Multi-agency guidance for the conduct of Domestic Homicide Reviews in Northern Ireland

Department of Justice

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Guidance

Section 1 – Introduction

1.1 Tragically, on average six people are killed every year in Northern Ireland by a current/former partner or close family member. The highest number of domestic homicides recorded by the Police Service of Northern Ireland (PSNI) in recent years was eleven in 2007/08. In total, 78 domestic homicides were recorded between 2007/08 and 2018/19. 59% were female and 41% were male. While slightly more female centric overall, in terms of domestic abuse crimes there is around a (70:30 split), in any one year there may be no victims of one of the two genders.

1.2 As set out in the Executive's *'Stopping Domestic and Sexual Violence and Abuse'* Strategy, in order to protect victims from domestic abuse and prevent domestic homicides, we need to develop and maintain good practice, improve services and strengthen the policies and strategies adopted to address domestic abuse. Through this we can strive to ensure effective delivery of policy, practice and services to keep victims safe from harm/further harm.

1.3 The Department of Justice continues to progress a range of measures to tackle domestic abuse, focusing on prevention, early intervention, support, protection and justice. The Department, in conjunction with our statutory and voluntary sector partners, lead on the introduction of Domestic Homicide Reviews (DHRs) in Northern Ireland, which is the subject of this guidance. It should be noted that DHRs may encompass, at a later date to this publication, relevant cases of suicide (with the criteria for selection still to be decided).

1.4 This guidance document is to be used for the purposes of establishing and conducting DHRs in Northern Ireland. It is written for the Senior Oversight Forum (SOF) (see page 24 for an explanation of the role of SOF) (chaired by the Department of Justice), Independent Chairs and panel members, as well as professionals involved in producing Internal Learning Reviews (ILRs). It should also be a useful resource for other key stakeholders and individuals interested in the process.

1.5 The guidance takes account of the Home Office Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews and has been informed by operational

experience and learning in England, as well as views expressed by key stakeholders and consultees in Northern Ireland.

1.6 The DHR process and this guidance will be kept under review and will take account of emerging learning, particularly as the process beds in. Any revised guidance will be made available online on the NI Direct website.

Section 2 - Status and purpose of this guidance

Status of the guidance

2.1 This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004.

2.2 As such, a person establishing or participating in a DHR must have regard to this guidance. This means that those persons involved in a review must take this guidance into account and, if they decide to depart from it, have clear reasons for doing so.

Purpose of the guidance

2.3 This guidance:

(a) sets out the reasons for carrying out a DHR;
(b) explains the criteria cases need to meet in order for a DHR to be established;
(c) explains the statutory nature of the process; and
(d) provides a description of the staged DHR process.

2.4 This document also provides detailed guidance on key topics (which can be read on their own) and a toolkit of templates to assist throughout the process.

2.5 This guidance document will be updated to recognise new interventions and legislation as necessary. This will, in the near future, include legislation to provide for a new domestic abuse offence.

Further information on the statutory basis and strategic context for Domestic Homicide Reviews in Northern Ireland is provided at Guidance 1.

Section 3 – Purpose of DHRs in Northern Ireland and when one should be carried out/guiding principles

The Purpose of a Domestic Homicide Review

3.1 The overarching purpose of a review is to prevent future domestic homicides by learning any lessons from the death and improving responses to domestic abuse victims (and their family and children) as a result of lessons learnt.

3.2 A DHR should:

(a) review the way in which local professionals and organisations that came into contact with the victim worked individually, and together, to safeguard victims;
(b) review the way in which local professionals and organisations that came into contact with the alleged perpetrator/perpetrator worked individually, and together, to tackle harmful behaviour and safeguard victims;
(c) 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;
(d) consider whether there were any barriers to accessing services and how these could be addressed. This might include addressing issues around race, identity or disability for example, but might also be about the availability of drop in services, access to services in rural areas or victims knowing that non-physical abuse will be taken seriously;
(e) 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 (importantly this will include early learning that should be implemented ahead of a DHR formally concluding and being reported on and is considered key to the impact of the process), who is responsible for implementing the learning and how this will be measured. This relates to learning both within and between organisations and agencies;
(f) apply identified lessons to service responses, including changes to policies and procedures as appropriate;

(g) contribute to the prevention of domestic abuse and homicides and improve service responses for all domestic abuse victims and perpetrators 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;

(h) contribute to a better understanding of the nature of domestic abuse; and

(i) highlight good practice.[1]

Circumstances in which a DHR should be carried out

3.3 The 2004 Act stipulates that a DHR should take place where the death:

- of a person aged 16 or over has occurred;
- has, or appears to have, resulted from violence, abuse or neglect;
- has been caused by:
  - a person to whom the victim was related;
  - or with whom he or she was or had been in an intimate personal relationship;
  - or was a member of the same household.
- may result in identifying lessons to be learned.

3.4 An **'intimate personal relationship'** for the purpose of this guidance includes relationships between individuals who are above the age of consent (16 years or over) and who are, or have been, intimate partners or family members, regardless of gender identity or sexual orientation. The relationship need not be sexual or long-term. A member of the same household is defined as:

a) a person is to be regarded as a "member" of a particular household, even if s/he does not live in that household, if s/he visits it so often and for such periods of time that it is reasonable to regard him/her as a member of it;

[1] Good practice should not be confused with standard practice. Good practice would include examples of innovation, where an agency has implemented something that goes above and beyond normal practice.

b) where a victim lived in different households at different times, “the same household” refers to the household in which the victim was living at the time of the act that caused his/her death.

3.5 Two people are related if one is the other’s parent, grandparent, child, grandchild or sibling. This also covers the parent, grandparent, child, grandchild or sibling of a person that someone is in a **relevant relationship** with. Two people are in a relevant relationship if they are married or are in a civil partnership, or they live together as if spouses. Half-blood relationships, relationships by affinity and stepchildren should also be included.

3.6 If the death can reasonably be judged to fit the circumstances above, the Senior Oversight Forum (SOF) should commission a DHR to review the circumstances of the death. If there is some ambiguity, SOF may wish to seek a recommendation from the Independent Chair. The review should also consider the range of domestic abuse that the individual may have been subject to, including coercive control, and potentially learning from previous cases where there has been a history of abuse. It should be noted that the Department will also review how death by suicide could be brought into the remit of the DHR process in due course.

3.7 It should also be acknowledged that there may be instances where a family does not wish a review to take place. Naturally this would need to be managed sensitively and due consideration given to any views. However, it would not in itself stop a review from happening as there would remain a need to seek learning to increase the safety of other potential or actual victims.

3.8 Notably, a lack of engagement with agencies by the victim or alleged perpetrator/perpetrator would also not, in itself, justify a review not being undertaken. There is likely to be learning to be gained even if there was no contact with services. In such circumstances there is an onus on agencies to consider why the victim did not approach them and how their services could be made more accessible; these organisations will need to be made aware of the findings of the Review and action that may need to be taken. It should not be assumed that victims of domestic homicide will be

female. Of the 78 domestic homicides recorded between 2007/08 and 2018/19, 59% were female and 41% were male.

16-18 year old victims

3.9 The legislation states that a *"domestic homicide review" means a review of the domestic homicide of a person aged **16** or over.* However, when a victim of domestic homicide is aged between 16 and 18, the Independent Chair should engage with the child Case Management Review (CMR) process to agree whether one process could be adopted (with one report published) to avoid duplication of work as well as placing undue pressure on the family and other bodies that are involved. This should be decided on a case by case basis and should consider factors such as whether the alleged perpetrator was related to the young person or whether they were in an intimate personal relationship. If it is decided that a CMR should be conducted the Independent Chair should ensure that the CMR Chair seeks opportunities for learning relating to the domestic violence and abuse. It may be appropriate in such circumstances for the Independent Chair or a DHR Panel member to sit on the CMR. Likewise, if a DHR is taken forward, a child protection expert may be invited to sit on the Panel. This would be decided on a case by case basis. In some cases it may be more appropriate for two reviews, with different focuses, to run in parallel. A Memorandum of Understanding will be agreed which clearly sets out how the lead review will be identified and how, practically, co-working will occur. Consideration will also need to be given to the content of the Terms of Reference (TOR) where there is a single review in order to ensure that appropriate aspects of the other review are captured.

Death by Suicide

3.10 As evidenced by research, including local *Insights and Lessons from Northern Ireland*[2] there is a substantial link between domestic abuse and poor mental health with many victims reporting suicidal thoughts, and some reporting attempting suicide as a result of this abuse.

[2] Intimate Partner Violence in Conflict and Post-Conflict Societies Insights and Lessons from Northern Ireland, Jessica Leigh Doyle and Monica McWilliams, Transitional Justice Institute, Ulster University, May 2018

3.11 Therefore, there will be instances where a victim has taken their own life and the circumstances give rise to concern, for example, if it emerges that there was coercive and controlling behaviour in the relationship. In these circumstances a review may be appropriate, even if an alleged perpetrator of abuse is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable. *These cases could fall within the DHR process in due course; however, a DHR will* ***not*** *be conducted for these cases at present.*

3.12 The Department is currently conducting a scoping exercise to identify learning from DHRs in other jurisdictions, where the death of the victim was by suicide, which will be taken account of in terms of further developing this aspect. Consideration will also be given to the work of voluntary sector partners and engagement with the Attorney General in relation to these such cases. Following a bedding-in period of around 18-24 months, the Department will review how death by suicide could be brought into the remit of the DHR process. We will work with key stakeholders to develop clear criteria on identifying those suicides that are to be included.

The Guiding Principles

3.13 It is important to note that DHRs should not simply examine the conduct of professionals and agencies. They should illuminate the past to make the future safer for those that may be at risk of, or subject to, domestic abuse. It follows, therefore, that the persons tasked with carrying out the reviews should be **professionally curious**, **gain an understanding of the nature, extent and longevity of the abuse** and **identify which agencies had contact** with the victim (and the victim's child or adult child if dependent on them due to learning disabilities). The review process must also consider the alleged perpetrator/perpetrator, and/or other family members and which agencies were in contact with each other. The review should also identify agencies that were **notable in not having contact** with any of the parties, where there may have been an expectation that they would have been.

3.14 From this position, appropriate solutions can be recommended to help recognise abuse and enable the design of safe interventions, such as better support for victims and more effective interventions with perpetrators.

3.15 Importantly the narrative of **each review should articulate the life through the eyes of the victim and their children, including any adult children with learning disabilities who are adults at risk**. This can best be achieved through talking to those around the victim including family, friends, neighbours, community members and professionals. This will help the Independent Chair and Panel to understand the victim's reality; to identify any barriers the victim faced in reporting abuse and learning why any interventions did not work for them. **Such interviews should not take place until police statements have been obtained** and the views of the SIO/disclosure officer have been obtained (including on how best to engage with any young person). Participants should be advised of the possible need for disclosure. Notes should be taken of any discussions, which may be disclosable as part of any criminal proceedings, and will require close liaison between the Chair and the SIO. The Chair should also consider talking to the perpetrator, once any criminal case has concluded. The key will be **situating the review in the home, family and community of the victim** and alleged perpetrator/perpetrator and **exploring everything with an open mind in a non-judgemental way**. This approach will help understand the context and environment in which professionals made decisions and took (or did not take) actions. The review process would include, for example, consideration of the culture of the organisation and whether there was an understanding of domestic abuse, the training provided to the professionals, the supervision of such professionals, the leadership of agencies and so forth. It would also be feasible to consider organisational issues and limitations, and how these may have impacted on the victim.

3.16 It is important to remember that the Review should also consider relevant information in relation to the alleged perpetrator/perpetrator, for example, their history, and engagement with services. This will lead to a more well-rounded review and ensure that learning is captured.

3.17 An effective review should go beyond focusing on the conduct of individual professionals, examining organisational culture, procedures/processes and reporting in order to ascertain whether the procedures/policies/services in place were sound and fit for purpose. Do policies operate in the best interests of victims? Is it accessible to victims who need it? How was the alleged perpetrator/perpetrator's behaviour addressed? Could an adjustment in policy or procedure have secured a better outcome for the victim? This

investigative technique, sometimes referred to as professional curiosity, is a thoroughly inquisitive approach to a review and will impact on all aspects of the review, reportage and learning, which will be dramatically improved by adopting this mind-set.

3.18 The rationale for the review process is to ensure agencies are responding appropriately to domestic abuse by providing appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide and violence/abuse. The review will assess whether agencies have sufficient and robust procedures and protocols in place, and whether these were understood and adhered to by staff and volunteers and whether the availability of their services is adequately communicated to members of the public who might need it.

3.19 There are a number of potential misconceptions about what a review should do. DHRs are not about apportioning blame. They are not inquiries into how the victim died or into who is culpable; that is a matter for the coroner and criminal court, respectively, to determine as appropriate. DHRs are also not specifically part of any disciplinary inquiry or process. Where information emerges in the course of a review indicating that disciplinary action may be appropriate, the established agency's disciplinary procedures should be undertaken separately to the review process. Alternatively, DHRs may be conducted concurrently with (but separate to) disciplinary action.

3.20 In conducting a DHR, there is an obligation to keep the victim who has lost their life at the heart of the inquiry. The victim's family and friends should be provided with information about the review and should be involved throughout the process **if they choose to be**. There will also be a need to ensure that there is signposting to appropriate support services, who are experienced in dealing with traumatised individuals, and which may (depending on the circumstances of the case) not necessarily be the nearest support organisation. Close liaison will be needed with voluntary sector partners on this.

3.21 These guiding principles govern the work of all those involved in the process.

Further information on the focus of a DHR is provided at Guidance 2

Section 4 - Involvement of family, friends and other support networks

4.1 The Independent Chair and Panel should recognise that the quality and accuracy of the DHR is likely to be significantly enhanced by family and friends. Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder. The Independent Chair should make every effort to include the family.

4.2 The involvement of family and friends is both necessary and complex as they can have important information about the nature and extent of the abuse which may not have been shared with agencies. Participation is voluntary. In some instances individuals may wish to provide information to the review through a voluntary sector organisation that they may have had contact with. If family or friends prefer not to take part in the review, their decision should be respected and recorded and they should be signposted to appropriate support services. However, the Independent Chair must maintain reasonable contact with the family throughout the process, even if they decline to be involved. This should include, informing them that the review has commenced; that a draft report has been produced; that a final report has been signed-off; and that a publication date has been confirmed. Family members can change their mind and decide after a review has commenced that they want to be involved. This should be taken account of by the Chair as the review progresses, with those affected sensitively given the opportunity to engage/re-engage with the DHR at any point in the process. Regular touch-in points may be useful in this regard. The advice of the Family Liaison Officer (FLO) could be sought in relation to handling this more generally.

4.3 **The Independent Chair should inform the victim's family of the commencement of the Domestic Homicide Review process at the earliest opportunity** and should advise that they will be the single point of contact going forward. Some families may wish to communicate through a designated advocate such as an individual from a voluntary and community sector organisation – depending on the circumstances of the case this may need to be different individuals from those that previously had direct contact with the family or a neighbouring group if not a regional organisation. It is not anticipated that solicitors would be advocates. If a family expresses

a desire for a legal representative to advocate on their behalf, the Independent Chair should sensitively explain that this would not be appropriate, as the purpose of a DHR and its focus is on improvement and learning rather than blame. Communication should initially be through a letter explaining the process, how they can contribute and the choices available to them. The Chair will want to consider whether this should be in tandem with a phone call or visit to the individuals. They may also wish to discuss, with the Family Liaison Officer, how best to take forward initial contact with the family.

