Safer Stronger Doncaster Partnership

Domestic Homicide Review/ Domestic Abuse Related Death Review Protocol

Version date	Changes
V.1 August 2018	First version of Protocol
V.2 June 2025	New sections on: • Producing the report • Intersectionality • Trauma informed reviews • Developing the Action Plan • Sharing the findings • SSDP scrutiny • Survivor input • Name change to Domestic Abuse Related Deaths (in anticipation of Government changes) New layout with hyperlinks to make it easier to navigate the document electronically New requirements to send the completed DHR's/DADR's to the Domestic Abuse Commissioners Office Improved sections on monitoring and assurance, governance by the CSP and completion of actions

To be reviewed in 2028 (or before if updated statutory guidance published by the Home Office).

Contents

1. About Domestic Homicide Reviews/Domestic Abuse Related Death Reviews

When a known domestic homicide, a suspected domestic homicide or suicides under some circumstances has happened, then the Community Safety Partnership in that area is required to undertake the statutory Domestic Homicide Review (DHR). Introduced in 2011, and then revised in 2016 the Home Office DHR statutory guidance provides a detailed framework for the Community Safety Partnership to ensure compliance with the process.

This local protocol does not seek to replace or duplicate the Statutory guidance. The purpose of this Protocol is to clearly set out how the DHR will be managed in Doncaster and key issues for consideration.

What is a Domestic Homicide?

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.

'Intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexual orientation.

A member of the same household is defined as:

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

A DHR should be undertaken in such circumstances, even if a suspect is not charged with an offence or they are tried and acquitted.

A domestic homicide is when someone has died as a result of domestic violence. This can include murder or manslaughter, causing death by neglect, and **can include suicides** in some circumstances, particularly in cases where a long-term history of coercive control is apparent.

Ordinarily the police or other agency will advise the Community Safety Partnership (Safer Stronger Doncaster Partnership) of suicides that may need to be considered for review. However, there may be cases where the links to domestic abuse do not become apparent until after the Police investigation has concluded. Doncaster Metropolitan Borough Council, Public Health Department, works in partnership with the Coroner's Office and audit all Doncaster suicides. If information comes to light during that audit Public Health colleagues will advise the Community Safety Partnership of such cases that may need to be considered for review.

What is the purpose of a Domestic Homicide Review (DHR)/ Domestic Abuse Related Death Review (DADR)?

a) Establish what action is needed from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims

b) Identify clearly what those changes should be both within and between agencies, how and within what timescales they will be acted on, and what outcome is expected as a result

c) Apply these changes to service responses including recommendations to inform national and local policies and procedures as appropriate

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and 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

e) Contribute to a better understanding of the nature of domestic violence and abuse

f) Highlight good practice

The outcome of the DHR/DADR should be to have a thorough independent process in place that produces an Overview report, with an executive Summary and a detailed action plan.

What a DHR/DADR needs to include to satisfy the statutory guidance

To achieve the purposes the DHR/DADR process the report needs to: -

- Be 'professionally curious', inquisitive and exploratory in its nature, identify areas for improvement and be action focused.
- have a narrative that *articulates the life through the eyes of the victim (and their children)*, it should include talking to those around the victim including family, friends, neighbours, interest groups, community members, employers, landlord and professionals
- keep an open mind
- Be situated in the victim's home, the family and the community
- Understand the history and trail of abuse, identifying which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other.
- Learn from the review and identify actions
- Understand the victim's reality; identify any barriers the victim faced to reporting abuse and learn why any interventions did not work for them.
- Understand the context and environment in which professionals made decisions and took (or did not take) actions. This would include, for example, the culture of the organisation, the training the professionals had, the supervision of these professionals, the leadership of agencies, multi-agency working.
- Understand the conduct of individuals and whether procedures were followed.
- Evaluate whether the procedure / policy was sound and operated in the best interests of the victim.

DHRs/DADR's are NOT inquiries into how the victim died – this is a matter purely for the coroner and criminal courts, respectively, to determine as appropriate.

DHRs/DADR's are NOT designed to assign blame: the person or people directly responsible should be subject to criminal investigation and prosecution, and the DHR/DADR is conducted entirely separately from any criminal proceedings. If any individual professional is found to have fallen short of the

standards expected of them, this is a matter for disciplinary or competency procedures within their own organisation.

Overlap with other statutory duties

In some domestic abuse related deaths there may be statutory requirements to hold another review, for example, a Safeguarding Review or Mental Health Investigation. The statutory guidance explains what needs to be considered in such cases, recognising that the statutory requirements of a DHR/DADR overlap with these processes and that there are potential opportunities to remove duplication.

It will be the initial responsibility of the Domestic and Sexual Abuse Strategic Service Manager and the Safer Stronger Doncaster Partnership Chair to ensure contact is made with the chair of any parallel process.

DHR/DADR Timescales

The Home Office statutory guidance provides a timetable for the DHR/DADR process in order to ensure all reviews are conducted within a set time period and changes to be made are identified and addressed in a timely manner.

A review should be opened promptly rather than waiting for the conclusion of criminal proceedings. The aim is to ensure any early areas for improvement can be identified and rapid action is taken to address them. Any best practice should also be recognised and shared across the partnership.

