

Domestic Homicide Review

[DHR] Protocol

**Document Control**

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 | Domestic Abuse Project Officer |

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**1.** **INTRODUCTION**

1.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis from 13 April 2011, under Section 9, Domestic Violence, Crime and Victims Act (2004).

1.2 The revised [Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf) states a DHR is 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/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 himself/herself,

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

1.3 In cases where a victim took their own life (suicide) and the circumstances give rise to concern, a review should be undertaken.

1.4 This protocol outlines the approach being taken across Lincolnshire in meeting this statutory requirement. It aims to supplement and not replace the full revised Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews issued by the Home Office in December 2016. Both the national guidance and this protocol should be used together in all cases. In the event of a conflict the Home Office guidance will prevail.

1.5 Statutory guidance indicates it is the duty of any ‘person or body establishing or participating in a DHR’ to have regard to the Home Office Guidance. As of 13 April 2011, the requirements for initiating and undertaking a DHR are the responsibility of the area in which ‘the victim was normally resident’ or ‘the victim was last known to have frequented.’

In Lincolnshire the governance of all DHRs sits with the Lincolnshire Domestic Abuse Partnership [LDAP] on behalf of the Safer Lincolnshire Partnership (SLP) who have statutory responsibility for this function.

1.6 Agencies required to participate under the above statutory guidance in any DHR are:

* Chief Officers of Police
* Local Authorities (Adult Social Care and/or Children's Services/Children’s Health, Borough, District, Unitary and County Councils)
* NHS Integrated Care Board
* Providers of Probation Services
* NHS trusts (LPFT, LCHS, ULHT)

1.7 Other relevant agencies may be invited to participate in the DHR at the request of the review panel.

1.8 This agreed protocol aims to give clarity regarding the process itself, in line with the DHR Flowchart available in section 16 and also the roles and responsibilities of the officers/partnerships in that process.

**2.** **THE PURPOSE OF A DHR**

2.1 The purpose is to:

* 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;
* identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
* apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
* prevent domestic abuse and homicide and improve service responses for all domestic abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
* contribute to a better understanding of the nature of domestic abuse; and highlight good practice.

**3.** **ROLES AND RESPONSIBILITIES**

3.1 The below table provides a summary of the roles and responsibilities of those involved in the conduct of DHRs.

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| --- | --- |
|  Lincolnshire Domestic Abuse Partnership [LDAP] | The LDAP has the statutory responsibility, delegated to it by the SLP, for undertaking DHRs. The LDAP will agree timescales for the review and amendments to those timescales, agree the content of and sign off the Overview Report and accompanying reports prior to submission to the Home Office, agree the recommendations regarding publication, provide a copy of the report to relevant parties and monitor progress against the action plan. |
| Chair of the SLP | The Chair of the SLP holds responsibility for establishing whether a homicide is to be subject of a DHR. This decision is taken in consultation with local partners. The Chair will also agree the details of the publication process. |
| Domestic Abuse Business Manager[[1]](#footnote-1) | The Domestic Abuse Business Manager will be the single point of contact for the reviews and ensure the DHR complies with statutory requirements, liaise with the SLP Chair and will lead regarding liaison with the Home Office on behalf of the Chair. They will provide advice and guidance to the Chair of the Review Panel (where needed) and facilitate the engagement of an independent overview report author on behalf of the LDAP (based on advice from the review panel). The DA Business Manager, on behalf of the panel, will also establish whether a parallel LCSPR/SAR process or other relevant reviews are being considered.They will ensure that the Domestic Abuse Operational Group, Strategic board and Programme board are presented with a status update for all DHR's being undertaken and provide regular reports including a summary of the recommendations from each review. |
| Legal Advisor  | Legal Services Lincolnshire (LSL) will be the legal advisers to the Review Panel. LSL will ensure that the Review Panel and its members manage the risk of legal challenge to the DHR process. The role of LSL will be to advise the Review Panel so as to ensure compliance with statutory guidance; give assurance that IMRs/summary reports and the Final Report are objective, proportionate and evidence based prior to their acceptance by the Review Panel. They will be the only point of contact with the Coroner once a DHR has been commissioned and will offer advice on the HO feedback and publication process.  |
| LDAP Senior Business Support Officer  | To support the administration of DHR's, including the circulation of documents, arranging meetings, taking minutes, receiving Individual Management Reviews and management of the delivery of the overview report. |
| Independent Domestic Abuse Expert (EDAN Lincs) | The Expert will act as the expert on the panel regarding domestic abuse and provide the links with specialist domestic abuse services. |

**4** **TIMESCALES FOR CONDUCTING A DOMESTIC HOMICIDE REVIEW**

4.1 The chair of the SLP holds responsibility for establishing whether a homicide is to be the subject of a DHR by giving consideration to the definition set out in section 1 of the 2004 Act – see section 1.1 above. This decision should be taken in consultation with local partners with an understanding of the dynamics of domestic abuse. In Lincolnshire this is undertaken within a decision panel meeting.

