ANNEX B

Milton Keynes Domestic Homicide Review Protocol

Version 1 (14/05/12)

Authors:
Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office
Neil Dodds - Domestic and Sexual Violence Reduction Co-ordinator Safer MK

Definition of Terms

Domestic Violence includes physical violence, psychological, sexual, financial and emotional abuse involving partners, ex-partners, other relatives or household members.

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

So called **'Honour'-Based Violence**, "honour crimes" and "honour killings" embrace a variety of crimes of violence (mainly, but not exclusively, against women); including assault, imprisonment and murder where the person is being punished by their family or their community. They are being punished for actually, or allegedly, undermining what the family or community believes to be the correct code of behaviour. In transgressing against this code of behaviour, the person shows that they have not been properly controlled to conform by their family and this is to the "shame" or "dishonour" of the family.

A **member of the same household** is defined in section 5 (4) of the Domestic Violence, Crime and Victims Act [2004] as:

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

Introduction

The purpose of a Domestic Homicide Review is to learn lessons in order to prevent further homicides. Domestic Homicide Reviews (DHR) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act 2004. This creates an expectation for local areas to undertake a multi-agency review following a domestic violence homicide. This provision came into force on 13th April 2011.

The provision also enables the Secretary of State, in particular cases (e.g. when a local area fails to initiate a review itself) to direct that a specified person or body establishes or participates in a review. Section 9 also introduces a duty for every person or body establishing or participating in the review, to have regard to the statutory guidance.

In Milton Keynes the responsibility for commissioning a review lies with the Community Safety Partnership. The Head of Community Safety will ensure the criteria are met and inform the Chair of the Community Safety Partnership. The Chair will decide with recorded rationale whether a review will be commissioned. This decision should be taken in consultation with local partners with an understanding of the dynamics of domestic violence.

The Milton Keynes protocol derives principally from the Home Office Statutory Guidance for Domestic Homicide Review and is localised for Milton Keynes. Consideration will always be given to the Milton Keynes Safeguarding Children Board Serious Case Review Toolkit. Information leaflets explaining the DHR process and the full Home Office guidance can be found at www.homeoffice.gsi.gov.uk.

A DHR means

A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

1. a person to whom he / she was related or with whom he / she was, or had been, in an intimate personal relationship, or
2. a member of the same household as himself / herself

Held with a view to identifying the lessons to be learnt from the death. This will include deaths where there is evidence of Honour-Based Violence.

The Rationale and Purpose of the DHR

The underlying purpose for the DHR process is to ensure relevant agencies respond appropriately to victims of domestic violence by offering and / or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence. The Review also assesses whether agencies have sufficient procedures and protocols in place, which were understood and followed by their staff, and where there may be a need to improve these procedures.

A DHR should be carried out 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 policies and procedures as appropriate.
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children, through improved intra- and inter-agency working.

DHRs are not inquiries into how the victim died or into who is to blame. That is a matter for Coroners and criminal courts to determine.

DHRs are also not a part of any disciplinary enquiry or process. Where information emerges in the course of a DHR suggesting that disciplinary action should be taken, the agency concerned will follow its own internal disciplinary procedures separately to the DHR process.

Circumstances of Particular Concern

The following factors are just some examples of the types of situations preceding homicide which will be of interest to review teams when conducting a DHR:

- 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, and / or it was not shared with others and / or it was not acted upon in accordance with their recognised best professional practice.
- Any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously, or not acted on appropriately by the other parties involved.
- The homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures, or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.
- The victim was being managed by, or should have been referred to, a multi-agency risk assessment conference (MARAC).
- The homicide appears to have implications / reputational issues for a range of agencies and professionals.

- The homicide suggests that national or local procedures or protocols may need to change, or are not adequately understood or followed.
- The perpetrator holds a position of trust or authority e.g. police officer, social worker, health professional, and therefore the homicide is likely to have a significant impact on public confidence.
- The victim had no known contact with any agencies. For example, could more be done in the local area to raise awareness of services available to victims of domestic violence?

Identification and Referral

When a domestic homicide occurs, Thames Valley Police should inform the Community Safety Partnership (CSP) in writing of the incident.

The CSP then has the overall responsibility for setting up a review. Where partner agencies of more than one local authority area have known about or had contact with the victim, the local authority area where the victim was resident should take responsibility for carrying out any review.

If the victim was of no fixed address before the incident took place, lead responsibility will lie with the area that they were last known to have lived or frequented as a first option, and then considered on a case-by-case basis.

Any professional or agency may refer such a case to the CSP in writing if it is believed that there are important lessons for inter-agency working to be learned from the case.

Principles

All agency representatives involved in the Milton Keynes DHR process agree to adhere to the following principles:

- **Safety and Welfare** The first and predominant consideration when a case is being looked at by the Review Panel is the safety and welfare of any children or family members of the deceased who could pose an ongoing risk of violence, or be put in danger as a consequence of identifiable practice or system flaws. In the case of a killing in the name of 'honour' this should extend to all siblings and any other family members that are potentially at risk of further violence.

- **Accessibility** Any partner agency at any time can refer a case for consideration for a DHR, and should do if they consider that the DHR criteria are, or might be met. For example, where a person has taken their own life and there is evidence that this was a direct result of domestic violence, or where there was pressure from the family for reasons of 'honour'.

- **Consistency** When considering whether or not the criteria are met and whether to commission a DHR, members will consistently use the agreed tools, proforma and mechanisms, based on the Home Office criteria, to make those judgements.

