Home Office

Domestic Homicide Review Toolkit

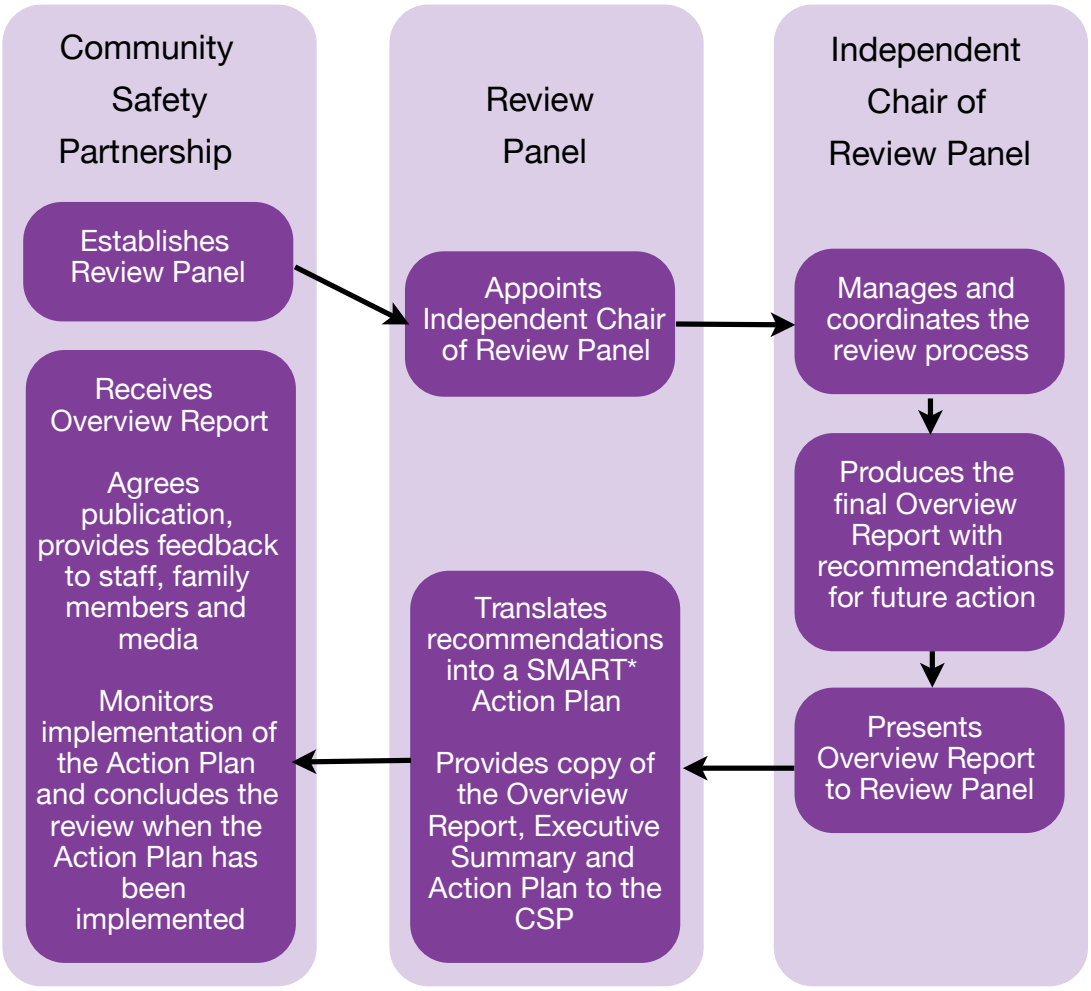
Guide to Overview Report Writing

Contents

1. Introduction

This Guide is written for and directed to those who are tasked with producing a final Overview Report for a Domestic Homicide Review.

The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (the Guidance) states that the independent Chair of the Review Panel (the Chair) is responsible for producing the final Overview Report.[1] Sometimes a separate Overview Report Writer will be appointed to undertake the task. However, the Chair will always retain final responsibility.



Summary of responsibilities of the CSP, Review Panel and Review Panel Chair as they concern Overview Report actions

(source; Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews)

* Specific, Measurable, Achievable, Realistic and Timely

The Overview Report Writer should be familiar with the above responsibilities of the Community Safety Partnership (CSP), Review Panel and Independent Review Panel Chair as they concern the Overview Report.

1 The Guidance Paragraph 5.8

The purpose of the Guide is to provide some practical advice on the writing of an Overview Report. It is intended to direct Overview Report Writers towards good practice and help towards the production of an Overview Report which satisfies the high standards of the Review Panel, the CSP, the Home Office Quality Assurance Group. Most importantly the report should also satisfy the families, public, professionals and others who will read the report and look to it for explanation and for reassurance that it has captured the essence of any learning needed to improve services and reduce the likelihood of future similar homicide.

The Guide does not replace the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

Using the Guide

Note that throughout this Guide the 'Overview Report Writer' is the person producing the report, whether or not he or she is also the Chair

The Guide makes suggestions for good practice. However, you should always apply the suggestions and advice according to the circumstances of each particular domestic homicide review

Nothing in this document replaces the Guidance, to which you should always refer if in doubt

2. Accountability and Quality Assurance

Be aware that the Review Panel Chair (not the Overview Report Writer if separate) carries ultimate responsibility for finalising the Overview Report for presentation to the Review Panel, who will ensure that the Overview Report is of a high standard before submitting it to the CSP.[2]

The Quality Assurance Group

You should know that the CSP will submit a copy of your report to the Home Office Quality Assurance Group.

Quality assurance for completed DHRs rests with an expert group made up of statutory and voluntary agencies and managed by the Home Office.[3] Where reviews are assessed as inadequate, a summary of findings is sent to the CSP Chair who is responsible for ensuring the areas of concern are revisited and amended.[4]

The Overview Report cannot be published until outstanding issues have been dealt with. Your report should therefore aim to meet the standards of the Quality Assurance Group first time, in order to avoid any delay to publication.

Note that the Home Office is developing quality assurance descriptors for Domestic Homicide Review reports which will be used by the Quality Assurance Group and which will be made available for Overview Report Writers when finalised.

2 The Guidance Paragraph 8.15
3 The Guidance Paragraph 11.1
4 The Guidance Paragraph 11.2

3. Preparation

Purpose

The purpose of a DHR 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 those lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims, their children and/or other relatives through improved intra and inter-agency working.