4.2 The DHR decision panel will have the following standing membership:

* LDAP/SLP Strategic board chair
* Panel legal advisor
* Chief Officers of Police (in Lincolnshire delegated to Protecting Vulnerable People [PVP] Senior Management)
* Local Authorities (Adult Social Care and/or Children's Services/Children’s Health, Borough, District, Unitary and County Councils)
* NHS Integrated Care Board
* Providers of Probation Services
* NHS trusts
* LDAP DA Business Manager
* Domestic Abuse Specialist Services [IDVA & Adult Intervention]

4.3 The decision on whether or not to proceed with a DHR must be taken by the decision panel within one month of a homicide coming to their attention.

4.4 The final Overview Report should be completed as soon as possible once the decision to proceed with a DHR has been agreed upon. However, there may by delays due to court dates for criminal proceedings, outcomes and coronial timelines. It may also be that the complexity of case does not become apparent until the review is in progress, and this could affect the ability of the review to report within a timely fashion. The LDAP/SLP should be kept regularly informed of progress by the DA Business Manager, through updates at the DA Operational group, Strategic board and Programme board.

4.5 [Paragraphs 48-50 of Section 5 of the Statutory Guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf) provide further details if the panel is considering waiting for the conclusion of criminal proceedings before commencing a review.

**5 PROTECTING INFORMATION**

5.1 A DHR involves processing information which is very sensitive and particular care must be taken when processing it. Information must be subject to proportionate and reasonable controls relative to the sensitivity of the information and in a manner which reduces the risk of compromise or loss.

5.2 Information must be processed in a manner which meets legal and regulatory requirements. This includes information received from, or exchanged with, partners and individuals acting on behalf of the DHR.

5.3. All personal data must be processed in accordance with the UK General Data Protection Regulation and the Data Protection Act 2018.

5.4. Data relating to the deceased, while not subject to the data protection legislation, must still be processed in a manner which maintains confidentiality.

5.5 Chairpersons and Authors must ensure that they are able to meet the requirements set out in the relevant consultancy agreement.

5.6 Organisations must ensure their own local security and data protection policies are applied.

5.7 In supplying data for the purposes of a DHR agencies should have regard to the purpose of a DHR set out in section 2 above and only provide data that is relevant and proportionate for that purpose.

**6.** **INVOLVEMENT WITH FRIENDS, FAMILY MEMBERS AND OTHER SUPPORT NETWORKS**

6.1 The Review Panel should determine the appropriateness of involving friends, family or other support networks in the DHR process. However, unless there are exceptional circumstances such as Honour Based Abuse issues, these individuals should be given ‘every opportunity to contribute.’ The Review Panel should also consider on-going risk in involving the individuals who may be witnesses, especially where Honour Based Abuse is suspected.

6.2 In relation to communication with minor children of the deceased this should be via the most appropriate professional involved with the support and guidance of the Children Services Representative.

6.3 It is essential to ensure no approach is made to potential witnesses, or people involved in the case without the knowledge of the Senior Investigating Officer (SIO) and, where appropriate, the Crown Prosecution Service (CPS). Consideration should also be given at an early stage to working with Family Liaison Officers (FLOs) and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the respective positions of the family, friends and other support networks with regards to the homicide.

6.4 The review panel should consider approaching the family of the perpetrator who may also have relevant information to offer. The chair should also be mindful that the perpetrator or members of the perpetrator’s family might in some cases pose an on-going risk 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.

6.5 Prior to sending the final review to the Home Office, a completed version of the review should be shared with the family who will complete a Confidentiality Undertaking and have an opportunity to comment on the findings and recommendations. Their views will be reflected in the final review.