4.4 **Should family members and friends wish to be involved in the process**, the Independent Chair should arrange **to meet with them** after the DHR has been commissioned. The Independent Chair should ascertain how often the family expects to receive updates and which method of communication they prefer (e.g. face-to-face, letter). The Independent Chair should take care to communicate carefully and sensitively and take a note of all meetings.

4.5 The Independent Chair should take into consideration that there may be disagreements between different parts of the family and that more than one group might choose to be involved in the process. It is also important to note that the alleged perpetrator/perpetrator may have been a family member rather than an intimate partner. The Independent Chair should also be aware that participation in the process could possibly lead to re-traumatisation and should signpost family members, friends and others to appropriate services to ensure that they are supported throughout the process. In addition, it is important to remember that there may be other victims who were injured in the incident but survived. Care should be taken to identify any wider vulnerabilities and needs and consider how best they can be supported through the DHR process if they choose to be involved.

4.6 Children can offer a unique insight and perspective into their parents' or family's lives and, where possible, consideration should be given to their involvement in a review. Engagement should reflect the child's age and stage of development. Account should also be taken of the safeguarding of children and young people as part of the process (see Guidance 3). The Independent Chair should consider how best they can be supported to participate in the review process when they feel they want to and where it is appropriate,

without exposing them to further harm. In cases where the victim has an adult child with a learning disability, efforts should be made to include them with a support person of their choice present. Again, it is vital that support is given to children and adult children involved in the review process, and the Chair should be aware of the pathways and signpost individuals to appropriate agencies. In this regard it will be vital that the Independent Chair is aware of relevant local support organisations. DOJ will ensure that they are provided with an up to date list.

4.7 The Independent Chair can help establish a positive experience for family and friends by offering clear communication about the process from the outset and throughout the review. The benefits of involving family, friends and other support networks include:

a) assisting the victim's family with the healing process;
b) giving family members the opportunity to meet the Independent Chair if they wish and allowing them the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the DHR journey, must be afforded the same status as other contributions. Participation by the family can help to humanise the victim, helping the process to focus on the victim's and alleged perpetrator/perpetrator's perspectives rather than just agency views;
c) helping families to contribute to the prevention of other domestic homicides, where they so wish;
d) enabling families to inform the domestic homicide review constructively, by allowing the Independent Chair to get a more complete view of the lives of the victim in order to see the homicide through the eyes of the victim. This approach can help the Independent Chair understand the decisions and actions taken by those involved;
e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given to police, in court, or to the coroner, can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. If additional or new information is provided, the SIO/disclosure officer MUST be advised as soon as possible as it may have an influence on the case as well as being expected under disclosure rules. Families should be able to provide factual information as well as

testimony to the emotional effect of the homicide. The Independent Chair should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to the statutory sector, voluntary sector and family and friends contributions;

f) revealing different perspectives of the case, enabling agencies to improve service design and processes;

g) enabling families to choose, if they wish, a suitable pseudonym for the victim to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym. Where families may wish to use the victims actual name the Chair will wish to consider this, taking account of the individual circumstances of the case in conjunction with the Department's data protection officer; and

h) enabling families to write a foreword about the victim to be included in the report.

4.8 In addition to the above the review process may also enable individuals to inform the domestic homicide review constructively, by allowing the Independent Chair to get a more complete view of the lives of the alleged perpetrator/perpetrator in order to see the homicide from their perspective perpetrator. This approach can help the Independent Chair understand the decisions and actions taken by those involved.

4.9 The Independent Chair should be aware of potential sensitivities and the need for confidentiality when meeting friends, neighbours, work colleagues, etc. during the review and a written note of all such meetings should be taken. The use of meeting records and information about how records are kept should be explained to family/friends etc. through a Privacy Notice which will be provided by DOJ. Copies of any discussions with the family should also be made available to them on request. Consideration must also be given, at an early stage, to working with Family Liaison Officers (FLOs) and Senior Investigation Officers (SIOs) involved in any related police investigation, to identify any existing advocates and the respective positions of the family, friends and other support networks with regards to the homicide.

4.10 When considering whether to interview family members, friends and other support networks, the Independent Chair must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial. The Independent Chair will need to discuss the timescales for interviews with the SIO/disclosure officer and take guidance from the SIO/disclosure officer in relation to any ongoing criminal proceedings. Where a young person is involved they should also take the views of the SIO in terms of how best to engage with them and consider whether there may already be sufficient information in the Achieving Best Evidence (ABE) interview. In some exceptional circumstances the SIO/disclosure officer may request that the family is not engaged in the process. In such cases there will be a requirement for this request to be made in writing by the SIO/disclosure officer and stored in case of any future criticism. It should also be remembered that families will have a great deal to cope with after the homicide, in terms of both emotions and practicalities, and many families will not feel able to meet with the Chair or be interviewed until after the criminal trial.

4.11 When engaging with family and friends the Independent Chair should:

a) contact family members and others at the earliest opportunity and offer signposting to specialist and expert advocacy support services to those who do not have a designated advocate, such as a family member, friend or support organisation. The Independent Chair cannot be the advocate for the family as they need to be fully independent and may reach conclusions that the family disagrees with;
b) arrange to interview family members and others at a place and time that is convenient to them;
c) communicate where appropriate, directly or, if preferred by the family, through an advocate, where one has been designated by them, who has, where possible, an existing working relationship with the family, for example a local domestic abuse service representative;
d) recognise their ethnic, cultural, developmental and linguistic needs and address barriers to their participation in the process. This may involve obtaining expertise and input from outside Northern Ireland. The Independent Chair should also consider the need for translators during interviews. Where a translator is used the

Independent Chair will be responsible for ensuring that the translator is aware of the possibility of vicarious trauma and provide advice and guidance on this;

e) make a decision regarding the timing of contact with the family based on information from them or any designated advocate and taking account of other ongoing processes i.e. post mortems, criminal investigations, and special dates e.g. the victim's birthday;

f) fully explain the purpose of the review and manage expectations;

g) ensure regular engagement and updates on progress (which may be through an advocate), including the timeline expected for publication;

h) explain clearly how the information disclosed will be used and whether this information will be published;

i) explain how their information has assisted the review and how it may help other domestic abuse victims;

j) invite the family to suggest changes that would help to prevent future domestic homicides;

k) share a completed draft of the DHR Report with the family prior to publication to identify if any information has been incorrectly captured. A record should be kept of any areas of disagreement[3]. A legal form of undertaking will need to be drawn up to maintain confidentiality of an unpublished review;

l) maintain reasonable contact with the family, through a designated advocate if appropriate, even if they decline involvement in the review process. This is particularly important when the review is completed, has been assessed and is ready for publication. They should also be informed about the potential consequences of publication i.e. media attention and renewed interest in the homicide. The Independent Chair should ensure the family are fully informed about any media statements and be mindful of the need to consider key dates, such as birthdays, anniversaries, etc.; and

m) bear in mind that homicides can reveal the frailty of family relationships, with competing views being expressed by family members.

4.12 Particular consideration should be given to DHRs where so-called 'honour-based' violence, human trafficking or paramilitary activity is suspected. If the Independent Chair

[3] The DHR Chair is not obliged to make changes on the request of the family, which they believe are not in line with their findings.

is concerned that there may be a risk of imminent physical harm to any known individual(s), they should contact the police immediately so that steps can be taken to secure protection. This is particularly important if the alleged perpetrator is still in the community. Steps will also need to be taken to ensure confidentiality in relation to agency members and interpreters where there are possible links with the family, who may be the alleged perpetrators. Any interpreters, where considered critical to the process, should be from a regulated/registered service where interpreters are ACCESS NI checked. An appropriate framework for any such use of an interpreter must be in place, with oversight from the Independent Chair. Extra caution will also be required when considering the level of participation from family members and should be carefully considered in consultation with a practitioner with expertise in this area, for example, a specialist BME organisation, given that the culture of foreign nationals can be very different to Northern Ireland. This may involve obtaining expertise and input from outside Northern Ireland. More generally chairs will wish to have a directory of local support organisations in order that appropriate signposting can be undertaken. Consideration will also be given to translating leaflets into those languages that are most commonly used at court (Latvian, Lithuanian, Mandarin, Romanian, Polish and Portuguese).

Engaging with the alleged perpetrator/perpetrator's family

4.13 At the conclusion of any criminal proceedings, the DHR Chair should write to the perpetrator and offer them the opportunity to participate in the review.

4.14 The Independent Chair should seek the view of the SIO/disclosure officer on whether or not to interview the family of the alleged perpetrator/perpetrator and at what stage in the process. A note will need to be taken of any interview. It should not be assumed that an alleged perpetrator/perpetrator's family would automatically align themselves with the alleged perpetrator/perpetrator. Sensitivity when contacting the alleged perpetrator's family will be necessary. They may not want to participate and this is their choice. The Independent Chair should also be mindful that the alleged perpetrator or members of their family might in some cases pose an ongoing risk of violence to the victim's family or friends, or vice versa, as well as others involved in the process.

Other networks

4.15 The Review Panel should also consider access to other networks to whom victims and alleged perpetrators may have disclosed information, for example, neighbours, employers (particularly given the recent introduction of domestic abuse workplace policies in many businesses and organisations), further education providers, health professionals, solicitors, local professionals in domestic abuse prevention work and local domestic abuse service agencies. Victims or alleged perpetrators/perpetrators may have disclosed details of abuse to support workers or volunteers working in the areas of, for example, mental health, addiction, debt advice or homelessness and the Independent Chair should also consider speaking to relevant individuals in those sectors.

4.16 There is a leaflet (available in English and other languages) explaining the DHR process which is available for family members, friends, employers and colleagues. An easy read version is also available for children and family members with a learning disability. This should be included alongside any invitation to be involved in the process at the initial point of contact. Further details on the purpose of a DHR, and its process, can be found on the NI Direct website.

4.17 The Independent Chair should ensure that there is a clear remit for the inclusion of any other individuals in the review and that the family are made aware of any other people involved.

4.18 The importance of confidentiality should be highlighted with all those who choose to be involved in a Domestic Homicide Review. They will however need to be made aware of the possibility that information provided may need to be disclosed as part of any criminal proceedings.

Engagement with the Media

4.19 In addition to media interest in the circumstances of a domestic homicide, journalists may contact family members regarding a domestic homicide review.

4.20 The independent chair will liaise with family members, as agreed, throughout a review. This will include discussion around possible publication dates and sharing the draft report ‘in confidence’. Information relating to the review should not be discussed or shared with the media or others not involved in the review process prior to any publication.

Section 5 – Domestic Homicide Review Stages

5.1 This section is operational in focus, outlining the key stages of the DHR process and those involved in its governance.

5.2 The review process is managed and delivered by:

- **a Senior Oversight Forum (SOF).** This is a multi-agency senior officials' forum chaired by the Department of Justice and comprising representatives from the Police Service of Northern Ireland (PSNI), the Probation Board for Northern Ireland (PBNI) and the Health and Social Care Board (HSCB). Membership will also include one individual who will represent all of the Health and Social Care Trusts. Representatives from voluntary sector organisations may be invited to participate in the quality assurance role of the SOF as a critical friend; and

- **an independently chaired DHR panel** which leads the review and produces a report.

5.3 Three individuals have been appointed to independently chair and undertake DHRs in Northern Ireland. They will be engaged for a period of three years initially. Each review will be allocated to one of the Independent Chairs from the pool of three. Reviews will be allocated to the Independent Chairs on a rota basis, subject to their availability and any perceived or potential conflict of interest considerations.

5.4 There will also be a secretariat function (the **DHR Secretariat**) associated with SOF, the Independent Chair and Panel, which will provide a level of administrative support to the DHR process. This function will be provided by the Department of Justice.

5.5 SOF is responsible for the commissioning of reviews and providing the core Terms of Reference (TOR), the oversight and quality assurance of the process, and the monitoring of the implementation of actions and lessons identified in Northern Ireland. The Independent Chair and Panel will be responsible for conducting and reporting on each DHR in Northern Ireland. In terms of guiding principles, SOF, Independent Chairs and

Panel members will be expected to conduct themselves with honesty, transparency, humility and a desire to learn lessons. They should strive to keep the humanity of the victim, and their experiences and journey, at the centre of the DHR.

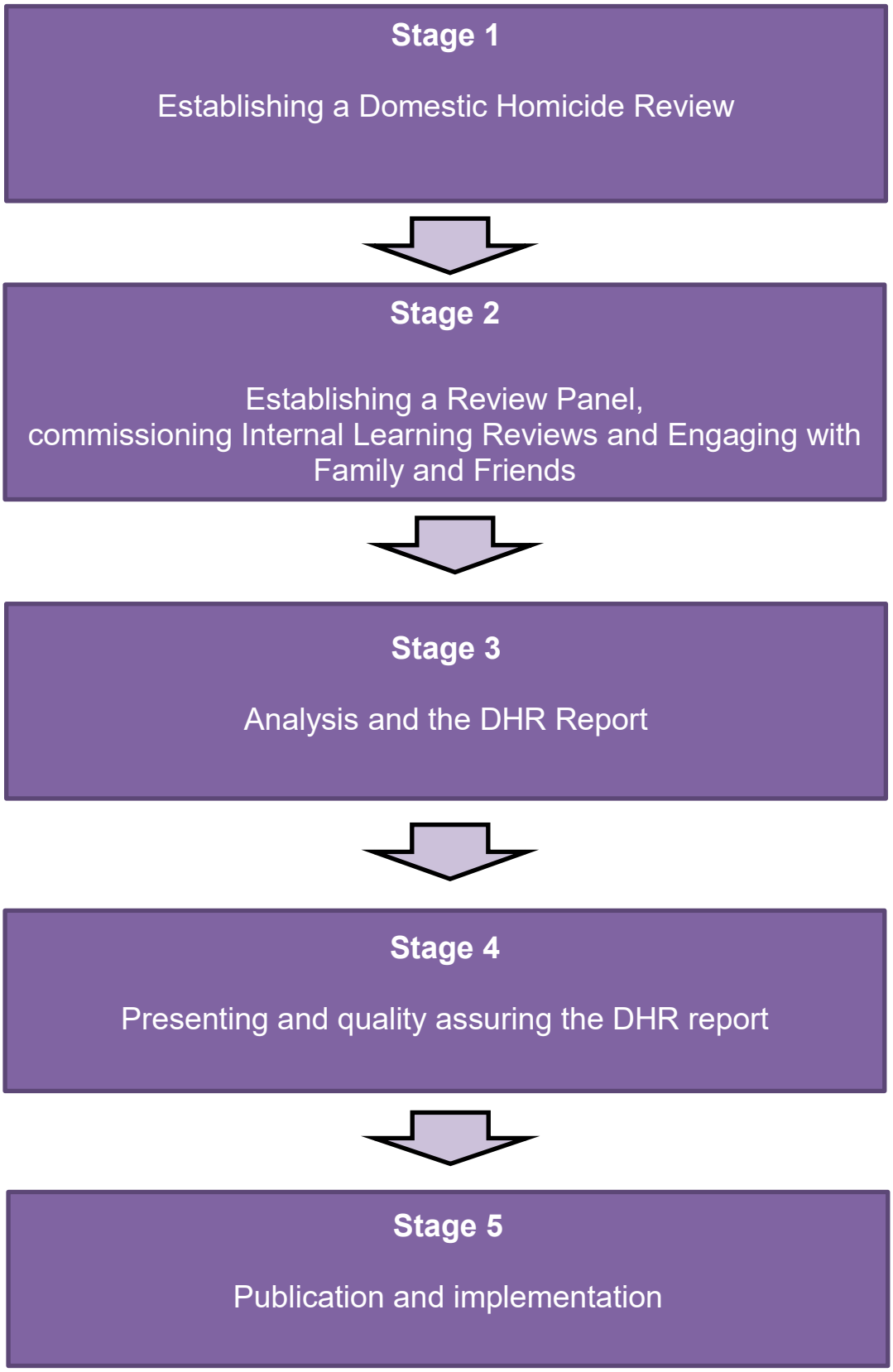
Further information on the role and responsibilities of SOF, Independent Chairs, Panel members and the Secretariat can be found in the accompanying Governance document.

