Safer Leicester Partnership
Working together for a safer City

LEICESTER CITY
DOMESTIC HOMICIDE REVIEW PROTOCOL
2020

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 co-ordinated 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 Safer Leicester Partnership (SLP). The SLP DHR sub-group carries out the required work for the SLP Executive with office support from the domestic and sexual violence team within Leicester City Council (Community Safety Service).

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. Referrals should be sent to slpoffice@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 Community Safety and Protection and the DHR Officer by email at the following address: SLPOffice@leicester.gov.uk .

11. The Police (or other agency) will keep the Leicester City Council Head of Community Safety and Protection informed as the circumstances around the death are clarified. The Police Detective Chief Inspector for Adult Safeguarding (if Police identification) submits a referral form to the DHR Officer at this point.

12. The Police Detective Superintendent for Safeguarding 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 SLP DHR sub-Group Chair might, if the SLP 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 SLP 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 DHR Officer 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 in order to make a decision on SAR criteria being satisfied,

    the DHR Officer 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 SLP DHR Sub-Group Chair might, if the SLP 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 SLP 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 give consideration to 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 Community Safety and Protection 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 SLP's decision on the recommendation has been made, the Domestic Homicide Review Officer (DHRO) will notify the Chair of the SLP'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 SLP.

Timescales

25. The decision to proceed with a review, or not, should be taken by the chair of the SLP **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.). The presence of the investigating officer at the first meeting of the convened review panel should be secured wherever possible. 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 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, analysing Independent Management Reports (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.

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

Notifying the Home Office

29. The DHR Officer (DHRO), on behalf of the SLP, 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.gsi.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 DHR Officer, on behalf of the SLP, and generally through liaison with the Family Liaison Officer (within the Police) 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 DHR Officer, on behalf of the SLP, will inform the victim's family, in writing, of its decision. The SLP DHR Group will take account of the timing and appropriateness of such a notification, given other parallel processes, where there are criminal proceedings following liaison with the investigating officer and Family Liaison Officer (FLO) and having waited for the response from the home office to that decision.

Notifying the Coroner

33. Where the decision to proceed with a Review is taken, the DHR Officer, on behalf of the SLP, should at the same time also 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 Senior Investigating Officer (or equivalent) 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 DHR officer 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 SLP'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 DHR officer and presented to the next SLP DHR sub-group meeting. Once the SLP's DHR sub-group knows which agencies have had involvement 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 SLP 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 SLP 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 by the trawl returns, the DHR officer 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 DHR officer, 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 DHR Officer, together with the DSV Team Manager and the Chair of the SLP'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 DHR Officer will liaise with, and 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 DHR Officer 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 DHR Officer, 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 SLP 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 Officer will inform the Chair/Author of the sub-group's decision.

Supporting the DHR process

56. The DHR Officer 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 DHR Officer will establish appropriate secure filing systems for DHR related information within the DSV Team 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 andits' 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 programme (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 Individual Management Review report and chronology should be completed using the template provided by the DHR Officer. The precise format of IMRs will depend on the particular features of the homicide, 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 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.

Identification convention for IMR Authors

66. 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

67. The Introductory letter from the Chair should not be sent to the family until after first panel meeting, where the Senior Investigating Officer (or equivalent) should confirm who are likely to be witnesses in the case.

68. 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.

69. 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

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

71. 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.

72. 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

73. 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).

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

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

76. 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.

77. 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 SLP 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

78. 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 SLP's DHR sub-group.

The Action Plan

79. 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 should 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 report prior to submission to the SLP DHR sub group.

Family engagement

80. The family should be offered the opportunity to read the draft report once the review panel think it is ready to progress to the SLP sub-group. The family should be able to read the report **prior to anonymization** and be invited to comment in general on the reports 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 SLP's DHR sub-group on receiving Overview Report and Executive Summary

81. It is preferable that the Chair/Author should attend the SLP'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.

82. The Review Group should consider the documents against the home office quality assurance panels assessment criteria and learning across other local DHRs.

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

84. The review group will then either with a recommendation to the SLP 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 SLP on receiving the Overview Report, Executive Summary and Action Plan

85. On receiving the documents, the Chair of the SLP 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 DHR Officer 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.gsi.gov.uk.

Quality Assurance

86. 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.

87. The SLP'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 SLP.

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

89. 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.

90. 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 SLP's DHR sub-group.

