Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

Background

- DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). The provision came into force on 13th April 2011
- Updated guidance has been produced by the Home Office which applies to all notifications made to the Home Office from 1st August 2013

What is a DHR?

- DHR means a review of circumstances in which the death of a person aged 16 or over has, or appears to have resulted from violence, abuse or neglect by:
  
  (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship; or
  (b) a member of the same household as himself, held with a view to identifying the lessons learnt from the death

Purpose of DHR

- 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; and
- Prevent domestic violence and abuse homicide and improve service responses for all DV and abuse victims and their children through improved intra and inter-agency working

How is a DHR undertaken?

- When a DH occurs, the relevant police force should inform the relevant Community Safety Partnership (Cardiff Partnership) in writing of the incident – overall responsibility for establishing a review should rest with the CSP
- The Chair of the CSP (Chair of CPB) holds responsibility for establishing whether a homicide is to be subject of a DHR by applying the definition above.
- The decision should be taken in consultation with local partners with an understanding of the dynamics of DV and abuse.
- The CSP should send in writing its confirmation of a decision to the Home Office
- A Review Panel should then be established including the named statutory partners:
  - Chief Officers of Police
  - Local authorities
  - Health Boards
  - Probation
- Consideration should be given to inclusion of voluntary and community sector and also other representatives such as GPs, Housing Associations, Dentists, teachers etc
• Where appropriate the CSP may wish to refer the DHR for action to domestic abuse forums to lead and manage the review
• Family, friends and community involvement in the Review should also be encouraged where appropriate.

Chair of DHR

• The Review Panel should appoint and Independent Chair of the Panel who is responsible for managing and co-ordinating the review process and for producing the final overview report
• CSPs may wish to consider a regional agreement where experienced individuals from neighbouring areas are exchanged to the Review Panel
• The Chair and Review Panel should consider in each homicide the scope of the review process and draw up clear terms of reference

Timescales

• The decision whether or not to proceed with a review should be taken by the Chair of the CSP within one month of a homicide coming to their attention. The terms of reference should also be drafted within this timescale.
• Agencies should be notified of the requirement to conduct a review and be obliged to secure any records
• The Overview Report should be completed within a further 6 months of the date of the decision to proceed unless the Review Panel formally agrees an alternative timescale with the CSP
• Where a criminal investigation/prosecution is anticipated to run parallel to the DHR, the Review Chair should inform the Senior Investigating Officer of the Terms of Reference of the review

Individual Management Reviews

• The Chair of the Review Panel should write to the senior manager in each of the participating agencies to commission the IMRs. These would look at individual and organisational practices, identify how changes will be brought about and identify examples of good practice within agencies.

Overview Report

• Should bring together and draw conclusions from IMRs and any other work commissioned in an agreed template.
• The report should make recommendations for future action which should be translated into a SMART Action Plan and agreed at senior level by each partner
• Once agreed the Panel should provide a copy to the Chair of the CSP who should then agree the contents
• The report should be quality assured by the Home Office before publication
• On receiving clearance from the HO, the CSP should:
  - Provide a copy to the PCC and senior manager of each partner
  - Publish a suitably anonymised copy on the Partnership website
  - Monitor the action plan
  - Formally conclude the review when the action plan has been implemented and include an audit process