5.6 All those involved in the DHR process (Senior Oversight Forum, the Independent Chair, Review Panel members and ILR leads), should have due regard for equality and diversity issues at all times throughout the review, from referral to implementation. ***See Guidance 4 for more information.***

5.7 Data protection and the sharing of information are important issues which must be considered throughout the DHR process. The Department of Justice will ensure that Independent Chairs are provided with encrypted laptops and secure email addresses. Panel members who do not have a secure email address will be provided with one. ***See Guidance 5 for more detail on data protection and information sharing.***

5.8 A series of meetings will take place through the DHR process. Please see ***Guidance 6*** for more information.

The five key stages of the Domestic Homicide Review Process



Stage 1: Establishing a Domestic Homicide Review

Referral of a domestic homicide

5.9 When there is a (suspected) domestic homicide of a person aged 16 years old or over[4], the Police Service of Northern Ireland (PSNI) will send a notification in writing to inform SOF[5] of the death. This will be sent to a dedicated mailbox[6] DHRnotifications@justice-ni.gov.uk generally within five working days of discovery of the death. A domestic homicide of a person who is a United Kingdom national and is normally resident in Northern Ireland, which takes place outside of the jurisdiction, should also be picked up by PSNI and notified to SOF. In these cases it is expected that the DHR should take place in Northern Ireland.

5.10 However, **any agency or third party can refer a homicide to the forum** if it is considered that there may be important lessons for inter-agency working to be learned. For example, there may be circumstances where a referral is prompted by the family of a victim through the police/professional body, agency or forum. It is anticipated, however, that the majority of referrals would come directly from police.

5.11 Ideally, within five working days of the referral, SOF should be aware of or have ascertained the following:

a) the cause of death of the victim;
b) if an alleged perpetrator has been identified and what charges are being brought against them (if they are living);
   - dates of planned court appearances for any defendant;
   - remand status/location of any defendant;
c) the status of the Coroner's proceedings; and
d) information concerning any significant family members or friends who may wish to be involved in the review.

[4] This guidance recognises that individuals between the ages of sixteen to eighteen are children (as per statute).
[5] The Senior Oversight Forum draws membership at senior official level from key statutory partners and may include senior representatives from key third sector organisations as a critical friend.
[6] E-mail account managed by the DHR Secretariat.

5.12 When the homicide is notified by the police, the Secretariat should identify the individuals, agencies and organisations who may have been in contact with the victim, alleged perpetrator and family (including children) and contact at least the relevant statutory agencies such as police, health and social care and probation, and any voluntary sector organisations that they are aware may have had contact to tell them to secure their records relating to the alleged perpetrator and the victim. The SIO/disclosure officer will already have a developing narrative about what happened and lines of inquiry which can help with identifying relevant organisations. The victim's GP, once identified, should be asked to hold any notes and records they have on the victim, as soon as possible after notification is received from the police, to help ensure the GP records are not transferred to Business Services Organisation (BSO), HSCNI, which is normal practice following a patient's death.

5.13 Paragraph 3.3 sets out the circumstances in which a DHR should be carried out. If the death can reasonably be judged by SOF to fit these circumstances, then there is no decision to be taken per se and SOF should commission a DHR at this point. If there is some ambiguity, SOF may wish to seek a recommendation from the Independent Chair.

Independent Chair invitation

5.14 Following a referral, the SOF Chair should allocate an Independent Chair, from the pool of Chairs, to lead the review. Should the Independent Chair decline a case, for example where there is a conflict of interest; an alternate Independent Chair should be selected from the pool. If SOF require a recommendation on whether or not to proceed with a DHR from the Independent Chair, following the scoping and initial information gathering exercise, they will write to the Chair accordingly.

5.15 The Independent Chair will be expected to sign a contract setting out how information will be shared and handled. The core values that Independent Chairs are expected to demonstrate when carrying out their functions are set out at **Guidance 7**. It will be vital that the Chair takes particular notice of this in the exercise of their functions.

Scoping and information gathering

5.16 The Independent Chair should consider the list of relevant agencies identified by the Secretariat and then ask the Secretariat to issue an urgent request to these agencies, asking that they search both manual and electronic records to identify whether their organisation has had any engagement with the individuals involved in, or affected by, the suspected homicide e.g. partner, children and alleged perpetrator, and to ensure any staff involved are aware of the death and can access support as appropriate. Agencies should respond quickly, usually within 5 working days, to advise that there has been no contact or to notify that there has been contact and to advise what contact there may have been with other organisations. If they have had contact, they should then provide an **initial brief summary** of their involvement, to a dedicated e-mail address specific to the DHR, within a further 5 days. To ensure that the information gathered is consistent, and to prevent over sharing of information, the request letter will include a template for agencies to use.

5.17 Agencies should also provide a named point of contact (who should be of senior management level, have the ability to effect change and hold delegated decision-making responsibility on behalf of their organisation) that the Independent Chair and Secretariat should engage with moving forward.

5.18 The Independent Chair and Secretariat will begin compiling a list of agencies that need to take part in the review process, should it go ahead**.** It is important to note that the victim or alleged perpetrator may have accessed services in the Republic of Ireland if they live near the border. These agencies should also be included in the list.

5.19 Agencies need to ensure that any case notes and files in relation to the case being reviewed are secured electronically or, if in hard copy, are removed to a secure place where they are not accessible to agency personnel other than through the nominated domestic homicide Internal Learning Review lead. If agencies cannot secure records electronically, a full copy of the original papers should be saved (likely in hard copy) to prevent future erroneous changes. It is considered unlikely that this would apply to police and PPS in terms of live investigations but could apply in terms of earlier contacts.

5.20 The deadlines indicated are needed in order to meet the key review timescales, for example decision to commence a review within six weeks.

Further information on DHR timescales is provided at Guidance 8.

Decision making

5.21 As noted in paragraph 5.13, if following receipt of the notification from the police, the death can reasonably be judged by SOF to fit the circumstances in which a DHR should be carried out (see paragraph 3.3), then there is no decision to be taken per se and SOF should commission a DHR at that point. However, if there is some ambiguity as to whether the death meets the criteria for a DHR, SOF may wish to seek a recommendation from the Independent Chair. In these cases, the Independent Chair, with the assistance of the DHR Secretariat, will collate the information received from the scoping and initial information gathering and will provide SOF with a recommendation by way of a brief written report. SOF will then meet[7] to agree whether a case is to be the subject of a DHR, based on the legislative provisions and this guidance.

5.22 **The Independent Chair** should consider what other reviews might be undertaken in this case, for example, a child Case Management Review (CMR), Public Protection Arrangements Northern Ireland (PPANI), a Serious Case Review (SCR) or a Mental Health Homicide Review, to ensure there is effective co-ordination and avoid duplication so that the family do not have to retell their story to different people. It may be that two separate reviews are not required. ***Further information on engagement with other processes is provided in Guidance 9.***

5.23 Full membership of SOF is not required for the commissioning of a DHR, however the decision should involve a minimum core subset of three members.

5.24 There may be occasion where there has been no agency engagement with the victim, alleged perpetrator or family prior to the death occurring. However, if the DHR

[7] The business of the group may be conducted by conference call or secure e-mail to achieve the outcome within timescales.

criteria is met and there is no overlap with other review processes, it is expected that a DHR would be commissioned. This is because learning may still be gained. **It would only be in exceptional circumstances that a review would not be commissioned**. *It should be stressed* that commissioning will be dependent on the circumstances of each case and a decision should not be taken by comparing one case to another, but rather assessing whether the legislative criteria is met.

Communicating decisions

5.25 The SOF Chair will formally record and save on the Department of Justice's secure file plan, a **decision to conduct** a domestic homicide review, as well as a **decision not to conduct a review**, with a clear rationale for the latter. SOF will write to the Independent Chair, at a dedicated mailbox, to advise them of the decision (if they have not already done so).

5.26 In circumstances where SOF **decides not to conduct a review** this decision will be considered by the Justice Minister. The Justice Minister (or, in their absence, the Department of Justice's Permanent Secretary) may overturn SOF's decision. Should the decision be overturned, SOF will be asked by the Justice Minister in writing to commence a review.

5.27 The (final) decision to review or not to review should be shared by the Independent Chair with the family, Senior Investigating Officer, Family Liaison Officer, Coroner, Attorney General, and all agencies contacted.

Engaging with Criminal Proceedings

5.28 Where there is an on-going criminal investigation, it is the responsibility of the Independent Chair to ensure **on-going engagement with the SIO/disclosure officer** to avoid any conflict existing between the DHR and criminal case. There must be early engagement with the SIO/disclosure officer for the case and the Public Prosecution Service (PPS). Consideration should be given to whether the SIO/disclosure officer and PPS should be invited to the first DHR panel meeting – it may be more appropriate to

receive a short written update from the SIO/disclosure officer given that there are likely to be limits to what can be shared at that stage. Engagement with other processes may also be required (e.g. Coroner's inquest etc.) A review may be paused when there are on-going criminal proceedings and at this stage the independent Chair should consider disseminating early learning already gleaned during the review process to statutory organisations etc. This will help ensure vital lessons are learned at the earliest stage possible, and changes made as a result, rather than being delayed pending the outcome of criminal proceedings. There will be a need for close and ongoing engagement and connectivity between the Chair and SIO/disclosure officer throughout the DHR process to ensure that they are fully aware of material which they can consider from a disclosure perspective. The SIO/disclosure officer will need to see all review material and assess for investigative and disclosure value.

Further information on disclosure and engaging with Criminal Proceedings is provided at Guidance 10 respectively.

Involvement of family and friends

5.29 The involvement of families, friends and other support networks is integral to the review and will also require close engagement with the SIO/disclosure officer and FLO in terms of timing. They will be able to articulate the voice of the victim and provide a rich narrative about the behaviour of the alleged perpetrator/perpetrator and any barriers the victim may have faced in accessing support. Such networks can often have important information about the nature and extent of the abuse which may not have been shared with agencies. **The Independent Chair should inform the victim's family of the commencement of the DHR process at the earliest opportunity once terms of reference are available** and should advise that they, the Independent Chair, will be their single point of contact going forward. A Privacy Notice should also be attached and an information leaflet should be included. They should also consider contacting the family in tandem by phone, in order to introduce themselves and ensure that any communications have been received. Some families may wish to communicate through a designated advocate. **The Family Liaison Officer should be made aware of the commencement of a review prior to any letter being sent or telephone contact being made with the family, as the victim's family may wish to discuss it with them.**

5.30 Should family members, friends and others wish to be involved in the process, the Independent Chair should offer to meet them at a time and place that is convenient. They should also offer to facilitate their involvement in other ways, such as by writing a statement or being interviewed by phone, if that is their preference. The Independent Chair will be required to communicate carefully and sensitively and should provide signposting to appropriate support services. They should also ask the family to sign consent and participation forms. Consent in terms of DPA is not actually needed to gather personal data as the DHR process is based in statute, however, it may still be preferable to have the consent of the family. Either way, consent must be appropriately recorded, freely given and explicit to comply with GDPR/DPA 2018. The Independent Chair must maintain reasonable contact with the family throughout the process, even if they decline to be involved. Members of the family have the right to change their minds about their involvement in the DHR, either deciding to become more involved when it is already underway or deciding that they no longer wish to participate. The Independent Chair should consider contact points with the family, potentially through the Family Liaison Officer, to ascertain any change in their wish to be involved in the DHR process.

5.31 It is vital to note that these individuals may also be significant witnesses and extreme care will be required to manage any potential conflict between the DHR and Criminal investigation. Slight discrepancies in accounts (even in the very early stages) could render a prosecution impossible. **It is best practice for police statements to be obtained first as this would be an important element of mitigating disclosure challenges later.**

5.32 Some families may not wish to meet with the Independent Chair until after the conclusion of the trial. The important thing is to contact the family as soon as possible and seek their views about the Terms of Reference (see para 5.48 and 5.49) as well as how and when they want to be involved, bearing in mind what is going on with the criminal investigation and the need to not prejudice it. If the family doesn't engage at the beginning, the Independent Chair should write again at the conclusion of the criminal proceedings when they will have had longer to come to terms with what has happened and may wish to engage with the review.

5.33 The family should be given the opportunity to feed into the Terms of Reference before they are finalised.

Further information on Involvement of family, friends and other support networks can be found at Section 4.

Stage 2 – Establishing a Review Panel and Commissioning Internal Learning Reviews

Establishing a Panel

5.34 Led by the Independent Chair, the Panel will be responsible for conducting and reporting on each DHR in Northern Ireland. The Panel should meet on an appropriate number of occasions to ensure there is robust oversight and rigorous challenge. For example, a Panel that only meet at the beginning and end of a review would imply a limited and arguably ineffective role in the review process. The number of meetings will be determined by the specifics and complexity of the case.

Panel Membership

5.35 SOF and the Independent Chair will be responsible for agreeing Panel membership.

5.36 Membership should include:

- a **core group of individuals** representing key relevant organisations and bodies. It is essential that this includes voluntary and community sector organisations representing either female or male victims of domestic abuse, depending on the circumstances of the case. This will include a minimum of:
  - the Police Service of Northern Ireland;
  - the Probation Board for Northern Ireland;
  - Health and Social Care Board/ or successor agency;
  - relevant Health and Social Care Trust; and
  - specialist domestic abuse services.

- **Representatives with expertise specific to the particular circumstances of the case**, for example, substance misuse, mental health, Black and Minority Ethnic (BME), LGBTQ, older people, rural issues, learning or physical disabilities (where the victim had a disability or was a carer for someone with a disability), or the impact of domestic abuse on children.

5.37 The Panel should be configured to ensure that relevant expertise is available to explore the particular circumstances of the case, and the dynamics of the relationship between the victim and the alleged perpetrator/perpetrator. Additional members can be invited to join the Panel where it becomes apparent during the review that their expertise would assist the Panel to understand the circumstances of the case and identify learnings from it. Panel members' names should be included in the DHR report as a way to ensure transparency.

