To: Cambridgeshire Community Safety / Crime and Disorder Reduction Partnerships / Cambridgeshire Domestic Abuse Partnership

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Community Safety Partnerships' Implementation of Statutory Domestic Violence Homicide Reviews (DHRs)

1. Purpose

1.1. To update Cambridgeshire's Community Safety / Crime and Disorder Reduction and Domestic Violence Partnerships on new statutory requirements arising from the implementation of Section 9 of the Domestic Violence, Crime and Victims Act (2004).

2. Background

2.1. As part of HM Government's current approach to tackling Violence Against Women and Girls (VAWG) through the National VAWG Action Plan (attached), Domestic Homicide Reviews (Sec. 9, Domestic Violence, Crime and Victims Act (2004)) will be established on a statutory basis from April 13th 2011 (please note that Cambridgeshire undertook a pilot of the DHR process in 2009 – review of this pilot attached).

2.2. A Domestic Homicide Review, under the terms of the above Act, means 'a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

It should be noted that the definition of domestic abuse includes:

'Physical violence, psychological, sexual, financial and emotional abuse involving partners, ex-partners, other relatives or household members.'

This definition includes so-called 'Honour-Based Violence (HBV),' Female Genital Mutilation (FGM),' and 'Forced Marriage (FM).'

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses for all domestic violence victims and their children through intra and inter-agency working.

2.3 As of April 13th 2011, the statutory requirements for initiating and undertaking a DHR will be transferred to the Community Safety Partnership in which 'the victim was normally resident' or where 'the victim was last known to have frequented.'

3. Status and Purpose of Guidance for the DHR

3.1. Statutory guidance has been issued regarding the implementation of DHRs (attached) and it is, therefore, the duty of any 'person or body establishing or participating in a domestic homicide review' to have regard to this guidance.

3.2. Agencies/individuals required under statute to participate under the above guidance in any future DHR are:

- Chief officers of police for police areas in England and Wales;
- Local Authorities (the council of a district, county or London borough);
- Strategic Health Authorities;
- Primary Care Trusts;
- Providers of probation services;
- Local Health Boards;
- NHS Trusts.

Other relevant agencies may be required to participate in the DHR at the request of the Review Panel (see 5.1 below).

4. Establishing a Domestic Homicide Review

4.1. It is the responsibility of the relevant police force to advise, in writing, the relevant CSP when a DV-related homicide has occurred. It is then the responsibility of the relevant CSP to establish and initiate a review (see above 2.3, and attached guidance 4.1 and 4.2).

4.2. It is then the responsibility of the relevant CSP Chair to decide whether to undertake a DHR (see 3.8 of attached guidance). The decision to review or not must be shared with the Home Office via dhrenquiries@homeoffice.gsi.gov.uk. Where the victim is aged 16-18, a Serious Case Review should take precedence over a DHR.

4.3. The decision of whether to review should be based on a range of factors set out in 4.8 of the attached guidance.

4.4. Local decisions on not implementing a DHR may be overturned by the Secretary of State (see 4.7 of attached guidance).

5. Conducting a Domestic Homicide Review

5.1. Where the Chair of the relevant CSP has determined that a DHR is appropriate, the CSP Chair has the responsibility of drawing together a DHR Review Panel (see 5.1 and 5.2 of attached guidance) that consists of the statutory agencies listed above (see 3.2) and any other agencies deemed relevant to the DHR.

5.2. The DHR Review Panel will be responsible for appointing an 'independent' Chair who will be responsible for coordinating the review and producing the final Overview Report. The Review Panel Chair should be 'an experienced individual who is not directly associated with any of the agencies involved in the review (see 5.9 of attached guidance).'

5.3. The Chair and Review Panel will then consider the scope of the review and develop clear terms of reference (see 5.11 of attached).

5.4. Please note that a flow-chart outlining the conduction of a Domestic Homicide Review is attached as an appendix.

6. Timescales for Conducting Domestic Homicide Reviews

6.1. The decision on whether to implement a DHR should be taken within one month of the homicide occurring. Terms of the DHR should also be drafted and agreed within this period. However, 'where lessons are able to be drawn out they should be acted upon as quickly as possible (see 6.1 of attached guidance).'

6.2. Individual agencies should secure case records 'promptly' and begin work 'quickly' on the Individual Management Reviews (IMRs) and chronologies.

6.3. The final Overview Report (OR) should be completed within six months of the initial decision to proceed with a DHR, unless an alternative timescale is agreed with the relevant CSP.

6.4. The Chair of the Review Panel must consider other ongoing investigations and/or legal proceedings at 'an early stage' and that such considerations could delay the implementation of the review (see 6.5 and 6.6 of attached guidance).

7. Involvement with Friends, Family Members and Other Support Networks

7.1. The Review Panel should determine the appropriateness of involving friends, family or other support networks in the DHR process. However, unless there are exceptional circumstances (such as HBV issues) these individuals should be given 'every opportunity to contribute.' Consideration should also be given to working with Family Liaison and Senior Investigating Officers (see 7.1 – 7.3 of attached guidance).

