and/or restricting electronic access. If the case remains open then a full copy of the file should be taken and the original file secured. Please could you confirm, via secure email below, that records have been secured.

Victim:

Date of Birth

Address:

As you are aware, the aim of the IMR is to:

a) Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
b) To identify how those changes would be brought about.
c) To identify examples of good practice within agency

The DHR will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised December 2016).

The review will also adhere to the guidance and standards for conducting a Safeguarding Adults Review. This is set out in the Care Act 2014 which specifies that Safeguarding Adult Reviews should be undertaken when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them.

In conducting your IMR you should ensure that you satisfy the guidance for both forms of review.

The person conducting your IMR should not have been directly involved with the victim, perpetrator or either of their families and should not have been the immediate line manager of any staff involved in the IMR. The IMR report should be quality assured by a Senior Manager in your organisation who is also responsible for ensuring that any recommendations from both the IMR and, where appropriate, the Overview Report, are acted on appropriately.

DHRs are not part of any disciplinary enquiries but information that emerges in the course of a review may indicate that disciplinary action should be taken under established procedures. This is a matter for agencies to decide in accordance with their disciplinary procedures.

Please ensure that the IMR is completed and returned to DHR Support Officer via dhr@cornwall.gov.uk by **Date**

If you have any queries please do not hesitate to contact me via the details below and I will be able to answer any questions you may have regarding the review.

Yours sincerely

Enc. DHR Guidance 2016

I have set out below some guidance for the conducting of the IMR. The goal of an IMR is to learn lessons that prevent domestic abuse homicides in the future and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working. This is done by reaching a clear understanding of any concerns about agencies' practices so that lessons can be learnt.

Do	**Don't**
Do ensure that the IMR explicitly relates to the terms of reference.	Don't lose sight of the terms of reference as you write or redraft your report
Ensure suitably independent authors have been identified to complete IMRs; and the independence of the authors from the case and their line management is explained in the IMRs.	Identify or appoint IMR authors who have been directly involved with the victim, perpetrator or either families and have been the immediate line manager of any staff involved in the IMR.
Do use the report format provided by the DHR panel and answer all the questions/ issues in the TOR, stating clearly any that do not apply to your area.	Don't use your own report format.
Include a comprehensive chronology of involvement and a genogram where applicable. Identify the records accessed and others consulted or interviewed in the completion of the report.	Don't stop at the point where facts are gathered.
Remember that that information provided will be disclosed to the police and provided to the Home Office.	
Do critically appraise the practice found. Identify poor practice as unacceptable, why these failings in practice took place and what issues contributed to that – for example staffing, training, audit and supervision/management – and suggest their relative importance. Consider alternative courses of action and what would have made a difference to the case.	Don't avoid identifying poor practice. It is not sufficient to write what actions should have taken place.
Do keep information about the work of other agencies factually based and not speculative.	Don't speculate about the work of other agencies.
Do try to establish what was it about the interactions with family members/the overall situation that generated a particular response from professionals at that time.	
Ensure recommendations arise directly from the evidence and issues identified. For example, if an IMR states that staff are appropriately trained in procedures and training in procedures is not raised as an issue, further training in procedures cannot be a logical recommendation. Also if staff are identified as ***not*** following procedures, changing procedures would be unlikely in itself to bring about any improvements in practice.	Don't write recommendations that do not flow directly from the evidence.

Do understand that information may be gathered in a number of a ways – from written records, by interview, reports, investigations and more.	Don't limit the report to information that was (or was not) recorded.
If other investigations are conducted in your agency, make clear the relationships between the investigation and the IMR.	Don't ignore organisations' reviews – the Panel should link those to the DHR where they can.
Do think about the reader of the report, and 'talk the reader through the process of finding the information and writing the report'. If additional information is needed once the IMRs have been written and submitted to the DHR panel, then ensure that the explanation as to why that was done is included and added to the report. Appendices to the report can be added to capture the processes followed. Information should be reader friendly and avoid using acronyms and jargon.	Don't ignore the needs of the reader.
Ensure the IMRs have each been signed off by a Senior Officer within the Individual agencies and evidence of that is supplied.	Don't combine more than one action to each recommendation.

