LEICESTER CITY
DOMESTIC HOMICIDE REVIEW
PROTOCOL 2021

Purpose of this document:

To provide a summary of the local procedures to be followed when there has been a domestic homicide in Leicester in alignment with the Home Office Guidance "*Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*" (December 2016) and any future updates to that guidance

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PART ONE: INTRODUCTION

1. Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004. Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews was issued in 2011 and again in 2016.

2. The main purposes of Domestic Homicide Reviews are to:

   - prevent domestic violence and homicide, and to
   - ensure that abuse is identified and responded to effectively at the earliest opportunity by improved service responses for victims, which have a coordinated multi-agency approach.

3. This guidance should be seen as a local summary of the Home Office document "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews", issued in December 2016. The two documents should be consulted together to provide the most complete view of the overall process.

4. The process detailed in this guidance is summarized in the diagram at Appendix A.

5. In Leicester the governance of DHR work rests with the Leicester Community Safety Partnership (LCSP). The LCSP DHR sub-group carries out the required work for the CSP Executive with office support from the Leicester Safeguarding Boards Office within Leicester City Council.

PART TWO: DETERMINING THE NEED FOR A DOMESTIC HOMICIDE REVIEW (DHR)

Referring relevant deaths

6. Any professional or agency can make a referral for a DHR following a death thought to be related to domestic abuse, including suspected suicide. This might include Community Safety Partnerships (CSPs) from other areas. A copy of the referral form is available either online or at Appendix A of this document. Referrals should be sent to DomesticHomicideReview@leicester.gov.uk.

7. Where partner agencies of more than one local authority area have known about or had contact with the victim, the community safety partnership of the local authority area in which the victim was normally resident should take lead responsibility for conducting any review.

8. A domestic homicide is defined to have occurred when 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.

9. If one or more of these criteria are met, 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.

10. Within 48 hours of incident, if the Police, or another agency, are aware that there has been a death which they believe might meet the definition of a domestic homicide, they need to inform the Head of Service Prevention and Safer Communities and the DHR Officer [DHRO] by email at the following address: DomesticHomicideReview@leicester.gov.uk.

11. The Police (or other agency) will keep the Leicester City Council Head Service Prevention and Safer Communities informed as the circumstances around the death are clarified. The Police serious case review partnership manager (if Police identification) submits a referral form to the DHR Officer at this point.

12. The Police Serious Case Review Partnership Manager will ensure that the Senior Investigating Officer (SIO), Officer in Charge (OIC), Disclosure Officer and Family Liaison Officer (FLO) for the case are notified of the process.

13. There might be occasions where there is a significant time lapse between death and referral. There is no time limit between a death occurring and a DHR referral being made.

Links with other reviews

14. The Child Safeguarding Practice Review Panel might receive a referral at the same time, or before a DHR referral is received, for matters related to the same case. Both referrals should be made if relevant criteria are met.

15. If the LSCPB (local safeguarding children partnership board) review group makes the decision to proceed to a Rapid Review, the LCSP DHR sub-Group Chair might, if the LCSP DHR sub-group agrees that DHR criteria are also met, instruct a temporary "hold" on further DHR related activity until it is ascertained whether another review process will need to be combined or run parallel to the DHR. This would happen before the decision to open a DHR is taken to the CSP Executive Chair.

16. In addition to receipt of direct referrals of the same case to more than one review board, when the victim of domestic homicide is aged between 16 or 17, and/or where the case:

    - highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.

    - highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.

    - highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.

    the LSCPB Manager and the DHRO will discuss as soon as practicable to agree a proposed way forward to reduce duplication and maximise learning from the earliest point.

17. Similarly, where the LSAB receives a referral that may fit the criteria for both a Safeguarding Adults Review, as well as a Domestic Homicide Review. If the LSAB (Leicester safeguarding adults board) review sub-group has received a SAR (safeguarding adults review) referral for an adult in its area with needs for care and support where domestic homicide review criteria may be satisfied, and the sub-group has indicated that:

    - the case meets the criteria for a SAR to be carried out, or

    - further information is needed to decide on SAR criteria being satisfied,

the DHRO and the LSAB Board Officer should discuss initial information gathering processes and propose an acceptable way forward to reduce duplication and maximise learning from the earliest point.

18. The LCSP DHR Sub-Group Chair might, if the LCSP DHR sub-group agrees that DHR criteria are also met, instruct a temporary "hold" on further DHR related activity until it is ascertained whether another review process will need to be combined or run parallel to the DHR. This would happen before the decision to open a DHR is taken to the CSP Executive Chair.

19. It will be the responsibility of the lead statutory reviewing body (and later Chair/Author, once commissioned) to ensure that the relevant safeguarding board/DHR managers are aware of any dual referral or process and put in place the necessary communication arrangements. This should include consideration of:

- Joint input into the draft terms of reference
- Panel membership
- Family engagement, including specialist panel input regarding voice of the child/adult.
- Expectations regarding feedback and learning events.
- Identification and sharing of learning from previous case reviews.

Consideration of the death by the Review Group

20. Having received the notification of the death, the task for the DHR sub-group is to consider the definition set out in Section 1 of the 2004 Act.

21. For the sake of clarity, this meeting of the Review sub-group should be regarded as the 'Notification meeting'. The Statutory Guidance states clearly that "Where the definition set out (in the Act) has been met, then a Domestic Homicide Review should be undertaken".

22. The Head of Service Prevention and Safer Communities and DHRO will then brief the Chair of the Safer Leicester Partnership, on its' recommendation of whether the definition for a DHR has been met.

23. Once the Chair of the CSP's decision on the recommendation has been made, the DHRO will notify the Chair of the LCSP's DHR sub-group at the same time as making the relevant notifications to the Home Office and the Coroner.

24. The Home Office must be informed whether the local decision is to hold, or not to hold a DHR. If the decision has been made not to conduct a DHR, on receipt of the notification the Home Office will circulate the decision not to hold a review to its' Quality assurance Panel for comment and feedback will be given to the LCSP.