6.6 Maintain reasonable contact with the family, even if they decline involvement in the review process; it will be important to communicate through the designated advocate when the review is completed and when the review has been assessed and is ready for publication. They should also be informed about the potential consequences of publication i.e. media attention and renewed interest in the homicide.

6.7 Family members, friends, employers and colleagues should be directed to the Home Office Information leaflets (available in English and other languages) explaining the DHR process:

The leaflets can be found at: <https://www.gov.uk/government/organisations/home-office/series/domestic-homicidereview>

**7.** **ESTABLISHING A DHR**

**Please refer to the DHR flow chart in section 16.**

7.1 Once a DHR notification form is received a decision panel will be convened within one month of receipt.

7.2 Confirmation of a decision to review, as well as a decision not to review a homicide, should be sent in writing to the Home Office DHR enquiries inbox (DHRENQUIRIES@homeoffice.gsi.gov.uk). This decision will be taken by the Chair of the SLP within one month of notification of the homicide. The LDAP should also inform the Coroner and immediate family of its decision.

7.3 If the decision is not to commission a review of the homicide however the panel agree that there is non-statutory learning required then the panel can refer the case to the DHR Sub- Group to consider a Domestic Abuse Learning review, see section 8.

7.3 The LDAP must then establish a Review Panel made up of the following standing membership:

* Chief Officers of Police (in Lincolnshire delegated to Protecting Vulnerable People [PVP] Senior Management)
* Local Authorities (Adult Social Care and/or Children's Services/Children’s Health, Borough, District, Unitary and County Councils)
* NHS Integrated Care Board
* Providers of Probation Services
* NHS trusts
* LDAP DA Business Manager –as an adviser to the Panel
* Legal Advisor – as an adviser to the Panel
* Representation from specialist domestic abuse service
* Independent Author/Chair

7.4 Based on the scoping exercise completed prior to the decision panel the DHR panel may require additional persons/bodies to be a member of the panel. This may include agencies/bodies from another local authority area. The Panel will consider at the outset and throughout the review the need for additional specific expertise to assist the Panel.

7.5 The Review Panel must appoint an independent Chair/and or Author in line with the section regarding appointing a Chair of the Review Panel in the Home Office DHR [Guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf) i.e. where possible, someone with the necessary skills and experience regarding domestic abuse and who is not a member of the LDAP. This person will also pull together all evidence and write the Overview Report, Executive Summary and a Learning paper, under the direction of the Review Panel.

7.6 The review panel should meet an appropriate number of times to ensure there is a robust oversight and rigorous challenge to the information shared. For example, a review panel that only met at the beginning and end of the review would imply a limited and arguably ineffective role in the DHR process. Some key meetings will be conducted in person only.

7.7 The deadlines set by the panel should be kept to by all agencies involved, so all elements of the review can be completed in a timely fashion.

7.8 Finally on completion of a DHR the panel will review the process to see if any amendments are required to the DHR protocol.

**8.** **CROSS BORDER AND OUT OF COUNTY DHR'S**

8.1 Where more than one local authority have known about or had contact with the victim, the review will be conducted by the area where the victim normally lives, which could result in cross border and out of County DHRs.

8.2 In these circumstances, if the normal area for living was Lincolnshire, we will conduct the DHR and invite the other counties agencies as panel members.

8.3 If the victim normally lived in the other county, we will pass information to them to lead on the DHR and involved agencies will liaise with them as panel members, while factoring in item 9.4 below.

8.4 Agencies completing an IMR/summary report for an Out of County DHR are to submit this to DHR Team & Legal Services Lincolnshire for the QA process to be completed as normal, before submission to the other county. For more information see the Out of County Information Requests Flowchart on page 17.

8.5 The Domestic Abuse Business Manager will attend all Out of County DHR meetings to represent Lincolnshire information, alongside those specific agencies involved. Also, all communications with the Out of County CSP will be made by the LDAP Senior Business Support Officer via DHR@lincolnshire.gov.uk on behalf of the individual agency. Therefore, if an individual agency is approached by an out of County CSP they are asked to direct them to the DHR email DHR@lincolnshire.gov.uk for the Flowchart on page 17 to be sent to them and the Out of County DHR process to be followed.

