Appendix 3

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Re: Domestic Homicide Reviews

This report deals with the response from the Metropolitan Police Service (MPS) relating to the consultation paper published by the Home Office entitled 'Guidance for Domestic Homicide Reviews under Section 9 of the Domestic Violence, Crime and Victims Act 2004'.
The paper contains a number of questions at the end of each section, my intention is to respond with the collective views of those who are either currently or have been involved in the MPS Domestic Violence Murder Review. This group is a Multi – Agency Strategic Group who oversees local Borough reviews and ensures that recommendations are implemented at a local, pan London or National level.
This report mirrors the format of the consultation document in respect of the sections and questions asked and assumes that the Consultation Document has been read.

Under Section 9(1) of the Act a domestic homicide review is defined as 'a review of the circumstances into the death of a person aged 16 years or over'. It should be noted that a review of a person up to the age of 18 years would be dealt with under a Chapter 8 SCR, the definition of which is contained within Sect. 9. This highlights the possibility of two reviews into a person aged between 16 – 18 years and would pose the question as to which one would take preference.
It is therefore suggested that the age limit within this definition should refer to those aged 18 years and over.

Style and Definition of Reviews

Question 1 – What format do you think would be appropriate for domestic homicide reviews? Though they have commonality with the SCRs, are there any issues that may arise if this process and style is adopted.

Answer – There must be a standard process and format for reviews and reports. They should be similar in style to Chapter 8 SCRs as shown in the Working Together To Safeguard Children recommendation published in the 1999 Dept of Health Act, re-published more recently in 2006.
There should be a Central team who coordinate and complete the process made up of personnel being far enough removed from the case as to make them independent.
All parties must be fully engaged in the process and action plans must contain meaningful, achievable recommendations that should be well thought out, specific and constructive.

Question 2 – A process for deciding when a review should take place is needed. What procedure can be used to ensure that the process is effective and who should take that decision?

Answer – When a Domestic Violence Homicide is identified the details should be forwarded to the elected body that will make a decision as to whether to commission a review. The responsibility to review or not should rest with this group; their decision will be made on the individual facts of a case and would only be effective if each statutory partner agency was represented, as per the Consultative Document.

Question 3 – What are your views on the possibility of holding reviews before the outcome of any legal proceedings or investigation? Do we adopt the same procedures as the SCRs and decide on a case – by - case basis?

Answer – The review should be allowed to go ahead at the same time as the investigation but it should be borne in mind that no action should be taken that might compromise the investigation. This will enable the review to ensure identified mistakes or learning can be acted upon at the earliest opportunity.
The guidance is inadequate on the subject of the status of review reports in respect of disclosure and Freedom of Information Act access. Families and the media will want access to reports. If the review is to be disclosed then this will affect the way they are written and concluded.
The Review Document is non - disclosable as it is an internal document. If the review runs alongside an investigation anything that appears to be disclosable must be brought to the attention of the SIO who will take this forward.

Which Body should take the lead responsibility for instigating the review?

Question 5 – How effective would CDRPs or equivalents be in taking the lead responsibility for reviews and are there any other agencies/partnerships that could do this?

Answer – CDRPs are the right format for taking the lead responsibility. They are enshrined by legislation and would be able to control the activity of the case. At the moment they fund the majority of Non-Government Organisations. The group consist of senior post holders within their organisations are at the appropriate level of authority to 'make things happen'.
MAPPA is another agency that could be considered for this role, but it is questionable whether they have sufficient senior authority to ensure that changes and recommendations are carried out.

Question 6 – Are CDRPs or equivalent in two - tier authority areas with responsibility for education and social services the only bodies that could conduct reviews?

Answer - It is difficult to imagine any other body undertaking such a role except to say that the review oversight panels could be built around MAPPAs rather than CDRPs.

Question 7 – How can local areas incorporate quality assurance steps into the review process and who should advise on quality assurance assessment of reviews?

