

Greater Manchester Domestic Homicide Review Policy

A product of the GMAC Team

Dated: February 2012

Originator: Serious Violent Crime Theme Group

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1. Introduction

- 1.1** Section 9 of the Domestic Violence, Crime and Victims Act (2004) was implemented in April 2011. This act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set in the guidance. This policy has been developed in line with the national Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews issued by the Home Office in March 2011.
- 1.2** The aim of this policy is to provide local CSPs and partner agencies within Greater Manchester with a template for action when considering a DHR and to provide a consistent level of service for victims of domestic abuse and their families across Greater Manchester.
- 1.3** The purpose of a DHR is clearly defined in the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews:
- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and agencies 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 victims of domestic violence/abuse and their children through improved intra and inter agency working
- 1.4** A DHR should not reinvestigate the crime or apportion blame, the main aim is to establish what lessons can be learnt, review procedures, facilitate inter-agency practice and disseminate findings.

2. Definitions

- 2.1** The definitions surrounding a DHR are clearly outlined in the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews:
- 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 a person to whom they were related, whom were in an intimate personal relationship, or a member of the same household (see item 2.3 regarding 16 – 18 year olds)
 - These definitions are 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. Violence can then be designed to make them conform and this can escalate to include murder. There is a high correlation between “honour” based violence and suicide
 - A “member of the same household” is defined in section 5 (4) of the Domestic Violence, Crime and Victims Act (2004) as an individual regarded as a ‘member’ of a household, even if he/she does not live in that household, if it is visited so often and for such periods of time that is reasonable to regard him/her as a member of the household. In cases where the victim has lived in different households at different times, the “same household” refers to the household he/she lived in at the time of the act that caused the death.
- 2.2** Suicides that are linked to issues of domestic abuse or “honour” based violence should also be included within the scoping for a DHR.
- 2.3** The Guidance document also describes how a child Serious Case Review (SCR) takes precedence when the victim of a domestic homicide is between 16 and 18 years.
- 2.4** The policy is not intended to create duplication of effort and where any internal reviews or disciplinary proceedings are ongoing cross communication to eradicate any duplication of effort will be needed.
- 2.5** In certain circumstances, such as when no more than one agency has had contact with the person, a DHR may not be instigated but learning can still be consolidated by key partners, in such instances a single agency review should be considered and placed within a report. The Home Office Quality Assurance Group will make the final decision on whether this approach is acceptable on a case by case basis.
- 2.6** In situations where more than one local authority is involved, the local authority the victim was normally resident will take the lead in a DHR. If there was no specific home address than the last known area in which they frequented will take the lead. After which decisions should be taken between authorities on a case by case basis.

3. Involvement of Family, Friends and Other Support Networks

- 3.1** Consideration should be made by the CSP and / or the Review Panel to include family members, friends, and work colleagues of both the victim and perpetrator within the DHR process. This enables those involved to feel supported by agencies, contribute information and build a fuller picture of the circumstances. However, this may not be suitable in all situations e.g. 'honour' based violence. There is a leaflet for distribution to these support networks at www.homeoffice.gov.uk/crime. Further leaflets and support can also be gained from Advocacy After Fatal Domestic Abuse www.aafda.org.uk.
- 3.2** Meetings with these support networks should be considered confidential and where possible a transcript of them completed. Consideration should be afforded to working with existing networks / agencies, e.g. GMP Family Liaison Officer, Coroners Liaison Officer, Witness Support Services. Once engaged these networks will need to be updated regularly on the progress of the review.
- 3.3** The final anonymised Overview Report should be presented to the families involved for their comments before being forwarded to the Home Office. Any areas of disagreement should be recorded in the Overview Report.
- 3.4** The Review Panel should be mindful that the perpetrator or members of the perpetrators family and informal support network may cause an ongoing risk of violence to other members of the victim's family. If the Review Panel become concerned that there may be an imminent risk of harm they should contact Greater Manchester Police immediately so that protection can be secured.