Officers managing and coordinating Doncaster Abuse Related Death Reviews:

Chair of the Safer stronger Doncaster Partnership (SSDP) (this is the local Community Safety Partnership with the statutory responsibility for conducting DHRs/DADR's in Doncaster)
peter.thorp@southyorkshire.police.uk

Domestic and Sexual Abuse Theme Manager – City of Doncaster Council
Tim.staniforth@doncaster.gov.uk

Domestic and Sexual Abuse Strategic Lead – City of Doncaster Council
karen.shooter@doncaster.gov.uk

Domestic Abuse Administration Officer – City of Doncaster Council
Sophie.bishop@doncaster.gov.uk

These Officers supporting the DHR/DADR process will make sure that all agencies involved in the process are made aware of expected deadlines in the early stages of the DHR/DADR. Timescales may however be extended due to unavoidable delays e.g., in relation to the complex scope of the DHR/DADR or on-going criminal proceedings.

2. The process

Steps in the process	Time from homicide	Deadline
Step 1 - The decision making process	Within one month	Notification *of DHR/DADR can be given in three ways :-*
		1. Police notify the Safer Stronger Doncaster Partnership (SSDP) Chair and the Domestic and Sexual Abuse contacts below of a possible domestic abuse related death via secure email: • Chair of the SSDP – PETER THORP peter.thorp@southyorkshire.police.uk • Domestic and Sexual Abuse Strategic Lead – Karen Shooter – karen.shooter@doncaster.gov.uk • Domestic and Sexual Abuse Theme Manager - Tim Staniforth – tim.staniforth@doncaster.gov.uk • Domestic abuse admin support – Sophie Bishop – Sophie.bishop@doncaster.gov.uk
		2. Any other professional or agency can refer a death to the same contacts for consideration
		3. The Coroner's Office may refer a death to the same contacts listed above
	Within one month of receipt of notification	The Chair of the SSDP takes the decision that the case meets the criteria and a DHR/DADR is to be conducted. This will be done in consultation with the Domestic and Sexual Abuse Strategic Lead and Theme Manager, Safeguarding Board Managers, and any other relevant agency, in order to determine whether other reviews are needed e.g. Serious Case Review, Safeguarding Review, Mental Health Review etc.
	With one month of receipt of notification	The Domestic and Sexual Abuse Strategic Lead, on behalf of the Chair of the SSDP notifies the Home Office that SSDP will be conducting a DHR/DADR dhrenquiries@homeoffice.gov.uk
	With one month of receipt of notification	The chair and of the SSDP and the Coroner to correspond following agreement of the commissioning.
Step 2 - DHR required. First panel meeting to agree TOR & family contact	Within 1 month of the decision to conduct a DHR	The Domestic Abuse admin support officer/Domestic and Sexual Abuse Strategic Lead issues a notification to agencies (via a list of agency DHR/DADR leads) asking whether the subjects were known to their agency and instructing them to secure their files.
		DHR/DADR Chair/Author appointed and invited to attend the first panel meeting
		The Senior Investigating Officer (SIO) will be invited to attend the first panel meeting
		Initial Terms of Reference drafted and circulated to panel members
		First meeting of the Review Panel to have been held
		Initial Terms of Reference agreed with timescales and scope of the review

		Decision made about contact with victim's family and friends in consultation with the SIO and Family Liaison Officer (FLO)
		Missing agencies identified and contacting by the DHR/DADR Chair/Author to participate in the review
		Contact made with relevant family and friends via the FLO in the first instance and where practicable, notifying them that a DHR/DADR will be conducted and asking for participation
Step 3 – Agency, and family/friends information supplied and collated	To be agreed at first panel meeting (consideration given to ongoing criminal investigation)	Agencies submit their chronologies. Chronologies merged by Domestic Abuse Administrator
		Agencies submit their Individual Management Reviews (IMRs) N.B. these must be signed off by senior managers
		Interviews with family and friends (as agreed with SIO and FLO)
		Merged chronology and IMRs circulated to panel members ahead of IMR presentation day
Step 4 – IMR presentation day	To be agreed at first panel meeting (with consideration given to ongoing criminal investigations)	IMR authors and panel members attend IMR presentation day. Any conflicting or missing information/agencies identified and addressed. Family and friends input given
Step 5 - Overview report	To be agreed at first panel meeting (with consideration given to ongoing criminal investigations)	Review panel meets to discuss the first draft of overview report and its recommendations and agree any alterations
		Chair/Author meets again with the family/friends to discuss the first draft of overview report and its recommendations
Step 6 - Approval process	Ideally within 6 – 7 months (with consideration given to ongoing criminal investigations)	Further drafts of the overview report
		Draft Action Plan produced
		Review panel meets to sign off the final version of the overview report and finalise the Action Plan
		Final version signed off by SSDP Board.
		Final version of the overview report sent to Home Office dhrenquiries@homeoffice.gov.uk
		The Domestic Abuse Act 2021 requires all Community Safety Partnerships to send final copies of any Domestic Abuse Related Death Review to the Domestic Abuse Commissioner: DHR@domesticabusecommissioner.independent.gov.uk