5.38 Where a voluntary sector or private sector agency, outside the core membership, is required or invited to sit on the panel, consideration should be given to the support they may require from the Independent Chair and Panel to ensure effective communication and learning.

5.39 Once SOF and the Independent Chair have agreed which organisations should be invited to sit on the Panel, the Independent Chair should write to the senior point of contact in each organisation. This letter should advise that a DHR has been commissioned and request that a suitable representative from the organisation sits on the Panel. Prior to the DHR model being introduced, the Department of Justice will have already contacted core organisations to ask them to identify suitable Panel representatives. The DHR Secretariat will provide the Independent Chairs with the names of the representatives identified and these names should be mentioned in the letter to the senior point of contact. They should also be copied into the correspondence. If other organisations with expertise specific to the case are to be invited to sit on the Panel, the Independent Chair should write to the CEO of these organisations, explaining what the DHR process is and asking them to identify a representative to sit on the Panel.

Role of Panel Members

5.40 Panel members should be independent of line management of staff involved in the case. They must be at a senior level and have sufficient authority to commit to decisions made during meetings, put forward and progress actions arising from the review, including throughout the wider organisation. They should have a good understanding of domestic abuse and the assessment of risk. Training for Panel Members will be provided by the Department of Justice.

5.41 Members will ensure effective agency participation by:

a) representing their agency and ensuring that its views and opinions are reflected at panel meetings;
b) supervising the Internal Learning Review (ILR) lead for their Agency;
c) ensuring the ILR Report is signed off at an appropriate senior level; and
d) implementing the actions relevant to their Agency, in conjunction with their SOF representative (where applicable), by way of dissemination through the wider organisation.

5.43 It should be recognised, however, that it may be difficult for a voluntary sector agency to provide someone with frontline experience as well as the authority to supervise the ILR within their agency and implement relevant actions.

5.44 Panel members may also be Internal Learning Review (ILR) Leads for their organisation, but the Panel should not, consist solely of such people.

Further information on the Panel Membership and the role of a Panel member can be found in the accompanying <u>Governance</u> document.

5.45 Memorandums of Understanding (MOUs) or Data Sharing Agreements (DSAs) will be put in place with panel members who are representing public authorities and contracts will be drawn up for voluntary and community sector members. The purpose of these MOUs/contracts is to set out how information should be shared and handled and to ensure compliance with GDPR/DPA 2018.

<u>Continuity and consistency of membership</u>

5.46 To ensure continuity, consistency and a build-up of knowledge, it is suggested that those individuals nominated by their organisation to be Panel members should remain as Panel members 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. However, this would be down to each organisation to decide.

5.47 Members are required to attend all Panel meetings. Only in exceptional circumstances should a deputy attend on their behalf. The deputy should be fully briefed and be of sufficient seniority to answer questions or take forward actions on behalf of the organisation. Following attendance, the deputy should ensure their colleague is fully briefed on the Panel meeting.

Confirmation of membership

5.48 Once nominations have been received from the relevant agencies, the Independent Chair should notify SOF of Panel membership.

Determining the scope of the review

5.49 Once SOF has been informed of membership, the Secretariat should convene the first meeting of the Panel, as soon as possible. At this meeting, the Independent Chair and Panel should consider in each case the scope of the review and develop clear Terms of Reference (TOR). SOF will provide core terms of reference for consideration, as a guide for the Independent Chair and Panel, in the expectation that this will be tailored to take account of the particular circumstances of the case. **It is important that the Terms of Reference are clear and concise and remain focused on the purpose and key issues to be addressed in the review.**

5.50 It is good practice for the SIO/disclosure officer to be invited (and where there is considered to be benefit attend) the first panel meeting. In an event the SIO/disclosure officer should, as a minimum, be asked to provide a written 1-2 page initial summary to the Panel on an agreed template. This would protect investigative integrity and enable the discussion to move quickly to whether these is a need to initially limit the scope of the Terms of Reference or delay the DHR (and identify at what stage(s) it should be delayed). This will be a particular issue in terms of avoiding interfering with a criminal case (not speaking to witnesses to the crime etc.);

5.51 Further information on issues for consideration when developing terms of reference for a review are provided in **Guidance 11**.

5.52 The Independent Chair should make the final decision on the suitability of the terms of reference for each review and ensure that they are proportionate to the nature of the homicide. The terms of reference should be sent to SOF for information.

5.53 Some of the issues considered during the development of the terms of reference may need to be revisited as the review progresses and new information emerges. This reconsideration of the issues may in turn mean that the terms of reference will need to be reviewed and agreed by the Panel and SOF as the Review progresses.

Commissioning Internal Learning Reviews

5.54 Following agreement of the Terms of Reference the Independent Chair should then write to the senior manager (point of contact) in each of the agencies, bodies or organisations to commission the Internal Learning Reviews (ILRs). The senior manager in each organisation is responsible for appointing an ILR lead or author for their organisation. An ILR lead should be an officer who was not directly (or indirectly through line management) involved in the case. If the organisation has a representative on the Panel, the Panel member should supervise the ILR Lead; however, as noted above, in some cases it may be appropriate for the Panel Member and the ILR Lead to be the same person. Agencies must ensure that the ILR lead has sufficient time to complete the report; this may involve relinquishing existing duties temporarily. Where a voluntary sector agency is required or invited to contribute through an Internal Learning Review, consideration should be given to the level of DHR (and ILR) guidance and information they may require to ensure effective communication and learning.

5.55 Once appointed, the ILR Leads should be invited to a briefing meeting in order that the Independent Chair can brief them on:

- the Terms of Reference;
- the process, timescale and requirements for the production of the ILR and the DHR Report;
- the specific issues pertinent to the case; and
- issues of concern that need exploring.

5.56 The Independent Chair should also provide guidance on how the ILR lead should engage, if needed, with staff who had been involved in working with the victim, alleged perpetrator, or family in order to inform their report. They should advise that interviews should not take place until police statements have been obtained. The Independent Chair should advise that staff are expected to engage in the process and that they cannot choose to opt out. The Chair should also draw ILR leads attention to the fact that staff members may also be witnesses already in a criminal investigation or provide/hold information that may be subject to disclosure or themselves be subject to ongoing disciplinary proceedings or other investigations.

5.57 The Independent Chair should then write to the ILR Lead in each agency, asking them to carry out an Internal Review of its involvement with the victim or alleged perpetrator using the template and guidance attached on disclosure and criminal investigations. If deemed worthwhile, ILR leads should be afforded the opportunity to observe one (or more) of the Review Panel meetings.

5.58 The aim of the ILR is to:

a) allow agencies to look openly and analytically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, duty of candour etc.) to see whether the homicide indicates that any practice needs to be changed or improved, to support professionals to carry out their work to the highest standards and achieve the best outcome;
b) identify how and when those changes or improvements will be brought about; and
c) identify examples of good practice within agencies.

5.59 The ILR should not solely focus on engagement with the victim. Any engagement with the alleged perpetrator/perpetrator should also be considered as this will also highlight learning. It should also cover, if relevant, involvement with children living within the household as matters disclosed by children in school; in police/social services investigations; or other services, may add to the quality of the ILR. Any new information relevant to a prosecution should be referred to the SIO.

5.60 The ILR report should be quality assured by the senior point of contact in the organisation. This senior officer should also approve any suggested actions or recommendations that the ILR has made for the organisation. They will be responsible for ensuring that these are acted upon and a progress report is submitted to SOF 3 months after the original request for submission of the ILR.

5.61 The Panel should consider each ILR received and evaluate it using a provided template. This template should help the Panel determine if enough information has been provided or not. The Independent Chair should provide feedback and a debriefing session for ILR leads, in advance of completion of the DHR Report. They should also hold a follow-up feedback session with these staff once the DHR report has been completed and before it is published. ILRs themselves should not be published but some single agency recommendations may be included in the final DHR Report.

Stage 3: Analysis and the DHR Report

Analysis by the Panel

5.62 A series of Panel meetings will be held to enable members to review all the information gathered, discuss findings, identify actions as needed and agree DHR report content.

5.63 The following broadly reflects this process. The Panel will:

a) receive ILR reports;
b) consider key event dates collated by the Secretariat;
c) critically analyse the information and judgements within ILRs and request any additional information;
d) consider any input from the family or friends of the victim;
e) form a view on practice and procedural issues;
f) ensure ILR findings and actions are translated into meaningful and measurable actions;
g) examine, identify and ratify relevant actions. Actions will normally be reached by consensus[8]; and
h) agree the key points to be included in the DHR report.

5.65 It is crucial that the Independent Chair and the Review Panel have access to all relevant documentation and, where necessary, individual professionals to enable them to effectively undertake their review functions.

The DHR Report

5.66 The DHR report, drafted by the Independent Chair, should be victim focused and should summarise the case, identify lessons to be learned, highlight good practice and draw overall conclusions from the information and analysis contained in the Internal Learning Review reports, or information commissioned from any other relevant interests.

[8] In the event of this not occurring the Independent Chair will consult with the Senior Oversight Forum to resolve outstanding issues.

It should also reflect the position reached as a result of panel discussions. No personal information should be included in the DHR Report.

5.67 While there is merit in providing detailed information on the key elements and background of a case, 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. The DHR report should not contain an exact log of each and every contact a victim has with services and a significant amount of detailed information should not be reported back. A streamlined approach should be taken which centres on the victim, with a DHR report that should be concise, succinct, focused and proportionate. The report should 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. The final report should include only relevant information and focus on good practice as well as opportunities for learning.

5.68 The report should be produced according to an agreed outline format and, as with ILR reports, the precise format will depend on the features of the specific homicide. It should also reflect the position reached as a result of panel discussions.

5.69 The Report should also include an **Executive Summary** that concisely abridges the DHR Report content. The report should again be victim focused and should contain:

a) purpose and scope of the review;
b) outline of the review process including organisations involved;
c) a brief outline of the circumstances which led to the review;
d) a succinct account of inter-agency practice issues identified; and
e) analysis of key findings and suggested actions.

Actions/Action Plan

5.70 The Independent Chair and Panel should ensure findings and suggested actions are translated into meaningful and measurable change. It is important that actions are realistic, take account of likely available resources and are not ‘wish lists’. The Independent Chair should attach the Action Plan to the Report. Actions should be

considered and agreed by the relevant agency before the action is finalised. Timeframes should also be agreed at a senior level by each of the participating agencies or organisations. In addition, the action plan should set out who will do what, by when, with what intended outcome and clearly describe how improvements in practice and systems will be monitored and reviewed. SOF will be responsible for monitoring implementation of actions.

Panel action on receiving DHR Report

5.71 The Independent Chair should share the **Draft Review Report and Action Plan** with the Panel. The Panel should be provided **ten working days** to consider the draft. Panel members should:

a) ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the report;
b) ensure that the views of the family are reflected;
c) be satisfied that the report accurately reflects Panel findings;
d) ensure that the report has been written in accordance with this guidance; and
e) be satisfied that the report is of a sufficiently high standard to be submitted to SOF.

5.72 A meeting of the Panel should then take place where the DHR Report and associated actions are formally signed off by the Independent Chair and relevant organisations.

Stage 4: Presenting and Quality Assuring the DHR Report

Presentation

5.73 Once the Panel has agreed the draft Review Report, it is the responsibility of the Independent Chair to formally present it to SOF. This will allow SOF to make comments and discuss actions and afford them the opportunity to explore salient issues. The presentation must allow sufficient time for discussion of the case and SOF should agree that the monitoring of the Report's action plan should become a standing item on the agenda of its quarterly monitoring meetings.

Quality Assurance[9]

5.74 Following this meeting, SOF will have at least two weeks to assess the standard and quality of the Report against this guidance. SOF should ensure that:

a) the Independent Chair and Panel have spoken with the appropriate agencies, voluntary and community sector organisations, family members and friends, to establish as full a picture as possible;
b) the report demonstrates sufficient probing and analysis and the narrative is balanced;
c) the report is fully anonymised, as far as possible, apart from including the names of the Independent Chair and Panel members;
d) lessons have been identified and that an appropriate action plan has been developed to ensure that this is the case (including oversight of its implementation); and
e) the likelihood of a repeat homicide is minimised.

5.75 SOF will review the DHR draft report and write back to the Independent Chair and Panel to sign-off the document or provide feedback and suggest changes. Further information on the quality assurance process can be found at ***Guidance 12.***

[9] Voluntary and community sector organisations may be invited to assist SOF in Quality Assuring the draft report

5.76 If feedback and suggested changes are provided from SOF, the Panel will consider and discuss these and the Independent Chair will work with the DHR Secretariat to make the necessary changes. The revised report and action plan will then be sent to SOF for sign off.

5.77 Once the report has been signed off by SOF, the Independent Chair should show a hard copy of the draft report to the family (or an advocate) prior to publication. The report will then be taken back by the Independent Chair. The Independent Chair should discuss the report with the family, as well as publication handling, possible media interest and timeframes. This provides an opportunity for questions to be answered, concerns to be expressed (and addressed), and to ensure the view of family members are appropriately represented. Should there be any areas of disagreement following their meetings, these should be recorded by the Independent Chair. The Independent Chair is not obliged to make changes to the Report on the request of the family which they believe are not in line with their findings.

5.78 Any legal issues should be resolved prior to sharing with the family, for example, where advice has been sought on libel issues.

5.79 To assist the family to understand the document they may wish to access the report in an alternative format or language other than English. This should be clarified during early engagement with family members.

5.80 If the Independent Chair decides to make any changes following engagement with the family, they should inform SOF and seek further sign-off if the changes are material. Work should then commence on publishing the document.

Stage 5: Publication and Implementation

Publication

5.81 Once SOF has signed-off the final DHR Report and Action Plan, it should be made publicly available. However, there may be circumstances, referenced below, where this is not feasible.

5.82 The Independent Chair should **proactively** advise the Forum of key dates to be avoided when choosing a publication date, for example, the anniversary of the homicide or the birthday of the victim. It will be important to ensure that the impact of further traumatisation on family and friends is thoroughly considered. **The publication also needs to be timed in accordance with the conclusion of any related court proceedings and other review processes. The Independent Chair should consult the SIO about timing of the publication.**

5.83 It is anticipated that publishing Domestic Homicide Review Reports should enhance public confidence and improve transparency of the processes in place across all agencies to protect victims. **SOF is responsible for agreeing a publication date with the Independent Chair.** Electronic copies of the DHR Report will be published on the DHR website on the agreed date. **Please note the associated ILRs will not be published**.

5.84 In some cases, there may be exceptional circumstances, involving the welfare of children or other persons directly referenced in the review, which mean that publication should not happen. The Independent Chair should raise any concerns with SOF who will assess all available information and make a decision on whether or not to publish a full Review report. Where a decision is taken not to publish the full report, the Forum will consider if publication of the **executive summary** is appropriate. In such cases, the Chair must meet with family (if they are willing) to ensure that they are informed of this and the reasons why.

Family engagement

5.85 The Independent Chair will arrange to contact or meet (based on their preference or method previously agreed) with the family, to talk them through the DHR Report and advise when it will be published.

