Hackney Domestic Homicide Review Protocol

1. The revised multi agency statutory guidance for the conduct of DHRs, published in June 2013, issued under section 9(3) of the DV, Crime and Victims Act (2004), should be referred to alongside the detailed Home Office Guidance:


   The Home Office guidance addresses issues to be considered and provides templates that can be used/amended. This Hackney Domestic Homicide Review Protocol summarises and in builds upon the Home Office guidance.

   What is a Domestic Homicide Review?

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

   a. a person to whom 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 her/himself.

   What is the purpose of the Domestic Homicide Review?

3. Assess whether agencies have sufficient and robust policies / procedures in place and whether these were understood and adhered to by staff.

4. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims, how and within what timescales any lessons will be acted on and what is expected to change as a result

5. Apply these lessons to service responses including changes to policies and procedures as appropriate

6. Prevent domestic homicides and improve service responses for all domestic abuse victims and their children through improved intra- and inter-agency working. This is done through ensuring agencies are responding appropriately to victims of domestic abuse by putting in place appropriate procedures, resources and interventions with an aim to avoid future incidents of domestic violence and homicide.
Notification of the Domestic Homicide

7. The Police Borough Commander is required to formally inform the Community Safety Partnership (CSP) Chair, London Borough of Hackney (The Council’s) Head of Safer Communities, Director of Children’s Services, and Chief Executive of any domestic homicide with details of all individuals in the household.

8. The notification from the Police Borough Commander should include:
   
a. Names, dates of birth and addresses of the victim, alleged perpetrator, others in the perpetrator’s and/or victim’s household and the children of the victim and/or alleged perpetrator.
   
b. An update concerning the status of the alleged perpetrator, others in the perpetrator’s and/or victim’s household and the children of the victim and/or alleged perpetrator.

9. The Head of Safer Communities will be responsible for notifying the Head of Public Health (who heads the Child Death Overview Panel), the Independent Chair of the City and Hackney Safeguarding Children Board and the Independent Chair of the City and Hackney Safeguarding Adults Board.

10. Confirmation of a decision to establish a DHR or a decision not to review a homicide should be sent by the Head of Safer Communities to dhrenquiries@homeoffice.gsi.gov.uk within one month of Police notification of the death.

Domestic Homicides and Serious Case Reviews

11. Serious case reviews (SCRs) are undertaken by the City and Hackney Safeguarding Children’s Board for every case where abuse or neglect is known - or suspected - and a child (anyone under 18)
   
   - has died
   - has been seriously harmed and there are concerns about how organisations or professionals worked together to protect the child.

12. If a DHR is to take place and the CHSCB feel that the Serious Case Review criteria have been met, consideration will be given to combining all or some of the aspects of these reviews and agreement will be reached between CHSCB and Safer Communities as to how the two processes will be integrated.
Domestic Homicides and Safeguarding Adults Reviews

13. Safeguarding Adults reviews are undertaken by City and Hackney Safeguarding Adults Board where an adult with needs for care and support

- has died and the CHSAB knows or suspects that the death resulted from abuse or neglect
- has experienced serious abuse or neglect

and there is reasonable cause for concern about how the CHSAB, members of it or other persons with relevant functions worked together to safeguard the adult

14. If a DHR is to take place and the CHSAB feel that the Safeguarding Adults Review criteria have been met, consideration will be given to combining all or some of the aspects of these reviews and agreement will be reached between CHSAB and Safer Communities as to how the two processes will be integrated.

Commissioning the Chair of the Domestic Homicide Review Panel

15. Overall responsibility for establishing and commissioning the DHR rests with the Community Safety Partnership. The CSP should appoint an independent Chair of the DHR Panel who is responsible for managing and co-ordinating the review process and for producing the Overview Report based on Independent Management Reviews and any other evidence the Panel decides is relevant. The Chair should not be directly associated with any of the agencies involved in the review.

16. The Chair should author the DHR Overview Report.

17. It is advised that the following are considered in the selection and appointment process of the DHR Panel Chair:

a. The prospective Chair should be asked to provide a CV and should have prior experience of chairing DHRs and/or extensive expertise on the issue of domestic abuse
b. References from any previous CSPs who have commissioned them should be sought
c. Anonymised published copies of previous DHR reports that the chair has authored should be requested; these should include the feedback letters received from the Home Office Quality Assurance Panel

18. A contract should be agreed which details the roles and responsibilities of the Chair and that of the Panel and the Council (including the CSP).
Coordinating and convening the DHR Panel

19. A senior manager from Safer Communities and the Chair of the DHR Panel will agree who will provide assistance in arranging and taking minutes of meetings, producing the combined chronology and editing the final reports.