The Overview Report should 'bring together and draw overall conclusions from the information and analysis contained in the Individual Management Reviews (IMRs) and reports or information commissioned from any other relevant interests'.[5]

Your starting point

As your starting point (please note this list is not exhaustive):

- You will need to have been present at all Review Panel meetings from the outset.
- You will need a clear understanding of the Terms of Reference of the Domestic Homicide Review, membership of the Review Panel, your position as Overview Report Writer and your lines of communication with the Chair (if this is a separate person to the report writer) and senior managers commissioning the IMRs.
- Well-drafted terms of reference are an essential starting point for the writing of an Overview Report. You should therefore be involved in the drafting of the terms of reference so that you can ensure they provide for an independent approach by the Chair and Report Writer and are free of undue bias. Where possible, and where criminal proceedings do not prevent you from doing so you may wish to recommend that family members are consulted about the terms of reference. There may be particular things they wish to know that agencies have not thought about. Once the terms of reference are drafted they should provide you with a guide. For example, you will be able to ensure that the IMR template is consistent with them and that the information included in the report meets their requirements.

5 The Guidance Paragraph 8.10

- You should have access to all the information you will need to write the Overview Report and should have personally read everything yourself:
  - You will need to read the relevant records and local operational policies for the agencies concerned
  - You must read the IMR reports and should consider asking the IMR writers to present their reports to the Review Panel
  - Where there are inconsistencies in an IMR or between IMRs then you must investigate further and get clarification from the IMR authors and extra documentation if necessary
  - You will need to read all information commissioned from other sources, including notes or transcripts of any interviews
  - Where an inquest is being held, you should seek the inquest documentation, (though be aware that in some cases this will only be made available to interested persons rather than the general public)
  - Where there has been a criminal prosecution, you should have a transcript of the judge's summing-up and comments on sentencing (although this may take some time to obtain)
- You will need to be satisfied that there are no legal barriers to your seeing any relevant material or to including any of it in the Overview Report (see below).
- Before writing the report it will be of benefit to meet with the Review Panel to discuss any emerging inter-agency issues so that they are effectively addressed in the Overview Report.
- Check the Suggested Contextual Factors for Domestic Homicide Review Analysis (below) to see whether you have sufficient information to consider relevant factors. If you think there are omissions in the material available, or queries arise from the IMR report, inform the Chair, as it may be necessary to ask for further information or arrange additional interviews. This should be followed up without delay.
- Ensure the family are informed when you are at the stage of drafting the report.

The Multi-agency Overview Report

As the Overview Report Writer, you will need to familiarise yourself with the procedures for any other review which is relevant, such as a Serious Case Review, Safeguarding Adults Review, Mental Health Homicide Investigation under HSG(94)27[6] and/or IPCC Investigation. The Chair may need to be in contact with the Chair of any other review if they are running in parallel. Be aware of the possibility that your review might reach different conclusions to that of another review. You will need to explain in the Overview Report what other relevant review reports you have seen.

Whether or not there is any other ongoing review, if the victim, the family and/or the perpetrator had (or could or should have had) significant involvement with a wide range of services, you can expect to be writing for a broad, multi-agency readership.

6 HSG(94)27 is the national guidance Independent investigation of adverse events in mental health services governing mental health homicide investigations, as amended in 2005.

Remember too that there are a broad range of circumstances that may fall within the definition of a DHR in section 9 of the Domestic Violence Crime and Victims Act 2004, and not all cases will necessarily involve a known history of domestic violence.

It is likely that domestic violence will be a feature of most cases that are subject to a Domestic Homicide Review. It is therefore important to ensure that you take advice from an expert with knowledge of domestic violence or experience working in the field of domestic violence services and also give consideration to inviting them to be a member of the review panel. For example, this may be an independent representative from a domestic violence service or a recognised expert.

You should always expect to draft multi-agency recommendations. Make sure that you have the necessary expertise available to you and that all relevant agencies have provided the information you need. Do not be worried about asking for further information or clarification if this is required.

Making sure specialist knowledge and expertise is available

In order to write an intelligent and articulate Overview Report you must have a full grasp of the specialist knowledge required for the areas involved in the review, which will differ according to the particular theme of the review.

Your specialist knowledge may come from any or all of the following sources:

(i) Knowledge you and/or the Chair already have in that area or which you acquire through independent research into the topics concerned
(ii) Knowledge available from within the Review Panel
(iii) Knowledge you have acquired through hearing from those who were involved with service provision at the time of the homicide and from family members
(iv) Independent experts appointed to assist the review

Specialist knowledge areas about which you must have relevant knowledge include:

1. **Domestic violence and stalking:** Knowledge of domestic violence will be key in almost all Domestic Homicide Reviews. Note especially that exertion of power and coercive control by the abuser over the victim is a key dynamic feature of domestic violence. Consequently, issues for the Overview Report might include whether staff and professionals fully understood the impact of coercive control upon the victim's behaviour (for example, when returning to an abusing partner), and whether risk assessment including use of the DASH Risk Model[7], training and policies on domestic violence were adequate to help agencies understand these issues and protect the victim. An understanding of the legal framework for the protection of victims will also be necessary. Stalking often co-occurs with domestic violence and expertise in this area, including an understanding of recent legislation, should be sought if it is relevant to a particular review.

2. **Honour-based violence:** An honour crime is a crime that is, or has been explained by the perpetrator of the crime on the grounds that it was, committed as a consequence of the need to protect or defend the honour of the family. There is no culture or religion that condones this practice and it affects many communities. A particular feature is that an apparent reluctance to access support and services may be evidence of a victim's fear and shame brought about by the family's intimidating behaviour in the name of family 'honour'. The Overview Report may need to address the question whether services were sufficiently

7 Reference www.dashriskchecklist.co.uk. The DASH Risk Model is key to domestic violence decision making.

proactive, sensitive and supportive. As the Overview Report Writer you should be aware of the need to explain an expert's independence from any culture or community which supports honour-based abusive behaviour.

3. **Additional Knowledge:** You will find it helpful to have a general understanding of the following areas. Additional appropriate expertise should be sourced as required.

(i) **Individuals experiencing problems with mental health, drugs or alcohol:** Where the victim and/or the perpetrator has experienced problems with mental health, drugs and/or alcohol, the Overview Report needs to make it evident that any issues arising from this have been understood and expert advice sought, for example on methods of treatment and the appropriateness of services provided. It should be remembered that Domestic Homicide Reviews may not always involve a history of domestic violence[8], for example where the homicide is linked with a perpetrator's untreated psychosis, but the requirement for an independent mental health homicide investigation under HSG(94)27[9] is not triggered.

(ii) **Vulnerable individuals and children:** A number of other specialist areas might be incidental to the review or central to the homicide, including care of elderly or disabled partners or relatives, care of children and disputes concerning them. These would require an understanding of family dynamics, the impact of domestic violence on children, relevant services and the legal framework. As with mental health investigations above, a specialist area might become the whole focus of the Domestic Homicide Review where, for example, the issue is neglect of a vulnerable adult but a safeguarding adults review is not carried out.[10]

(iii) **Other specialist areas:** You may need to acquire knowledge concerning the particular context of the homicide which may involve race/ gender/ sexual orientation and any differences in treatment by agencies. All the grounds for discrimination or "protected characteristics" in the Equality Act 2010 i.e. age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, religion/belief will need to be considered. Experts may be needed and interpreters used to assist where necessary.

