Suffolk Domestic Homicide Review Guidance 2021 v3 Apr 2022

This overview document outlines the approach being taken in Suffolk in meeting the Domestic Homicide Review statutory requirement. It is aimed to supplement and not replace the full Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Dec 2016) issued by the Home Office and available at www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews. Both the National Guidance and the Suffolk Protocol should be used together in all cases.

Defining a Domestic Homicide Review

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

(a) a person to whom 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, held with a view to identifying the lessons to be learnt from the death.

Recent changes to the DHR guidance include where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a Review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

Leading and Contributing to a Domestic Homicide Review

It should be noted that an 'intimate personal relationship 'includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

In March 2013, the Government introduced a cross-government definition of domestic violence and abuse. The new definition states that domestic violence and abuse is: "any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

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

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and

capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

In December 2015, a new domestic abuse offence to tackle coercive and controlling behaviour was commenced in legislation. More information about controlling and coercive behaviour in an intimate or family relationship can be found in the statutory guidance: https://www.gov.uk/government/publications/statutory-guidance-framework-controlling-orcoercive-behaviour-in-an-intimate-or-family-relationship 16.This definition includes so-called 'honour-based' violence, and includes crimes such as female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

It is a statutory requirement for a Community Safety Partnership (CSP) to initiate and undertake a DHR in which 'the victim was normally resident' or where 'the victim was last known to have frequented.' Statutory guidance also states it is the duty of any 'person or body establishing or participating in a domestic homicide review' to have regard to the guidance. In relation to England and Wales the persons and bodies this refers to includes:

- Chief officers of police for police areas in England and Wales;
- Local authorities;
- Strategic Health Authorities;
- NHS Commissioning Boards (NHS England);
- Clinical Commissioning Groups;
- Providers of probation services.

In Suffolk, the associated costs of a DHR are shared by the statutory partners of the local CSP the DHR is conducted within. The decision to share the cost was made in April 2016, another decision to share the additional costs of administration (not Community Safety Officer time) was made in November 2017.
The partners that share the costs of the DHR including administration costs are:

1. Suffolk Constabulary
2. Babergh District Council
3. Mid Suffolk District Council
4. West Suffolk Council
5. Ipswich Borough Council
6. East Suffolk Council
7. West Suffolk Clinical Commissioning Group
8. Great Yarmouth and Waveney Clinical Commissioning Group
9. Ipswich and East Suffolk Clinical Commissioning Group
10. Suffolk County Council

The National Probation Service (NPS) are a statutory partner of Community Safety Partnerships. NPS policy states that they will not financially contribute to DHRs.

The total cost of the DHR should be shared equally across those remaining statutory CSP partners.

The Domestic Homicide Review Process in Suffolk

Step 1 - Notification

1. Constabulary Protecting Vulnerable People Directorate liaises with Senior Investigating Officer (SIO) in advance of formal notification to CSP.

2. Suffolk Constabulary notifies the CSP Chair, District/Borough Lead CSP officer, SCC CSP Lead and Safeguarding Leads of a suspected domestic homicide.

3. SCC/District or Borough CSP Lead informs appropriate Management and Cabinet Member.

Step 2 – Establishing if DHR

1. Suffolk Constabulary provides formal notification using DHR1 form (Appendix A) and further information when available using DHR1A (Appendix B).

2. The District/Borough CSP Lead liaises with CSP Chair to establish date for initial Advisory Panel meeting to establish whether the homicide meets the criteria for a Domestic Homicide Review (which should take place as soon as possible to meet 1 month formal notification by the CSP of potential DHR to the Home Office) and identifies appropriate partners to attend (Police, SCC, District and Borough, Safeguarding and Health).

3. Consideration should be given to the likelihood of the DHR meeting the definitions (as below) before resources are invested/Independent Author commissioned.

   Definitions

   Under section 9(1) of the 2004 Act, Domestic Homicide Review means a view 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 *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,

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

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

   * *denotes he or she*

4. Where partner agencies of more than one local authority area have known about or had contact with the victim, the CSP of the local authority area in which the victim was normally resident should take lead responsibility for conducting any Review. If there was no established address prior to the incident, lead responsibility will relate to the area where the victim was last known to have frequented as a first option and then considered on a case by case basis. There may be circumstances in which lead responsibility for conducting a Review may not be easily determined due to the complex nature of the case. It is for local areas to come to an appropriate arrangement in such circumstances.