- **Transparency** Records of reasons for decisions and processes undertaken will be shared with referring agencies and be made available on request to the Chief Constable, Local Authority Chief Executive Officers, Statutory Agency Chief Executive Officers, Chair of the Milton Keynes Community Safety Partnership, Chair of Milton Keynes Safeguarding Children Board and Chair of the Milton Keynes Safeguarding Adults Board, under the Milton Keynes Information Sharing Protocol.

Process

The Statutory Guidance recommends that the Milton Keynes CSP Chair inform the Home Office of the decision whether or not to have a DHR within one month of the homicide. Lessons learned at each step must be implemented as soon as possible, and should not wait until completion of the DHR process.

Please note timescales are flexible but emphasis should be on completing the DHR in the shortest time possible.

Step 1

In the event of a domestic homicide the Thames Valley Police Local Area Police (LPA) Commander should inform the Chair of the CSP in writing of the incident.

Timescale – within 5 working days of the homicide

Step 2

If the victim is aged 16 to18 then the referral should also be made to the Milton Keynes Safeguarding Children's Board (MKSCB) by the Chair of the CSP for their consideration of a Serious Case Review (SCR). Domestic abuse advisors should be members of the SCR. In a domestic homicide case where a parent and children have been killed the Chair of the CSP and MKSCB should consider a combined review to avoid duplication (refer to MKSCB SCR Toolkit). Where there are surviving children the Chair of MKSCB should be informed.

Timescale – within 3 working days of receiving a referral from the Thames Valley Police

Step 3
If the victim is 18 years and over then the Advisory Group (Appendix 1 – Advisory Group) will convene to briefly scope agency involvement with the victim, discuss whether early indications show that the criteria for a DHR have been met and collate relevant information. Where the victim is a vulnerable adult a representative from the MKSAB will be invited to attend the meeting with the Advisory Group.

Timescale – within in 7 days of a domestic homicide

Step 4
The Chair of the CSP will convene a meeting with members of the Advisory Group, the LPA Commander and representatives from Domestic Abuse Specialist Agencies to take advice on whether the criteria for a DHR have been met. If a DHR is required the Chair of the CSP, with advice from the Advisory Group, should identify membership of the Review Panel (Appendix 1 – The Review Panel). The Chair of the CSP will write to the relevant Chief Executives of the participating agencies requesting their membership on the Review Panel.

Timescale – within 2 weeks of the referral

Step 5
The Chair of the CSP should in writing inform the Home Office of the decision to hold a DHR. If the Chair considers that a DHR is not required then they should explain why to the Home Office and any relevant agencies. Subject to considerations of any comments, no further action need be taken.

Timescale – within 3 working days of the decision

Step 6
The Review Panel will appoint an Independent Chair (IC) based on the criteria (Appendix 3). The IC (Appendix 1 – The Independent Chair) should, in consultation with the Review Panel, consider the scope of the review process (see appendix 5 for considerations when scoping) and draw up clear terms of reference (TOR) – (see appendix 4).
A copy of the TOR**,** where there are children / young people / vulnerable adults involved in the case, should be sent to the appropriate Local Children and Adult Safeguarding Boards.

Timescale – within 1 month of the homicide

Step 7
The DHR Panel Chair will write to the senior manager in each of the relevant participating agencies to ensure records are retained and an Individual Management Review (IMR) is commissioned.

Timescale – within 1 week of the Chair appointment

Step 8
Agencies will provide IMR (see Appendix 6 & 7) within timescales set by Chair of Review Panel.

Step 9
The IC will produce an overview report, executive summary and action plan (Appendix 8, 9, 10 & 15), agreed by the Review Panel.

The Domestic and Sexual Violence Reduction Co-ordinator in liaison with the Family Liaison Officer (FLO) will give a copy of the overview report to the victim's family for their comments.

If there are parallel investigations, for example criminal proceedings, then there may be a delay before the overview report is finalised. This should be negotiated with the Chair of the CSP.

Timescale – within 6 months of the decision to hold a DHR

Step 10
The CSP Chair should agree the content of the fully anonymised report. Once agreed the Chair will send the overview report to the Home Office for quality assurance. The action plan should be sent to the Milton Keynes Domestic and Sexual Violence Delivery Group and relevant agencies to implement.

Timescale – within 2 weeks of the completion of the overview report

Step 11
The Home Office will provide clearance to publish the overview report and executive summary.

Step 12
The CSP should publish the overview report and executive summary on the CSP website and monitor the action plan.

Involvement of Family and Friends and other Informal Support Networks

In domestic violence homicides, members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences.

The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Consideration should also be given to interviewing the perpetrator's family. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances, for example, where there are suspicions of 'honour'-based violence. For more detailed information on communicating with family and friends please read Roles and Responsibilities for the Review Panel (Appendix 1).

Considerations

- The Review Panel should be aware of the potential sensitivities and need for confidentiality when meeting with members of informal support networks during the review and all such meetings should be recorded.
- Consideration should also be given at an early stage to working with Police Family Liaison Officers (FLOs) and Senior Investigating Officers involved in any related police investigation, to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.

The Review Panel should also access other networks which victims may have disclosed to, for example employers, health professionals or their local VCS agencies. Information leaflets explaining the DHR process can be found at www.homeoffice.gsi.gov.uk.

