1.0 ISSUE

1.2 To present a Domestic Violence Homicide Review Protocol that will guide the work of the Community Safety Partnership (CSP) in the event of a domestic violence related homicide in the District. In addition, the paper will discuss a revised Service Level Agreement between ECDC and Cambridgeshire County Council for the provision of Domestic Abuse interventions in the District.

2.0 RECOMMENDATION(S)

2.1 That Members note the Domestic Violence Homicide Review Protocol at Appendix A and the contribution of the District Council in developing and implementing the document for the CSP.

2.2 That Members approve the revised Service Level Agreement for provision of Domestic Abuse services between Cambridgeshire County Council and East Cambridgeshire District Council (Appendix B)

3.0 BACKGROUND/OPTIONS

3.1 The Domestic Violence, Crime and Victims Act 2004 Section 9 requires that, following a domestic homicide, the local area should organise a multi-agency review. This requirement came into force on 31 March 2011.

3.2 Responsibility for co-ordinating Domestic Violence Homicide Reviews (DHRs) lies with the local CSP. The Partnership will initiate Domestic Homicide Reviews and select who should sit on the review panel. The panel will then carry out the review as an independent body of the CSP.

3.3 Though overall responsibility for DHR’s is with the CSP, the District Council as a key partner to the CSP is committed to contributing to any DHR process and to leading the development of suitable polices and procedures to cover this commitment.
3.4 For 2012-13, a revised arrangement will be put in place with Cambridgeshire County Council for the provision of Domestic Abuse interventions and Domestic Homicide Review support. A revised Service Level Agreement (SLA), relating to this new working arrangement, is at Appendix B. It replaces a former agreement in 2011-12 that provided £6K support from the East Cambridgeshire District Council Community Safety budget. This will provide counselling and support to victims, and full delivery of any Domestic Homicide Review (DHR) in the district.

3.5 For 2012-13 ECDC will commit the same £6K resource to funding Domestic Abuse interventions in the District to reduce the likelihood of Domestic abuse, and County Council support in the event of any DHR. The new arrangement will mean however that the CSP will need to provide greater in kind contribution to administration and general support in the event of a DHR arising than previously, hence the need to have a guiding document in the form of a DHR Protocol.

3.6 The new SLA has taken time to put in place, however most of the district councils in the County are buying into the new SLA arrangement with Cambridgeshire County Council because it provides effective value for money and expertise.

4.0 ARGUMENTS/CONCLUSIONS

4.1 Up to 31 March 2011 Cambridgeshire County Council led on Policy and Development of DHR provision on behalf of local CSP’s. That arrangement changed from 01 April 2012, and although Cambridgeshire County Council will retain a significant role in the DHR process, it is up to local CSP’s to have a suitable DHR Protocol in place and identify the necessary capacity to resource any DHR in their district.

4.2 The Protocol presented with this report is East Cambs CSP’s response to this requirement.

4.3 The next step for the Protocol is to gain formal adoption by the District CSP Board at its October 2012 meeting, along with buy in from the lead partners.

4.4 To secure adequate support for the delivery of any DHR in the district and to enable delivery of preventative interventions around Domestic Abuse, a revised Service Level Agreement is being taken forward with Cambridgeshire County Council.

4.5 The revised SLA will operate for 2012-13 financial year and be reviewed before 31 March 2013 when it expires.
5.0 FINANCIAL IMPLICATIONS/EQUALITY IMPACT ASSESSMENT

5.1 The SLA with the County Council to provide DHR support requires a £6K contribution for 2012-13, which has been budgeted for within ECDC’s Community Safety budget.

5.2 Equality Impact Assessment (INRA) required. Initial Screening Template (IST) is at Appendix C.

6.0 APPENDICES


6.2 Appendix B – revised Service Level Agreement (SLA) for the provision of Domestic Abuse interventions, between Cambridgeshire County Council and East Cambridgeshire County Council.

6.2 Appendix C – Initial Screening Document for INRA
EAST CAMBRIDGESHIRE COMMUNITY SAFETY PARTNERSHIP DOMESTIC HOMICIDE REVIEW PROTOCOL 2012
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Introduction
The Domestic Violence, Crime and Victims Act 2004 Section 9 requires that, following a domestic homicide, the local area should organise a multi-agency review. This requirement came into force on 31 March 2011.

The lead responsibility for co-ordinating Domestic Homicide Reviews (DHRs) lies with the local Community Safety Partnership. The partnership will initiate Domestic Homicide Reviews and select who should sit on the review panel. The panel will then carry out the review as an independent body.

The ethos of the reviews should be around what we would have done differently to stop this Domestic Homicide happening if we had hindsight and is not about apportioning blame. This process should open and transparent and viewed as a positive process.

The Government published full guidance on DH Reviews on 31st March 2011. This is available from: http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-homicide-reviews/ for more information.

The process in East Cambridgeshire is based on the statutory guidance and is set out in more detail in the following guidance.

