How have the findings from Domestic Homicide Reviews in England and Wales from 2017 to 2019 impacted professional practice?

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ABSTRACT

Domestic Homicide Reviews (DHRs) have been conducted in England and Wales since 2011. Local authority Community Safety Partnerships (CSP) are responsible for conducting DHRs, which aim to identify lessons regarding how local professionals and organisations work individually and collectively to safeguard victims, identify where practice should change or improve as a result of these lessons, and apply these lessons and prevent domestic homicide. This research reviewed a sample of fourteen DHRs conducted by CSPs in Cleveland and Greater Manchester, between 2017 and 2019, to identify evidence and examples of how DHRs have impacted professional practice. Practice across policing, health care, social care, probation was considered, as well as examples across the social housing sector, in the education setting and fertility treatment providers. National recommendations and recommendations at the Home Office in DHRs were also reviewed. Themes highlighted in these DHRs included training and awareness raising, information sharing and partnership working. The research could not conclusively identify any evidence or examples of policy or practice improvement as a direct result of DHRs. The research did identify improved practice through independent governance and also highlighted that in many cases, DHRs would benefit from a more coherent national approach. The research also provides quantitative results and concludes that women are disproportionally the victims of domestic homicide at the hands of men. Recommendations are made in respect of improving coherency of domestic abuse prevention and responses across public sectors, and creating a single repository for DHRs to improve learning, research, professional practice and sharing, nationally and internationally.

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2. LIST OF ACRONYMS

ANI (Ask for ANI)	Action Needed Immediately
APP	Authorised Professional Practice
BiDAS	Bolton integrated Drug and Alcohol Service
CJA 2003	Criminal Justice Act 2003
CJS	Criminal Justice System
CSP	Community Safety Partnership
DASH RIC	Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification Checklist.
DHR	Domestic Homicide Review
DVDS	Domestic Violence Disclosure Scheme
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Protection Order
DWP	Department for Work and Pensions
FOI	Freedom of Information
HFEA	Human Fertility and Embryo Authority
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services

HMPPS	Her Majesty's Prison & Probation Service
IDVA	Independent Domestic Violence Advisor
IPF	Intimate Partner Femicide
IRIS	Identification and Referral to Improve Safety
LGBT+	Lesbian, Gay, Bisexual & Transgender +
MAPPA	Multi-Agency Public Protection Arrangements
MAPPS	Multi-Agency Public Protection System
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MHA 1983	Mental Health Act 1983
MHHR	Mental Health Homicide Review
NHS	National Health Service
ONS	Office for National Statistics
PCSO	Police Community Support Officer
PDP	Potentially Dangerous Persons
PEEL	Police Effectiveness, Efficiency and Legitimacy
UNODC	United Nations Office for Drugs and Crime

3. ACKNOWLEDGEMENTS

Every story in the Domestic Homicide Reviews included in this research offers an opportunity to learn, improve practice, training and understanding of the dynamics of abuse and control; ultimately, they present the opportunity to prevent further tragic deaths. They also allow us the opportunity to remember and pay tribute to all the victims, whose lives have been taken by those who should have protected them from harm. To Annie, Jessica, Jean, Annie, Michelle, Sarah, Jenny, Shawn, Niki, James, Catherine, Ethel, Olivia and Susan [pseudonyms], you all remain in my thoughts. My deepest condolences to their families, friends, colleagues, and those that have been touched by their heart-breaking loss'.

My sincere respect and gratitude to all the professionals, campaigners and survivors that work tirelessly and selflessly, often and unknowingly, saving lives each day.

4. INTRODUCTION

''A Domestic Homicide Review should be comprehensive, collaborative and blame free activity to learn from the past and make the future safer'' (Frank Mullane, Advocacy After Fatal Domestic Abuse).

According to the Office for National Statistics (ONS), over the last ten years, there was an average of eighty female victims, aged sixteen and over, a year killed by a partner or ex-partner. In contrast, over the same period, an average of twelve male victims, aged sixteen years and over, a year were killed by a partner or ex-partner. However, the number of female domestic homicides in 2019 (n = 81), was the lowest figure since relationship data has been collected on the Homicide Index in 1977; this figure is inclusive of domestic homicide perpetrated by partners and ex-partners, and other familial relationships (i.e., son/daughter, parent and other family members). The number of female victims killed by a partner or ex-partner in 2019 was sixty-one (ONS, 2021); this figure represents a twenty-four percent (n = 19) decrease from the ten-year average. Homicides are most likely to take place in or around a house or dwelling or residential home; the number of victims killed in this setting has been largely consistent over the past ten years (ONS, 2021). This data indicates that learning and improving legislation, policies and professional practice to prevent homicide by intimate and ex-intimate partners must remain an enduring commitment. Domestic Homicide Reviews (DHR) are the principal method to identify, record and disseminate these lessons.

A DHR is a multi-agency review of the circumstances in which the death of a person aged sixteen or over has or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had

been, in an intimate personal relationship, or a member of the same household as themselves (Home Office, 2016). DHRs are a vital source of information to inform national and local 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 (Home Office, 2016).

Chantler, et al. (2019) posit that the biggest single risk factor for domestic homicide victimisation is gender, as the majority of domestic homicide victims are women. According to the United Nations Office for Drugs and Crime (UNODC), women comprise eighty-two percent of victims of intimate partner homicide, with men the majority of killers (Monckton Smith, 2021). Figures of women who kill their male partners are much lower, and homicides in LGBT+ relationships are dominated by male perpetrators (Monckton Smith, 2021).

The Femicide Census outlined that between 2009 and 2018, in the UK, a woman was killed by a male partner or ex-partner every four days, with no sign of reduction over this ten-year period (Long, et al, 2020). Research conducted by Bridger, et al. (2017) found that intimate partner homicide cannot be predicted from police records alone and that assessment techniques require, at minimum, that prior abuse (before homicide) become known to professionals. Monckton Smith (2019) conducted research around intimate partner femicide (IPF), which identified that coercive control was the dominant discourse in IPF and organises the perpetrator’s journey into eight steps to homicide. This research shows that IPF is predictable through analysis of the perpetrator’s patterns of behaviours, and therefore opportunities for intervention can be identified to prevent homicide. Monckton Smith (2019) explains

that the coercive control discourse is resistant to the ideology that violence alone is the most significant predictive risk factor or that IPF is spontaneous and situational; it is therefore the motive of the perpetrator, to maintain their perceived entitlement of power and control over the victim that is central to understanding risk (Monckton Smith, 2019). However, the Standing Together Report: Domestic Homicide Review Case Analysis, found that lack of understanding around the risks of non-physical coercive controlling behaviour has meant that some domestic abuse cases assessed at standard and medium risk did not reach the threshold for intervention by agencies (Sharp-Jeffs and Kelly, 2016). These narratives highlight the requirement for a greater understanding of risk identification and risk assessment; this is supported in the Home Office report Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews (2016), which found that a lack of training amongst professionals was consistently the highest proportion of recommendations from DHRs.

The victims of domestic homicides have been silenced by death; it is also unrealistic that a perpetrator will disclose the nature and extent of prior abuse. The Femicide Census informs us that social and family networks can know far more than agencies about the extent of abuse and risk associated with the perpetrator's behaviours (Long, et al, 2020). Therefore, to attempt to understand the journey to homicide, there is a requirement for in-depth analysis of the victim's and perpetrator's history, both individually and shared, through the narratives of friends, families and colleagues, and review of police records, health records, social services records etc (where such records exist). This analysis provides the greatest opportunity for learning and prevention of homicide because it presents the narrative through the eyes of the victim, and their children, which can identify barriers faced to reporting

abuse and learning why intervention did not work, and understanding the context of why professionals made certain decisions (Home Office, 2016).

Since 13 April 2011, there has been a statutory requirement for local areas to conduct a DHR following a domestic homicide. The purpose of a DHR is outlined in the Statutory Guidance (Home Office, 2016), these are;

- To 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.

In any homicide, the Criminal Justice System (CJS) is the means to establish culpability or guilt and bringing offenders to justice. Additionally, there is a requirement for a Coroner's Inquest when a cause of death is unknown, a person might have died a violent or unnatural death, or a person has died in prison or police custody (UK Government, 2021). DHRs are separate from these proceedings, although the outcome of CJS and Coroner's Inquest will likely inform the decision to conduct a DHR. Therefore, the purpose of a DHR is not to establish culpability for the homicide; its aim is to avoid future incidents of domestic homicide and violence.

To initiate a DHR, the relevant police force will inform the Community Safety Partnership (CSP) who will have the responsibility to conduct the DHR (Home Office, 2016). CSPs were set up under Sections 5 – 7 of the Crime and Disorder Act 1998 to work together to protect their local communities; they are made up of representatives from the police, local authorities, fire and rescue authorities, probation services and health authorities (Home Office, 2015).

In December 2016, the Home Office published a report, entitled, Domestic Homicide Reviews: Key findings of analysis from Domestic Homicide Reviews. Analysis was conducted of forty DHRs published between 2013 to 2016 in England and Wales. The report broadly outlined common themes and trends and identified learning that emerged across the sample of DHRs. The purpose of which was to promote key learning and trends from the sample of DHRs with the aim of informing and shaping future policy development and operational practice both locally and nationally (Home Office, 2016).

