



Domestic Homicide Reviews – Consultation

July 2018

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Section 1 – About this consultation

1.1 This consultation seeks views on a proposed model for the introduction of Domestic Homicide Reviews (DHRs)¹ in Northern Ireland, which will seek opportunities for learning from cases of homicide resulting from domestic violence and abuse.

1.2 With the assistance of a small working group of key partners/stakeholders² the Department of Justice (the Department/DOJ) have developed a model to review the interaction services and organisations had with a victim.

1.3 The review will also consider organisational and service engagement with the perpetrator, including the nature of offending behaviour. The DHR will seek out and share opportunities for learning, identify what worked well and inform the development of practice to improve services, ultimately with a view to preventing domestic violence and abuse and domestic homicide happening in the future.

1.4 This consultation seeks the views from our main stakeholders, including the police, health practitioners and organisations within the voluntary and community sector. We would also welcome views, through your organisation, from the individuals you represent. This provides an opportunity for individuals to comment on, and shape, how the DHR process will work here.

1.5 The result of initial equality screening is included in Section 7, '*Impact of the consultation proposal*', and a copy of the full equality screening has been published on our consultation page and is also available on request.

¹ A Domestic Homicide Review is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

- (a) a person that they were related to (*familial relationship*);
- (b) a person with whom they were, or had been, in an *intimate personal relationship* (this would cover a current or past relationship at the time of death); or
- (c) a *member of the same household*.

² The group included the Department of Health, the Department of Justice, the Health and Social Care Board, Men's Advisory Project, the Police Service of Northern Ireland, the Probation Board for Northern Ireland, the South Eastern Domestic and Sexual Violence Partnership, Victim Support NI and Women's Aid.

Section 2 – How to respond

Duration and closing date

2.1 The consultation will be open for 12 weeks. The closing date is Friday 28 September (please note that it is unlikely that we will be able to accept consultation responses after this date).

Questions

2.2 There are a number of questions posed throughout the document to assist you in considering the proposed model. A consultation questionnaire is also provided separately to help in framing your response. As far as possible it would be helpful for this to be used, for analysis purposes.

Enquiries and Responses

2.3 Please address any enquiries you may have and responses to:

By phone: 028 9052 3772

By e-mail: DOJCommunity.SafetyUnitProjMailbox@justice-ni.x.gsi.gov.uk

In writing: Community Safety Division
Room A4.03
Castle Buildings
Stormont Estate
BELFAST
BT4 3SG

2.4 The Department intends to publish responses to the consultation and a summary response report on our website. Any contact details or information that will identify a respondent as a private individual will be removed prior to publication. All information will be handled in accordance with the General Data Protection Regulations (GDPR).

2.5 Respondents should also be aware that the Department's obligations under the Freedom of Information Act 2000 (FOIA) may require that any responses not subject to specific exemptions under the Act be communicated to third parties on request.

Alternative Formats

2.6 An electronic version of this document is available in the consultation section of the Department of Justice website (www.justice-ni.gov.uk/consultations). Hard copies of this consultation document, and copies in other formats (including Braille, large print etc.), can be made available on request. If it would assist you to access the document in an alternative format or language other than English, please let us know and we will do our best to assist you.

Complaints

2.7 If you have any concerns about the way this consultation process has been handled, you should send them to the following address:

Standards Unit
Department of Justice
Knockview Buildings
Stormont Estate
Belfast
BT4 3SL

Email: Standardsunit@justice-ni.x.gsi.gov.uk

Section 3 – Introduction

3.1 Since 2010 on average five people have been killed every year in Northern Ireland by a current/former partner or close family member. The highest number of domestic homicides, eleven, was recorded by the Police Service of Northern Ireland (PSNI) in 2007/08.

3.2 Everyone deserves to live in a safe community where we respect the law and each other. The Department is acutely aware of the importance of protecting victims from domestic violence and abuse. We consider that this can only be done through developing and maintaining good practice, improving services and strengthening the policies and strategies adopted to address domestic violence and abuse. Through this we can try to ensure that a range of bodies and organisations can be more effective in keeping victims safe from harm.