Legal Consisderations

Before you begin you must be absolutely certain as to these points:

- That criminal proceedings do not prevent your use of any information arising from reports or interviews. If commissioning of the Overview Report has been put on hold until the criminal proceedings are concluded, no problems will arise. Otherwise, inform the Chair and refer to the Guidance at Chapters 6 and 10. In all cases where there are criminal proceedings ongoing it will be necessary to communicate with the Senior Investigating Officer involved with the criminal investigation to ensure that all disclosure issues are addressed and that interviews or actions undertaken for the review do not prejudice criminal proceedings.

8 S9 Domestic Violence, Crime and Victims Act 2004 applies where a death results from violence, abuse or neglect. This includes homicides caused by individuals suffering from mental illness and homicides resulting from neglect of a vulnerable adult. Usually, but not always, these would be covered by other specialist reviews.

9 Supra

10 Ibid

- That all confidential documents concerning the perpetrator or other surviving members of the family have been disclosed either with their consent or with the authority of each agency in the public interest.[11]

- That individuals providing information either in writing or at interview, have been informed that their material may be mentioned in the published Overview Report and know they will be given an opportunity to comment upon the report in draft form where there is any potential criticism of their actions.[12]

- That any information in Children Act 1989 proceedings has been disclosed to you with the consent of the court. Such information may include documents in family proceedings involving the residence of children, contact with children and care proceedings.

- That if the victim was subject to a Multi-Agency Risk Assessment Conference (MARAC) or the perpetrator a Multi-Agency Public Protection Arrangement (MAPPA), a Memorandum of Understanding has been provided for release of the Minutes.

If you are prevented from gaining access to any documentation for legal reasons you should state that at the beginning of the report. You should make it plain that the absence of certain material, may have had an impact on the conclusions you were able to reach. You simply do not know what crucial information might be missing.

Where there is any doubt on a legal matter, the Chair should ensure that legal advice is obtained. This may require specialist legal advice to be sought or, in some cases, legal advice may be obtained from existing Local Authority lawyers.

11 According to Caldicott Guardian guidelines. See "Striking the Balance" Practical Guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences). **www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133594.pdf**
Note that in rare cases it may be necessary to ask a Court to order disclosure.

12 The Guidance Paragraph 8.15 and Paragraph 7.3 bullet point 7.

4. Key Procedural Issues

Personal data and anonymity

You will need to draft both the Overview Report and an Executive Summary of the report. Both documents should contain your name, as the Overview Report Writer[13], plus the names of the Chair and Review Panel members. All other personal data must be 'fully anonymised'.[14] You should explain in your report that anonymisation is in order to comply with the Guidance.

Bear in mind that reports will be published and widely available on the internet so it is important to minimise the risk that existing family members could be identified from your Overview Report.

You should discuss with the Review Panel the matter of redacting any part of the report prior to publication.

The report should be marked 'Restricted' until the agreed date of publication.[15]

Ensuring organisations and individuals are satisfied with their information in the Overview Report

It is the Review Panel's responsibility on being presented with the Overview Report to ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Overview Report.[16]

In non-statutory reviews and investigations, individuals who might be criticised should be entitled to see and comment on reports in draft form where there is any actual or implied criticism[17]. These same principles, intended to promote fairness, have been incorporated into The Inquiry Rules 2006 supporting the Inquiries Act 2005 for statutory inquiries[18].

Although it is the Review Panel's responsibility, you or the Chair might be asked to carry out this task. It would be sensible to consult with the senior managers responsible for each IMR to establish whether all individuals had already indicated they were satisfied their information was fully and fairly represented in the IMR report. If there is no change in the Overview Report, that might suffice.

Otherwise, you should agree the form of a template letter to contributing organisations and individuals which explains they are being given an opportunity to check factual accuracy, correct errors and comment on any matters in the draft report which concern them. Relevant extracts of the draft Overview Report (or if necessary the whole document) should be sent out with each

13 The Overview Report Writer's name should be included if he or she has been responsible for any content of the report
14 The Guidance Paragraph 8.19
15 The Guidance Paragraph 8.13
16 The Guidance Paragraph 8.15
17 Known as 'Scott Compliance' or Maxwellisation' after the Scott Inquiry into the Matrix Churchill Affair (the 'Arms to Iraq Inquiry'), published in1996.
18 'Warning letters' at Rule 13 of The Inquiry Rules 2006.

letter as appropriate. You will need to make it clear that this is a draft extract and is 'Restricted' because it is highly confidential (there may be parts concerning colleagues which they have not yet had a chance to comment upon). You may need to consider Data Protection Act implications and you may also need to redact any parts they should not see.

If any additional observations are made by individuals or organisations as a result of this procedure, you should consider them but you do not need to alter your conclusions. The Overview Report can still be published if there is disagreement.

Sharing the Overview Report with family members

It may be appropriate for the Overview Report Writer to share findings of the Overview Report with family members, in agreement with the Chair[19]. This will especially be the case where family members have contributed to the review. If the report is 'Restricted' a hard copy could be shared in a meeting with family members and then collected at the end of the meeting with a full explanation concerning confidentiality prior to publication given to the family.

It is important that the family are given adequate opportunity to consider the report if the report is to be shown to them in a meeting and collected from the family at the end of the meeting. The process should not be too rushed in order to ensure overall fairness. If the version which is shared with the family has not yet gone through the quality assurance process and it is therefore not the final version, this should be made clear to the family so that they are aware that they are not being given the final product for consideration. This is a different responsibility to that of the CSP who, on receiving the Overview Report must 'make arrangements to provide feedback and debriefing to family members'[20]. This would usually take place at a meeting just prior to publication when family members must receive an embargoed copy of the Overview Report.[21] You may be asked, with the Chair, to be present at that meeting.

If you are involved with any feedback of the Overview Report to family members, make sure you have taken all the appropriate advice which is available on the sensitive management of this[22].

Dissemination and Publication

Local publication and dissemination of the report's conclusions are matters for the CSP.

The CSP will provide a copy of the Overview Report, Executive Summary and Action Plan to the Quality Assurance Group at the Home Office. Once clearance has been given by the Quality Assurance Group, completed reviews should be published at a local level on the local CSP website.[23]

The Home Office Quality Assurance Group is responsible for dissemination of lessons learned at a national level, identification of serious failings and common themes nationally, communication with other government departments, provision of a central storage for Domestic Homicide Reviews for auditing purposes, and recommendations for national training and service needs.[24]

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19 The Guidance Paragraph 8.13
20 The Guidance Paragraph 8.19
21 The Guidance Paragraph 7.3 bullet point 7.
22 The Guidance Chapter 7 and the Home Office Information Leaflet to victim's families at **www.homeoffice.gov.uk/publications/crime/DHR-leaflet2?view=Binary**
23 The Guidance Paragraph 11.3
24 Refer to the Guidance Paragraph 11.4 for a more detailed list.