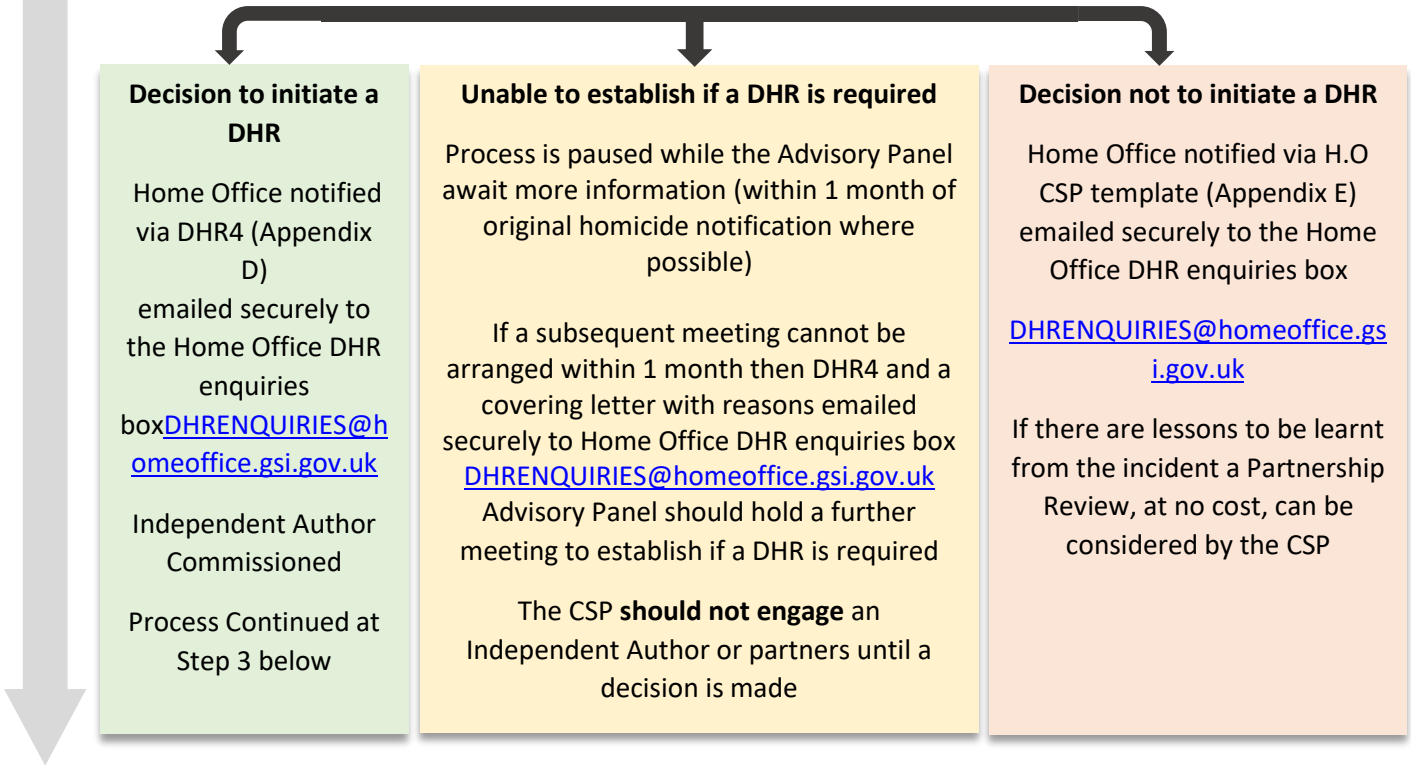
5. Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a Review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

6. The Advisory Panel is Chaired by the CSP Chair who has overall responsibility for establishing whether a homicide is to be the subject of a DHR, giving consideration to the definitions, in consultation with the Advisory Panel members.
7. If during the Advisory Panel meeting the Panel members are unable to establish whether a Domestic Homicide Review should be undertaken as records from key agencies and/or enquiries relevant to the incident i.e. Police are outstanding, then a 2nd Advisory Panel meeting should be arranged as soon as practicable.
8. If at the 2nd Advisory Panel meeting following completion of any outstanding enquiries and sight of agency records there is:

   - **no evidence that the homicide was as a result of domestic abuse and was due to other causes; and/or**
   - **there is no evidence from the records/information presented that there had been domestic abuse in the relationship**

   Then a Domestic Homicide Review SHOULD NOT be undertaken and partners will not be liable to share any subsequent costs that incur

9. A Domestic Homicide Review should not be undertaken as a way of trying to establish whether there *might* have domestic abuse in the relationship.
10. At this point there are several options available to the DHR Advisory Panel.



Step 3 – Conducting a DHR

Conducting a Domestic Homicide Review (DHR)