Answer – Any person carrying out a quality assurance process should be independent and at least twice removed from the investigation. All agencies should have their own quality assurance facility.
The length and quality of SCRs vary greatly around the country. Copies of SCRs are sent to an Inspectorate so at least there is some interface with an inspectoral body. In the consultative document it states that a copy of the report should be sent to the relevant government department.
Recommendations arising from the reports should be aimed at three levels, **local, national and legislative.**
Where local, the report should be sent to a local Strategic Murder Review Panel made up of Chief Executives from each of the agencies that should discuss the recommendations and oversee the implementation.
Where the recommendations are set at national and legislative level, they should go to a new specially formed Domestic Violence Forum within the Home Office. Their role should be judgemental of the final report and oversee the implementation of recommendations.

Determining the scope of the review

Question 9 – What other factors need to be considered?

Answer – The lead body should identify a multi-agency SCR team made up of senior personnel from all agencies with the ability to review, write the reports, and make decisions on behalf of their agencies. The lead body also needs to set the 'Terms of Reference' the scope of the review and to set the time scales.
Other factors to be considered should include how to involve other professionals, and who makes the link with interested parties from outside the main statutory agencies.
Consider procedures for obtaining relevant records from other countries especially in light of the increased immigration to the UK and the feasibility of using information from databases such as Europol.

Question 11 – Views on the proposal of a maximum duration of 3 months for a review?

Answer – It is important to conclude reviews as soon as possible in order that issues or learning is circulated without hesitation. However, a time scale of three months for a Multi-Agency Review is considered too ambitious, as it often takes as long for a single agency to complete. Chapter 8 SCRs are given 3 months to complete which can be extended because of the nature of the review however, completion within those 3 months is rarely achieved.
It is recommended that the time period be extended to 6 months but a caveat be included that allows reviewers to extend this time period for good, documented reasons.
See also 'Costs' question 22.

Individual Agencies Management Reviews

Question 13 – Are there any other areas that could be included here, and are the questions outlined relevant?

Answer – There must be supervision of all recommendations to ensure they are implemented and a decision should be made as to who the report and executive summary of the CDRP or other identified body is sent to. Already within this report it is suggested that a Home Office Department be formed to deal with this.

A document produced by Laura RICHARDS of the MPS titled 'Multi-agency Domestic Violence Murder Reviews in London' recorded within many of the review reports that some agencies are sceptical of the aims and objectives of multi-agency murder reviews, which has had an impact on the effectiveness of the process. Some agencies voice concern about creating a blame culture and took legal advice concerning participation. Agencies who did seek legal advice were told not to participate due to the potential detrimental effect it might have possibly culminating in litigation if an agency had prior contact with the family and had not dealt with it according to their policy.

There must be the right balance struck between bringing people to account and finding out what happened. Whilst the consultation paper leans toward the importance of not blaming agencies, the message within is not clear. In other organisations (aviation, nuclear fuels) they have learnt that not blaming and shaming individuals is the best way to gather comprehensive information, and to correct mistakes or improve communications and coordination. The consultation paper however, is a little ambiguous on these matters for example: under para. 4.2 of this section there is the recommendation to avoid focusing on individual practice or any attribution of blame. Then just a few lines down under para.4.4 it states that - Agencies' reviews are not part of a disciplinary enquiry but information that emerges in the course of the reviews may indicate that disciplinary action should be taken under established procedures. Such a position may affect the flow of information from rank and file professionals of all kind. Staff are sometimes not as open/forthcoming about events where there is the threat of misconduct proceedings in the background.

The final document should make clear that it should be a no blame culture, however it should also indicate that if the gross negligence is so bad it must be dealt with.

Family Involvement

Question 15 - Are there any areas not covered that you think would be helpful?

Answer – Partial inclusion of the family should be considered where there is initial doubt as to the facts of the case. Overall however in order to get the right information and to reassure the families that a fair and proper process is being undertaken, it is recommended that they should be included as much as possible.