3.3 We are currently taking forward a range of new measures to tackle domestic violence and abuse, including DHRs. We anticipate that progressing this suite of initiatives will assist in ensuring that the services that are delivered work ‘on the ground’.

3.4 In tackling domestic violence and abuse our obligation will always be to the victims. We consider that this focus should not stop in the tragic circumstances where an individual has been killed as a direct result of domestic violence and abuse.

3.5 When a domestic homicide occurs we need to consider what action was taken to help and protect, and what, if anything, could have been done differently to secure a better outcome. As there may be opportunities for learning it is crucial that these are identified as early as possible. We anticipate that DHRs will provide a forum for agencies such as the police, probation, health, and social services to consider the circumstances of the case, assess their response, and potentially learn critical lessons, improve services and work to prevent future victims from coming to harm.

3.6 It should be stressed that these reviews will not seek to apportion blame; that is not their purpose. Rather they will provide the appropriate forum and framework to consider what happened and what, if anything, could have been done differently. The homicide reviews are intended to maintain good practice, where needed improve frontline services

by informing changes, and ultimately learn from these tragic crimes to save lives in the future.

Section 4 – The Government strategy and legislation

4.1 In 2016 the Department, in partnership with the Department of Health, published the ***Stopping Domestic and Sexual Violence and Abuse*** Strategy. The Strategy takes a zero tolerance approach to domestic and sexual violence and abuse and provides a framework for delivery.

4.2 This can only be achieved through providing robust services and effective partnership working. The Department committed within the Strategy's first action plan to develop an appropriate model to review the circumstances of a domestic homicide, consider organisational and service responses and seek out opportunities for learning. **This consultation seeks views on that proposed DHR model**, created with the help of key statutory and voluntary sector partners.³

4.3 DHRs were introduced in England and Wales in 2011 under **Section 9 of the Domestic Violence, Crimes and Victims Act 2004** (the 2004 Act).⁴ While they have not yet been introduced locally we want to ensure that the proposed model will meet our needs and dovetail with the range of case reviews and public protection arrangements (including PPANI) already working here. We also want to learn from other processes and jurisdictions and have considered how DHRs and case management reviews are conducted elsewhere. We have developed what we consider to be an appropriate model for Northern Ireland in order to review a case, seek out and share opportunities for learning and, where relevant, inform changes to policy and practice across the sectors at the earliest opportunity.

4.4 **We are not seeking views on the primary legislation** for Northern Ireland. This is already in place and we would intend to commence the relevant provision ahead of the formal introduction of DHRs. The scope of the 2004 Act provides for:

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

³ Department of Health, Health and Social Care Board (member also representing the Northern Ireland Adult Safeguarding Partnership), Office of Social Services, Police Service of Northern Ireland, Probation Board for Northern Ireland; South Eastern Area Domestic Violence Partnership, Men's Advisory Project NI, Victim Support NI and Women's Aid Federation NI.

⁴ http://www.legislation.gov.uk/ukpga/2004/28/pdfs/ukpga_20040028_en.pdf

- (i) a person that they were related to (familial relationship);
- (ii) a person with whom they were, or had been, in an intimate personal relationship (this would cover a current or past relationship at the time of death); or
- (iii) a member of the same household.