5. General advice on drafting the Overview Report

This section is intended to provide some helpful suggestions and general advice. It should not be taken as a definitive guide and does not replace the Guidance.

Key reference material

- The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
- The 'Outline Format for Overview Report' is at Appendix 3 of the Guidance (Page 28)
- The 'Domestic Homicide Review Overview Report Template' is at Appendix 4 of the Guidance (Page 29)
- The 'Executive Summary Template' is at Appendix 4 of the Guidance (Page 31)
- The 'Action Plan Template' is at Appendix 5 of the Guidance (Page 37)

The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews is available on the Home Office website at **www.homeoffice.gov.uk/publications/crime/DHR-guidance?view=Binary**

As other relevant documents become available, they will be added on the Home Office website.

Creating an authoritative report

Make your report the human face of the Domestic Homicide Review

Above all, show that the review has been fearless, impartial, fair, balanced and thorough in its approach, challenging where necessary but also compassionate in the face of the tragedy which led to the review.

You are entrusted with a weighty task. Put yourself in the position of each reader of the report and check whether you have explained every procedural aspect and accounted for all conclusions reached.

Your report is the culmination of the Review Panel's work. Use a language and style which is understandable by the victim's family, friends, the perpetrator and public, as well as the agencies and individuals who have contributed to the review.

Layout of the report

The Overview Report should follow the headings outlined in the Guidance 'Outline Format for Overview Report' and the 'Domestic Homicide Review Overview Report Template' (Appendices 3

and 4 of the Guidance).[25] The purpose of this standardisation is to enable quality assurance and to gather data at a national level so that lessons can be learned effectively.

Add headings from the terms of reference and any relevant sub-headings. Consider creating a concise index for the report for ease of reference as many of them can run into hundreds of pages. Where possible, findings and conclusions within the reports should be referenced, including the page number and paragraph in the original document. Charted chronologies, glossary of terms and genograms can be attached as appendices.

Suggestions to assist with drafting

Using the Guidance 'Outline Format for Overview Report' as a skeleton, add material gradually to each sub-section, cross-referencing by page number as you go to reports, policy documents and other material. As an aide memoire this will prove invaluable later.

Flesh out the chronology. Avoid paraphrasing and let the contemporaneous records speak for themselves. Original wording can be contrasted with commentary from interviews and reports in your analysis section (known as 'triangulation').

Be careful to avoid premature findings. If discrepancies appear in the chronology, make a note for now. Include your thoughts in the Analysis Section as they occur to you. They can be developed later.

As you draft the report, beware of expressing your opinions. Keep focussed on those who have contributed to the review. Quote from them rather than paraphrase. Produce an evidence-based report.

Wherever possible, include commentary not only from those who provided services but also from those who received services. Their words should be heard throughout the report.

You will need to find your personal way of managing the task of drafting the report

The creation of a skeleton draft may be helpful

25 The Guidance Paragraph 8.11

6. Using the Guidance 'Outline Format for the Overview Report'

Drafting the Introduction Section

- Begin with a Preface containing the purpose of the review as described in the Terms of Reference, with acknowledgements and expressions of sympathy for the family of the victim. State that the review is held in compliance with the legislation and follows the Guidance. Thank those who have contributed for their time, patience and cooperation.

- At the beginning of the report list the names of the Review Panel Chair, the Overview Report Writer[26] and the Review Panel members[27]. As a matter of good practice and in the interests of openness and transparency, you should describe each person's occupation, professional or management status and the agency in which they are employed. It is very important that the Chair is, and seen to be, independent both from involvement in the case itself and from those responsible for delivery and commissioning of relevant services. In order to provide confidence in the impartiality of the Overview Report, the same standard of independence should apply to the Overview Report Writer. An explanation of the Chair's independence should be included in the final Overview Report.

- If there are any conflicts of interest for Review Panel members they should be stated so that readers of the Overview Report can be aware of them. IMR authors should be described according to their professional status and their independence from involvement with the case being reviewed.

- State if any other reviews have been conducted or combined within this or another report.

- If timescales have changed, outline why.

- Summarise the circumstances that led to a review being undertaken in this case.[28]

- Clearly state the original scope and terms of reference of the review, recording the methodology used, what documents were obtained, whether any interviews were undertaken and the rationale for those decisions.[29]

- Make it clear that the Review Panel has obtained all family and perpetrator confidential documentation on the basis of their consent (or in the absence of their consent, in the public interest). If it has not been possible to obtain any confidential material for legal reasons, explain which parts are missing from the Overview Report.

- If confidential information concerns children, remember that children, depending on their age and maturity, will not be able to consent to release of that material. You should make reference

26 The Overview Report Writer's name should be included if he or she has been responsible for any content of the report
27 The Guidance Paragraph 8.19
28 The Guidance page 28
29 Ibid.

to the way in which the Review Panel has dealt with this area of confidentiality and, if applicable, mention that information has been released from Children Act (1989) proceedings.

- Explain that there is a statutory expectation that certain bodies will have regard to the Statutory Guidance for the Conduct of DHRs[30] and that these bodies can be directed by the Secretary of State to participate in a review (section 9(2) of the Domestic Violence Crime and Victims Act 2004).

- Explain that although certain bodies (as described above) can be directed to participate in a review, reviews, including Domestic Homicide Reviews, cannot issue a witness summons.[31] This means there is no legal sanction or power to enforce a request made by the Review Panel Chair or Overview Report Writer that an individual attend for an interview. If any individual does choose not to participate, with the consequence that there are gaps in the information available, this should be mentioned in the report.

- Add that all family, friends, colleagues, the perpetrator, staff, professionals and personnel have had an opportunity to comment on any actual or potential criticisms in the draft report as it concerns them.[32]

- State whether the victim's family and the perpetrator have been given an opportunity to contribute their views either to an IMR or directly to the Chair. If they have not been given an opportunity, explain why.

- Taking into account any limitations as above, list all the agencies and individuals (anonymise by role rather than name e.g. PC A, Dr B or Social Worker C) who contributed to the review, explaining the nature of their contribution, and the rationale for any gaps.

- Expand on individual IMRs to explain the agencies' roles. Explain what each IMR was commissioned to do and how the IMRs were quality assured.

Drafting the Facts Section

- State where the victim lived (the area rather than the full address) and where the homicide took place.[33]

- Include a synopsis of the homicide, explaining what actually happened and how the victim was killed.[34]

- Give details of the Post Mortem, Inquest and/or Coroners Inquiry, if already held.[35] Include details of any pending Inquest, Inquiry or trial, including the trial date.