Information Classification: CONTROLLED

INDIVIDUAL MANAGEMENT REVIEW DHR XX

PART ONE

INTRODUCTION

THE PURPOSE OF UNDERTAKING THIS REVIEW

The purpose of this Domestic Homicide Review in accordance with Statutory Multi-Agency Guidance for the conduct of Domestic Homicide Reviews (2016) is:

1. To establish the facts about events leading up to and following the death of Adult A (pseudonym of victim) on …

2. To examine the roles of the organisations involved in the case, the extent to which Adult A and Adult B (pseudonym of perpetrator) had involvement with those agencies, and the appropriateness of single agency and partnership responses to the case.

3. To establish whether there is learning from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard Adult A's wellbeing and identify clearly how such learning will be acted upon to impact change.

4. To identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Cornwall in order to improve our work to better safeguard victims of domestic abuse and their families.

Terms of Reference for this Domestic Homicide Review (DHRXX)

The specific Terms of Reference for DHR .. is;

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SUBJECTS OF THIS INDIVIDUAL MANAGEMENT REVIEW

Name	Date of birth	Relationship	Ethnic origin	Address

PART TWO

Domestic Homicide Review DHR10

Individual Management Report (IMR) Template

Review into the Death of Adult A on …

IMR Author:

IMR Agency:

IMR Role/Title:

IMR Commissioned on:

IMR Completed on:

AGENCY OWNERSHIP OF INDIVIDUAL MANAGEMENT REVIEW

Information Classification: CONTROLLED

IMR Competed By:	
IMR Agreed By: (Chief Executive/Director/Head of Services/Senior Officer)	
Date	

STATEMENT OF INDEPENDENCE

I certify that I ………………………………………………… (IMR Author) have not been directly concerned with the victim and family and am not the immediate line manager of the practitioner(s) involved

Signed…………………………………………………
Dated:…………………………………………………

Methodology

Please record the methodology used including the extent of documents reviewed and interviews undertaken, policies and procedures referred to during the course of the review and include any relevant comments for the panel (e.g. whether the policy has since been updated or the author of the case records has left the organisation.)

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Details of Parallel Reviews/Processes

Please include details of any parallel reviews being undertaken by your organisation for either Adult A, Adult B or any dependents. Provide details of the officer/staff member leading the review and record whether arrangements have been made to dovetail the themes of work.

Chronology of agency involvement

Please construct a comprehensive chronology of involvement by your agency for **ADULT A** from **date range provided**, unless you hold relevant information to support the aims of the Terms of Reference (see Part One).

Please provide a chronology of contact for **Adult B** from **date range provided** unless you hold relevant personal information which supports the purpose of a DHR and/or the Terms of Reference of the Review.

This includes;

a) Any previous concerning behaviour or history of abusive behaviour from Adult B towards other ex-partners/family members/dependents/professionals, or;

b) Information (such as medical issues or escalating behaviour) which would assist in examining if the homicide was predictable, and therefore preventable;

c) Information or a chain of events which would have (or should have) triggered a professional response,

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leading to a direct or indirect link to the behaviour of Adult B leading up to the death of Adult A.

Please do not include information that predates xxx for either subject.

State the precise dates when Adult A or Adult B were seen. Include details of the professionals from within the agency who were involved and whether they were interviewed or not for the purposes of the IMR.

Analysis of Involvement

Please provide a comprehensive analysis and evaluation of your agency's involvement as described in the chronology of involvement (above). This is an opportunity to explain why something happened, or did not happen, or why it happened the way it did. Please include context and explain in your own words why particular decisions were made or actions taken, using the benefit of hindsight to examine whether practice was acceptable/standard practice at the time and if it is acceptable practice today.