1. The CSP Lead, on behalf of the Advisory Panel, issues instruction to statutory partners and other partners as appropriate to secure files/ case records relating to the victim, offender and wider family networks where they are known to that service.
2. CSP Lead starts to log additional admin costs from initial DHR Advisory Panel onwards and the CSP Lead creates a timeline of the process from date of homicide through to date of publication of the DHR Overview Report, Executive Summary and Action Plan. (Appendix C). Timeline is used to feed back to the CSP to learn from challenges or opportunities within the process for future Reviews.
3. District/Borough Community Safety (CS) Lead completes DHR4 (Appendix D) on behalf of CSP Chair, signed with electronic signature of CSP Chair , logs and sends DHR4 (Appendix D) to Home Office DHR enquiries box DHRENQUIRIES@homeoffice.gsi.gov.uk securely via email using encryption methods and marked confidential/official sensitive within 1 month of the notification of a domestic homicide.
4. All documents, forms and correspondence relating to DHR should be password protected and stored electronically in a folder with restricted access due to sensitivity and confidentiality of the DHR.
5. SCC Community Safety Team hold a list of approved DHR Chairs/Authors and the Advisory Panel members should appoint from this approved list based on the Authors expertise in that area or best meets the needs of the case and their availability. This negates the need for lengthy procurement which can often delay the DHR process.
6. The CSP Lead should contact the prospective DHR Chair/Author and request a written quotation for the work, a Terms of Reference for the work and anticipated timeline.
7. Once a DHR Independent Chair/Author is appointed, the District/Borough CSP Lead securely shares a copy of the DHR1 and DHR4 with Independent Chair/Author. The District/Borough CSP Lead will be the point of contact for DHR Independent Chair/Author. The CSP Lead liaises with the Independent Author and agrees which partners/agencies/organisations need to be invited to Review Panel meetings (Appendix F for list of potential Review Panel members). As the DHR progresses, additional partners/agencies/organisations may need to be included as part of the Review. The Chair/Author and Review Panel members should consider the scope of the Review process and establish and agree a Terms of Reference.
8. If the domestic homicide victim is aged between 16 and 18, there are separate requirements in statutory guidance for a range of review methods, Safeguarding Adult Review, Child Safeguarding Practice Reviews and a Domestic Homicide Review. Consideration should be given to these Reviews being managed in parallel (if there is a need to complete more than one) and CSP Chair and subsequent DHR Chair/Author will need to liaise with SCC Suffolk Safeguarding Partnership (Children and Adult).
9. The District/Borough CS Lead will be the Single Point Of Contact (SPOC) in notifying statutory partners and other partners to advise them the Domestic Homicide Review process has been triggered, attendance requirement for the first DHR Review Panel meeting and subsequent Review Panel meetings.
10. In the case where the homicide occurred in Suffolk and the services accessed by the victim are in a different County, it is the responsibility of the District/Borough CSP Lead to identify the contacts in each of the statutory partners to advise them of the DHR and to secure files/ case records relating to the victim, offender and wider family networks

where they are known to that service. The CSP Lead should also advise of the date of the 1st Review Panel meeting.

11. Both CSP Chair and DHR Chair/Author will attend the first DHR Review Panel meeting which will be opened by the CSP Chair. Subsequent meetings will be chaired by the DHR Chair/Author for the remainder of the process. The CSP Chair is integral to the Review and should attend the Review Panel meetings as a Panel Member.

12. The DHR Chair/Author on behalf of the CSP will write to family members of the victim to advise them of Domestic Homicide Review process and give the family the opportunity to be integral to the Review and be treated as a key stakeholder. The DHR Chair/Author may ask the CSP Lead to write the letter on his/her behalf. (Appendix G) template family letter.

13. The DHR Chair/Author in conjunction with the Review Panel members should consider approaching the family of the perpetrator who may also have relevant information to offer. However, the Chair should also be mindful that the perpetrator or members of the perpetrator's family might in some cases pose an ongoing risk of violence to the victim's family or friends, or vice versa. If the Chair is concerned that there may be a risk of imminent physical harm to any known individual(s). they should contact the Police immediately so that steps can be taken to secure protection.

14. The DHR Chair/Author will write to the agencies, bodies or organisations identified as part of the scope of the Review to commission Individual Management Reviews (IMRs) and/or chronologies from organisational records.

15. A series of DHR Review Panel meetings to align with the pace of the Review will take place, chaired by the DHR Chair/Author. If the DHR is cross-border, i.e. victim and any children accessed services in another County, the Independent Chair/Author will conduct enquiries with those agencies in that County to participate in the Review. It is likely agencies from out of County will be represented at Panel meetings and may form the majority of the agencies represented on the Review Panel.

16. Following the Trial, members of the victims family and friends may want to engage with the DHR and participate in a Review Panel meeting. Involvement of family and friends will be organised by the DHR Chair/Author.

17. As the DHR progresses, the DHR Review Panel members in conjunction with the CSP Lead will formulate the recommendations into an Action Plan which the Review Panel members should translate into Specific, Measurable, Achievable, Realistic and Timely (SMART) outcomes. (Appendix H) Action Plan example.

18. If the DHR is cross-border with another local authority/CSP area, a single Action Plan will be produced and may include some recommendations that apply to lead agencies cross-border. An agreement between the CSP authorities in relation to the leadership of the monitoring and sign-off upon completion of implementation of the recommendations will need to be developed and agreed. To ensure the other CSP is engaged in the process, the Suffolk CSP Chair should make contact with the cross-border CSP Chair and formalise an agreement as soon as the recommendations have been finalised and before the documents are submitted to the Home Office Quality Assurance Panel.

Step 4 – DHR process

1. The DHR Chair/Author presents a draft DHR Overview Report including the recommendations to the Review Panel for consideration. The Review Panel members should ensure they are satisfied that the report accurately reflects the Review Panel findings.

2. Whilst undertaking the Review process the DHR Author may relay to the Review Panel members some compelling reasons relating to the welfare of the children or other persons directly concerned in the Review as to why the Overview Report and Action Plan should not be published. The decision whether or not to publish should be agreed by the DHR Author and Panel members prior to presenting to the CSP and submitting to the Home Office Quality Assurance Panel.