Definition
The definition of a Domestic Homicide Review, as set out in the 2004 Act is:

A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by –

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

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

A member of the same household is defined as:

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

Where the victim is aged between 16 and 18, the guidance states that a child serious case review (SCR) should take precedence over a DHR. However, it is vital that any elements of domestic violence relating to the homicide are addressed fully and the SCR includes representatives with a thorough understanding of domestic violence. Where the criteria for a SCR are not met and a DHR goes ahead, the reverse will also be true.
DHR Timeline

Partnership Response:
The Domestic Homicide Review

Agency Response
The Individual Management Review

Domestic Homicide occurs

CSP informs Home Office of decision to carry out DHR or not

Police informs CSP in writing

CSP informs all agencies in writing of a possible DHR

CSP establishes whether to carry out a DHR and identifies if any other reviews are taking place

CSP sets up Panel

Panel Chair and Panel draw up terms of reference for DHR

Panel Chair writes to senior manager in each agency, commissioning IMR

Panel informs family/friends/others of review through a designated advocate and agrees their involvement

Panel interviews people, holds discussions, reviews evidence

Panel Chair draws together IMR’s, reports from other professionals and other evidence

Secures case records and begin to draw up a chronology of involvement

Senior manager commissions Individual Management Review

IMR author interviews staff, holds discussions, reviews evidence

IMR author produces Individual Management Review

Senior manager quality assures IMR

Senior manager feeds back to and debriefs staff on IMR
11 Panel Chair drafts report
12 Panel review the report for quality assures
13 Panel develops action plan
14 Provide draft report to family etc for their consideration
15 Panel sends final report, exec summary and action plan to CSP
16 CSP agrees reports and action plan and anonymises them
17 CSP feeds back to and debriefs family etc
18 CSP sends final reports and action plan to the Home Office
19 Home Office expert panel quality assures report and gives clearance for publication
20 CSP publicises exec summary and overview report on website
21 CSP implements and monitors action plan through the Domestic Abuse Forum
22 CSP formally concludes DHR process and audits progress
23 The debriefs are used to review the protocol

LEGEND:
- **Lead Agency**
  - E.Cambs CSP
  - Review Panel
  - Agencies
  - Home Office
  - CSP Working Group
**DHR Procedures** (numbers relate to DHR Timeline above)

**Box One** – The Constabulary informs the East Cambridgeshire Community Safety Partnership (CSP) Chair in writing that a probable domestic homicide has taken place in their area.

Additionally, where a domestic violence related death occurs and another professional or agency believes that there are important lessons for inter-agency working to be learned, then that professional or agency can also refer the homicide to the CSP chair (in writing).

**Box Two** – The CSP Chair will inform all relevant agencies in writing that a DHR is being considered See appendix 1.

**Box Three** – The Chair of East Cambridgeshire CSP, in consultation with the CSP Working Group, decides whether a review should take place. The Officer Support Group should consider the definition in the guidelines and any other reviews that are taking place including Serious Case Reviews and Mental Health Investigation. Where a homicide does not meet the definition in the Act, or where a Serious Case Review takes priority, it may still be appropriate to carry out a more limited audit of involvement, or individual agencies may wish to carry out the IMR process.

**Box Four** – The Chair of the CSP informs the Home Office of their decision by emailing them at DHRENQUIRIES@homeoffice.gsi.gov.uk. The Home Office may override the CSP decision so that, even if the CSP decided not to initiate a DHR, the Secretary of State may respond by insisting that a DHR be carried out.

**Box Five** - The Chair of the CSP, in consultation with the CSP Working Group appoints an independent Panel Chair. The Chair will be responsible for managing and co-ordinating the process and should be an experienced individual who is not directly associated with any of the agencies involved in the review. In E.Cambs the CSP Chair could consider using outside agency or an appropriate locally known lay person.

The panel membership may include contacting standing members from Table one - Participating Agencies or recruiting a tailored membership. A tailored membership may prove useful where specialist advice and knowledge needs to be sought; for example, if the victim and/or perpetrator are from a BME background, if it was a same-sex partner relationship, if it is a male victim and female perpetrator, etc. Other agencies with key roles may include: the prosecution service, housing associations and social landlords, the HM prison service. Practitioners from domestic violence forums should be invited to join the Review Panel, along with specialist ‘experts’ as appropriate for the case.

It should be noted at this point that ongoing investigations such as the criminal investigation, mental health or any legal review occurring parallel to the DHR could significantly affect the completion of the DHR within the timescales outlined in the Guidance document. The CSP may agree an extended timescale if the case is particularly complicated.

The co-ordination and the admin support will covered by the CSP.

**Table One** - Participating agencies

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Post</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief officers of police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local authorities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Box Six – The review panel will draw up Terms of Reference based on Appendix 2 and appoint lead individuals or agencies to act as liaison for the family members and for the media. The review panel will co-ordinate contact with family, friends and other support networks and decide on the timing of first contact, conduct meetings, and ensure regular engagement/updates.

Where the homicide is thought to be the result of ‘honour-based’ violence, the usual contact with the family may need to be avoided. An ‘expert’ should be included on the panel, but there may be issues of confidentiality with regards to using individuals from local communities.

Box Seven - The Panel Chair will commission Individual Management Reviews (IMR) and ensures the DHR ‘dovetails’ with any other reviews or investigations e.g. serious case reviews. The Panel Chair will link in with the Disclosure Officer in the criminal investigation. It will be the responsibility of the Panel Chair to ensure contact is made with the chair of any parallel process (such as SCR) to consider whether combing the reviews would be a more effective approach.