Timescales

25. The decision to proceed with a review, or not, should be taken by the chair of the LCSP **within one month** of a domestic homicide coming to their attention.

26. Every effort must be made to avoid delay and to run the review parallel with other processes (e.g., Coronial, Prosecution etc.). A full update on the investigation will be provided by the Police representative at the first convened panel. This representative will be the Serious Case Review Partnership Manager. This will enable the panel's decision to be informed by police knowledge of likely witnesses, and whether their involvement in the Review process may compromise the investigation and/or any prosecution.

27. The default expectation is that the learning is to be derived as soon as possible and that Individual Management Reviews [IMR's] are completed as soon as possible.

28. 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 requesting IMR's, analysing content and drafting a first iteration of a chronology, whilst avoiding speaking to potential witnesses, can be undertaken before a criminal trial has taken place.

PART THREE: PROCEEDING WITH A DOMESTIC HOMICIDE REVIEW (DHR)

Notifying the Home Office

29. The DHRO, on behalf of the LCSP, sends in writing the confirmation of a decision to review (as well as a decision not to review a homicide, with its' rationale) to the Home Office DHR enquiries inbox: DHREnquiries@homeoffice.gov.uk **within the month of the decision.**

Notifying the victim's family

30. Where the decision to proceed with a Review is taken, the DHRO, on behalf of the LCSP [and generally in cooperation with the Police Family Liaison Officer) will inform the victim's family, in writing, of its' decision **as soon as possible** with details of the support options available to them.

31. The letter of notification to the family must state that the Chair will make contact in due course, once any parallel processes have been discussed, at the first Panel meeting.

32. Where the decision is taken **not** to proceed with a Review, the DHRO on behalf of the SLP, will inform the victim's family in writing of its decision. The LCSP DHR Group will consider the timing and appropriateness of such a notification, Taking account of.

- Other parallel processes.
- Where there are criminal proceedings following liaison with the investigating officer and Family Liaison Officer (FLO),

and having waited for the Home Office response to that decision.

Notifying the Coroner

33. Where the decision to proceed with a Review is taken, the DHRO, on behalf of the LCSP, will inform the Coroner of its decision, by emailing Coroner-inquests@leicester.gov.uk .

Support for victims' families

34. As set out in Section 6 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, the DHR chair/review panel should ensure that families are given the opportunity to be integral to reviews.

35. There is information from the Home Office for Chairs of DHRs, on the range of support available to families.

36. Following appointment of a chair/author, they should write to the family to introduce themselves. The Introductory letter from the Chair should not be sent to the family until after first panel meeting, where the Police panel representative should confirm who are likely to be witnesses in the case.

37. Families' involvement in the review can be supported by advocacy services. The family should also be allowed the opportunity to comment on the scoping period of the review and the terms of reference.

The trawling process

38. In the event of the decision to hold a DHR, the DHRO will arrange for local agencies to be notified of the decision, with a request for them to secure and search their records for any trace of involvement with the victim, the alleged perpetrator and any other individuals deemed to be of interest to the review. This is referred to as 'the trawling process'.

39. The time period for the trawling request should be considered at the decision-making meeting of the LCSP's DHR sub-group. It needs to be proportionate and cover what is likely to be the key period for events in the time before the death. Periods of three to five years are common.

40. In general, agencies will be given **14 days** to respond to the request for information.

41. Information from agencies on the nature and scope of their involvement (including 'no trace' returns) will be collated by the DHRO and presented to the next LCSP DHR sub-group meeting. Once the LCSP's DHR sub-group knows which agencies have been involved with key individuals, it can recommend which agencies should be invited to attend the first DHR Panel meeting.

42. The DHRO will track agencies' responses over the course of different trawling processes, to identify patterns, and share this with the LCSP subgroup. The DHRO will also ensure an annual (minimum) review of the standard list used for trawling requests.

43. It is the responsibility of the agencies receiving the trawl request to check all available records systems to identify all information held across the full scoping period and to record the systems checked on the trawl return form for clarity.

Sharing information

44. During the DHR process, partner agencies are required to trawl their records for information they hold on the adults and children in the scope of the review. They may also be required to trawl back on the perpetrator's previous partners. It is the trawling agencies' responsibility to ensure the relevant lawful basis for sharing information is met.

45. The LCSP DHR group members have signed an overarching information sharing agreement (ISA) for DHR panel work. If additional agencies are brought on to the panel, they will be required to sign the individual panel ISA. Each panel meeting will also have a confidentiality agreement, which all present will be required to sign.

46. It is the responsibility of the DHRO to ensure there are secure communication systems established with the appointed DHR Chair/Author, to generate a password for the review and to maintain a central store of information connected to the review.

Chronology of information known

47. Once the key agencies are identified, the DHRO will send a request to those agencies for a detailed chronology of their involvement with the individuals concerned. This information will be collated by the DHRO, with administrative support, in the form of a merged Chronology, so that it is available for the independent chair and/or author at the first DHR Panel meeting.

Commissioning an independent chair and author for the review

48. The DHRO together with the Safeguarding boards manager and the Chair of the LCSP's DHR, sub-group, will arrange the process of commissioning and appointing an independent chair of the panel and author of the review report. These can be combined or distinct roles.

49. The DHRO will follow city council procurement processes in the commissioning and appointment of the independent chair and/or author for the review.

50. The review panel chair (and author, if separate roles) should be an experienced individual who is, wherever possible, not 'directly associated' with any of the agencies involved in the review or the Community Safety Partnership. The chair and/or author will be required to insert into the final report an 'independence statement' which sets out their career history, relevant experience, and independence.

51. The DHRO will ensure that the appointed Chair/Author have copies of the local DHR protocol, most recent local domestic violence needs assessment and other local information to support them in their duties including any area profiles.

Establishing a Review Panel

52. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency and to make decisions during a panel meeting. Members of statutory agencies who have responsibilities for completing IMRs may also be members of the Review Panel, but the Panel will not consist solely of such people.

