North Lincolnshire COMMUNITY SAFETY PARTNERSHIP

Community Safety Partnership Policy and Procedures

Domestic Homicide Review

December 2021

Contents

Introduction

This local policy and procedure has been approved by the North Lincolnshire Community Safety Partnership (NLCSP). It incorporates and links to the requirements in the latest Domestic Homicide Review (DHR) statutory guidance 'Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews' (Home Office 2016).

This policy and procedure should be read in conjunction with the statutory guidance and key links are provided as footnotes.

Overall responsibility for establishing a review rests with the NLCSP as they are ideally placed to initiate a DHR and a Review Panel due to their multi-agency design. This policy and procedure ensures that when a DHR is required in North Lincolnshire, all those involved follow a single process.

This policy and procedure sets out:

- the relevant definitions, purpose and timescales of a DHR
- how a DHR is conducted
- the involvement of family, friends and other support networks
- Individual Management Reviews, Overview Report and Executive Summary
- approval and publication of the Overview Report and Executive Summary

In North Lincolnshire, the DHR process will be co-ordinated by the NLCSP Development and Review Officer (referred to as the DHR Co-ordinator within this guidance).

Definitions

The Home Office Guidance (2016) sets out the following definitions.

Under section 9(1) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act):

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

- *a person to whom he[1] was related or with whom he was or had been in an intimate personal relationship, or*

- *a member of the same household as himself*

held with a view to identifying the lessons to be learnt from the death.

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

A member of the same household is defined as:

[1] Section 6 of the Interpretation Act 1978 - words importing the masculine gender includes the feminine.

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

Where the definition set out in this paragraph has been met, then a DHR should be undertaken.

In March 2013, the Government introduced a cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies.

The new definition states that domestic violence and abuse is:

- *'any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality*

This can encompass, but is not limited to, the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'.

In December 2015, a new domestic abuse offence to tackle coercive and controlling behaviour was commenced in legislation. More information about controlling and coercive behaviour in an intimate or family relationship can be found in the statutory guidance:

https://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship

The definition of domestic abuse includes so-called 'honour-based' abuse / violence and crimes such as female genital mutilation (FGM) and forced marriage. It is clear that victims are not confined to one gender or ethnic group.

So-called 'honour-based' abuse / violence, sometimes referred to as 'honour crimes' or 'honour killings', encompasses crimes or incidents which are committed to protect or defend what is considered to be the 'honour' of the family or community. Victims may be 'punished' for not complying with what the family and/or community believe to be the 'correct' code of behaviour and therefore viewed as bringing 'shame' or 'dishonour' on the family or community. It is important to note that notions of 'honour' may not be obvious and victims / family members or friends may not identify or perceive what has happened as 'honour-based' abuse / violence.

The purpose of a Domestic Homicide Review

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 they will be acted on, and what is expected to change as a result
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate
- prevent domestic violence and homicide and improve service responses for those experiencing domestic abuse by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity
- contribute to a better understanding of the nature of domestic violence and abuse
- highlight and share good practice

It is, however, important to note that reviews should not simply examine the conduct of professionals and agencies. Reviews should illuminate the past to make the future safer. Reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, domestic abuse can be identified at the earliest opportunity, and signposting to safe and suitable interventions can be completed.

The narrative of each review should articulate the life through the eyes of the victim (and their children) by talking to those around the victim including family, friends, neighbours, community members and professionals. This will help reviewers to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why any interventions did not work for them. The key is situating the review in the home, family and community of the victim and exploring everything with an open mind. It will also help understand the context and environment in which professionals made decisions and took (or did not take) actions. This would include, for example, the culture of the organisation, the training the professionals had, the supervision of these professionals, the leadership of agencies and so forth.

A successful DHR should go beyond focusing on the conduct of individuals and whether procedure was followed to evaluate whether the procedure or policy was sound. Does it operate in the best interests of victims? Could an adjustment in policy or procedure have secured a better outcome for the victim? This investigative technique is sometimes referred to as professional curiosity. It is a thoroughly inquisitive approach to a review and the impact on the tone of the report and the detail in the learning can be dramatically improved by adopting this mind-set.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts to determine. DHRs are not specifically part of any disciplinary inquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken separately to the DHR process. Alternatively, some DHRs may be conducted concurrently with (but separate to) disciplinary action.

The rationale for the review includes ensuring that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence. The review will also assess whether agencies have sufficient and robust procedures and protocols in place which were understood and adhered to by their staff.

Timescales for conducting a Domestic Homicide Review

A DHR must be conducted expeditiously so that lessons are able to be drawn out which can then be acted upon as quickly as possible.

The decision on whether or not to proceed with a DHR will be taken by the chair of the NLCSP within one month of a death coming to their attention.

Agencies and interested parties should be notified of the requirement to conduct a review and be obliged to secure any records pertaining to the case against loss and interference. Agencies should also begin to work quickly to draw up a chronology of involvement with the victim, perpetrator and their families to help inform the terms of reference.

The overview report should be completed within a further six months of the date of the decision to proceed unless the Review Panel formally agrees an alternative timescale with the NLCSP. It is acknowledged that some DHRs will necessarily go beyond this further six-month timescale due to the complex scope of the DHR and/or due to on-going criminal justice proceedings. If the NLCSP believes that the delay to completion of the review is unreasonable, they should refer the issue to the Home Office Quality Assurance Panel for further advice.

In some cases, mental health investigations, criminal investigations or other legal proceedings may be carried out after a death. The chair of the Review Panel must discuss with the relevant criminal justice and/or other agencies (e.g. HM Coroner, Senior Investigating Officer (SIO), Independent Police Complaints Commission), at an early stage, how the review process should take account of such proceedings. For example, how does this affect timing, the way in which the review is conducted (including interviews of relevant personnel), its potential impact on criminal investigations, and who should contribute at what stage? The chair of the Review Panel needs to consider if they are becoming aware of information that may be of interest to judicial processes including, for example, an inquest.

Where a criminal investigation / prosecution is anticipated to run parallel to a DHR, the Review Panel chair should inform the SIO of the Terms of Reference of the review – this is so that the SIO can have an opportunity to express any views on the content before the terms of reference are finalised. Good practice is to invite the SIO to attend the first panel meeting to brief the panel on the investigation and for the SIO to be party to the setting of the terms of reference.

Some local areas are waiting until the conclusion of criminal proceedings before commencing a review. It is important that a review is opened promptly so that early lessons can be identified and rapid action taken to address them. Preliminary work, such as commissioning and analysing IMRs and drafting a first iteration of a chronology, whilst avoiding speaking to potential witnesses can be undertaken before a criminal trial has taken place.