3. If the decision is not to publish, the DHR Author should add in a paragraph to the Preface along the lines of 'For the reasons outlined later within this report, this Review is considered **inappropriate for publication.** It is intended that it remains **confidential** to professionals within Suffolk and that **learning is disseminated through local mechanisms**. The DHR Overview Report and Action Plan should be watermarked 'Official Sensitive. Not for publication.'

4. If the decision is to publish, the District/Borough CSP Lead removes the 'Confidential' watermark to the completed DHR Overview Report and DHR Action Plan.

5. The CSP Lead proof-reads Overview Report and checks the report has been suitably anonymised and the pseudonyms have been used to replace names. Any oversights are to be highlighted to the DHR Author.

Step 5 – Submission to Home Office

1. The final Overview Report and Action Plan is tabled for information only, not sent electronically, including the reasons for not publishing (if applicable), at the next CSP meeting. An extra-ordinary meeting may ne held to avoid unnecessary delays in emailing the report to the Home Office Quality Assurance Panel. The CSP role is to agree and sign of the Overview Report and Action Plan.

2. The District/Borough CS Lead completes the Home Office Domestic Homicide Review Data Collection Form (Appendix I) which is not for publication. The link to the Domestic Homicide Review Community Safety Partnership Reporting Form for completing for the Home Office can be found at: https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

3. The DHR Overview Report, DHR Action Plan and Home Office DHR Collection Form should be password protected and stored in the electronic restricted folder along with all other DHR documents.

4. A copy of the DHR Overview Report, DHR Action Plan and Home Office DHR Collection Form are saved as PDF documents and submitted securely via email encryption methods to the Home Office enquiries box for Quality Assurance (DHRENQUIRIES@homeoffice.gsi.gov.uk) by the CSP Lead on behalf of the CSP Chair.

5. The Home DHR Quality Assurance Panel is held approx. every 3 months; however, the documents will go through a Pre-Quality Assurance Assessment (PQAA). The aim of the assessment is to speed up the quality assurance process by making sure that reports heard by the QA Panel are signed off for publication on their first hearing. The PQAA process has been created to assist CSPs in expediting their report through the QA Panel.

6. During the PQAA, some areas may be highlighted as needing further consideration before it can be heard by the QA Panel and the CSP Lead will receive notification by email from the Home Office Domestic Abuse Policy Team.

7. The CSP Lead should forward the email to the DHR Chair/Author for consideration and upon completion of the actions, the report and any associated documents should be emailed by the CSP Lead to the Home Office. The CSP Chair should be notified of the

letter and response from the DHR Chair/Author. Any amended reports/documents should be stored in the electronic restricted folder along with all other DHR documents.

Step 6 – Publication

1. Following the DHR Quality Assurance Panel meeting, the Home Office Quality Assurance Panel Chair provides a letter for the CSP via email to the CSP Lead with a recommendation to publish or acknowledgment that the report is not to be published.
2. The CSP Lead provides a copy of the Home Office Quality Assurance Panel response to the DHR Chair/Author and CSP Chair.

If to be published

1. If the Overview Report and Action Plan are to be published, the DHR Chair/Author will produce an Executive Summary which is to be published along with the Overview Report and Action Plan.
2. The DHR Chair/Author in conjunction with the CSP Lead and CSP Chair, notifies the local authority and Suffolk Constabulary Communication Teams (and where there are restrictions in publicity, i.e. children's anonymity, the local authorities legal team) of the pending publication date (Embargoed). The CSP Lead checks pending publication date against key dates for sensitivity and avoidance (date of homicide, birth dates of victim and offender and immediate family members, Mother's Day/Father's Day etc).
3. The CSP Lead emails the DHR Overview Report and Action Plan using secure email encryption to each of the Review Panel participating agencies (to share with their Senior Management), and to the Police and Crime Commissioner (PCC) before publication with a covering email explaining the Overview Report and Action Plan are Embargoed and detail the date the report is to be published.
4. If there are restrictions in publicity or recommendations that relate to certain organisations, the Review Panel member of that organisation should bring it to the attention of their organisations Communication Team, who should liaise with the Local Authority and Suffolk Constabulary Communications Teams to ensure continuity of message.
5. There are media guidelines to help journalists report on Domestic Violence deaths in a dignified way. Details of Level Up media guidelines can be found at: https://setdab.org/resource/media-guidelines-to-help-journalists-report-on-domestic-violence-deaths/
6. The DHR Chair/Author notifies the victims' family and offenders family of the pending publication date (only in cases where the Overview Report and Action Plan are to be published).and provides the family with a copy of the Overview Report and supporting documents including the letter from the Home Office Quality Assurance Panel.
7. The CSP Lead publishes the Overview Report, Executive Summary and Action Plan on the CSP page of the District/Borough Council website along with legal letters detailing any restrictions. The report is also added to the Suffolk Adult Safeguarding Board Website (not the Action Plan).