53. The independent chair and/or author will be instrumental, with the DHRO, in determining the Review Panel membership. The Panel membership will reflect the equality and diversity issues known from the review as they emerge. On occasion specialist representatives will be invited to join the panel or otherwise feed into the review process. The review panel must also include specialist or local domestic violence and abuse service representation.

54. In the interests of transparency, all members of the Review Panel will be named in the report, their respective roles set out and the agencies which they represent.

55. If at any stage of the review process, the Author/Chair wishes to apply to the Coroner to be considered an 'interested person' they should approach the LCSP DHR sub-group before an approach is made to the Coroner. The issue of IP status will be discussed by the sub-group and a decision will be taken on a case-by-case basis. The DHRO will inform the Chair/Author of the sub-group's decision.

Supporting the DHR process

56. The DHRO is available to the Chair and/or Author, as well as Panel members, to assist with the DHR process. When seeking feedback on document drafts, Panel members will be **given 14 days** to respond wherever possible. Papers for Panel meetings will be sent out at least **5 working days** prior to the meeting.

Record Keeping and Secure Storage and Transfer of Information

57. The DHRO will establish appropriate secure filing systems for DHR related information within the LCSP Shared Drive. Record keeping and retention will be in accordance with Leicester City Council policies and procedures. Any personal data that is provided by Agencies will be processed in accordance with current data protection laws, the statutory duty to conduct Domestic Homicide Reviews (DHRs) under the Domestic Violence, Crime and Victims Act 2004 and related legislation.

58. Collated data will be used by Leicester City Council and its' partners to deliver and improve services, and to fulfil legal duties.

59. Sensitive information will be sent via Leicester City Council (secure) email. Where the email exchange is not secure, documents will be password protected.

Support for IMR Authors

60. Once Panel Members have identified the Author of their Agency's IMR, the IMR Author will be invited to a group meeting with the Chair. The purposes of this meeting will be to clarify the Chair's expectations and to provide guidance on what the features of a good IMR are.

61. IMR Authors are expected to attend a Panel meeting to present their report and respond to any questions that Panel members may have.

Timescales and Extension Requests

62. IMR Authors must be aware of the timescales for completing the chronology and then the Management Review report and raise any difficulties in meeting timescales as early as possible with their agency's designated Senior Manager who in turn will notify the Review Panel Chair of any delay. IMR Authors need to be aware how their work fits into the whole program (e.g., the timescales for creating the merged chronology being dependent on each agency's chronology being available).

63. It is for the Chair/Author, with support from the DHRO, to identify if there will be a significant delay in progressing the DHR. If this is the case, the Chair/Author must note this in the overall timeline of the review and notify the SLP DHR sub-group (via the DHRO and subsequently the Home Office.

Templates

64. The IMR and chronology should be completed using the template provided by the DHRO. The precise format of IMRs will depend on the features of the homicide/ death in question, but the basic features will mirror the format described in the Statutory Guidance.

65. The report should be a 'standalone' document encapsulating information from the chronology in a summarised form, sufficient for the facts of the family history and agency involvement to be clear. Where this has not been demonstrated, the Review Panel may ask the IMR author to complete further work on the report.

Recommendations arising from early draft Overview reports

66. As soon as draft recommendations for partnership bodies (such as the SLP, the LSCPB, the LSAB etc.) are created, they should be forwarded to the single or multi-agency group that they are attributed to. The Panel should ask:

- what is the accountable body for the recommendation(s) and any subsequent actions?
- who will be responsible for providing quarterly updates on progress to the DHR subgroup?
- is/are the recommendation(s) realistic and meaningful?
- who is going to hold responsibility for shaping the recommendation(s) into the aims/outcome desired and action(s) required?

Identification convention for IMR Authors

67. IMRs must include the real names of practitioners and service users. Only after the final draft of the DHR reports are complete will the Author assign pseudonyms to those referred to in the reports.

Engagement with family members and other interested parties

68. The Introductory letter from the Chair should not be sent to the family until after first panel meeting, where the police panel representative should confirm who are likely to be witnesses in the case.

69. Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder. The DHRO and the chair/author should make every effort to include the family and ensure that, when approaching and interacting with the family, the Panel follows best practice.

70. The Chair and review panel will help establish a positive experience for family and friends by offering clear communication about the process from the outset and throughout the review.

The use of witness statements in the DHR process

71. Witness statements given to the Police during criminal proceedings (investigation and/or prosecution) can be requested for the purposes of a DHR.

72. Statements that are made to the Police are done so in anticipation that they are likely to only be used in the criminal proceedings and not for any other purpose. At the earliest convenient point in the DHR the Chair/Author should liaise with the police panel representative to discuss with the investigating officer key people identified through any criminal process and the timeline/appropriateness of an offer of engagement in the DHR process.

73. The Chair/Author, if gaining information direct from witness statements, has to be very clear in the DHR reports of any text that directly relates to information gained from those witness statements so that appropriate permission and redaction takes place prior to publication of the report.

Content of the Overview Report

74. The overview report should bring together and draw overall conclusions from the information and analysis contained in the IMRs, and reports or information commissioned from any other relevant interests. The overview report and executive summary are drafted by the Review Panel author, and then approved by the Review Panel Chair (if the roles are separate).

75. The Overview report should be produced according to the statutory DHR guidance and the local action plan template.

76. The findings of the review should be regarded as 'Official' as per the Government Security Classification Scheme until the agreed date of publication.

77. The report author should, in their final reports, make reference to any requests to delay the planned work of the DHR panel, and include a copy of the written request as an appendix, so that it can clearly be understood why the request was made, taking into account any data protection restrictions.

78. At the conclusion of the Review Panel's work, it should satisfy itself that the criteria on which the Home Office's Quality Assurance Panel will assess the review, have been met. Namely that:

    a) the review has spoken with the appropriate agencies, voluntary and community sector organisations, and family members and friends, to establish as full a picture as possible;

    b) the report demonstrates sufficient probing and critical analysis and the narrative is balanced;

    c) lessons will be learnt and that the LCSP has plans in place for ensuring this is the case;

    d) the likelihood of a repeat homicide is minimised.