If, following representation from the SIO, it is agreed by the panel to delay progressing the DHR at any stage, then following the criminal proceedings, the review should be concluded without delay. Further information on disclosure and criminal proceedings is available in section 9 of the Home Office guidance. Any appeals lodged following the conclusion of criminal proceedings should not delay the submission of a DHR to the Home Office for quality assurance.

Indicative timescales are summarised below, and a flowchart of indicative timescales is shown in appendix 1. Should a decision be made to pend the DHR, the indicative timescales for stage 2 will be adjusted. However, the process indicated below will be followed.

Steps in the process	Time from homicide	Timescale
Stage 1 - Decision making process	ASAP	Notification of DHR can be given in two ways:
		1. Police notify the NLCSP of the incident and a possible domestic homicide verbally, and confirmed in writing
		2. A professional or agency refers a homicide to the NLCSP in writing
	15 working days	Discussion held between the DHR Co-ordinator and the chair of the NLCSP to consider whether the case meets the DHR definition The chair of the CSP will consult with local partners as necessary prior to making the decision about whether to conduct a DHR or not
	ASAP	NLCSP issues a notification letter to all relevant agencies instructing them to secure their records, and complete and return the NLCSP Agency Initial Information Report
	ASAP – no later than 10 working days after agency receiving notification	Agencies submit their Agency Initial Information Report to the NLCSP in order to clarify agencies involved
	Within 1 month	NLCSP to inform the Home Office of the decision to undertake a DHR or not
Stage 2 – Conducting a DHR	Within 6 weeks	Independent Chair / Author to be appointed
		Independent Chair / Author to make contact with victim's family via the Family Liaison Officer (FLO) where possible, to inform them of the decision to undertake a DHR
		NLCSP to invite the relevant professionals and the SIO to attend the first Review Panel meeting
		Initial Terms of Reference drafted and circulated to panel members
		Meeting between Independent Chair / Author and family arranged
		First meeting of the Review Panel to be held
		Terms of Reference agreed
		Dates issued to agencies of schedule for DHR process, including future panel dates

		Agencies are requested to prepare chronologies and Individual Management Reviews (IMR)
Stage 3 – Individual Management Reviews	Within 7 weeks	IMR authors briefing meeting held
	Within 3 months	Agencies submit first draft of chronologies and IMRs
	Within 4 months	Agencies submit final draft of chronologies and IMRs
Stage 4 - Overview Report and Executive Summary	5 - 6 months	Independent Chair / Author compiles first draft of Overview Report
		Independent Chair / Author meets with the family and advocate to discuss the draft Overview Report and agree any amendments
Stage 5 - Approval of the DHR	6 – 7 months	Further drafts of the Overview Report
		Review Panel meets to sign off the final version of the Overview Report and finalise the Action Plan
		Final Overview Report signed off by Review Panel and approved by the NLCSP Board
	Within 7 months	Final version of the Overview Report sent to the Home Office If the process is delayed for any reason, permission must be obtained for the delay from the Home Office and evidence of this included as an attachment to the Overview Report
Stage 6 - Publication	Within 7 months	Overview Report, and / or Executive Summary of report published after approval from the Home Office
Stage 7 - Action Plan Implementation and Review	Quarterly	The Action Plan will be reviewed at least quarterly and signed off by the NLCSP upon completion

STAGE 1 – Decision making process

Notification of a suspected DHR

The police, or any professional from any agency may refer a domestic homicide to the NLCSP in writing if it is believed that there are important lessons for inter-agency working to be learned[2].

As soon as a suspected domestic homicide occurs, Humberside Police will notify the NLCSP or relevant CSP in writing in order that the NLCSP can begin co-ordinating the DHR process. Where partner agencies of more than one local authority area have known about or had contact with the victim, the CSP of the local authority area in which the victim was normally resident should take lead responsibility for conducting any review.

It may not be necessary to conduct a DHR in the following circumstances:

- The facts of the case do not fit the definition of a domestic homicide, as set out above
- The victim and perpetrator were not ordinarily resident in North Lincolnshire and did not have contact with any agencies here for example the homicide happened when they were visiting the area or had very recently moved here

Agency Notification and Initial Information Reports

The DHR Co-ordinator will circulate a Notification Letter to the relevant agencies as soon as possible following notification of a potential DHR, advising them to secure any records relating to the individuals involved in the suspected homicide, and to ensure any staff involved are aware of the death and can access support as appropriate.

In the event that the DHR Co-ordinator is informed by agencies that the individual has recently lived outside of the local authority area, the DHR Co-ordinator will contact the equivalent domestic abuse lead in the local authority in which they lived.

Following confirmation that North Lincolnshire will lead the DHR, the domestic abuse lead in the other local authority will be asked to send out notification to their local agencies that NLCSP are undertaking a DHR on the individual who previously resided in their area.

As part of the notification process, agencies are asked to submit an Agency Initial Information Report regarding confirmation or otherwise of their involvement with the individuals to enable the DHR Co-ordinator to begin compiling a list of agencies required to take part in the review process should it go ahead**.** All agencies are required to submit information only on this template to ensure that the information can be stored securely and that information is shared consistently.

Agencies should return their Initial Information Report within the timescale requested to ensure that the DHR process is managed in a timely way.

Circumstances of particular concern

The following factors are examples of circumstances preceding a homicide which will be of interest to review teams when conducting a DHR:[3]

[2] Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews (Home Office 2016) page 9, paragraph 21

[3] Ibid, page 10, paragraph 27

a) 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, it was not shared with others and/or it was not acted upon in accordance with their recognised best professional practice
b) any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously
c) the victim had little or no known contact with agencies. It is often incorrectly assumed by local areas that no contact with agencies indicates a DHR is not required. In fact, a DHR should probe why there was little or no contact with agencies. For example, were there any barriers to the victim accessing services, e.g. language, cultural, etc? Were the circumstances described in h) below a barrier? Were there particular reasons why local services were not appealing to a victim in these particular circumstances? Could more be done in the local area to raise awareness of services available to victims of domestic violence and abuse? Did contact diminish after initial engagement?
d) the homicide suggests that there have been failings in one or more aspects of the local operation of formal domestic violence and abuse procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency
e) the victim was being managed by, or should have been referred to, a Multi Agency Risk Assessment Conference (MARAC) or other multi-agency forum
f) the homicide appears to have implications/reputational issues for a range of agencies and professionals
g) the homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed
h) the perpetrator holds a position of trust or authority e.g. police officer, social worker, health professional, and the homicide, therefore, is likely to have a significant impact on public confidence
i) services were not available locally to refer/support the victim and/or the perpetrator

Death by suicide

The 2016 guidance clarifies[4] the position to take on suicides where coercive control is known, e.g. where a victim took their own life (suicide) and the circumstances give rise to concern, for example if it emerges that there was coercive and controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable and focussed on learning to inform future practice and procedures.