4. Process

Scoping

- 4.1** The Greater Manchester Police (GMP) Serious Case Review Team as part of the Public Protection Division will send notification to the chair (s) of the local CSP regarding any domestic related death for them to consider. However, any agency can refer a case to be considered for a DHR if it is felt inter-agency lessons can be learned. Also, the Secretary of State has the authority to direct areas or bodies to instigate a DHR.
- 4.2** The CSP should inform all agencies of the domestic homicide. Either the CSP or a designated board will send out initial information requests and instruct agencies to secure records. They will then instigate a DHR Screening meeting to review agency involvement with the victim, suspect and other relevant persons. They will then make a recommendation to the chair as to whether the case fits the criteria and need for a DHR. The Screening Panel will start to formulate the terms of reference on any review as they will have identified the main areas for learning. It is then the CSP chair's responsibility to decide if a review is needed and to coordinate (or delegate coordination) of a DHR. It is the CSP who will give final sign off to the DHR process. It is advisable for CSPs to involve Safeguarding Children and Adult Boards in these decisions and processes as in many cases they will have expertise in conducting reviews and also some cases may need to be joint reviews looking at Adult and Child Safeguarding issues.

- 4.3** At this point the CSP chair or DHR independent chair should liaise with the GMP Senior Investigating Officer, Crown Prosecution Service, Strategic Health Authority, Safeguarding Boards and the HM Coroner's officers or legal representatives when instigating a review.
- 4.4** Communication of the decision to conduct a review or not will need to be sent to the Home Office within one month of notification of a domestic homicide to dhrenquiries@homeoffice.gsi.gov.uk. Please note that any emails regarding DHRs will need to be sent and received via secure email addresses.
- 4.5** CSPs will also need to consider at this point resource allocation and any budgetary requirements for the review. Depending on the case involved will depend on the level of resources the CSP will need to allocate to the review.

Review Panel

- 4.6** A review panel will need to be created which should contain the main statutory agencies involved in the domestic abuse arena (see the guidance document for a definitive list) and any other partners who hold specialist knowledge and expertise in domestic abuse.
- 4.7** All members of the Review Panel must immediately set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be encrypted but this is time consuming and unreliable.
- 4.8** When establishing the review panel membership, equality and diversity issues should be considered at all times; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation may all have a bearing on the review process and how outcomes are communicated to the victims family and local communities.

Independent Chair

- 4.9** The review panel should appoint an independent chair who will have responsibility for managing and coordinating the review process. It will need to be decided on a case by case basis whether the same person will produce the Overview Report. The Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews gives information regarding the suggested skills for an independent chair and there are resources available on the Home Office website for independent chairs (www.homeoffice.gov.uk). Local Safeguarding Children and Adult Boards can also be contacted to assist with finding a suitable person to fulfil this role.
- 4.10** The independent chair in conjunction with the Review Panel will need to develop terms of reference for the DHR within one month of notification of a domestic homicide. These terms of reference will need to establish the scope of the review, time periods to be covered, and deadline dates. If over time, as new information arises, and the scope of the review changes in any way, then the terms of reference will need to be amended and agreed by the panel.

- 4.11 The chair of the review panel will need to write to the senior managers of all partner agencies involved in the DHR to instruct them to complete an Individual Management Review (IMR) if their agency had had any contact with the victim, perpetrator or relevant persons. Consideration for inclusion in the report should be the chronology of involvement, transcription of any interviews, analysis of involvement and any lessons learnt. Terms of reference must be set in order to instigate the IMR process and provided to the IMR author along with a summary of the case.

Individual Management Reviews (IMRs)

- 4.12 IMRs will need to be completed by a manager not directly involved with the case, in direct line management of those involved in the case and they should be quality assured by a senior manager. Partner agencies will also need to consider debriefing and facilitating feedback with staff. It is also suggested that the IMR author is not part of the Review Panel. However, please note that some partner agencies may not have the capacity or management structure that will enable them to be indirectly involved with a case.
- 4.13 An IMR template should direct services to consider their involvement with the victim, perpetrator, immediate relevant family members and particularly children and vulnerable adults. A review should be holistic and use a 'whole family approach' to ensure the full amount of learning and participation from relevant partners.
- 4.14 Regardless of the complexity of a case, **all lessons to be learnt will be drawn out and acted upon as expeditiously as possible**. It is **not** necessary to wait until the DHR is completed.
- 4.15 CSPs will need to consider their local partners training needs with regards to producing IMRs. Links into the Local Safeguarding Boards or expertise from other local authority areas could be beneficial.