If not to be published

8. If the Overview Report, Executive Summary and Action Plan are not to be published they should be password protected, marked, RESTRICTED, DO NOT PUBLISH and stored in the electronic restricted folder along with all other DHR documents.

9. Where it is not to be published and to maintain control over the restricted documents, the final version of each document should be retailed by the CSP Lead only and should not be distributed to the DHR Review Panel members or CSP partners.

Home Office and DA Commissioner (DA Act 2021) Final Report Requirements

10. A copy of the Executive Summary, Overview Report and Action Plan must be sent to the Home Office in PDF format to DHRENQUIRIES@homeoffice.gsi.gov.uk even if the documents are not to be published.

11. In addition, the Domestic Abuse Act 2021 requires all Community Safety Partnerships to email **final** copies of Domestic Homicide Review reports to the Domestic Abuse Commissioner. This will be a legal requirement from 01 November 2021; however the DA Commissioner would like to start receiving final DHR reports from now onwards. All Domestic Homicide Reviews should be emailed to DHR@domesticabusecommissioner.independent.gov.uk

Media interest in DHRs not to be published

12. There may be instances where the Media may contact a local authority to follow up on the publication of a DHR. Where a DHR is not to be published, which has been approved by the Home Office Quality Assurance Panel, the CSP Lead should inform SCC Community Safety Lead of the Media interest.

13. Section 8, Publication of the Overview Report in the Home Office Domestic Homicide Review guidance *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.*

14. The CSP Chair should respond directly to the Media request and should provide a response along the lines of:

    We cannot comment on individual cases, however, in relation to the xxxx case you are referring to, the Home Office were informed that the Domestic Homicide Review is not to be published and the reasons for that decision. Under the guidance it is clear that in exceptional circumstances the CSP do not have to publish the report.

15. If the Media respond and ask the reason why the Review will not be published, the response should be along the lines of:

    The CSP do not have to explain the exceptional circumstances and the decision remains that the Review will not be published.

16. The CSP Lead should notify the DHR Review Panel members of any media interest who should inform their Comms Team in the event the media may contact one of the statutory partner agencies.

17. The CSP Lead should notify the DHR Chair/Author of the Media interest as the Media may make contact with family members.

Step 7 – Role of the CSP

1. The CSP Lead will notify the SCC Community Safety team DHR Lead of the cost of any additional admin support (not Community Safety Officer time) for the DHR.

2. The SCC Community Safety DHR Lead raises a Purchase Order (PO) and invoices statutory CSP local partners for DHR Chair/Author costs including any additional admin

costs The total cost should be shared equally across the CSP partners including the District/Borough in which the DHR occurred. (See page 2 for CSP partners). Once the invoices have been paid the SCC DHR Lead will reimburse the District/Borough where the DHR occurred (minus their DHR Chair/Author cost contribution).

3. Following the successful completion of the work, in line with the terms of reference, SCC Community Safety Team will pay the DHR Chair/Authors invoice.
4. The CSP is responsible for monitoring and ensuring the recommendations within the Action Plan are implemented by the lead agencies in a timely manner and escalates to the Violence Against Women and Girls, Men and Boys Strategy Group (VAGMB) for exception reporting.
5. Where the DHR is cross-border, the CSP in which the homicide occurred retains overall responsibility for monitoring and ensuring the recommendations within the Action Plan and implemented.
6. VAWGMB collates the recommendations and identified common themes which are shared with the wider Suffolk System including the Safeguarding Boards.
7. The CSP Lead regularly updated the CSP page on the District/Borough website with the updated DHR Action Plan as the recommendations are implemented.
8. The CSP formally concludes the Review when all the actions are complete.
9. The CSP Lead updates the CSP page on the District/Borough website with the completed DHR Action Plan and notifies the VAWG Strategic Group.

Retention and Disposal

1. Agencies/organisations involved in the DHR should retain copies of minutes and any other notes for no longer than a period required by legislation or their own policy.
2. Each agency/organisation will be responsible for the safeguarding of information in line with the Data Protection Act (DPA) 1998.
3. When the information is no longer regarded as being relevant, each individual agency/organisation will be responsible for its secure disposal/destruction.
4. Information should be deleted if:
    - the information has been shown to be inaccurate, in ways which cannot be dealt with by amending or appending the record, or
    - it is no longer considered that the information is necessary for Police or partners' legitimate purposes;
    - it reaches the end of the agreed retention period in each partner agency.

Freedom Of Information (FOI) Requests and Subject Access Requests (SARs)

1. If an agency/organisation receives a Freedom Of Information (FOI) request or a Subject Access Request (SAR), then you should refer to their in-house Legal Team/Freedom Of Information specialist(s)/Data Protection Officer (DPO).
2. The agency/organisation will respond to a request for information under an individual right of access within the statutory time limit.
3. Where a partner agency/organisation receives an information request under Section 1 of the Freedom Of Information Act 2000 and the request involves access to information

received from a partner agency, the partner who receives the request will forward the request onto the partner from whom the information was given for the DHR.

Appendix A

DHR1

To be completed as soon as possible following identification of a domestic homicide by Suffolk Constabulary).