Where a death has been by suicide within the context of a relationship where domestic abuse has been a feature, it is likely to be a more complex decision as to whether to conduct a DHR. Humberside Police have a process in place whereby they are informed by the Coroner of all suicides in order that they can ascertain if the suicide appears to be domestic abuse related. If indications have been given by the deceased prior to their death that they have experienced domestic abuse and that this has directly contributed to suicidal thoughts, this would indicate that a DHR should be carried out. This would be confirmed further if a suicide note has been left attributing the reason for the suicide to domestic abuse.

If this is not clear, then as much information should be sought by the DHR Co-ordinator as possible to include in the Briefing Report about the context of the relationship(s) of the deceased, for the chair of the NLCSP to comment on whether they believe this is significant enough to warrant a DHR. As per the revised guidance, the DHR can be proportionate with regard to the incident being reviewed.

[4] Ibid, page 8, section 18

Interface with other statutory reviews

In some domestic homicide cases there may statutory requirements to hold another type of review, for example, a Safeguarding Adult Review, Mental Health Investigation or Child Safeguarding Practice Review. The 2016 Home Office guidance explains what needs to be considered in such cases, recognising that the statutory requirements of a DHR overlap with these processes and that there are potential opportunities to remove duplication and dovetail with other investigations that are running in parallel.

The DHR Co-ordinator will determine if any other statutory review processes have or intend to be invoked through the Agency Initial Information Reports.

A set of working principals to be used when carrying out a safeguarding review (children or adults) or Domestic Homicide Review have been agreed across Yorkshire and the Humber.

These principals will be used when managing a Safeguarding Adults Review (SAR), Child Safeguarding Practice Review (CSPR) or a Domestic Homicide Review (DHR) alongside a police investigation by Humberside Police. These principles have been developed to enable both processes to run concurrently, and to support a timely response to both, and are to be used in conjunction with national guidance.

The Yorkshire and Humber working principals for safeguarding reviews document is available on the Children's MARS website.

Circumstances where the perpetrator is deceased

In cases where the perpetrator is deceased (for example in cases of homicide-suicide), the case will be referred to the Coroner and a file will be prepared. In these circumstances, it is appropriate for a DHR to be conducted without delay.

The Overview Report and supporting documents should be submitted to the Coroner to help inform the Inquest, however this should only happen once the Home Office Quality Assurance Panel has reviewed them[5].

Where the alleged perpetrator is arrested and charged

One of the following two outcomes may occur:

1. that the DHR be pended until the outcome of any criminal proceedings
2. that the scope of the DHR is temporarily restricted until after the outcome of any criminal proceedings, such as consideration being given to not interviewing people who may be witnesses or defendants in criminal proceedings until the criminal justice needs have been satisfied. Where a restriction in scope is being considered, this should be for a defined need and/or applicable to named individuals

No individuals acting as witnesses or defendants would be interviewed as part of the DHR process until the criminal trial had finished, without agreement from Humberside Police and the Crown Prosecution Service.

[5] Ibid, page 26, paragraph 97

There is a need to ensure that these parallel processes are run without compromising criminal proceedings or delaying the remedial actions required as per the recommendations of the DHR.

Following the conclusion of the criminal proceedings, the DHR should be concluded without delay.

Supporting the criminal justice process

There is a need to inform the SIO of any disclosures made during the course of the DHR process. It is the Chair's role therefore to ensure a robust disclosure process is in place with all agencies.

The SIO for the case will be invited to the Review Panel meetings and will contribute to the Terms of Reference therefore will be included at all stages of the review process.

The statutory guidance outlines the disclosure of sensitive material during the DHR:

All material generated or obtained in the DHR whilst the criminal case is ongoing must be made available to the SIO and disclosure officer to assess whether it is relevant to the criminal case. Where it is relevant, it will be for the CPS to decide whether it should be disclosed to the defence. Where the material is sensitive, the CPS or the SIO will consult with the independent chair of the Review Panel before disclosure is made to the defence. Sensitive material in this context can be 'any material the disclosure of which he or she believes would give rise to a real risk of serious prejudice to an important public interest and the reason for that belief'[6].

Making the decision

The decision on whether to proceed with a DHR will be taken by the chair of the NLCSP within one month of notification of a death.

Where circumstances are complicated and it is not clear that the death meets the criteria or it appears to have been a suicide, the DHR Co-ordinator may be requested to prepare a briefing for the chair of the NLCSP. This will be compiled from the information returned in the Agency Initial Information forms. The NLCSP Chair may then take the decision to complete a DHR in conjunction with other statutory board members of the CSP.

Within one month of the receipt of the notification of a potential DHR, NLCSP chair will inform the Home Office of their decision.

Final decision

The statutory guidance is clear that a DHR must be carried out where a death meets the criteria. If a decision is made not to carry out a DHR in any circumstances and the Secretary of State disagrees, they can then direct that a DHR is conducted.

Notification of final decision

When a final decision has been made about whether a DHR will be undertaken or not, notification will be provided to the following:

[6] Ibid, page 26, paragraph 94

- the SIO and FLO
- all relevant agencies
- the coroner
- family, friends and support network as appropriate

STAGE 2 – Conducting a DHR

Role of Review Panel Independent Chair and Author

The statutory guidance states:
As local circumstances determine, the CSP or the Review Panel should appoint an independent chair of the panel who is responsible for managing and coordinating the review process and for producing the final overview report based on evidence the Review Panel decides is relevant. The chair may also be the author of the overview report. When appointing the chair, provision may be made for the chair to be made aware of the response from the Quality Assurance Panel and potentially to be involved in making any changes required as a result of this quality assurance[7].

In North Lincolnshire, the following applies:

- where possible, the Independent Chair of the Review Panel will also be the author of the Overview Report, however in some circumstances these roles may be undertaken separately
- the role of the Chair is to manage and co-ordinate the process of the DHR and ensure the Overview Report is produced
- after the initial meeting and an appointment of the Chair and / or Author, the appointed Chair will chair for all meetings of the Review Panel and IMR Author meetings
- the Independent Chair should be an experienced individual, who is not directly associated with any of the agencies involved in the review
- the Chair should consider if the panel is becoming aware of any information that may be of interest to the judicial process, including for example an inquest[8], to ensure that an inquest may be aware of any agency failings being revealed in the DHR process. It is the role of the Chair to contact the SIO accordingly

Appointing an Independent Chair and Author

In North Lincolnshire, an individual working as a private consultant will usually be appointed as an Independent Chair / Author. The Chair should not be a member of the NLCSP. Where the Chair has worked for the NLCSP or an associated agency in the past, there needs to be a clear statement of the time elapsed. The final report should have an independence statement[9] which specifically states the Chair's employment history, relevant experience and independence in relation to the report.

The preferred local process for DHRs in North Lincolnshire is to commission an Independent Chair on a case by case basis. This enables the opportunity to select the candidate with the most appropriate skills and expertise for each review.