Extensive research has been undertaken utilising information from DHRs; much of which seeks to identify patterns and trends regarding perpetrator behaviour and public authority responses. However, less research is available which examines how successfully DHR learning has been implemented, if indeed learning has resulted in practice and/or policy improvement, and if similar issues continue to occur after recommendations have been made. Understanding this, assists to understand if the DHR process is valuable and effective in preventing homicide. The ONS reports that there has been a general downward trend in the number of domestic homicides over the last ten years (ONS, 2021), therefore it is probable that learning from DHRs has positively impacted improvement to policies and professional practice, resulting in

better risk identification, risk assessments, intervention and safeguarding. This research sought to identify specific examples where changes to policies and professional practice can be evidenced as a result of lessons learned from DHRs.

5. METHODOLOGY

The methodology approach to this research was through the pragmatic paradigm, using mixed methods to answer the research question. First, a systematic review of a sample of DHRs was required to inform the basis of the research. Additionally, relevant Government publications, national and local policy relating to relevant issues identified in the DHRs, and existing literature on the subject of domestic homicide reviews were examined. Where DHRs provided findings and recommendations in respect of single agency policy and/or practice improvement, requests under the Freedom of Information Act 2000 were submitted to measure the application of these recommendations. Research results are primarily qualitative results, however relevant quantitative data was recorded to provide a breakdown of victim and perpetrator gender, and to categorise recommendations into relevant sub-themes, i.e., policing, health care, social care, probation, national policy and legislation, and 'other'. Ethical approval was sought prior to conducting this research; the ethics approval form is at Appendix C.

To select DHRs for analysis, it was established through a Freedom of Information (FOI) request (Freedom of Information Act, 2000) submitted to the Home Office that between 1 January 2017 and 31 December 2019, 294 DHRs were heard by the Quality Assurance Panel; this is an expert panel made up of statutory and voluntary sector agencies and managed by the Home Office. All completed DHRs are submitted to the Home Office and are assessed by the panel (Home Office, 2016). The Home Office does not collect data on the number of DHRs conducted in police forces areas in England and Wales, and therefore were unable to provide a breakdown of how many DHRs were conducted within each police force area, or which police force area conducted the most DHRs over the prescribed period. The

Home Office were also unable to provide data regarding how many CSPs there are in total in England and Wales, and therefore how many DHRs each CSP conducted over the specified period. The researcher was therefore unable to identify which police force areas and CSPs might present the broadest opportunity for analysis from this request. Examination of the Femicide Census (Long et al, 2020) identified that between 2015 to 2018, the two UK police force areas that recorded the highest average annual rate of femicide per 100,00 population were; Cleveland ($n = 0.336$) and Greater Manchester ($n = 0.320$). Therefore, the researcher considered that selecting DHRs conducted in these police forces areas presented an opportunity for a diverse portfolio for analysis. FOI requests were submitted to the Police and Crime Commissioners for each of these police forces. These FOIs provided an accurate breakdown of the number of CSPs in each area.

- Cleveland has four CSPs which are delivered by four local authorities, these are; Hartlepool Borough Council, Middlesbrough Council, Redcar & Cleveland Borough Council and Stockton Borough Council.
- Greater Manchester has ten CSPs which are delivered by ten local authorities, these are; Bolton Council, Bury Council, Manchester City Council, Oldham Council, Rochdale Council, Salford City Council, Stockport Council, Tameside Metropolitan Borough Council, Trafford Council and Wigan Council.

FOI requests were submitted to each of these fourteen local authorities, which established that collectively, thirty DHRs were conducted between 1 January 2017 and 31 December 2019, these are broken down as follows;

- Hartlepool Borough Council CSP – One DHR conducted.

- Middlesbrough Council CSP – Four DHRs conducted. One was not relating to intimate partner homicide and one was exempt from disclosure under Section 22 of the Freedom of Information Act.
- Redcar & Cleveland Borough Council CSP – Two DHRs conducted. One DHR was exempt from disclosure under Section 22 of the Freedom of Information Act.
- Stockton Borough Council CSP – No DHRs conducted.
- Bolton Council CSP– One DHR conducted.
- Bury Council CSP– One DHR was conducted, however, Bury Council explained that DHRs are only available on their website for one year after publication. The DHR conducted is no longer available on their website and therefore could not be accessed by the researcher.
- Manchester City Council CSP – Six DHRs conducted. Two DHRs were not relating to intimate partner homicide. One DHR was a joint DHR with Salford City Council (noted below).
- Oldham Council CSP – Two DHRs conducted.
- Rochdale Council CSP– Five DHRs were conducted, however, only three were available online and therefore two DHRs could not be accessed by the researcher. One DHR was not relating to intimate partner homicide. The three available DHRs were analysed, however, one was later removed from the website; therefore, the data gathered has been used in this research, however, the content was not analysed further.
- Salford City Council CSP – Four DHRs conducted. One of these DHRs was a joint DHR with Manchester City Council (noted above). Tree DHRs were exempt from disclosure under Section 22 of the Freedom of Information Act.

- Stockport Council CSP – Two DHRs were conducted; one DHR was exempt from disclosure under Section 22 of the Freedom of Information Act and one DHR was not relating to intimate partner homicide.
- Tameside Metropolitan Borough Council CSP – Two DHRs conducted, however, these were both exempt from disclosure under Section 22 of the Freedom of Information Act.
- Trafford Council CSP – No DHRs conducted.
- Wigan Council CSP – One DHR conducted.

Only domestic homicides that were perpetrated within an intimate partner relationship (including ex-intimate partner homicide) were included in the research, rather than the familial or other domestic arrangements; the same criteria were applied in the Home Office research in order to avoid conflating issues within the findings (Home Office, 2016). No other criteria were applied; therefore, all genders of victims and perpetrators are included in this research. However, the genders of the perpetrator and victim were noted from each DHR to provide a representation in the data. After DHRs not relating to intimate partner homicide (n = 5) those exempt from disclosure under Section 22 of the Freedom of Information Act (n = 8) and DHRs not available online (n = 3) were discounted from the sample, fourteen DHRs were included for research; this represents five percent of DHRs conducted in England and Wales over the prescribed period. The DHRs were accessible through CSP websites.

The relevant CSPs were allocated a group; A to H. Each DHR was numbered in their respective group; A1, B1 to B2, C1, D1, E1 to E4, F1 to F2, G1 to G2 and H1; a full breakdown is at Appendix A. The DHR Chair will ordinarily assign pseudonyms, with

the permission of the victim’s family. Pseudonyms given to victims in the DHRs are also listed and included in the narrative of the research findings accordingly. Every DHR was read in its entirety in order to fully understand the circumstances, context and significance in which lessons were identified and subsequent recommendations were made. Recommendations recorded in each DHR were broadly placed into two categories by the researcher. The first category, recommendations assigned to the CSP concerning assurance of existing policy and practice, awareness raising and training in the local community; the outcome of these recommendations is difficult to measure because they do not necessarily place actions on individual organisations or are they explicit in the desired outcome, therefore, the researcher did not examine the implementation of these recommendations as it was concluded that they would provide little evidence of improvement in policy or practice across England and Wales. The second category, recommendations assigned to specific organisations, in respect of policy, practice or training etc; these provided the researcher with a much greater opportunity to follow up on the recommendations made and understand how they have been implemented to improve professional practice across England and Wales.

Recommendations recorded from each DHR were recorded in a table (Appendix B). FOI requests were submitted to each agency responsible for taking action against recommendations, these agencies included; the Home Office, Cleveland Police, Greater Manchester Police, Lancashire Constabulary, Her Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), National Health Service (NHS), The Human Fertility and Embryo Authority (HFEA), Her Majesty’s Prison & Probation Service (HMPPS) (formerly the National Probation Service), Department

for Work and Pensions, North West Ambulance Service, Manchester City Council Children's and Education Directorate and local housing providers.

6. RESEARCH FINDINGS

In the fourteen DHRs analysed (Appendix A), eighty-six percent (n = 12) involved a female victim; all of these homicides were committed by a male perpetrator. Female perpetrators were responsible for the homicides of the two male victims. No same-sex relationships were identified in this sample.

From the fourteen DHRs analysed, 204 recommendations were recorded. Sixty-six of these were placed on local CSPs and therefore were not analysed further. There were 138 recommendations were placed on individual organisations which were included for analysis. In total, twenty-six FOI responses were received, which provided responses to the questions asked relating to eighty-eight recommendations. A full breakdown of the recommendations and responses is provided at Appendix B.

6.1 Policing

In total, thirty-five recommendations were made at Police Forces; Cleveland Police, Greater Manchester Police and Lancashire Constabulary. This represented twenty-five percent of all recommendations from the sample analysed. Responses were received in relation to twenty-two of these recommendations.