Box Eight – The Panel Chair will initiate contact with family, friends and other support networks see Appendix 3, naming the Family Liaison Representative, providing contact details and further Home Office guidance on DHR.

Box Nine - The Family Liaison Representative meets with and interviews any family, friends and colleagues of the victim and the perpetrator that are willing to be part of the DHR. A panel member also interviews any relevant professionals not participating in the IMRs.

Box Ten – The Panel Chair will draw together and analyse the IMRs, and other information.

Box Eleven – The Panel Chair prepares the report using the format in appendix 4 and 5. However, in cases where the suspect is arrested and charged, the commissioning of the report should be held temporarily until the conclusion of the criminal case. Following the criminal proceedings the DHR should be concluded without delay. Findings of the Review should be regarded as ‘Restricted’ until the document has been received and cleared by the Home Office Quality Assurance Group.

Box Twelve - The review panel will quality-assure the report. The report should be of a high standard, discussing and identifying key lessons learnt and good practice.

Box Thirteen – The review panel will produce a SMART action plan see appendix 6.

Box Fourteen – The Panel Chair, through the Family Liaison Representative will share the draft report with family members and key participants prior to publication.
Box Fifteen – The review panel will supply the report, exec summary and action plan to CSP Chair.

Box Sixteen – The Chair of the CSP and the Performance Group approves the DHR documents and agree the content for publication, ensuring it is fully anonymised.

Box Seventeen – The Chair of the CSP, through the Family Liaison Representative will feed back to family members and to all other participants.

Box Eighteen – The Chair of the CSP will send DHR report to the Home Office for quality assurance. If the Home Office Quality Assurance Team identifies any problems the Chair of the CSP and the CSP Working Group will ensure these are addressed and if necessary reconvene the review panel.

Box Nineteen - The Home Office gives clearance for publication to the Chair of the CSP.

Box Twenty – The Chair of the CSP will publish the report and exec summary on relevant webpages and will make arrangements for any further feedback and debriefing, including to the media, to disseminate lessons learnt and good practice as widely as possible

Box Twenty One – E.Cambs CSP will monitor the implementation of the action plan through the Cambridgeshire Domestic Abuse Implementation Group.

Box Twenty Two - E.Cambs CSP will formally conclude the DHR process and audit process.

Box Twenty Three – E.Cambs CSP will formally review this protocol using the evidence gathered through the debriefs and amend as appropriate.

Box A – Agency senior managers will ensure case records are secured immediately and draw up a chronology of their organisation’s involvement. Appendix 7 gives further guidance on circumstances of particular concern which senior managers should take in to consideration.

Box B - Agency senior managers will appoint a person to produce the IMR. This should not be anyone involved in the case or the line manager of a staff member involved. Appendix 7 gives further guidance on circumstances of particular concern and should be used to inform the process.

Box C - Agency IMR authors using the outline format in appendix 8, will interview staff involved with case, make a written record and share relevant evidence to the Disclosure Officer for the criminal case.

Box D - Agency IMR authors will draw together and analyse information and produce an IMR report using template format in appendix 9.

Box F - Agency senior managers will feedback and debrief staff on the completion of an IMR.
Conclusion

The process set out above is supported by statutory guidance, including templates for the report and IMR, which are attached as Appendices 5 and 9.

An e-learning training package for relevant agencies and information leaflets for friends and family members of the victim are also available.
Appendix One
Letter from Chair to inform agencies that a DHR is being considered.

To:
East Cambridgeshire Community Safety Partnership, c/o
The Grange, Nutholt Lane, Ely Cambridgeshire. CB7 4EE
Ask for: Nick Ball, Community Safety Officer
Direct Line: 01353 616455
Email: nick.ball@eastcambs.gov.uk

Date:

Dear Colleague

RE: Domestic Homicide Reviews for

I am writing to inform you that the East Cambridgeshire Community Safety Partnership may undertake a Domestic Homicide Review for:

- Victims Name
- Victims Date of Birth
- Victims Date of Death
- Victims Last Known Address

The alleged perpetrator details are as follow
- Name
- Date of Birth
- Last Known Address

Domestic Homicide Reviews (DHR) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004).

If the partnership deems a DHR is appropriate in this case you will be required to complete an Individual Management Review for your agency. At this time, in preparation, please secure any records your agency holds pertaining to the victim or the alleged perpetrator.

The Government published full guidance on DHR on 31st March 2011. This is available from: http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-homicide-reviews/ for more information.
The Panel Chair will contact you in due course with further information.

Yours Sincerely

Lorraine Lofting

Chair of East Cambridgeshire Community Safety Partnership
Appendix 2

DRAFT TERMS OF REFERENCE FOR THE DOMESTIC ABUSE HOMICIDE REVIEWS

This Domestic Homicide Review is commissioned by the E.Cambs Community Safety Partnership (ECCSP) in response to the death(s) of ________ on (Date ____________).

This Domestic Homicide Review (DHR) was commissioned because under the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (3.1) (a) the incident involved ‘a person to whom he was related or with whom he was or had been in an intimate personal relationship’ (Home Office 2011:5). The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

The CSP Chair appointed (name of independent Chair and Job Title) as Chair of the review panel at the CSP Working Group meeting held on (date). (Name of Chair) is not employed by any of the statutory agencies involved in the review as identified in section 9 of the Act.