5.86 The family should be informed about the potential consequences of publication i.e. media attention and renewed interest in the homicide. The Independent Chair needs to ensure that the **family are fully sighted on any media statements** in advance of the publication of the review. On the day that the DHR Report is published, SOF should write to the family, providing a copy of the DHR Report. The DHR Secretariat should also provide a copy to the senior manager of each participating agency, on behalf of SOF.

5.87 The content of the report must be anonymised as much as possible (recognising that given the number of homicides per year and that Northern Ireland is a small jurisdiction, it may not be possible to guarantee this) in order to protect, as far as possible, the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the Data Protection Act 2018. This means preparing reports in a form suitable for publication. Where a request is made for the DHR not to be anonymised, for example by the family, **legal advice should be sought** as well as the views of the Department's data protection officer**.** The SIO should also be consulted on whether or not the perpetrator should be advised of the publication.

5.88 On the day of publication, the DHR Report and Executive Summary will be uploaded onto the DHR website.

Agencies

5.89 SOF should, with DHR Secretariat support, provide a copy of the DHR report to the **senior point of contact** in each participating agency and other interested stakeholders. They should also be provided with any media statement in advance.

Access

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

Media Strategy

5.91 Naturally the publication of the DHR Report may lead to media interest. SOF is responsible for agreeing any, and all, engagement with the media for the purpose of undertaking this. The Independent Chair is responsible for providing any interviews to the media. Organisations referenced in the review should be provided with an embargoed copy of any press release and notified of publication in advance by the DHR secretariat.

Dissemination of lessons identified

5.92 Ultimately the purpose of the review will be to shed light on the past in order that the future is safer for those who are subject to domestic abuse. In order for these lessons to be learned locally and regionally, professionals need to be able to understand fully what happened in each homicide, and importantly, what needs to change in order to reduce the risk of future tragedies.

5.93 SOF will drive the dissemination of lessons identified. The Forum will need to agree what type and level of information needs to be disseminated, how and to whom, in light of the contents of the DHR. It will also be responsible for monitoring the implementations of lessons learnt and actions arising from this.

5.94 The Independent Chair should host a meeting or learning event for practitioners/professionals who came into contact with the victim and alleged perpetrator/perpetrator. While attendance would not be compulsory it would be important that organisations participate in terms of dissemination of learning. It is important for the Independent Chair to remember that staff who worked with the victim may find this difficult or re-traumatising and they should adjust their approach to ensure that it is appropriate. Staff should also be made aware of any available support. The Independent Chair may alternatively or additionally be asked to produce a learning brief or dashboard. An

example of good practice can be found at:
http://www.safeineastsussex.org.uk/Domestic%20Homicide%20Reviews.html

Monitoring and enforcement of actions

5.95 Monitoring progress against the action plan is an important part of the process. The Secretariat should collate a regular action plan update, for SOF's consideration. This should be framed using the Outcome Based Accountability model which asks; what did we do? How did we do it? Who is better off? SOF will hold a quarterly meeting to monitor progress against the various action plans for all completed DHRs and the extent to which change has been secured. Each review will remain as a standing item on the agenda of this meeting until all of the actions in its action plan have been implemented. SOF will also wish to consider how change has been brought about as a result of the DHRs and associated action plans

5.96 If SOF consider that there has been an unreasonable delay in the implementation of actions, or change has not been effected as a result of this, it should hold the organisation to account. More information on the dissemination of lessons identified and monitoring the implementation of actions can be found at **Guidance 13.**

Thematic report

5.97 Each DHR will contribute to a brief thematic report following a series of reviews. SOF will commission the pool of Independent Chairs to work together to produce a thematic report; a minimum of every two years, to reflect what has been learned from DHR cases collectively and also what has changed as a result of this. The thematic report will be published on the DHR website.

Guidance 1

Statutory basis for Domestic Homicide Reviews and strategic context

Statutory Basis

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004) and introduced in England and Wales in 2011. This provision was commenced in Northern Ireland on 10 December 2020.

The provision is set out in full below. It should be noted that sections 9(4)(a), 9(5) and 9(6), as included below, do not apply to Northern Ireland.

9 Establishment and conduct of reviews

(1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself,

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

(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) to establish, or to participate in, a domestic homicide review.

(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.

(3A) Any reference in subsection (2) or (3) to the Secretary of State shall, in relation to persons and bodies within subsection (4)(b), be construed as a reference to the Department of Justice in Northern Ireland.

(4) The persons and bodies within this subsection are—

(a) in relation to England and Wales—

chief officers of police for police areas in England and Wales;

local authorities;

local probation boards established under section 4 of the Criminal Justice and Court Services Act 2000 (c. 43);

the National Health Service Commissioning Board;

clinical commissioning groups established under section 14D of the National Health Service Act 2006;

providers of probation services;

Local Health Boards established under section 11 of the National Health Service (Wales) Act 2006;

NHS trusts established under section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006;

(b)in relation to Northern Ireland—

the Chief Constable of the Police Service of Northern Ireland;

the Probation Board for Northern Ireland;

Health and Social Services Boards established under Article 16 of the Health and Personal Social Services (Northern Ireland) Order 1972 (S.I. 1972/1265 (N.I. 14));

Health and Social Services trusts established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 (S.I. 1991/194 (N.I. 1)).

(5)In subsection (4)(a) "local authority" means—

(a)in relation to England, the council of a district, county or London borough, the Common Council of the City of London and the Council of the Isles of Scilly;

(b)in relation to Wales, the council of a county or county borough.

(6)The Secretary of State may, in relation to England and Wales, by order amend subsection (4)(a)or (5).

(7)The Department of Justice in Northern Ireland may, in relation to Northern Ireland, by order amend subsection (4)(b)."

Human Rights basis

The Attorney General for Northern Ireland has provided human rights guidance for the police service, the public prosecution service, the probation board and the courts and tribunals service on domestic abuse and stalking. Those organisations are under a statutory duty to have regard to this guidance when exercising their functions. It is a useful resource for others and can be accessed at:

https://www.attorneygeneralni.gov.uk/sites/ag/files/media-files/Section%208%20Guidance%20in%20Relation%20to%20Domestic%20Abuse%20and%20Stalking%20-%20Final_0.pdf

Strategic context

The '*Stopping Domestic and Sexual Violence and Abuse'* Strategy takes a zero tolerance approach to domestic and sexual violence and abuse and provides a framework for delivery. It defines domestic and sexual violence and abuse as:

'threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former intimate partner or family member.'

A Domestic Abuse Bill has been introduced to the Northern Ireland Assembly which will create a new domestic abuse offence to capture controlling and coercive behaviour, for example psychological, emotional, financial and social abuse. This guidance document will be updated to recognise new interventions, including this legislation, once introduced.

It is important to acknowledge that domestic abuse may also manifest itself through the actions of immediate and extended family members and could take the form of unlawful and harmful activities and practices, such as 'honour' based violence and crimes, human trafficking, forced marriage, female genital mutilation and paramilitarism.

Definitions

For the purpose of the DHR:

- an **'intimate personal relationship'** includes relationships between individuals who are above the age of consent (16 years or over) and who are, or have been, intimate partners or family members, regardless of gender identity or sexual orientation. The the relationship need not be sexual or long-term.

- a member of the same household is defined as:

(a) a person is to be regarded as a "member" of a particular household, even if s/he does not live in that household, if s/he visits it so often and for such periods of time that it is reasonable to regard him/her as a member of it;
(b) where a victim lived in different households at different times, "the same household" refers to the household in which the victim was living at the time of the act that caused his/her death.
(c) two people are related if one is the other's parent, grandparent, child, grandchild or sibling. This also covers the parent, grandparent, child, grandchild or sibling of a person that someone is in a relevant relationship with. Two people are in a relevant relationship if they are married or are in a civil partnership, or they live together as if spouses. Half-blood relationships, relationships by affinity and stepchildren should also be included.

Coercive behaviour can be described as an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten a victim.

Controlling behaviour can be described as acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Domestic abuse (including violence) is defined by the Northern Ireland Government under the Stopping domestic and sexual violence and abuse' strategy as *"threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former intimate partner or family member"*

Domestic abuse is generally recognised as a pattern of behaviour which is characterised by the exercise of coercive control and the misuse of power by one person over another. The behaviour is usually frequent and persistent and is used to harm, 'punish' or frighten

the victim. In some instances this could involve incidents of non-fatal strangulation or having links to stalking.

Guidance 2

Focus of a Domestic Homicide Review

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 to better understand domestic 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 identified and what needs to be changed as a result of the DHR.

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 identified are shared and practice changed regionally (across Northern Ireland), including early learning ahead of a DHR formally completing;
- good practice is regionally promoted and shared; and,
- the future is made safer for those that are, or may be, subject to domestic abuse.

In conducting a Domestic Homicide Review, there is an obligation to keep the victim who has lost their life, at the heart of any inquiry. The victim's family and friends should be provided with information about the review and should be involved throughout the process if they choose to be.

It is important to remember that the Review should consider relevant information in relation to the perpetrator/alleged perpetrator, for example, their history, lifestyle, criminal record and engagement with services. The review should consider the availability of perpetrator services in addition to services for victims. This will lead to a more well-rounded review and ensure that learning is captured. Consideration should also be given to whether the perpetrator was an adult with care and support needs.

Guidance 3

Protocol for the support and safeguarding of children and young people involved in the DHR process

Children and young people can offer a unique insight and perspective into their parents' or family's lives and, where possible, consideration should be given to their involvement in a review. Engagement should reflect the child's age and stage of development. Account should also be taken of the safeguarding of children and young people as part of the process. Independent Chairs should be familiar with the Co-operating to Safeguard Children and Young People in Northern Ireland policy, which outlines how communities, organisations and individuals must work both individually and in partnership to ensure children and young people are safeguarded as effectively as possible.

The Independent Chair should consider how best children and young people can be supported to participate when they feel they want to and where it is appropriate, without exposing them to further harm.

It is vital that support is given to children involved in the review process, and the Chair should be aware of the pathways and signpost individuals to appropriate agencies, including those listed below:

- NSPCC
- Childline
- Barnardo's

Guidance 4

Equality, Diversity and Rural Needs

All those involved in the DHR process (SOF, the Independent Chair, Review Panel members and ILR leads), should have due regard for equality and diversity issues at all times throughout the review, from referral to implementation. Consideration should be given to the nine protected characteristics under Section 75 of the Northern Ireland Act 1998.

Age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation (including gender identity) may require special consideration as well as have a bearing on how the review is explained and conducted, and how the outcomes are disseminated to local communities.

Provided below are some examples and points for consideration. Naturally the impact and how these present will vary depending on the case.

Religious Belief

When engaging with family members or friends of the victim, the Independent Chair and Review Panel members should be aware of and sensitive to their religious beliefs. For example, different (lawful) religious customs, practices or holidays should be upheld and respected throughout the process. It should also be recognised that family or friends choosing to engage in the process may encounter language barriers. Consideration should be given to how best individuals can access the Review process and are able to participate. This may require literature in different languages or whether the assistance of a translator is needed.

Where the victim (or alleged perpetrator/perpetrator) is a foreign national, their cultural context and 'norms' should be examined by the Independent Chair and Panel. In some cases, an expert may be required to sit on, or provide evidence to, the Panel. *However,*

careful consideration must be given to individuals selected to provide specialist cultural knowledge, as there may be issues of confidentiality with regards to using individuals from local communities.

Some religious groups may not be willing to engage with police/statutory agencies and therefore the DHR process. This may, for example, be due to fear of authorities, because of their political opinion (which may be associated with their religious belief), or they may be of the view that domestic abuse is a private family matter.

A range of different practices are considered acceptable and traditional within certain religions. Where possible, religious freedoms should be supported within the Review process and individuals' religious needs handled sensitively. However, this would not be feasible or appropriate where the practice in question is illegal in Northern Ireland.

In certain cultures and religions there may be clear customs as to how individuals, particularly men and women, interact and communicate. For example there may be an expectation that an individual will only speak to another individual of the same sex. Every effort should be made to accommodate this. However, it may not always be feasible. The DHR process should endeavour to recognise and respect the (lawful) customs and practices of other cultures/religions, as far as possible.

Political opinion

When seeking to engage with family or friends, the Independent Chair and Review Panel members should bear in mind that political opinion may affect some individuals' willingness to engage with the police/statutory agencies and therefore the DHR process.

The political opinion of the family or any expert providing evidence, if known, should be taken into consideration when arranging a suitable venue/location for meetings to take place. Also, the language used in the final report should be carefully considered to ensure that it does not alienate anyone of a particular political opinion.

Racial group

As noted previously under Religious Belief, cultural and language barriers in communities are considered to have an impact on willingness to share information or engage with the police/statutory agencies e.g. Gypsy & Traveller groups, victims of honour violence and killings and human trafficking. This may be a significant factor when attempting to gather information in such cases.

The Independent Chair and Panel members are required to recognise and respond appropriately to cases where the racial group may require special consideration. For example, an expert may be required to sit on, or provide evidence to, the Panel. The expert may have particular beliefs, customs or practices linked to their racial background. As noted under Religious Belief, careful consideration should be given when engaging experts as there may be issues of confidentiality with regards to using individuals from the same community as the victim. Some communities may be small or unlikely to share information outside their community. It is also possible that using experts may cause tension in the community.

Consideration may need to be given to arranging qualified translators[10] for families and written correspondence may need to be translated into the relevant language. It may also be appropriate to consider providing the DHR final report in a different language or format.

It will also be important to use qualified interpreters rather than family members/individuals from the local community, which would not be appropriate.

As noted under Religious Belief, certain cultures may have customs as to how men and women communicate. This may mean that an individual would expect to communicate with someone of their own sex. Where possible, this should be accommodated.

In addition, consideration should be given to immigration status which may impact on the willingness of individuals to be involved. The Chair and Panel will wish to bear this in mind.

[10] Qualified translators should be used rather than family members/individuals from the local community.

Sexual orientation

It should be noted that domestic abuse is prevalent in all relationships; however, there may be additional issues to consider in relation to LGBTQ+ relationships, for example whether concerns about homophobia affected access to support. In some cases, the victim (and any current or former partners) may not have wished others to know about their sexuality due to the prejudice they might face. The DHR Chair and Panel members should be sensitive to the sexual orientation of the victim or alleged perpetrator/perpetrator and their families. Where a homicide occurs in a same-sex relationship, further specialist knowledge may need to be obtained to understand the circumstances of the case. This might include inviting an LGBTQ+ organisation to participate in the panel.

In some cases, the victim (and any current or former partners) may not have wished others to know about their sexuality. This must be managed sensitively and appropriately throughout the DHR process. The disclosure of an individual's sexuality can have a significant adverse impact on individuals and may lead to stigma for the individual and families in communities. Also, the disclosure of a victim's sexual orientation may, in instances where it is not an opposite sex partner, disclose the alleged perpetrator/perpetrator's sexual orientation. For others, they may have opposite sex partners and still have their sexual orientation used against them by abusive partners.

It should be noted that the family may not be aware of the victim's sexuality, or may not want to engage with the process because of it/fear of disclosure of their sexuality. There will be a need to handle the sexual orientation of a victim with care, while not reinforcing any associated stigma.

Age

The Independent Chair and Panel members may need to engage with people of all ages.