When meeting with friends, family members and others, the Review Panel should:

- Communicate through a designated advocate who has, where possible, an existing working relationship with the family i.e. a VCS representative or Police FLO.

- Make a decision regarding the timing of contact with the family based on information from the advocate, and taking account of other ongoing processes i.e. post mortems, criminal investigations.
- Ensure initial contact is made in person and deliver the relevant information letter and leaflet.
- Ensure regular engagement and updates on progress through the advocate, including the timeline expected for publication.
- Explain clearly how the information disclosed will be used and whether this information will be published.
- Explain how their information has assisted the review and how it may help other domestic violence victims.
- Provide a completed version of the review to the family, prior to sending the final review to the Home Office. This will allow consideration of the findings and recommendations and enable a record to be made of any areas of disagreement.
- Maintain reasonable contact with the family, even if they decline involvement in the review process. It will be important to communicate through the designated advocate when the review is completed and when the review has been assessed and is ready for publication. The family should also be informed about the potential consequences of publication, i.e. media attention and renewed interest in the homicide.

Cases which Cross Organisational Boundaries

Any agency where services have been provided to the victim prior to the homicide, irrespective of organisational geographical boundaries, will be required to contribute to the DHR if agreed in the scope of the Review Panel's TOR.

Single Agency Individual Management Review

In some homicides that do not meet the criteria for a DHR but give rise to concern from a particular agency, it may be valuable to conduct a single agency individual management review or a smaller-scale audit. For example where there are lessons to be learnt about the way staff worked within one agency, rather than about how agencies worked together.

Overview Report, Executive Summary and Lessons Learned

DHRs are a vital source of information to inform and improve national and local policy and practice. All agencies involved have a responsibility to identify and disseminate common themes and trends across review reports, and act on any lessons identified to improve practice and safeguard victims.

Once the Review Panel have agreed the Overview Report, Executive Summary and Action Plan (hereafter referred to as 'supporting documents') the Panel should provide the Chair of the CSP with a copy. The Chair of the CSP should make a copy available to the deceased's family for comment. Once these have been agreed by the Chair, the Chair should send the Overview Report and Executive Summary, which should include Lessons Learned, to the Home Office Quality Assurance Group. **The time frame for this is 6 months from the commissioning of the DHR, and prior to publication unless otherwise agreed by the Chair of the District CSP and the Home Office.**

Publication of the Overview Report and Executive Summary

In all cases, the Overview Report and Executive Summary should be suitably anonymised, edited and made publicly available. The Action Plan will not be published. IMRs should not be made publicly available. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person(s) is killed as a result of domestic violence. 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. The aim in publishing the Overview Report and Executive Summary is to restore public confidence and improve transparency of the processes in place, across all agencies, to protect victims.

All Overview Reports and Executive Summaries should be published unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen. Where there are children of the deceased / deceased's family / perpetrator then the decision to publish should be taken in consultation with Children's Social Care and / or MKSCB.

The publication of the documents needs to be timed in accordance with the conclusion of any related court proceedings (including any court proceedings in regard to related children) and other review processes. The content of the Overview Report and Executive Summary must be suitably anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998. This means preparing Overview Reports in a form suitable for publication, or redacting them appropriately before publication.

Where information is sought using the Freedom of Information Act 2000 (FOIA), it is important to carefully consider whether any exemptions can be relied upon.

Where appropriate, consideration should also be given to translating the executive summary into different languages and other formats, such as Braille or British Sign Language.

Publication of Overview Reports and the Executive Summary will take place following agreement from the Quality Assurance Group at the Home Office, and should be published on the local CSP web page.

A copy of the Overview Report, Executive Summary and Action plan should be sent to the Milton Keynes Council Chief Executive, MKSCB, MKSAB, MK LPA Commander and the Domestic and Sexual Violence Delivery Group.

The Action Plan

The Overview Report should make recommendations for future action which the Review Panel should translate into a specific, measurable, achievable, realistic and timely (SMART) Action Plan (see appendix 15). The Action Plan should be agreed at senior level by each of the participating organisations.

The Action Plan should set out who will do what, by when, with what intended outcome. It should also set out how improvements in practice and systems will be monitored and reviewed. The Chair of the CSP should provide the Domestic and Sexual Violence Delivery Group and relevant agencies with the Action Plan to implement all actions arising from the DHR. The Chair of the CSP will be responsible for monitoring the actions until complete.

Guidance to Agencies on Information Sharing

In the first instance refer to the Milton Keynes Information Sharing Protocol. Your role (i.e. that of your agency) in ensuring a successful DHR process is to take a balanced approach to sharing public protection information effectively; to improve confidence and to protect people from the risk of harm. Experience shows that the successful way to do this is to assess the risk of harm of sharing, or not sharing the information. You have a responsibility to action and share information in compliance with the data protection act where there is a risk of harm to public protection.'

The Data Protection Act 1998 is frequently perceived as a barrier to sharing information. However, section 29 provides an exemption for the purposes of crime prevention; the aim of public protection is to prevent serious crime so this exemption applies to public protection cases. This exemption does not negate compliance with the principles. For example, the Act allows data to be shared, but the data must be accurate, up to date, adequate, relevant and not excessive. The sharing of data using this exemption is usually explained in an Information Sharing Agreement; this sets out the rationale, purpose and practicalities for sharing information. A summary of the principles are included in Appendix B; the Data Protection Act 1998 is available at: http://www.legislation.gov.uk/ukpga/1998/29/contents.