Overview Report

- 4.16 The chair of the panel or appointed report writer will need to consider all IMRs, internal reports and other analysis generated from the process and produce an Overview Report. Both the Overview Report and Executive Summary should have personal details in an anonymous format and be marked 'Restricted' as per the Government Protective Marking Scheme.
- 4.17 The final Overview Report should be brought before the review panel and agreed by all as a suitably robust DHR and all partners are in agreement with regards to the information contained within it.
- 4.18 The Overview Report should be completed within six months of the decision to proceed with a DHR. Situations occurring that compromise this deadline should be communicated to the chair of the CSP, the Home Office and recorded within the Overview Report. Any other issues arising during the process of conducting a DHR should also be recorded. Publication must not occur until the Home Office Quality Assurance Group have given their approval of the final reports.

Action Plan

- 4.19** An action plan should be developed from the recommendations contained with the Overview Report within six months of instigation of a DHR. These should be SMART (specific, measurable, achievable, realistic and timely) actions that are agreed by all and have specific timescales and outcomes.

Sign Off & Completion

- 4.20** The Overview Report, Executive Summary and Action Plan will need to be sent to the chair of the CSP for agreement and sign off. Who in turn will need to email these documents to the Home Office at dhrenquiries@homeoffice.gsi.gov.uk.
- 4.21** The Home Office Quality Assurance Group meet on a quarterly basis and all documents will be considered by this group. Once clearance has been given by the group the following steps will need to be taken:
- Final documents to be forwarded to participating agencies
 - Electronic copy of the Overview Report and Executive Summary to be put on the CSP web page (consideration to be given to translating to different languages and formats). A link may also be put on the Local Safeguarding Boards website particularly where the Boards have worked together
 - A decision not to publish the report may in some circumstances be justified if there is a risk to the safety of surviving relatives or children, but this must be discussed with the Home Office who hold the final decision
 - CSP / delegated board must monitor outcomes from the Action Plan
 - Formally conclude the review when the Action Plan is complete and include an audit process

5. Disclosure & Data Sharing

- 5.1** As quoted in the Guidance document, disclosure is one of the most important issues in the criminal justice system and the application of proper and fair disclosure is a vital component of a fair criminal justice system. This is best achieved by early communication between the Independent Chair and the Senior Investigating Officer.
- 5.2** Reviews will need to take cognisance of any criminal proceedings or coroners reviews. In cases where the suspect is arrested the Overview Report should be delayed but IMR and securing of records to still continue. In cases whereby there is a Coroner's Inquest / Review the DHR is to progress without delay but communication and liaison with the Coroner is essential.
- 5.3** CSP's should check their data sharing protocols cover them for situations arising during a DHR. Amendments to these or insertion of a schedule within existing data sharing protocols should be considered where necessary.
- 5.4** CSPs will need to liaise with their local legal representatives on a case by case basis when issues arise regarding legislation such as the Data Protection Act and Freedom of Information.

- 5.5** It is important that all agencies involved in a DHR have use of a secure email system at all points during the DHR process. Confidential information exchange and discussions between partner agencies and Review Panel members can only be done via secure email systems.

6. Dissemination of Best Practice

- 6.1** The Serious Violent Crime Theme Group will facilitate the dissemination of the themes surrounding lessons learned, best practice ideas and any implications for multi-agency policy and practice. This should then be fed back to the local CSP and out to relevant partner agencies in each district. Also, those theme areas that are not suitable for insertion into the reports can be discussed via the Serious Violent Crime Theme Group, verbally to the Home Office and between local areas.
- 6.2** The Serious Violent Crime Theme Group will facilitate an annual review each year of Domestic Homicide Reviews and the surrounding best practice.
- 6.3** Subsequently the Greater Manchester Domestic Homicide Review Policy will need to be dynamic and therefore will be reviewed each year for its content and applicability.

7. Media & Communications

- 7.1** Communication and media protocols will be needed at various stages of the DHR process to manage media interest and to keep the local community informed. This would be from initial incident development to the instigation of the DHR and then to publication of the reports.
- 7.2** Liaison between the communication officers of the key partner agencies will be needed to form a consistent message from the partnership. One particular key agency e.g. GMP or the CSP, should act as a lead press office contact.
- 7.3** Any response to the media from partners involved in the process should be sent to the lead press office contact for approval.

Appendices

Below are examples of the documentation that could be used during the DHR process.