**9.** **THE ROLE OF THE INDEPENDENT CHAIR OF THE DHR PANEL:**

9.1 Consideration should be given to the skills and expertise required to effectively chair a review. The following is a guide:

* Enhanced knowledge of domestic abuse issues including so-called 'honour'-based abuse, research, guidance and legislation relating to adults and children, including for example the Children's Act 2004, the Care Act 2014 and the Equality Act 2010.
* An understanding of the role and context of the main agencies likely to be involved in the review.
* An understanding of the local picture of domestic abuse in Lincolnshire.
* Managerial expertise.
* Strategic vision so that opportunities are identified to link in and inform strategies such as the Government's Call to End Violence Against Women and Girls: 2021 to 2024.
* Good investigative, interviewing and communication skills.
* An understanding of the discipline regimes within participating agencies.
* An understanding of wider statutory review frameworks such as child/adult and/or mental health reviews.
* The completion of the Home Office E-Learning Training Package on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing Overview Reports.
* Attendance at the DHR Chair's Training events run by the Home Office.

The roles and responsibilities of the Chair include:

* Lead on setting the terms of reference with the review panel
* Leading the DHR review
* Ensure the Senior Investigating Officer is fully informed of the review.
* Ensure the appropriate expertise is available on the review panel
* Coordinate with parallel proceedings e.g., Independent Office for Police Conduct, mental health reviews, LSCPR's and Safeguarding Adult Reviews.
* Ensure disclosure issues are managed
* Ensure links with victim's family and friends of those individuals identified in the Terms of Reference, also ensuring that different methods and times of communication are used to make these links.
* Work effectively alongside the LDAP Business Manager and Safeguarding Board Managers (if a joint review) to ensure the smooth running of the process
* Where there is no separate independent author, the Chair will be responsible for the production of the Overview Report, Executive Summary and a Learning Paper.

The chair and review panel should consider in each homicide the scope of the review process and draw up clear terms of reference which are proportionate to the nature of the homicide. The Chair and Author can be single or combined roles.

**10.** **SCOPING, CHRONOLOGIES and INDIVIDUAL MANAGEMENT REVIEWS [IMRs]**

10.1 Prior to the decision-making panel a request for information, known as a 'data trawl' will be sent to the full partnership in order to better inform the decision panel as to whether a DHR should be commissioned. Details of the victim(s), alleged perpetrator(s) and any children will be sent to partners via secure email asking them to ascertain whether they have had any involvement with the named persons and requesting them to secure any relevant documentation associated with the case, in line with individual agencies policies and procedures.

10.2 At the first panel meeting the chair and review panel should consider in each case the scope of the review process and begin to draw up clear terms of reference which are proportionate to the nature of the homicide, bearing in mind all the information gathered so far by the data trawl. The scope of the review is based on information presented to the author and panel and can go back as many years as required. The scope is usually set at this stage however if further information is revealed then the scope may need to change, this should be agreed by the panel and documented in the minutes.

10.3 The terms of reference for each review will be agreed upon by the Chair/Author, LDAP business manager and approved at the first Panel meeting. A template for the terms of reference is available in section 17.1.

10.4 A template for the chronology to gather information within the scoping timeframe will be sent out to all panel members, with a deadline for completion as determined by the Review Panel.

10.5 Once the chronologies have been returned, a merged chronological timeline should be produced by the LDAP Senior Business Support Officer. This merged chronology will then be sent to the DHR panel members.

10.6 It is then decided which agencies need to complete and an IMR or summary report, within the agreed timescales and return to the LDAP Senior Business Support Officer. Each agency is to ensure that their IMR or summary is quality assured internally before submitting to the Review Panel. The IMR/summary reports will then be quality assured by the Panel Legal Advisor prior to submission to the Chair/Author/Panel.

10.7 Those conducting Chronologies and IMRs should not have been directly involved with the named persons or either of their families and should not have been the immediate line manager of any staff involved.

10.8 If IMR authors wish to interview agency staff **contact should be made with the SIO, via the Police DHR Panel Representative first** to ensure that it does not jeopardise any on-going criminal investigations. Additionally, material gathered by the review may be of benefit to the defence in any criminal proceedings. The Police disclosure officer and the Independent Chair must remain in contact with regard to such matters.

10.9 A Practitioner Event may be held and can be decided on a case by case basis, to obtain the contributions of the practitioners that had direct contact with the named persons subject to the review, their line managers if appropriate, the DA Business Manager, Legal advisor to the review and the chair/author. It may be relevant for the IMR authors and panel members to also attend. The purpose of the event is to understand the frontline practitioners’ contributions.