Forming and populating the DHR Panel

20. The senior manager from Safer Communities should be a member of the DHR Panel and work alongside the Chair of the DHR Panel to identify and request membership of key appropriate individuals to join the panel.

21. It is the duty of the following persons or bodies to have regard to the Home Office statutory guidance and participate in a DHR:
   a. Chief officers of Police for Police areas in England and Wales
   b. Local Authorities
   c. NHS Commissioning Board
   d. Clinical Commissioning Groups
   e. Providers of Probation services.

22. There are other agencies which may have a key role to play in the review process but are not named in legislation, for housing associations and social landlords, the HM Prison Service and voluntary sector agencies. Involvement with other agencies will need to be decided on a case by case basis and should be agreed by the Chair and the Panel.

23. The Panel should include representation from a local independent specialist domestic abuse services e.g. the nia project or Refuge - even if they have not had contact with the individuals concerned - to provide additional insight and expertise.

24. The Panel should include representatives of the City and Hackney Safeguarding Adults Board and the City and Hackney Safeguarding Children Board.

The Initial DHR Panel Meeting

25. The Initial DHR Panel should be convened at the earliest practicable date after the Chair has been appointed. The Initial DHR Panel should:
   a. Clarify the scope of the DHR
   b. Clarify membership of the Panel
   c. Clarify what information is needed and from whom
d. Agree how the DHR process will interact with any parallel processes e.g. Serious Case Review / Safeguarding Adults Review / criminal investigations

e. Identify any issues likely to cause delay or require additional input

f. Request an update from Metropolitan Police Service (potentially through a report from the Family Liaison Officer) and agencies attending the Panel regarding any issues facing the victim’s family

g. Agree with partner agencies any actions they can take to help resolve issues for the victim’s family as soon as possible

h. Agree which family members will be communicated with by the Chair – taking into consideration issues such as their known relationship to the victim, whether they were potentially collusive, any issues relating to so-called honour based violence, their involvement as witnesses in any criminal proceedings– and how they will be involved in the DHR process, being mindful to utilise any advocates who the family are known to have identified as support. The final decision on which family members to involve in the DHR process and how rests with the Chair. Communication by the Chair with agreed family members should be within one week of the Initial DHR Panel.

i. Agree if further Panel meetings are required prior to the final Panel

26. Any protected characteristics of the individuals should be identified and examined and relevant community groups may be invited to join the Panel to offer expertise if required. This input may need to be commissioned if not available locally, such as an expert resource. The Chair should incorporate their contribution into the analysis of the circumstances of the death and the consideration of the protected characteristics.

27. The Chair should agree a process of involving agreed family members on an ongoing basis regarding the progress / outcome of the Review process and the delivery of the action plan. This includes thinking about support around the publication of the DHR Overview Report.

28. The involvement of and communication with agreed members of the victim’s family should be a standing agenda item at all Panel meetings

29. Members of statutory agencies who have responsibilities for completing Individual Management Reviews may also be members of the DHR Panel, but the Panel should not consist solely of such people.

**Timescales**

30. The Overview Report should be completed within six months of the date of the decision to proceed unless the Review Panel formally agrees an alternative timescale with the CSP. Please see Appendix A (page 10) for a timeline of the DHR process in Hackney.
Individual Management Reviews

31. The Chair of the Review Panel should write to the senior manager in each of the participating agencies to commission their Independent Management Review (IMR). The IMRs will form part of the DHR Overview Report.

32. The aim of the IMR is to:
   a. Allow agencies to look openly and critically at individual and organisational practice within their respective agencies and the context within which people were working to identify strengths and weaknesses in the agency’s systems / practice and identify whether the homicide indicates that changes should be made. Agencies may conduct disciplinary action / complaint investigations regarding specific employees due to issues relating to the DHR
   b. Identify how any agreed changes will be brought about.
   c. Identify examples of good practice.

DHR Overview Reports and DHR Action Plans

33. The DHR Overview Report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports and discussions with or information from any other relevant source.

34. The presumption should be that the agreed members of the victim’s family and the perpetrator will be interviewed by the Chair as part of their work in understanding the case and writing the DHR Overview Report unless they decline or the DHR Panel feels it to be inappropriate.

35. The findings of the review should be regarded as ‘restricted’ as per the Government Protective Marking Scheme (GPMS) until the agreed date of publication. Prior to this, information should be made available only to participating professionals and their line managers who have a pre-declared interest in the review. The presumption should be that these findings will be shared with agreed family members as directed by the Chair, taking into account ongoing criminal proceedings.