Step 7 - Publication	Overview Report, and / or Executive Summary of report published after approval from the Home Office (how much is published depends on the wishes of family members or any other issues of sensitivity).	
Step 8 - Actions audited	Quarterly from submission date until completion	Audit progress on action plans.
Step 9 Assurance	Throughout and on completion of all actions/or escalation if actions are not being completed	The Safer Stronger Doncaster Partnership has statutory responsibility for DHRs/DADRs and as such must be kept informed of all DHRs/DADRs and completion of actions. In addition, the Doncaster Domestic Abuse Strategic Board must be kept informed of progress, action updates and findings. Chair of the Domestic Abuse Strategic Board kathryn.anderson-bratt@doncaster.gov.uk

3. Coordination and administration of DHRs/DADRs

When the decision has been made to undertake a DHR/DADR, the Domestic and Sexual Abuse Strategic Lead and the Domestic Abuse Administrator/DHR Coordinator will take the following actions:

- Notify the DHR team at the Home Office (DHRENQUIRIES@homeoffice.gov.uk)
- Notify all agencies, asking them to take the next step of nominating a Review Panel member and an Individual Management Review author
- Notify the coroner
- Notify the Council Communications Team
- Notify the lead Police Officer for any investigation and the Family Liaison Officer,
- Inform family and significant friends or colleagues of the decision to complete the DHR process – with the agreement of the SIO. This will be facilitated by the FLO. Ask Family and friends for consent and inform them that they will be invited to participate at a later stage.
- Co-ordinate the first meeting of the Review Panel to happen as soon as practicably possible
- Inform the Council Legal Department

Secure Email correspondence, passwords for notification and all case documents

Email - All electronic correspondence must be sent from and to a secure email addresses. City of Doncaster Council systems do not allow Password protection of documents, and so partners contributing to the review process will be required to hold a secure email address for correspondence. Alternatively, partners who do not have a secure email address can sign up to Egress Switch, which is compatible with City of Doncaster Council systems.

The disclosure of sensitive material during the course of the DHR/DADR

Any information collated as part of the DHR/DADR whilst a criminal investigation is ongoing must be made available to the Senior Investigating Officer and Disclosure Officer, South Yorkshire Police. The Statutory guidance is more explicit with regard the disclosure of sensitive material during the course of the DHR.

Staff, family, friends and colleagues must not be interviewed during a criminal investigation without consultation with the SIO.

The DHR/DADR Overview report will not be signed off by the SSDP until the conclusion of any criminal investigation to ensure that the investigation is not compromised.
Following the conclusion of the criminal proceedings, the DHR/DADR should be concluded without delay.

Circumstances where the alleged perpetrator is deceased

In cases where the perpetrator is deceased (for example in cases of murder-suicide), the case will be referred to the Coroner and a file will be prepared. In these circumstances, it is appropriate for a DHR/DADR to be conducted without delay.

The Overview Report and supporting documents should be submitted to the Coroner to help inform the Inquest; however this should only happen once the Home Office Quality Assurance Panel has reviewed them.

The Review Panel

The Review Panel **must** include individuals from the statutory agencies listed under section 9 of the Domestic Violence, Crime and Victims Act 2004 and a specialist or local domestic abuse service must be included on the Panel. Therefore, the panel must include representatives from:

- Police
- Local Authority
- Probation
- Health agencies

In Doncaster the approach is to have a review panel made up of a nominated representative of each agency involved in the DHR/DADR in question – this will have been ascertained when the agencies submitted initial information as to their involvement. This Review Panel member will not always be the Individual Management Review (IMR) Author (each agency must nominate its own IMR author) but rather, be a senior representative of the agency who will attend all Review Panel meetings throughout the process. It has also been agreed that other agencies, who may be able to provide specific expertise, may be invited to attend as a Review Panel member and this will be determined on a cases by case basis.

Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting. IMR authors normally present their IMRs to the panel and are often invited to meetings to discuss the draft overview report. Members of statutory agencies who have responsibilities for completing IMRs may also be members of the review panel but the panel should not consist solely of such people.

The Review Panel should meet an appropriate number of times to ensure there is robust oversight and rigorous challenge. The 2016 guidance explicitly states that meeting at the beginning and at the end of the process is not sufficient.

The Doncaster process is for *at least* three Review Panels to be undertaken:

- Initial panel meeting to agree scope, agency involvement and terms of reference
- Individual Management Review (IMR) presentation day
- Presentation of Overview report

Survivor input

To ensure that the review keeps victim and survivors of domestic abuse at the heart of everything we do, the City of Doncaster Council's Survivor Liaison Worker will be included on all Domestic Abuse Related Death Reviews.

Confidentiality

Domestic Abuse Related Death Reviews can be subject to high levels of public interest and complex legal processes in the criminal and civil courts. Individual Management Review (IMR) authors, panel members and any others involved with the review process need to be clear that the information they learn about the case and agency's involvement is confidential. This means it should not be discussed with anyone apart from key officers within the agency who are responsible for either the current case management or the agencies former involvement with the subjects, or the senior managers in the agency who need to be kept informed in order to ensure the agency's approval of the Overview Report.