10.10 An IMR Presentation Day should be held, for IMR Authors to present their IMRs or summaries.

10.11 The review panel should bear in mind all equality and diversity issues at all times; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation may all have a bearing on how the review is explained and conducted and the outcomes disseminated to local communities.

**11.** **Overview Report and Action Plan**

11.1 Sample Overview Report template is available in the [Home Office Guidance 2016](https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews), with information regarding the content available on page 21.

11.2 A first draft of the Overview Report will be produced by the Independent Author/Chair following the IMR Presentation Day. The Overview Report will adhere to the Statutory Guidelines required by the Home Office and will include analysis and recommendations from the author as well as the agencies.

11.3 Enable families to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

11.4 At this stage and if appropriate bearing in mind potential criminal legal proceedings, front line practitioners and their first line managers may be involved in discussions, as determined by each agency and the DHR panel, to provide them feedback with the findings from the review.

11.5 The first draft of the Overview Report will be circulated to members of the Review Panel for comment and amendment by the LDAP Senior Business Support Officer. The Panel should ensure that contributors are satisfied that their information is fully and fairly represented and that the Overview Report is of a high standard and written in accordance with statutory guidance. There may be a number of iterations of the report before it can be finalised. Once the Overview Report recommendations are confirmed, the Review panel should produce an Action Plan, which must be SMART and should be agreed by senior members of each agency.

Once agreed, the Review Panel should provide a copy of the Overview Report, Executive Summary, Learning paper and the Action Plan to the Chair of the LDAP, marked as Restricted.

The report does not need to express a conclusion on predictability or preventability.

11.6 On receiving the restricted version of the Overview Report and supporting documents, the SLP & LDAP should:

* Agree the content of the Overview Report, Executive Summary, action plan and Learning paper for publication [bar the action plan], ensuring that it is fully anonymised apart from including the names of the Review Panel Chair and members;
* Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate;
* Sign off the Overview Report, executive summary, learning paper and action plan;
* Complete page 41 of the Home Office DHR Guidance, Data Collection form, which is not for publication and will be used by the Home Office only for data collection purposes;
* Submit a copy of the overview report, executive summary, learning paper, action plan and data collection form to the Home Office via a secure email to: DHREnquiries@homeoffice.gsi.gov.uk

11.7 The Final Overview Report must be submitted to the Home Office as soon as is possible.

11.8 The document should not be published until clearance has been received from the Home Office Quality Assurance Group. On receipt of this clearance, the LDAP shall:

* provide a copy of the Overview Report, executive summary, learning paper and action plan to the Police and Crime Commissioner and the senior manager of each participating agency;
* Ensure the chair, review panel and family members are involved in the publication date to consider key dates, e.g. the anniversary of the homicide or the birthday of the victim;
* publish suitably anonymised electronic copies of the Overview Report, Executive Summary and the Learning paper on the local SLP webpage;
* provide a copy of the overview report to the family;
* notify the Home Office using the email address DHREnquiries@homeoffice.gsi.gov.uk that the reports have been published and provide links and copies of the reports and feedback letter, copying in the Domestic Abuse Commissioner to this email;
* monitor implementation of the actions set out in the action plan via the DHR sub-group;
* formally conclude the review when the Action Plan has been implemented and include an audit process: by adding the actions from this DHR to the amalgamated list of all actions from all DHRs and making sure that the Domestic Abuse Operational Group and DHR Subgroup address any outstanding actions at each of their quarterly meetings.

11.9 **In all cases, where lessons are able to be drawn out, they should be acted upon as quickly as possible without necessarily waiting for the DHR to be completed.**

**12.** **DISCLOSURE AND CRIMINAL PROCEEDINGS**

12.1 Disclosure is one of the most important issues in the criminal justice system and the application of proper and fair disclosure is a vital component of a fair criminal justice system. All disclosure issues must be discussed with the police SIO, the CPS and the HM Coroner’s representative as appropriate. Regard must also be given to the Criminal Procedure and Investigations Act 1996.

12.2 There may be homicides where the investigator believes that a third party (for example, a local authority or social care organisation) has relevant material or information. In such cases, if the material or information might reasonably be considered capable of undermining the prosecution case or of assisting the case for the accused, prosecutors are asked to take steps they regard as appropriate to obtain it and review to decide whether it has to be disclosed to the defence. This may include applying for a witness summons requiring a representative of the ‘third party’ to produce the material to the court.

