Home Office

Criteria for considering Domestic Homicide Review reports

Criteria	Adequate	Inadequate
Timescales	Decisions and notifications are made in line with the timescales stipulated in the guidance, unless otherwise agreed.	Decisions and notifications are not made, or are made much later than the timescales stipulated in the guidance, and no prior agreement for this has been sought, nor any explanation provided in the overview report.
	Lessons have been drawn out and acted upon quickly, without necessarily waiting for the DHR review to be completed.	Lessons to be learnt have not been drawn out. The lessons learnt have not been acted upon quickly prior to the end of the review.
	Individual agencies have been informed of the requirement for them to participate in the review promptly in order to allow them to secure records.	Individual agencies are not notified of the requirement for them to participate and secure records in an adequate timeframe.
	The review is completed within a reasonable timescale in relation to the factors of the case. This should be within 6 months unless an alternative timeframe has been agreed with the CSP.	The review is not completed within a reasonable timeframe in relation to the factors of the case.
Decision to undertake a review	The CSP chair makes a decision to undertake a domestic homicide review when the definition in section 9 of the Domestic Violence Crime and Victims Act (2004) is met and this is done in partnership with local experts as set out in the statutory guidance.	A decision is made by the chair of the CSP in isolation.
Scope of the review	The scope of the review has been carefully considered by the panel and clear terms of reference have been drawn up.	The scope of the review has not been fully considered and clear terms of reference are not drawn up.

	Real efforts have been made to involve the family at this stage where that is possible.	No attempt was made to consider a family contribution at this stage.
	The review encompasses a full range of issues relevant to the homicide, victim and alleged perpetrator, and clearly identifies learning opportunities.	The review does not encompass a full range of issues relevant to the homicide, victim and alleged perpetrator, and does not identify learning opportunities.
	The review seeks to identify areas to develop locally and identifies the relevant agencies who will develop them.	The review does not effectively identify areas to be developed locally and/or does not identify the relevant agencies that will develop them.
Equality and Diversity	Equality and Diversity issues have been fully taken into account including; race, gender, sexual orientation and any differences in treatment by agencies. All the grounds for discrimination or "protected characteristics" in the Equality Act 2010 i.e. age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, religion/belief have been considered.	Equality and Diversity issues have not been fully taken into account. All the grounds for discrimination or "protected characteristics" in the Equality Act 2010 i.e. age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, religion/belief have not been considered.
Panel membership	The DHR Panel membership is appropriate in relation to the individual case and the required knowledge and expertise. The potential involvement of all appropriate agencies is fully explored and details given as to why excluded.	The DHR Panel membership is not appropriate in relation to the individual case and the required knowledge and expertise. The potential involvement of all agencies is not fully explored and no detail is given as explanation for non-inclusion.
Contribution of relevant agencies	The contribution of all relevant agencies is maximised throughout the review. All contributions are clearly noted even when there	The contribution of all relevant agencies is not maximised and it is unclear why relevant agencies contributions are not part of the review

	is nothing relevant to add to the review process.	process.
Independent element	A high level of independence is built into the process including the appointment of an independent chair and author of the overview report.	The chairperson is not independent from the case.
	Authors of individual management reviews are independent of line management of the service.	Authors of individual management reviews are not independent of line management of the service.
Involvement of family members, friends, colleagues and community members (where appropriate)	The family was informed of the review and offered the opportunity, where possible, to contribute throughout the review period. The process and framework for this was kept flexible. Real efforts were made to involve and support relevant family members, friends, colleagues, employers and community members (where appropriate). It was made clear that there were different ways that they could contribute to the review. For example, face to face being just one way, others being via Skype, other social media, in writing, audio tape etc. Contributors had been given the leaflets that the Home Office has made available on its web-site. Contributions were not rushed and individuals were given opportunity for more than one interaction with the review panel if required. The appropriate method of contact was considered properly. The statutory guidance suggests contact be established through an existing relationship for example; family liaison	Family members, friends and colleagues have not been invited to take part in the review and it would have been appropriate to do so. Contact was not established in an appropriate way and/ or no advocate was used where it may have been appropriate. Contributors had not been given the leaflets that the Home Office has made available on its web-site. Contributions were rushed and these individuals were not given opportunity for more than one interaction with the review panel. If family members had communication difficulties, no real effort was made to assist the family to contribute.