It is vital that documents related to the Domestic Abuse Related Death Review are stored securely with restricted access. Once a review is completed the agency should securely archive all relevant

documents but draft copies of overview reports and executive summaries should be shredded. The un-redacted SSDP Overview Report should be kept securely and access restricted.

A confidentiality agreement will be signed by all attendees at each meeting of the process. Any breach in confidentiality will be discussed with relevant agencies.

A confidentiality statement needs to be signed by all family members, involved in the review process.

Case Anonymisations and the use of pseudonyms

Ideally, pseudonym should be agreed at the first panel meeting or raised by the FLO, if the family decide not to attend the panel meeting, as soon as the family want to engage with the process.

Where the family members want this to happen, the process should allow this to happen. When discussing the case with the family and sharing any documentation with the family, agreed pseudonyms should be used.

The draft and final reports should all use these agreed pseudonyms.

Out of area Individual Management Reports

If it has been established that an out of area agency needs to submit an individual management report, the Domestic and Sexual Abuse Strategic Lead and the domestic abuse administration officer should inform that agency of the review after discussion with the Independent Chair.

The agency should be asked to nominate an Individual Management Review (IMR) author as well as a senior officer who will sign off the IMR report and sit on the Review Panel going forwards.

The nominated individuals will then be included in all circulated emails relevant to the review and kept informed of progress.

Out of area agencies MUST use the templates provided by the review Chair/Author and not their own area templates. The review Chair/Author should provide these to the nominated individual as soon as they are informed, they must complete an IMR – they should also be given a copy of the terms of reference. Out of area agencies are, wherever possible, expected to attend IMR briefings and Review Panel meetings.

4. Intersectionality

Intersectionality recognises that there are cross cutting issues that impact on a person's experiences, responses, the service they receive and the barriers they face. It is a way of understanding society by examining intersecting forms of discrimination and barriers.

Intersectionality must be analysed as part of Domestic Abuse Related Death Reviews. The panel may need to reach out to community leaders and activists, and specialist services, who are representative of our diverse society, and help develop a better understanding of the people who are subject to the review and whether their intersecting needs were identified and addressed. This could include reaching out to regional or national agencies.

5. Trauma Informed Reviews

Domestic Abuse Related Death Reviews need to be trauma informed. This means:

- Having an awareness trauma and how it impacts on a person's life choices, attitudes and behaviour. This may involve being cognisant of events in the lives of the victim and perpetrator that might fall out of the scope of the review.
- Learning from the traumatic events in the lives of those subject to the review to prevent and reduce the impact of trauma in others.
- Understanding that the review could cause additional trauma to the family, friends, colleagues, etc. of the people subject to the review.
- Having an awareness of vicarious trauma for workers involved in the review process.

The Domestic Abuse Related Death Review panel should aim to understand those events that have caused trauma and how agencies can improve trauma responses, and also prevent re-traumatization.

The potential to cause trauma to those known to the victim/perpetrator/children involved in the review in the review and every step must be taken to prevent trauma/re-traumatization and to provide support services.

Panel members must be mindful of vicarious trauma and ensure that support services are available from within their own agency, including regular supervision, to ensure that the review process does not have an adverse effect on them.

6. Involvement of family, friends and other support networks

The participation of the family, friends, colleagues, neighbours etc. is integral to the review process. They must be treated as a key stakeholder, and be offered clear communication from start to finish, offering them the opportunity to meet the Independent Author at the earliest opportunity. These individuals are asked to contribute to the process, including sharing information that can give a fuller picture to the DADR Chair and Panel, and can help inform each part of the process. They can offer their opinions of the services offered and received and may be able to offer an insight into the victim's life and their views.

Once a decision has been made to conduct a review any significant individuals should be written to informing them of this decision, asking them to participate. This will involve the production of a letter detailing the review process which will be personally shared by the Family Liaison Officer, in consultation with the SIO.

The family will also be signposted to specialist and expert advocates e.g., Victim Support Homicide Service and AAFDA.

If the death is a result of suicide, family members should be referred or signposted to https://amparo.org.uk/ This is a support service for anyone bereaved by suicide.

Children should be given specialist support and an opportunity to contribute as they may have important information to share. This will be arranged on a case-by-case basis in consultation with City of Doncaster Council children, young people and families Services.

More information can be found in Section 6 of the DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

The family and the Overview report

Adequate time should be given for the family to consider and absorb the information received. The amount of time determined should be discussed by the Chair with the family and agreed on the basis of their particular dynamics and the deadlines required of the review process.

The Chair/author should share completed and full versions of the review reports with the family prior to sign off by the Community Safety Partnership and prior to sending them to the Home Office.

Once approved by the Home Office, the family should have full sight of any media statements prior to their release and the publication of the review.

Action to take when the family do not wish to participate

There are many reasons why family members do not wish to be involved in the review and their right to decline engagement with the process must be respected.

Where family and friends do not wish to participate, this should be clearly recorded within the Overview Report.

If there is no engagement there is a need to still share the final report with them and make them aware of any media statements.