Consider the events that occurred, the decisions made, and the actions taken or not taken and evaluate (in accordance with best practice guidance and relevant legislation);

a) what went well

b) what didn't go so well

c) what you would change and why

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Addressing the Terms of Reference

Please consider further analysis in respect of key critical factors recorded within the specific terms of reference for the DHR (see Part One) and answer any questions that are relevant to your agency (if not already included within the Analysis of Involvement, above). If your agency has no information regarding a particular question, please include a statement to this effect.

Independent Chair Questions

If not already covered within your agency analysis or analysis of the terms of reference, please include your professional opinion of:

a)

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Leave blank if not relevant.

Effective Practice and Learning

Please include any learning from this Individual Management Review and any areas of good practice. Include any implications for working and suggestions for ways in which policy or practice can be improved.

Recommendations

Drawing on the key findings from this Individual Management Review please include your agency recommendations and be specific about the outcome which they are seeking. If you have identified local and national recommendations include them under a separate heading.

RETURNING YOUR IMR:

All IMR reports should be sent to dhr@cornwall.gov.uk no later than **5pm** on the **date** by secure email or password protected.

Information Classification: CONTROLLED

Information Classification: CONTROLLED

Letter to Family

Dear

I am writing to you as the Chair of Safer Cornwall (Cornwall’s Community Safety Partnership to say how sorry I was to learn of <victim’s name> death.

Because of the circumstances of <victim’s name> death, the Community Safety Partnership has to carry out what is called a Domestic Homicide Review. The Review looks at the involvement of different agencies and individuals that had been, or were working with <victim’s name> and his/her family. The purpose of this Review is to understand whether there is anything to be learnt and changed about the way in which local professionals and organisations work together to protect people that are experiencing domestic abuse within their relationships. It is also important that family members, friends and colleagues are given an opportunity to contribute about the ways that services can safeguard people at risk of domestic abuse better.

Domestic Homicide Reviews are not part of any police investigation process and must be kept completely separate from any possible legal proceedings. The Community Safety Partnership has to publish the results of its Domestic Homicide Review findings and whilst this is done in an anonymised way, it can attract media interest. Any publication will follow after any possible legal proceedings have been concluded and the publication date will be agreed with the family.

At this stage we are in the process of appointing an independent person to undertake the Review. Once they have been appointed I will ask that they contact you to offer you an opportunity to contribute to the review, and to talk with you about any ways in which services in Cornwall can help safeguard people at risk of domestic abuse better.

In the meantime if you have any questions please feel free to contact the DHR Support Officer who will be happy to answer any questions you may have on <contact number>.

May I again offer my sincere condolences to you and your family.

Yours sincerely

Cc <contact person named above >

Information Classification: CONTROLLED

Leaflets for family

aafda leaflet2.pdf

DHR-leaflet for
Family Members April

Information Classification: CONTROLLED

OVERVIEW REPORT TEMPLATE

TITLE PAGE OF OVERVIEW REPORT

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

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

insert

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.

Information Classification: CONTROLLED

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 (Section 4 paragraph 36). Confirm that the chair/author have had no connection with the Community Safety Partnership. If they have worked for any agency in the area previously state how long ago that employment ended.

PARALLEL REVIEWS

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

EQUALITY AND DIVERSITY

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

DISSEMINATION

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

BACKGROUND INFORMATION (THE FACTS)

- Where the victim lived and where the homicide took place. A synopsis of the homicide (what actually happened and how the victim was killed).

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- 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

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

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

ANALYSIS

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

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CONCLUSIONS

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

LESSONS TO BE LEARNT

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

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

Information Classification: CONTROLLED

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.

Information Classification: CONTROLLED

EXECUTIVE SUMMARY TEMPLATE

TITLE PAGE OF EXECUTIVE SUMMARY

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

LIST OF CONTENTS PAGE

THE REVIEW PROCESS

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

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

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

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

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

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

CONTRIBUTORS TO THE REVIEW

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

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

THE REVIEW PANEL MEMBERS

List the names of DHR panel members, their role/job title and the agency they represent (Section 4 paragraph 29).