DHR Panel action on receiving Overview Report and Executive Summary

79. On being presented with the draft overview report and executive summary the review panel will:

    a) ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the reports.

    b) be satisfied that the reports accurately reflect the review panel's findings.

    c) ensure that the reports have been written in accordance with this guidance; and

    d) be satisfied that the reports are of a sufficiently high standard for them to be submitted to the Home Office

    e) forward a copy of the overview report, executive summary, and the action plan, *once endorsed by the DHR Panel*, to be scheduled for the next meeting of the LCSP's DHR sub-group.

The Action Plan

80. The overview report should also make recommendations for future action which the review panel should translate into a specific, measurable, achievable, realistic, and timely (SMART) action plan. The action plan will set out who will do what, by when, with what intended outcome and clearly describe how improvements in practice and systems will be monitored and reviewed. The Action Plan must form part of the final draft overview report and executive summary and be agreed by Panel members prior to submission to the LCSP DHR subgroup.

Family engagement

81. The family should be offered the opportunity to read the draft report once the review panel think it is ready to progress to the LCSP sub-group. The family should be able to read the report **prior to anonymization** and be invited to comment in general on the report's contents, preferred pseudonyms, and their experience of the review process. Comments can be invited, but not limited to:

- Matters of accuracy
- Thoughts on what the key periods were.
- Thoughts on what the local and national learning should be.

Action by the LCSPs DHR sub-group on receiving Overview Report and Executive Summary

82. It is preferable that the Chair/Author should attend the LCSP's DHR sub-group meeting at which the Overview Report, the Executive Summary and the Action Plan is to be signed off. For clarity, this meeting should be regarded as 'The sign-off' meeting.

83. In addition, the City Council Communications Lead should be invited to attend and contribute on behalf of the LCSP.

84. The Review Group should consider the documents against the Home Office quality assurance panels assessment criteria and learning across other local DHRs.

85. The Review Group are asked to endorse (or not) the documents for onward transmission to the Chair of the CSP, with a record of their comments.

86. The review group will then either with a recommendation to the CSP Chair to accept the documents and their submission to the Home Office's Quality Assurance Panel or refer the document back to the review panel for further work.

Action by the Chair of the LCSP on receiving the Overview Report, Executive Summary and Action Plan

87. On receiving the documents, the Chair of the CSP will:

a) consider approving the content of the overview report, executive summary, and action plan,

b) sign off the overview report, executive summary, and action plan.

c) direct the DHRO to:

- complete the form on page 41 of the statutory guidance, which is not for publication and will be used by the Home Office for data collection purposes.
- submit a copy of the overview report, executive summary, action plan and data collection form to the Home Office via a secure email to: DHREnquiries@homeoffice.gov.uk.

Quality Assurance

88. The DHR Panel has an important role in quality assuring draft reports as they develop. With each iteration of a draft DHR Overview Report, Panel members are asked to consider the report in the light of criteria that will be applied by the Home Office's Quality Assurance (QA) Panel.

89. The LCSP's DHR sub-group shares the responsibility for quality assurance and will consider the final report against the same criteria before recommending approval of the report to the Chair of the CSP.

90. Quality Assurance for completed DHRs rests with an expert panel made up of statutory and voluntary sector agencies and managed by the Home Office.

91. The Quality Assurance Panel will review the DHR and will write back to the area making recommendations for change or agreeing that the report is fit for publication. This letter will also be copied to the Police and Crime Commissioner for Leicestershire.

92. On receipt of the letter from the Quality Assurance Panel, the DHRO will copy the Home Office's response to the Chair/Author, the DHR Panel and the LCSP's DHR sub-group.

93. If a DHR report requires a significant number of changes, the Chair/Author will consider these and provide a response which either accepts the QA panel's view or rejects the view with reason(s) as to why particular changes are not necessary. It may be necessary to reconvene the Panel, or the process of revisions may be managed by email consultation. Once the revised overview report is agreed by the Review Panel, the new version should go for approval to the LCSP's DHR sub-group. A further recommendation on submission to the Home Office is then sent to the Chair of the CSP.

Pre-Publication Planning

94. When the Home Office has given permission to publish the reports, the DHRO should organize a briefing for the Chair of the CSP and other Councilors whose portfolios (e.g., Housing, Social Care etc.) include services that have featured in the reports. The feedback provided by Councilors will inform the Publication planning process.

Requests by the Media for statements

95. During the review, especially at times of trial and inquests there maybe media inquiries put to agencies about the case. If such an inquiry comes through to agencies, it is the receiving agencies responsibility to bring this to the attention of the Chair of the Review Panel and the DHRO.

96. If the inquiry is specifically about the DHR process or the published report this needs to be fed through the Leicester City Council press desk, which will co-ordinate responses on behalf of the partnership. No comments about the DHR should be made without agreed partnership consent.

The Publication Process

97. Under the direction of the LCSP's DHR sub-group, once the Home Office has given its' clearance for the report to be published, a multi-agency publication planning group meeting will be convened to co-ordinate the publication of the final overview report, executive summary and the letter from the Home Office.

98. Prior to this meeting, the DHRO will approach the Chair of the DHR process to obtain the Chair's views about publication arrangements.

99. A template of issues to consider when planning publication is attached at Appendix B.

100. All overview reports and executive summaries should be published, unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen. The reasons for not publishing an overview report and executive summary should be communicated initially to the LCSP's DHR sub-group for its' consideration, and then to the Home Office's Quality Assurance Panel. The Home Office will then respond to the request.

101. The content of the overview report and executive summary must be suitably anonymised to protect the identity of the victim, perpetrator, relevant family members, staff, and others and to comply with the Data Protection Act 2018. This means redacting non-essential identifiable information appropriately before publication. This is the responsibility of the DHRO, once they have received the confirmation from the LCSP's DHR sub-group that the final draft has been agreed for publication.