7.2. The Review Panel should also consider ongoing risk in involving the individuals above, especially where HBV is suspected.

8. Content of the Individual Management Review (IMR) and the Overview Report

8.1 The Chair of the Review Panel is responsible for initiating the relevant IMRs by writing to the senior manager in each of the participating agencies.

8.2 IMRs should begin as soon as a decision has been taken to implement a DHR and once the terms of the review are established.

8.3 Those conducting IHRs should not have been directly involved with the victim, perpetrator or families concerned, nor should they be the direct line manager of any staff involved in the IMR.

8.4 IMRs should be quality assured by the senior manager in the organisation who has commissioned the report. This manager will also be responsible for ensuring that any recommendations arising from the Overview Report are actioned. IMRs should be produced according to the format and template provided in Appendix 1 and 2 of the attached guidance.

8.5 The Overview Report should 'bring together and draw overall conclusions from the information and analysis contained in the IMRs (see 8.10 of attached guidance) and should be produced according to the format and template provided in Appendix 3 and 4 of the attached guidance.

8.6 The Overview Report should also make recommendations for future action, which should be developed into a SMART action plan using the template provided in Appendix 5 of the attached guidance.

8.7 On receipt of the Overview Report, the CSP should agree the content of the report and Executive Summary for publication and provide a copy of the report for quality assurance to the Home Office at dhrenquiries@homeoffice.gsi.gov.uk. The documents should not be published without clearance from the Home Office.

8.8 Once cleared by the Home Office, the CSP should provide a copy to the senior manager of each participating agency, publish a copy of the Overview and Executive Summary on the local CSP webpage, monitor the implementation of the SMART action plan and formally conclude the review (see 8.20 of attached guidance).

9. Publication of the Overview Report

9.1 In all cases, the Overview Report and Executive Summary should be suitably anonymised. IMRs should not be made publicly available and publication of any document should not be undertaken without clearance from the Home Office (see 9.1 – 9.5 of attached guidance).

10. Disclosure and Criminal Proceedings

10.1 All disclosure issues should be discussed with the police, Senior Investigating Officer (SIO), the Crown Prosecution Service (CPS) and HM Coroner (see 10.1 – 10.4 of attached guidance).

11. Quality Assurance and Dissemination of Lessons Learned

11.1 Quality assurance of the completed DHRs rests with the Home Office (see 11.1 of attached). The Home Office is also responsible for disseminating learning from the DHRs at a national level and for communicating with the media to raise awareness (amongst other responsibilities – see attached guidance 11.4).

12. Opportunities for Cambridgeshire

12.1 As Cambridgeshire's Domestic Abuse Partnership has previously piloted a DHR (May 2009), learning from that process is available to relevant stakeholders (an evaluation of this DHR is attached as an appendix).

12.2 Cambridgeshire's five CSPs have sufficient resilience and expertise to develop a reciprocal agreement to provide 'independent' Chairs across the county to undertake DHRs as the need arises.

12.3 The current jointly-funded post of Domestic Abuse Partnership Manager has previously undertaken IMRs and has the necessary knowledge to provide training and support on the DHR process and to author any future DHRs with the support of an 'independent' Chair.

12.4 Using established networks, experience and CSP officers / members, it is possible to conduct DHRs with a minimum of additional resourcing. Officer time will be the greatest required input to the process.

13. Risks

13.1 Although there have been relatively few domestic-violence related homicides in Cambridgeshire in the past three years (3), it is not inconceivable that several may occur within the county in a short space of time in future. If this scenario is realised, the capacity of the five CSPs and relevant officers / members may be overstretched.

13.2 Considering the above, it may, in extraordinary circumstances, be necessary for funds to be identified by the CSPs and agencies undertaking the DHRs in order that the reviews are completed in a timely fashion by commissioning external agents/consultants.

13.3 If more than one homicide occurs in a single Cambridgeshire District, then the risks outlined in 13.1 and 13.2 (above) may be compounded.

14. Recommendations

14.1 It is recommended that each Cambridgeshire CSP and relevant partner agency reviews and understands this report, appendices and associated statutory guidance and that this is acknowledged through discussion and recording at the earliest possible relevant CSP meeting.

14.2 It is recommended that the five Cambridgeshire CSPs begin the process of identifying relevant individuals to sit on DHR Review Panels for their District and that these individuals undertake the associated DHR e-learning at www.homeoffice.gov.uk.

14.3 It is recommended that the five Cambridgeshire CSPs each identify two potential 'independent' Chairs from their cohort of Councillors and that these individuals undertake the e-learning training on DHRs provided via the Home Office.

14.4 It is recommended that the Domestic Abuse Partnership Manager identifies relevant training for Overview Report authors and that each CSP identifies two individuals from partners agencies that would act as Overview Authors in future DHRs.

14.5 It is recommended that Cambridgeshire Constabulary develop a pro-forma letter that the SIO in any future DV-related homicide would use to advise the relevant CSP Chair of the homicide.