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

AUTHOR OF THE OVERVIEW REPORT

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

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TERMS OF REFERENCE FOR THE REVIEW

SUMMARY CHRONOLOGY

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

KEY ISSUES ARISING FROM THE REVIEW

(Add issues as required)

CONCLUSIONS

LESSONS TO BE LEARNED

RECOMMENDATIONS FROM THE REVIEW

(Add recommendations as required)

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ACTION PLAN EXAMPLE TEMPLATE

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
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?
Fictional examples;						
All coroners are fully trained in identifying domestic violence and abuse	National	- Review current coroners' training and identify gaps - Develop training module. - Roll-out revised training package as follows: June-July – Coroners in region X Aug-Sept – Coroners in region Y	Ministry of Justice Coroner's team	- Review completed in January 2017 - Training package agreed April 2017 - Roll-out begins June 2017	All coroners to be trained by September 2017	All coroners received training by December 2017 and their narrative verdicts are beginning to reflect that this training has been effective.

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SAFER CORNWALL

Strictly Confidential

HM Coroner
The New Lodge
Newquay Road
Penmount
TRURO
TR4 9AA

Date

Dear xxx

DOMESTIC HOMICIDE REVIEW:

I have been appointed by the Safer Cornwall Community Safety Partnership as the Independent Chair and Author of the Domestic Homicide Review in relation to the death of…….

As you know Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts to decide. Neither are they part of any disciplinary process. The purpose of a DHR is to:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what the 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 the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.

The purpose of writing to you is to inform you of this process and to include a copy of the terms of reference for your information. Could I also please ask you provide a copy of the Inquest papers, including any transcript or notes of the comments made by you in summing up the case and delivering your verdict.

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In due course, if you so wish, you may have a copy the final report but in the meantime if you have any queries please contact me via the DHR Support Officer at Safer Cornwall on phone number or via email: dhr@cornwall.gov.uk

Yours sincerely

Independent Chair and Report Writer of the Domestic Homicide Review Panel

Enc: Terms of Reference for the Review

Information Classification: CONTROLLED

SPECIFICATION FOR THE ROLE OF THE DOMESTIC HOMICIDE REVIEW CHAIR

1. CONTEXT OF ROLE

1.1 Responsible to undertake Domestic Homicide Reviews (DHR) as requested by the Chair of the Cornwall Community Safety Partnership (CSP); and

1.2 To Lead the Domestic Homicide Review and produce overview reports and executive summaries and present them to the Community Safety Partnership.

1.3 To act in accordance with the guidelines set out in Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

2. THE PURPOSE OF DOMESTIC HOMICIDE REVIEWS

2.1 DHRs carried out under the statutory guidance (2016) should:

- Establish what lessons are to be learned from the domestic homicide in relation to how local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are, 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 local and national policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve services for all domestic violence and abuse victims and their children;
- Contribute to a better understanding of the nature of domestic abuse and violence;
- Draw on other relevant local and national reviews and highlight good practice.

3. MAIN PURPOSE OF ROLE

3.1 Following a decision by CSP Chair to undertake a DHR the CSP will commission an Independent Chair to manage the process. The Independent Chair should not be a member of the CSP(s) involved in the DHR or an employee of any of the agencies involved in the DHR. The Chair can be someone from another CSP which is not involved in the DHR or from an agency which is not involved in the case or an independent person commissioned by the CSP.

4. RESPONSIBLE TO:

The Independent Chair will be responsible to the Safer Cornwall Partnership Board who discharge their duties through the Safer Cornwall Management Group.

5. MAIN DUTIES AND RESPONSIBILITIES

5.1. To lead Domestic Homicide Reviews in accordance with Home Office guidance 2016.

5.2 To provide the independent perspective to the work of the Review Panel and ensure that the process remains within those set out in national and local guidance.