- Anonymise individuals, list members of the family and the household (including who else lived at the address and, if children, their ages at the time).[36] Consider 'humanising' the report by giving fictitious names to victims and families rather than initials. Include, if appropriate, an anonymised genogram of family members.

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30 Domestic Violence, Crime and Victims Act 2004 s9(3) and quoted at Page 5 of the Guidance.
31 To create the power to witness summons an individual, the Secretary of State would need to convert the Domestic Homicide Review to a statutory inquiry under the Inquiries Act 2005.
32 The Guidance Paragraph 7.3 bullet point 7.
33 The Guidance page 28
34 Ibid
35 Ibid
36 Ibid

- Describe how long the victim and the perpetrator(s) had been living in the same household, and if a partner/ex-partner, how long they had been together as a couple, including whether they had separated.[37]

- Explain if there had been a history of domestic violence in the relationship, if the alleged perpetrator was known to have been abusive in previous relationships, or if the victim had experienced domestic violence in any previous relationships.

- If domestic violence is known to have been taking place, ensure you have taken advice from relevant experts. The review should take into account the dynamics of any such abuse including things such as coercive control. The fact that a victim may have been coerced or controlled into taking certain actions or decisions should also be considered in such circumstances.

- Explain which agencies had been providing services over what period of time and to whom. This should include responses to any known domestic violence in previous relationships.

- Set out relevant policies, procedures and protocols applicable to the actions taken by staff, professionals and managers within the agencies.

- Explain which, if any, risk assessment and risk management tools were being used at the time or that had been used previously and may be relevant to this review, with particular reference to (i) risk assessments concerning protection of the victim, and (ii) risk assessments concerning the perpetrator. Describe any risk factors for domestic violence identified by staff at the time and any conclusions reached by those staff and others as to risk management. Mention risk assessments from other agencies such as mental health services and include MARAC and MAPPA as appropriate.

- Include a description of training and supervision of staff as relevant to the issues in the review.

- Mention any management, resource, technology, service delivery, commissioning or inter-agency matters which were relevant at the time.

- Explain any charges that have been made and to whom; for example, who has been charged with or convicted of murder or manslaughter, and if convicted summarise the details as set out in the judge's summing-up or upon sentencing.[38]

- Basing it on the scope of the review as set out in the Terms of Reference, write a chronology charting contact or involvement with the victim, the perpetrator and their families by agencies, professionals and others who have contributed to the review process. Note the time and date of each occasion the victim, perpetrator and/or child(ren) were seen and the views and wishes that were sought or expressed.[39] The chronology should be based on original source documentation. As stated above, avoid paraphrasing – use words from the original records. Consider using chronology software to produce accurate timelines such as the ChronoLator (**http://berrick-computing.co.uk/chronolator/index.htm**).

- Context is all important. Set the documentation alongside relevant local and national policy, procedure and guidance. Mention any staffing, supervision or other issues which were having

37 Ibid
38 Ibid
39 Ibid

an impact on services being provided at the time.

- Include an overview that summarises what information was known to the agencies and professionals involved about the victim, the perpetrator and their families.[40]

- Consider explicitly any ethnic, cultural or equalities matters that had a bearing on agency involvement.

- Mention any agencies which could have been expected to have had contact with the victim or perpetrator, but did not.

- Include other relevant facts or information concerning any individual or provision of services prior to the homicide.[41] A list of previous offending might need to be included for example.

- Make sure the Overview Report contains information from the IMR reports concerning local implementation of recommendations and Action Plans, along with evidence supporting completion.[42]

Drafting the Analysis Section

'This part of the Overview Report should examine how and why events occurred, information shared, decisions made and actions taken or not taken. You can consider whether different decisions or actions may have led to a different course of events. The analysis section is also where any examples of good practice should be highlighted'.[43]

This is the place where the report should answer the questions set out in the Terms of Reference. The analysis may be carried out by the Review Panel Chair together with the Overview Report Writer or by the Overview Report Writer alone. However, it is a task best undertaken by more than one person in order that bias can be identified and rectified where possible.

The Guidance does not require or advocate application of any particular theoretical framework, methodological approach or analytical technique. However, some understanding of common pitfalls is desirable, and a grasp of the ways these can be avoided through good analytical practice.

Hindsight bias and outcome bias

Care should be taken to avoid hindsight bias and outcome bias:

- **Hindsight bias** is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This tends towards a focus upon blaming staff and professionals closest in time to the incident.

- **Outcome bias** is when the outcome of the incident influences the way it is analysed, for example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged

40 Ibid
41 Ibid
42 Ibid
43 Ibid

one way when the outcome is poor and another way when the outcome is good, accountability becomes inconsistent and unfair.[44]

Reducing hindsight bias

Your report should acknowledge that hindsight is difficult to eliminate but that everything possible has been done to limit it, for example, as described in the Pemberton Domestic Homicide Review.[45]

The Pemberton Homicide Review 2008

'We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice. We have, however, made every effort to avoid such an approach where possible.'

A tendency towards hindsight bias can be reduced by ensuring the Overview Report focuses on how things were perceived at the time, with the rationale for decisions, actions or inactions at the time.

When drafting your report you should show that you have thoroughly considered the context of an individual's decision, action or inaction by checking through the factors in the ***Suggested Contextual Factors for Domestic Homicide Review Analysis*** (below), any or all of which might have had an impact on the decision, action or inaction at the time. Note that the final box is for you to complete. There are likely to be more factors, depending on the circumstances of each homicide.

This kind of contextual analysis is helpful not only to assist with an understanding of events as they occurred, but also to provide a framework for recommendations.

Suggested Contextual Factors for Domestic Homicide Review Analysis
Factors to be considered at the time of the homicide. Note these are a guide only. They are not intended to be an exhaustive list and should be used as part of a thorough review of the circumstances in each case.