91. 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 SLP's DHR sub-group. A further recommendation on submission to the Home Office is then sent to the Chair of the SLP.

Requests by the Media for statements

92. 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 DHR Officer.

93. 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

94. Under the direction of the SLP'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.

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

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

97. 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 SLP'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.

98. The content of the overview report and executive summary must be suitably anonymised in order 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 DHR Officer, once they have received the confirmation from the SLP's DHR sub-group that the final draft has been agreed for publication.

99. 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.

100. 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 12-36 months, based on the views of panel agencies and the family, where engaged. The DHR Officer will supervise this.

Supporting the family

101. The DHR Officer 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

102. The Chair of the SLP 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.

103. In addition to this ongoing reporting, the DHR sub-group is committed to providing a written report to the SLP 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

104. The Safer Leicester 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. Such learning will inform the continual improvement across all services in the Partnership, to make children, families and adults safer.

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

106. 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.

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

PART SIX: GLOSSARY

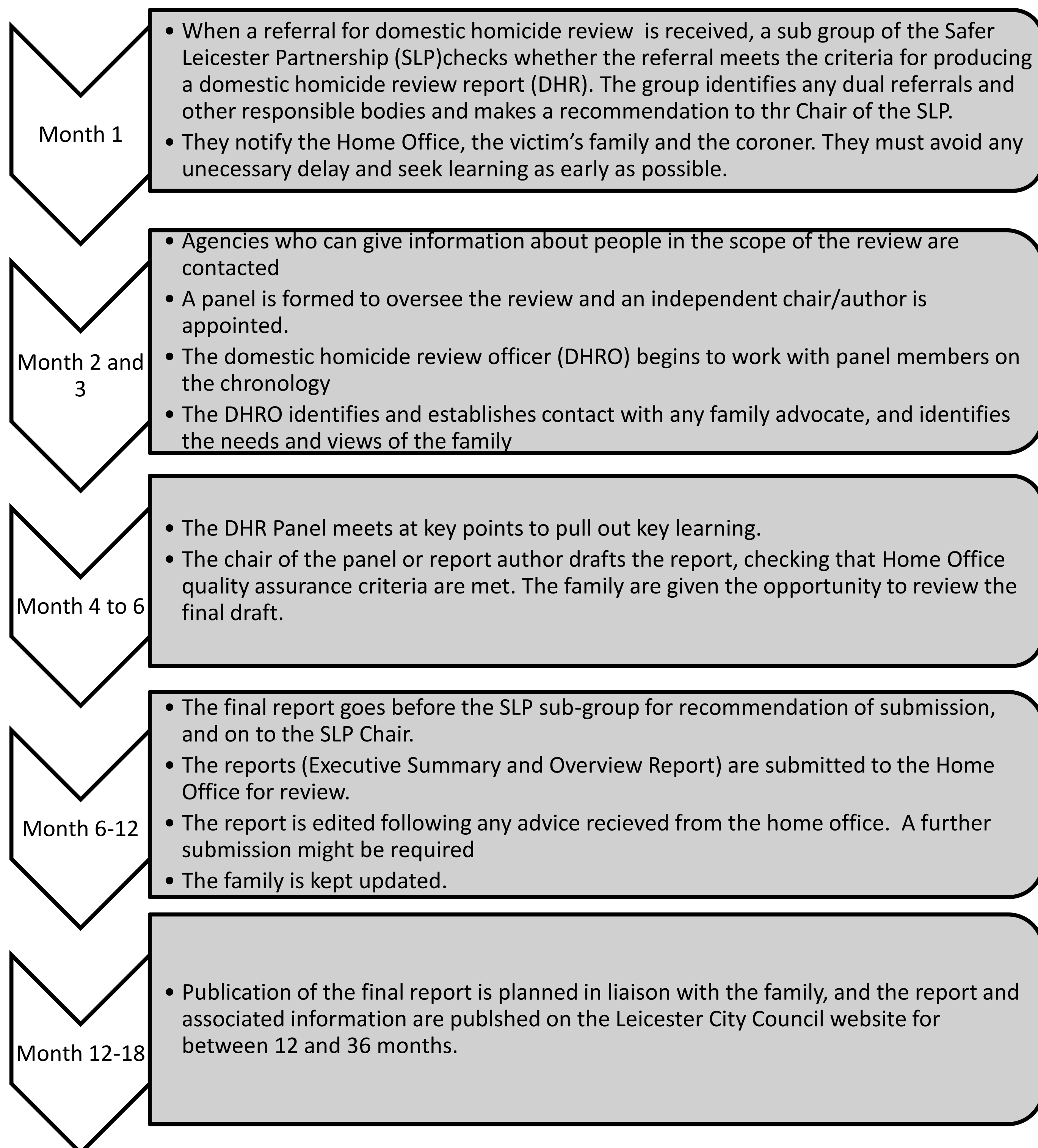
Acronym/ Abbreviation	Full title
BME	Black Minority Ethnic
CPS	Crown Prosecution Service
DHR	Domestic Homicide Review
DSV	Domestic and Sexual Violence
FLO	Family Liaison Officer
HO	Home Office
IMR	Independent Management Report
LGBT	Lesbian, Gay, Bisexual, Transgender
LSAB	Leicester Safeguarding Adults 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:	Process summary diagram
APPENDIX B:	Issues to consider when planning publication
APPENDIX C:	Learning and Improvement Framework