The first DHR examined related to the murder of Annie R (A1). This DHR made four recommendations to Cleveland Police. In this DHR, there was believed to be a long history of abuse by the perpetrator. The relationship between Annie and the perpetrator began in 2006 and a year later the couple had their first child; a second child followed in 2010, and a third child in 2016. The first reference to domestic abuse is documented by Children's Services in 2007 but the case was closed in

2008. The only documented report by the victim to the police was in 2012, where the perpetrator received a caution for common assault. There is a long-documented history of the perpetrator's access to mental health provision, self-harm and attempted suicide throughout the relationship. In 2014, the perpetrator disclosed to a social worker that he has access to a shotgun; the social worker disclosed this information to Annie and to the police, who investigated this claim and found no evidence to substantiate it. The perpetrator later claimed that this was a throw-away comment. In May 2017, Annie attended a medical facility with the youngest child who has sustained a puncture wound to the face, caused by the perpetrator discharging an air rifle in the kitchen and causing a foreign body to ricochet and hit the child's face. The perpetrator was arrested for alleged assault and the children were placed with family members under safeguarding arrangements and were later placed into foster care. During this investigation, Annie's brother disclosed to the police that Annie had experienced prolonged emotional and physical abuse from the perpetrator. Following this, there is extensive documented evidence of the perpetrators' access to mental health services, where serious concerns resulted in a referral to Cleveland Police in October 2017 for review and management under Potentially Dangerous Persons (PDP) protocols (further information regarding PDP protocols is at section 6.5, page 37). Following this, the Multi-Agency Public Protection Arrangements (MAPPA) co-ordinator was consulted and recommended a multi-agency meeting for information sharing and in order to agree on safeguarding arrangements, however, the meeting never took place. MAPPA is designed to ensure the successful management of violent and sexual offenders (UK Government, 2014). Cleveland Police discussed the perpetrator at the Force Tasking and Co-ordination meeting in December 2017, where it was agreed that the

Detective Inspector Child Abuse Investigation Unit (DI CAU) would manage the risk. The Force Tasking and Co-ordinating meeting process enables police senior managers to consider and agree on tactical options and align resources to priorities (College of Policing APP, 2015). The perpetrator was reviewed at the next meeting in February 2018, where no update on actions was given; the decision was that the DI CAU would continue to manage the risk. Also relevant at this time, Care Orders were obtained for all three children in January 2018. On 3 August 2018, the perpetrator murdered Annie. The DHR concluded that the investigation conducted by Cleveland Police primarily focussed on the vulnerability of the children, and there were missed opportunities by Cleveland Police related to their understanding around the vulnerability of Annie. The resulting four recommendations were focussed around the review of domestic abuse training for officers and staff to effectively encompass and address the hidden signs of domestic abuse, recording of decision-making rationale for prioritisation of investigations, governance and oversight of investigations, and engagement with partner agencies, in particular HMPPS, in reviewing multi-agency knowledge and where appropriate involvement in the identification and management of a PDP. Cleveland Police responded to the researcher that they had embarked on a force-wide training programme with regards to domestic abuse and intends on training all operational officers and staff. The force has invested in the Safe Lives Domestic Abuse Matters (Safe Lives, 2018) training programme which has seen over 800 officers currently trained and sixty Domestic Abuse Specialist Champions. The champions work in all disciplines throughout the organisation and will receive continued professional development in areas of domestic abuse and will cascade to the wider force. Cleveland Police have reviewed its crime allocation policy, in addition, it has updated its supervisor's crime

management procedures which clearly outline supervisor responsibilities and times scales for review. The force has also invested in raising investigative standards for all officers and staff this has included interactive magazines and College of Policing training packages, along with toolkits, and aide-memoirs. Cleveland Police has reviewed and updated its PDP policy in line with Authorised Professional Practice (APP).

In the DHR relating to the murder of Jean (B2), eight recommendations were made to Cleveland Police. In this DHR, there is documented history of Jean in abusive relationships. The first relationship was for eleven years (from when Jean was thirteen years old); Jean had three children with this abuser, who were all placed with the victim's parents to bring them up following intervention of Children's Social Care. Between 2012 and 2016, there were no reports of domestic abuse involving Jean, who had during this time formed a new relationship with another abuser; the couple had two children. However, in 2017, Cleveland Police started to receive reports of domestic abuse involving Jean and this abuser; there were nine reports up until June 2018 of assaults, criminal damage and theft. There were also reports of drug and alcohol misuse, which led to Children's Social Care intervention, and both children were permanently removed and placed outside the family. Very soon after this relationship broke down, Jean formed a new relationship in June 2018; this time with the perpetrator of her murder. The perpetrator's criminal history documents a previous abusive relationship from 2012 to 2013; eight incidents of domestic abuse are recorded against this former partner, who obtained a non-molestation order against the perpetrator. In 2014, the perpetrator was sentenced to six years imprisonment for a range of violent offences including robbery. Whilst he was in prison, another victim obtained a restraining order against the perpetrator in relation

to an allegation of sexual assault. The perpetrator was released from prison on licence under National Probation Service supervision in August 2017. The licence was due to expire on the 24 August 2020. Between leaving prison in August 2017 and forming a relationship with Jean in June 2018, the perpetrator is known to have had relationships with two other women, who both complained to the police regarding domestic abuse. It is believed that the perpetrator moved into Jean's home within days and the relationship became abusive within the first few weeks. The first recorded instance of domestic abuse was on 7 July 2018, when a third party, concerned for Jean's safety called the police. Over the following months, there were six reports of domestic abuse. In one of these incidents, police attempted to contact Jean in person at the address and via phone, documenting unsuccessful attempts. Some days later, police called again, and the perpetrator answered the phone, who said Jean was not there and would pass a message on. Following a supervisor review, an officer was directed to attend the address again as a priority. The perpetrator was not believed to be in the house and Jean denied calling the police and she refused to conduct a Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment. DASH risk assessments are used by professionals and aim to provide a uniform understanding of risk; there is a specific police version of the risk checklist, which is used by most police forces in England and Wales (Safe Lives, 2021). Following review, the case was referred to Multi-Agency Risk Assessment Conference (MARAC) due to the volume of domestic incidents in a short relationship. A MARAC is a meeting where information is shared on high-risk domestic abuse cases between representatives, including, police, health care professionals, child protection professionals, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the

statutory and voluntary sectors (Safe Lives, 2021). One evening in October 2018, the couple went out together and the perpetrator bought alcohol, cannabis and diazepam. They returned home and spent the rest of the evening in the house. The following morning the perpetrator telephoned for an ambulance and claimed that he had found Jean injured. Paramedics found that Jean had died and it was clear to them that she had suffered severe injuries. Jean suffered eighty-five blows, but the cause of her death was strangulation. The DHR documents that a referral for disclosure under the Domestic Violence Disclosure Scheme (DVDS), known as Claire's Law (Home Office, 2016) was made following attendance to the first incident in July 2018, however, the request took thirteen weeks to progress, and during this time, several domestic abuse incidents were reported by Jean, but a disclosure was never made. The DVDS sets out procedures that can be used by the police in relation to disclosure of information about previous violent and abusive offending by a potentially violent individual to their partner; where this may help protect them from further violent and abusive offending (Home Office, 2016). Cleveland Police stated the delay in making the disclosure was due to the pressure of work in terms of the volume of disclosures which had to be progressed at that time. The DHR also found that the perpetrator was only arrested once when a witness reported that the perpetrator had assaulted Jean in the street, but Jean did not make a statement. The police officers dealing with the incident did not obtain available evidence, such as witness statements. Further, the interviewing officer did not view the CCTV evidence. It concluded that a poor investigation led to the perpetrator being released quickly without charge. Also, Domestic Violence Protection Notice (DVPN) and subsequent Domestic Violence Protection Order (DVPO) could have been applied for on this and other occasions, but Cleveland Police did not consider this. When the victim did

contact the police to make a complaint on 31 July 2018, she was not seen until five days later on 4 August 2018, and by then she had changed her mind. As such, the eight recommendations to Cleveland Police were focussed around the review of process around the application of Clare's Law disclosures, investigation 'golden hour' actions, training to all operational officers around evidence-led prosecutions, that all domestic abuse crimes should be reviewed by a supervisor prior to closure, training and guidance around the quality of supervisory reviews, domestic abuse policy to be updated in respect to the handling of 'no reply' domestic abuse incident, review of control room management and tasking of domestic incidents, creation of guidance around the ongoing management of domestic abuse investigations where there is a suspect who still needs to be traced. Cleveland Police responded that the request was exempt from disclosure because some of the information is answered in the Integrated vulnerability inspection post-inspection review of Cleveland Police (HMICFRS, 2021). Following this response, the researcher submitted an FOI request to HMICFRS to establish if completed DHRs are shared with HMICFRS and reviewed, and how these are used to understand policing issues to assist inspections. HMICFRS responded that they do not routinely review completed DHRs, as such there is no policy. They stated that within the course of inspection activity for Police Effectiveness, Efficiency and Legitimacy (PEEL) inspections (HMICFRS, 2021), Force Liaison Leads may be referenced by constabulary employees within interviews or focus groups. If the DHR has concluded, then the force representative may discuss the outcomes of the DHR, and activity undertaken or planned within the force to address any linked recommendations. The Force Liaison Lead may review a copy of the DHR dependent on the timescale in which it was completed, and whether it falls within the evidence gathering window for

consideration. In cases where a DHR publication and HMICFRS inspection activity run in parallel but independently, concerns may be noted, and suggestions made for improvement activity being aligned. Many of the improvement themes established with the DHR process are already considered within the PEEL inspection methodology.