5.3 To ensure the Review Panel actively manages the DHR process, seeking legal advice as necessary, so that the findings from other relevant processes such as criminal proceedings, an inquest or inquiry/investigation are managed alongside the DHR report.

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5.4 To ensure that the CSP Chair and Management Group are kept informed of the progress of the Review and any potential difficulties or delays in meeting the locally agreed timescales.

5.5 To maintain good working relationships with all those involved in the Domestic Homicide Review process.

5.6 To ensure that a process is developed for relevant family members/friends and employers/colleagues to be consulted as part of the Review process and to undertake that role on behalf of the Review Panel. Any decision not to involve family members will need to be recorded clearly detailing the appropriate decision-making process.

5.7 To ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report.

5.8 To ensure that the overview report is of a high standard and is written in a format suitable for publication in accordance with Home Office national guidance 2016.

5.9 If there is disagreement around the contents and/or recommendations of the Overview Report, the CSP Chair and Management Group must be consulted.

5.10 With the Review panel translate findings and recommendations into an action plan that should be signed up to by the senior manager in each of the organisations which will be involved in implementing the action plan. The plan should set out who will do what, by when, with what intended outcome and how success will be measured. The plan should set out the means by which improvements in practice/systems will be monitored and reviewed.

5.11 Ensure arrangements are made to provide feedback and debriefing to the child/ren (if surviving) and family members/carers of the subject person as appropriate, following completion of the overview report.

5.12 To attend relevant Community Safety Partnership meetings as required in order to present the work of the Review Panel, in particular identifying key findings and recommendations for action.

6. GENERAL

6.1 To be aware of and adhere to applicable rules, regulations, legislation and procedures e.g. Council (Equal Opportunities Policy/Code of Conduct), national legislation (Health and Safety/Data Protection), local procedures.

6.2 To maintain confidentiality of information acquired in the course of undertaking duties for the CSP.

6.3 To be responsible for own continuing self-development, undertaking training as required.

6.4 To work within timescales set out in local policy and Home Office national guidance 2016.

6.5 To have Public/ Professional Liability Insurance

7. SKILLS

7.1 The Lead Reviewer shall produce evidence that they have the following skills:

- Chairing multi-agency and complex meetings.
- Case analysis.
- Report writing.
- Presentation skills.
- Dealing with media.
- IT skills.
- Ability to work with bereaved families.

Information Classification: CONTROLLED

- Ability to work with staff from other agencies.
- Ability to produce clear concise reports which are evidence-based and reflect good practice and to draft appropriate relevant recommendations.
- Ability to work as a member of a multi-agency group.
- Ability to be able to question and analyse written and oral information.
- Ability to work to timescales in line with relevant policies and procedures.

8. EXPERIENCE

8.1 Relevant professional experience in services working with vulnerable adults, children and young people.

8.2 Previous experience of domestic homicide review panel membership preferable but not essential.

9. KNOWLEDGE

9.1 Good understanding of systems methodology and its application in Case Reviews.

9.2 Good working knowledge of policies and procedures in relation to domestic abuse and sexual violence, child abuse and neglect and the wider safeguarding agenda.

9.3 Good understanding of legislation and its application to vulnerable adults, children & young people.

9.4 Good understanding of findings from previous adult and child case reviews and lessons from research.

10. REMUNERATION

10.1 Payment of <Insert> per day (agreement of days will be reflected within individual contracts) but this will be dependent upon the complexity of the review.

10.2 In the first instance there will be a ceiling of <Insert> per Review.

10.3 Where a Review is particularly complex or where there is a likelihood of going over 20 days the Chair of <Insert> CSP may agree an extension of the hours and ceiling.

11. ADDITIONAL EXPENSES

11.1 The Council shall on the presentation of invoices or vouchers or other evidence of actual payment as the Council may reasonably accept, reimburse the Consultant for expenses incurred wholly and exclusively in respect of the Consultant performing his duties pursuant to this Agreement.