The individuals who experience the loss of a family member or friend are likely to be traumatised or distressed. The age of those individuals may influence how they respond to trauma and may influence what they need. It is therefore essential that any engagement is carried out sensitively.

Individuals engaging in the process, for example, family members or experts, may be of working age and may not always be available to meet or communicate during working hours.

Older people taking part in the process may have additional needs that need to be taken into account.

It should be noted that children can offer a unique insight and perspective into their parents lives and, where possible, consideration should be given to their involvement in a DHR (see Guidance 3). It should be recognised that children and young people involved in the process may be at school/university/studying and might not be available to engage at particular times. Engagement should reflect the child's age and stage of development and consideration should be given to entrusting an individual in whom the child trusts to collect this information from the child as appropriate or be present when the information is being collected. In some cases it may be preferable for the interview to be conducted by a specialist with the Chair sitting in. It is important to recognise that children who have experienced or witnessed domestic abuse or a domestic homicide may display fear, mistrust or hypervigilance. Each child will be different and the approach adopted will need to differ on a case by case basis, working at the child's pace. Advice from police ABE interviewers or children's trauma specialists should be sought.

It should be noted that in intimate partner homicides, the victim and the alleged perpetrator/perpetrator may share a child and the child may not wish the alleged perpetrator/perpetrator to know they contributed to the DHR. The older the child the more their right to be involved should be recognised, however, their involvement will need to be negotiated with whoever has parental responsibility for them.

When engaging family members it is vital to note that these individuals may also be significant witnesses and extreme care will be required to manage a potential conflict between the DHR and criminal investigation. Slight discrepancies in accounts (even in the very early stages) could render a prosecution impossible. Close and ongoing engagement with the SIO/Disclosure officer will be key in this regard.

Marital status

It should be acknowledged that people who are separated, divorced or widowed are more likely to be a victim of domestic abuse compared with all other marital status groups. Separation is a particularly high risk period for domestic abuse, including domestic homicide.

Sex

Although domestic affects both men and women (with domestic abuse crimes split around 30:70 male/female and domestic homicide split more evenly at around 40:60), it is recognised that it affects women to a greater extent. In terms of offenders around 86% are male, 12% female. Domestic abuse against males or females can include acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.

As noted under Religious Belief and Racial Group, in certain cultures and religions there may be clear customs as to how individuals, particularly men and women, interact and communicate, e.g. only speaking to an individual of the same sex. Every effort should be made to accommodate this. The DHR process should endeavour to recognise and respect the (lawful) customs and practices of other cultures/religions in relation to men and women generally, as far as possible.

Pregnant women or women who are breast feeding might be involved in the process. It should be recognised that pregnant women may not be able to attend meetings at certain times due to antenatal appointments and that breastfeeding mothers might need to feed their baby during meetings.

Both women and men may have caring responsibilities and the process should try to accommodate the needs of all individuals who have dependants. For example, consideration should be given to ensure that the timing, length and location of meetings align with caring arrangements.

Gender identity

The victim or alleged perpetrator/perpetrator may have undergone gender reassignment and they (and any current or former partners) may not have wished others to know this, perhaps due to the impact of prejudice and stigma. The Independent Chair and Panel should ensure that this is managed sensitively and appropriately throughout the process.

Disability

Individuals invited to be involved in the domestic homicide review process may require additional support or reasonable adjustments to fully participate in the process due to a disability.

The Independent Chair and Panel members should ensure, for example, that meetings are held in appropriately accessible venues and that information is provided in clear and accessible language and formats.

If the victim or alleged perpetrator has been provided with services in relation to mental health a Serious Adverse Incident Review may be more appropriate. This will be considered and assessed on a case by case basis and as referenced within the document, learning in relation to domestic abuse should still be captured.

Where information/review findings are published, this should be made available in a variety of formats, on request, for example: large print, Braille and audio.

Dependants

As noted under ‘men and women generally’, individuals may have responsibility for caring for dependants. The process should try to accommodate this. For example, every effort should be made to ensure that the timing, length and location of meetings align with caring arrangements. In some cases it may be necessary to arrange care provision to enable participation.

In that regard, dependants of the victim, including children, may wish to contribute to the process. Where the child is a minor this will need to be considered on a case by case basis and managed sensitively. Dependants may have been exploited or used as part of a campaign of abuse.

Rural needs

The Independent Chair and Panel members should bear in mind that there are additional barriers for victims of domestic abuse in rural areas. There are many factors in small, local communities that make it harder for an individual to leave a domestic abuse situation. Some of these come from the fact that the individuals (both the victim and the alleged perpetrator) are often well known in rural communities. Victims may be reluctant to be open about domestic abuse because of perceived shame, desire to keep their personal business private or because of their (or the alleged perpetrator's) standing in the community.

It is also important to consider issues around the availability of, and access to, services in rural communities, meaning that it may be more difficult for victims to report issues and take action.

In general women and men suffering domestic abuse are reluctant to disrupt their children's lives by leaving the family home, school/university and local communities. This can be even more difficult for rural victims who may not only have to uproot their home and family, but even their whole way of life, potentially moving to an urban area to access services such as social housing or refuge. It is considered that these issues may make rural victims more susceptible to a homicide situation as they feel even more pressured to stay in the family home.

It may be necessary to ask organisations representing rural areas to provide insight and guidance on particular cases.

Mental Health/Addiction

The Independent Chair and Panel members should bear in mind there are additional

barriers, for those engaging with the Review, who have mental health or addiction issues. Interviews should be arranged to suit the individual to ensure that medication can be taken or other appointments kept.

Paramilitarism

The Independent Chair and Panel members should bear in mind there may be additional barriers, for those engaging with the Review, who have been subject to paramilitary pressure or are affected by the particular circumstances of the conflict. This could impact on a person's ability to disclose information or who they are willing to engage with. Associated issues and risks will need to be borne in mind where such individuals are involved in the review process, including any impact for the Chair and Panel members.

Guidance 5

Data Protection and Information Sharing

The Department of Justice has carried out a Data Protection Impact Assessment in relation to the DHR process and has engaged with the Information Commissioner's Office on the matter.

The Data Protection Act 2018 governs the processing of personal data of living individuals and places strict obligations on organisations to follow 'data protection principles' when processing that information. The personal data involved in DHRs will be extremely sensitive and relate to a wide range of all aspects of personal life, of all parties involved (victim, family and perpetrator). Data protection issues in relation to DHRs tend to emerge in relation to access to records, for example medical records. Data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors however, the Chair and panel members should be mindful of publishing personal information relating to the deceased which may have a detrimental impact on the wider family circle.

To process personal data under Article 6 of the GDPR, there must be a valid lawful basis. In the case of DHRs, the valid lawful basis which applies is Article 6(1)(e) of GDPR, "*processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller*". This is defined in s.8 of the Data Protection Act 2018 as "*the administration of justice*" and relates to the practical outworking of s.9 of the Domestic Violence, Crime and Victims Act 2004.

PSNI may provide information to the DHR on the victim and perpetrator's engagement with the police. Section 32 of the Data Protection Act 2018 indicates that personal data collected for a law enforcement purpose may not be processed for a purpose that is not a law enforcement purpose unless that processing is authorised in law. In the case of DHRs, the authorisation in law is the Domestic Violence, Crime and Victims Act 2004.

For special category data and criminal conviction data being shared for the purposes of a DHR, section 10 of the Data Protection Act 2018 states that in order to meet the requirements of Article 9(g) GDPR it must meet a condition contained in Schedule 1 Part 2. In this case the condition would be Paragraph 6 of that Schedule.

A Privacy Notice and easy read Privacy Notice will be made available on the NI Direct website.

If it is decided that personal information belonging to the perpetrator, the child of the victim or any other individual, needs to be gathered and processed for the purpose of the DHR, the individual (or their legal guardian) must be contacted and informed. The Privacy Notice should be attached. It is possible that the individual will object, however this should not necessarily stop the processing of information when there are legitimate grounds for doing so which override the interests, rights and freedoms of the data subject.

Children over the age of 13 are deemed to have the capacity to make their own decisions regarding the processing of their information. Therefore, if personal information relating to a child over 13 is being gathered and processed, the child should be contacted and advised and an easy read version of the Privacy Notice should be provided. If information is being gathered and processed in relation to a victim's adult child with learning disabilities, the adult child's carer should be advised and the easy read version of the Privacy Notice should be provided to enable the carer to explain the process to the adult child.

Information sharing process

Information Asset Owners

The Head of the Violence Against the Person Branch in the Department of Justice will be the Information Asset Owner and the Chair of SOF will be the Senior Information Asset Owner. Separate training and advice will be provided to the Chairs.

MOUs/Data sharing agreements, encrypted laptops and secure emails addresses

The Department will ensure that a Data Sharing Agreement or Memorandums of Understanding (MOUs) are put in place with panel members who are public authorities and that similar contracts are agreed with voluntary and community sector members as necessary. The purpose of these data sharing agreements is to set out how information should be shared and handled.

Independent Chairs and members of the DHR panel will receive personal information about the victim, or relevant other individuals, that is pertinent to the domestic homicide and the case history. This could relate to health matters, criminal records, or other personal or family related private information. The Department will ensure that the Independent Chairs are provided with encrypted laptops and secure email addresses. Panel members who do not have secure email addresses will be provided with one. Members of SOF should all have, or be provided with, secure email addresses. As Chairs will be working from home a large proportion of the time, the Department will ensure they are provided with guidance on remote working. The Department of Justice procedures on remote working, state that printing at home is not permitted. Chairs will be able to print documents in the office facilities provided to them, where secure storage will be available, but careful consideration should be given as to whether printing needs to be taken home. If this cannot be avoided, consideration will be given to providing the Chairs with secure home filing cabinets and lockable briefcases for use with 'hard-copy' documents.

The organisations and agencies involved in the DHR process will deliver their own statutory responsibilities and obligations relating to data protection and will be expected to adhere to the data sharing agreements in place.

<u>Ensuring only relevant information is gathered and the secure sharing and storing of information</u>

As part of the process, the DHR Secretariat will issue an urgent notification letter, on behalf of the Chair, to a list of relevant agencies requesting that they search both manual and electronic records to identify whether their organisation has had any engagement with the individuals involved in, or affected by, the suspected homicide (e.g. partner, children), and to ensure any staff involved are aware of the death and can access support as

appropriate. It is important that the Chair and Secretariat consider what information needs to be provided to enable agencies to carry out this task. No additional information should be requested or provided.

The agencies will then be asked to submit relevant information using a template so that the DHR Chair and Secretariat can begin compiling a list of agencies that need to take part in the review process, should it go ahead**.** The template should ensure that information gathered is consistent and prevent "oversharing" of information that is not required. Completed templates should be sent to the DHR Chair's secure email address. Agencies will also be asked to identify a senior manager who will be the main point of contact going forward. If the agency sending the information does not have a secure email address they will be asked to password protect completed documents and send the password separately or hand deliver the papers to the DHR Secretariat.

Information received should be saved by the Secretariat on the Department of Justice's secure file plan during the duration of the DHR but should be deleted upon its completion, in compliance with the Department's Disposal and Retention Schedule.

The Independent Chair, with the assistance of the DHR Secretariat, will collate the information received and provide SOF with a recommendation on whether a Review is needed, by way of a brief written report. The report will be sent by secure email to the SOF Chair who will then arrange a meeting[11] of SOF to establish and record whether a case is to be the subject of a DHR, based on the legislative provisions and the DHR guidance.

Information will be brought to the SOF meeting on encrypted laptops. Data sharing agreements will set out that the Independent Chair and Panel members should not bring hard copies to meetings. Any confidential information that cannot be emailed will be brought to the meeting in hard copy for members to view and will then be collected and shredded after the meeting. SOF will then agree or disagree that the case presented reasonably meets the circumstances in which a review should be carried out. SOF will

[11] The business of the group may be conducted by conference call or secure e mail to achieve the outcome within timescales.

formally record a decision to conduct a DHR, as well as a decision not to conduct a review, and inform the Independent Chair in writing by secure email.

The (final) decision to review or not to review will be shared by the Independent Chair with the family, Senior Investigating Officer, Family liaison Officer, Coroner, Attorney General, and all agencies contacted. *These letters will need to include the name of the victim for identification purposes but should not include any other details*.

Once Panel membership for the review has been agreed, the Independent Chair (through the DHR Secretariat) will write to the nominated senior manager in each of the agencies, bodies or organisations as part of the scoping for the review to commission the Internal Learning Reviews (ILR's). This letter will need to include the name of the victim and the alleged perpetrator but should not include any other personal information.

The agencies will be provided with an ILR template to complete. The template should ensure that information gathered is consistent and prevent "oversharing" of information that is not required. Completed ILRs should be sent to the DHR Chair's secure email address. If the agency sending the ILR does not have a secure email address they will be asked to either password protect completed documents and send the password separately or hand deliver the papers to the DHR Secretariat.

ILRs received should be saved on the Department of Justice secure file plan during the duration of the DHR but will be deleted upon its completion in compliance with agreed procedures.

<u>Recording interviews</u>

A note should be taken of any interviews with the family, friends or other relevant individuals by secretariat staff during the interview.

A series of Panel meetings should be held to enable Members to review all the information gathered, discuss findings, identify actions as needed and agree DHR report content. Any confidential information that cannot be emailed will be brought to the meeting in hard copy for members to view and will then be collected and shredded after the meeting.

Adopting a streamlined approach

While there is merit in providing detailed information on the key elements and background of a case, 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. The DHR report should not contain an exact log of each and every contact a victim has with services and a significant amount of detailed information should not be reported back. A streamlined approach (including to the final report) should be taken which centres on the victim, with a DHR report that should be concise, succinct, focused and proportionate. That report should 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. The final report should 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, by secure email.

Anonymising information and publication

It should also be noted that given the significant media and public interest involved in these cases a range of information will likely already be in the public domain (through the press, social media etc.). Also, given the number of homicides annually in Northern Ireland, that would meet the criteria of a domestic homicide review, it is unlikely that the risk of identification could be removed, however, steps should still be taken to anonymise the information included in the final report as far as possible. It should be written sensitively, given the tragic circumstances giving rise to it.

The DHR report should be 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 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.

The Independent Chair should show a hard copy of the draft report to the family (or an advocate) prior to publication. The report will then be taken back by the Independent Chair. A legal form of undertaking to maintain confidentiality of the unpublished report will be drawn up.

Guidance 6

Meetings

A series of meetings will take place during the DHR process. A minute of these meetings will need to be taken by the Secretariat, as a necessary safeguard to criminal proceedings. The main meetings are listed below.

Meeting – Panel meets the SIO and establishes Terms of Reference

The first Panel meeting should do the following:

a) Establish the draft Terms of Reference for the Review;
b) Meet the SIO/disclosure officer of the investigation. Consideration should be given to whether the SIO/disclosure officer should be invited to attend the first panel meeting. At a minimum the SIO/disclosure officer should be asked to provide a written 1 – 2 page initial summary to the Panel on an agreed template. This would protect investigative integrity and enable the discussion to move quickly to whether these is a need to initially limit the scope of the Terms of Reference or delay the DHR (and identify at what stage(s) it should be delayed). This will be a particular issue in terms of avoiding interfering with a criminal case (not speaking to witnesses to the crime, the timing of this etc.);
c) Establish initial timescales for the Review;
d) Establish if any independent experts are required to join the Review Panel or assist the Independent Chair with the DHR report;
e) Consider legal proceedings and how this may impact on the interviewing, for example, of staff members;
f) Discuss involvement of family members / friends etc;
g) Meet the family members - the family should have an opportunity to meet with the Panel if they choose to do so. The decision on whether family members attend the full meeting, or part of it, should be based on information gathered by the Independent Chair and DHR Secretariat and should be agreed by the SIO/disclosure officer and the

Family Liaison Officer (FLO), taking into consideration the particular nature of the case.