Lancashire Constabulary received nine recommendations in the DHR relating to the death of Michelle (D1). The DHR outlined that Michelle's family reported her missing to the police in October 2016; prior to this, they had not been in contact with her for over a year. Michelle had several health issues, including epilepsy, depression and short-term memory loss. She was addicted to heroin was contributed to estrangement from her children and other family. Two of her children were adults at the time of her death, and her youngest child was cared for under a Special Guardianship Order. An indication of a previous domestic abuse relationship was documented in 2011, when Michelle was accessing substance misuse services. Following this, it appears Michelle re-established a relationship with her husband, but he died suddenly in May 2013. After this incident, there is documented history of access to mental health provision and attempted suicides. Michelle began a relationship with the perpetrator who is known to have moved into the address in January 2014. The perpetrator had a significant criminal history, including domestic abuse on two previous partners. Michelle's mother reported her missing on 24 October 2016, following an extended period with no contact from her. Details of Michelle's medical conditions, drugs and alcohol abuse and previous suicide attempts and her mobile phone number were provided to the police. Lancashire Constabulary contacted Greater Manchester Police and requested them to visit a previous address, which was visited by a Police Community Support Officer (PCSO)

on the same day as the report. The perpetrator was at the property, who told the PCSO he had not seen Michelle for about fifteen months and believed she had returned to a previous address. This address was also visited, to no avail. The incident was reviewed by an Inspector who did not class Michelle as 'missing from home'; Lancashire Constabulary has since confirmed that this was an incorrect application of policy by the Inspector. The DHR concluded that it appears that significant weight was attached to the fact that absence of contact with her family was not out of character, and that the reviewing officers do not appear to have considered Michelle's vulnerabilities or the perpetrator's criminal history. Greater Manchester Police visited the perpetrator's address again on 3 November 2016, at the request of Lancashire Constabulary; again, the perpetrator said he had not seen Michelle since June or July 2015. Enquiries continued and the case was reviewed by Senior Detectives in November 2016; this review identified a number of lines of enquiry. In December 2016, a Detective Chief inspector formally recorded that he suspected the perpetrator to be involved in Michelle's disappearance, and was given 'suspect' status in the investigation, with the hypothesis that the perpetrator had killed Michelle or disposed of her body following a drug-related death. Lancashire Constabulary later transferred the case to Greater Manchester Police. On 16 January 2017, Greater Manchester Police executed a search warrant at the perpetrator's address and Michelle's body was discovered in the boiler cupboard. The perpetrator claimed that on 6 October 2015, he and Michelle had taken a substantial amount of drugs and he has woken up in the early hours to find her dead; he panicked and placed her body in the boiler cupboard. The post-mortem indicated that it was a strong possibility that foul play was a factor in Michelle's death as there was evidence of strangulation which may coincide with the time of her death. There was

insufficient evidence to prosecute the perpetrator with Michelle’s murder, but he was prosecuted with preventing the lawful burial of a body and perverting the course of justice in relation to her death. As Michelle’s death appears to have resulted from violence, abuse or neglect, this satisfied the requirement to conduct a DHR, in the absence of a prosecution of murder or manslaughter. The nine recommendations made to Lancashire Constabulary in this DHR were focussed around dealing with Missing persons, such as, ‘Golden hour’ tasks, cross border missing person investigations, information to be gathered in missing persons incidents, training to staff involved in missing persons enquiries, review of procedures in reviewing missing persons enquiries, specialist skills available to officers in missing persons investigations, development of a missing persons management IT solution that assists in the delivery of investigations, and clear ownership of investigations and an officer in the case allocated to the family. Lancashire Constabulary responded to the researcher that they had completed, and implemented where necessary, all the organisational single agency recommendations assigned, however, they did not provide further explanation regarding these recommendations in their response.

6.2 Health Care

The highest number of recommendations were made at Health Care, with thirty-five percent (*n* = 48) of all recommendations in total made to various NHS departments; these are inclusive of national and local recommendations. Responses were received in relation to thirty of these recommendations.

There were seven recommendations made to Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) in a DHR relating to the murder of Annie (A1). In this DHR, the perpetrator had a long-documented history of access to mental health services,

self-harm and attempted suicide, as well as ongoing police investigation in relation to an assault of one of his children. Electronic care records documented an identifiable risk to Annie, their children and professionals, in particular, lone female workers were not permitted to see the perpetrator and professionals were not permitted to attend the home address. However, there were no records to suggest that domestic abuse was discussed in any depth with the perpetrator, or with Annie, or any other agencies involved, despite that the perpetrator had been referred to a domestic abuse perpetrator programme. The recommendations were focussed around domestic abuse training to frontline staff, policy and guidance to staff working with perpetrators, supervision processes, information sharing with other agencies, recording safeguarding concerns and risk assessment processes. TEWV explained to the researcher that in response to these recommendations, a domestic abuse training package was devised and delivered as part of the Trusts Safeguarding Children's mandatory update training, between October 2018 and September 2019, and that domestic abuse continues to feature in all Safeguarding Adults and Children's training and a stand-alone non-mandatory training package for basic awareness of domestic abuse is also available. The Trust also outlined that domestic abuse procedures were updated in December 2020 and a briefing was circulated to managers to share with their team members the learning as a result of the review; the Trusts Intranet was also updated with guidance for Health professionals working with perpetrators of domestic abuse. The Trusts safeguarding Adult and Children's training has also been reviewed to reflect the need for information sharing with the multi-agency network to ensure risks are shared and safeguarding is prioritised. All staff have been made aware of the need to maintain channels of communication with all agencies involved and all safeguarding concerns should be recorded in line with

TEWV processes, policies and procedures. Risk assessment arrangements have also been reviewed. A briefing has been devised to communicate with All Trust staff; this included guidance of record-keeping standards. In addition, reports are produced for the Trust Safeguarding & Public protection subgroup of the board which captures adherence of record keeping. The Trust Safeguarding team is linked in with ongoing work for the new electronic patient records to streamline the recording process. Dip Sampling has been introduced for safeguarding adults' concerns for quality assurance and findings fed into the auditing process. Processes for staff recording safeguarding concerns are also monitored through the Trust Safeguarding and Public protection subgroup. The Trust has reviewed its risk assessment arrangements and their ability to react to dynamic information and intelligence and as a result, the current risk assessment does include current dynamic risks.

NHS England (North) conducted a Mental Health Homicide Review (MHHR) alongside the same DHR (A1). A MHHR is an independent report commissioned by the NHS into homicides that are committed by patients being treated for mental illness. It is done by an independent, expert organisation, which is given access to all the relevant information and reports about the individual patient's care and treatment; they can also request interviews with any NHS staff involved in the case (NHS, 2021). The DHR requested that NHS England share the MHHR report when finalised with the CSP to ensure co-ordination between relevant recommendations. NHS England outlined to the researcher that the Independent Investigation commissioned by NHS England was undertaken in parallel with DHR, to reduce the impact of investigative processes on family members and staff. The resultant independent investigation report was shared with the CSP, the wider NHS and with appropriate professional forums. Further, NHS England commissioned mental health

expertise to assist the Independent DHR Chair and to inform the mental health component of the DHR report, the mental health expert also formed part of the commissioned independent investigative team to ensure that the findings which led to the formulation of recommendations were aligned.

In the DHR following the death of Michelle (D1), whose body was discovered in the perpetrator's boiler cupboard in January 2017, nine separate recommendations were made to Joint Achieve Bolton and Bolton Clinical Commissioning Group. The DHR highlighted that before her death, Michelle was using Bolton Integrated Drug and Alcohol Service (BiDAS), but there appears to be a complete lack of contact between this service and her GP until November 2015; by this time, unknowingly to all concerned, Michelle had already died, about a month previously. BiDAS wrote to her GP to inform them that her case had been closed. Both BiDAS and Michelle's GP recognised that Michelle had vulnerabilities, but their focus was primarily on vulnerabilities associated with her mental health, including previous suicide attempts and her use of illicit and prescription drugs. There appeared to be no consideration of how Michelle might be faring in her most intimate relationship. The DHR also highlighted that research suggests that victims of domestic abuse who misuse substances feel that they are constantly judged and stigmatised by agencies, with false assumptions made (Local Government Association, 2013) and that in Michelle's case, it seems possible that stigma may have been a factor in the lack of professional interest in how Michelle, who had been a victim of domestic abuse, had a history of mental health problems including several suicide attempts and was a substance misuser, was coping in her relationship with the perpetrator, who also had mental health problems, was a substance misuser and was known to be manipulative. As such, the recommendations focussed around the effectiveness of

systems and processes regarding the non-collection of methadone, communications of concerns for health and wellbeing of service users, understanding relationships between individual service users and therefore to understand risk of domestic abuse, improving information sharing with GPs, risk assessments and care planning, and improved partnership working. The response provided by Greater Manchester Mental Health NHS Foundation Trust provided a breakdown of where policies and/or practices regarding these issues could be located, but did not specifically address how the recommendations had been implemented. However, they did outline that following the conclusion of this DHR, a service-wide learning event was held where this incident was discussed, and all were made aware of the recommendations. Further that domestic violence is covered as part of clinical risk training and is part of the assessment and review process. Achieve Consultant Addiction Psychiatrist has engaged with Bolton GPs with training provided and this has contributed to improved communication. Achieve Bolton regularly ensure GPs are aware of how to make contact with the service. BiDAS was replaced by Achieve Bolton, who sub-contract The Big Life Group to undertake an assertive outreach function. There is a shared electronic record system, incident reporting system and staff are co-located. Assertive Outreach includes home visits and welfare checks, which would have included Michelle, had this model been operational at the time of this incident. They outlined that Michelle's murder pre-dated the GMMH contract and the model in place now would mitigate for many of the shortfalls highlighted.