Section 5 – The main purpose of a domestic homicide review

5.1 Before looking at how DHRs could operate locally it is helpful to explain their purpose, setting out what a DHR is and is not about. The purpose of the DHR is to:

- (i) Review the way in which local professionals and organisations that came into contact with the victim work individually and together to safeguard victims;
- (ii) Review the way in which local professionals and organisations that came into contact with the perpetrator work individually and together to tackle harmful behaviour and safeguard victims;
- (iii) Seek out opportunities for learning regarding the way in which local professionals and organisations work individually, and together, to safeguard victims and address offending behaviour;
- (iv) Identify clearly the lessons that are to be learned and the actions that are needed to change practice as a result, how and within what timescales this will be progressed, what is expected to change as a result (this will include early learning that may be implemented ahead of a DHR formally concluding and being reported on) and how this will be measured. This relates to learning both within and between organisations and agencies;
- (v) Apply identified lessons to service responses, including changes to policies and procedures as appropriate;
- (vi) Prevent domestic violence and homicides and improve service responses for all domestic violence and abuse victims through improved working (including strengthened partnership working) and ensure that domestic abuse (and associated abusive behaviour) is identified and responded to effectively at the earliest opportunity;
- (vii) Contribute to a better understanding of the nature of domestic violence and abuse; and
- (viii) Highlight good practice.

5.2 The review process should aim to ensure that relevant organisations maintain, refine, or change service policies and procedures as appropriate and that there is effective

dissemination and implementation of lessons learned, so that change can be actioned, as well as promotion and wider sharing of good practice.

5.3 There are potentially a number of misconceptions about what a DHR should do. For that purpose the following paragraphs set out what a DHR does not do and the key elements that it is intended a DHR would encapsulate. A DHR is not about:

- how the victim died;
- who was responsible for the death;
- attributing blame – rather the focus is very much on seeking out opportunities for learning and proposing, where appropriate, how service procedures, provision and delivery may be improved; or
- disciplinary action.

These issues will be addressed through other processes, for example a police investigation, a criminal trial, a coroner's inquest, disciplinary procedures etc.

5.4 Rather the focus of a DHR is about:

- seeking out and capturing early and ongoing learning;
- identifying what lessons, if any, are to be learned (this might be for individual organisations, a range of organisations and/or how the organisations work separately and together);
- helping us to better understand domestic violence and abuse (including the nature of offending behaviour);
- recognising where and what immediate and longer term action is needed as a result of the DHR; and
- having a clear outcome, for example, a succinct report that focuses primarily on good practice, lessons learned and what needs to be changed.

5.5 The review process should, as appropriate, ensure that:

- organisations identify when and how action will be taken;

- organisations outline what changes will be made and how they will be measured;
- organisations do change how they work as a direct result;
- lessons learned are shared and practice changed regionally (across Northern Ireland);
- good practice is regionally promoted and shared; and
- the future is made safer for those that are subject to domestic violence and abuse.

Q1. *Do you have any comments to make about the purpose of a Domestic Homicide Review?*

Section 6 – The proposed DHR process

Referral to the Senior Oversight Forum

6.1 When there is a domestic homicide of an adult (aged 16 years old or over) the PSNI will notify the Senior Oversight Forum (SOF) of the death. This will then in turn begin the DHR process and SOF's engagement, as appropriate, with the DHR Chair and Panel to undertake a review.

6.2 As part of the policy development process consideration was given to who may oversee the DHR process and disseminate best practice and lessons learned. Options included the Policing and Community Safety Partnerships, Public Protection Arrangements Northern Ireland (PPANI), the Coroners' Court and the Northern Ireland Adult Safeguarding Partnership. It was considered that these bodies were not necessarily best placed or appropriate to take these reviews forward. In light of this it is proposed to establish a multi-agency Senior Oversight Forum (SOF) to commission and oversee the review process and ensure implementation of associated findings.

6.3 Full membership of SOF would not be required for the commissioning of a DHR; this could involve a core subset of members, as determined by SOF (membership of SOF is discussed later in the document).

Is it only the PSNI that can make a referral?

6.4 A referral could be made by another professional body/agency or other multi-agency forum, if appropriate, where it considers that important lessons may be learned from a domestic homicide. There may be circumstances where a referral is prompted by the family of a victim requesting a DHR through the PSNI/professional body, agency or forum. It is anticipated that the majority of referrals would come directly from PSNI.