Purpose of the review

The purpose of the review is to:

- Establish the facts that led to the incident on (date) and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on (date).
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

Scope of the review

The review will

- Seek to establish whether the events of (date) could have been predicted or prevented.
- Consider the period of one calendar year prior to the events, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

- Take account of the coroners' inquest in terms of timing and contact with the

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Aim to produce the report by the end of (date) subject to responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.

**Family involvement**

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process of the coroners inquest and ensure that the family are able to respond to this review and the inquest avoiding duplication of effort and without undue pressure.

**Legal advice and costs**

Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

There may be a requirement to access independent legal advice on the part of the review team, and the team will seek funding of this advice from the E.Cambs CSP statutory partners and agree from which source this advice will be sought.

At this stage it is not anticipated that the review will require additional resources or funding for their time to undertake this review. Should the scope of the review extend beyond the anticipated internal review, the review team will raise this through the E.Cambs CSP for further guidance.
Expert witnesses and advisors

It is intended to consider consulting with the following agencies and individuals to provide a view of the findings and recommendations arising from the report.

- (as appropriate)

Other appropriate agencies and people may be identified through the course of the review.

Media and communication

The management of all media and communication matters will be through a joint team drawn from the statutory partners involved.

There will be no presumption to inform the public via the media that a review is being held in order to protect the family from any unwanted media attention. However, a reactive press statement regarding the review will be developed to respond to any enquiries to explain the basis for the review, why and who commissioned the review, the basic methodology and that the review is working closely with the family throughout the process.

An executive summary of the review will be published on the E.Cambs CSP website, with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed through the partnership website, the Cambridgeshire Domestic Abuse Implementation Group and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

All written communication from the review team will be sent under the E.Cambs CSP logo, using business addresses for the review team members.

Sign by Review Panel
Appendix Three
Letter from Chair to Family Members

To: C/O The Grange, Nutholt Lane, Ely, Cambs CB7 4EE
   Ask for: Nick Ball – Community Safety officer
   Direct Line: 01353 616455
   Email: nick.ball@eastcambs.gov.uk

Date:

Dear Colleague

I am writing to you following the sad loss of ................. We are completing a Domestic Homicide Review and we would like you to be part of this review. The purpose of the review is to identify lessons to be learned and improve ways to protect people, this review isn’t about ‘blame’ it is about ‘learning’.

As well as Statutory and Voluntary organisations being involved, it is important to have involvement from family, friends, work colleagues and any other people who knew ................. because they are likely to be aware of information not known to the agencies.

The contribution of family and friends will help us to better understand the circumstances and to improve the services offered to domestic abuse victims.

The Domestic Homicide Review Panel will not include any individuals directly involved in the case. If you decide you want to take part in this review the family liaison representative is ................. and be contacted at ................................................ who can guide you through this process and we aim to complete interviews between ................. and .................

I am truly sorry for your loss of ................. I hope that you can help this review process; your input would be invaluable. If you have any further questions or queries please do not hesitate in contacting me or the family liaison representative. Please see the enclosed guidance form the Home Office for further information.

Yours Sincerely
Chair
Domestic Homicide Review Panel
Address
Telephone number
E mail
Appendix Four

OUTLINE FORMAT FOR REPORT

Introduction
- Summarise the circumstances that led to a review being undertaken in this case.
- State the terms of reference of the review and record the methodology used, what documents were used, whether interviews undertaken.
- List the contributors to the review and the nature of their contribution.
- List the DHR panel members and the author of the overview report.

The Facts
- Where the victim lived and where the victim was murdered. A synopsis of the murder (what actually happened and how the victim was killed).
- Details of the Post Mortem and inquest and/or Coroner’s inquiry if
- Members of the family and the household. Who else lived at the address and, if children were living there, what their ages were at the time.
- How long the victim had been living with the perpetrator(s). If a partner/ex-partner, how long they had been together as a couple.
- Who has been charged with the murder and the date of the trial (if known).
- A chronology charting contact/involvement with the victim, the perpetrator and their families by agencies, professionals and others who have contributed to the review process. Note the time and date of each occasion when the victim, perpetrator or child(ren) was seen and the views and wishes that were sought or expressed.
- An overview that summarises what information was known to the agencies and professionals involved about the victim, the perpetrator and their families.
- Any other relevant facts or information.

Analysis
This part of the overview should examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It can consider whether different decisions or actions may have led to a different course of events. The analysis section is also where any examples of good practice should be highlighted.

Conclusions and recommendations
This part of the report should summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action. Recommendations should include, but not be limited to those made in individual management reports and may include recommendations of national impact. Recommendations should be relatively few in number, focused and specific, and capable of being implemented.
Appendix Five

DOMESTIC HOMICIDE REPORT TEMPLATE

To be anonymised for publication and dissemination

REPORT INTO THE DEATH OF
(add victim’s name/reference)
Report produced by ___
Date _____
Introduction
This report of a domestic homicide review examines agency responses and support given to (victim's name), a resident of (area name) prior to the point of (his/her) death on (date of death).

The review will consider agencies contact/involvement with (victim's and perpetrator's name) from (indicate date/s/period that the scope of the review will be examining).