102. IMRs will not be made publicly available. The aim in publishing these reviews is to restore public confidence and improve transparency of the processes in place across all agencies to protect victims.

103. Publication of overview reports and executive summaries will take place following agreement from the Home Office Quality Assurance Panel and will be published on the appropriate city council web page for a period of 36 months, based on the views of panel agencies and the family, where engaged. The DHRO will supervise this.

Supporting the family

104. The DHRO and Independent Chair/Author will involve the family in setting a publication date and check that they are aware of the publication arrangements and the likely impact this may have. This will include identifying whether further support, referral or signposting is required to address any unmet need.

PART FOUR: REPORTING ON THE WORK OF THE SLP'S DHR SUB-GROUP

105. The Chair of the CSP Executive, and City Council Lead Member for Domestic Abuse will receive regular reports about the progress of DHRs. These updates will take part in a confidential slot on the agenda.

106. In addition to this ongoing reporting, the DHR sub-group is committed to providing a written report to the LCSP Executive every 6 months. This report will address issues including:

- Volume of work
- Learning and Improvement, including dissemination of key messages
- Timeliness of the work
- Ongoing developmental tasks
- Finance, including commitments made.
- Risks to the Partnership associated with DHR work.

PART FIVE: LEARNING FROM DOMESTIC HOMICIDE REVIEWS

107. The LCSP is committed to ensuring that learning arising from DHRs and associated quality assurance processes are shared with staff working across local agencies. Such learning will inform the continual improvement across all services in the Partnership, to make children, families, and adults safer.

108. The learning and improvement framework sets out how the learning from DHRs will be derived and disseminated. The Framework is included at Appendix C.

109. The collection and analysis of data from DHRs allows the partnership to understand patterns and themes within the reviews, including equality issues, recurring recommendations, and demographics within the cohort.

110. Headline data from local DHRs, updated annually, will be published on the LCSP's webpage within the City Council website.

PART SIX: GLOSSARY

Acronym/ Abbreviation	Full title
BME	Black Minority Ethnic
CPS	Crown Prosecution Service
DHR	Domestic Homicide Review
DSV	Domestic and Sexual Violence
FLO	Family Liaison Officer
HO	Home Office
IMR	Independent Management Report
LGBT	Lesbian, Gay, Bisexual, Transgender
LSAB	Leicester Safeguarding Adults Board
LSCPB	Leicester Safeguarding Children Partnership Board
NHS	National Health Service
QA	Quality Assurance
SIO	Senior Investigating Officer
SLP	Safer Leicester Partnership (Leicester's Community Safety Partnership)
SMART	Specific, measurable, achievable, realistic and timely

APPENDICES

APPENDIX A: Blank form to make a referral for a DHR

APPENDIX B: Process summary

APPENDIX C: Issues to consider when planning publication

APPENDIX D: Learning and Improvement Framework

APPENDIX A

Blank form to make a referral for a DHR

Each agency should ensure that serious incidents which may meet the criteria for a Domestic Homicide Review (DHR) are brought to the attention of the Leicester Community Safety Partnership (LCSP) using this form. Please ensure that a robust assessment of the criteria is included and if it does not meet the threshold for a DHR what alternative review or audit could yield useful learning. All cases that are being considered should be notified to your agency Safeguarding Lead as soon as possible and they will ensure that the information known to the agency is made available and shared appropriately with the LCSP DHR sub-group.

After considering the referral the Safeguarding Lead Person should forward any cases for consideration to the LCSP office secure Email: DomesticHomicideReview@leicester.gov.uk.

If you have any queries on whether to refer a serious incident, or how to make a referral, please telephone the Domestic Homicide Review Officer, on 0116 454 6270.

REFERRER'S DETAILS

NAME	AGENCY & JOB TITLE	CONTACT DETAILS – telephone number and e-mail address

Signature of referrer:

Date of referral to Safeguarding lead:

SAFEGUARDING LEAD'S DETAILS

NAME	AGENCY & JOB TITLE	CONTACT DETAILS – telephone number and e-mail address

Signature of Safeguarding Lead:

Date of referral to LCSP:

SECTION 1

1.1 DETAILS OF THE DECEASED PERSON

Full name of Deceased Person	
Date of Birth	
Date of Death or Serious Incident	
Home address	
Sex	
Sexual orientation	
Ethnicity	
Country of Birth	
Religion of Belief	
Did the deceased person have caring responsibilities (if yes, please give details)	
Vulnerabilities (state yes [and if yes, the extent if known], no or not known)	
Mental ill-health	
Problematic drug use	
Problematic alcohol use	
Pregnancy in last 12 months	
Physical disability	
Learning disability	
Significant relationships to adult: (partner/ carer/ family members)	
Was deceased person accessing Services before the homicide? If so, which Services?	
Had the deceased person experienced domestic abuse by a current or previous partner or family member? If so, what details are known?	
Had the deceased person's case been heard at MARAC? If so, when?	

1.2 DETAILS OF OTHERS RESIDING AT THE VICTIM'S ADDRESS

Name	Date of Birth	Contact Details –Telephone number and E-mail Address	Relationship to Victim

1.3 THE FATAL INCIDENT

Address of location of incident(s)	
Who is the lead investigator?	
Could this case form part of an investigation of multiple victims or offenders?	
Have any simultaneous referrals to the Leicester Safeguarding Adults Board and/or the Leicester Safeguarding Children's Partnership Board been made (or are planned to be made) in relation to this incident?	

1.4 SUSPECT/PERPETRATOR DETAILS

Full name of Suspect/Perpetrator	
Date of Birth	
Date of Death or Serious Incident	
Home address	
Sex	
Sexual orientation	
Ethnicity	
Country of Birth	
Religion or Belief	
Did the Suspect/Perpetrator have caring responsibilities (if yes, please give details)	
Vulnerabilities (state yes [and if yes, the extent if known], no or not known)	
Mental ill-health	
Problematic drug use	
Problematic alcohol use	
Pregnancy in last 12 months	
Physical disability	
Learning disability	
Significant relationships to Suspect/Perpetrator: (partner/ carer/ family members)	
Was suspect/perpetrator accessing Services before the homicide? If so, which Services?	