11.2 The Council shall pay all correct and valid claims for Additional Expenses on a monthly basis in arrears.

11.3 The Consultant shall present a correct and valid invoice to the Council for all authorised Additional Expenses.

11.4 The Consultant shall obtain the approval of the CSP before incurring any Additional Expenses.

11.5 The Council shall not pay any Additional Expenses claim which exceeds the following list:

11.5.1 Rail fare — most economical 2nd class rail fare

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11.5.2 Mileage 40p per mile

11.5.3 Accommodation most economical budget rate hotel

11.6 The above expenses will only be paid when the Consultant is away from <insert> on official CSP business. No expenses and/or mileage allowances will be paid for travel between the Consultant's home address and any CSP meeting within the <insert> area.

12. THE OVERVIEW REPORT

12.1 The Domestic Homicide Report remains the property of the Cornwall Community Safety partnership.

Information Classification: CONTROLLED

Appendix 15 – Rapid Review Referral form

Our Safeguarding Children Partnership

for Cornwall and the Isles of Scilly

RAPID REVIEW REFERRAL FORM

REFERRAL & PROFESSIONAL DETAILS

(PLEASE FILL IN AS MANY CONTACT DETAILS AS POSSIBLE, ADD ROWS IF NECESSARY

AND EMAIL TO

oscpreviews@cornwall.gov.uk (confidential)

If required, please contact the Practice Development and Standards Unit for further guidance on completing this form (01872 224703)

Electronic Versions Preferred

As referrer you confirm that from your analysis this referral meets the following criteria for a Serious Child Safeguarding Case SCSC:

A serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

REFERRAL	

Information Classification: CONTROLLED

DATE:			
Name of Referrer	Designation/Organisation:	Telephone Number:	Email Address:

CHILD'S DETAILS			
Name of Child:			
Date of Birth:		Date of Death	
Associated Addresses:			
FAMILY DETAILS	Name	D.O.B.	Address
Related Adults:			
Related Children:			

DETAILS OF CHILD DEATH / SERIOUS INCIDENT

Please include location/address where alleged incident occurred.

(Please give as many details as possible).

Information Classification: CONTROLLED

OTHER ORGANISATIONS INVOLVED IF KNOWN			
Organisation	**Contact person**	**Phone**	**e-mail**
Child and Family Services			
Education and Early Years			
CAMHS			
Police			
General Practitioner			
Health			
Voluntary Organisations			
Other			
FOR OSCP ADMIN			

Date received in OSCP:		**TIME**	

Information Classification: CONTROLLED

Appendix 16 – Criteria for rapid review and Local Child Safeguarding Practice Review

Criteria for Rapid Review and Local Child Safeguarding Practice Review (LCSPR) - Working Together 2018

Working Together 2018 requires safeguarding partners to consider conducting a child safeguarding practice Review in serious child safeguarding cases. In order to determine if a serious incident should become subject to a practice Review, safeguarding partners must undertake a Rapid Review meeting to:

- Gather the facts of the case as far as they are readily established at the time
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- Consider the potential for identifying immediate improvements to safeguard and promote the welfare of children
- Decide what steps they should take next including whether or not to undertake a child safeguarding practice Review

A Serious Child Safeguarding Case means cases in which—

(a) abuse or neglect of a child is known or suspected; and
(b) the child has died; or been seriously injured

Serious harm includes (but is not limited to) serious and/or long–term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. When making decisions, judgement should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

The criteria which the local safeguarding partners must take into account include whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the Child Safeguarding Practice Review Panel have considered and concluded a local Review may be more appropriate

Safeguarding partners should also have regard to the following circumstances:

- where the safeguarding partners have cause for concern about the actions of a single agency
- where there has been no agency involvement and this gives the safeguarding partners cause for concern
- where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings

(Working Together - 2018)