[7] Ibid, page 12 paragraph 36
[8] Ibid, page 16, paragraph 47
[9] Ibid, page 12, section 37

Recruitment of the Chair

In North Lincolnshire, a list of individuals who may be able to act as DHR Chairs has been established. When a DHR Independent Chair / Author is needed, the individuals are contacted and sent an Expression of Interest form to determine whether they are able to act as the Independent Chair / Author and undertake the DHR.

The Expression of Interest form includes the statutory guidance recommendations in relation to the required skills and expertise as follows:

- enhanced knowledge of domestic violence and abuse issues including so-called 'honour'-based violence, research, guidance and legislation relating to adults and children, including for example the Children's Act 2004, the Care Act 2014 and the Equality Act 2010
- an understanding of the role and context of the main agencies likely to be involved in the review
- managerial expertise
- strategic vision so that opportunities are identified to link in and inform strategies such as the Government's *Tacking Violence against Women and Girls strategy: November 2021*[10]
- good investigative, analytical, interviewing and communication skills
- an understanding of the discipline regimes within participating agencies
- an understanding of wider statutory review frameworks such as child or adult reviews
- completion of the Home Office online training on DHRs, including the additional modules on chairing reviews and producing Overview Reports

Of those who submit an Expression of Interest, a minimum of three candidates are shortlisted by the DHR Co-ordinator in conjunction with senior manager representation from the NLCSP.

A preferred candidate is then appointed based on experience, availability and cost. Reserve choices will also be selected in the event that the first choice for the role cannot then commit to this process. A contract is then agreed and signed. This will allow for an understanding of the work required, timescales and the expected total fee with some flexibility for if more work is required.

The Review Panel

The Home Office guidance clearly sets the expectation for membership of the Review Panel, stating:

The Review Panel can either have a fixed, standing membership or be created on a bespoke basis for the purposes of undertaking a particular DHR. The Review Panel must include some or all individuals from the statutory agencies listed under section 9 of the 2004 Act. Consideration must also be given to including voluntary and community sector organisations who may have valuable information on the victim and/or perpetrator and, as circumstances determine, may be able to represent the perspective of the victim and/or perpetrator. The Review Panel must also include specialist or local domestic violence and abuse service representation. In essence, the Review Panel composition needs to be sufficiently configured to bring relevant expertise in relation to the particular circumstances of the case as they will see the dynamics of the relationship through a different lens[11]

In North Lincolnshire, the Review Panel will be created on a bespoke basis for the purposes of undertaking a DHR, including people with specialist knowledge where the case calls for such additional expertise.

[10] Policy paper overview: Tackling violence against women and girls strategy - GOV.UK (www.gov.uk)
[11] DHR 2016, page 11, paragraph 29

The nominated Review Panel member will not always be the Individual Management Review Author (and each agency must nominate its own IMR Author) but rather, be a senior representative of the agency who will attend all Review Panel meetings throughout the process.

Panel members must be independent of direct line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting. IMR Authors normally present their IMRs to the panel and may be invited to meetings to discuss the draft overview report.

To ensure transparency, all names, roles and agencies represented on the panel will be included in the DHR report[12].

The Review Panel should meet an appropriate number of times to ensure there is robust oversight and rigorous challenge. The 2016 guidance states that meeting at the beginning and at the end of the process would imply a limited and potentially ineffective role in the DHR process.

Role of the Review Panel

The aim of the Review Panel is to work with the Independent Chair / Author to:

- establish the scope and Terms of Reference for the DHR which will normally be completed through the initial panel meeting
- should the Terms of Reference be completed through an initial panel meeting, the Chair will provide a briefing. This briefing will include a confidentiality statement and members of the panel will be expected to sign a confidentiality agreement. During the meeting the contact list of agencies who will be completing IMRs will be confirmed
- establish lessons to be learned from the case about the way in which local professionals and organisations worked individually and together, to safeguard the victim
- identify how and within what timescales lessons learned will be acted on, and what is expected to change as a result
- improve intra and inter-agency working and provide a better service to victims of domestic abuse
- ensure the review is conducted according to best practice with effective analysis and conclusions drawn on the information related to the case
- rigorously challenge the information presented[13]
- establish how to communicate with the family in each particular case
- receive the Overview Report and Executive Summary and ensure that
    - all contributing organisations and individuals are satisfied that their information is accurately and fairly represented
    - the Review Panel findings are accurately reflected
    - they are written in accordance with the statutory and local guidance
    - they are of a sufficiently high standard for them to be submitted to the Home Office [14]

The Review Panel should bear in mind all equality and diversity issues including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and

[12] Ibid, page 11, paragraph 30
[13] Ibid, page 11, paragraph 31
[14] Ibid, page 21, paragraph 74

belief, sex and sexual orientation and immigration status, and that these may all have a bearing on how the review is explained and conducted and the outcomes disseminated to local communities.

The panel member for the Police or the SIO can advise the panel whether they can interview staff members about the case and notify the group of the trial date for any alleged perpetrator as soon as this is known. This is to allow any contact with family and friends or staff members of agencies who might be acting as witnesses to be interviewed as part of the DHR process without influencing the criminal proceedings in any way, as this is strictly prohibited.

Role of Review Panel member

This role will be undertaken by a senior officer within each agency who will ensure the agency's effective participation in the DHR process by:

- representing their agency and ensuring that their agency's views are shared
- ensuring that their agency complete an IMR
- implementing the recommendations and actions relevant to their agency

The panel member needs to have sufficient authority within their agency to approve and take forward the recommendations of the DHR.

It may be problematic for small organisations, such as those in Voluntary, Community and Faith organisations to provide a Review Panel member who does not have direct line management responsibility for the case. The Chair may advise that a mentor from another agency is appointed to support the organisation and / or ensure that the IMR is produced with adequate independent scrutiny.

Requesting consent from the family to be involved in the DHR

It is important to know from the start of the DHR process, if possible, whether significant family members or friends wish to be involved in the DHR. This includes an opportunity to be interviewed by the Independent Chair / Author once the criminal proceedings are finished.

Where possible, it is helpful to seek assistance from agencies that have a good relationship with these individuals to discuss the issue on the Independent Chair / Author's behalf, or to liaise with the FLO involved with the case who will be in close contact with the family during the criminal proceedings.

Case anonymisation and the use of pseudonyms

The statutory guidance outlines that families are able 'to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns, or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.'[15]

[15] Ibid, page 18, paragraph 53(g)

If possible, a pseudonym should be agreed at the first panel meeting. The draft and final reports should use the agreed pseudonym for the victim and any other parties included in the report.

Should the family decline the use of a pseudonym, this will be reflected in the report. In such cases, anonymisation will be used.