Had the suspect/perpetrator perpetrated domestic abuse against a previous partner or family member? If so, what details are known?	
Was suspect/perpetrator managed/supervised by any of the following?	
MAPPA	
National Probation	
Community Rehabilitation Company	
Attended or Attending Perp Programme	

1.5 DETAILS OF OTHERS RESIDING AT THE SUSPECT'S ADDRESS

Name	Date of Birth	Contact Details –Telephone number and E-mail Address	Relationship to Victim

1.6 THE RELATIONSHIP BETWEEN THE DECEASED AND THE SUSPECT/PERPETRATOR

Are any of the following known or believed to be factors in the relationship between the deceased and the suspect/perpetrator?	
Forced Marriage	
Honour-based Violence	
Physical violence	
Coercive Control	
Stalking	
Digital Stalking	
Financial Abuse	
Trafficking	
Kidnapping	
Immigration Issues	

1.7 OTHER AGENCIES WITH KNOWN INVOLVEMENT

Agency	Contact Details – Name of contact, Telephone number and E-mail Address	Reason for involvement

1.8 BRIEF SUMMARY OF CASE

Please outline the events and circumstances:
PLEASE NOTE: The information you provide will be used to help establish whether the case meets the criteria for a DHR.

1.9 CRITERIA FOR A DHR

From information known to the referrer:

	Criteria	Yes	No
This criterion must be met in all cases[1]	Is the deceased person aged 16 or over?		
One of these criteria must be met, **in addition to the first one above**	Has the death, or does the death appear to have, resulted from violence, abuse or neglect by— (a) a person to whom the deceased was related or with whom he was or had been in an intimate personal relationship		
	Has the death, or does the death appear to have, resulted from violence, abuse or neglect by— (b) a member of the same household as himself,		
	Did the deceased take their own life (suicide) and the circumstances gave rise to concern?[2]		

From: "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (*Home Office, December 2016*)

13. Under section 9(1) of 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) a person to whom the deceased 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.

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

[1] Paragraph 13
[2] Paragraph 18

18. Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive 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.

For reference:

Leicester City Domestic Homicide Review Protocol 2020

https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-safety/leicester-community-safety-partnership/domestic-homicide-reviews-dhrs/.

SECTION 2

2.1 FOR COMPLETION AT DHR SUBGROUP CONSIDERING THE REFERRAL

Does the referral meet the criteria for a DHR?	Yes / No
Who are 'relevant people' for the purposes of trawling?	
How many years prior to the death should agencies be asked to trawl for the relevant people?	

SECTION 3

3.1 FOR COMPLETION BY THE DHR OFFICER:

Date referral received by email:	
Referral considered by LCSP DHR sub-group on:	
Recommendation of sub-group:	
Recommendation notified to CSP Chair on:	
Recommendation notified to Home Office on:	

APPENDIX B

How Leicester's Domestic Homicide Review reports are produced.

Month 1

- When a referral for domestic homicide review is received, a sub group of the Leicester Community Safety Partnership (LCSP)checks whether the referral meets the criteria for producing a domestic homicide review report (DHR). The group identifies any dual referrals and other responsible bodies and makes a recommendation to the Chair of the LCSP.
- They notify the Home Office, the victim's family and the coroner. They must avoid any unnecessary delay and seek learning as early as possible.

Month 2 to 3

- Agencies who can give information about people in the scope of the review are contacted
- A panel is formed to oversee the review and an independent chair/author is appointed.
- The domestic homicide review officer (DHRO) begins to work with panel members on the chronology
- The DHRO identifies and establishes contact with any family advocate, and identifies the needs and views of the family

Month 4 to 6

- The DHR Panel meets at key points to pull out key learning.
- The chair of the panel or report author drafts the report, checking that Home Office quality assurance criteria are met. The family are given the opportunity to review the final draft.

Month 6-12

- The final report goes before the LCSP sub-group for recommendation of submission, and on to the CSP Chair.
- The reports (Executive Summary and Overview Report) are submitted to the Home Office for review.
- The report is edited following any advice received from the home office. A further submission might be required
- The family is kept updated.

Month12-18

- Publication of the final report is planned in liaison with the family, and the report and associated information are published on the Leicester City Council website for between 12 and 36 months.

APPENDIX C: ISSUES TO CONSIDER WHEN PLANNING PUBLICATION

Contact the DHR Chair/Author prior to the planning meeting to see if he/she has any issues of note to contribute to the Publication Planning process.

	DOMESTIC HOMICIDE REVIEW PUBLICATION PLANNING MEETING HELD ON XX/XX/XXXX **List those partners and agencies attending the planning meeting and involved in the planning discussion:** • xxx Add details as necessary xxx		
	Issues for consideration	**Notes**	**Action (what, by whom and timescale)**
1.	Authority from the Home Office that reports are fit for publication	Received in the HO letter dated [X]	
2.	Does Chair/Author have any issues of note to contribute to the Publication Planning process?	Contacted [when?]. Reply was: [what?]	
3.	Does the report contain any information derived from non-IMR sources? E.g., Witness statements, Media reports, Interviews with Family, Friends, employers. Is this information appropriate to include for publication? Could any of this information lead to individuals being identified?		

	Issues for consideration	**Notes**	**Action (what, by whom and timescale)**
4.	Are there compelling reasons relating to the welfare of any children or other persons directly concerned in the review for full publication not to happen? If so, this should		

	be communicated to the Home Office's QA Panel.		
5.	Victim's Family viewpoint on the final review report, key learning and publication, including dates.	Date of discussion: Main points:	
6.	Are further changes necessary to the reports prior to publication; for example, further redaction?		
7.	Is the publication likely to draw media attention?		
8.	Is the publication likely to prompt family/friends to appear in the media? What actions may be necessary to respond to this?		
9.	Is it necessary to prepare a reactive statement if the LCSP is approached for a comment?		
10.	Set proposed date to brief Lead Member on plans for publication.		
11.	Set proposed date for publication of reports on City Council's LCSP webpage.		