Family and friends should be offered more than one opportunity to participate as their views regarding participation may change overtime. There is a need to explain to the family, that late participation in the process could mean some limitations with regards to shaping the DADR process, as this is set out in the TOR at the start of the process, but every effort should be made to accommodate family at any stage.

The Perpetrator/Alleged Perpetrator or other 'subjects' and their family

The review should consider approaching the convicted perpetrator, or alleged perpetrator and the family of the alleged perpetrator. In cases of suicide there may be other subjects of the review linked to the victim and consideration should be given to their involvement.

The Review Panel should be mindful that the convicted perpetrator, alleged perpetrator or members of the perpetrator's family might in some cases pose an on-going risk of violence to the victim's family or friends or members of their own family. Any concerns of immediate risk that become evident should be communicated to the police. Particular consideration should be given to this issue in reviews where 'honour' based violence is suspected.

In such situations extra caution will be needed around confidentiality in relation to agency members and interpreters where there are possible links with the family, who may also be perpetrators. In addition, the level of participation from family members. The decision to include should be carefully considered in consultation with a practitioner with expertise in this area, e.g., a specialist in immigration law / specialist BME women's organisation.

The Alleged Perpetrator and their family – again, alleged, now I know there is a LOT of debate on this, but if for example if they were already arrested and charged with Murder, or pleaded guilty if this is public facing and a victims family read it, would it diminish there belief in the process or the belief we acknowledge a murder, or cause trauma? Tricky one I know.

7. Producing the Report and Executive Summary

The independent author of the review will produce the draft report in line with the DHR Statutory guidance.

The overview report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and chronologies and interviews with family/friends/professionals.

The findings of the review should be regarded as 'Official' as per the Government Security Classification Scheme 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 i.e., the panel members and their line managers.

The Chair/Author must be cognisant of any ongoing criminal proceedings and any possible civil action. Any information collated as part of the DHR whilst a criminal investigation is ongoing must be made available to the Senior Investigating Officer and Disclosure Officer, South Yorkshire Police.

8. Developing the Action Plan

The overview report should have a detailed action plan which reflects the findings and recommendations in the body of the report. Recommendations should include: -

- Appropriate solutions to help recognise abuse and either signpost victims to suitable support or design safe interventions.
- Adjustments / amendments to policy or procedures to secure better outcomes, including the multi-agency approach, support services to victims and the family and agency working.
- All actions should be tested out by the agency, prior to the action being finalised, where possible and time frames agreed at the senior level by each agency.

Action plans should be specific, measurable, achievable, relevant and with clear timescales (SMART). Consideration should be given about how the actions are monitored and effectiveness of the action/change.

9. Approval

Review panel approval

The approval of the overview report document needs to be FIRST approved by the Review Panel. This will have followed a process of amendment over more than one meeting depending on the complexity of the case.

Throughout this process Review Panel members need to update their relevant Senior Manager regarding any changes that impact on their agency.

The Review Panel need to scrutinise the overview report to

a) ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the reports
b) be satisfied that the reports accurately reflect the review panel's findings
c) ensure that the reports have been written in accordance with this guidance; and
d) be satisfied that the reports are of a sufficiently high standard for them to be submitted to the Home Office. The Quality Assurance Panel[1] will only sign off the report if it has: -
    - established a full as picture as possible, speaking to the appropriate agencies, voluntary and community organisations, family and friends.
    - demonstrated sufficient probing, analysis and has a balance narrative.
    - Identified lessons to be learned and has plans in place to ensure this happens.
    - minimised the likelihood of a repeat homicide.

Safer Stronger Doncaster Partnership approval

The final approval of the overview report, executive summary and action plan lies with the SSDP.

The SSDP needs to agree the content and ensure the report is fully anonymous apart from including the names of Review panel members and Chair and that it meets the four expectations required of the Quality Assurance Panel.

If the SSDP members are not satisfied they will feed back to the Review Panel, requesting further amendments and a further panel meeting as necessary.

Once sign off is agreed by the SSDP, the **Home office Data Collection form (Appendix A)** should be completed.

The Data Collection form should be submitted with the Overview Report, the Executive Summary and the Action Plan by the Domestic and Sexual Abuse Theme Manager to the Home Office. DHRENQUIRIES@homeoffice.gov.uk

Note - It will not be possible to finalise the Individual Management Reviews (IMRs) or the Overview Report until after the coronial/criminal justice proceedings, however, this should not prevent early areas for improvement or best practice being shared within agencies and relevant recommendations acted on.

Engagement with family/friends after approval BUT before publication

Once the reports are approved, but before publication, a discussion should be arranged with family, friends, colleagues etc. explaining the findings of the DHR/DADR and what the next steps will be. The Independent Chair will normally lead this meeting/s.

Quality assurance / Home Office Approval

The Home Office Quality Assurance Panel currently meets on a monthly basis, therefore a response would be expected within one month.

IF the Home office Quality Assurance Group does not approve - the report is found to be inadequate, then the Panel give a summary of their concerns to the SSDP, who will request amendments and may need to need to reconvene the Review Panel. The new guidance explains how when significant changes are required the SSDP should agree with the Chair the changes required, and they will be listed on the revised report, as the author of the original report.