44 Page 32, National Patient Safety Agency (February 2008) Independent investigation of serious patient safety incidents in mental health services: Good Practice Guidance.
45 Paragraph 4.6, A Domestic Homicide Review into the deaths of Julia and William Pemberton, A Report for West Berkshire Communities Partnership, November 2008

Policies and procedures	Whether they were appropriate, audited, reflected best practice, relevant guidance and national policy
Organisational	Whether systems worked effectively, for example, teams and integrated structures of professionals
Providing and commissioning	Whether relevant services were provided and commissioned
Training	Whether training was relevant, mandatory, current and whether staff were in a position to use their training
Working conditions	Whether there were any staff pressures, vacancies, high staff turnover, disputes
Resources	Whether there were there any funding or staffing issues
Information systems	Whether IT systems, telephone communications, data storage were operating effectively, with trained staff
Management systems	Whether leadership and accountability structures were effective, with implementation of policies
Risk assessment tools	Whether appropriate models were being used, for example DASH, with sufficient training
Staff morale	Whether morale was good or whether there was a 'fire-fighting' mentality, with complaints and disputes
Inter-agency systems	Whether there was effective operation of MARAC, MAPPA, Child Protection, Drug and Alcohol services etc
Working culture	Whether there was attention to detail and good practice or a 'rule of optimism' 'it will be all right' approach
Inter-agency communication	Whether inter-agency information sharing protocols were operational and joint working effective
Professional standards	Whether professional standards were being met, best practice guidance followed and supervision provided
Patterns of communication	Whether there were open channels of communication families, the victim, perpetrator, local community
Employment	Whether job descriptions covered tasks undertaken, whether grievance or discliplinary proceedings
Domestic violence awareness	Whether there was domestic violence training and engagement with organisations aiming to reduce domestic violence
Cultural awareness	Whether interpreters available and links to support organisations, for example for 'honour'-based violence
National issues	Whether, for example, new legislation or national guidance was having an impact on services
Governance systems	Whether there had been other national and local reviews and recommendations implemented
Community	Whether there were links with the local community and joint development of plans for reducing domestic abuse
OTHER FACTORS	CONSIDER OTHER FACTORS RELEVANT TO THE REVIEW

Risk assessment will be a vital component of most Domestic Homicide Reviews. In this complex area, many of the above factors will contribute to the picture.

You should make sure the Overview Report is able to comment authoritatively. Independent experts on risk assessment can be helpful here.

Bear in mind that risk assessments may have been undertaken in mental health, children's services, adult safeguarding, drug and alcohol units and elsewhere. You must know about these if they apply in your review.

Example of contextual factors applied to a risk assessment
This example is simplified. It would need to be tailored to the circumstances of each Domestic Homicide Review.

Note that this kind of analysis can also be applied to other subject matter in the review.

A wide-angle view

Do not forget that in order to establish whether there were in fact open channels of communication between staff and professionals and the victim and/or perpetrator at the time, the Domestic Homicide Review should have done its best to hear from the victim's family, the perpetrator and from others who might have known, such as friends, colleagues, employer and those in the local community. If you have been able to take this 'wide-angle view'[46] of the situation, it will add to the authority of the report. If you are prevented from receiving that information, there should be an acknowledgement in the report that you have been able to present only the agency and professional's views.

You should be familiar with the Home Office leaflets encouraging the victim's family, friends and colleagues to participate in the review[47].

Asking how and why

The Overview Report should examine 'how and why events occurred'.[48] Families, the public, staff, managers, professionals and others may look for answers to the following questions:

- Could the homicide have been prevented?
- Was anyone (other than the perpetrator) to blame?

These are understandable questions, bearing in mind that your report may sometimes be read through emotions of anger, anxiety and grief. You should not avoid addressing the issues they raise, even though the answers are likely to be complex and may not always prove satisfying for those deeply involved with the review.

No specific methodology need be applied here. However, you must explain how you came to your conclusions and check they are not affected by outcome bias (above). Statements made without a clear rationale can be confusing when the report is published.

If you use any tools such as Root Cause Analysis or carry out any other form of structured analysis you should explain your technique in simple terms and the reasons for the conclusions you reach.

Preventability

Preventability is a particularly difficult area to address in the report.

- You must reach your own conclusions based on the circumstances of your particular review.

- However, you are advised to exercise great care when saying 'the homicide could have been prevented' or 'the homicide could not have been prevented'. Both may be oversimplifications, could inadvertently appear biased or blame-focused and are in danger of being misunderstood. However, it is possible to arrive at a reasoned conclusion about preventability without

46 Page 163, Mullane, F (2012) A Personal Account of the Murders of Julia and Will Pemberton and the Subsequent Domestic Homicide Review - in Monckton Smith J. (2012) Murder, Gender and the Media. Narratives of Dangerous Love Hampshire: Palgrave Macmillan

47 **www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-violence/domestic-homicide-reviews/**

48 The Guidance page 28

expressing bias. The aim should be to achieve an objective perspective, and to ensure that all conclusions are well-reasoned.

- Given that so much is attached to use of the word 'preventable', think carefully how you use it. Explain exactly what you mean and ensure your point is scrupulously argued and accurate.

Preventability pitfalls - the following examples illustrate some potential difficulties:

- Human action is complex and the effect of decisions on subsequent actions of others is best seen in terms of the likelihood of particular outcomes.

- A narrative explanation based on the likelihood of events occurring and the likelihood that the homicide could have been prevented if certain services had been effective, will be much more accurate and helpful when drafting recommendations for improvement.

- The conclusions you reach as to likelihood should always be evidence-based. Although an individual's views in interview will have been affected by hindsight, it is their views you must endeavour to capture. You should not replace their views with your own.

- From your accumulated evidence, you may be able to conclude that events were 'very unlikely', possible or 'highly likely'. However, you should also be prepared to state that there is insufficient evidence to reach any conclusion.

- Review and investigation reports sometimes refer to 'missed opportunities' when there were several events and a sense of gathering momentum, with risk, which remained undetected. If this appears to be the case in a Domestic Homicide Review, endeavour to present an evidence-based view as to the likelihood that alternative decisions could have been taken at the time and the difference that may or may not have made.

- Be aware that all readers of your report will have different expectations. You should take care with the words you use and anticipate their possible interpretation when the report is published.

- A narrative approach can be usefully constructive. A range of individuals and experts can be asked about the likelihood that redesigned services might at the time have reduced the chance of that homicide and might in the future help reduce further homicides. This is part of the evidence and will be helpful when drafting recommendations for improvement.

Evidence is your raw material

The conclusions you reach as to likelihood of a particular outcome should always be evidence-based. Individuals should have been asked what they think about their decisions, actions or inactions at the time, what they think would have been the likely outcome of different decisions. This is your raw material for the report. This makes it particularly important that interviews are conducted carefully. It is so important to get this right that if a crucial area of evidence is missing, you should be prepared to say that you cannot reach a conclusion in the report without it.

Dealing with 'blame' in the report

Blame is rarely a helpful concept when the aim is to learn lessons and improve services.

- The Guidance states that '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'.[49]

- This does not mean you should avoid commenting upon errors or poor professional practice. However, any such comment should always be accompanied by a full explanation of the context, as described above.

- Always bear in mind that individual staff and professionals may have done whatever they reasonably could, acted entirely within procedures, adhered to protocols and made appropriate judgments based on best practice, yet still the homicide occurred. A decision that lead to a death was not necessarily a wrong or even a poor decision.

- Remember that even when decisions were properly made there might have been changes which could have improved the standard of certain services. Ideas for improvements to practice or services may have emerged during the review from individuals or community and support organisations which could make a positive contribution to the review's recommendations. This positive approach contrasts with the unproductive culture of 'blame'.