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Timescales
This review began on (date) and was concluded on (date). Reviews, including the report, should be completed, where possible, within six months of the commencement of the review.

Confidentiality
The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

Dissemination
(List of recipients) have received copies of this report.
Executive Summary (To be anonymised for publication and dissemination)

1. The review process
This summary outlines the process undertaken by (local area) domestic homicide review panel in reviewing the murder of (victim).

(Suspect) is currently awaiting trial for (victim)'s murder / Criminal proceedings have been completed. (Details of outcome)

The process began with an initial meeting on (date) of all agencies that potentially had contact with (victim) prior to the point of death.

Agencies participating in this case review are:

(This will vary for every homicide)
- (Area) Local Authority
- (Area) Housing
- (Area) Education (Access and Inclusion Services)
- (Area) Social Care (Adult and Children’s Social Care Services)
- (Area) Police Domestic Abuse Unit/Child Abuse Investigation Unit
- (Area) Local Probation Board
- (Area) Strategic Health Authority
- (Area) Primary Care Trust
- (Area) Local Health Board
- (Area) NHS Trusts
- (Area) Mental Health Team
- (Area) Victim Support Services
- (Area) IDVA
- (Area) Local Refuge
- (Area) Community Police Consultative Group
- (Area) Friends / Family / Employer
- other

Agencies were asked to give chronological accounts of their contact with the victim prior to his/her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency’s report covers the following:

A chronology of interaction with the victim and/or their family;
what was done or agreed;
whether internal procedures were followed; and
conclusions and recommendations from the agency’s point of view
The accounts of involvement with this victim cover different periods of time prior to their death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

(Number) of the (total number) agencies responded. In total, (number) agencies have responded as having had no contact with either the victim or the suspect or with any children involved: (name agencies).

(Number) have responded with information indicating some level of involvement with the victim: (name agencies).

(Indicate here if an agency’s contact is of no relevance to the events that led to the death of the victim, state their last record of contact and detail)

The police report shows that on (number) occasions between (date) and (date) the police had contact with (victim) in relation to allegations of (name allegations and who the alleged offences were committed by). (State what the victim’s wishes were at the time in terms of proceeding or withdrawing)

(Agencies) responded as having no trace of the victim, the suspect or any children on their database or general registry. (State here if information has come to light showing the contrary)

(State here any agencies showing contact or interaction with the victim or their family)

2. **Key issues arising from the review**
   (Add issues as required)

3. **Conclusions and recommendations from the review**
   (Add conclusions and recommendations as required)
(AREA) DOMESTIC HOMICIDE REVIEW PANEL CONCLUDING REPORT

Introduction

This review report is an anthology of information and facts from (number) agencies, all of which were potential support agencies for (victim). Essentially, only (number) agencies had records of contact with (victim) prior to their death. They are:

(agency)
(agency)

(State whether any of the accounts bear any direct relation to the victim's murder)

The Facts

(State any agency involvement)
(State whether the review panel is of the opinion that all agency intervention was appropriate and that agencies acted in accordance with their set procedures and guidelines)

Conclusion / Lessons Learnt

(State whether the review panel, after thorough consideration, believes that under the circumstances agency intervention potentially could have or would not have prevented the victim's death, given the information that has come to light through the review)

(State whether the information available to the review panel suggests that there were/were no recorded incidences of domestic violence between the victim and the suspect and whether this is/is not conclusive)

(State anything else that is relevant to the conclusions resulting from the review)

To note: It will not always be possible to arrive at a definitive judgement about what intervention could have or would not have prevented the death.

Recommendations

(Add recommendation(s))

(Name of author of report)

(Position in agency)

(Date)
HOUSING REPORT

MURDER OF (VICTIM)

Of (address)
(age and ethnicity)
(name and address of Housing Office)
(details of housing provider if victim was supported by UK Border Agency)
  Tenancy reference: (reference)

Tenancy commenced (date). Tenancy ended/was due to end (date).
Other occupants: (name, date of birth and relationship)

History of involvement:
  • (When the victim applied for housing and any other housing applications chronological order)
  • (Whether the victim was on the at-risk house file)
  • (Details of any medical problems)
  • (Details of relationships and children)
  • (Details of repairs undertaken in terms of locks being changed, for example)
  • (Anything else that suggests that the victim may have been at risk)

(Name of officer completing report)
(Position in agency)
(Date)
POLICE REPORT

Introduction

Methodology

Terms of Reference

Chronology
(Describe the events in a chronological order)

CALL (number) and CRIME (number) on (date)
For example: Police were called to 25 Reinmouth Close, Birmingham by Mrs Bernays, who wished to report an assault. The police attended and reported an allegation of common assault on Mrs Bernays – CRIS (number) refers. The circumstances were ___

CRIME (number) on (date)
For example: The above crime report refers to a (non-crime-book domestic incident) whereby Mrs Bernays called the police to report the fact that her husband, Mr Bernays, had been verbally abusive towards her. ___

INTELLIGENCE (log number) on (date)
For example: Intelligence shows that Mr Bernays has a history of violence against an ex-partner and has previously used a weapon.
The murder investigation
CRIME (number) Report dealing with the murder of (victim).

INTELLIGENCE (reference number)
Police intelligence record regarding the murder investigation.