Appendix 1 – Initial Information Request Letter

Appendix 2 – Individual Management Review Request Letter

Appendix 3 – IMR Template

Appendix 4 – Quality Assurance Template

Appendix 5 – Letter Informing the Family

Appendix 6 – Flowchart

Appendix 1 – Initial Information Request Letter

<i>Insert CSP logo</i>	<i>Insert CSP Address CSP Street M11 000</i>
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Dear *partner / agency*

I am writing to inform you that **CSP** are considering whether to commission a Domestic Homicide Review in respect of *victim / family*.

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. Such reviews will be commissioned, conducted and reviewed by **CSP**.

The **CSP** seeks further information before this decision is made, and to assist, would like to know if you have had any involvement with this family. Please can you check all your agency records and databases.

Subject Name	<i>Jane Doe</i>
Date of Birth	<i>01/01/9999</i>
Address	<i>Insert address</i>

Family Composition

Name	Date of Birth	Relationship to Subject	Address
<i>Mr / Mrs Doe</i>	<i>01/01/9999</i>	<i>Partner / Spouse</i>	<i>Insert address</i>
<i>Junior Doe</i>	<i>01/01/9999</i>	<i>Son / Daughter</i>	<i>Insert address</i>

If your agency has **NOT** had any involvement with this family, please advise **CSP contact** (0161 444 4444 CSP.Contact@CSP.gsi.gov.uk) as soon as possible.

If your agency **HAS** had involvement with this family the CSP require you to send a brief outline of your agency's involvement. Please send your report to **CSP contact** (0161 444 4444 CSP.Contact@CSP.gsi.gov.uk) no later than *date*. If delays are unavoidable please alert **CSP contact** as soon as possible. The **CSP** also advise you in this circumstance to secure all records in relation to this family.

Please note we only require **BRIEF** summaries of involvement and if a DHR is recommended further detailed information will be sought at a later date.

We have organised an initial scoping meeting on *date and venue*. If you have had any involvement with this family then please can you ensure that someone from your agency attends and inform us who the representative will be.

The CSP are seeking to have as much information as possible about the individual and their family before the decision is taken to move to a formal Domestic Homicide Review process.

If you have any queries regarding the above please contact *xxxxxx*

Thank you for your cooperation.

Yours sincerely

Name
CSP Chair

Appendix 2 – Individual Management Review Request Letter

<i>Insert CSP logo</i>	<i>Insert CSP Address CSP Street M11 000</i>
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Dear *partner / agency*

I am writing to inform you that the Domestic Homicide Review scoping group has now met and concluded that the case of *name* requires a Domestic Homicide Review.

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011.

The process now requires your agency to complete an Individual Management Review (IMR). Please see appendices 1 and 2 of the statutory guidance for further details on completion of IMRs, www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-violence/domestic-homicide-reviews.

The aim of the IMR is to consider:

- What happened (comprehensive chronology)
- Why (analysis of involvement)
- What has been learnt from the case?
- What we need to change (recommendation for action)
- How we are going to change it (single agency action plan)

Attached is an IMR template containing further guidance. In addition please ensure that the report is anonymised, including the chronology (e.g. Doctor Smith should be Doctor S, or Joe Bloggs should read JB). You may find it easier to write your report out in full initially and amend the initials on completion.

Please can you ensure that your completed IMR is returned with the accompanying quality assurance form by *date*.

Yours faithfully

Independent Chair of the Domestic Homicide Review Panel

Appendix 3 – IMR Template

This following document template aims to assist individuals who have been requested to complete an Individual Management Review (IMR) report. This will be in relation to a case that has been considered by the Domestic Homicide Review Panel as one that would provide lessons to be learnt and inform development in safeguarding practice. When completing the IMR report on the template, the notes in *red italics* are there as support and guidance to authors. These notes must be deleted before the IMR report is submitted.

It is important that IMR authors do not assume that people who read their reports have any knowledge of the issues under examination. Consequently, it is important to ensure that the evidence, upon which conclusions and recommendations are drawn, is clearly stated. Do not use agency abbreviations, jargon or initials.

To ensure independent oversight and analysis are brought to the Domestic Homicide Review process, IMRs should not be written by anyone with direct involvement, or first line management involvement, with the victim or their family.