- Consider how you will explain the position if the perpetrator has been invited to contribute his or her views on services. The victim's family may be fearful that the Overview Report might share the perpetrator's views and 'blame' the victim. You will need to include some reassurance that the Domestic Homicide Review is impartial and has dealt with all contributors on equal terms, whether service users, providers or commissioners of services. You must also demonstrate that you have shown that balance in your analysis.

- Be scrupulous about ensuring legally accurate words are used. Remember to refer to the 'alleged perpetrator' if criminal proceedings are not concluded. Do not use the words 'murder'

49 The Guidance Paragraph 11.6 bullet point 1.

or 'manslaughter' until there is a conviction. The Domestic Homicide Review legislation uses the word 'death' which is a neutral term and the Guidance also refers to 'killing'. These would be the most neutral terms to use in the report.

- Emotive terminology and moral judgement should be avoided since this could be construed as bias.

Catharsis

- In the midst of the review's analysis, consider the value of weighing opposing arguments and bringing them together in words which can provide some resolution, even reconciliation. Catharsis is a legitimate function of the review and your report can assist with this.

Drafting the Conclusions and Recommendations Section

'This part of the report should summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action. Recommendations should include, but not be limited to those made in individual management reports and may include recommendations of national impact. Recommendations should be relatively few in number, focused and specific, and capable of being implemented'.[50]

Findings

The Guidance refers to the 'findings of the Review'.[51] Care should be taken to explain what is meant when using the word 'findings', since it could be taken to mean general conclusions or findings of fact. Both may be included in the Conclusions Section.

The latter is very specific and involves coming to a conclusion on a factual matter. Since the Domestic Homicide Review is not making legal findings based on evidence heard under oath, it is best to be cautious about reaching conclusions as to facts. Different or disputed versions of events can simply be presented in the report along with the discrepancies. If you do favour one account of events over another say so, but you should explain why you come to that view, for example because several individuals supported that version whereas only one person gave the differing account. Avoid saying "it is obvious that", as it contains no explanation.

It is not uncommon to find there are differing understandings between professionals, for example as to risk management. Again, be careful to look at the reasons for that. Take into account that professionals can legitimately hold differing views but both be acting quite properly within their professional guidelines.

Experts might also have their own opinions. Generally, it is best to outline the strengths on one side of an argument and the weaknesses on the other.

It will be up to you as the Overview Report Writer to present a balanced view.

50 The Guidance Page 28
51 The Guidance Paragraph 8.13

Conclusions

Findings and conclusions may be included in the main body of the report as they emerge. They could for, example, be included alongside the text in a separate box under the heading 'Conclusion', being numbered along the way.

In the 'Conclusions' section it would be appropriate to gather all the findings and conclusions together, listing them and including references to the text of the report.

It may be helpful to put them into topic-based sections. Alternatively, they could be listed chronologically as they have arisen in the report. The IMR conclusions could be included as a subsection or linked with the Overview Report conclusions on particular topics. This will be a matter for the Overview Report Writer. Their presentation should make them easy to read.

- When drafting the conclusions, think about how each one will be used. Bite-sized pieces of information are often best. Accuracy is essential. They should be articulately expressed.
- Each conclusion should be firmly evidence-based.
- Try to express complex conclusions in straightforward ways, subdividing them if necessary. Those set out simply will have the strongest impact and be easier to convert into recommendations.
- If the Terms of Reference have been to review local services, your conclusions should relate to those local services. If you stray beyond your remit and comment on services about which you have received only partial information, you should add that this would need further examination.
- Review your conclusions carefully, making sure that where there are criticisms of services, recommendations flow from them. The reader should not be left wondering why suggestions for improvement have not been made.

Providing reassurance that services have improved

The Multi-agency Guidance states 'The aim in publishing these reviews is to restore public confidence and improve transparency of the processes in place, across all agencies, to protect victims'.[52]

52 The Guidance Paragraph 9.1

- IMRs may already have made recommendations, and senior managers in the relevant agencies may have acted on these by the time of publication. This information should be available to you in the IMR reports.[53]

- If you are to offer any reassurance to the public you must have seen evidence that recommendations have been implemented and can say this in the Overview Report. Evidence might include a new policy in place, audit results, a mandatory training schedule for staff or leaflets for families.

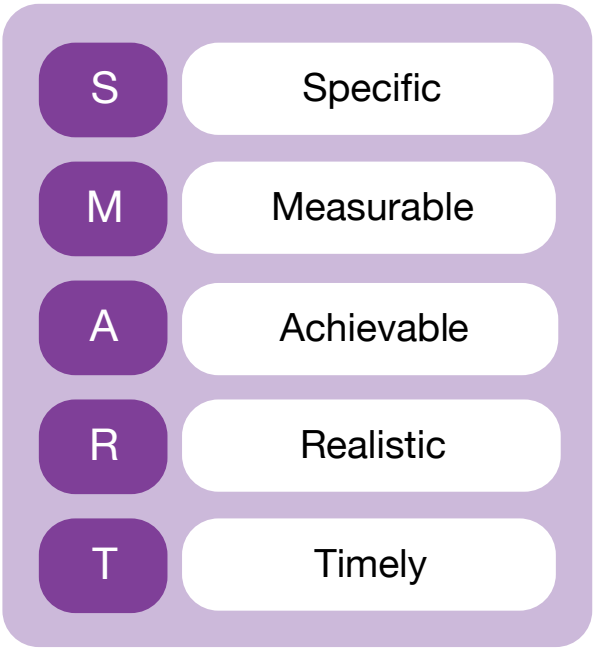
- If you do not have that kind of evidence and your information is limited to a statement by the agency concerned, you should explain in your report that you have not been able to confirm the information.

- Always be aware that it may be relatively straightforward to establish that a leaflet has been produced, but quite another thing to know that this has reduced any likelihood of homicide. Improvement in the standard of services can nevertheless offer some reassurance.

Recommendations

Amalgamate recommendations from the IMRs with those that you draft, so that each agency can easily identify its own. When the Review Panel produces the inter-agency Action Plan, it will be attached as an appendix.

When the Overview Report, with its recommendations, is presented to the Review Panel, the Review Panel will translate the recommendations into SMART Action Plans.[54]



You should aim to draft recommendations that are also SMART so that the transition to an Action Plan is straightforward.