There are a range of factors to consider throughout the duration of the DHR. These include confidentiality, consent from family members and the perpetrator, children and consent, family engagement in the DHR process, the involvement of family, friends and other support networks, support to the family and interviews with them, the Independent Chair / role with family, friends and others, the family and the Overview Report. These can be found within appendix 2.

STAGE 3 - Individual Management Reviews

The three aims of the Individual Management Review (IMR) are to: [16]

1) allow agencies to look openly and critically at individual and organisational practice and the context within which people were working (cultural, leadership, supervision, training etc) to see whether the homicide indicates that changes to practice could and should be made to support professionals to carry out their work to the highest standards
2) identify how and when those changes or improvements will be brought about
3) identify examples of good practice within agencies

The issues to be addressed in each IMR will be identified by the Terms of Reference agreed by the chair and Review Panel. IMRs should be requested as soon as the Terms of Reference have been set and sooner if a homicide gives cause for concern within the individual agency.[17]

The Independent Chair / Author will make the final decision as to whether any agency needs to submit an IMR as part of the DHR. If it is decided that agencies do not need to complete an IMR, they will be notified formally in writing. Where the agency is out of area, they will be notified by their area's domestic abuse lead.

Where an agency is required to submit an IMR they:

- should adhere to the time frame provided
- should liaise about issues of concern and raise queries as soon as they are known
- should make recommendations clear in the report focussing on the key findings of their analysis and lessons learned

IMRs will include a comprehensive chronology that outlines the involvement of the agency with the victim, alleged perpetrator and their families over the time period set out in the Terms of Reference. Agencies should also include any specific areas of interest outside those parameters to enhance the content of the review. A template IMR can be found in the appendices of the statutory guidance.

The agency chronology will guide the process of interviews, drafting of the IMR, identify key episodes of agency involvement and will be merged with the chronologies of other agencies that will inform the DHR Overview Report.

If it has been established that an out of area agency needs to submit an IMR, they will be required to use North Lincolnshire's IMR template and will adhere to North Lincolnshire's DHR procedures and timescales.

Involvement of professionals in IMRs

The IMR Author must be a staff member who had no direct involvement with the victim, perpetrator or any family member and was not supervising any staff member involved in the case.

During the process of the IMRs being written, professionals who have worked with the individuals' subject of the DHR will be involved in the IMR process. As this can be a difficult and potentially stressful process for workers who knew the individuals well, it needs to be managed sensitively.

As soon as a DHR has been agreed:

[16] Ibid, page 20, paragraph 61
[17] Ibid, page 20, paragraph 65

- the nominated leads from all agencies involved will be notified
- the nominated leads will notify their staff members who have been involved in the case and clarify with them who will be required to contribute to the IMR

All staff members who are asked to provide information or give an interview should be:

- given at least one weeks' notice where possible
- offered the opportunity to be accompanied by their trade union representative or other appropriate person if in accordance with the policies of the organisation
- provided with information about sources of independent support mechanisms they may wish to use in connection with their involvement in the DHR e.g. employee assistance schemes, human resources, occupational health or welfare services, trade unions or professional bodies

In the interview all staff should be:

- given the chance to share their views on the case, in line with the scope and Terms of Reference of the DHR. This will include their individual and organisational practice and the context in which they were working
- allowed to view the relevant paperwork to aid their recall
- asked for their views about what could have made a difference for the victim/perpetrator
- interviewed separately, but a staff member can bring an appropriate supporter if they wish

On occasion information may be disclosed in the course of a DHR that indicates the need for disciplinary action against an individual member of staff. This would remain the responsibility of the employing agency and the staff member should be supported through this process according to the agency's established procedures.

If at any point during an interview new evidence comes to light that would assist either the prosecution or defence in any criminal case, this should be forwarded to the SIO immediately.

Where interviews with staff are undertaken as part of the IMR, written records should be taken and shared with the relevant interviewee. All such records should be retained for the purposes of disclosure to any criminal investigation should the need arise.[18] Staff will be asked to agree the accuracy of the information contained in the records following their interviews.

A domestic homicide can have an impact on entire teams, workplaces and organisations. Agencies are responsible for making sure all staff are provided with and given access to emotional support. Measures being taken should be clearly identified and communicated widely. It is important that all staff are made aware that the process is not to apportion blame, but rather to learn lessons in order to improve future practice.

Following the completion of each IMR report, a process of feedback and debriefing for the staff involved will take place ahead of completion of the Overview Report. Senior managers in the relevant agencies will also complete feedback with these staff members when the Overview Report has been completed and prior to its publication.

Agency non-engagement

DHRs are a statutory process overseen by the Home Office and agencies are therefore obliged to fully participate in the process. This means that agencies should communicate fully during the DHR

[18] Ibid, page 20, paragraph 64

process, attend all relevant meetings and meet timescales for submissions of chronologies and IMRs.

Lack of engagement in the process can be detrimental to all agencies involved as well as the progress of the DHR as the agreed timescales allow information to be shared and analysed in a timely manner.

The following stages will be followed in the event of difficulties with agency engagement:

- the panel member or IMR author should discuss any concerns they may have or difficulties with meeting timescales and agree a resolution with the independent chair and/or the DHR Co-ordinator
- if the panel member or IMR author is unable or unwilling to resolve the issue then the Independent Chair and / or the DHR Co-ordinator will contact the agency's nominated senior manager, in writing, and discuss the issue with them to agree a resolution
- if none of the above resolve the issue it may be necessary to escalate it to a senior officer at the highest level within the agency, in writing and discuss the issue with them to agree a resolution
- if the issue is not resolved through the above measures then legal advice will be sought. It may require a Public Interest Consideration Report to be completed and sent to the agency concerned

STAGE 4 - Overview Report and Executive Summary

The Overview Report

The author for the Overview Report will be identified at the start of the DHR process and this individual may also undertake the role of independent chair.

An Overview Report and Executive Summary template can be found in the appendices of the statutory guidance. These templates are likely to be adapted on a bespoke basis to reflect the scope and Terms of Reference of a DHR.

The Overview Report will closely reflect the areas identified in the DHRs scope and Terms of Reference and will achieve the statutory aims of a DHR.

The chair should ensure that the report is professionally curious, investigative, analytical, highlights lessons to be learned and effective practice and makes specific, measurable, achievable, realistic and time scaled (SMART) recommendations.