12.3 Dependent on the case, material gathered in the course of a DHR may be capable of assisting the defence case and would almost certainly be material that the defence would seek to gain access to. If a DHR is being conducted in parallel to a criminal investigation, the disclosure officer will be obliged to inform the prosecutor. Any interviews with other agency staff, documents, case conferences etc may all become disclosable. It is the responsibility of a disclosure officer to link in with the review panel chair. It is incumbent on the chair to ensure that there is a robust process in place for the purpose of disclosure to the disclosure officer responsible for the criminal investigation.

**Circumstances where the perpetrator is arrested and charged** –

12.4 In cases where the perpetrator is arrested and charged, one of the following two outcomes may occur:

a) that the DHR be pended until after the outcome of any criminal proceedings; (in Lincolnshire this is often the preferred course of action)

b) that the scope of the DHR is temporarily restricted until after the outcome of any criminal proceedings, such as consideration being given to not interviewing people who may be witnesses or defendants in criminal proceedings until the criminal justice need has been satisfied. Where a restriction in scope is being considered, this should be for a defined need and/or applicable to named individuals.

12.5 In either outcome, the overview report could be considered in draft form until after the criminal trial as organisational intra and inter learning needs to take place. However, consideration should be given before releasing an early draft on whether it could be potentially misleading if there is more evidence/information to come.

12.6 Regardless of the outcome, every effort should be taken to ensure that learning arising from the homicide is taken forward where this does not compromise the integrity of relevant criminal proceedings. It is essential that necessary learning is not delayed to prevent the same mistakes being replicated in other cases. In these circumstances, the review panel should ensure records are reviewed and a chronology drawn up to identify any immediate lessons to be learned (an immediate IMR). These should be brought to the attention of the relevant agency or agencies for action, secured for the subsequent overview report and forwarded to the disclosure officer for the criminal case. Any identified recommendations should be taken forward without delay.

12.7 It is permissible for the review panel to carry out further work in relation to the review in tandem during ongoing criminal proceedings, for example, conducting professional interviews, producing a draft overview report. However, any such work must take into account the views of the SIO to ensure that the criminal proceedings are not compromised.

12.8 All material generated or obtained in the DHR whilst the criminal case is ongoing must be made available to the SIO and disclosure officer to assess whether it is relevant to the criminal case. Where it is relevant, it will be for the CPS to decide whether it should be disclosed to the defence. Where the material is sensitive, the CPS or the SIO will consult with the chair before disclosure is made to the defence. Sensitive material in this context can be “any material the disclosure of which he or she believes would give rise to a real risk of serious prejudice to an important public interest and the reason for that belief.

12.9 If there are family members, colleagues, friends or other individuals that a DHR Author wishes to speak to as part of the review and who are witnesses in a criminal case, the Chair or legal advisor to the panel may be asked by the SIO not to contact them for interviews until after the criminal case conclusion. The SIO will consult with CPS where the DHR panel proposes to speak to witnesses in an on-going criminal case.

12.10 If there are family members, colleagues, friends or other individuals that a review chair wishes to speak to as part of the review and who are witnesses in the criminal case, the chair may be asked by the SIO not to contact them for interviews until after the conclusion of the criminal case. The SIO should consult with the CPS where the DHR panel proposes to speak to witnesses in an ongoing criminal case. Any representations to the DHR panel to delay contact with the witnesses will be informed by such liaison with the CPS.

12.11 Following the conclusion of the criminal proceedings, the DHR should be concluded without delay. Further information about disclosure can be found at: [www.cps.gov.uk/legal/d\_to\_g/disclosure\_manual](http://www.cps.gov.uk/legal/d_to_g/disclosure_manual).

**Circumstances where the perpetrator is deceased** –

12.12 Where evidence indicates that the perpetrator is deceased and either:

a) the cause of death is unknown;

b) the death was violent or unnatural;

c) the death was sudden and unexplained;

d) the person who died was not visited by a medical practitioner during their final illness;

e) the medical certificate is not available;

f) the person who died was not seen by the doctor who signed the medical certificate within 14 days before death or after they died;

g) the death occurred during an operation or before the person came out of anaesthetic;

h) the medical certificate suggests the death may have been caused by an industrial disease or industrial poisoning;

the case will be referred to the Coroner and a file will be prepared. In these circumstances, it is appropriate for a DHR to be conducted without delay and the overview report and supporting documents once they have been reviewed by the Quality Assurance Panel should be submitted to the Coroner to help inform the Inquest.