(State: what occurred prior to the murder (events and sequence); whether there was an argument and what it was about; whether there was alcohol or drugs involved; brief details of the murder in terms of:
- how the victim was found;
- where the victim was found;
- how the victim was killed (modus operandi and weapons); and injuries sustained by the victim, etc;
- any other relevant details about the history of police involvement with the victim and/or the family, i.e. if the suspect had assaulted anyone else.
- the court result, if there is one, and when and where the suspect is appearing

(Name of officer completing report)
(Area)
(Date)
APPENDIX
Confirmation of no record of contact from:
  - (Agency 1)
  - (Agency 2)
  - (Agency 3)
  - (Agency 4)
  - (Agency 5)
  - (Agency 6)
### Appendix Six

#### ACTION PLAN TEMPLATE

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Scope of recommendation i.e. local or regional</th>
<th>Action to take</th>
<th>Lead Agency</th>
<th>Key milestones achieved in enacting recommendation</th>
<th>Target Date</th>
<th>Date of completion and Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overarching recommendation?</td>
<td>Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for national level)</td>
<td>How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?</td>
<td>Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?</td>
<td>Have there been key steps that have allowed the recommendation to be enacted?</td>
<td>When should this recommendation be completed by?</td>
<td>When is the recommendation actually completed? What does outcome look like?</td>
</tr>
</tbody>
</table>

**Fictional examples:**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Action</th>
<th>Date of</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>All coroners should receive training on domestic violence</td>
<td>- Review current coroner's training and identify gaps  - Develop training module.  - Roll-out revised training package as follows:  June-July – Coroners in region X  Aug-Sept – Coroners in region Y</td>
<td>Ministry of Justice Coroner’s team  - Review completed in January 09  - Training package agreed April 09  - Roll-out begins June 2009</td>
<td>All coroners to be trained by September 2009  All coroners received training by December 2009 and their narrative verdicts are beginning to reflect that this training has been effective.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Scope of recommendation i.e. local or regional</td>
<td>Action to take</td>
<td>Lead Agency</td>
</tr>
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</tr>
<tr>
<td>Educate the community on the risk factors around domestic abuse</td>
<td>Local and national</td>
<td>- Identify mediums to advertise these risk factors by July 2012 and how and if it should be done in a targeted way so they are accessible to all, i.e. Local authority web-site, GP surgeries, Accident and emergency clinics, Dentist surgeries, Job Centres etc. - Circulate briefing and hold meetings to discuss - Get leaflet printed nationally advising family, friends and community on how to help victims of domestic violence and distribute by December 2012</td>
<td>CSPs and Home Office</td>
</tr>
</tbody>
</table>
Appendix Seven

Circumstances of Particular Concern
The following factors are just some examples of the types of situations preceding homicide which will be of interest to review teams when conducting a DHR:

- There was evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim and/or the perpetrator, it was not shared with others and/or it was not acted upon in accordance with their recognised best professional guidance.

- Any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved.

- The homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.

- The victim was being managed by or should have been referred to a Multi Agency Risk Assessment Conference (MARAC).

- The homicide appears to have implications/reputational issues for a range of agencies and professionals

- The homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed

- The perpetrator holds a position of trust or authority e.g. police officer, social worker, health professional, and therefore the homicide is likely to have a significant impact on public confidence.

- The victim had no known contact with any agencies. For example, could more be done in the local area to raise awareness of services available to victims of domestic violence?
Appendix Eight

OUTLINE FORMAT FOR INDIVIDUAL MANAGEMENT REVIEWS

Agency involvement with the victim, the perpetrator and their families

The review should include a comprehensive chronology that charts the involvement of the agency with the victim, the perpetrator and their families over the period of time set out in the review’s terms of reference. It should summarise the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to the victim, the perpetrator and their families; and any other action taken.

Analysis of involvement

The review should consider the events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why. Each homicide may have specific issues that need to be explored and each review should consider carefully the individual case and how best to structure the review in light of the particular circumstances. The following are examples of the areas that will need to be considered:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence
- and are aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil expectations?
- Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective?
  - Was the victim subject to a MARAC?
- Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?
  - What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made?
  - Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim’s wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
- Was anything known about the perpetrator? For example, were they being managed under MAPPA?
- Had the victim disclosed to anyone and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary
• Were senior managers or other agencies and professionals involved at the appropriate points?
• Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
• Are there ways of working effectively that could be passed on to other individuals?
• Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
• How accessible were the services for the victim and perpetrator?
• To what degree could the homicide have been accurately predicted and prevented?
Appendix Nine

INDIVIDUAL MANAGEMENT REVIEW TEMPLATE

1. INTRODUCTION
Brief factual/contextual summary of the situation leading to the DHR including an outline of the TOR and date for completion:
- Identification of person subject to review
- Date of Birth:
- Date of death /date of serious injury/offence
- Name, job title and contact details of person completing this IMR (include confirmation regarding independence from the line management of the case).

Victim, Perpetrator, Family Details if relevant

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
<th>Relationship</th>
<th>Ethnic origin</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
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Include family tree or genogram if relevant.

2. TERMS OF REFERENCE

3. METHODOLOGY
Record the methodology used including extent of document review and interviews undertaken.

4. DETAILS OF PARALLEL REVIEWS/PROCESSES

5. CHRONOLOGY OF AGENCY INVOLVEMENT

What was your Agency’s involvement with the victim?
Construct a comprehensive chronology of involvement by your agency over the period of time set out in the review’s terms of reference. State when the victim/child/family/perpetrator was seen including antecedent history where relevant.