IF the Home office approves - Once the Quality Assurance Group approves the DHR documents, a letter is sent to the SSDP, confirming this, including any additional feedback.

Once approval is received by the area the report can be published, usually following a process of redaction.

The agreed publication date (being mindful of key dates) should be agreed by the Domestic and Sexual Abuse Strategic Lead, and shared with the Chair, the review panel, the family and staff members involved in the case.

10. Domestic abuse commissioner

The Domestic Abuse Act 2021 requires all Community Safety Partnerships to send final copies of any Domestic Homicide Review to the Domestic Abuse Commissioner. Send all final versions of Domestic Homicide Reviews to DHR@domesticabusecommissioner.independent.gov.uk

11. Publication

Communication after the Home office Approval BUT before Publication

Family, friends and other support networks – All should be briefed before publication regarding the proposed publication date and any new objections should be taken into account. Extra support should be offered at this time.

Relevant professionals involved in the lives of those people subject to the review should be notified of the publication to ensure that they are aware of the completion of the review and publication and are to access support if needed.

Elected members should be briefed in advance, especially in cases where they have given personal support to the family. This may include the Mayor, Leader of the Council, cabinet members, local councillors and MPs.

The Domestic and Sexual Abuse Strategic Lead should also ensure that the communications departments of the key organisations are aware and media arrangements are agreed.

Significant dates should be avoided when planning the publication i.e. wedding anniversary, date of death and funeral, birthdays (including children's birthdays), etc.

Key speakers from all relevant organisations should be agreed ready for the date of publication, and beyond, to deal with any media enquiries.

Amending the approval document into a document for publication.

The OFFICIAL marking and any draft numbering can now be removed from the documents.

The Overview Report and Executive Summary should be suitably anonymised and made publicly available.

On the day of publication

The following is required

- The anonymised/ personified Overview Report and Executive Summary will be uploaded onto the City of Doncaster Council website – Domestic Homicide Reviews - Doncaster Council - unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen. The reasons for not publishing an Overview Report or Executive Summary should be communicated to the Home Office Quality Assurance Panel.
- Confirmation of publication should be emailed to the Home Office DHRENQUIRIES@homeoffice.gov.uk and include a link to the published documents.
- The Domestic and Sexual Abuse Strategic Lead will email a link to this webpage to the Review Panel, Individual Management Review (IMR) authors and full contact list of agencies. In this email they should be advised of where to direct any media enquiries.
- The family should be provided with the Home Office Quality Assurance Panel letter, a copy of the overview report and executive summary.

- An email containing the letter and a link to the report should be sent to relevant elected members and senior managers of each participating agency.
- The Panel's feedback should be made available to the Chair and author of the review, to help inform future reviews they may be commissioned to undertake.

Media arrangements

All communication about the review needs to contain the clear message that its purpose is not to apportion blame, but to ensure improvements are made where necessary.

The lead communication service, which will be City of Doncaster Council Communications in the case of Doncaster Domestic Abuse Related Death Reviews (as identified in the Terms of Reference), should provide communications advice on the content of the review webpage, and, if deemed desirable, draw up a press release to announce the publication. However, this will only apply where the Criminal Justice process has concluded – up until this stage, the Police will be the lead communications service.

If there is likely to be considerable media interest, a communications strategy should be drawn up, involving the communications teams for the key agencies involved.

The family should be made aware of and have sight of any media statements, and all should remain mindful of key dates, such as family birthdays and anniversaries.

The Chair's contract will need to include time to prepare in collaboration with communications advisers, and to be available to the media around the time of publication.

Refer to the media reporting guidelines from the Samaritans if the death is a suicide Media_Guidelines_FINAL.pdf

Refer to We Level Up - Media guidelines for reporting domestic abuse deaths:
Media-Guidelines-V2-1.pdf (welevelup.org)

12. Recommendations and delivering against the action plan

The action by the Home Office

The Home Office website will be updated with recommendations and implications for national training and practice.

Implementation

The guidance stipulates that action plans are the *'beginning of the (change) process'* and that local governance structures should be in place to monitor the delivery against the action plans.

There is a local governance structure in process to ensure all actions drive change and the action plan is completely delivered.

The Safer Stronger Doncaster Partnership (SSDP) is the partnership that has the statutory responsibility for DHRs/Domestic Abuse Related Death Reviews. The SSDP has delegated coordination and oversight of the reviews to the Council's Domestic and Sexual Abuse Team and the Doncaster Domestic and Sexual Abuse Strategic Board.

The Doncaster Domestic and Sexual Abuse Strategic Board will take the lead responsibility for ensuring the completion of the action plans by each Domestic Abuse Related Death panel. Domestic Abuse Related Death Reviews is a standing item on the strategic board agenda.

Prior to each strategic board meeting, the Domestic and Sexual Abuse Strategic Lead will ensure all ongoing review action plans are updated and provide a briefing to the strategic board.

The Board has the authority to escalate 'blocks' in progress to the SSDP for resolution.