Your recommendations should always be evidence-based and drafted with SMART implementation in mind. Make them **single-topic and specific**. Direct them to the agencies concerned. Think about whether implementation could be **audited, or measured** in another

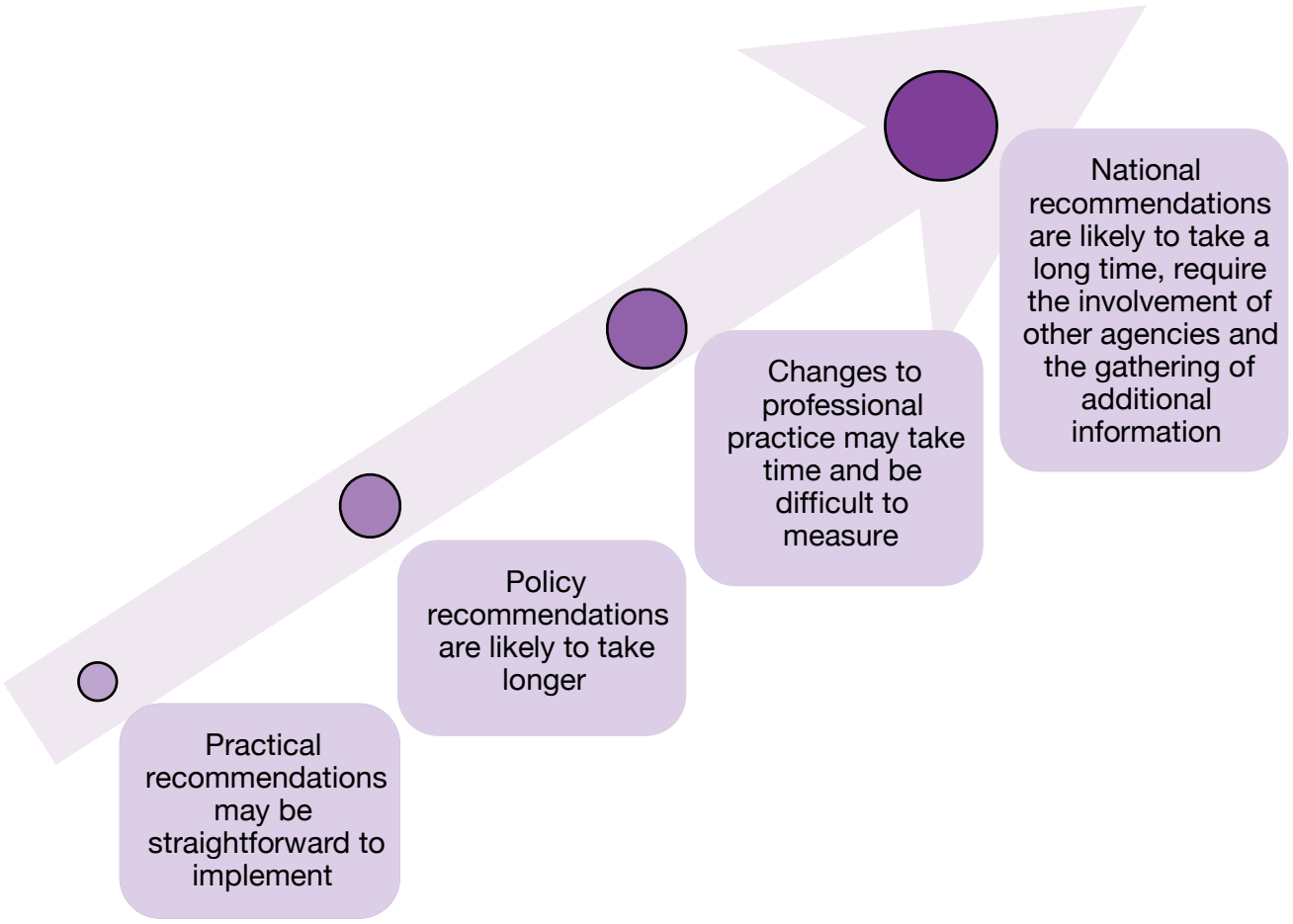
53 The Guidance Paragraph 8.8
54 The Guidance Paragraph 8.16

way. A common mistake is to put two recommendations into one sentence. Another is to make sweeping, generalised statements concerning what should be better. If your recommendations are not drafted well they will not be capable of implementation and will not be **achievable**.

Recommendations should be based on the conclusions of the review. It is never appropriate to add your own ideas, unrelated to the review.

If the Terms of Reference have been to review local services, your recommendations for service improvement should be directed to those local services.

However, there may be occasions when you wish to ensure that learning from the review on a certain topic is promoted as widely as possible. You can use recommendations to help achieve this through recommending that the report is disseminated to particular organisations or forms the basis of specific training beyond the local area. If the review has uncovered an issue which may have national implications, you can draft a recommendation that more information be gathered nationally on this by a specific body or agency. You can recommend an evidence-based independent review[55] of some or all of the implementation after a specific period of time.



Some recommendations are harder to implement than others. In these examples, it becomes harder to measure and achieve implementation as the recommendations become more complex.

You should not be deterred by recommendations that may be difficult to implement. Be prepared to make recommendations that are far-reaching, but acknowledge that the time scale for

55 Downham, G., Lingham, R., Using Inquiries for Change, Journal of Mental Health Law (Spring 2009) Page 58

implementation will be longer and that more difficulties may be encountered.[56] Be realistic and do not create expectations that cannot be fulfilled. Explain this in the Overview Report.

You will also need to be aware that timely implementation of more practical recommendations may sometimes take priority. You can assist by making sure your recommendations are reasonably limited in number, SMART and goal-focused.

You are advised to share the draft recommendations with families and with the agencies to which they are directed. This ensures you have worded them sensibly, that agencies are aware of your recommendations and agree to undertake the work involved. Everyone will usually wish to get this right. If done well it can be a constructive phase of the review process.

The Review Panel Chair should consider seeking comment on recommendations from the start. All individuals who are contributing may be asked, in writing or at the end of an interview, whether there is any aspect of service delivery they would like to see improved and which in their opinion might help prevent further homicide. This is usually welcomed and focuses on future prevention at the outset. The Chair might include this in the commissioning of the IMRs or write separately to contributors inviting suggestions.

56 Ibid Page 59

7. National analysis

The development of risk assessment and risk profiling has produced optimism that the incidence of domestic violence homicide can be reduced.

Domestic Homicide Reviews provide a means of establishing how effective risk assessment and victim protection procedures are at reducing homicide.

Your Overview Report will form the basis, with others, of a growing body of knowledge about domestic violence from which common themes and trends might emerge and which may inform national improvement in service provision.[57]

Bear in mind that the national analysis will only be as good as the information that is collected, included and submitted. Therefore, ensure you use the template and address the areas that have been specifically highlighted. In time this should result in better identification of the issues which need to be addressed.

57 The Guidance Paragraph 11.5

Sequeli Consortium members are Sequeli Limited, a not-for-profit limited company, Laura Richards Consultancy and the Health and Social Care Advisory Service (HASCAS), a registered charity. Consortium associates are Amerdeep Somal, Independent Police Complaints Commissioner, Professor Jill Manthorpe and James Blewett, both of King's College London, and David Mason, Partner Capsticks Solicitors.

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