Identify the details of the professionals from within your agency who were involved with the victim, family, perpetrator and whether they were interviewed or not for the purposes of this IMR.

6. ANALYSIS OF INVOLVEMENT
Consider the events that occurred, the decisions made, and the actions taken or not. Assess practice against guidance and relevant legislation.

Addressing terms of reference
Consider further analysis in respect of key critical factors, which are not otherwise covered by the sections above.

7. EFFECTIVE PRACTICE/LESSONS LEARNT
8. RECOMMENDATIONS
Recommendations should be focused on the key findings of the IMR and be specific about the outcome which they are seeking.
Appendix 10.

The undersigned agree to sign up to this Protocol and agree to commit appropriate levels of Resource to enable the completion of any DHR

John Hill, Chief Executive Officer

Russell Waterstone, Chief Inspector for East Cambridgeshire, Cambridgeshire Constabulary

Vanessa Allen, Area Manager, Sanctuary Housing East Cambridgeshire

Val Thomas, NHS Cambridgeshire

Tom Jefford, Director, Cambridgeshire County Council
APPENDIX B

SERVICE LEVEL AGREEMENT

Domestic Abuse Partnership Manager

1 April 2012 to 31 March 2013

1. Purpose:

1.1 This is a service level agreement between Cambridgeshire County Council and East Cambridgeshire District Council.

2. Background:

2.1 Domestic abuse is a key priority for the County of Cambridgeshire with over 7,000 incidents reported to the Constabulary in 2010/11.

Police reporting, however, is not indicative of the true scale of the local issue as research has shown that fewer than 50% of all victims ever report their experiences of abuse to the police. British Crime Survey estimates indicate that over 15,000 Cambridgeshire women and girls are affected each year. There have been 3 domestic abuse-related homicides in the county since 2009.

National and local studies have also shown domestic abuse to be a ‘high cost / high prevalence’ issue costing Cambridgeshire agencies an estimated £113 million per annum with each police reported incident costing agencies over £15,000.

To ensure that all those affected by domestic abuse have access to relevant services, agencies in Cambridgeshire work to a ‘community coordinated response model’ of intervention that stresses the importance of partnership working, information sharing and common risk assessment. This model is supported by the Cambridgeshire Domestic Abuse and Sexual Violence Partnership and key partner agencies.

2.2 To service the Cambridgeshire Domestic Abuse and Sexual Violence Partnership and lead on domestic abuse/sexual violence issues (including supporting Community Safety Partnerships to undertake statutory Domestic Homicide Reviews (DHRs)), delivery and strategy, the post of Domestic Abuse Partnership Manager was created in 2008, with the addition of ‘Sexual Violence’ to the post’s remit in 2012. This post is hosted and resourced by Cambridgeshire County Council on behalf of the Cambridgeshire Domestic Abuse and Sexual Violence Partnership.
3. **Service Specification:**

3.1 **Policy & Protocol Across Agencies:**

The post of Domestic Abuse and Sexual Violence Partnership Manager will develop and establish a countywide, multi-agency domestic abuse strategy on behalf of the relevant partners and other key stakeholders that will seek to address the issue of domestic abuse and ‘Violence Against Women and Girls (VAWG)’ in Cambridgeshire. This strategy will be client-focused, cost effective and based on best practice.

3.2 **Delivery of Statutory Domestic Homicide Reviews:**

The post will support the delivery of/author (as appropriate) statutory Domestic Homicide Reviews (DHRs) via the East Cambridgeshire Community Safety Partnership within the timescale agreed through this service level agreement.

3.3 **Commissioning and Delivery of Specialist Services:**

The post will be responsible for securing appropriate funding and resourcing for specialist domestic abuse and sexual violence services (Independent Domestic Violence Advocacy Service, Independent Sexual Violence Advocacy Service and Multi-Agency Risk Assessment Conferences) and for commissioning these services depending on need and risk. The post will also ensure that delivery of these services is appropriate to local need, based on sound statistical evidence and that all specialist services are performing in a safe, appropriate and cost-effective way.

3.4 **Provide Link and Strategic Overview to County Domestic Abuse and Sexual Violence Partnership and Other Key Agencies:**

The post will be responsible for providing a strategic overview and advice on domestic abuse and VAWG issues to partner agencies, the Domestic Abuse and Sexual Violence Partnership and other key stakeholders. The post will also work with key partners to produce accurate data on relevant issues and ensure that this data is disseminated appropriately.

3.5 **Provide Good Practice Advice to Practitioners:**

The post will provide, via a range of formats (including regular newsletters, web-based media and training), advice and guidance for relevant practitioners on domestic abuse and VAWG issues.
3.6 **Develop Preventative Work in Conjunction with Partner Agencies:**

The post will work to Central Government’s ‘End Violence Against Women and Girls (VAWG)’ Strategy and prioritise preventative work and awareness of VAWG via the county’s Domestic Abuse and Sexual Violence Partnership.