It is important to note that individual agencies will have their IMR process reports assessed sequentially by:

- The designated Senior Manager who will ‘quality assure’ the IMR report against required standards and accept its contents on behalf of the agency, before its submission, ensuring that the report is appropriately thorough, analytical and challenging; accept its contents on behalf of the agency and submit it to the Case Review Panel. Please note that appropriate arrangements for the ‘quality assurance’ of IMR reports should be made by each individual agency prior to submission of the report and sufficient time should be made to get this task completed within the timescale.
- The Chair of the Case Review Panel and the Panel members have the authority to challenge IMR reports where they deem them not to be of a sufficient standard. All the IMR reports will be closely scrutinised, and if not of sufficient quality to aid the analysis and learning required for a Case Review, these will be returned for ‘revision’ to the agency.

**STRICTLY CONFIDENTIAL
NOT TO BE DISTRIBUTED OR REPRODUCED WITHOUT
THE PERMISSAION OF THE REVIEW PANEL CHAIR**

<p style="color: red; font-style: italic;">Insert name and / or agency logo here</p>	<h2 style="margin: 0; color: #4F81BD;">INDIVIDUAL MANAGEMENT REVIEW REPORT FOLLOWING DOMESTIC HOMICIDE</h2>
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Domestic Homicide Review in respect of	
Date of Birth	
Date of Death	
Ethnicity / Diversity issues for the victim	
Details of perpetrator (s)	Including ethnicity / diversity issues and relationship to victim
Details of other relevant persons	Children or adults including ethnicity / diversity issues
Author of IMR	<p style="color: red; font-style: italic;">Insert name and designation of IMR author here</p> Signature..... Date.....
Agency	Name of agency Including a brief agency profile describing what the agency does
Quality assured and approved by	<p style="color: red; font-style: italic;">Insert name and designation of the person quality assuring and signing off the report on behalf of the agency</p> Signature..... Date.....
Date of first submission	Date the first IMR was submitted to the Domestic Homicide Review Panel
Date of revision	Date revised version submitted (if applicable)
Date of final submission	Date the final IMR was submitted (if applicable)

2. Methodology

We have included what we consider to be relevant to the terms of reference for this Domestic Homicide Review. The following sources of information regarding the victim, perpetrator and other relevant persons have been used to inform the report.

Guidance – List the interventions undertaken; documents and sources of information your agency has used to compile the IMR report. For example, consultation, case file notes made by named professionals, interviews with named persons.

3. Terms of Reference

Guidance – The specific Terms of Reference for the DHR will be inserted here. You should already have been provided with the Terms of Reference, if they are not available please contact your DHR Panel representative.

Include here details of any parallel reviews or processes.

It is possible that the Terms of Reference will be amended by the DHR panel and independent chair in the course of the review. Keep your Terms of Reference numbered and keep to the numbering throughout when making any reference to the Terms of Reference.

4. Agency Involvement

Guidance – Provide a brief factual and contextual summary of your agency's involvement with the victim, perpetrator or family for the time period identified in the Terms of Reference. It should summarise:

- *The events that occurred*
- *Information known to the agency*
- *Decisions reached*
- *Services offered and provided, and*
- *Any other action taken*

5. Comprehensive Agency Chronology

Guidance – The comprehensive agency chronology template can be seen on the next page. This will detail your agency's involvement with the victim, perpetrator and other relevant persons. Construct a comprehensive chronology of involvement by your agency and / or professional (s) in contact with the victim, perpetrator or relevant persons over the time period set out in the Terms of Reference.

It is important that you insert the date as per the example to facilitate merging with chronologies from other agencies and that nothing else is entered in the date column. Where abbreviations are used please provide a glossary at the back of the document. You may be required to submit a completed chronology template before the other sections of the report.

The information required under each heading relates to each contact your agency had in relation to the victim, perpetrator or relevant persons. The 'comment' column should be used if the agency reviewer wishes to comment on the appropriateness / quality of the interventions or whether it raises any other professional issue.

<i>Insert agency name and / or logo</i>	<h2 style="color: #4F81BD;">Comprehensive Agency Chronology</h2>
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Name of Agency:	IMR Report Writer:
Dates as given in the Terms of Reference:	
Name (s) or initials of victim, perpetrator or relevant persons:	

Date	Time	Source of evidence	Name of professional	Contact with	Event description, actions taken, decisions made	Comments
<i>01/01/2012</i>	<i>17:00</i>	<i>E.g. case record, interview, minutes</i>	<i>Name of professional that had the contact</i>	<i>Victim, perpetrator or relevant persons</i>	<i>Detail what the contact involved, what actions or decisions were made, and the outcome of the contact</i>	<i>Were internal policies adhered to, is it relevant to the DHR Terms of Reference, any gaps or missing records, any gaps in contact.</i>

6. Summary of Agency Involvement

Guidance – The report writer must review the information in the comprehensive chronology and provide a description of the key events, highlighting concerns, omissions and good practice.

