Wakefield Safeguarding Children Partnership

Domestic Homicide Review (DHR)

(July 2022)

One Minute Guide

What is a Domestic Homicide Review?

A Domestic Homicide Review (DHR) is a comprehensive review of the circumstances in which the death of a person aged 16 or over, has or appears to have resulted from domestic abuse.

DHR's are part of the Domestic Violence, Crime and Victims Act 2004 and became law in April 2011. They do not replace, but are in addition to, the inquest or any other form of inquiry into the homicide.

Information within DHR's is anonymised to protect the family and friends of the victim. All the information shared between agencies to undertake the review remains confidential until the Home Office has reviewed and approved it for publication.

What is the purpose of a DHR?

A DHR is held with a view to identifying the lessons to be learnt from the death, and to establish how these lessons can be applied to practice. Consideration will be given to:

- How professionals work together to safeguard victims of domestic abuse
- Identifying clearly how lessons will be implemented within both single agencies and between agencies
- Applying these lessons to service responses, including changes to policies and procedures as appropriate
- The prevention of homicides in domestic settings and improving service response for all domestic abuse victims which include children, through improved single and multi - agency working.
- Highlighting good practice and contributing to a better understanding of domestic abuse.

Conducting a DHR – the process

- The Police inform the Safer Together Partnership (STP) when a Domestic Homicide occurs. The STP have overall responsibility for establishing if a review should be conducted.
- The STP will inform the Home Office that a DHR will be conducted once they have established that the criteria is met.
- Relevant organisations and agencies will be contacted and asked to submit information about their contact with the victim or perpetrator – this is known as 'Scoping'.
- A chronology will be completed.
- An Independent Chair is appointed who will then hold a series of meetings with relevant agencies to establish the circumstances around the case.

  The Chair is responsible for producing the final Overview Report for the DHR and may also contact family, friends and colleagues or anyone important to the victim, as they are considered central to the review process, should they wish to be.
- A Review Panel is established from the relevant agencies and organisations who then agree confidentiality and Terms of Reference for the review.

  A panel can consist of representatives from Police, Health, Local Authority, Probation Service, Domestic Abuse Services etc. They meet on several occasions to consider the information provided and will offer robust oversight and challenge.

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An Independent Management Review (IMR) may also be required, depending on the level of contact agencies may have had,

The IMR is a process which produces a report detailing, analysing, and reflecting on decisions made, any missed opportunities and areas of good practice within the individual organisation.

Action Plan

The Overview Report will make recommendations for future action, which the Review Panel should translate into a specific, measurable, achievable, realistic, timely (SMART) Action Plan.

This is how the 'lessons learned' will be applied in practice.

Domestic Homicide Review —The Overview Report

- The Report and Action Plan is submitted to the Safer Together Partnership for final sign off.
- The DHR will then be submitted to the Home Office Quality Assurance Panel for approval.

[Since the Domestic Abuse Act 2021, all published DHR's must be sent to the Domestic Abuse Commissioner to bring together learning, regionally and nationally].

When the report has had the necessary oversight and approval by the Home Office Quality Assurance Panel, the Local Authority who has dealt with the case will publish the anonymised Domestic Homicide Review, alongside an Executive Summary.

Timescales

- The decision to proceed with a review must be taken within one month of the Safer Together Partnership Chair being notified of the homicide.
- The overview report should be completed within six months from the decision to proceed, unless another timescale is agreed by the Partnership.

If the circumstances are complicated the reports can often take much longer to complete, but will be published as soon as possible.

Disseminating Lessons Learned

If the review has highlighted any need for change to process, policy or working practice, these changes will be implemented immediately, without the need to wait until the report is published.

Any actions or learning which have required action will be monitored as part of a Strategic Action Plan. Oversight will be continuous.

The Review is formally concluded when the Action Plan has been implemented.

The Strategic Domestic Abuse Team provide training sessions on 'DHR – Lessons Learned', to ensure practitioners are informed within the process of review, emerging themes from recent Domestic Homicide Reviews and how to adapt practice accordingly.

For further information on training get in touch with daforum@wakefield.gov.uk

Safer Together Community Safety Partnership Wakefield & District

Wakefield & District safeguarding adults board