APPENDIX A

How Leicester's domestic homicide review reports are produced



APPENDIX B: 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.

<table>
<tr><td></td><td colspan="3">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:
• John Leach (Chair, and Director of Neighbourhood & Environmental Services, Leicester City Council)
• Daxa Pancholi (Deputy Chair, Manager of the Safer Leicester Partnership, and Head of Community Safety & Protection, Leicester City Council)
• Debra Reynolds (Media & PR Manager, Leicester City Council)
• Stephanie McBurney (Team Manager of the Domestic & Sexual Violence Team, Leicester City Council)
• Mark Fitzgerald (Domestic Homicide Review Officer, Leicester City Council)
• Panel members
• Communications Leads from Agencies represented on the DHR Panel (to be added)</td></tr>
<tr><th></th><th>Issues for consideration</th><th>Notes</th><th>Action (what, by whom and timescale)</th></tr>
<tr><td>1.</td><td>Authority from the Home Office that reports are fit for publication</td><td>Received in the HO letter dated [X]</td><td></td></tr>
<tr><td>2.</td><td>Does Chair/Author have any issues of note to contribute to the Publication Planning process?</td><td>Contacted [when?].
Reply was: [what?]</td><td></td></tr>
<tr><td>3.</td><td>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?</td><td></td><td></td></tr>
</table>

	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 SLP 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 SLP 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 C: LEARNING & IMPROVEMENT FRAMEWORK

DHR Learning and Improvement Framework

Version endorsed by the Safer Leicester Partnership's (SLP) Domestic Homicide Review (DHR) sub-group on 15/09/20

1. Introduction

1.1 Work to address Community Safety is complex, demanding and necessary. Nothing is more important than helping and protecting our communities.

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

1.3 The Partnership and its' member agencies seek to ensure that each lesson identified, drives and sustains improvement in front-line practice.

1.4 An important statutory function of the SLP, 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 services can help to protect members of the public in the future.

1.5 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. Such learning will inform the continual improvement across all services in the Partnership, to make children, families and adults safer.

1.6 To do this, the SLP introduced a DHR Learning and Improvement Framework in 2018. To ensure that this framework is effective, the SLP will monitor its impact and review every three years, via the DHR sub-group of the SLP.

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 new 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:

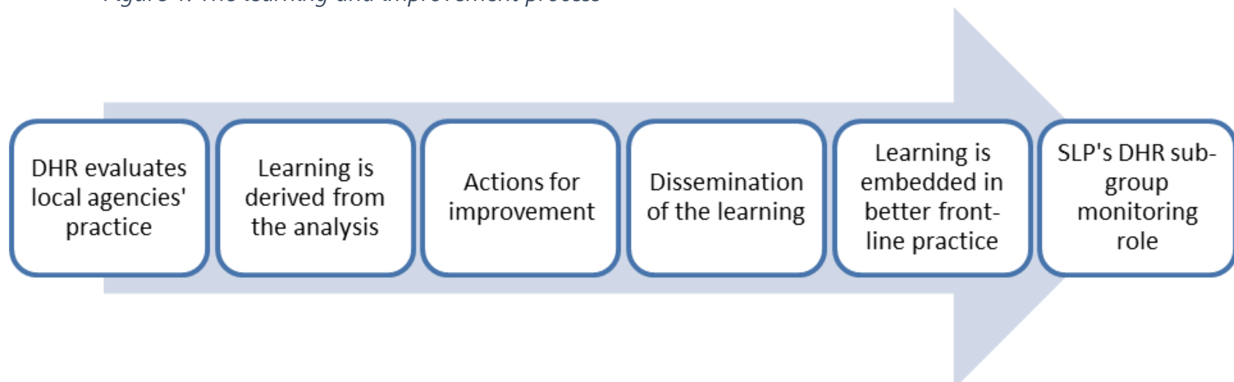
- prevent domestic violence and homicide, and to
- ensure that abuse is identified and responded to effectively at the earliest opportunity by improved service responses for victims, which have a co-ordinated multi-agency approach.