7. Analysis of Involvement

Guidance – The report writer must review the information in the comprehensive chronology and produce a report which rigorously analyses the involvement of their agency. Please use the template questions provide below, and if any sections do not apply to your agency then identify that this is the case.

Consider the events that occurred, the decisions made, the actions taken or not. Analyse where judgements were made, or actions taken, which indicate that practice or management could be improved. Practice at individual and organisational levels must be openly and critically analysed against national and local statutory requirements, professional standards and current procedural guidance.

Your analysis should reflect willingness by your agency to challenge practice and address wider agency responsibility. Analysis must always relate to the Terms of Reference and the time period at the beginning of the document unless there is a significant incident outside of this.

Good practice should be highlighted and areas for change in practice must be clearly identified. Where practice has changed from that detailed in the chronology i.e. a new service or revised procedures, this should be explained.

Facts should not be stated without their origin and all abbreviations and acronyms should be fully explained.

Some specific questions to consider in this section include:

Summarise your analysis of the involvement of your agency with the victim, perpetrator or other relevant persons.
Summarise decisions reached, the services offered and / or provided to the victims, perpetrator and other relevant persons.
Were practitioners sensitive to the needs of the victim or other relevant persons, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about someone experiencing domestic abuse? Was it reasonable to expect them, given their level of training and knowledge to fulfil these expectations?
Did the agency have in place policies and procedures for acting on domestic abuse, sharing information and safeguarding children and adults at risk? How are staff made aware of the agency's policies and procedures? Were these assessment tools, procedures and policies professionally accepted as effective?
Did the agency have in place policies and procedures for risk assessment and risk management for domestic abuse victims (e.g. Domestic Abuse Stalking and Harassment DASH risk assessment model) or perpetrators and were those assessments correctly used in the case of this victim / perpetrator? Was the victim subject to a MARAC and if not was there evidence that they should have been?
What were the key relevant points / opportunities for assessment and decision making in this case in relation to the victim, perpetrator or other relevant persons?

Do decisions appear to have been reached in an informed and professional way?
Describe how actions accorded with assessments and decisions made? Were appropriate services offered / provided, or relevant enquiries made, in the light of assessments. Was the victims or other relevant persons satisfied with services offered / provide?
When, and in what way, were the wishes and feelings of adult victim (s) or children ascertained and considered? Was this information recorded? Is it reasonable to assume that the wishes of the victim should have been known?
How accessible were services for the victims, perpetrator or other relevant persons?
Was it deemed necessary to complete a Mental Capacity assessment and was the person's mental capacity taken into account throughout the agency's involvement with the client? Why, where and how was this information recorded?
Where relevant were appropriate care plans or safeguarding adults or children's processes in place? Or care plan reviews and / or safeguarding reviewing processes complied with?
Was the agency practice sensitive to the racial, cultural, linguistic and religious identity of the victim, perpetrator or other relevant persons? Was consideration for vulnerability and disability required? Is this information routinely collected by your agency and used in assessments?
Was the perpetrator known? For example, were they managed under MAPPA?
Were senior managers, or other agencies and professionals, involved at points where they should have been? Were there any organisational difficulties such as resources and capacity issues? Are training, supervision, administrative and recording systems satisfactory?
Was the work in this case consistent with agency and Safeguarding Adults and Children's Board policy, protocols, guidance and wider professional standards?
Are there any particular features of this case, or issues surrounding the death or injury of the victim, that you consider requires further comment in respect of your agency's involvement? To what degree could the homicide have been accurately predicted or prevented?

What has been learned from this case?

Guidance - The report author will identify specific lessons which his / her agency can learn from the case. These can include areas of good practice as well as ways in which practice can be improved. This section will inform the subsequent section on recommendations for action.

Are there lessons from this case, for the way in which this agency works, to safeguard children, adults at risk of abuse and those experiencing domestic abuse, and promote their welfare?
Is there good practice to highlight, as well as ways in which practice can be improved?
Are there implications for ways of working, training, management / supervision, working in partnership with other agencies or resource / service provision?