	officers or Senior Investigating Officers (SIO) or VCS representative. In other cases, using an advocate known to the family may not work and consideration should be given to using a different advocate. If family members had communication difficulties, efforts were made to assist the family to contribute.	
	Actions to involve family members, friends, colleagues and community members are appropriate, and take into account their ethnic, cultural, linguistic and religious needs.	Ethnic, cultural, linguistic and religious needs were not taken into account when meeting with family members, friends or colleagues. Actions have been taken to exclude family members, friends or the wider community from the review that could be interpreted as bias.
Links to parallel investigations (e.g. criminal, mental health)	All other parallel reviews are considered and where appropriate, effective information sharing processes or jointly commissioned review arrangements have been agreed. Data sharing protocols have been agreed in advance of the review. Links to other investigations or reviews are clearly noted in the completed overview report.	Parallel processes are not considered and opportunities to share information are missed. The agencies have demonstrated their reluctance to share information with the Review panel. Other investigations or reviews are not noted at all in the overview report.
Individual management reviews (IMRs)	All relevant agencies produce a comprehensive and well-structured individual management review (IMR) of their full involvement with the victim and the alleged perpetrator. Lessons to be learnt and proposals for addressing have been drawn out from the IMRs and clearly presented in the overview report.	Relevant agencies fail to produce IMRs or fail to disclose their full involvement with the victim or alleged perpetrator.

Overview report	The overview report brings together all of the elements from overall conclusions taken from the information and analysis contained within the IMRs and any other information commissioned from relevant interests. It is clear why the information presented in the review is relevant to the homicide. The overview report includes relevant information collated from family and friends where they have participated. Where domestic violence and abuse was a factor there was a good understanding of the dynamics of such abuse and no victim blaming. Consideration is given to whether agencies had a good understanding of the dynamics of domestic violence and abuse. The review panel has probed, taken into account a wide range of insights and (where applicable) assessed all contributions to the review as well as conducted its own analysis and drawn its own conclusions about the case before creating an overview report. Risk factors for domestic violence and abuse have been identified and highlighted in the report. The review has considered the lessons that can be learnt from the homicide and these reflect the content of the review.	Overall conclusions are lacking, information and analysis from IMRs has not been brought together effectively or information has not been commissioned. It is not clear why the information included is relevant to the homicide. The overview report does not include any information brought forward from family and friends where appropriate. Where domestic violence and abuse has been a feature of the case, it does not feel like there was a good understanding of this. No consideration has been given to the understanding of domestic violence and abuse amongst agencies. The report appears to be blaming the victim. It is not obvious how much reviewing the panel has done. The review panel may have simply acted as messengers of others' comments. It is not apparent if any probing or analysis of the information provided has been done. The review has concluded that the homicide could not have been prevented when it has also identified missed opportunities. The report is biased or makes assumptions on behalf of the victim and or perpetrator that could not be known to the chairperson or report writer.
	Outcomes are transparent, open and honest and evidenced well by the information known to	Outcomes are not open and honest or evidenced well by the information provided by