The same DHR (D1), made eight separate recommendations to Bolton Clinical Commissioning Group. The DHR documents that GPs are expected to take the opportunity to sensitively ask questions about domestic abuse, but it appears that Michelle's GP never took this opportunity. It was also identified that Michelle's GP

practice was unaware of the Identification and Referral to Improve Safety (IRIS) practice. IRIS is a general practice domestic abuse training and referral programme, evaluation of which indicates a substantially increased likelihood of victims having discussions about domestic abuse with their GP and being referred for support. The recommendations to Bolton Clinical Commissioning Group focussed around; a more robust additional system for messages to be transmitted between the pharmacy and substance misuse services, assurance from providers as to the immediate response to a patient disclosing recent suicide attempts and suicidal ideation, GP practices should consider the benefits of obtaining more medical, psychological and social information when patients register with their service, GP and clinical practice staff to enquire regarding suicidal ideation self-harm and risk of harm to self at every contact regarding mental health, GP practices to encourage all members of a household to register with the same GP practice, practices to have a repeat prescribing policy which indicates the frequency of medication review for certain conditions, where a patient fails to attend for their methadone there should be a liaison between providers to agree a plan of action to ensure the patient is safe and on-going prescribing is appropriate, and GP practices to continue to engage with the IRIS programme and enquire regarding domestic abuse when appropriate. Bolton Clinical Commissioning Group responded to the recommendations but did not outline any improved policy or practice. They outlined that they shared and discussed the findings from the DHR and with the Local Authority and NHS England, and that the Greater Manchester Care Record enables the GP record to be shared with community pharmacies where appropriate. The Safeguarding Team seek assurance as the lead commissioner within the NHS safeguarding contractual standards annually. GPs would consider obtaining more medical, psychological and social

information on the first consultation and apply as appropriate but it is not a pre-requisite or a requirement of registration. Suicidal ideation self-harm is considered at every consult as part of an ongoing risk assessment, but there are times when this may not be appropriate and may not be beneficial to the consultation; the individual practitioner will make this call, in line with their GP training in such conditions. Registration of households with the same GP practice is down to individual choice and convenience and there may well be justifiable reasons for registering with a different Practice to others in the household. GP's all have a repeat prescribing policy and the frequency of medication reviews will be guided by the BNF or shared care arrangements with providers; the vulnerability of the patient is often very complex and not dependent on Methadone alone. In respect of a patient failing to attend for their Methadone, Community Pharmacies will contact the Provider who in turn would contact appropriate services. And, the CCG safeguarding team has a good working relationship with the IRIS Project and within GP Primary Care services; there is ongoing training offered by the provider across the system.

In the DHR relating to the murder of Sarah (E1), the Manchester Clinical Commissioning Group (GP) received two recommendations. Sarah, who had a fourteen-year-old son from a previous relationship, was murdered by her husband, through a severe assault and strangulation. The DHR highlighted that Sarah and the perpetrator attended the same GP surgery, and on one occasion they visited together and violence within the relationship was disclosed, appropriate steps to speak to them separately were not taken. As such, recommendations were made to improve GP awareness of symptoms and behaviour associated with domestic violence and abuse through IRIS training, and to disseminate learning from the DHR via Safeguarding Newsletter. Manchester Clinical Commissioning Group that all 85

Manchester GP practices have received IRIS training which includes identifying the symptoms and behaviour associated with domestic violence and abuse. The training is regularly reviewed to include learning from DHRs and other statutory reviews. The training is also provided as an update session every three years and any new starters can access training at ‘mop up’ sessions offered locally. The effectiveness of training is evidenced by increased referrals by Primary Care to IRIS. Further, learning was circulated and all learning from DHRs is included within the IRIS training delivered to practices.

Also, in the same DHR (E1), North West Ambulance Services received a recommendation to ensure that awareness raising with staff takes place in relation to the consideration of immigration status and to be curious why a patient may not have a GP. North West Ambulance Service provided training slides which are delivered to relevant staff.

A DHR relating to the murder of Jenny (E2) made one recommendation to Manchester Clinical Commissioning Group (CCG). Jenny was murdered by her husband after she had decided to end the relationship. The DHR highlighted that in December 2012, Jenny presented with an injury to her elbow which she said was the result of a fall in the kitchen that had happened six weeks previously. She reported that she had been taking her sister’s painkillers. The GP examined Jenny and prescribed painkillers for the injury. During this consultation, there was no routine enquiry with regard to the cause of the injury, and whether domestic abuse may have been a factor. Jenny had also previously talked to the GP about stress-related issues for which it appears she was prescribed anti-depressants. The DHR concluded that although there were no other presenting issues, it would have been

good practice for the GP to enquire about domestic abuse to allow Jenny an opportunity to disclose any issues or concerns. The practice was IRIS accredited and staff in the practice were trained about domestic abuse. As such a recommendation was made to ensure that all appropriate staff in General Practice are IRIS trained and confident in making safe enquiries regarding domestic abuse where clinically indicated. Similar to the response from Manchester CCG to the recommendation in the DHR relating to Sarah (E1), they responded that all 85 Manchester GP practices have received IRIS training, which has resulted in increased referrals.

A recommendation was made to a GP practice in the DHR relating to the death of Shawn (E3). Shawn was forty-seven years old and died after sustaining multiple stab wounds in 2017; his partner was convicted of manslaughter. Shawn had a lengthy documented history of using alcohol and drugs, and had been prescribed methadone as an opioid substitute since at least 1990. He was registered with the same GP practice from 1993 until his death. He was referred to Drug Services in 2002 and a consultant letter was written the following year noted that in addition to his daily methadone, he was using around three bags of heroin a day as well as crack cocaine. Shawn had been known to the police from 1989, primarily for offences involving dishonesty, many of which may have been committed to fund the purchase of illicit drugs. The DHR made a recommendation to ensure that patients with drug dependency have a medication review at least annually. The response outlined that the majority of patients with a drug dependency are now supported by Change Grow Live in Manchester who prescribe and monitor, regularly review medications used in drug treatment, offer referrals to rehabilitation services, signpost to needle exchange and provide holistic advice and support.

6.3 Social Care

Eleven recommendations in three separate DHRs were made in the Social Care setting; this represents eight percent of recommendations of the sample analysed. Responses were received regarding three of these recommendations.

The DHR of Michelle (D1) concluded that the agencies involved with Michelle and the perpetrator worked almost exclusively in silos, which had several consequences, for example, the care plans prepared by BiDAS for both Michelle and the perpetrator were insufficiently informed by their physical and mental health issues. As such, Greater Manchester Health and Social Care Partnership received three recommendations; to disseminate the anonymised details of the case to other NHS contractors to consider their operational systems for resilience and response to concerns concerning to domestic abuse, to update safeguarding training for community pharmacies that provide Drug and Alcohol Services, and to develop standards for the administration, prescribing and dispensing of controlled drugs by community pharmacy across Greater Manchester. The Greater Manchester Health and Social Care Partnership respond that they shared the findings with Community Pharmacists, Pharmacy Superintendents and at the Local Intelligence Network for controlled drugs. Pharmacists are required to be Level 2 safeguarding trained and the Primary Care team commissioned Safeguarding training. They also used a lessons learnt model to disseminate information.

6.4 Probation

HMPPS (formerly the National Probation Service) received eight recommendations in two DHRS and nine recommendations were made to CRC in two DHRS. Therefore, collectively, recommendations regarding probation services represent

twelve percent of the total recommendations of the sample analysed. Responses were received regarding four of these recommendations.

In the DHR of Michelle (D1), two recommendations were made to the NPS. The DHR discovered that the NPS and CRC were aware of the two historical domestic abuse incidents (from previous relationships) but these incidents did not sufficiently inform their assessments of the perpetrator, as well as and other more recent offences, therefore, the NPS risk of serious harm assessment omitted reference to the domestic abuse incidents in contravention of NPS policy. As such, the two recommendations were; that a short-term piece of work should be undertaken to develop existing practice which ensures that all PSR (pre-sentence report) writers in the Bolton NPS Court Team are briefed and reminded of the need and importance of recording all relevant historical information, and to improve the focus of domestic abuse when preparing sentencing reports, despite the index offence not including any evidence of domestic abuse. HMPPS responded that there was an NPS Court Team briefing to discuss initial DHR findings and that the NPS Court Team manager completed 10 assessment dip samples after the briefing to check if the learning had been embedded. Case study training was also conducted and DHR learning was discussed. The case study/learning was also discussed within the NPS Court Team; there is specific domestic abuse training for court practitioners/PSR authors supported by guidance on what safeguarding checks are required to prioritise the safeguarding of children and adults at risk. There are regular audits of PSRs; the performance team collate all cases assessed at Court for the surety that domestic abuse and safeguarding checks are completed so there is evidence of ongoing proactivity and learning to the actions.

In the same DHR (D1), two recommendations were also made to the Cheshire & Greater Manchester CRC focussed on improving the Information Sharing Agreement with GMP, and that all relevant issues identified in the DHR are communicated to all practice staff. HMPPS responded that regarding these recommendations that as part of the DHR process, a Senior Probation Officer sat on all panels to contribute to understanding and learning, and actions set for the CRC had oversight by the Community Director (CD), to ensure that they were completed in a timely manner. The CD reviews all DHRs and learning identified is shared across the organisation, including development and training days. In terms of domestic abuse, a full training package was delivered as a refresher between 2019 and 2020 to all practitioners in Cheshire & Greater Manchester. This was complemented by further e-learning. In respect of the specific action concerning information sharing, under Section 8 of the contract held by Cheshire & Greater Manchester, all cases, regardless of offence were required to have a check with the local police area for domestic abuse call-outs. This was achieved through the Service Level Agreement with Cheshire and Greater Manchester Police. Performance with this was measured by the performance team and reported to the Senior Leadership Team on a monthly basis.