Local DHR procedures

2.5 The Leicester DHR Protocol (2020) 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

Figure 1: The learning and improvement process



The DHR process

3.1 The process enshrined in the Protocol document referred to in paragraph 3.6 aims to derive learning from both single-agency and multi-agency (partnership) perspectives.

Process learning

3.2 In the course of conducting reviews, new challenges arise associated with each case. These challenges (and the responses to them) are recorded by the SLP Office (DHR Officer), and such learning is reported to the SLP sub through the DHR related activity report, received at every meeting.

3.3 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.

The learning derived from the analysis and actions for improvement

3.4 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.

3.5 The 2016 key findings document on DHRs conducted by the Home Office concluded that recommendations for action could be associated with the following 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

3.6 Independent Chairs of reviews will be required to categorise DHR actions emerging from Leicester reviews against these headings.

3.7 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 SLP and the LSAB as part of the 'Open DHRs' summary provided at every sub-group meeting.

Dissemination of the learning

3.8 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".

3.9 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.

3.10 In addition to meeting the requirement to publish the DHR Overview report and Executive Summary on its' website, the SLP (via the DHR Officer and Domestic and Sexual Violence Team within the City Council) will:

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

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

c) Offer ‘Learning from DHRs’ workshop sessions as part of the multi-agency Domestic & Sexual Violence Training Programme, administered by the domestic and sexual violence team.

   The workshops are:

   - Half a day in length, to allow more practitioners the opportunity to attend
   - Free to attend
   - For groups of up to 15 practitioners and managers
   - Accessible to all local agencies
   - Interactive
   - Facilitated by two members from the Domestic & Sexual Violence Team

   The aim of the workshops is to make links with practitioners’ day to day work, and by using case examples, share the learning from each of the local DHRs that have been opened.

   The learning outcomes of the workshops are to understand:

   - The purposes and processes of DHRs
   - The findings from the analyses of DHRs, locally and nationally
   - The experiences of those who have been victims of Domestic Homicides, and their families
   - How participants could apply DHR learning within their own role and organisation.

d) 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.

e) Incorporate findings into the development and content of inter- and multi-agency training on domestic violence and abuse.

f) Undertake ongoing analysis into Leicester DHRs and compare against national and other regions findings to better understand the risks to the local population.

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

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

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

Embedding learning into front-line practice

3.11 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.

3.12 The findings of DHRs will be routinely shared by the DHR Officer with the sub-groups responsible for the development of safeguarding policies and procedures for children and adults, across Leicester, Leicestershire and Rutland.

3.13 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 SLP's DHR sub-group

3.14 In addition to commissioning, receiving progress reports and endorsing the findings of DHRs, the SLP's DHR sub-group has a responsibility to monitor the actions arising from DHRs.

3.15 On a quarterly basis the sub-group will review DHR actions that are outstanding. The sub-group may also commission specific work to test the effectiveness of completed actions.

3.16 The SLP DHR sub-group will raise matters regarding learning and improvement, where relevant, to the SLP 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, these will be saved by the DHR Officer for reference purposes.

Service User Accountability

4.3 The Domestic and Sexual Violence Service User Scrutiny and Reference Group is a useful way to test the utility of learning and actions and proposed communication methods aimed at services users, practitioners and members of

the public. The briefings and new campaigns mentioned in 3.9 will go through this group as a scrutiny process.

Involvement of Family, Friends and Other Support Networks

4.4 The SLP 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 involvement of family, friends and others is both necessary and complex as they can have important information about the nature and extent of the abuse which may not have been shared with agencies.

4.6 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 SLP Office (DHR Officer).