The Seven Golden Rules of Information Sharing are:

1. **Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately.

2. **Be open and honest** with the person (and / or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.
4. **Share with consent** where appropriate and where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
5. **Consider safety and well-being:** Base your information-sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion and is shared securely.
7. **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Financial Implications

The cost of a DHR is the responsibility of the Community Safety Partnership. Arrangements for payment should be confirmed by the Chair of the CSP when the Review Panel Chair is commissioned.

Appendices

1. Summary of Roles & Responsibilities
2. DHR Confidentiality Agreement
3. Criteria for an Independent Chair
4. Milton Keynes DHR TOR Template
5. Scoping by Review Panel
6. Outline format for IMRs
7. IMR template
8. Outline format for Overview Report
9. Overview Report template
10. Area Concluding Report
11. Milton Keynes DHR Flowchart
12. Police Report
13. Confirmation of No Record of Contact From
14. Housing Report
15. Action Plan template
16. Glossary

APPENDIX 1

Domestic Homicide Review: Summary of Roles and Responsibilities

Role of the Milton Keynes CSP Chair

- Establishing whether a case is to be subject of a DHR by applying the definition set out in the DHR Guidance.
- Making the final decision on whether a review should be conducted. This decision should be taken in consultation with local partners with an understanding of the dynamics of domestic violence.
- Confirmation of a decision to review, as well as a decision not to review a homicide, should be sent in writing to the Home Office.
- Once the CSP has agreed that a DHR is to be undertaken they will utilise local contacts and request a DHR review panel is set up.
- If there are parallel processes, for example criminal proceedings, the Chair will make the decision whether or not to postpone the Overview Report and Executive Summary until the parallel process is complete.
- If a postponement is agreed this decision should be conveyed to the Home Office with reasons why and estimated timescale for completion.

Post Review:

- Agree the content of the Overview Report, Executive Summary and Action Plan.
- Make arrangements to provide feedback and debriefing to staff, family members and the media where appropriate.
- Provide a copy of the Overview Report, Executive Summary and Action Plan to the Home Office quality assurance group.
- On receiving clearance from the Home Office quality assurance group, the CSP should provide a copy of the Overview Report, Executive Summary and Action Plan to the senior manager of each participating agency.
- Provide Milton Keynes Domestic and Sexual Violence Delivery Group with a copy of the Action Plan to manage the actions.
- Publish electronic copies on the local CSP website.
- Monitor the implementation of the SMART Action Plan.
- Formally conclude the review when the action plan has been implemented and include an audit process.
- Where reviews are assessed as inadequate by the Home Office quality assurance group the CSP chair is responsible for ensuring the areas of concern are revisited and amended by the review panel.

Both members of the Review panel and Independent Chair will complete the E-Learning Training Package on DHR’s, including the additional modules on chairing reviews and producing Overview Reports.

The Review Panel

The Review Panel will have a fixed standing membership at senior level from:

- Thames Valley Police DI Protecting Vulnerable People
- Community Safety Partnership (Safer MK)
- Health
- Probation Service
- MK-Act (Milton Keynes Women's Aid)
- Milton Keynes Safeguarding Adult Board
- Milton Keynes Safeguarding Children Board
- Domestic and Sexual Violence Reduction Co-ordinator

The Chair of the CSP will determine whether all or some of the fixed standing members should sit on the Review Panel on a case-by-case basis and proportionate to the DHR.

Other agencies that may have a key role in a DHR include:

- Crown Prosecution Service
- Commissioned service providers i.e. CRI for drugs and alcohol
- Housing Providers
- HM Prison Service
- Voluntary Agencies
- Specialist Black & Minority Ethnic (BME) organisations

Members of statutory agencies who have responsibilities for completing IMRs may also be members of the Review Panel, but the Panel should not consist solely of such people.

The role of the Review Panel includes:

- Appoint an independent Chair of the Panel and where applicable a report author.
- With the Chair, should consider in each homicide the scope of the review process and draw up clear terms of reference.
- If new information or issues arise during the Review the Panel will revise and agree a new terms of reference.
- Should bear in mind all equality and diversity issues at all times; age, disability, gender reassignment, marriage & civil partnerships, pregnancy & maternity, race, religion & belief, sex and sexual orientation may all have a bearing on how the review is explained and conducted and the outcomes disseminated to local communities.
- If there are concerns that there may be imminent risk of violence to the victim's family and /or friends they should contact Thames Valley Police immediately so that steps can be taken to secure protection.
- Communicate through a designated advocate who has, where possible, an existing working relationship with the family.
- Make a decision regarding the timing of contact with the family based on information from the advocate and taking account of other ongoing processes i.e. post mortems, criminal investigations.
- Ensure initial contact with the family is made in person and deliver the relevant information leaflet.