1. Referrer

Name		**Designation**	
Email		**Line Manager**	
Phone No		**Phone No**	

Email the completed DHR 1 to: the chair of the CSP and Lead Officer from the list below for the related area of the potential DHR		
Name	**Organisation**	**Email address**
Derek Davis	West Suffolk CSP Chair	Derek.davis@baberghmidsuffolk.gov.uk
Mark Jepson	East Suffolk CSP Chair	mark.jepson@eastsuffolk.gov.uk
Alasdair Ross	Ipswich CSP Chair	Alasdair.Ross@councillors.ipswich.gov.uk
Lesley-Ann Keogh	West Suffolk Council West Suffolk CSP Lead Officer	Lesley-ann.keogh@westsuffolk.gov.uk
Rachael Young	Babergh and Mid Suffolk West Suffolk CSP Lead Officer	Rachael.young@baberghmidsuffolk.gov.uk
Alex Heys	East Suffolk Council East Suffolk CSP Lead Officer	Alex.Heys@eastsuffolk.gov.uk
Deborah Carr	Ipswich Borough Council Ipswich CSP Lead Officer	Deborah.carr@ipswich.gov.uk

Please also cc all the people below		
Name	**Name**	**Name**
David Giles	Suffolk Police, Detective Superintendent	David.Giles@suffolk.pnn.police.uk
Clair Harvey Melanie Yolland	Suffolk County Council, Community Safety Manager Community Safety Project Officer	clair.harvey@suffolk.gov.uk melanie.yolland@suffolk.gov.uk

BRIEF RESUME OF FACTS AND FAMILY COMPOSITION

2. Victim:

Name of Victim	
Date of Birth	
Date of death	
Home address	
Gender	
Ethnic origin	
Nationality	
Disability	
Faith	
Sexual Orientation	
Whereabouts at time of death	

Suspected Perpetrator:

Name of suspected perpetrator	
Date of Birth	
Home address	
Relationship to victim	
Gender	
Ethnic origin	
Nationality	
Disability	
Faith	
Sexual Orientation	
Arrested?	
Charged?	
In custody?	

Family Composition/Significant Others:

Name	Relationship to victim	Relationship to suspected perpetrator	DoB	Address	Other comments

3. Other agencies Involved:

Agency	Contact Details	Extent of involvement

4. Circumstances that triggered the notification

The death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

a) person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or
b) a member of the same household as him- or herself

5. Date of Referral

6. Confirmation of line manager awareness: Yes/No

Note: Agencies are reminded of the need to secure their files as soon as they become aware that a Domestic Homicide Review might take place

Appendix B

DHR1A supplementary information to DHR1

Supplementary Information to Notification of a Domestic Homicide to the Chair of a Community Safety Partnership

To be completed as soon as possible following identification of a domestic homicide by Suffolk Constabulary).

1. Referrer

Name		**Designation**	
Email		**Line Manager**	
Phone No		**Phone No**	

Email the completed DHR 1 to: the chair of the CSP and Lead Officer from the list below for the related area of the potential DHR		
Name	**Organisation**	**Email address**
Derek Davis	West Suffolk CSP Chair	Derek.davis@baberghmidsuffolk.gov.uk
Mark Jepson	East Suffolk CSP Chair	mark.jepson@eastsuffolk.gov.uk
Alasdair Ross	Ipswich CSP Chair	Alasdair.Ross@councillors.ipswich.gov.uk
Lesley-Ann Keogh	West Suffolk Council West Suffolk CSP Lead Officer	Lesley-ann.keogh@westsuffolk.gov.uk
Rachael Young	Babergh and Mid Suffolk Councils West Suffolk CSP Lead Officer	Rachael.young@baberghmidsuffolk.gov.uk
Alex Heys	East Suffolk Council East Suffolk CSP Lead Officer	Alex.heys@eastsuffolk.gov.uk
Deborah Carr	Ipswich Borough Council Ipswich CSP Lead Officer	Deborah.Carr@ipswich.gov.uk

Please also cc all the people below		
Name	**Name**	**Name**
David Giles	Suffolk Police, Detective Superintendent	David.Giles@suffolk.pnn.police.uk
Clair Harvey	Suffolk County Council, Community Safety Manager	clair.harvey@suffolk.gov.uk
Melanie Yolland	Suffolk County Council Community Safety Project Officer	Melanie.yolland@suffolk.gov.uk

V3 Updated April 2022. Inserted and referenced new H.O template (Appendix E) for CSPs for further information when a decision not to conduct a Domestic Homicide Review (DHR) has been made. Forms - Appendix reference changes from Appendix E onwards. WSCSP Chair and CSP leads updated.

BRIEF RESUME OF FACTS AND FAMILY COMPOSITION

2. Victim:

Name of Victim	
Date of Birth	
Date of death	
Home address	
Gender	
Ethnic origin	
Nationality	
Disability	
Faith	
Sexual Orientation	
Whereabouts at time of death	

Suspected Perpetrator:

Name of suspected perpetrator	
Date of Birth	
Home address	
Relationship to victim	
Gender	
Ethnic origin	
Nationality	
Disability	
Faith	
Sexual Orientation	
Arrested?	
Charged?	
In custody?	

