**DHR - FAQ’s**

1. **What is a Domestic Homicide Review (DHR)?**

*Domestic Homicide Reviews (DHRs) were established on a statutory basis* *under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011.*

*Domestic homicide review means a review of the circumstances in which the*

*death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —*

*(a) a person to whom he was related or with whom he was or had been in*

*an intimate personal relationship, or*

*(b) a member of the same household*

*as himself, held with a view to identifying the lessons to*

*be learnt from the death.*

*‘intimate personal relationship’ includes relationships between adults who are or have been intimate partners or family members, regardless of gender or*

*sexuality.*

1. **What is the purpose of conducting a Domestic Homicide Review?**

*Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;*

*• Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;*

*• Apply these lessons to service responses including changes to policies and*

 *procedures as appropriate; and*

*• Prevent domestic violence homicide and improve service responses for all*

 *domestic violence victims and their children through improved intra and*

 *inter-agency working.*

*The rationale for the review process is to ensure agencies are responding*

*appropriately to victims of domestic violence by offering and putting in place*

*appropriate support mechanisms,* procedures, resources and interventions

*with an aim to avoid future incidents of domestic homicide and violence.*

*The review also assess whether agencies have sufficient and robust*

*procedures and protocols in place, which were understood and adhered to by their staff.*

1. **What is a DHR Review Panel and which agencies were members of the Panel?**

*A DHR Review Panel led by an independent chair and consisting of representatives from statutory agencies, listed under section 9 of the Domestic Violence, Crime and Victims Act 2004, and voluntary agencies is commissioned to undertake the DHR. The panel reviews each agency's involvement in the case and makes recommendations to improve responses in the future. The panel will also consider information from the victim's family, friends and work colleagues.*

*For this DHR Panel membership was as follows:*

* *Independent Chair and Overview Author*
* *NHS England, Eastern Region*
* *Suffolk Clinical Commissioning Group (CCG)*
* *GP Surgery, Primary Care*
* *Suffolk Constabulary*
* *Suffolk County Council, Specialist Domestic Abuse Advisor*
* *Suffolk County Council Children’s and Young People’s Services*
* *Suffolk County Council Adult and Community Services*
* *East of England Ambulance Service*
* *National Probation Service*
1. **What is an IMR and what is the purpose?**

*An IMR is an Independent Management Review. The Chair of the DHR Review Panel writes to the senior manager in each of the participating agencies to commission the IMRs. IMRs are not made publicly available; however IMRs do form part of the Overview Report.*

1. **What is a Community Safety Partnership (CSP)?**

*Community safety partnerships (CSPs) are made up of representatives from the ‘responsible authorities’, which are the:*

* *police*
* *local authorities*
* *fire and rescue authorities*
* *probation service*
* *health*

*The responsible authorities work together to protect their local communities from crime and to help people feel safer. They work out how to deal with local issues like anti-social behaviour, drug or alcohol misuse and reoffending. They annually assess local crime priorities and consult partners and the local community about how to deal with them.*

*CSPs were set up under* [*Sections 5-7 of the Crime & Disorder Act 1998*](http://www.legislation.gov.uk/ukpga/1998/37/part/I/chapter/I/crossheading/crime-and-disorder-strategies)*.*

1. **Why does a CSP undertake a DHR and not the Police or the Council?**

*Community Safety Partnerships have overall statutory responsibility for undertaking a Domestic Homicide Review.*

1. **Why was the DHR written by an Independent Chair and not the Chair of the CSP?**

*The Review Panel should appoint an independent Chair of the Panel who*

*is responsible for managing and coordinating the review process and for*

*producing the final Overview Report based on IMRS and any other evidence*

*the Review Panel decides is relevant. The Review Panel Chair should, where*

*possible, be an experienced individual who is not directly associated with any of the agencies involved in the review.*

1. **What is the timescale for completing a Domestic Homicide Overview?**

*The Overview Report should be completed within a further six months of the date of the decision to proceed with a DHR, unless an alternative timescale is formally agreed with the relevant CSP. Sometimes the complexity of a case does not become apparent until the review is in progress.*

1. **Why has it taken longer to complete this DHR?**

*It was not possible to complete the Review within the six month timescales set out within the statutory guidance due to appropriate care and sensitivity taken by all involved as to the importance of contact with friends, family and work colleagues this case and the proximity of this review to HM Coroner’s Inquest.*

1. **What will change as a result of this DHR?**

*The Overview Report contains recommendations for future action. These recommendations are translated into a SMART Multi Agency Action Plan (Appendix A). This Action Plan has been agreed at senior level by each of the participating agencies. The Action Plan sets who will do what, by when and what intended outcome. The Action Plan should set out how improvements in practice and systems will be monitored and reviewed.*

1. **When will there be an update on the recommendations?**

*The Community Safety Partnership will monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan and will formally conclude the review when the Action Plan has been implemented and include an audit process*

1. **Is anyone going to be prosecuted for the deaths?**

*DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts, respectively, to determine as appropriate.*

1. **Who does the DHR document get issued to?**

*Senior Management of each participating agency*

*Chair of West Suffolk Community Safety Partnership*

*Suffolk Police and Crime Commissioner*

*Home Office – Quality Assurance Team*

1. **Why are there redactions in this DHR document?**

*In all cases, the Overview Report and Executive Summary, should be*

*suitably anonymised*. *The content of the Overview Report and Executive Summary must be suitably anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the Data Protection Act 1998. This means preparing Overview Reports in a form suitable for publication, or redacting them appropriately before publication.*

1. **Why is it only being published on the Mid Suffolk District Council website?**

*Publication of Overview Reports and the Executive Summary should be published on the local CSP web page. Therefore, it has been published on the local CSP web page on the Mid Suffolk District Council website.*