- Ensure regular engagement and updates on progress through the advocate, including the timeline expected for publication.
- Explain clearly how the information disclosed will be used and whether this information will be published..
- Explain how their information has assisted the review and how it may help other domestic violence victims.
- Prior to sending the final review to the Home Office, a completed version of the review should be provided to the family. This will allow consideration of the other findings and recommendations. It is then possible to record any areas of disagreement.
- Maintain reasonable contact with the family, even if they decline involvement in the review process; it will be important to communicate through the designated advocate when the review is completed and when the review has been assessed and is ready for publication. They should also be informed about the potential consequences of publication i.e. media attention and renewed interest in the homicide.
- Should access other networks which victims and perpetrators may have disclosed to, for example employers, health professionals, professionals involved in mandatory and voluntary Domestic Violence Perpetrator Programmes or their local VCS agencies. Information leaflets explaining the DHR process should be disseminated.
- Where 'honour'-based violence is suspected extra caution will be needed around confidentiality in relation to agency members and interpreters where there are possible links with the family, who may be the perpetrators. Extra caution will also be required when considering the level of participation from family members and should be carefully considered in consultation with a practitioner with expertise in this area.
- Need to bear in mind the importance of keeping personal details anonymous within the final report and Executive Summary.
- On being presented with the Overview Report the Review Panel should ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Overview Report.
- Should ensure that the Overview Report is of a high standard and is written in accordance with this guidance.
- Should translate the Overview Report recommendations for future actions into specific, measurable, achievable, realistic and timely (SMART) Action Plan.
- Once agreed, should provide a copy of the Overview Report, Executive Summary and the Action Plan to the Chair of the CSP.

Independent Chair of the Review Panel

- Responsible for managing and coordinating the review process.
- With the Review Panel, the Chair should consider in each homicide the scope of the review process and draw up clear terms of reference.
- Make the final decision on the suitability of the terms of reference for each DHR. If new information emerges or issues are raised the terms of reference may need to be revised, this will be agreed with the Review Panel.

- Write to the senior manager in each of the participating agencies to commission the IMRs, including timescales for reporting back to the Review Panel.
- Should appoint lead individuals or agencies to take responsibility for engaging with family members and friends.
- Should respond to media interest about the review.
- Consider the postponement of the Overview Report and Executive Summary if there are parallel investigations on going, for example criminal proceedings. Inform the Chair of the CSP the consideration for postponement, including the rationale. The Chair of the CSP will decide whether or not there is a postponement.
- Responsible for producing the final Overview Report based on the IMRs and any other evidence the Review Panel decides is relevant.

The Advisory Group

The Advisory Group will have a fixed standing membership including:

- Milton Keynes Head of Community Safety
- Domestic and Sexual Violence Reduction Co-ordinator
- Thames Valley Police DI Protecting Vulnerable People PVP
- Adult and Children Safeguarding Leads
- Other membership on a case-by-case basis

The Role

- Meet within 7 days of the domestic homicide to gather initial information on the circumstances of the homicide and agree whether the criteria for a DHR has been met to advise the Chair of the CSP Identify any other agency who could help inform the Advisory Group.
- Consult with the Chair of the CSP on whether or not a DHR is required.
- Advise the Chair of the CSP on relevant agencies to be invited to sit on the Review Panel.
- Where applicable, members of the Advisory Group should be invited onto the Review Panel as ‘experts’ on domestic abuse and / or honour-based violence.

APPENDIX 2

Confidentiality Statement

To enable the exchange of information between attendees at this meeting to be carried out in accordance with the Data Protection Act 1998, the Human Rights Act 1998 and the Common Law duty of confidentiality, all attendees are requested to agree to the following. This agreement will be recorded in the minutes.

1. Information can be exchanged within this meeting for the purpose of identifying any action that can be taken by any of the agencies or departments attending this meeting to resolve the problem under discussion.

2. A disclosure of information outside the meeting, beyond that agreed at the meeting, will be considered a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

3. All documents exchanged should be marked 'Restricted – not to be disclosed without consent'. All minutes, documents and notes of disclosed information should be kept in a secure location to prevent unauthorised access.

4. If further action is identified, the agency(ies) who will proceed with this action(s) should then make formal requests to any other agencies holding such personal information as may be required to progress this action quoting their legal basis for requesting such information. Information exchanged during the course of this meeting must not be used for such action.

5. If the consent to disclose is felt to be urgent, permission should be sought from the Chair of the meeting and a decision will be made on the lawfulness of the disclosure such as the prevention or detection of crime, apprehension or prosecution of offenders, or where it is required to prevent injury or damage to the health of any person.

This confidentiality agreement is in relation to (*specify nature of the meeting*)

…………………………………………………………………………………………….

…………………………..……………………………………………………………..

Signature……………………………………………………..Date…………………
Name…………………………………………………………….
Representing (*name / organisation*)…………………………………………………..
…………………………………………………………………………………………………

APPENDIX 3

Criteria for an Independent Chair:

Consideration should be given to the skills and expertise required to effectively chair a review. The following is a guide:

- Relevant knowledge of domestic violence issues including 'honour'-based violence, research, guidance and legislation relating to adults and children, including the Equality Act 2010.
- An understanding of the role and context of the main agencies likely to be involved in the review.
- Managerial expertise.
- Good investigative, interviewing and communication skills.
- An understanding of the discipline regimes within participating agencies.
- The completion of the E-Learning Training Package on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing Overview Reports.

APPENDIX 4

Milton Keynes Domestic Homicide Review

Terms of Reference

Introduction
Include: background and legislation

Aims:
- *Overall aim*
- *Key objectives*
- *Measures of success*

Purpose:
Why DHR is required

Scope & Methodology:
- *What should be covered in a DHR*
- *How will the relevant information been obtained*
- *What are the constraints (if appropriate)*

Terms of Reference Agreed:
- *When was it agreed?*
- *By whom?*
- *Review date*

APPENDIX 5

Determining the Scope of the Review

The Chair and the Review Panel should consider in each homicide the scope of the review process and draw up clear terms of reference. Relevant issues to consider include the following:

1. What appear to be the most important issues to address in identifying the learning from this specific homicide? How can the relevant information best be obtained and analysed?