Decision to commission a DHR

6.5 Following notification of a domestic homicide SOF would assess, as promptly as possible, whether there should be a DHR. They would consider if the case is within the

scope of the DHR process/legislation and if any other review processes are relevant/involved. Where the case meets the criteria for a DHR SOF would commission this by engaging with the DHR Chair and panel. The Chair would then inform the victim's family of the commencement of the DHR process.

When would SOF not commission a review?

6.6 There will be specific circumstances where it may be more appropriate to hold a review under a different process, for example where there is considerable overlap with other review mechanisms and the core area of concern sits elsewhere such as mental health or public protection. Any decision for the lead to be taken by another review body would be based on the detail of the case. Where another review is commencing SOF would engage with the relevant review body to seek opportunities for learning relating to the domestic violence and abuse within the alternative process. It may be appropriate in such circumstances for the Chair of the DHR, or a panel member, to sit on the alternative review process. This will be decided on a case by case basis and in any event there would need to be close liaison with other relevant processes (such as PPANI) and reviews. It may also be appropriate in some cases for two reviews, with different focuses, to run in parallel.

6.7 There may also be instances where there is no scope for seeking out learning, for example, where there is a 'one off' incident, with no history of domestic violence and abuse and no contact with services. In such cases while the DHR criteria would be met it may be unlikely that a DHR would be carried out or that there would be lessons to be learned. It would however only be in very exceptional circumstances that a review would not be commissioned, given that generally questions should be asked to identify good practice and seek out and share learning.

6.8 Any decision not to commission a DHR would be proposed by SOF, who has an oversight role within the process, to the Department. In such cases the final decision as to whether or not there should be a DHR will be taken by the Department and advised to SOF. The family of the victim would then be advised of any decision not to conduct a review.

Will a DHR be commissioned if the victim is under 18?

6.9 The legislative scope of the DHR process covers victims aged 16 and over. There is already a robust legislative and safeguarding framework in place to tackle child abuse and review the circumstances of cases where the victim is under 18 and has been the victim of a domestic homicide, for example, by a close family member. In these instances another review process may be more appropriate, for example a case management review (CMR). With regard to young victims we would consider the homicide of a 16 – 18 year old victim, within a teenage intimate relationship, sitting firmly within the scope of the DHR process. Where a case involves the death of both an adult and a child the DHR Chair would liaise with the other review body to ensure that good practice and engagement with service provision is identified and lessons are sought and shared in relation to the domestic violence and abuse.

Will a DHR cover death by suicide where there is a history of domestic abuse?

6.10 As the DHR process is in the early stages we do not consider that it should, at this stage, cover death by suicide. This will be kept under review given the recognised links between domestic violence and abuse, suicide and homicide.

Q2. Do you have anything to say about when a DHR will or will not be commissioned?

SOF commission a DHR

6.11 Where SOF decides to commission a DHR they would identify those best placed to sit on the Review Panel. This would include core panel members as well as any bodies that it may be considered appropriate to involve, given the particular circumstances of the case.

6.12 It is considered that a 'typical' terms of reference might include or capture:

- what appear to be key issues in seeking to identify learning;
- how best relevant information can be obtained;

- who should contribute to the review, including organisations that may not have had (but may have been expected to have had) contact with the victim or perpetrator;
- how the review will interact with other investigations/reviews that are running in parallel;
- the timeframe for the review;
- the time period that the review should cover (this may not become clear until the detail of the case is known). There will be a need to balance proportionality with a relevant time period from which to identify good practice and seek to capture learning;
- whether there are any evident equality and diversity issues for example, gender identity, ethnicity, disability, etc. that may require special consideration or if an outside expert will be needed to assist in understanding these crucial aspects of the case;
- any interaction with a Multi-Agency Risk Assessment Conference; public protection arrangements; perpetrator programme arrangements; protection notices/orders; or a domestic violence disclosure scheme, etc.;
- any contact with a support organisation, charity or helpline;
- any contact with other relevant domestic violence and abuse services;
- how family members, friends, employers, support networks and the perpetrator/perpetrator's family contribute to the review, where they wish to;
- how engagement with the family, friend, the public etc. will be managed (considering the views of the family) before, during and after the review and who will be responsible for this;
- whether the victim made a disclosure at work and if it had a domestic violence policy in place;
- whether the victim or perpetrator was a NI Housing Executive or housing association tenant, if there were any associated difficulties with the property tenure, and their policies and processes around domestic violence;
- the 'modus operandi' of the perpetrator and any notable changes to their behaviour;
- how account will be taken of good practice and lessons learned from previous reviews;