Every 6 months the SSDP we ensure closer scrutiny of the progress of current DHR's and review audit/action plan progress.

Auditing action plans and SSDP Scrutiny

A year after the publication of the Domestic Abuse Related Death Review report, agencies should conduct an audit of progress against each review action plan, ensuring that the recommended improvements have been implemented, that any new or revised processes or policies are working and checking that there have been no unintended consequences.

A full assurance report following the audit will be discussed in detail at a Safer Stronger Doncaster Partnership Executive Board Meeting, or specially convened separate meeting of the SSDP. This will take place every 6 months.

13. Sharing the findings

The findings must be shared with:

- Safer Stronger Doncaster Partnership
- Domestic and Sexual Abuse Strategic Board
- Domestic and Sexual Abuse Theme Group
- Safeguarding partnerships
- Multi-agency Domestic Abuse Champions Network

The findings must be incorporated into or shared via the:

- Doncaster Domestic Abuse Protocol - Domestic Abuse Protocol - Doncaster Council
- The Doncaster Domestic Abuse website – www.doncaster.gov.uk/domesticabuse
- Domestic and Sexual Abuse Newsletter
- Domestic abuse training programme
- Safeguarding training programme

Appendix 1 - Home Office DHR Data Collection Form

DHR Data
Collection Spreadsh

Appendix 2 – Terms of Reference Template

(DHR/DADR Chair and Authors may choose to develop their own Terms of Reference with each panel)

CONTAINS CONFIDENTIAL INFORMATION

Restricted use only

DHR???? Terms of Reference (template)

1. REASON FOR DOMESTIC HOMICIDE REVIEW

On <<DATE>> South Yorkshire Police attended an incident in <<Town>>, Doncaster.

On <<DATE>>, <<AGENCY NAME>> notified the Chair of the Safer Stronger Doncaster Partnership that the incident was being investigated as a homicide, as per the Doncaster Domestic Homicide Review Protocol. The Chair of the Safer Stronger Doncaster Partnership considered the case, in conjunction with other key agencies that had contact with the family, and concluded that the case did meet the criteria and justification for a Domestic Homicide Review; the Home Office were notified accordingly.

2. SUBJECTS

Victim Details			
Name	**Date of Birth**	**Relationship**	**Home Address**

Alleged Perpetrator/Partner/Ex-partner/Family member Details [Delete as appropriate, also death might be suicide]			
Name	**Date of Birth**	**Relationship**	**Home Address**

3. PURPOSE OF THE REVIEW

The purpose of the review is to:

a. establish what changes are needed from the domestic homicide or suicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b. identify clearly what those actions 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;

c. apply the findings of the review to service responses including changes to inform national and local policies and procedures as appropriate;

d. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e. contribute to a better understanding of the nature of domestic violence and abuse; and

f. highlight good practice

4. SCOPE

The review will cover the individuals listed at Section 2 above. The historical period for the review will be from <<DATE>> to <<DATE>>. However, if during the review any Agency feels there is relevant information pertaining to other individuals or relevant information outside the time period under review, they should include this information in their Individual Management Review (IMR). This should be provided in summary form rather than on the chronology template.

The Domestic Homicide Review must not undermine any other inquiry. The DHR is cognisant of other parallel processes such as the criminal trial and coroner's inquest and will ensure appropriate liaison with those processes is established.
Agencies must ensure that work to address any areas for improvement that have been identified at an early stage begins immediately and should not wait until the production of IMR's or the overview report and action plan.
Further in-depth information to include within the Scope of the review can be found on page 13 of the Home Office DHR Guidance.

5. PANEL AND ADVISORS

Agency	Advisor
City of Doncaster Council	<<NAME>>
South Yorkshire Police	<<NAME>>
RDaSH	<<NAME>>
Doncaster Integrated Care System	<<NAME>>
GP	<<NAME>>
Housing	<<NAME>>
Etc .	<<NAME>>

[add or remove as needed]

- Independent Chair/Author – <<NAME>>
- Domestic Homicide Review Coordinator– Sophie Bishop, City of Doncaster Council
- Domestic and Sexual Abuse Strategic Service Manager, Karen Shooter, City of Doncaster Council
- Senior Survivor Liaison Officer, Laura Bunting, City of Doncaster Council
- Family Liaison Officer - <<NAME>>, South Yorkshire Police
- Senior Investigating Officer - <<NAME>>, South Yorkshire Police

6. INDIVIDUAL MANAGEMENT REVIEW (IMR) AUTHORS

Agency	Author
City of Doncaster Council	<<NAME>>
South Yorkshire Police	<<NAME>>
Etc.	<<NAME>>
GP	<<NAME>>
Etc.	<<NAME>>
Etc.	<<NAME>>

[add or remove as needed]

7. IMR STRUCTURE

The aim of the IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.(Multi- Agency Statutory Guidance for the conduct of DHR's , para 8.2)

Please follow the template layout as set out in Appendix A when writing your IMR.