2. Which agencies and professionals should be asked to submit reports or otherwise contribute to the review including, where appropriate, agencies that have not come into contact with the victim or perpetrator but might have been expected to do so? For example, victims may come from within hard-to-reach communities and consideration should be given to how the community can improve engagement and access to such groups.

3. How will the DHR process dovetail with other investigations that are running parallel, for example a child or adult serious case review, a criminal investigation or an inquest? Would a co-ordinated or jointly commissioned review process be more effective in addressing all the relevant questions that need to be asked, ensuring staff are not interviewed twice and that there are individuals who sit on both panels to ensure good cross-communication? It will be the responsibility of the Review Panel Chair to ensure contact is made with the chair of any parallel process to consider combining the reviews.

4. Should an outside 'expert' be consulted to help understand crucial aspects of the homicide? For example, a representative from a specialist BME women's organisation.

5. Over what time period should events in the victim's and perpetrator's life be reviewed taking into account the circumstances of the homicide i.e. how far back should enquiries cover and what is the cut-off point? What history / background information will help better to understand the events leading to the death?

6. Are there any specific considerations around equality and diversity issues such as ethnicity, age and disability that may require special consideration?

7. Did the victim's immigration status have an impact on how agencies responded to their needs?

8. Was the victim subject to a MARAC? If so, is there a need for a Memorandum of Understanding for the release of the minutes from the relevant meetings?

9. Was the perpetrator subject to Multi Agency Public Protection Arrangements (MAPPA)? If so, is there a need for a Memorandum of Understanding for the release of the minutes from the relevant meetings?

10. Was the perpetrator subject to a Domestic Violence Perpetrator Programme, either a mandatory one through Probation or a voluntary programme? If so, the professionals working with the perpetrator may know important information relating to the homicide as well as a key focus on the management of risk posed by the perpetrator.

11. Did the victim have any contact with a domestic violence organisation or helpline? How will they be involved and contribute to the process?

12. If appropriate, how will issues of 'honour'-based violence be covered and what processes will be put in place to ensure confidentiality?

13. How should friends, family members and other support networks (for example, co-workers and employers, neighbours etc) and where appropriate, the perpetrator contribute to the review, and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process taking account of possible conflicting views within the family?

14. How should matters concerning family and friends, the public and media be managed before, during and after the review, and who should take responsibility for this?

15. Consideration should also be given to whether either the victim or the perpetrator was a 'vulnerable adult' – a person "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation". If this is the case, the Review Panel may require the assistance or advice of additional agencies, such as adult social care, and / or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act [2005].

16. How will the Review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process? (See section 10 for further information).

17. Is there a need to involve agencies/professionals working in other Local Authority areas with an interest in the homicide, including members of the VCS and what should their roles and responsibilities be?

APPENDIX 6

OUTLINE FORMAT FOR INDIVIDUAL MANAGEMENT REVIEWS

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

Analysis of involvement
The review should consider the events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why. Each homicide may have specific issues that need to be explored and each review should consider carefully the individual case and how best to structure the review in light of the particular circumstances. The following are examples of the areas that will need to be considered:

• Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

• Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim / perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

• Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?

• What were the key points or opportunities for assessment and decision-making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

• Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

• When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim

should have been known? Was the victim informed of options / choices to make informed decisions? Were they signposted to other agencies?

• Was anything known about the perpetrator? For example, were they being managed under MAPPA?

• Had the victim disclosed to anyone and if so, was the response appropriate?

• Was this information recorded and shared, where appropriate?

• Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?

• Were senior managers or other agencies and professionals involved at the appropriate points?

• Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

• Are there ways of working effectively that could be passed on to other organisations or individuals?

• Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

• How accessible were the services for the victim and perpetrator?

• To what degree could the homicide have been accurately predicted and prevented?

APPENDIX 7

INDIVIDUAL MANAGEMENT REVIEW TEMPLATE

1. INTRODUCTION

Brief factual / contextual summary of the situation leading to the DHR including an outline of the TOR and date for completion:

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

VICTIM, PERPETRATOR, FAMILY DETAILS IF RELEVANT

Name	Date of Birth	Relationship	Ethnic Origin	Address

Include family tree or genogram if relevant.

2. TERMS OF REFERENCE

3. METHODOLOGY

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

4. DETAILS OF PARALLEL REVIEWS / PROCESSES

5. CHRONOLOGY OF AGENCY INVOLVEMENT

What was your Agency's involvement with the victim?

Construct a comprehensive chronology of involvement by your agency over the period of time set out in the review's terms of reference. State when the victim / child / family / perpetrator was seen, including antecedent history where relevant

Identify the details of the professionals from within your agency who were involved with the victim, family, perpetrator and whether they were interviewed or not for the purposes of this IMR.

6. ANALYSIS OF INVOLVEMENT

Consider the events that occurred, the decisions made, and the actions taken or not. Assess practice against guidance and relevant legislation.

Addressing terms of reference

Consider further analysis in respect of key critical factors, which are not otherwise covered by the sections above.

7. EFFECTIVE PRACTICE / LESSONS LEARNT

8. RECOMMENDATIONS

Recommendations should be focussed on the key findings of the IMR and be specific about the outcome which they are seeking.