	the agencies and professionals concerned about the victim and the alleged perpetrator. Outcomes include information known to family, friends and neighbours (where these people have participated in the review).	agencies or professionals about the victim or alleged perpetrator. Outcomes do not include any information known to family and friends and they had participated in the review.
Overall feel of the report	The report shows that a real effort has been made to conduct a meaningful and penetrative review. The report is not defensive and shows that the reviewers employed a broad based, honest, open and comprehensive approach. The review made a determined effort to see the events through the eyes of the deceased, family, friends and the community- where they have been involved the review.	The report gives signals that the review has been overly process driven at the expense of its quality. It may be defensive and narrow in its outlook. It may not be clear how much effort was made to conduct a broad based, honest, open and comprehensive approach. It may lead a reader to believe that insufficient efforts have been made to see the events through the eyes of the deceased, family, friends and the community.
Lessons to be learned	Lessons to be learned, nationally and locally, are clearly identified and supported by specific and achievable recommendations for improving practice in a timely manner. Where appropriate, lessons learned include those gained from family, friends and neighbours.	Lessons to be learned, nationally and locally, are not identified adequately and are not supported by recommendations. Lessons to be learned from family, friends and neighbours are not taken into consideration and it would have been beneficial to have done so.
	The access to services and availability of referral pathways to existing local services has been examined, as well as any potential gaps, including looking at how agencies work together to safeguard potential victims and what more could be done both locally and nationally.	The access to services and availability of local referral pathways has not been examined and opportunities to examine how agencies work together locally and/ or nationally have not been fully addressed.

	If no contact has been made with services the review has appropriately examined the potential reasons for this including, if there were any barriers to accessing services. Proper consideration has been given to the way in which services were perceived by the victim and/or the perpetrator. The review has considered the barriers to services and perceptions made by the family, friends and neighbours.	The review does not examine potential reasons as to why no contact has been made with agencies. Barriers to accessing services have not been considered thoroughly, nor consideration given to how the services may have been perceived by the victim and/or the perpetrator. No consideration has been given to the perception of services from family, friends and neighbours, or if this was not possible, no explanation has been provided.
Action plan	A comprehensive joint agency action plan is in place that is agreed at a senior level by the agencies involved. The plan is corporately adopted and signed off. Where the family have contributed to the report, consideration has been given to including the family's issues and suggested solutions in the action plan where appropriate.	A joint action plan has not been produced or has not been agreed at a senior level by the participating agencies. The plan has not been corporately adopted and signed off. Consideration has not been given to including the family's issues and suggested solutions within the action plan and it would have been beneficial to do so.
	The plan is outcome focussed and includes actions to disseminate good practice as well address areas for improvement. Robust arrangements are in place to monitor progress and evaluate the impact of actions taken. Timescales for implementation are clear and the appropriate lead has been identified. Actions included in the Action Plan are SMART.	The plan is not outcome focused and does not include any actions to disseminate good practice or address areas for improvement. Arrangements put in place to monitor progress and evaluate actions are not robust. The Action plan is unclear about the timescales involved and there are no clear leads for the actions. Actions included in the Action Plan are not SMART.

Executive summary	An executive summary is completed and includes succinct information about the review process, lessons learned from the case, recommendations made and the timescales for implementations.	The executive summary is incomplete or does not include succinct information about the review process, lessons learned case or recommendations made and the timescales for implementation.
	The summary is suitably anonymised to protect the identity of the victim, perpetrator and family members.	The summary is not suitably anonymised.
Completed report	The completed overview report and supporting documentation is sent to the Home Office for quality assurance within the agreed timeframe. Prior to sending the final review to the Home Office, and where possible, a completed version of the review was provided to the family to allow consideration of the other findings and recommendations and to record any areas of disagreement.	The completed report and supporting documentation is not sent to the Home Office for quality assurance within the agreed timeframe. Prior to sending the final review to the Home Office, a completed version of the review was not provided to the family and reasons for this were not evidenced in the final overview report.
The statutory Guidance for the Conduct of Domestic Homicide Reviews	The persons participating in the review have had adequate regard to the guidance, as set out in section 9(3).	The persons participating in the review have not had adequate regard to the guidance, as set out in section 9(3).
Publication	The report is not published until permission to do so has been given by the Home Office Quality Assurance Panel.	The report is published without prior agreement from the Home Office Quality Assurance Panel.
	All elements of the report have been suitably anonymised before publication.	The report has not been suitably anonymised before publication.

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