The report should:

- be written in a way that articulates the life of the victim (and their children), using information collated from a variety of sources throughout the DHR, including their family, friends, and community, as well as professionals involved with the family
- fully understand and explain the history and trail of abuse, identifying which agencies had contact with the victim, alleged perpetrator or family and which agencies were in contact with each other
- have understood the victim's reality and identify any barriers the victim faced in reporting abuse and learn about why any interventions did not work for them
- bring together the findings of agency IMRs, interviews with family, friends and others, the outcome of criminal investigations and court proceedings and any other relevant information including reviews of local practices, processes, systems, legislation and national guidance
- have understood the context and environment in which professionals made decisions and took (or did not take) actions. This should include for e.g. the culture of the organisation, training that professionals had, supervision of these professionals, leadership of agencies and multi-agency working

Anonymisation and classification of the Overview Report and Executive Summary

Both the Overview Report and the Executive Summary must be completely anonymised. They should include the name of the Independent Chair / Author and Review Panel members but the identities of the victim, alleged perpetrator, child(ren), household members, workers involved in the case or others involve will not be revealed. The statutory guidance also specifies that other identifying features, such as precise dates[19] should be anonymised.

All reports should be regarded and marked as 'Official'[20] as per the Government Security Classification Scheme until the agreed date of publication.

[19] DHR 2016, Section 7, point 70, Page 21
[20] Ibid, Section 7, point 72, Page 21

Action Plan development

The Overview Report should include a detailed action plan which reflects the recommendations based on the lessons learned. All actions should be SMART and be tested out by the agency prior to the action being finalised where possible [21]. A template Action Plan is available in the appendices of the statutory guidance and may be adapted on a bespoke basis to reflect the particular circumstances, scope and Terms of Reference of the DHR.

[21] Ibid, Section 7, point 75, page 22

STAGE 5 - Approval of the DHR

There is a staged process to secure approval of the Overview Report, Action Plan and Executive Summary prior to publication and this includes by:

- the Review Panel
- the family
- a senior manager within each agency involved in the DHR
- agencies legal services as appropriate
- NLCSP

Following sign off by the NLCSP the Overview Report, Action Plan and Executive Summary will be submitted to the Home Office along with the Home Office Data Collection Form.

It will not be possible to finalise the IMRs or the Overview Report until after the coronial / criminal justice proceedings. This should not prevent early lessons being shared within agencies and relevant recommendations acted upon.

Debriefings after approval but before publication

Following approval of the Overview Report, Action Plan and Executive Summary by the NLCSP, a series of debriefings will be arranged for:

- family, friends, and other support networks e.g. colleagues. These will be led by the chair who will explain the findings of the DHR and what the next steps will be
- staff across the agencies involved in the collation of the IMRs. This will be led by a senior manager in each agency and will focus on the findings of the DHR and begin implementing the action plan
- key professionals e.g. the Coroner

Quality assurance by the Home Office

All completed DHRs will be approved by the Home Office Quality Assurance Panel prior to publication. All completed Overview Reports and supporting documents will be sent to the Home Office to be assessed against the statutory guidance.

The Quality Assurance Panel ensures that:[22]

- areas have spoken with the appropriate agencies, voluntary and community sector organisations, and family members and friends, to establish as full a picture as possible
- the report demonstrates sufficient probing and analysis and the narrative is balanced
- lessons will be learned and that areas have plans in place for ensuring this is the case
- the likelihood of a repeat homicide is minimised

The Quality Assurance Panel will provide written feedback to the NLCSP to agree that the report is fit for publication or make recommendations for change. In North Lincolnshire there would be discussion with the Author and / or Chair of the DHR should any changes be required. Following the completion of any changes required, the NLCSP will publish the report and Home Office letter from the Quality Assurance Panel on the NLCSP webpage.

[22] Ibid, Section 11, point 102, page 28

STAGE 6 - Publication

Once the Home Office confirms that the DHR can be published, a briefing will be prepared to notify the following parties of the publication of the Overview Report and other documents including:

- family, friends, and other support networks
- senior managers and staff across the agencies involved in the DHR
- key professionals e.g. the Coroner

Briefings will also be provided to others such as:

- the leader of the Council and Elected Members
- the Police and Crime Commissioner
- communications teams within the key organisations

The documents should be anonymised and redacted where necessary and formatted appropriately for publication.

On the day of publication:

- the anonymised / personified Overview Report and Executive Summary will be published on the NLCSPs webpages[23] unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review. The reasons for not publishing an Overview Report or Executive Summary should be communicated to the Quality Assurance Panel[24]
- confirmation of publication will be emailed to the Home Office, including a link to the published documents
- the family will be provided with the Home Office Quality Assurance Panel letter, a copy of the Overview Report and Executive Summary

The Domestic Abuse Act 2021 requires all Community Safety Partnerships to send final copies of any Domestic Homicide Reviews to the Domestic Abuse Commissioner. This will be a legal requirement from 1 November 2021. Final copies of the DHR should be sent to DHR@domesticabusecommissioner.independent.gov.uk

[23] https://www.northlincs.gov.uk/CSP
[24] DHR 2016, page 21 points 74 and 75

STAGE 7 - Action Plan implementation and review

The statutory guidance stipulates that action plans are the *'beginning of the (change) process'*[25]

The NLCSP will ensure that the actions within a DHR Action Plan are taken and that they lead to change or improvements across agencies to prevent domestic abuse and homicide and improve service responses for those experiencing domestic abuse also to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

The NLCSP will ensure that the Action Plan is completely delivered prior to sign off at the CSP Board.

The Domestic Abuse Strategy Group has responsibility for implementing and monitoring the Action Plan prior to sign-off. Regular oversight of the Action Plan will be provided by the quarterly meetings of this group and informed by input from the relevant agencies around progress and barriers. The group has the authority to escalate any barriers to progress to the NLCSP for resolution.