APPENDIX 8

OUTLINE FORMAT FOR OVERVIEW REPORT

Introduction

- Summarise the circumstances that led to a review being undertaken in this case.
- State the terms of reference of the review and record the methodology used, what documents were used, whether interviews undertaken.
- List the contributors to the review and the nature of their contribution.
- List the DHR panel members and the author of the overview report.

The Facts

- Where the victim lived and where the victim was murdered. A synopsis of the murder (what actually happened and how the victim was killed).
- Details of the Post Mortem and inquest and / or Coroner's inquiry if already held.
- 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.
- 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 murder and the date of the trial (if known).
- A chronology charting 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.
- 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.

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 is also where any examples of good practice should be highlighted.

Conclusions and recommendations

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. Recommendations should include, but not be limited to those made in individual management reports, and may include recommendations of national impact. Recommendations should be relatively few in number, focused and specific, and capable of being implemented.

APPENDIX 9

Domestic Homicide Overview Report Template

To be anonymised for publication and dissemination

REPORT INTO THE DEATH OF
(add victim's name / reference)
Report produced by …..
Date …..

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

The review will consider agencies contact / involvement with (victim's and perpetrator's name) from (indicate dates / period that the scope of the review will be examining).

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. 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.

Confidentiality
The findings of each review are confidential. Information is available only to participating officers / professionals and their line managers.

Dissemination
(List of recipients) have received copies of this report.

APPENDIX 10

DOMESTIC HOMICIDE REVIEW PANEL CONCLUDING REPORT

Introduction
This review report is an anthology of information and facts from (number) agencies, all of which were potential support agencies for (victim). Essentially, only (number) agencies had records of contact with (victim) prior to their death. They are:

(Agency)

(Agency)

(State whether any of the accounts bear any direct relation to the victim's murder)

The Facts

Analysis
(State any agency involvement)

(State whether the review panel is of the opinion that all agency intervention was appropriate and that agencies acted in accordance with their set procedures and guidelines)

Conclusion / Lessons Learnt

(State whether the review panel, after thorough consideration, believes that under the circumstances agency intervention potentially could have or would not have prevented the victim's death, given the information that has come to light through the review)

(State whether the information available to the review panel suggests that there were / were no recorded incidences of domestic violence between the victim and the suspect and whether this is / is not conclusive)

(State anything else that is relevant to the conclusions resulting from the review) To note: it will not always be possible to arrive at a definitive judgement about what intervention could have or would not have prevented the death.

Recommendations
- (Add recommendation(s))

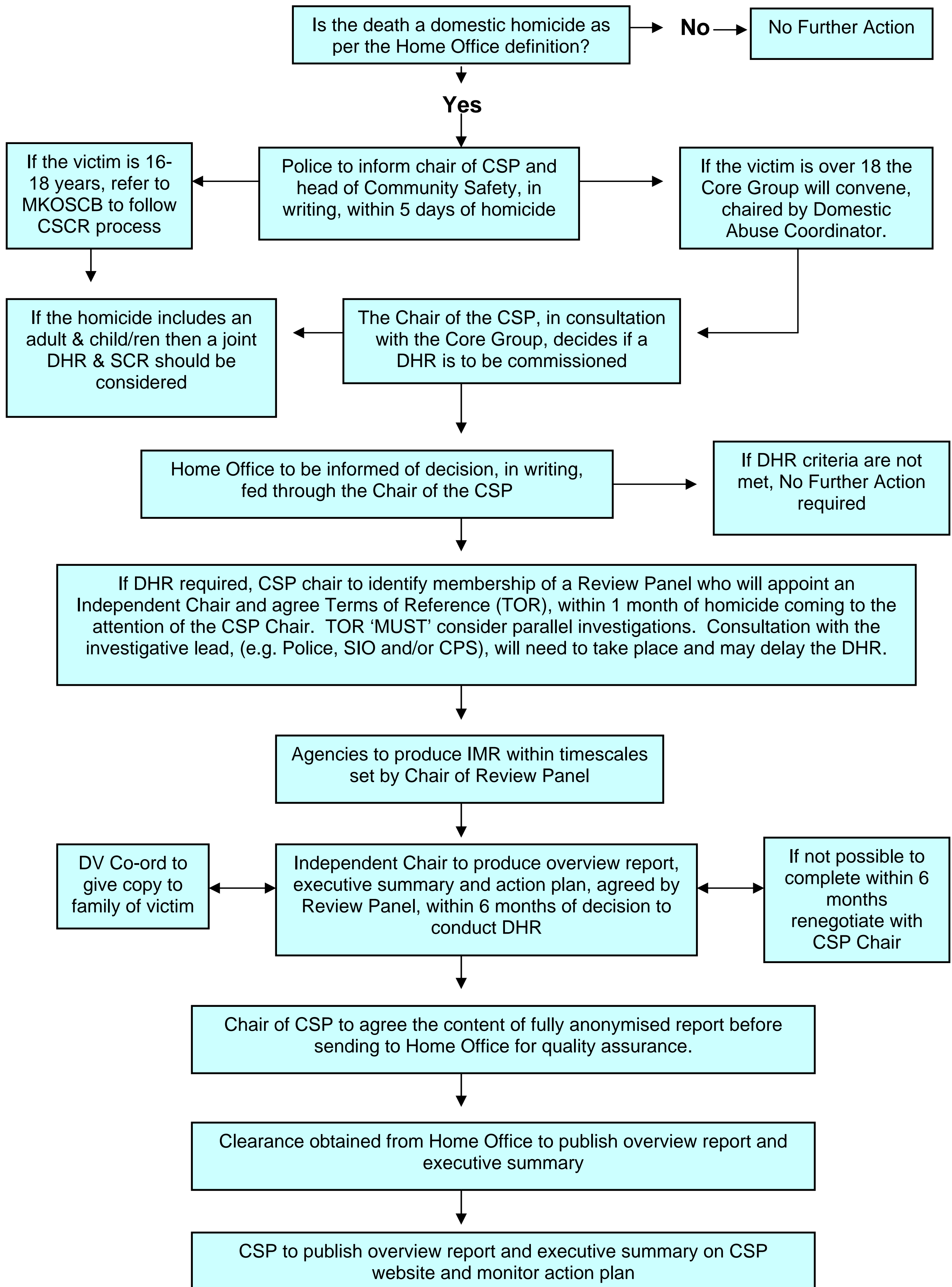
(Name of author of report)