	Issues for consideration	Notes	Action (what, by whom and timescale)
12.	Which partner agencies need to be made aware of the plans to publish the reports on a given date?	City Safeguarding Partnership Office L&R Safeguarding Board Office Police & Crime Commissioner's Office DHR sub-group member agencies Agencies represented on the DHR Panel	
13.	Who will contact family/friends/AAFDA to tell them what the plans are for publication?		
14.	Who will contact Home Office to tell them what the plans are for publication?		
15.	Who else needs to be briefed/notified following this meeting? (Politicians, Chief Execs of local agencies etc.)		
16.	Are there any other issues to be considered that have not been listed on this template pertinent to this specific review?		

APPENDIX D: LEARNING & IMPROVEMENT FRAMEWORK

Leicester DHR Learning and Improvement Framework

Approved by the Leicester Community Safety Partnership's (LCSP)

1. Introduction

1.1 Working together to make our communities safer is the primary aim of the Leicester Community Safety Partnership (LCSP). It is essential that both professionals and organisations learn lessons when things don't go right, and equally importantly, when they do.

1.2 The Partnership and its' member agencies seek to ensure that each lesson identified, drives improvement.

1.3 An important statutory function of the LCSP, as the local Community Safety Partnership, is the review of Domestic Homicides. At the core of this work, is the commitment to ensuring that local agencies understand the events leading to a death, and the ways in which those same agencies and others can help to protect members of the public in the future.

1.4 The Partnership is committed to ensuring that learning arising from Domestic Homicide Reviews and associated quality assurance processes are shared with staff working across local agencies at all levels. Such learning will inform the continual improvement across all services in the Partnership, to make children, families and adults safer.

1.5 To do this, the LCSP introduced a DHR learning and improvement framework in 2018. To ensure that this framework is effective, the LCSP monitors impact and reviews every three years, via the DHR subgroup of the LCSP.

2. Domestic Homicide Reviews

Legislation

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

Statutory Guidance

2.2 The original multi-agency statutory guidance for the conduct of Domestic Homicide Reviews was issued in 2011.

2.3 In December 2016, the Home Office published the document "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews". To complement the statutory guidance, the Home Office published key findings from analysis of DHRs across England and Wales.

Purposes of DHRs

2.4 The main purposes of Domestic Homicide Reviews are to:

- prevent domestic violence and homicide, and to
- ensure that abuse is identified and responded to effectively at the earliest opportunity by improved service responses for victims, which have a co-ordinated multi-agency approach.

Local DHR procedures

2.5 The Leicester DHR Protocol (2023) is the local procedural version of the Home Office's statutory guidance. The two documents should be consulted together to provide the most complete view of the overall DHR process.

3. Deriving and using the learning from DHRs

The learning and improvement process;

1. DHR evaluates local agencies practice
2. Learning is derived from the analysis
3. Actions for improvement
4. Dissemination of the learning
5. Learning is embedded in better practice
6. LCSP's subgroup monitoring role

The DHR process

3.1 The process enshrined in the Protocol document referred to in paragraph 2.5 aims to derive learning from both single-agency and multi-agency (partnership) perspectives.

Support for report authors

3.2 A training resource is available to assist IMR authors who provide Individual Management Review (IMR) reports for Domestic Homicide Reviews. The resource covers:

- Statutory duties
- Terminology
- Best practice

- Links to other processes
- The role of a review report author
- How to confidently plan and conduct an enquiry
- Understanding the components of a high quality, professional review report

Process learning

3.3 In the course of conducting reviews, new challenges arise associated with each case. These challenges (and the responses to them) are recorded by the LCSP Office-DHR officer[DHRO], and such learning is reported to the LCSP subgroup through the DHR related activity report, received at every monthly meeting.

3.4 Any necessary changes to reflect process learning are subsequently incorporated into the Protocol document either immediately or at the point of annual review of that document, as appropriate.

3.5 From 2021 there has been a commitment to make the briefing sessions for the authors of Individual Management Review reports (IMRs) routine rather than 'on request'.

The learning derived from the analysis and actions for improvement

3.6 The learning arising from the death that is the subject of the review, is incorporated into formal recommendation(s) for action in the final DHR Overview Report. These recommendations and actions may be local, regional or national in their scope.

3.7 The 2016 key findings document on DHRs conducted by the Home Office catalogued recommendations as follows in the list below. These headings are used locally in understanding common themes.

- Technology/ Systems
- Guidelines
- Identification of risk
- Training
- Policy
- Inter-agency communication
- Multi-agency working
- Record keeping
- Awareness raising
- Report on/share action plan/findings

3.8 Independent Chairs of reviews are asked to categorise DHR actions emerging from Leicester reviews against these headings.

3.9 Before draft recommendations are finalised there is a process for checking that the organisation or partnership that will be accountable for ensuring that the actions required to meet the recommendation are completed, have accepted the recommendation and briefed relevant leads appropriately.

3.10 Throughout the DHR process, the Independent Chair/Author is asked if there is any 'Critical Early Learning' arising from the review that requires the Partnership or individual Agencies to take immediate corrective action. This is then reported to the LCSP as part of the 'Open

DHRs' summary provided at every subgroup meeting. Following the meeting a redacted version of the open DHRs summary sheet is forwarded by the LCSP DHR sub chair to the LSAB and LSCPB review subgroups. This process is summarised in the diagram at Appendix A.

3.11 The analysis of each published DHR is included as part of the annual DHR Data report. The report sets out what is known about the domestic homicide reviews that have opened in Leicester and draws out comparisons as far as possible, with other national studies. This report is updated annually and shared with key strategic leads.