- panel interaction with the Senior Investigating Officer, as well as the Public Prosecution Service directing officer, as well as (where appropriate) PPANI and the Coroners' Court; and
- what will be published.

6.13 This is not a complete list and the terms of reference would be different for each case. We consider that there should generally be core terms of reference aspects common to each DHR. However the terms of reference would need to be kept under review as the DHR progresses.

6.14 The DHR Chair and panel would determine the terms of reference for the review, considering relevant standard elements and others as required by the particular circumstances of the case. This would then be approved by SOF within a period of no more than five working days.

Q3. Do you have anything to say about what may 'typically' be outlined within the terms of reference?

6.15 At this early stage the DHR Chair will conduct scoping to establish the engagement the victim and the perpetrator had with services and ensure those organisations involved secure their records so that information relating to the case can be made available to the DHR Panel when requested.

The Domestic Homicide Review Panel

6.16 The DHR would be progressed by a Chair and multi-agency panel. It is considered that the DHR Panel should be led by a **Chair** who:

- has practical and/or academic expertise in domestic violence and abuse issues and an awareness of sexual violence and abuse;
- is independent, ideally from all agencies involved in the process;
- has an understanding of the role and context of the main agencies likely to be involved;

- has proven managerial expertise, as well as sound investigative, interviewing and communication skills; and
- has experience in preparing reports with concise and clear findings.

6.17 It is proposed that the Chair would hold the position for a specific period of time (at least three years), with the possibility of this being extended. A recruitment or procurement process would need to be conducted to select the most appropriate individual(s).

6.18 It is considered that a regional panel and Chair would work well, given the size of Northern Ireland and the presence of a range of province-wide bodies.

6.19 There is however a need to ensure that there is contingency and capacity should the Chair be absent for a significant period of time or should there be an increased level of DHRs in year. This could be managed by, for example:

- (i) having more than one Chair, with cases allocated appropriately (this would be our suggested way forward);
- (ii) having a reserve list when recruiting/procuring the chair;
- (iii) drawing a deputy from the DHR panel that is commissioned (however they would not be independent); or
- (iv) having an associate chair for a brief period of time throughout the year.

Q4. Do you have anything to say about:

- *the knowledge and skills of the chair*
- *the recruitment and contingency for the role of chair?*

6.20 It is considered that there would be merit in a core **Panel** membership of individuals from the key relevant organisations and bodies. To ensure continuity, consistency and a build-up of knowledge it is suggested that individuals would sit on the panel for a period of three to five years, following which they may be replaced by someone else in their organisation for a further period of time. Having a panel and Chair in place for a minimum

number of years would also provide the opportunity to assess and improve the DHR process.

6.21 It has been suggested that there may be merit in having **deputy** panel members, to build up knowledge and provide resilience. It would be for organisations to determine whether this would be beneficial and how best it would operate. One option may be that the panel work could be split on a case by case basis, between a main and deputy member.

6.22 It should be noted that under the 2004 Act the panel must include individuals from:

- (i) the Police Service of Northern Ireland;
- (ii) the Probation Board for Northern Ireland;
- (iii) Health and Social Services Board; and
- (iv) Health and Social Services Trusts.

It is envisaged that these bodies would also be represented on the SOF.