6.5 National policy and legislation

Two recommendations were made to the Home Office and one national recommendation was made.

A recommendation was made in the DHR relating to the murder of Annie (A1) to consider placing the guidance for the identification and management of PDP on a statutory footing to mirror MAPPA to prevent differing practices across England and Wales. A PDP is not defined in statute; the College of Policing Authorised

Professional Practice (APP) (2020) defines a PDP as a person who is not currently managed under one of the three MAPPA categories, these are (College of Policing APP, 2021);

- Category 1 - Registered Sexual Offender.
- Category 2 - An offender who has been convicted of an offence under Schedule 15 of the Criminal Justice Act 2003 (CJA 2003) and, who has been sentenced to 12 months or more in custody, or, who has been sentenced to 12 months or more in custody and is transferred to hospital under s47/s49 of the Mental Health Act 1983 (MHA 1983), or, who is detained in hospital under s37 of the MHA 1983 with or without a restriction order under s41 of that Act.
- Category 3 - Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management. This might not be for an offence under Schedule 15 of the CJA 2003.

In the case of a PDP, reasonable grounds exist for believing that there is a risk of them committing an offence(s) that will cause serious harm. An example of a PDP in the context of domestic abuse is a person charged with domestic abuse offences on a number of occasions against different partners but never convicted of offences that would make them a MAPPA-eligible offender (College of Policing APP, 2020). Home Office explained to the researcher that during the passage of the Domestic Abuse Act 2021, they have committed to refreshing and strengthening the MAPPA Statutory Guidance to make clear that convicted offenders who demonstrate a pattern of offending behaviour that either indicates serious harm or an escalation in risk of serious harm, related to domestic abuse or stalking but which is not reflected in the

charge for which they were actually convicted, should be considered for management.

A DHR relating to the murder of Jessica (B1) made a recommendation to the Home Office. Jessica and the perpetrator were married for nine years, they were Hindu and both worked as Pharmacists in a business they owned together. The perpetrator murdered Jessica in 2018; he staged the scene to attempt to make it look like the home had been burgled and the victim had been killed by intruders. The subsequent police investigation established the perpetrator's guilt and highlighted abuse throughout their marriage. The DHR recommended the Home Office to work with the Employers Initiative to create a best practice policy for small family-owned and run businesses, such as pharmacies, that provides guidance on how staff and employers deal with disclosures, suspicions or indicators of domestic abuse. The Home Office explained that they had introduced the 'Ask for ANI' codeword scheme nationally; this was launched in January 2021 to provide direct support to victims of domestic abuse through their local pharmacy.

In the DHR relating to Sarah (E1) one national recommendation was made regarding developing a process whereby information about high-risk domestic abuse offenders is shared across international boundaries. The Home Office was asked how this recommendation has been implemented, however, they responded that the Home Office does not tend to respond to national recommendations made in DHRs when writing to CSPs, however, they do record all recommendations and are considering how they can improve the oversight and implementation of national recommendations, including how they can provide feedback to local areas on actions taken in response to them.

6.6 Other

Responses were received in relation to thirteen recommendations made to other organisations, including Human Fertility Embryo Authority (HFEA), Department for Work and Pensions (DWP),

In the DHR relating to the murder of Jessica (B1), a recommendation was made to the HFEA. The DHR highlighted that Jessica had undergone private fertility treatment, as such, the recommendation to HFEA was that they are to ensure that health professionals working in this sector have policies, systems and training in place that ensure staff proactively look for risk indicators of domestic abuse and ask direct questions when appropriate opportunities are available. The HFEA explained to the researcher that when the recommendation was considered, there was already guidance contained within the HFEA Code of Practice (HFEA, 2019) addressing safeguarding issues such as this, so no further guidance or new policy was introduced.

A recommendation was made to the DWP in the DHR of Michelle (D1). The DHR found that the DWP suspended Michelle's benefits without completing all the checks required or considered good practice in the case of a customer regarded as vulnerable. The DHR recommended that DWP will look to strengthen the instructions when Employment and Support Allowance (ESA) claims are suspended. The DWP responded that they have provided instructions which are available on the DWP intranet and are available to all benefit processing staff. The DWP also explained that senior staff have engaged with all colleagues through telephone conferences to increase awareness and Team Leaders will promote these with their staff.

Five recommendations were made at an undisclosed school in the DHR relating to Sarah (E1); this was the school that Sarah's son attended. The DHR concluded that the school was not aware of anything specific to suggest domestic violence or abuse was happening within the family home, but with hindsight, there is some learning relating to changes of patterns of behaviour that may be indicators of domestic violence within families. As such the recommendations were; the school should take action to ensure that staff are familiar with the possible indicators of domestic abuse and the impact on the child. The school should consider accessing Healthy Relationships Awareness sessions for pupils, which looks specifically at domestic abuse and relationships, to review the effectiveness of changes to the system where Deputy Head Pastoral reviews all counselling appointments every week to check who has attended and who hasn't, to ensure that all records relating to children are accurate and visits to the school nurse are included in the Head of House Meeting Minutes. And, to ensure that where children are concerned with their workloads, a referral is made to their personal tutor to discuss and plan support. Manchester City Council Children's and Education Directorate responded to the researcher regarding these recommendations, who outlined, the school participates regularly in safeguarding networks and training on a range of topics arranged by the Local Authority. Training has included Domestic Violence and Abuse, mental health and also healthy relationships. This is evidenced by the completed annual Safeguarding returns as requested by the Local Authority which covers policies, procedures, staff training and curriculum. The school keeps their safeguarding policy up to date, which includes sections on staff awareness of the signs of abuse and relevant referral processes. The actions for the school in the Domestic Homicide Review Action Plan were reviewed with the school at the time. The Safeguarding Lead for

Education, together with the Domestic Homicide Review Lead, liaised with the Senior Leadership Team and visited the school; the school had amended their processes around welfare and record keeping in line with the recommendations in the action plan.

The DHR relating to the death of Shawn (E3), highlighted that social housing providers have an important role to play in responding to and preventing domestic violence and abuse, but may not currently be sufficiently well equipped to do so. The DHR made three recommendations to Equity Housing to issue a reminder to colleagues about the importance of maintaining detailed and accurate records, give consideration to providing potential witnesses with written information about domestic abuse and advice about timely contact with appropriate agencies such as Domestic Abuse helplines, the Police, Crime Stoppers etc, and to review the Domestic Abuse policy and procedure in the light of any recommendations from the DHR. Equity housing is not a public authority as defined in section 3(1) of Freedom of Information Act 2000, and therefore do not have a statutory obligation to respond to requests for information under this legislation, however, they responded that they are reviewing policy documentation, in addition to training and resources for colleagues and customers, in line with the Domestic Abuse Bill (Home Office, 2020) and Social Housing White Paper (Ministry of Housing, Communities & Local Government, 2021). They have a Strategic Safeguarding Group that oversees the implementation of training, policies and procedures, and their response to Domestic Abuse is kept under constant review to ensure best practice.

The same DHR (E3) also made three recommendations to Wythenshawe Community Housing Group (WCHG) focussed around referrals to the MASH and/or

Mental Health services, improvement of case reviews and improving links and information sharing with GP practices via the local care organisations and other partnership working. WCHG responded that they take a holistic approach to the way it delivers its services. They have developed 'Wythenshawe Integrated Neighbourhood Service (WINS) team; the team specifically focuses on high demand service users regularly presenting themselves to the Greater Manchester Police, NHS and Manchester City Council/social services for support. The WINS team review cases of mental health, safeguarding issues, crime, anti-social behaviour, domestic violence and alcohol misuse to provide a bespoke and tailor-made support package to the user. The team meets every week with associated partners to discuss each support package for individual users. Further, WCHG meets weekly with the Local Care Organisation to discuss demands, challenges and initiatives within their localities. Information is shared and acted upon if necessary.

DISCUSSION

The research sought to identify specific examples where changes to policies and professional practice can be evidenced as a result of lessons from DHRs. In the case of Annie (DHR A1), there would appear to be a series of missed opportunities by Cleveland Police, namely that a planned multi-agency meeting regarding the perpetrator didn't take place, and the vulnerability of Annie was not considered by the police in the investigation involving an assault on the youngest child by the perpetrator. This was primarily attributed to a lack of training by staff, supervisory and governance arrangements, and working with partner agencies. This indicates that missed opportunities resulted from a poor application of policy or practice, rather than the absence of policy or practice that may have prevented Annie's murder. Cleveland Police report updated investigative procedures and standards accordingly, as well as updates to PDP policy and partnership working. They also outline that over 800 officers have since undertaken the Safe Lives Domestic Abuse Matters (Safe Lives, 2018) training, and in addition sixty domestic abuse specialist champions throughout the organisation. For context, Cleveland Police employ approximately 1,200 officers (ONS, 2019), therefore the data provided by Cleveland Police indicates that approximately sixty-seven percent of their officers have since undertaken this training, and five percent were now specialist domestic abuse champions. Similarly, in the case of Jean (DHR B2), police officers identified the necessity for a disclosure under Claire's Law (Home Office, 2016), but again in this scenario, poor application of policy resulted in a significant delay in processing this referral; combined with poor investigative work by officers, safeguarding opportunities were missed.

The case involving Michelle (DHR D1), also highlighted the incorrect application of policy when Michelle was reported missing, and that officers did not consider Michelle's vulnerability or the perpetrator's criminal history. Lancashire Constabulary reported that changes had been implemented but provided no greater detail.