Dissemination of the learning

3.12 Explicit in the statutory guidance is the requirement to share the learning. Paragraph 109 states: "*DHRs are a vital source of information to inform national and local policy and practice. All agencies involved have a responsibility to identify and disseminate common themes and trends across review reports, and act on any lessons identified to improve practice and safeguard victims*".

3.13 Key learning from DHRs is arrived at through the DHR Panel's analysis of the available evidence. Individual Management Reviews of practice enables partner agencies to identify learning where it relates not only to their own organisation, but also to the quality of partnership working. Where such learning is identified, the expectation is that the agency concerned makes whatever changes are necessary to improve safeguarding in its' practice. The agency should not wait for the DHR process to conclude, to act on the learning and to deliver single-agency training and/or briefings.

3.14 The LCSP (via the DHRO) will:

a) Publish each DHR's Overview report, Executive Summary and the Home Office's feedback letter on its' website for a period of three years.

b) Maintain the Domestic Homicide Review data summary provided on the SLP's webpage.

c) Ensure that 'early' learning identified (as in paragraph 3.7, above) is promptly brought to the attention of the DHR subgroup and relevant partnerships, to ensure that immediate actions are carried out, where necessary.

d) Produce a double-sided A4 Learning Summary Sheet of the key messages arising from each DHR once each review process has been concluded. These are short but succinct guides that capture the main aspects of each case.

e) Offer 'Learning from DHRs' workshop sessions as part of the multi-agency Domestic & Sexual Violence Training Programme.

f) Produce Briefing Presentations, which will be made available to Safeguarding Leads, the Leicester, Leicestershire & Rutland Domestic and Sexual Violence Operational Group and other key stakeholders, to assist in the sharing of key messages within their own agencies/organisations.

g) Share findings into the development and content of inter- and multi-agency training on domestic violence and abuse with the domestic violence and sexual violence team .

h) Undertake annual analysis into Leicester DHRs and compare against national and other regions findings to better understand the risks to the local population and areas for improvement.

i) Use collated learning in campaign and promotional material developed by the domestic and sexual violence team, where appropriate.

j) Use the Leicester City Council hosted LCSP web page and the DSV Team's Twitter account to disseminate key messages and direct people to additional resources.

k) Be creative, continually develop and improve the ways in which learning is disseminated across Leicester to best effect.

Embedding learning into front-line practice

3.15 Another way in which the learning is utilised (and one of the most common themes for recommendations from DHRs nationally) is the way in which learning translates to policy/procedures, and then how this is reflected in front-line practice.

3.16 The findings of DHRs will be routinely shared by the DHRO with the subgroups responsible for the development of safeguarding policies and procedures for children and adults, across Leicester, Leicestershire and Rutland.

3.17 Partner agencies have a responsibility to use the findings from DHRs as part of their support for Team/Service meetings, Reflective Practice and Supervision.

The oversight provided by the LCSP's DHR subgroup

3.18 In addition to commissioning, receiving progress reports and endorsing the findings of DHRs, the LCSP's DHR subgroup has a responsibility to monitor the actions arising from DHRs.

3.19 On a quarterly basis the subgroup reviews progress against DHR actions. The subgroup may also commission specific work to test the effectiveness of completed actions.

3.20 The LCSP DHR subgroup will raise matters regarding learning and improvement, where relevant, to the CSP Executive and Chair.

4. Other sources of learning

4.1 Learning to safeguard communities does not only derive from DHR processes. Front-line practice and DHR process learning is informed from a variety of other sources and quality assurance processes.

DHRs conducted by other Community Safety Partnerships

4.2 Links with the Leicestershire and Rutland Safeguarding Board Office (which co-ordinates DHRs in the county) provide mutual opportunities to share DHR learning. As DHR reports by other Community Safety Partnerships and research bodies come to attention via news media, and the Domestic and Sexual Violence and Abuse Operational Group, these will be saved by the DHRO for reference purposes.

Service User Accountability

4.3 The DHRO takes data reports and developments to the Domestic and Sexual Violence Service User Scrutiny and Reference Group for feedback.

Involvement of Family, Friends and Other Support Networks

4.4 The LCSP recognises that the quality and accuracy of a DHR is likely to be significantly enhanced by family, friends and wider community involvement. Families are given the opportunity to be integral to reviews and are treated as a key stakeholder.

4.5 The learning emerging from family, friends and other third parties engaged in a DHR process, both process learning and specific to that individual DHR, will be identified and collated by the DHR panel throughout the review and there are specific prompts and milestones to seek this feedback if family members choose to engage.

Appendix A: Sharing learning from DHRs

How does the Chair/Author of the DHR raise critical early learning about partnership working issues?	How does the Chair/Author of the DHR raise critical early learning about single agency working issues?	How are partnerships made aware of emerging learning (*not critical early learning*) /recommendations arising from the Panel process/report drafts?
↓	↓	↓
• Item on each Panel agenda "Is there any critical early learning that needs to be passed on?" • Monthly e-mail exchange with Chair/author asking the same question (between Panel meetings) • Requirements set out in contract with Chair/Author	The Chair/Author raises the critical early learning with the Panel Member from the relevant single agency.	• Each review group referral and information gathering template asks whether key identifiers present for: domestic abuse/ adult with care and support needs/ child safeguarding to allow for aggregate data collation • Each Panel and review group agenda has a specific item: "Notifications of learning relevant to other Partnerships"
↓	↓	↓
What is done with the critical early learning raised by the Chair/Author?	**What is done with the critical early learning raised by the Chair/Author?**	**What is done with the emerging learning/recommendations identified by the Panel?**
↓	↓	↓
• It goes to the monthly partnership DHR subgroup/ review group to decide how to respond • The Chair of that group will pass on as appropriate to the chair(s) of other local review groups.	• The Panel Member from the relevant single agency has a duty to raise this with their Managers to enable them to decide how to respond.	• The Panel/Review group agrees who will share the learning and the timeframe for this