After this initial Panel meeting the Independent Chair and Secretariat will circulate the draft Terms of Reference via secure e mail for any amendments or comments.

The Independent Chair will:

a) review the Terms of Reference and make further changes as they see fit;
b) share with family members and give them the opportunity to contribute;
c) email the finalised version to SOF; and
d) send to Panel Members and Internal Learning Review (ILR) Leads once identified.

The Review Panel members need to:

a) ensure that their agency's internal learning review will be completed within agreed timescales;
b) read all the circulated Internal Learning Reviews and information reports prior to the next Review Panel meeting;
c) consider what additional information may be required from their agency; and
d) consider what issues or inconsistencies they need to raise regarding other agency information.

Meeting – Initial briefing for ILR Leads

ILR Leads are invited to this meeting in order that the Independent Chair can brief them on:

a) the Terms of Reference;
b) the process, timescale and requirements for the production of the ILR and the DHR Report;
c) the specific issues pertinent to the case;
d) issues of concern that need exploring.

Meeting – Feedback and debriefing session for ILR leads

The Independent Chair should provide feedback and a debriefing session for ILR leads, in advance of completion of the DHR Report. They should also hold a follow-up feedback session with these staff once the DHR report has been completed and before it is published.

Meeting – Facilitated practitioner's event

In some cases, it may be agreed by the Review Panel that a facilitated practitioners' event should be held.

This event would be organised to provide an opportunity for the front line practitioners who were involved with this individual or family to come together to look at what lessons can be learned from this case. This would be conducted in a spirit of enquiry with the focus on learning and not in any way to attach blame to any single individual or agency. This would be an opportunity for practitioners to share their knowledge and experience of working with individuals and families who are living in situations of domestic abuse, explore areas of 'good practice' and identify the challenges and barriers to effective practice (these may be individual, organisational or systemic) with the aim of identifying ways of moving forward. The learning from such an event would be shared with the Review panel to inform the review outcomes.

Meeting - Panel Meeting/s – to Review and discuss Internal Learning Reviews

At least one week prior to the meeting, the completed Internal Learning Reviews should be circulated. A template to evaluate the ILRs will also be provided at this time, to assist panel members in determining whether sufficient evidence has been provided in the ILRs by the agencies involved.

Panel members are responsible for reading all papers before the meeting.

At the meeting, the panel should review and consider the Internal Learning Reviews in light of the terms of reference and:

a) highlight the key issues emerging from the internal findings so far, which should be addressed in the Domestic Homicide Review Report.
b) identify if any agencies need to provide further information or consider issues or episodes of interaction further.
c) offer challenge to agencies, and where issues cannot be resolved, the DHR report will need to record the areas of disagreement and actions taken towards a resolution. The Department of Justice will not arbitrate in such circumstances.

Following this meeting, panel members should ensure that any additional information requested from their agency is provided within agreed timescales. They should also ascertain that any immediate actions arising from the ILR are being implemented.

If necessary, this meeting can be repeated one or more times, until the Review Panel is satisfied that enough information has been provided from all sources for a comprehensive DHR report to be written. However, it is the responsibility of agencies to respond in a timely manner to all information requests/amendments to their ILRs, in order to avoid duplication of meetings.

Meetings – Domestic Homicide Review Report review meeting(s)

At least one week before the meeting, the first draft of the DHR report should be circulated.

Panel members are responsible for reading all papers before the meeting.

At this meeting, the panel should:

a) review any new information from the earlier panel meeting(s);
b) review the draft DHR Report and provide comment;
c) share and discuss agency actions;

d) consider the report's actions;
e) agree the attached Action Plan; and
f) agree the content of the Executive Summary.

If necessary, this meeting can be repeated one or more times, until the Panel is satisfied with the DHR Report and the actions are as per the guidance.

The Panel needs to:

a) ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the reports;
b) be satisfied that the report accurately reflects the review panel's findings;
c) ensure that the report has been written in accordance with this guidance; and
d) be satisfied that the report is of a sufficiently high standard for it to be sent to SOF.

It is the responsibility of both the agencies and the Independent Chair to respond in a timely manner to all information requests/amendments to the DHR Report, in order to avoid duplication and meet the overall timescales.

Once the report is at a final stage, panel members must ensure the senior responsible manager from their agency is satisfied that the agency's involvement is accurately represented, the actions are achievable and there is commitment to implement them and that they will sign off the report.

Guidance 7

Core Values and Independence

Independent Chairs will be expected to:

Treat everyone with dignity and respect

In practice this means:

- respecting others and respecting differences;
- communicating sensitively;
- being sincere;
- taking into account the needs and feelings of others; and
- recognising others' achievements and successes.

Be fair, open and transparent

In practice this means:

- leading with integrity;
- being approachable; and
- being open and inclusive.

Listen to and learn from others

In practice this means:

- taking time to listen;
- learning from mistakes and shortcomings;
- learning from others;
- sharing learning with others; and
- seeking others' input and considering others' views.

Guidance 8

Timescales for conducting a Domestic Homicide Review

The timescales below are indicative only, though may prove helpful. They aim to provide a sense of how long may be spent at each point of the process. It is recognised that the length of time to complete the DHR will vary depending on the specifics of the case. This is balanced with a need to ensure that lessons to be learned are identified and addressed in a timely manner through changes made. Notably timescales may be extended due to unavoidable delays e.g. in relation to the complex scope of the DHR or on-going criminal proceedings.

Stage 1 – Establishing a Review

When there is a domestic homicide of a person aged 16 years old or over, the police will notify SOF of the death in writing (Template 1) of the incident, through the Department of Justice SOF Chair within 5 working days of the death being reported or discovered.

The timescales set out below provide an indication of how long should be spent at each point of Stage 1. They are not definitive. Ultimately Stage 1 should be completed within six weeks.

Timescales relevant to actions within Stage 1 are outlined below:

- Ideally, within **five working days** of the referral SOF should be aware of, or have ascertained the following:

a) the cause of death of the victim;
b) if an alleged perpetrator has been identified and what charges are being brought against them (if they are living);
c) dates of planned court appearances for any defendant;
d) remand status/location of any defendant;
e) the status of the Coroner's proceedings; and

f) information concerning any significant family members or friends who may wish to be involved in the review.

- When the homicide is notified, the Secretariat should identify the individuals, agencies and organisations who may have been in contact with the victim, alleged perpetrator and family (including children) and contact at least the relevant statutory agencies such as police, health and social care and probation, and any voluntary sector organisations that they are aware may have had contact to tell them to secure their records relating to the perpetrator and the victim. The SIO/disclosure officer will already have a developing narrative about what happened and lines of inquiry which can help with identifying relevant organisations.

- Within **five working days** of a notification being received the agencies represented on SOF should secure their records. Any additional agencies can be contacted once the Chair is appointed. The SOF Chair should then write (see Template 2) inviting an Independent Chair to lead the review. Within **two working days** the Independent Chair should accept/decline the invitation (by e-mail).[12] SOF should indicate if they have commissioned a Review or whether they require a recommendation (on whether or not to proceed with a DHR) from the Independent Chair following the scoping and initial information gathering exercise.

- The Independent Chair should consider the list of agencies compiled by the Secretariat with immediate effect and, in discussion with the Senior Investigating Officer, should ask the Secretariat to write to agencies to request that a search be undertaken of both manual and electronic records to identify whether their organisation has had any engagement with the victim or any other named individuals. Agencies should respond quickly, usually **within 5 working days**, to advise that there has been no contact or to notify that there has been contact and to advise what contact there may have been with other organisations. If they have had contact, they should then provide an **initial brief summary** of their involvement, to a dedicated e-mail address specific to the DHR, within **a further 5 days**. Independent Chair and Secretariat should then begin compiling a list of agencies that need to take part in the review process, should it go ahead**.**

[12] If the Independent Chair invited declines and Alternative Independent Chair should be asked.

- If SOF has asked for a recommendation on whether a review should take place, the Independent Chair (with the support of the Secretariat) should, within **four days** of receiving the summaries from agencies, collate the information received and will present the findings to SOF in a written report. A core subset of members of SOF will then meet (or agree by correspondence) within **two working days** of receiving the report to establish whether a case is to be the subject of a DHR by applying the definition set out in this guidance (see Section 3).

- Confirmation of a decision to conduct a homicide review, as well as a decision not to conduct a review, with a clear rationale for the latter, should be formally recorded by SOF and sent in writing to the Department of Justice domestic homicide review inbox: within **three working days** of SOF's meeting.

The Independent Chair should inform the victim's family of the commencement of the DHR process once a draft Terms of Reference is available to share. The Independent Chair should engage with the SIO/disclosure officer and Family Liaison Officer to determine who the family of the victim is and who should be engaged. Should family members, friends and others wish to be involved in the process, the Independent Chair should arrange to meet them. However, the Independent Chair must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial. The Independent Chair will need to discuss the timescales for interviews with the SIO/disclosure officer and take guidance from the SIO/disclosure officer in relation to any ongoing criminal proceedings. In some exceptional circumstances the SIO/disclosure officer may request that the family is not engaged in the process. In such cases there will be a requirement for this request to be made in writing by the SIO/disclosure officer and stored in case of any future criticism. It should also be remembered that families will have a great deal to cope with after the homicide, in terms of both emotions and practicalities, and some families may not feel able to meet with the Chair or be interviewed until after the criminal trial.

Stage 2 – Establishing a Review Panel and Undertaking Internal Learning Reviews (ILRs)

- Once a DHR has been commenced, SOF and the Independent Chair should correspond with immediate effect, to agree which organisations should be invited to sit on the Panel. The Independent Chair should then write, via the Secretariat, asking them to reply within **5 working days**, identifying a suitable representative to sit on the Panel.

- Within **3 working days** of receiving nominations, the Independent Chair should write to SOF to confirm Panel membership. SOF should reply within a **further 3 working days** to provide core terms of reference as a basis for development (Template 9).

- Once SOF has been informed of membership, the Secretariat should convene an initial meeting of the Panel, as soon as possible, to **identify any early learning that should be progressed immediately**, consider how best to disseminate this and to develop clear terms of reference. Once drafted, the terms of reference should be sent to SOF for information.

- The Independent Chair should, **within three working days of the Panel meeting**, write to the senior manager in each of the agencies, bodies or organisations identified as part of the scoping of the review to commission the ILRs. Senior managers should respond **within five working days**, to provide contact details for their ILR Lead. ILR Leads should then be invited to a briefing meeting (**within a further ten working days**) in order that the Independent Chair can brief them on:

  - the Terms of Reference;
  - the process, timescale and requirements for the production of the ILR and the DHR Report;
  - the specific issues pertinent to the case; and
  - issues of concern that need exploring.

- Agencies should then submit their ILRs **within 4 weeks**. The Panel should consider each ILR received and evaluate it using Template 12. This template should help the Panel determine if enough information has been provided or not. The Independent Chair should then provide feedback to each agency and a debriefing session for the staff involved in the review, in advance of completion of the DHR Report. This should take place **within 14 working days of the ILRs being submitted**.

In some cases, it may not be possible to finalise the ILRs until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons identified from being acted upon. It is the responsibility of the Independent Chair and panel to ensure that this happens.

Stage 3 – Evaluation and DHR Report

A series of meetings will be held through which the Panel will review all the information gathered, debate the findings and agree actions. It is expected that this stage of the process will take **2-3 months**. However, this may vary depending on the specifics of the case.

The Independent Chair will then draft the DHR Report, Executive Summary and Action Plan. **The Report drafting stage is expected to take a further 2-3 months.**

Once drafted, the Independent Chair should share the draft DHR Report, Executive Summary and Action Plan with the Panel. **The Panel should be given two weeks to consider the draft.** A meeting of the Panel should then take place where the DHR Report is signed off for presenting to SOF.

In some cases, it may not be possible to finalise the DHR report until coronial or criminal proceedings have been concluded, but this should not prevent early lessons identified from being acted upon. It is the responsibility of the Independent Chair and panel to ensure that this happens.

Stage 4 – Presenting/Submitting the DHR Report

It is the responsibility of the Independent Chair to formally present the DHR Report to SOF at a meeting. Following the meeting, SOF will have **two weeks** to assess the standard and quality of the draft DHR Review Report (against associated guidance). SOF should provide feedback and advise what changes (if any) are needed.

The DHR Secretariat will make **necessary changes within one week**, and the Independent Chair will send a final DHR Report, Executive Summary and Action Plan back to SOF for sign-off. It is expected that sign-off will be given within a further **7 working days.**

Once the report has been signed off by SOF, the Independent Chair should show a hard copy of the draft report to the family (or an advocate) prior to publication. The report will then be taken back by the Independent Chair. The Independent Chair should discuss the report with the family, as well as publication handling, possible media interest and timeframes. This provides an opportunity for questions to be answered, concerns to be expressed (and addressed), and to ensure the view of family members are appropriately represented. Should there be any areas of disagreement following their meetings, these should be recorded by the Independent Chair. The Independent Chair is not obliged to make changes to the Report, on the request of the family, which they believe are not in line with their findings.

Any legal issues should be resolved prior to sharing with the family, for example, where advice has been sought on libel issues.

To assist the family to understand the document they may wish to access the report in an alternative format or language other than English. This should be clarified during early engagement with family members.

If the Independent Chair decides to make any changes following engagement with the family, they should inform SOF and seek further sign-off. Work should then commence on publishing the document.

Stage 5 – Publication and Implementation

When agreeing to sign-off the DHR Report, SOF should agree a publication date and should instruct the DHR Secretariat, in writing, to place electronic copies of the DHR Report on the DHR website on the agreed date.

Prior to publication, the DHR Secretariat will be required to brief the Minister on the key issues arising from the Report.

On the day that the DHR Report is published, SOF should write to the family, providing a copy of the DHR Report. The DHR Secretariat should also provide a copy to the senior manager of each participating agency, on behalf of SOF. Ahead of this agencies should also have been provided with any associated media statement.

Within two weeks of the publication of the DHR report, SOF should meet to agree what type and level of information needs to be disseminated, how and to whom, in the light of the DHR.
It will not be possible to publish the DHR report until after coronial or criminal proceedings have been concluded. Ahead of this, at an early stage in the process, it is vital that early lessons are identified, disseminated and acted upon. It is the responsibility of the Independent Chair and panel to ensure that this happens.

DHR timeline

DHR stage	Completion
1	within 6 weeks of notification
2	Generally within 8-12 weeks
3	Generally within 10-12 weeks (this stage may take longer due to complexity of case/criminal proceedings)
4	Generally within 4-6 weeks
5	Depending on complexity and whether the report is delayed due to any criminal proceedings, it is anticipated reviews will be completed within 26 – 39 weeks

Guidance 9

Engagement with other Review Processes

There will be specific circumstances where there is a statutory requirement or 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 public protection. Any decision for the lead to be taken by another review body would be made by SOF and based on the detail of the case.