It has been difficult to measure if recommendations to the police have resulted in improved practice. The Safe Lives Domestic Abuse Matters training (Safe Lives, 2018) rolled out in Cleveland Police is positive, but it is unlikely that such an investment has been made primarily as a consequence of the recommendations in the DHR. Further, it is worthy to note that Cleveland Police force area was identified as having the highest average annual rate of femicide in the UK per 100,000 population ($n = 0.336$) between 2015 to 2018, according to the Femicide Census (Long et al, 2020). It was also highlighted during this research that Cleveland Police has been subject to HMICFRS 'national oversight process' since 2019 (HMICFRS, 2019), therefore, correlation might be drawn between the femicide data and wider institutional issues and culture within Cleveland Police. The PEEL assessment of Cleveland Police (HMICFRS, 2019) reported concerns about the performance of the force in keeping people safe and reducing crime, and that the force was not adequately protecting vulnerable people. It reported that due to significant resource issues within the force, some high-risk domestic abuse cases were being investigated by officers in prisoner-handling teams who hadn't been trained (HMICFRS, 2019, p. 17). Further, that the force wasn't making disclosures under Clare's Law (Home Office, 2016) and Sarah's Law [Child sex offender disclosure scheme] (Home Office, 2010) promptly, and wasn't making sufficient use of domestic abuse protection notices (HMICFRS, 2019, p. 22). There were twelve homicides in Cleveland in the twelve months to the end of March 2019, whereas the force usually

investigates one to three homicides per year (HMICFRS, 2019, p. 17); again, a correlation to the force's performance may be drawn to this data.

Although HMICFRS do not routinely review DHRs as a matter of policy whilst conducting police force inspections, comparisons can be easily drawn from the findings of these independent processes. As such, DHRs are extremely useful in this context, as evidence and learning from specific examples, if used in this way, but also to establish a weight of evidence and audit trail when police forces are under-performing. This source of information and evidence is extremely important in terms of transparency to the public and assurance that police forces will be held to account. Considered holistically, the HIMCFRS report (2019) would indicate that failings highlighted in the DHRs relating to the deaths of Annie and Jean (DHR A1 and B2) were directly attributable to the force's culture and leadership, rather than individual failings. Therefore, in order to measure improved practice, the force would require re-inspection; this occurred in November 2020 (HMICFRS, 2021). The report outlines that the force has now appointed a new executive team and senior leaders, and has started a significant programme to implement changes across the whole organisation. As part of this, it has prioritised how it deals with vulnerable people, particularly victims of domestic abuse, and started to develop its overall approach to vulnerability (HMICFRS, 2021, p. 5) and that the force is better at identifying, assessing, protecting and supporting victims of domestic abuse (HMICFRS, 2021, p.7). The force has also reviewed its processes for Clare's Law and Sarah's Law disclosures, and requests are now managed by a dedicated officer (HMICFRS, 2021, p. 13). The research has concluded that it is not possible to accurately conclude whether the specific findings of the DHRs have impacted or improved

police practice in these samples, however, improved performance can be clearly evidenced in the HMICFRS report.

Health care providers in the UK and globally are increasingly on the frontline in terms of the identification of domestic abuse (McGarry, 2016). This research highlighted that the highest number of recommendations were made at health care providers, with thirty-five percent (*n* = 48) of the recommendations made in the sample analysed. Chantler, et al (2019) highlight that mental health is a striking feature in domestic homicide perpetration. Further, that victims are known to experience depression, anxiety, psychosis and personality disorders (Chantler, et al (2019). A long history of the perpetrator's access to mental health provision was evidenced in the DHR relating to the death of Annie (DHR A1) and highlighted missed opportunities in this respect. Staff training and partner agency information sharing emerged as key themes in the health care setting in this case. TEWV also outlined that dip sampling had been introduced for safeguarding adults' concerns for quality assurance which was fed into the auditing process. Further, MHHRs conducted alongside the DHR are likely to benefit the learning opportunities and therefore improve practice, although specific learning examples were not evidenced. Michelle (DHR D1) and her perpetrator both had a documented history of mental health concerns, as well as drug addiction; again, a theme here was improved partnership working and information sharing, but no evidence of improved practice was provided.

There is increasing recognition in public policy and academic research of the association between experiences of domestic abuse and numerous negative health outcomes, the high prevalence of domestic abuse among those attending health care settings, and the important role that can be played by clinicians in identification

and referral for specialist support (Dowrick, Kelly and Feder, 2020). Research suggests that there remains limited movement of patients between health care settings and specialist support services and that clinicians infrequently enquire about domestic abuse (Dowrick, Kelly and Feder, 2020). Medical practitioners' knowledge and use of IRIS was a repeated theme in the DHRs relating to the death of Michelle (D1), Sarah (E1) and Jenny (E2). Manchester Clinical Commissioning Group did report that all 85 Manchester GP practices had now received IRIS training and reported an increase in referral by Primary Care, however, the data to support this claim was not provided. A recommendation to North West Ambulance Service focussed around awareness raising, as such improved practice could not be measured.

The research has not conclusively identified any specific examples of improved practice in the health care setting resulting from DHRs recommendations, although the response provided does indicate improved compliance and training regarding IRIS. However, IRIS is not utilised in primary care throughout England and Wales. Research over a four-year period from five London boroughs shows the sustained effectiveness of IRIS, with clinicians significantly increasing referrals to domestic abuse services; the difference between the boroughs where IRIS was implemented and the other comparator borough was substantial (Sohal et al, 2020). Sohal et al, (2020) posit that for health professionals to engage effectively, further resources are required, best care reconsidered and funding of healthcare-based programmes that combine direct referral pathways to specialist domestic abuse services with training and ongoing reinforcement. McGarry (2016) explains that while there has been an increasing onus on the role of health care professionals in the context of domestic abuse, it is less clear how this should be institutionally organised.

Similarly in the social care setting, domestic abuse awareness training was the main theme highlighted, therefore improved practice could not be measured. Themes in the probation setting also highlighted a requirement for better domestic abuse awareness raising and information sharing; and evidence was provided of improved procedures in information sharing arrangements with a Service Level Agreement with Cheshire and Greater Manchester Police, which is measured through a performance team. Victims of domestic abuse access multiple agencies, and require multiple services to keep safe and rebuild their lives; multi-agency working is considered as the most effective way to approach domestic abuse cases, leading to more holistic, streamlined and effective service delivery (Cleaver, Maras, Oram and McCallum, 2019). In England and Wales, Multi-agency Safeguarding Hubs (MASH) were established in 2010 and are seen as a way to improve communication and coordination around safeguarding matters (Jeyasingham, 2017). Multi-agency partnerships have become a central feature of safeguarding practices, however, achieving successful collaboration is difficult to implement as practitioners are often unwilling to move away from their traditional working practices, as well as the inability or reluctance to share information, limited understandings of roles and differences in organisational priorities (Shorrock, McManus and Kirby, 2019). The UK Government's Tackling Violence Against Women and Girls Strategy (2021) outlines that to ensure that the police, prisons, probation service and others have the right systems in place to share information regarding dangerous individuals and registered sex offenders, the Home Office and Ministry of Justice will invest £8.1 million to develop a new multi-agency public protection system (MAPPS) which will enable more effective and automated information sharing.

The Home Office responses to the recommendations around strengthening PDP management and creating best practice for small family-owned businesses in dealing with disclosures of domestic abuse, were, in the researcher's opinion, misleading. Firstly, their response around strengthening PDP management outlined that during the passage of the Domestic Abuse Act 2021, they have committed to strengthening MAPPA guidance, for perpetrators of domestic abuse or stalking, but it does not address the recommendation around PDP; that is for those offenders that do meet the criteria for MAPPA. More than this, the response says that they have 'committed to strengthening', but does not outline that the guidance has been or will be strengthened. In this respect, they have not addressed the recommendation. The Domestic Abuse Act 2021 Factsheet (Home Office, 2021) outlines that the Act will 'provide for a statutory domestic abuse perpetrator strategy' but provides no further explanation than this. The reality of this issue is that there is no consistent and dedicated model in place for managing perpetrators of domestic abuse (HMICFRS, 2021).

Secondly, in the response regarding creating best practice for small family-owned businesses, the Home Office stated that they have introduced the 'Ask for ANI' codeword scheme (Home Office, 2021) nationally, however, this response is not in context with the background and rationale in which the recommendation was made, and therefore the 'Ask for ANI' scheme is of limited relevance to this recommendation. In the DHR relating to the murder of Jessica (B1), she and her perpetrator husband owned a Pharmacy. The DHR highlighted that staff had concerns about domestic abuse in their relationship, but there were significant barriers in this case as the perpetrator and the victim were their employers; as such, the recommendation was made to develop a strategy around this type of scenario.

The ‘Ask for ANI’ scheme doesn’t address this recommendation, as the scheme is a ‘’Codeword scheme to enable victims of domestic abuse to access immediate help from the police or other support services, from the safety of their local pharmacy’’ (Home Office, 2021). The response provided by the Home Office has a loose connection with a pharmacy setting, but offers no reassurance that they have understood the recommendation or taken any action in response.