(Position in agency)

(Date)

APPENDIX 11

Milton Keynes Domestic Homicide Review Flowchart



APPENDIX 12

POLICE REPORT

Introduction

Methodology

Terms of Reference

Chronology
(Describe the events in a chronological order)

CALL (number) and CRIME (number) on (date)
For example: Police were called to 25 Reinmouth Close, Birmingham by Mrs Bernays, who wished to report an assault. The police attended and reported an allegation of common assault on Mrs Bernays – CRIS (number) refers. The circumstances were ….

CRIME (number) on (date)
For example: The above crime report refers to a (non-crime-book domestic incident) whereby Mrs Bernays called the police to report the fact that her husband, Mr Bernays, had been verbally abusive towards her. ….

INTELLIGENCE (log number) on (date)
For example: Intelligence shows that Mr Bernays has a history of violence against an ex-partner and has previously used a weapon.

The Murder Investigation

CRIME (number) Report dealing with the murder of (victim).

INTELLIGENCE (reference number)

Police intelligence record regarding the murder investigation.
(State: what occurred prior to the murder (events and sequence); whether there was an argument and what it was about; whether there was alcohol or drugs involved; brief details of the murder in terms of:

- How the victim was found;
- Where the victim was found;
- How the victim was killed (modus operandi and weapons); and injuries sustained by the victim, etc;
- Any other relevant details about the history of police involvement with the victim and / or the family, i.e. if the suspect had assaulted anyone else.
- the court result, if there is one, and when and where the suspect is appearing for trial)

(Name of officer completing report)

(Area)

(Date)

APPENDIX 13

Confirmation of No Record of Contact From:

- (Agency 1)
- (Agency 2)
- (Agency 3)
- (Agency 4)
- (Agency 5)
- (Agency 6)

APPENDIX14

HOUSING REPORT

MURDER OF (VICTIM)
Of (address)

(Age and ethnicity)

(Name and address of Housing Office)

(Details of housing provider if victim was supported by UK Border Agency

Tenancy reference: (reference)

Tenancy commenced (date). Tenancy ended / was due to end (date).

Other occupants: (name, date of birth and relationship)

History of involvement:

- (When the victim applied for housing and any other housing applications listed in chronological order)
- (Whether the victim was on the at-risk house file)
- (Details of any medical problems)
- (Details of relationships and children)
- (Details of repairs undertaken in terms of locks being changed, for example)
- (Anything else that suggests that the victim may have been at risk)

(Name of officer completing report)

(Position in agency)

(Date)

APPENDIX 15

Action Plan Template

Recommendation	Scope of recommendation i.e. local/regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendations	Target Date	Date of completion and outcomes
What is the overarching recommendation?	Should this recommendation be enacted at a local or regional level? (NB. National learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for a 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?	When should this recommendation be completed by?	When is the recommendation actually completed? What does the outcome look like?
Fictional example						
All coroners should receive training on domestic violence	National	- review current coroner's training and identify gaps - Develop training module - Roll-out revised training package as follows: June-July Coroners in region X	Ministry of Justice Coroners Team	- review completed in Jan 09 - Training package agreed April 09 - Roll out begins June 2009	All coroners to be trained by September 2009	All coroners received training by December 2009 and their narrative verdicts are beginning to reflect that this training has been effective

APPENDIX 16

Glossary

DHR	Domestic Homicide Review
CSP	Community Safety Partnership
MARAC	Multi-Agency Risk Assessment Conference
MAPPA	Multi-Agency Public Protection Arrangements
IDVA	Independent Domestic Violence Adviser
SCR	Serious Case Review
VCS	Voluntary and Community Sector
SIO	Senior Investigating Officer
FLO	Police Family Liaison Officer
IMR	Individual Management Reviews
DASH	Domestic Abuse, Stalking and 'Honour'-Based Violence Risk Identification Checklist
TOR	Terms of Reference
CPS	Crown Prosecution Service
SMART	Specific, Measurable, Achievable, Realistic and Timely
DVPP	Domestic Violence Perpetrator Programme
GPMS	Government Protective Marking Scheme
FOIA	Freedom of Information Act
BME	Black and Minority Ethnic
TVP	Thames Valley Police
MKSCB	Milton Keynes Safeguarding Children's Board
MKSAB	Milton Keynes Safeguarding Adults Board
DSVDG	Domestic and Sexual Violence Delivery Group
LPA	Local Police Area