Where another review is commencing the Independent Chair should engage with the relevant review body to seek opportunities for learning relating to the domestic abuse. It may be appropriate in such circumstances for the Independent Chair or a DHR Panel member to sit on the alternative review process. This will be decided on a case by case basis. Naturally there should be close liaison with other relevant processes (such as PPANI Serious Case Reviews). Adopting one process that meets the two statutory criteria, would avoid duplication of work and not unduly confuse or distress the family. However, it may be more appropriate in some cases for two reviews, with different focuses, to run in parallel. A Memorandum of Understanding should be agreed which clearly sets out how the lead review will be identified and how, practically, co-working will occur and how the family will be informed and engaged so that they do not have to give the same information more than once. There will be a need to ensure that key issues for the other review are reflected within the Terms of Reference where a single review is to be undertaken and that there is appropriate representation provided on any panel.

When a victim of domestic homicide is aged between 16 and 18, the Independent Chair should engage with the child Case Management Review (CMR) process to agree whether one process could be adopted to avoid duplication of work as well as placing undue pressure on the family and other bodies that are involved. This should be decided on a case by case basis and should consider factors such as whether the alleged perpetrator was related to the young person or whether they were in an intimate personal relationship. If it is decided that a CMR should be conducted the Independent Chair should ensure that

the CMR Chair seeks opportunities for learning relating to the domestic violence and abuse. It may be appropriate in such circumstances for the Independent Chair or a DHR Panel member to sit on the CMR. This would be decided on a case by case basis. In some cases it may be more appropriate for two reviews, with different focuses, to run in parallel. A Memorandum of Understanding will be agreed which clearly sets out how the lead review will be identified and how, practically, co-working will occur. There will also be a need to ensure appropriate coverage of key issues for both reviews in the agreed Terms of Reference.

It is not considered that a Serious Adverse Incident (SAI) review should take place in addition to a DHR. When a health care professional is notifying the Health and Social Care Board of an incident, they will be required to advise if a DHR has been commissioned. If it has, the SAI will not take place.

Guidance 10

Disclosure and Criminal Proceedings

General Principles

Disclosure is one of the most important issues in the criminal justice system and the application of proper and fair disclosure is a vital component of a fair criminal justice system. All disclosure issues must be discussed with the police SIO/Disclosure Officer, the Public Prosecution Service (PPS) and the Coroners Service representative as appropriate. There will be a need for **ongoing and regular engagement between the Chair and SIO/Disclosure officer throughout the DHR process** and this guidance must be considered in that context. Regard must also be given to the Criminal Procedure and Investigations Act 1996.

There may be homicides where the investigator believes that a third party (for example, a GP or social care organisation) has relevant material or information. In such cases, if the material or information might reasonably be considered capable of undermining the prosecution case or of assisting the case for the accused, the investigator should take steps they regard as appropriate to obtain it and decide upon its relevance (or part thereof) to any issue in the case. Material or information that the investigator deems relevant should be forwarded to the prosecutor to review and decide whether it has to be disclosed to the defence. In cases where the third party fails to provide any potentially relevant material or information an application can be made for a witness summons requiring a representative of the 'third party' to produce the material to the court.

Dependent on the case, material gathered in the course of a DHR may be capable of assisting the defence case and would almost certainly be material that the defence would seek to gain access to. If a DHR is being conducted in parallel to a criminal investigation, the SIO/disclosure officer will be obliged to inform the prosecutor. Any interviews with other agency staff, documents, case conferences etc. may all become disclosable. ILR leads should inform staff being interviewed of this. It is the responsibility of a disclosure

officer to link in with the Independent Chair. It is incumbent on the Independent Chair to ensure that there is a robust process in place for the purpose of disclosure to the SIO/disclosure officer responsible for the criminal investigation, given that **any material may potentially be disclosable**, **involving regular and ongoing liaison with the SIO/disclosure officer** (including in relation to material provided to the review). Normal police/PPS process would apply in relation to the onward provision of material that is to be disclosable.

It is permissible for the Panel to carry out further work in relation to the DHR in tandem with ongoing criminal proceedings, for example, conducting professional interviews, producing a draft DHR Report. However, any such work must take into account the views of the SIO/Disclosure Officer and the PPS to ensure that the criminal proceedings are not compromised.

Circumstances where the alleged perpetrator is arrested and charged

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

a) that the DHR be pended until after the outcome of any criminal proceedings, which will be dependent on the particular circumstances of the case and having discussed with the SIO/Disclosure Officer and the PPS;

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

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

information gathered by the review would be of interest to the defence and they may apply to court to see this.

Regardless of the outcome, every effort should be taken to ensure that early learning arising from the homicide is taken forward as soon as possible, where this does not compromise the integrity of relevant criminal proceedings. It is essential that necessary learning is not delayed to prevent the same mistakes being replicated in other cases. In these circumstances, the Panel should ensure records are reviewed to identify any immediate lessons to be learned (an immediate ILR) and changes that are needed. These should be brought to the attention of the relevant agency or agencies for action, secured for the subsequent DHR Report and forwarded to the disclosure officer for the criminal case. Any identified actions should be taken forward without delay.

All material generated or obtained in the DHR whilst the criminal case is ongoing must be made available to the SIO/Disclosure Officer to assess whether it is potentially relevant to the criminal case. Where it is potentially relevant, PSNI will schedule the material and forward the schedule to the PPS, to enable the disclosure test to be applied to the defence. Where the material is sensitive, PPS or the SIO/Disclosure Officer will consult with the Independent Chair before disclosure is made to the defence. Sensitive material in this context can be "any material the disclosure of which he or she believes would give rise to a real risk of serious prejudice to an important public interest and the reason for that belief."[13]

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

[13] Taken from chapter 8 of the CPS guidance set out in paragraph 96.

Following the conclusion of the criminal proceedings, the DHR should be concluded without delay. Further information about disclosure can be found at: https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/Disclosure-Manual-December-2018.pdf

and

https://www.ppsni.gov.uk/sites/ppsni/files/publications/PPS%20Code%20for%20Prosecutors.pdf

Circumstances where the Perpetrator is deceased

Where evidence indicates that the perpetrator is deceased and either:

a) the cause of death is unknown;
b) the death was violent or unnatural;
c) the death was sudden and unexplained;
d) the person who died was not visited by a medical practitioner during their final illness;
e) the medical certificate is not available;
f) the person who died was not seen by the doctor who signed the medical certificate within 14 days before death or after they died;
g) the death occurred during an operation or before the person came out of anaesthetic;
h) the medical certificate suggests the death may have been caused by an industrial disease or industrial poisoning;

the case will be referred to the Coroner and a file will be prepared. In these circumstances, it is appropriate for a domestic homicide review to be conducted without delay. The DHR Report, as well as any supporting documents, once they have been reviewed by the Senior Oversight Forum should be submitted to the Coroner to help inform the Inquest.

Guidance 11

Terms of Reference – issues for consideration

The Senior Oversight Forum (SOF) will consider the scope of the review and provide core Terms of Reference to the independent chair, within 6 weeks of a decision to initiate a domestic homicide review. It is important that the TOR is focused on the purpose and key issues to be addressed.

The core TOR will be considered by the DHR panel, led by the independent chair, during their first panel meeting. Any changes or refinements suggested will be provided to SOF for approval.

When developing terms of reference for the review, SOF, the independent chair and DHR Panel, should consider the following:

a) What appears to be the most important issues to address in identifying the learning from this specific homicide? How can the relevant information best be obtained and analysed?
b) Which agencies and professionals should be asked to submit reports or otherwise contribute to the review including, where appropriate, agencies that have not come into contact with the victim or alleged perpetrator but might have been expected to do so?
c) How will the DHR process dovetail with other investigations that are running in parallel, for example a child safeguarding Case Management Review or adult Serious Case Review or, a criminal investigation or an inquest? Would a co-ordinated or jointly commissioned review process be more effective in addressing all the relevant questions that need to be asked, ensuring staff are not interviewed twice and that there are individuals who sit on both Panels to ensure good cross communication? How will the Review take account of a coroner's inquiry, and/or any criminal investigation related to the homicide, including disclosure issues, to ensure that

relevant information can be shared without incurring significant delay in the review process?

d) Are there any parallel reviews being carried out ie. Mental Health Homicide Review, SBNI, SCR etc.? It will be the responsibility of the Independent Chair to ensure contact is made with the Chair of any parallel process to consider: combining the reviews, information sharing and/or inviting representatives from parallel reviews to sit on the DHR panel.
e) Should an outside 'expert' be consulted to help understand crucial aspects of the homicide? For example, a representative from a specialist BME organisation.
f) Are there any specific considerations around equality and diversity issues such as ethnicity, age and disability that may require special consideration?
g) Did the victim's immigration status have an impact on how agencies responded to their needs?
h) Was the victim subject to a MARAC? If so, is there a need for a Memorandum of Understanding for the release of the minutes from the relevant meetings?
i) Was the alleged perpetrator subject to Public Protection Arrangements (PPANI)? If so, is there a need for a Memorandum of Understanding for the release of the minutes from the relevant meetings?
j) Did the victim seek information about the alleged perpetrator's criminal history under the Domestic Violence and Abuse Disclosure Scheme? Did the police make a disclosure under "Right to Ask" or "Power to Tell"?
k) Was the alleged perpetrator subject to a domestic abuse behavioural change programme? If so, the professionals working with the alleged perpetrator may know important information relating to the homicide as well as a key focus on the management of risk posed by the alleged perpetrator.
l) Does the alleged perpetrator hold a position of trust or authority; for example a police officer, social worker, or health professional, and is the homicide likely to have a significant impact on public confidence?
m) Was the alleged perpetrator a member of a proscribed group/organised crime group or did they claim to be?
n) Did the victim have any contact with a domestic abuse organisation, charity or helpline? How will they be involved and contribute to the process? Helplines, charities and local specialist domestic abuse services, including refuges, can be a useful source

of information, although the disclosure of information about alleged perpetrators may be subject to legal considerations.

o) If appropriate, how will issues of 'honour'- based violence or human trafficking will be covered and what processes will be put in place to ensure confidentiality?

p) How should friends, family members and other support networks (for example, co-workers and employers, neighbours etc.) and where appropriate, the alleged perpetrator, contribute to the review? How will they be involved and contribute throughout the overall process taking account of possible conflicting views within the family? (Further information is available at section 4).

q) How matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for this?

r) Consideration should also be given to whether either the victim or the alleged perpetrator was a child or an adult at risk of harm and in need of protection as defined in the Department of Health/Department of Justice Adult Safeguarding Policy 2015. –If this is the case, the Panel may require the assistance or advice of additional agencies, such as adult/child social care.

s) Was the victim (and/or alleged perpetrator) a social housing tenant? If so were there any rent arrears or frequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? These could be indicators of a potential domestic abuse situation.

t) How will the Review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process? (See Guidance 10 Disclosure and Criminal Proceedings for further information)

u) Is there a need to involve agencies/ professionals working in other jurisdictions with an interest in the homicide, including members of the voluntary and community sector and what should their roles and responsibilities be?

v) Who will make the link with relevant interested parties outside the main statutory agencies, for example independent professionals and voluntary organisations?

w) How should the review process take account of previous lessons identified i.e. from research and actions contained within previous DHRs?

x) Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

Guidance 12

Quality Assurance process

Quality assurance for completed DHRs rests with SOF, assisted by invited voluntary and community sector organisations. All completed DHR reports should be securely sent by the Independent Chair to the SOF Chair. SOF will meet to assess the report standards against this guidance as well as identifying good practice and training needs.

The key issue for Quality Assurance is to ensure that:

a) the Independent Chair (and Panel) has spoken with the appropriate agencies, voluntary and community sector organisations, and family members, friends etc., to establish as full a picture as possible;
b) the report addresses the scope and limitations of the Terms of Reference;
c) the report demonstrates sufficient probing and analysis and the narrative is balanced;
d) the report articulates the voice of the victim and their family;
e) the report is streamlined and does not contain an exact log of each and every contact a victim has with services;
f) lessons to be learned are clearly identified and there are proposed actions in place for ensuring this is the case and change is brought about;
g) the report is not focussed on 'blame;'
h) any legal issues have been resolved, for example, where advice has been sought on libel issues;
i) the report is anonymised; and
j) the likelihood of a repeat homicide is minimised.

The QA process is not about second-guessing or seeking to alter the substantive content of the report with regard to the recommendations.

SOF and invited voluntary and community sector organisations will review the draft DHR report and the SOF chair will write to the Independent Chair and Review Panel making recommendations for change or agreeing that the report is fit for publication.
On receipt of the letter, and following Panel discussion, the Independent Chair and Secretariat should make any necessary changes.
Feedback should be shared with all Independent Chairs to inform future reviews that they may be commissioned to undertake.

When the report is considered fit for publication by SOF the Independent Chair should arrange for the report and letter to be published on the DHR website.

SOF, in terms of Quality Assurance, is also responsible for:

a) disseminating lessons identified and good practice locally and regionally;
b) assessing local and regional progress;
c) identifying serious failings and common themes;
d) communicating with the media to raise awareness of the positive work of statutory and voluntary sector agencies with domestic abuse victims and alleged perpetrators so that attention is not focused disproportionately on tragedies;
e) communicating and liaising with other government departments to ensure appropriate engagement from all relevant agencies;
f) providing central storage for Official DHR records to allow for clear auditing of review documentation and quick retrieval if required (Department of Justice);
g) recommending regional training needs and working across government to ensure existing training is highlighted; and
h) recommending service needs.

Guidance 13

Dissemination of lessons identified and monitoring the implementation of actions

DHRs are a vital source of information to inform regional policy and practice. All agencies involved have a responsibility to identify and disseminate common themes and trends across review reports, and act on any lessons identified to improve practice and safeguard victims (including early learning ahead of a DHR formally completing). Publishing the Review and completing the action plan is only the beginning of the process. To derive value from the DHR process and reduce the risk of further abuse and homicide, a robust governance mechanism is required to monitor delivery against DHR action plans. SOF should satisfy themselves that an appropriate framework is in place.

It is important to draw out key findings of DHRs and their implications for policy and practice. The following may assist SOF, which has a leading role, in achieving maximum benefit from the DHR process:

a) As far as possible, the review should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.
b) Consider what type and level of information needs to be disseminated, how and to whom, in light of the review. Be prepared to communicate both examples of good practice and areas where change is required.
(j) Subsequent learning should be disseminated to the local MARAC, other multi-agency fora, e.g. the Safeguarding Board for Northern Ireland and PPANI, as well as other interested parties such as the Public Health Agency.
(k) Share and incorporate the learning (including any national lessons learnt) across the strands of adult and children safeguarding and utilise into local and regional training programmes for frontline staff.
(l) SOF should put in place a means of monitoring and auditing the actions and intended outcomes, with a focus on what has changed as a result of the DHRs.

(m)Establish a culture of learning lessons by having a standing agenda item for DHRs on the meetings of relevant domestic abuse forums and similar groups.