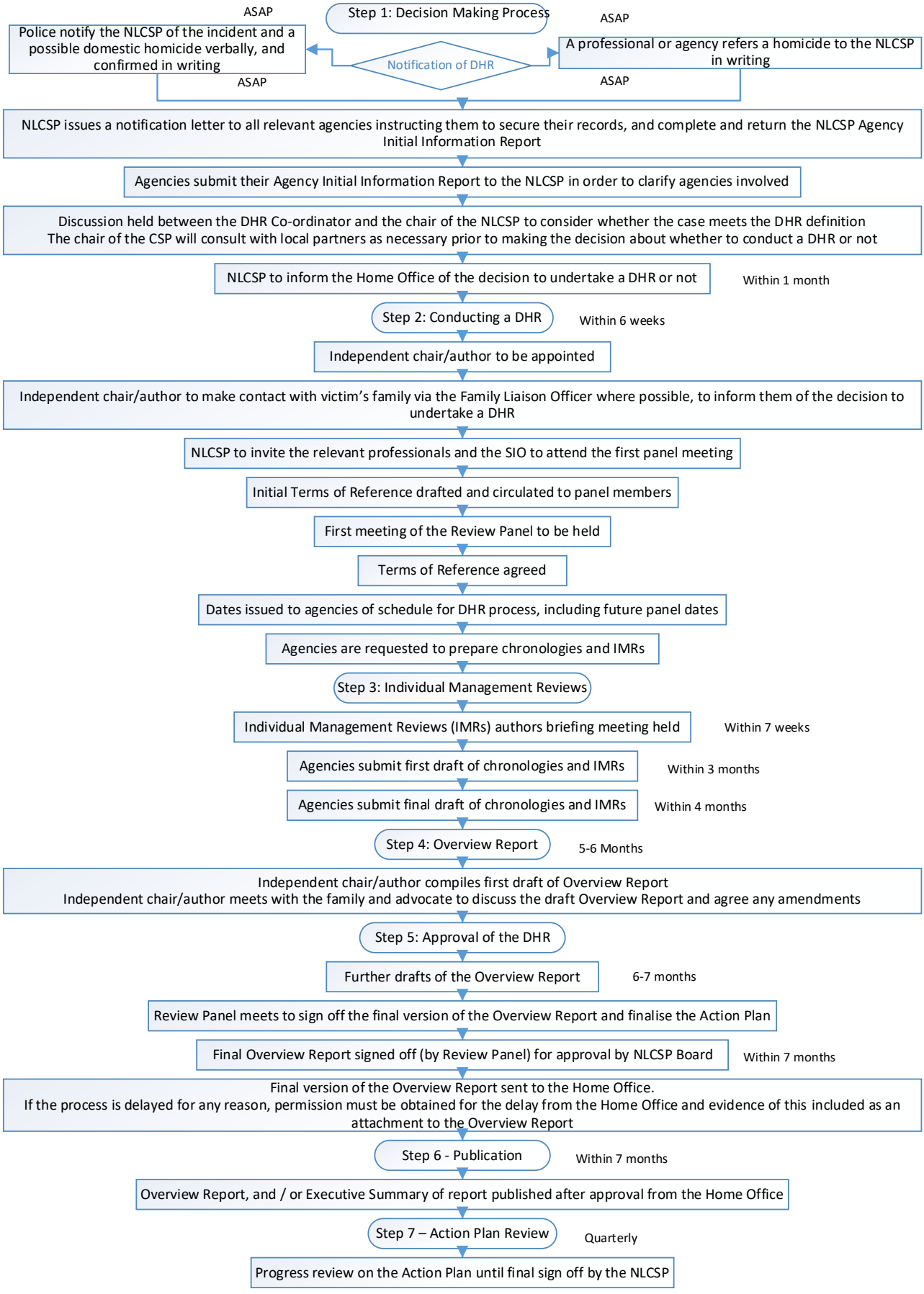
The Domestic Abuse Strategy Group will provide a regular progress report to the NLCSP. The same report will also be provided to the Children's Multi Agency Resilience and Safeguarding (MARS) Board and Local Safeguarding Adults Board (LSAB) where relevant.

In order to ascertain the impact of the recommendations and actions from the DHR, agencies should conduct an audit of progress against the Action Plan. This will ensure that the recommended improvements have been implemented, that any new or revised practices, processes, systems, or policies are working and evaluate whether there have been any unintended consequences to be addressed.

The NLCSP will sign off the action plan following its completion.

[25] Ibid, Section 7, point 76, page 22

Appendix 1 – Flowchart



Appendix 2: Factors to consider throughout the duration of the DHR

Confidentiality

DHR cases can be subject to high levels of public interest and complex legal processes in the criminal and civil courts. IMR Authors, panel members and any others involved with the review process need to be clear that the information they learn about the case and agency involvement is confidential. This means it should not be discussed with anyone apart from key officers within the agency who are responsible for either the current or former case management, or the senior managers in the agency who need to be kept informed in order to ensure the agency's approval of the Overview Report.

It is vital that documents related to the DHR are stored securely. Once a DHR is completed the agency should securely archive all relevant documents and draft copies of overview reports and executive summaries should be disposed of securely. The un-redacted Overview Report should be kept securely and access restricted.

A confidentiality agreement will be signed by all attendees at each meeting of the process. Any breach in confidentiality will be discussed with relevant agencies by the Independent Chair / Author.

A confidentiality statement for family members will be agreed as part of the DHR process.

Consent from family members and the perpetrator to access personally identifiable information

The DHR Co-ordinator should take the following steps when seeking consent from individuals involved in the case:

- a letter should be prepared for the individual from whom consent is being sought to access their agency records
- included with this should be a bespoke consent form prepared for the circumstances of the particular DHR for that individual to sign and return to the DHR Co-ordinator
- in situations where consent is refused, or no answer is given and all reasonable efforts have been made to obtain consent it may be appropriate to proceed without consent. A Public Interest Consideration document should be prepared, checked with Legal Services, and then circulated to the Independent Chair / Author and Review Panel for discussion and approval if deemed appropriate

Children and consent to access personally identifiable information

In cases where there are children (under 18 years of age) involved, there will be a need to review the agency information that is held by services supporting and in contact with the children, e.g. GP.

Consent is therefore required for all children involved in the case. The parent or the carer of the child/ren will need to be contacted to ask for their consent. However in some cases it may be determined that a child is of *'sufficient understanding and intelligence to be capable of making up*

his own mind on the matter requiring decision'[26], as per the Gillick competency test and therefore may be in a position to be able to provide their own consent.

There is a need for the Review Panel to determine whether children can consent to sharing their information, using specialist advice.

Data Protection and the professional sharing of information

The sharing of personal information is integral to the DHR process and needs to be in accordance with the Data Protection Act 2018 (DPA) principles.

There are two sharing of information issues that the DHR process may experience:

1. the family and/or perpetrator refuse to share information or consent cannot be sought
2. a lack of openness to sharing data of a personal level by agencies (when consent is and is not given)

Section 10 of the statutory guidance outlines the following:
The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles'. Data protection issues in relation to DHRs tend to emerge in relation to access to records, for example medical records. Data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors. In the case of a living person, for example the perpetrator, the obligations do apply. It is recognised that some local areas have faced resistance from clinicians and health professionals when seeking release of medical records on perpetrators.

The Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and, where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:

a) The review team should be informed about the existence of information relevant to an inquiry in all cases; and
b) The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.

The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest.[27]

The Department of Health recognises that DHRs have a strong parallel with Serious Case Reviews (now termed Child Safeguarding Practice Reviews). Guidance advises doctors that they should participate fully in these reviews. It goes on to say "When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information,

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[26] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/
[27] DHR 2016, page 27 paragraphs 98-99

even when a child or young person or their parents do not consent." The Department of Health believes it is reasonable that this should be the principle that doctors should follow in cooperating with DHR's. This action was further supported by recommendations in the Department of Health document 'Striking the Balance' (2012)[28]

The DPA governs the personal data of living persons. Therefore, following the death of the victim, the data protection principles do not normally apply and the full sharing of information (e.g. health, legal) is permissible.