8. Action Plan

Guidance – Recommendations for the Action Plan must flow from the previous section. Individual agency recommendations contained in this report will be considered by the DHR panel for inclusion in the Overview Report. The DHR Panel may also recommend further actions for your agency to be included in the Overview Report. Any individual agency recommendations not included in the Overview Report are expected to be acted on within individual agency governance arrangements. Recommendations should be few in number, focused and specific, and capable of being implemented. Views on how these could be achieved and resources required should be included

Recommendations should where needed be divided into Multi-agency and Single Agency recommendations

<p style="color: red; font-style: italic;">Insert agency name and / or logo</p>	<h2 style="color: blue; margin: 0;">Single Agency Recommendations for Action</h2>
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Name of Agency:	IMR Report Writer:
Dates as given in the Terms of Reference:	
Name (s) or initials of victim, perpetrator or relevant persons:	

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	As they are written in the report	<p>Indicate the actions or series of actions to be taken to achieve the expected outcomes. These must be</p> <p>Specific Measurable Achievable Realistic and Timely.</p> <p>Examples might be, delivery of training, development of new policy, introduce new standards, review working practices etc.</p>	<p>Describe the evidence you will provide to the Review Panel to show the actions are being undertaken or achieved.</p> <p>These might include correspondence, minutes of meetings, new policy, training materials etc</p>	<p>What improvement in service should result from the action?</p> <p>E.g. increased awareness of multi-agency referrals, quicker access to services etc.</p>	<p>Designation of lead officer charged with implementing the action</p>	<p>01/01/2012 Date by which actions will be completed</p>

Appendix 4 – Quality Assurance Template

<i>Insert CSP logo</i>	INDIVIDUAL MANAGEMENT REVIEW QUALITY ASSURANCE FORM
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This Quality Assurance form is to assist you with ensuring that all elements of a ‘good’ IMR have been considered. It should be used by your counter-signatory or QA manager to check the content of your report and any issues should be addressed before the IMR is submitted.

Please return this form together with the IMR report and any accompanying documentation.

Agency	
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Name and contact details of person completing the form	
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Anonymised details of victim, perpetrator and other relevant persons	
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Criteria	Yes	No	Partially	Comments
The scope of the review is unambiguous, outcome-focused and supported by clear terms of reference				
Author was independent				
Access to legal advice available for critical aspects				
Report is completed within agreed timescale				
Report includes genogram and full details of changes to the family composition for the identified time period including transient members as appropriate				
Report includes chronology of involvement for identified time period				
Report takes account of the individual needs of the victim and family members				
Report is sensitive to the racial, cultural and linguistic identity of the victim and family members				

Criteria	Yes	No	Partially	Comments
Report reflects a critical examination of the facts and provides a credible explanation for how and why events occurred				
Report reflects a critical examination of the facts and provides a credible explanation for actions/ decisions that were/ were not taken				
Practice at individual and organisational level is analysed openly and critically against local and national requirements, professional standards and local procedural guidance				
Good practice is highlighted beyond expected minimum practice				
Report has drawn on relevant and contemporary research				
Report contains an action plan with measurable and relevant recommendations for improvement and a timescale for implementation.				
Action plan has been agreed with relevant senior management groups				

Signed:

Date:

Role:

Appendix 5 – Letter Informing the Family

<i>Insert CSP logo</i>	<i>Insert CSP Address CSP Street M11 000</i>
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Dear *family member*

I am writing firstly to offer my sincere condolences on the very tragic death of your *daughter / son / sister / brother, name*.

I also wanted to inform you that a Domestic Homicide Review has been commissioned as since April 2011 the law says we must “ensure that we learn lessons regarding the way in which local professionals and organisations worked to safeguard victims”.

It is often the case that family members and other close caring figures are invited to contribute their views about their relative’s experiences of domestic abuse and how other homicides could be prevented. I will be in touch with you at the conclusion of the criminal trial to extend that invitation and assure you that this is completely your decision whether or not to participate and that this would be a confidential process.

CSP will be leading on the Domestic Homicide Review and they have appointed myself as the independent chair to examine the circumstances of *name’s* death in accordance with the Home Office “Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews”.

In the meantime, please once again accept my condolences for your loss and do not hesitate to contact me on *9797979797* or *CSP contact* on *434343434* if you have any questions at this point.

Yours sincerely,

Independent Chair Domestic Homicide Review

Appendix 6 – Flowchart