36. The Chair should meet with agreed members of the victim’s family to summarise the findings and lessons identified, outline the proposed DHR Action Plan and to check that the information contained in their draft DHR Overview Report is factually correct.

37. The draft DHR Overview Report should then be updated by the Chair to include the family’s input (highlighting where they agree / disagree with findings), correct any factual errors before a final draft of the DHR Overview report and DHR Action Plan are circulated to Panel members.

38. The Chair’s draft DHR Overview Report and Action Plan should be circulated to Panel members at least one week before the Final DHR Panel.
Final Domestic Homicide Review Panel

39. The Chair and Panel members should identify any issues pertaining to the DHR Overview Report, its recommendations and/or the Executive Summary regarding inaccuracies or issues requiring greater clarity/investigation.

40. The Panel should translate the recommendations contained in the DHR Overview Report into an Action Plan.

41. The Chair should make any agreed changes to the Overview Report, the Executive Summary or Action Plan and obtain final agreement from Panel members before submitting all three to the Chair of the CSP Strategic Officers Group and the Chair of the VAWG Strategic Board

Community Safety Partnership approval

42. On receiving the Overview Report, Executive Summary and Action Plan the Chairs of the CSP Strategic Officers Group and the Chairs of the VAWG Strategic Board should meet with the Chair of the DHR Panel, Head of Safer Communities and, as applicable, the Chair of the CHSAB / CHSCB to:

a. Agree the content of the Overview Report, Executive Summary and Action Plan for publication, ensuring that it is fully anonymised apart from including the names of the Review Panel Chair and members

b. Approve arrangements to provide feedback and debriefing to agreed family members, staff and the media as appropriate.

c. If changes have been made to the DHR Overview Report, Executive Summary or Action Plan since the family gave feedback (point 37) prior to the Final DHR Panel then the family will need to be sent the finalised version before it is sent to the Home Office. Depending on the nature and number of changes a further meeting with the agreed family members by the Chair, possibly with a senior manager from Safer Communities can be agreed.

d. Agree how the VAWG Strategic Board will be provided with a briefing e.g. by the Chair of the DHR Panel / Safer Communities.

e. Agree a plan to disseminate learning to staff and the wider partnership including through forums such as CHSCB, CHSAB, and Hackney Health and Wellbeing Board

f. Sign off the Overview Report, Executive Summary and Action Plan

g. Ensure that documents are not published until clearance has been received from the Home Office Quality Assurance Panel

h. Agree that the Head of Safer Communities will provide the Home Office’s Quality Assurance Panel the anonymised DHR Overview Report, Executive Summary and Action Plan to dhrenquiries@homeoffice.gsi.gov.uk.
Home Office clearance

43. The DHR Overview Panel will notify the Chair of the DHR Panel and Head of Safer Communities of their approval of the documents and clearance to publish. Any revisions to the Overview Report, Executive Summary and Action Plan requested will be provided by the Chair to the DHR Overview Panel until approval has been confirmed.

Publication of Overview Report and Executive Summary

44. Following Home Office clearance, the publication of the Overview Report, Executive Summary and Action Plan needs to be timed in accordance with the conclusion of any related court proceedings or other review processes and with reference to Section 9 of the Home Office guidance.

45. The Community Safety Partnership will need to consider a media plan prior to publishing the Domestic Homicide Review Overview Report, Action Plan and Executive Summary, which must include discussion with appropriate family members (and any other significant individuals such as friends, colleagues) who contributed to the review, along with the Chair of the DHR Panel.

46. The Chair of the DHR Panel and potentially a senior manager from Safer Communities should meet with agreed family members prior to publication and go through the version of the DHR Report, Executive Summary and Action Plan due to be published. Any further needs for support can be followed up by the senior manager from Safer Communities.

47. Publication of the Domestic Homicide Overview Report, Executive Summary and Action Plan should follow briefings with agreed family members, friends and colleagues and should avoid important dates such as the anniversary of the death and the victim’s birthday.

48. On receiving clearance from the Home Office Quality Assurance Group, the CSP should:

   a. Provide a copy of the anonymised Overview Report, Executive Summary and Action Plan to the senior manager of each participating agency
   b. Publish an electronic copy of the Overview Report and Executive Summary on the Council Community Safety Partnership web page
   c. Monitor the implementation of the Action Plan via the VAWG Strategic Board including multi-agency training (potentially delivered jointly with CHSAB / CHSCB)
   d. Formally conclude the Review when the Action Plan has been implemented and include an audit process.
49. Any elements of the DHR Action Plan which pertain to Hackney agencies should be incorporated into the Violence Against Women and Girls Action Plan. Members of the VAWG Strategic Board should update the Board on progress regarding both local and national actions contained within the DHR Action Plan.