If personal data/information is required of a living person, then the data protection principles need to be adhered to. This includes when to share and when not to share information, and with regard to what information to share. This is important for DHRs when living individuals do not consent to share their information, often in the case of the perpetrator.

There is a need to ensure all professionals, including clinicians and health professionals disclose information regarding all individuals identified in the DHR process, to cooperate with the DHR process, with or without that person's consent.

In some situations, a professional may not want to make a full disclosure (due to confidentiality obligations or other human rights considerations).

The panel's aim is to ensure the principles of the DPA are achieved, and that all professionals share sufficient information to meet the DHR objectives of reducing the risk of future harm.

Where there are issues with consent or agencies sharing information to the level required, then a Public Interest Consideration Report will be completed and approved by Legal Services. The report outlines the rationale for sharing personal level data factoring in the data protection principles, common law, and Human Rights Act. This report is then sent to the agency concerned.

Family engagement in the DHR process

The statutory guidance thoroughly outlines the engagement with, and involvement of the family, friends and other support networks throughout the DHR process.[29]

The family should be given the opportunity to attend the first Review Panel meeting, where the scope and Terms of Reference for the DHR are formulated. If the family decide not to meet the Review Panel they should be given the opportunity to influence the scope and Terms of Reference. If the family do not wish to engage, the FLO or another professional will share the outcomes of the first Panel meeting.

Involvement of family, friends and other support networks

Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder. Their participation must be afforded the same status as other contributions. They should be offered clear communication about the process from the outset and throughout the review. Family members should be given the opportunity to meet the Review Panel if they wish, and given the opportunity to influence the scope, Terms of Reference, content and impact of the review.

[28]Ibid, page 27, paragraph 100 https://www.gov.uk/government/publications/striking-the-balance-practical-guidance-on-the-application-of-caldicott-guardian-principles-to-domestic-violence-and-maracs-multi-agency-risk-assessment-conferences

[29] Ibid, pages 17-19, paragraphs 51-59

An effective DHR process provides family, friends, and other support networks with opportunities to contribute, acknowledging that they may have important information to offer. The benefits of involving family, friends and other support networks include assisting the victim's family with the healing process and allowing the Review Panel to get a more complete view of the lives of the victim and / or perpetrator in order to see the homicide through the eyes of the victim and / or perpetrator.[30]

Once a decision has been made to conduct a DHR any significant family members, friends, or other support networks e.g. employers and colleagues should be written to informing them of this decision, seeking their consent to access their records if they are to be subject of the DHR, or asking them to participate if they are not.

The Review Panel and chair can help establish a positive experience for the family, friends and other support networks by offering clear communication about the process from the outset and throughout the review. The communication will be bespoke to each family.

The family should be offered the opportunity to voluntarily participate in the process. The opportunity will be offered to the family in person by the FLO or another professional. They will be offered a letter that explains the process, how they can contribute, choices available to them, a consent form (if necessary) and participation form and a copy of the most appropriate national DHR leaflet.[31]

Support to the family, the use of advocates and children involved in the case

Consideration should be given at an early stage to working with FLOs and SIOs involved in any related police investigation to identify any existing advocate and the respective positions of the family with regard to the homicide.

Children should be given specialist support and an opportunity to contribute as they may have important information to share. This will be arranged on an individual basis in consultation with appropriate agencies.

Interviews with the family, friends or others engaged with the DHR

The family may provide relevant information which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents.

Any face-to-face interviews agreed should be conducted by the Independent Chair / Author or an individual who is not an IMR author or who has had involvement or direct management in the case.

All meetings with family, friends and others should be recorded and transcripts of any interviews should be securely stored by the DHR Co-ordinator.

Families can provide factual information as well as testimony to the emotional effect of the homicide. The Review Panel need to be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to the statutory sector, voluntary sector and family and friends contributions.

[30] Ibid, page 17-18, paragraph 53
[31] http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-homicide-reviews/.

The Independent Chair / Author's role with family, friends and others

The Independent Chair / Author should meet with family, friends and others as agreed by the Review Panel at the earliest opportunity. The Chair will make a decision regarding the timing of the contact with the family, friends and others based on a range of information including from the families advocate(s) should they have these, the SIO and FLO and other's relevant to the case.

The Independent Chair / Author should offer signposting to specialist and expert advocacy support services to those who do not have an advocate. The Independent Chair / Author cannot act as the advocate as they need to remain fully independent.

After meeting with the Independent Chair / Author, the family or their advocate should understand:

- how their involvement and information will assist with the review
- how the information they disclose will be used in the review, and whether it will be published
- the benefits of being involved in the review
- when they will be involved in the process
- that they will have an opportunity to be interviewed
- how frequently they will be updated
- that they will be offered the opportunity to see draft reports and final Overview Report prior to publication
- the timeline for publication of the Overview Report
- that they have an opportunity to help *'create the change after the review'*

After the meeting with the family, friends and others the Independent Chair / Author should be aware of:

- significant people in the victim's life to consider being included in the review process (e.g. friends, colleagues etc.)
- preferred methods of communication (written, electronic, in person, via a specific person e.g. advocate or FLO)
- any specific areas of sensitivity (e.g. avoiding certain dates within the year for meeting with family members, or publication of the report)

The family and the Overview Report

NLCSP will ensure that adequate time is given for the family to consider and absorb the report, identify if any information has been incorrectly captured and record an areas of disagreement.

The NLCSP should ensure that the family are fully sighted on any media statements and be mindful of the need to consider key dates such as birthdays, anniversaries etc.[32]

Action to take when the family refuse to participate

Where the family have declined to participate, this should be clearly recorded within the Overview Report.

When the family refuse to participate, there is a need to still share the final Overview Report with them and make them aware of any media statements.

[32] DHR 2016, page 19, paragraph 56 (j)

Family and friends should be offered more than one opportunity to participate as their views regarding participation may change over time. There is a need to explain to the family that late participation in the process could mean some limitations with regards to shaping the DHR process, as this is set out in the Terms of Reference at the start.

The alleged perpetrator / perpetrator and their family

The review should consider approaching the alleged perpetrator/perpetrator and their family.[33]

The Independent Chair / Author and Review Panel should be mindful that the alleged perpetrator or members of the alleged perpetrator's family might in some cases pose an ongoing risk of violence to the victim's family or friends or members of their own family (and vice versa) [34]. Any concerns of immediate risk that become evident should be communicated to the police. Particular consideration should be given to this issue in reviews where 'honour' based abuse / violence is suspected[35].

In situations where 'honour' based abuse / violence is suspected or known, extra caution will be needed around confidentiality in relation to agency members and interpreters / translators where there are possible links with the family or local community and wider. 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 / organisation with expertise in this area.

[33] Ibid, page 19, paragraph 57
[34] Ibid, Section 6, point 58, page 19
[35] Ibid, Section 6, point 59, page 19