If there is a need to exclude families from the process, it should be properly documented e.g. might harm the investigation.
If a family is excluded from all or part of the process, consideration should be given to allowing a legal/family representative to be present. Experience shows that representatives can be very helpful and can in many cases absorb some of the anger and frustration that might otherwise be directed at the police/agencies.
In Chapter 8 SCRs, consideration is made as to whether or not the family are consulted. Normally the family is informed in writing to make them aware a review is being conducted and they are asked if they wish to comment on the service they received from any agency leading up to the incident.
Consideration should also be given to deploying Family Liaison Officers to the victim/suspect family always having regard to disclosure issues.

Media Involvement

Great care is needed with any ongoing investigation in respect of information to be disclosed which one would not normally wish to see in the public domain. Any media strategy **must** be a consensus and needs to be coordinated by the chairperson.
A single point of contact media representative should be appointed in all cases.

Expert Advisors/Witnesses

Question 18 – Do you have any views or comments on the appointment and use of expert advisors/witnesses?

Answer – The consultation document uses the term of expert advisors/witnesses. This response suggests that the term used should be: expert witnesses/independent consultants.
There is no definitive legal definition of an expert. It is a matter for the Court to rule upon in each case (Chapter 36 CPS Disclosure Manual). However, for the purpose of usage within criminal Law an expert is defined as: -
'A person whose evidence is intended to be tendered before a Court and who has relevant skills or knowledge achieved through research, experience or professional application within a specific field sufficient to entitle them to give evidence of their opinion and upon which the Court may require independent, impartial assistance'.
Considering the definition, it is questionable whether such a person would get involved in a Domestic Violence Review where evidence relating to the criminal offence is not examined.
In Chapter 8 SCRs, an independent consultant with relevant skills is used to collate reports from participating agencies then produce the final report together with recommendations. This could be mirrored in DV Homicide Reviews.
Consideration should also be given to setting up a centrally held skills register of Independent Consultants.

Question 20 – What other factors should be taken into consideration during the process of the review?

Answer – The review process should be about learning and justice for those who have been let down by the authorities. The review should not be just a 'paper review' but should be one of 'consulting and speaking to people'. This must involve the review team leaving their offices and speaking to Senior Investigating Officers, Borough Commanders and agencies.
The review must always link in with the criminal investigation (SIO/CPS) at an early stage in respect of disclosure issues and the Freedom of Information Act.

Costs

Question 22 – What are the issues that may arise following this protocol and do you have any suggestions on how costs may be met?

Answer - Although the proposed review unit will initially not have an overwhelming amount of work to deal with their workload will increase with the expansion of its terms of reference and parameters.
There is no funding provided to agencies to carry out these reviews. It is suggested that such costs should be absorbed into the daily working routines of the relevant agencies. This is at a time when all agencies are being told to cut costs and the MPS to identify significant budget reductions over the next 3 years. If the review process is inadequately funded it will be less likely that it will achieve its purposes; the quality of the reviews will inevitably be affected.
With the recommendation that external independent consultants are paid to integrate the single agency internal management reviews into the combined review report, such consultants would be costly and would impact significantly on any budget.
The first response should be that government use central funds as this is the only realistic proposition. Thereafter, then there should be further consultation seeking alternative funding.
If agreed that costing was obtained through government funding, this might be aligned to time scales, e.g. funding made available if the review process was completed within the agreed time scale.

Producing the Final Report

Question 23 – Do you have any views on how the report should be made available – full report or executive summary and recommendations etc?

Answer – The style of the report should be along the same lines as a Chapter 8.
The Serious Case Review Group elected by the lead body to carry out the review should have responsibility for completing the final report and executive summary together with recommendations. The final report should be non-attributable and sent to the relevant lead body for agreement and to sanction the report and recommendations.

Careful consideration should be given to the method for spreading learning and understanding obtained from the reviews. These should be monitored and circulated by the proposed government department.

At the end of each section within the consultative document is the question: -

‘What are the equality and diversity impact issues that should be considered under this section’?

This is at questions 8-10-12-14-16-17-19-21 and 24. In all sections such issues would have to be considered on a case-by-case basis, including taking into consideration issues such as elder abuse, disability and same sex relationships. In fact, the whole issue around ‘families’ can be quite complex e.g. biological families and chosen families.