50. The senior manager within Safer Communities should check in with the agreed family members 6 months after publication of the DHR Overview Report.
## Appendix A  Domestic Homicide Review Checklist

<table>
<thead>
<tr>
<th>Action</th>
<th>Person / agency responsible</th>
<th>Timescale (after death)</th>
<th>Date of completion / Date to be completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal notification is given to CSP Chair, Head of Safer Communities, Director of Children's Services and Chief Executive of domestic homicide with details of all individuals in the household and details of victim's/perpetrator’s children</td>
<td>MPS Borough Commander</td>
<td>12 hours</td>
<td></td>
</tr>
<tr>
<td>Formal notification is given to Head of Public Health and Independent Chairs of the CHSAB and CHSCB</td>
<td>Head of Safer Communities</td>
<td>24 hours</td>
<td></td>
</tr>
<tr>
<td>Agreement is reached on whether to combine the DHR process with Safeguarding Adults Review and/or Serious Case Review</td>
<td>Head of Safer Communities and Chair of CHSAB and Chair of CHSCB</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Home Office are notified of decision to establish a DHR (including whether this is joint with SCR and/or SAR) or not to via <a href="mailto:dhrenquiries@homeoffice.gsi.gov.uk">dhrenquiries@homeoffice.gsi.gov.uk</a></td>
<td>Head of Safer Communities</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>Chair of DHR / joint Safeguarding Adults Review and/or Serious Case Review is formally appointed</td>
<td>Head of Safer Communities</td>
<td>6 weeks</td>
<td></td>
</tr>
<tr>
<td>Agreed family members are written to with introduction, outline of DHR process and proposed meeting times</td>
<td>DHR Chair</td>
<td>7 weeks</td>
<td></td>
</tr>
<tr>
<td>Initial DHR Panel takes place</td>
<td>DHR Chair</td>
<td>10 weeks</td>
<td></td>
</tr>
<tr>
<td>Agreed family members are interviewed</td>
<td>DHR Chair</td>
<td>12 weeks</td>
<td></td>
</tr>
<tr>
<td>Perpetrator and any other relevant individuals are interviewed</td>
<td>DHR Chair</td>
<td>16 weeks</td>
<td></td>
</tr>
<tr>
<td>Individual Management Reviews are provided to the DHR Chair</td>
<td>DHR Panel Members</td>
<td>16 weeks</td>
<td></td>
</tr>
<tr>
<td>Draft DHR Overview Report shared with agreed family members and opportunity given for views / factual corrections</td>
<td>DHR Chair</td>
<td>20 weeks</td>
<td></td>
</tr>
<tr>
<td>Final DHR Panel takes place</td>
<td>DHR Chair</td>
<td>22 weeks</td>
<td></td>
</tr>
<tr>
<td>Draft DHR Overview Report, Executive Summary and Action Plan sent to Chair of the CSP Strategic Officers Group and the VAWG Strategic Board Chair</td>
<td>DHR Chair</td>
<td>24 weeks</td>
<td></td>
</tr>
<tr>
<td>CSP send Home Office a final version of the DHR Overview Report, Executive Summary and Action Plan</td>
<td>Head of Safer Communities</td>
<td>28 weeks</td>
<td></td>
</tr>
</tbody>
</table>

Following clearance from the Home Office Quality Assurance Group (timeline = weeks after clearance):

<table>
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<th>Person / agency responsible</th>
<th>Timescale (after death)</th>
<th>Date of completion / Date to be completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deputy Mayor for Policing and senior managers from agencies involved in the DHR receive copies of Overview Report, Executive Summary and Action Plan</td>
<td>Head of Safer Communities</td>
<td>1 week</td>
<td></td>
</tr>
<tr>
<td>Agreed family members are met with to discuss publication and any issues around timing and any outstanding support needs</td>
<td>DHR Chair and Safer Communities Manager</td>
<td>4 weeks</td>
<td></td>
</tr>
<tr>
<td>DHR Overview Report, Executive Summary and Action Plan are published</td>
<td>Safer Communities Manager</td>
<td>6 weeks (avoiding key dates)</td>
<td></td>
</tr>
<tr>
<td>Agreed family members are met with to see how they are and identify any areas where support is needed</td>
<td>Safer Communities Manager</td>
<td>6 months</td>
<td></td>
</tr>
</tbody>
</table>