6.23 We are of the view that organisations from the **voluntary and community sector** will be vital to the core membership of the panel and the forum, bringing a particular expertise and insight into the case that may not be gained through statutory partners. In this respect, there would be considerable merit in the panel having members from groups representing both male and female victims of domestic violence and abuse. We consider that all the organisations referenced above, together, would represent core members on the panel, with additional members (representing other areas) as the circumstances of the case requires. This ad hoc membership would be considered as and when necessary, in terms of additional knowledge and expertise. It could include, for example, representatives from the Northern Ireland Housing Executive/housing associations or the education sector. The Panel should have due regard to equality and diversity issues in relation to persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; men and women generally; persons with a disability and persons without; and persons with dependants and persons without. Please note this would also include rural needs.

6.24 Panel Membership would be agreed by SOF, through the terms of reference, prior to commencement of the DHR. This could of course be kept under review, as necessary and determined by the circumstances of the case (taking account of the views of the DHR Chair).

Q5. Do you have any comments to make about DHR panel membership?

Q6. Do you have any comments to make about the consideration of equality and diversity issues by the Panel?

How will families be involved in the DHR process?

6.25 A DHR provides a victim's family with an opportunity to comment on, inform and improve services/responses to tackle domestic violence and abuse, given that they will provide a unique perspective on the circumstances leading to the homicide. They can also provide valuable insight and vital information about the case, potentially from the victims' perspective, that will not be captured by the statutory organisations participating. As a consequence the involvement of the victim's family will be a key aspect of the DHR process, should they wish to be involved.

6.26 In any event, it will be important to have clear communication, from the outset, with the family about the process and their role within it. This communication should be carefully and sensitively managed by the DHR Chair.

Q7. Do you have anything to say about family involvement in the process?

Involvement of other individuals in the DHR process

6.27 Often individuals who would have come into regular contact with the victim (informal networks), such as friends, work colleagues or employers may also have information that would assist in the DHR process and provide further insight into the circumstances leading

up to the homicide. The perpetrator and their family may also have information useful to identifying learning. The involvement of these individuals would also have to be considered.

Q8. Do you have anything to say about the involvement of other individuals in the process?

Progress of the Domestic Homicide Review

6.28 We envisage two key elements to the review process, that is:

- at an early stage, initial findings, learning and identification from the Chair and panel of actions needed; and
- identification of key findings, learning, actions and longer term change necessary to maintain and improve services and the response in future cases of domestic violence and abuse.

6.29 At the initial DHR panel meetings consideration should be given to any immediate findings or actions that may need to be undertaken to address issues raised at this very early stage of the process. Should there be criminal proceedings it may be some time before the review is able to formally conclude and key findings are fully outlined and progressed. It would therefore be vital that steps for any easily identifiable and obvious change be progressed as soon as possible. Advice from the PSNI and the Public Prosecution Service (PPS) would also be sought as necessary, in relation to any potential impacts on the progress of the case through the criminal justice system. If there are associated criminal proceedings, while the work of the review may be progressed (in terms of gathering information and analysing this), it may be that the formal completion of the review process (including reporting publication) would have to be put on hold pending the outcome of those criminal proceedings. This should not however hamper the collection of information. A snapshot of the review process is outlined at page 26.

Q9. Do you have any comments about the two key elements of the DHR process:

- (i) initial findings, learning and identification of actions needed; and**
- (ii) identification of key findings, learning, actions and longer terms change**

to improve service and the response in future cases of domestic violence and abuse?

6.30 To capture key issues in England and Wales information is sought through Individual Management Reviews (IMRS). In discussion with stakeholders we wish to explore adapting the IMR process slightly to obtain information in a more dynamic way, focusing on seeking opportunities for learning and ensuring open engagement with all relevant organisations involved in the case. We would propose that each organisation would gather information on their involvement and bring a summary narrative to the DHR Panel for discussion. We anticipate that the information provided would help identify factors that support good practice and the conditions in which poorer practice is more likely to occur. Under this approach those directly involved in the case could be central and active in seeking to capture learning and providing proposals for change.