8. INDEPENDENT AUTHOR AND CHAIR

The Independent Author/Chair is:
<<NAME>>
Safer Stronger Doncaster Partnership has commissioned an independent chair and author to carry out the review. The review is supplied by <<NAME>> and the lead reviewer is <<NAME>>. <<NAME>> is independent of any agency within Doncaster. <<FURTHER BIO>>

9. TIMELINE FOR THE DOMESTIC HOMICIDE REVIEW

The following may be subject to review and will be dependent on criminal/legal proceedings:

<<DATE Month/Year>>

- <<DATE>> - Initial panel meeting with appointed Chair/Author to agree Terms of Reference
- Name of IMR authors to be sent to DHR Coordinator
- Family and friends informed of DHR (in consultation with Senior Investigating Officer and Family Liaison Officer)

<<DATE Month/Year>>

- <<DATE>> - Deadline for submission of completed chronologies

<<DATE Month/Year>>

- Deadline for submission of completed IMRs to DHR Coordinator by <<DATE>>
- IMRs to be circulated to panel members <<DATE>>

<<DATE Month/Year>>

- <<DATE>>- IMR presentation meeting

<<DATE Month/Year>>

- Draft Overview Report and action plan to be circulated to panel members

<<DATE Month/Year>>

- Panel meeting to present draft Overview Report<<DATE>>
- Amended Overview Report submitted to Panel members for comment <<DATE>>
- Comments returned <<DATE>>
- Action plan completed by all agencies and returned to DHR Coordinator <<DATE>>
- Overview report, Executive summary and action plan signed off by all agencies and the Chair of the Safer Stronger Doncaster Partnership <<DATE>>
- Report submitted to the Home Office <<DATE>>

10. COMMUNICATION & MEDIA ISSUES

Doncaster Metropolitan Borough Council will lead on media and communication's issues together with representatives from partner agency communication teams.

11. ANONYMITY

The overview report and executive summary is to be anonymised for publication and dissemination. IMR authors should use full names. The DHR Chair/Author will ensure that a suitable pseudonym will be used in the Overview Report.

12. INVOLVEMENT OF FAMILY AND RELEVANT OTHERS

The DHR Panel recognise the value and importance of involvement of friends, family members and other support networks to the review and will make every effort to facilitate their involvement with the Panel Chair and Author.
No interviews will take place until after the trial.

Appendix 3 – Individual Management Review (IMR) Template

(DHR/DADR Chair and Authors may choose to develop their own IMR template or summary report template with each panel)

1. INTRODUCTION

Brief factual/contextual summary of the situation leading to the DHR and date for completion:
• Identification of person subject to review
• Date of Birth:
• Date of death /date of serious injury/offence

Victim, perpetrator, family details if relevant

Name:	Date of birth	Relationship	Ethnic origin	Address

Include family tree or genogram if relevant.

Please set out what service your Agency provides, population it covers etc. and indicate which part of the service was provided to the individuals subject to the review. This 'scene setting' about your Agency and what services were offered is helpful context for the reader before moving into detailed analysis of involvement later in the IMR.

2. AUTHOR & METHODOLOGY

Name, job title and contact details of person completing this IMR (include confirmation regarding independence from the line management of the case).

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

Explain what records have/have not been reviewed together with the rationale and consideration of the impact on the review.
Explain who has/has not been interviewed together with the rationale and consideration of the impact on the review.

3. DETAILS OF PARALLEL REVIEWS/PROCESSES

IMRs will be requested when appropriate so that it does not interfere with criminal proceedings. Interviews are not to be undertaken until after the trial. However, agencies should ensure that any findings that have been identified at an early stage should be acted upon and must not wait until the production of the IMR, the overview report or the action plan.

4. CHRONOLOGY OF AGENCY INVOLVEMENT

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

Construct the chronology in a separate document taking account of the above advice and refer under this section.

5. ANALYSIS OF INVOLVEMENT

Depending on the period under review you may find it helpful to breakdown the period under review into 'episodes of service provision'. Agencies must ensure that practice is evaluated against policies and procedures that were current during the period of time being reviewed.

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

To provide a comprehensive response to the above specific terms of reference for this DHR the following areas, taken from the statutory guidance, should be considered by the IMR author, and the report set out using these headings.

a) To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects or given rise to other concerns or instigated other interventions.

b) When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

c) When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

d) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

e) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it?

f) Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

g) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

h) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

i) Were any issues of disability, diversity, culture or identity relevant?

j) To consider whether there are training needs arising from this case

k) To consider the management oversight and supervision provided to workers involved

l) Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

6. EFFECTIVE PRACTICE/AREAS FOR IMPROVEMENT

Use this section to identify any effective practice or areas for improvement that you feel should be highlighted in the report.

In addition, the Independent author will use your analysis of involvement, engagement of family and friends to identify ways of working effectively that could be passed on to other organisations or individuals.

The panel will identify any improvement actions from this case relating to the way in which all agencies worked to safeguard victims and promote their welfare, or the way they identify, assess and manage the risks posed by perpetrators.

7. RECOMMENDATIONS

Recommendations should be focussed on the key findings of the IMR and be specific about the outcome which they are seeking. Please do not make recommendations about practice that has already changed but you can indicate that as a result of those practice changes that is why there is no longer a need to make a recommendation. Recommendations should be SMART.