**13** **LEARNING LESSONS AND BEST PRACTICE**

13.1 It is important to draw out key findings of DHRs and their implications for policy and practice.

13.2 The Domestic Abuse Operational Group and LDAP will adopt the following process and principles:

* As far as possible, the review should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.
* Consider what type and level of information needs to be disseminated, how and to whom, in the light of the review. Be prepared to communicate both examples of good practice and areas where change is required.
* Subsequent learning should be spread to the local MARAC, the LDAP and the Lincolnshire Safeguarding Children Partnership, Lincolnshire Safeguarding Adults Board and commissioners of services.
* Include the learning into local and regional training programmes.
* The LDAP will put in place a means of monitoring and auditing the actions against recommendations and intended outcomes.
* Set up a culture of learning lessons by having a standing agenda item for DHRs on the meetings of the DHR Subgroup, DA Operational Group, DA Strategic Board and report annually to the SLP.
* Agreed locally that where there is an open social services file in relation to the child of a victim of a DHR, a copy of the final DHR report will be placed upon their file by Children Services.
* The Learning Bulletin provided by the Author will be disseminated by all agencies and placed on the [Professionals Hub](https://professionals.lincolnshire.gov.uk/downloads/download/210/dhr-published-reports).

**14.** **PUBLICATION OF THE OVERVIEW REPORT**

14.1 In all cases, the Overview Report and Executive Summary should be suitably anonymised and made publicly available. IMRs should not be made publicly available.

14.2 All Overview Reports and Executive Summary’s will be published on the Safer Lincolnshire Partnership website unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen. The reports will only be published following agreement from the Quality Assurance Panel at the Home Office. The reasons for not publishing an Overview Report or Executive Summary should be communicated to the Home Office QA Panel.

14.3 Where information is sought using the Freedom of Information Act (FOIA) 2000, it is important to refer to sections 21, 22, 30, 31, 40, 41 and 42 of that Act which identify key exemptions.

14.4 Where appropriate, consideration should also be given to translating the executive summary into different languages and other formats, such as Braille or British Sign Language.

14.5 In some cases, it may not be possible to finalise the IMRs and the Overview Report or to finalise and publish an Executive Summary until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons learned from being acted upon.

14.6 The Independent Overview Report Author should, in their final Overview Report, make reference to any requests to delay the planned work of the DHR panel, and include a copy of the written request as an appendix so that it can clearly be understood why the request was made.

14.7 The Panel will ensure that there is a designated person for family and friends and members of the public to contact when the report is published.

**15.** **DOCUMENT RETENTION**

15.1 Retention Period of Published Reports

The following DHR reports on the Safer Lincolnshire Partnership website will be removed 1 year after publication:

* Overview Report
* Executive Summary

These will then be retained for a period of 25 years after the publication date along with the Feedback letter from the Home Office.

If the report involves any children who have been open to children services, the report will also be held on the children services' files in line with LCC Children and Family Services Document Retention Schedule.

15.2 Retention Period of all other Data held for the DHR

The following information relating to a DHR:

* Notification form
* Chronologies
* Draft IMRs
* Agency Narrative/Summary
* Draft Overview Reports
* Terms of Reference
* Emails
* Minutes of meetings

These will be retained for a period of 5 year after the publication date.

**16.** **Sample Templates:**

16.1 In this Protocol we have supplied templates: [All in line with the [Home Office DHR Guidance](https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews) and with what has worked best in Lincolnshire for current DHRs.]

All are available to download from [the](https://professionals.lincolnshire.gov.uk/homepage/63/domestic-abuse) [Professionals Hub](https://professionals.lincolnshire.gov.uk/downloads/download/207/dhr-resources)

* Agency Narrative/Summary Template
* DHR Action Plan Template
* DHR Flowchart for Partners
* DHR & DA Learning Review Notification form
* DHR Terms of Reference
* Domestic Abuse Learning Review Template
* IMR Template
* Out of County Information Requests Flowchart

16.2 These are also available in the [Home Office DHR Guidance](https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews).

* Overview Reports
* Executive Summaries
1. The role of the Review Panel, and Independent Overview Author and chair are referred to under Section 6 and 7 of the protocol [↑](#footnote-ref-1)