Q10. Do you have any comment on the approach proposed regarding gathering information, or any suggestions as to how best this could be undertaken?

6.31 A single **report** will normally be completed at the end of the review process. While there is merit in providing detailed information on key elements and background of the case we would be concerned that such an approach could potentially detract from the core focus of a DHR, that is identifying good practice, seeking opportunities for learning, and proposing actions arising from this. Having considered a range of review processes elsewhere it is proposed to move away from a report format in which there is an exact log of each and every contact a victim has with services and a significant amount of detailed information reported back. We would propose that in a Northern Ireland context there is merit in a streamlined approach which centres on the victim, with a single DHR report that

should be concise, focused and proportionate. The report would also highlight the ‘modus operandi’ of the perpetrator, any notable changes to their behaviour and the learning arising from this. The report would outline opportunities for learning, key findings and actions that organisations need to consider in terms of changes to be brought forward, where appropriate, and what this is expected to achieve. We would expect the final report to include only relevant information and focus on good practice as well as opportunities for learning. The report would be drafted by the DHR Chair and forwarded to SOF for agreement.

6.32 What will be important is that the report should be written sensitively, given the tragic circumstances giving rise to it.

6.33 We would welcome views on report publication. Consideration was given to preparing two separate reports, one for families and operational bodies and another shorter summary report (with only the latter published). Having taken account of a range of views we consider that a single report should be prepared and made publically available and take account of data protection issues, in order that there is transparency and accountability. Furthermore, it is considered that a failure to publish a report (or a longer report) could inadvertently lead to increased focus, investigation and adversely impact on a family given the increased media attention and associated investigation that may ensue. There may of course be exceptional circumstances, to consider non-publication, for example where there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review. We would welcome any views that you may have around publication. We would also seek views on what the frequency of report publication should be, that is whether a report is published after each individual DHR; an ‘end of year report is published’ focusing on the key themes and commonalities across the DHRs that have been completed in that year, or a combination of both. We consider that there would be merit in a brief thematic report being produced, a minimum of every two years, to reflect what has been learned from domestic homicide cases collectively, along with an individual report for each case. These would be prepared by the Chair(s) of the DHR Panel.

Q11. Do you have any comment on the suggested approach around publication of the DHR report and do you have any views on the frequency of report publication?

What will come out of the reviews/reports?

6.34 Again, having taken account of a range of processes elsewhere we consider that the outcome of the review process should focus very much on tangible results including information and guidance regarding the identification of, and anticipated outcomes from, actions.

6.35 Central to the reports will be including actions that make a difference to victims, provide improvements, and importantly are achievable and proportionate. To facilitate this we consider that in preparing the report, as part of the DHR panel process, that:

- organisations should have the opportunity to address the issues/learning identified and suggest actions that could be taken forward;
- organisations should identify how they would measure progress on the actions;
- organisations should also have the opportunity to comment on actions specifically identified by the Chair. If they are not considered achievable the reasons for this should be noted, and the opportunity provided for an alternative action to be proposed by the organisation to the Chair;
- good practice needs to be highlighted and consideration given to how this can best be disseminated;
- organisations should be held to account for the delivery of actions, through representation on SOF; and,
- the consistent interpretation and application of learning objectives would need to be ensured at both local and operational levels.

Q12. Do you have any comment on the potential outcome of the reviews through the development of reports?

Quality Assurance in the DHR process

6.36 We consider that there is merit in a quality assurance function as part of the DHR process. Locally we consider that this function could be taken forward by SOF. We also consider that there is a need for robust oversight of the progression of actions from the reports and the dissemination of good practice, thus reducing the risk of recommendations being repeated in subsequent reports.

6.37 We consider SOF should also be responsible for monitoring the implementation of the findings/actions coming out of the review process and the dissemination of associated good practice.

What would SOF do?