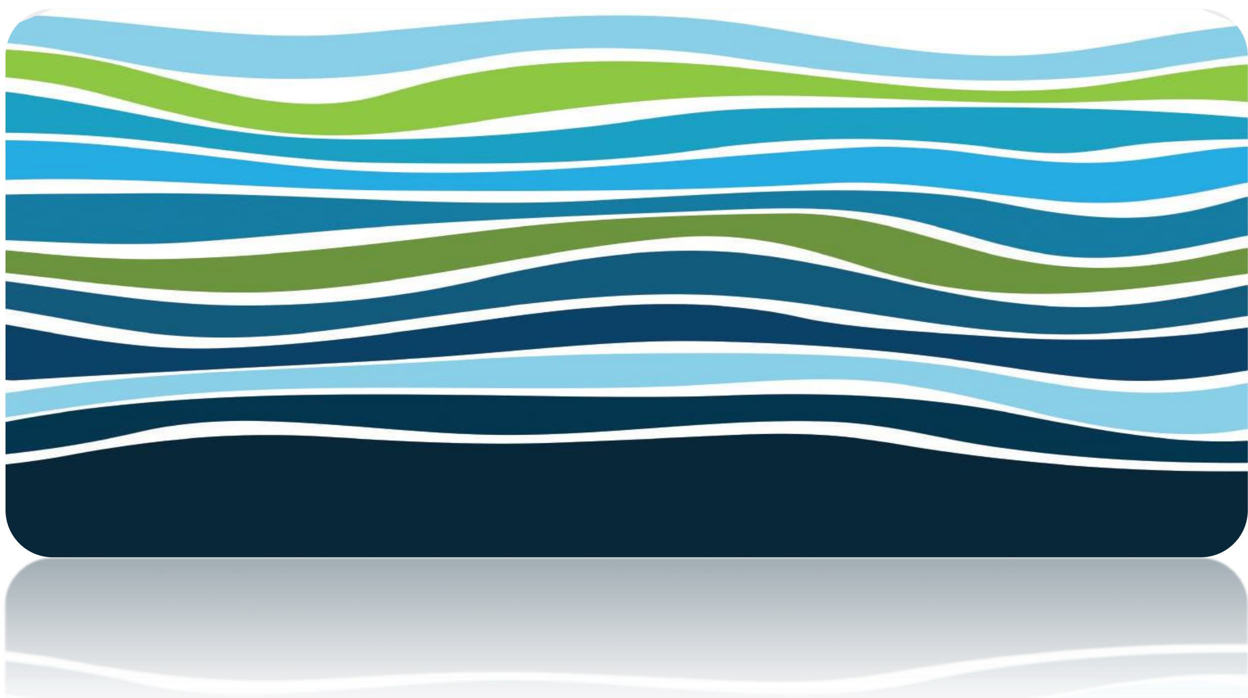
Information Classification: CONTROLLED

Appendix 17

SAFER
CORNWALL
Kernow Salwa

Cornwall & The Isles of Scilly Safeguarding Adults Board & Safer Cornwall Partnership Board.

Joint Safeguarding Adult Review (SAR) & Domestic Homicide Review (DHR) Procedure 2023.



Information Classification: CONTROLLED

Cornwall and the Isles of Scilly, Safeguarding Adults board & Safer Cornwall Partnership board – Joint SAR/DHR procedure:

1.Introduction:

1.1. The Cornwall & Isles of Scilly (CIOS) Safeguarding Adults Board (SAB) has a statutory duty to complete Safeguarding Adults Reviews (SARs) for any cases which meet the criteria set out in section 44 of the Care Act 2014- https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

1.2 The Safer Cornwall Partnership Board is responsible for undertaking a Domestic Homicide Review (DHR) for any case where the definition set out in paragraph 13 of the Home Office multi-agency statutory guidance for the conduct of Domestic Homicide reviews has been met.https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

1.3. When there are local referrals made that are assessed to meet both the SAR and DHR criteria as detailed above, there is the consideration of both boards to complete a joint review process (SAR/DHR) in these cases. This will avoid replication, enhance the analysis and scrutiny of the information and circumstances to identify the themes, recommendations and learning, adding to the overall quality and outcomes of the review.