3.7 **Reduction of Repeat Incidence of Domestic Violence:**

The post will work to agreed performance indicators as set out in the Cambridge Community Safety Plan 2011/14 to reduce the prevalence of repeat incidents of domestic abuse based on the work of specialist services such as the IDVAS and MARAC.

4. **Staffing Resources:**

4.1 The post will be provided on a full-time basis at Cambridgeshire County Council.

4.2 Administrative support will be available as needed. Administration costs will be taken from the core budget.

4.3 Line management will be provided by the Head of Service, DAAT and Community Safety, Cambridgeshire County Council. Management costs will be provided in kind.

5. **Management, Review & Communications:**

5.1 Quarterly performance monitoring reports will be provided by the post to funding partners and other key agencies and the East Cambridgeshire Community Safety Partnership.

5.2 Priorities and performance may be reviewed as necessary at other meetings with partners.

5.3 The agreement is for the period 1st April 2012 to 31st March 2013.

Signed on behalf of the Domestic Abuse Partnership Manager
Date: 30th June 2012

Name/designation

Simon Kerss
Domestic Abuse Partnership Manager
Cambridgeshire County Council

Signed on behalf of East Cambridgeshire District Council

________________________________________

Date:

Name/designation
Appendix C - Impact and Needs/Requirements Assessment (INRA)

Initial Screening

Initial screening needs to take place for all new/revised Council policies. ‘Policy’ needs to be understood broadly to include all Council policies, strategies, services, functions, activities and decisions. This stage must be completed at the earliest opportunity to determine whether it is necessary to undertake an INRA for this activity.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Lead Officer (responsible for assessment):</td>
<td>Nick Ball, Community Safety Officer</td>
</tr>
<tr>
<td>Department:</td>
<td>Communities and Leisure</td>
</tr>
<tr>
<td>Others Involved in the Assessment (i.e. peer review, external challenge):</td>
<td>Cambridgeshire Constabulary / Cambridgeshire County Council.</td>
</tr>
<tr>
<td>Date Initial Screening Completed:</td>
<td>28 June 2012</td>
</tr>
</tbody>
</table>

(a) **What is the policy trying to achieve?** i.e. What is the aim/purpose of the policy? Is it affected by external drivers for change? What outcomes do we want to achieve from the policy? How will the policy be put into practice?

The Domestic Violence, Crime and Victims Act 2004 Section 9 requires that, following a domestic homicide, the local area should organise a multi-agency review. This requirement came into force on 31 March 2011.

The lead responsibility for co-ordinating Domestic Violence Homicide Reviews (DHRs) lies with the local Community Safety Partnership. The partnership will initiate Domestic Homicide Reviews and select who should sit on the review panel. The panel will then carry out the review as an independent body.

Though the overall responsibility of the Community Safety Partnership (CSP), the district council as a lead responsible authority to the CSP is committed to contribute to any DHR process and to the development of suitable polices and procedures to cover this commitment.

The Protocol represents the CSP’s response to this Policy issue.

(b) **Who are its main beneficiaries?** i.e. who will be affected by the policy?
Statistical evidence indicates that women are by far the more prevalent victims of domestic violence. Thus women would be the main beneficiaries of this policy. Children also are very often witnesses of domestic abuse and thus are the second main beneficiary. This does not mean that men as occasional victims of domestic abuse are not also to be counted as beneficiaries.

(c) Is this assessment informed by any information or background data? i.e. consultations, complaints, applications received, allocations/take-up, satisfaction rates, performance indicators, access audits, census data, benchmarking, workforce profile etc.
(d) Does this policy have the potential to cause an impact (positive, negative or neutral) on different groups in the community, on the grounds of (please tick all that apply):

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Age</th>
<th>Religion and Belief</th>
<th>Disability</th>
<th>Sexual Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x</td>
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Please explain any impact identified (positive, negative or neutral): i.e. What do you already know about equality impact or need? Is there any evidence that there is a higher or lower take-up by particular groups? Have there been any demographic changes or trends locally? Are there any barriers to accessing the policy or service?

As already noted women and children would be the main beneficiaries of domestic abuse related policies and procedures.

There would statistically be more chance of the victim of a domestic violence related homicide being female. Thus the document will by default be addressing equality and diversity issues.

The protocol is inward facing and for implementation by partner agencies to the Community Safety Partnership. Therefore any access issues with regards the Policy, involve adequate sharing and understanding of the document amongst those public service partner agencies and not the wider public themselves.

(e) Does the policy affect service users or the wider community?

(f) Does the policy have a significant effect on how services are delivered?

(g) Will it have a significant effect on how other organisations operate?

(h) Does it involve a significant commitment of resources?

(i) Does it relate to an area where there are known inequalities, e.g. disabled people’s access to public transport etc?

If you have answered YES to any of the questions above, then it is necessary to proceed with a full equality impact assessment. If the answer is NO, then this judgement and your response to the above questions will need to be countersigned by your Head of Service and then referred to the Council’s
Equal Opportunities Working Group (EOWG) for scrutiny and verification. Please forward completed and signed forms to Nicole Pema, Principal HR Officer.

**Signatures:**

<table>
<thead>
<tr>
<th>Completing Officer:</th>
<th>Nick Ball, Community Safety Officer</th>
<th>Date: 28 June 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Service:</td>
<td></td>
<td>Date:</td>
</tr>
</tbody>
</table>