6.38 The functions of SOF would include:

- deciding to commission a DHR, while referring any proposal not to commission a DHR to the Department for consideration;
- taking appropriate action when advised that a review will not be completed within agreed timeframes;
- assessing DHR reports against quality standards and associated guidance, providing feedback and advising what changes are needed;
- endorsing the finalisation and publication of a DHR report;
- assessing and making a decision on any proposal not to publish a full DHR report;
- taking action, as needed, at a senior level regarding barriers to progress against out-workings and actions emerging from DHRs;
- monitoring the implementation of recommendations emerging from each DHR;
- ensuring communication of regional improvements as a result of DHRs;
- ensuring regional promotion and dissemination of existing good practice identified through the DHR process; and
- overseeing performance of the DHR process.

6.39 Timings of SOF meetings would be dictated by the demands of the review process. However, it is anticipated that the frequency of full meetings should be no less than quarterly once the process has bedded in. Meetings may not always be needed as correspondence may, on occasion, suffice.

6.40 It is considered that SOF could include representatives from some of the following organisations:

- the Department of Justice;
- other Departments relevant to the type of review being undertaken;
- Health;
- Local Domestic and Sexual Violence and Abuse Partnerships;
- other relevant multi-agency partnerships (e.g. public protection);
- voluntary sector organisations representing victims of domestic abuse and violence;
- Victim Support NI; and
- relevant NI inspectorates (such as the Criminal Justice Inspection Northern Ireland).

6.41 Consideration is also being given to a range of other bodies that there may be benefit in having involved in SOF. Decisions on the exact make up will be taken following this consultation.

6.42 Any member of SOF will be expected to withdraw their involvement from the aspect at hand should a conflict of interest arise.

Q13. Do you have any comment on the role and scope of the Senior Oversight Forum?

Q14. Do you have any comment on the organisations that would make up the Senior Oversight Forum, particularly the additional bodies that could be considered, or others that should be considered?

Section 7 – Impact of the consultation proposal

Equality impact

7.1 As a public authority the Department of Justice is required, under Section 75 of the Northern Ireland Act 1998, to have due regard to the need to promote equality of opportunity. Public authorities are also required to identify whether a policy has a differential impact upon relevant groups; the nature and extent of that impact; and whether such an impact is justified. These obligations are designed to ensure that equality and good relations considerations are made central to government policy development.

7.2 During the initial development of this policy and discussions with key partners, the Department has given due consideration to the impact the proposed DHR model will have on different groups and does not consider that the model as set out in this consultation paper has any particular issues in relation to specific groups.

7.3 We believe that this model will be beneficial to all Section 75 groups in terms of reviewing cases to capture learning that will ultimately inform and improve domestic violence and abuse policies and services in Northern Ireland. The proposal has been subjected to Equality Screening and at this point, we do not consider that an Equality Impact Assessment (EQIA) is required. Our screening form, which is available on the Department's website, outlines consideration and mitigating actions that may need to be taken to ensure equality access to the DHR process.

7.4 We envisage that a DHR will apply equally, as envisaged, to all individuals and it is not anticipated that the policy will adversely affect any particular group. As noted in this consultation paper, and the equality screening form, the legislation and DHR does not cover the domestic homicide of a child (under 16 years old). However a robust review process is already in place within the Northern Ireland child safeguarding framework. We will however take account of the evidence gathered through this consultation in developing final policy proposals and revisit the equality screening as required.

Q15. Do you have any comment on the potential implications the proposed model may have on equality or human rights?

Financial and public sector impact

7.5 We anticipate that the proposed model will have some costs in terms of the role of the independent chair for example. It will also have resource implications in terms of staff time/staff being away from their normal business for those organisations that will participate in the DHR review process. We do however consider that the process will, in time create savings in terms of improved inter and intra-organisational working and practice. This financial impact will be explored, through a regulatory impact assessment, following the consultation as the DHR model is consolidated.

Q16. Do you have any further comment to make about the proposed model?

Section 8 – Snapshot of the Domestic Homicide Review Process