Brief Details of Incident:

Family Composition/Significant Others:

Name	Relationship to victim	Relationship to suspected perpetrator	DoB	Address	Other comments

3. Other agencies Involved:

Agency	Contact Details	Extent of involvement

4. Circumstances that triggered the notification

The death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

a) person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or
b) a member of the same household as him- or herself

5. Date of Referral

6. Confirmation of line manager awareness: Yes/No

Note: Agencies are reminded of the need to secure their files as soon as they become aware that a Domestic Homicide Review might take place

Appendix C

XXXXXXX DHR Timeline

Date	Event	Notes
17/01/2020	Domestic incident in xxxx	
17/01/2020	*LAK notified Manager, Chief Exec and Cabinet Member of potential DHR	
17/01/2020	LAK notified **CH and CSP Chair of potential DHR	Passed on most up to date press release and email to Manager, Chief Executive, CSP Chair
20/01/2020	DHR1 received from Suffolk Constabulary	DHR1 emailed encrypted and password protected to CSP Chair
20/01/2020	LAK emailed CSP Chair to request availability for Advisory Panel meeting (need to be held within 1 month of notification)	
23/01/2020	Response received from CSP Chair with various dates/times	
20/01/2020	LAK emailed key contacts in statutory partners (CSP Chair, Police, SCC Safeguarding Adults, SCC Safeguarding Children and CCG) with date of Advisory Panel meeting, requested secure records and to provide information held on record at Advisory Panel meeting	
27/01/2020	Advisory Panel meeting held. Deemed to meet the criteria for a DHR	LAK completed DHR4 form and emailed to DHREnquiries to advise Home Office undertaking a DHR

*LAK - Lesley-Ann Keogh

** CH – Clair Harvey

Appendix D

DHR 4 (To be completed by the Chair of the CSP)

Completed by Chair of *XXXXCSP Date:XXXXX.*

Following meetings with Advisory Panel colleagues in Suffolk, reviewing all available information in connection with the homicide of:

Name/Address/Date of homicide

…….

It is recommended that this case should be subject to a Domestic Homicide Review for the following reasons: -

Reason should include outcome of Advisory Panel decision including any Police information in relation to the Homicide (victim(s)/perpetrator)

These circumstances therefore satisfy the criteria that the death of a person aged 16 or over has, or appears to have, resulted from violence abuse or neglect by:

"a person to whom she was related or with whom she had been in an intimate personal relationship"

This decision will be notified to the Home Office in accordance with 4.6 of the Statutory Guidance. (A decision not to proceed with a Domestic Homicide Review could be overturned by the Secretary of State)**.**

The following agencies/professionals have been consulted: -

Date	**Name**	**Agency**
		Suffolk County Council, Specialist Lead, Locality and Partnerships Team
		Suffolk Constabulary, Protecting Vulnerable People Directorate
		Suffolk County Council, Safeguarding Adults Manager
		Borough/District Councils, Community Safety Lead
		Others as appropriate

Legal advice has not been sought

Signed: XXXXXXXXXXX

Chair of XXX CSP

Dated: XXXXXXXXXX

Appendix E

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

www.homeoffice.gov.uk

Template for CSPs for further information when a decision not to conduct a Domestic Homicide Review (DHR) has been made

Decisions not to conduct a DHR are sent to our Quality Assurance (QA) Panel for review and can also be escalated to the Home Secretary. As such, a clear rationale for why you have not commissioned a DHR is needed in consultation with the statutory guidance on DHRs found here: DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk).

We would be grateful if you could please outline your rationale in the table below.

Case name: CSP:

1. Background of the case, including; **a. what criteria triggered the DHR discussion** **b. What type of homicide (or suicide) intimate partner, family, house of multiple occupancy etc.** **c. the process which led to this case being considered for a DHR**
2. Circumstances and events surrounding the death
3. Process and rationale behind the decision not to conduct a DHR

4. Scoping timelines and process
5. Agency involvement and other contacts involved in the process, including details of any specialist advocacy services involved
6. Views or wishes of the family, for example, any objections to a DHR being conducted or different views **To note, the family should not be informed that a DHR is not going ahead until the Home Office QA feedback is received and a decision is made**
7. Any other additional relevant information **For example, please state if an alternative review, such as Adult Safeguarding Review, has been considered**

Email: DHREnquiries@homeoffice.gov.uk

Appendix F

DHR Review Panel members

Detailed below is a list of individuals/partners/agencies who should form part of the DHR Review Panel. However, this is not an exhaustive list and the DHR Chair/Author may wish to include other organisations as the Review progress who have/may have had involvement with the victim/perpetrator or family members.