1.4 The procedure below sets out the process of how the CIOS SAB and SCP can work effectively together where necessary to complete a joint SAR/DHR review that meets the core duties of both boards.

2. Procedure:

2.1. New referrals

When new referrals for potential SARs or DHRs are received by the CIOS SAB or SCP, each board will gather information from partner agencies and arrange for the referral to be reviewed against the criteria set out in section 44 of the Care Act 2014 Care act or section 3.8 of the Home Office multi-agency statutory guidance as per their usual agreed procedures.

At this point if it is identified by the SAR subgroup or DHR review panel members that the referral may met the criteria for both a SAR/DHR this will be recorded in the minutes of the meeting, these minutes will then be sent with the information already gathered to the appropriate board business team. This information will then be considered as a new referral and be reviewed by the SAR subgroup or DHR review panel members to meet one of the outcomes below.

- Does not meet SAR criteria
- Does not meet DHR criteria
- Meets the SAR criteria
- Meets the DHR criteria
- Meets the joint SAR/DHR criteria
- Does not meet the SAR or DHR criteria

The decision will be recorded in the minutes of the review meeting and the outcome will be sent to the appropriate board business team and shared with the chair of each board.

If a joint SAR/DHR is agreed, then the structure of the review and methodology will follow the guidance set out in the Home Office multi-agency statutory guidance for the conduct of Domestic Homicide reviews. The coordination of

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the joint SAR/DHR review process will be jointly led and facilitated by the SCP DASV team and the SAB business team.

Please note that if a SAR referral has been reviewed by the SAR subgroup members and has been assessed not to make the S44 criteria it can still be referred to SCP as a potential DHR if members feel it may meet the section 3.8 home office criteria.

Likewise, if a DHR referral has been assessed by the DHR review panel not to meet section 3.8 of the Home Office multi-agency statutory guidance it can still be referred to the SAR subgroup if the members feel it may meet S44 criteria.

2.2 Author commissioning:

- Expression of interest (EoI) in the joint DHR/SAR to be jointly drafted
- Expressions of interest to be sent out via SCP normal routes from both the SCP and SAB
- Joint Service Level Agreement (SLA) drafted by SCP and SAB
- SLA to be agreed with the author
- SAR subgroup to be appraised of the author decision

2.3 DHR/SAR panel

- Panel membership to be agreed – including SAR members who should be part of panel

2.4 Terms of reference:

- Agreed by the DHR/SAR panel with input from family members/ carers
- Reviewed via email by the SAR subgroup members for comments
- Members of DHR/SAR panel to be taken from statutory members of the SAR subgroup

2.5 Review methodology:

- To follow the HO DHR guidance as SAR Care act is flexible on methodology
- Again, members of DHR panel to be taken from statutory members of the SAR subgroup to ensure consistent joint working at all stages of the process

2.6 Final report- feedback and ratification:

- Final report to be initially signed off by DHR/SAR panel
- When the final draft report is ready it can be shared with the SAR subgroup members via email for final comments
- It can then be taken to the SCP board for ratification with one of the statutory SAR subgroup member present.
- The SAB independent chair will also be present to ratify and make any add final comments

2.7 Findings and recommendations:

- Recommendations are developed at a panel/ practitioner workshop
- The findings and recommendations will then be taken to the Quality and improvement subgroup to be reviewed, agree any actions and include in the joint thematic action planning process.
- This will be reviewed with the SCP action planning procedure as not to duplicate request to partners
- Learning brief will be created by SCP/SAB and disseminated through their and the SAB SCP networks

2.8 Publication:

- A decision will be made at the SCP board to publish, not publish, publish executive summary or learning briefing, following recommendations from the panel
- This decision will be supported by the SAR subgroup Statutory members and SAB chair who will be present
- Statements will be agreed via email
- Time/date to be agreed to publish on the SAB SCP websites