Organisations
Community Safety Partnership - Chair
District/Borough Council – CSP Lead
Clinical Commissioning Group: Ipswich and East Suffolk CCG Great Yarmouth and Waveney CCG West Suffolk CCG
Suffolk Constabulary - Protecting Vulnerable People Directorate
Suffolk County Council - Community Safety
Suffolk County Council – Adult Community Services (ACS)
Suffolk County Council – Children and Young People Services (CYP)
Norfolk and Suffolk Foundation Trust (NSFT) – Mental Health Lead/Patient Safety Lead
East of England NHS Ambulance Trust – Safeguarding Lead
Women's Aid
Women's Refuge
Local Domestic Abuse Forum/Partnership
Coroner's Office

Appendix G

Template Family letter

CSP Logo

CSP Address
CSP Address
CSP Address (WSCSP)
CSP Address
CSP Address
CSP Address

Family Address
Family Address
Family Address
Family Address
Family Address

Date: XX XXX 2021

Dear xxxxxxx

I am writing firstly to offer my sincere condolences on the very tragic loss of your *mother/daughter/sister/father/son/brother (delete as appropriate)* and how sorry I am to intrude at this difficult time.

I also wanted to inform you that an independent review, known as a Domestic Homicide Review, which is a legal requirement has been commissioned by XXX Community Safety Partnership. (XXX CSP).

XXXX Community Safety Partnership will be leading on the Domestic Homicide Review and they have appointed myself as the independent chair/author to examine the circumstances of *(name of homicide victim)* death in accordance with the Home Office "Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews."

The review will examine what happened to *(name of homicide victim)* and identify any lessons that need to be learned in order to prevent this tragedy being repeated. It will try to ensure that public bodies like health, Police and other community based organisations understand what happened leading up to the death of *(name of homicide victim)* and identify where responses to the situation could be improved. These reviews do not seek to lay blame but seek to improve responses to domestic violence in the future and is separate from the criminal proceedings that are underway.

The Home Office has a leaflet for family members explaining more about Domestic Homicide Reviews. *However, as a result of home working, unfortunately there is currently no access to paper copies of the leaflets.(Delete if no longer applicable)*

Therefore, I have enclosed the link on the Home Office website for further information on Domestic Homicide Reviews for family members:

https://www.gov.uk/government/publications/domestic-homicide-review-leaflet-for-family

It is often the case that family members, friends and other close caring people who knew the victim are the best people to understand what happened and it is important that they are invited to contribute their views about their relative's experiences of domestic abuse and how other homicides could be prevented.

I will not be speaking to any individual involved in the case until the criminal proceedings are finished, so as not to interfere with this process.

I will be in touch with you at the conclusion of the criminal trial to extend that invitation and assure you that this is completely your decision whether or not you wish to participate in the review and that this would be a confidential process.

I appreciate that discussing this might be an upsetting prospect, but we hope you will agree that it is really important that we hear from people who knew *(name of homicide victim)* personally.

In the meantime, please once again accept my condolences for your loss and do not hesitate to contact me on *(insert email address/contact number as appropriate)* if you have any questions at this point.

Yours sincerely

Name of DHR Independent Chair/Author

Chair of the DHR Review Panel

Appendix H

Action Plan Template

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key Milestones achieving in enacting recommendations and outcomes	Target Date	Completion Date and Outcome
What is the over-arching recommendation?	Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the Home Office Quality Assurance Panel; however, the Review Panel can suggest recommendations for national level)	How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?	Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?	Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved	When should this recommendation be completed by?	When is the recommendation actually completed? What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?
Fictional example						
Community educated on the risk factors around domestic violence and abuse	Local and national	Identify mediums to advertise these risk factors by July 2021 and how and if it should be done in a targeted way so they are	CSPs and Home Office	Plan agreed July 2021 Mediums told of information and advertising it by September 2021	December 2021	The Community is much more aware of the risk factors and reports are being heard of the community making safe and early

		accessible to all i.e. local authority website, GP surgeries, Hospital Accident and Emergency clinics, dentist surgeries etc Circulate briefing and hold meetings to discuss Leaflet printed nationally advising family, friends and community on how to help victims of domestic violence and abuse and distribute by December 2021		Leaflet distributed nationally by December 2021		interventions to avert domestic violence and abuse More questions are being received from the community on how to help victims of domestic violence and abuse

Appendix I

DOMESTIC HOMICIDE REVIEW DATA – Extract from Home Office form for completion.

Form can be found at: Domestic homicide reviews: statutory guidance - GOV.UK (www.gov.uk)

PLEASE MARK EACH BOX: IF QUESTION IS NOT APPLICABLE PLEASE STATE: N/A
IF ANSWER IS NOT KNOWN PLEASE STATE THIS OR PUT: N/K

Name of Community Safety Partnership	
Local Authority	
Police Force Area	
Date of death	
Postcode and location of death	
Is location victim's home address? (Y, N or N/K)	
Review Panel Chair	
Review Author	
Date Home Office notified of DHR	
Local DHR Reference	
Date report completed by author	
Date signed off by CSP Board	
Date submitted to Home Office by CSP Board	
Home Office Reference Number given for report	

Please return to the Home Office with your completed DHR documents to: DHREnquiries@homeoffice.gsi.gov.uk

V3 Updated April 2022. Inserted and referenced new H.O template (Appendix E) for CSPs for further information when a decision not to conduct a Domestic Homicide Review (DHR) has been made. Forms - Appendix reference changes from Appendix E onwards. WSCSP Chair and CSP leads updated.