Chantler, et al (2019) conclude in their research that analysis of DHRs offers huge potential to share the learning nationally and internationally, however, the response received from the Home Office in this research concerning the death of Sarah (E1) would indicate a significant gap in the DHR process, in that they are ‘considering how they can improve the oversight and implementation of national recommendations’. Whilst only one national recommendation was recorded in this sample of DHRs, it related to developing a process whereby information about high-risk domestic abuse offenders is shared across international boundaries. Improvement of information sharing was highlighted in numerous single agencies recommendations of the sample analysed; in this example, the recommendation extends to the potential benefits of cross border information sharing; however, it is not clear which agency will take this national recommendation forward or if it will be taken forward at all. This research has not found any evidence that the recommendations from DHRs made at the Home Office and national recommendation have been taken forward.

In the case of Jessica (DHR B1), who had been undergoing fertility treatment, the HFEA responded that they did not take any action in response to the DHR recommendations, as the policy was already outlined in the HFEA Code of Practice (HFEA, 2019) addressing safeguarding issues around domestic abuse. The Code of

Practice outlines, ‘’Centres are expected to have a policy and procedures for safeguarding those who use their services’’ and that ‘’These should set out what staff should do if they suspect that a person has been abused, neglected or harmed in any way’’ (HFEA, 2019). It also outlines that ‘’Centres should review procedures annually, or more often to incorporate any lessons learned or changes to legislation’’ and that ‘’Centres should provide training for staff on the safeguarding policy and their responsibilities’’ (HFEA, 2019). However, there is no assurance that the [undisclosed] Centre has learned lessons in this case, reviewed procedures or provided training to staff. Further, it is unclear whether the HFEA has or will provide governance around this particular issue.

The DWP reported an increase in awareness training as a result of the DHR recommendations. The DWP is a national organisation, and as such, the impact of this training is much less likely to be localised, like many of the examples in this sample. However, the impact of this training and therefore whether there has been improved professional practice as a consequence cannot be measured in this research. In the Education setting, training and safeguarding policy emerged as themes in the learning, which were reported as complete; however, again, improved practice cannot be measured. DHRs do not systematically report children’s experiences of harm or abuse, but for many of the children, their mother’s death was the culmination of a long history of domestic abuse (Stanley, Chantley and Robbins, 2018). Stanley, Chantley and Robbins (2018) research provides examples where children had been previously injured in domestic abuse incidents, and physical abuse, assaults and threats of violence towards children by the perpetrator, and that these histories were not always known to services prior to the homicides. This

highlights the necessity for greater training and safeguarding governance in the education setting.

Key themes highlighted in the social housing setting were record keeping, policy, training and information sharing. Good practice was highlighted in this respect around partnership working and information sharing; however, the delivery of this cannot be measured in this research. It's important that social housing providers continue to develop their understanding, policies and practices around domestic abuse; some domestic homicides are committed by people not previously known to the police for domestic abuse and therefore information from agencies such as social housing providers can be used as part of the identification and assessment process (College of Policing, 2020)

The research could not conclusively identify evidence of improved practice as a direct consequence of DHRs conducted in England and Wales from 2017 to 2018. There were repeat themes identified throughout the sample analyses, such as training, awareness raising, information sharing and partnership working. Similar findings were evident in research around DHRs conducted by Benbow, Bhattacharyya and Kingston (2018); they suggest that these repeat recommendations suggest that professionals are not learning or improving from DHRs. Further, Stanley, Chantler and Robbins (2018) describe that DHRs have their limitations, in that they are partial documents that often reflect the particular interests or professional background of their author, and are inconsistent in the quality, nature and quantity of data they provide. Despite these limitations highlighted regarding the quality and rigour demonstrated in DHRs, they are a means of synthesising information from a large number of agencies that would require considerable

resources to collect otherwise (Stanley, Chantley and Robbins, 2018). This research has demonstrated that DHRs do continue to provide a weight of evidence where improvement in professional practice is needed, however, their impact is restricted because their reach is primarily locality based. Many of the DHRs comment on agencies are working in silos, however, this research indicates that CSPs are also working in silos within their immediate community. DHRs have the potential to be much more effective than their current limitations. Chantler, et al (2019) conducted research around learning from DHRs in England and Wales, and highlighted that as CSPs are locality based, learning from outside the local area can be hard to consolidate; this research supports this conclusion. Jaffe, Dawson and Campbell (2013) researched the development of a national collaborative approach of DHR in Canada; they identified that professionals felt that it was important to enhance DHR collaboration across the country and that a national website should be created, containing DHR literature from across the country, as well as international DHR literature. Benbow, Bhattacharyya and Kingston (2018) research around domestic violence in elderly victims also concluded that research would benefit from a central repository for DHRs.

The research approach was laborious and slow as it was reliant on FOI responses from single agencies, many of which provided circumlocutory responses. FOI requests were submitted within sufficient time to allow agencies their statutory twenty working days to respond; some requests were re-submitted to provide further opportunity to respond. However, eleven FOI requests, relating to twenty-six recommendations did not receive a response; a full breakdown of FOI responses is at Appendix B. Further, Chantler, et al (2019) posit that there is potential for agencies to protect their own reputations rather than engage in a process of

reflective learning, therefore there is potential that single agencies lack objectivity in their responses in this research.

The research provided a reliable statistical breakdown of the male to female ratio of perpetration and victimhood. It outlined that eighty-six percent (n = 12) of perpetrators were male and fourteen percent (n = 2) of perpetrators were female. Chantler, et al (2019) research around DHRs in England and Wales recorded identical results, although from a larger sample. All victims in this research were opposite gender to the preparator, however, Chantler, et (2019) recorded slightly different results, in that females accounted for eighty-one percent of victims in their research; five percent less than the results of this research. However, the results are consistent with the plethora of research indicating that domestic homicide is most likely to be committed by male perpetrators against female intimate partners.

CONCLUSION

DHRs are unique in that they bring together a thorough source of information considered relevant to the homicide being reviewed. Although the research could not conclusively evidence examples improved practice as a direct result of the DHRs, it did highlight areas that have shown improvement in general over the last few years, most notably the performance of Cleveland Police around domestic abuse, as evidenced in the HMICFRS post-inspection report (2021), improved use of the IRIS system in primary care across Greater Manchester, improved information sharing through a Service Level Agreement with probation services and Cheshire and Greater Manchester Police. As such, independent governance is most important in all sectors highlighted in this research, which specifically measures policies and practices around domestic abuse, as well as other vulnerable groups. DHRs complement this governance but are not designed to replace it; however, there could be greater coherency in regards to how DHR recommendations are reviewed and shared outside the immediate locality or single agency, in particular, recommendations made to the Home Office and other national recommendations. Relevant to this conclusion is that this research highlighted a gap in policy into how national recommendations from DHRs are taken forward and which agency is responsible for taking them forward.

The research also identified many examples of improved training across single agencies, however, whilst single agency responses may provide an explanation of improved training and professional practice, the impact of this cannot be measured across England and Wales. When establishing the review methodology, it was established through FOI response from the Home Office that DHRs conducted

across England and Wales are not consolidated in a single repository, therefore it is impossible to know how many national recommendations have been made in DHRs across England and Wales, and if these have been taken forward for consideration. The Home Office does not collect data on the number of DHRs conducted in police forces areas in England and Wales, or any breakdown of how many DHRs were conducted within each police force area. Also, the Home Office did not hold any data regarding how many CSPs there are in total in England and Wales, and therefore how many DHRs each CSP conducted. This research identified that DHR information cannot be easily accessed through a straightforward pathway, as such the development of a national repository is recommended. This has significant potential to enhance the ability of researchers and professionals in improving professional practice across the UK, as well as open pathways to share and learn internationally.

The health care setting received the most recommendations in the sample reviewed in this research, indicating that the impact the health care setting has in homicide prevention is substantial, however, a lack of consistency in practice across England and Wales is apparent. Research evidence demonstrates that the IRIS framework improves the healthcare response to domestic abuse (Sohal et al, 2020); as such, the NHS should seek to develop greater coherency in their response to domestic abuse in all settings across the UK.

Domestic abuse is recognised internationally as a human rights issue that permeates through all sociodemographic groups (Saxton, Jaffe and Olszowy, 2020). Women are disproportionally the victims of domestic homicide at the hands of men. Other crimes which disproportionally affect women and girls include rape and other sexual

offences, stalking, domestic abuse, ‘honour-based’ abuse, including female genital mutilation, forced marriage and ‘honour’ killings and ‘revenge porn’ (UK Government, 2021). The HMICFRS inspection on how effectively the police engage with women and girls (2021) outlines that were an estimated 2.3 million victims of domestic abuse in the year ending March 2020, 1.6 million of whom were female. Further, between 2009 and 2019, on average, one woman was killed by a man every three days in the UK. A current or former partner was responsible for sixty-two percent of these killings and a history of abuse was known in fifty-nine percent of the 1,042 female homicides committed by current or former partners or other male relatives (HMICFRS, 2021). The report states, ‘‘These figures are alarming. We consider they represent an epidemic of violent and abusive offending against women and girls in England and Wales’’ (HMICFRS, 2021). The Domestic Abuse Act 2021 and the Tackling Violence Against Women Strategy (UK Government, 2021) present significant opportunities for progress in tackling this epidemic, but we always rely on learning from the past to make the future safer; the qualitative analysis of recent DHRs in this research indicates that we have much more learning to do. DHRs are a key tool in this learning, both in the academic and professional contexts; as such, the Home Office, Police Forces, NHS, HMPPS and social care sector should seek to implement greater coherency and shared learning, nationally and internationally.

REFERENCE LIST

Advocacy After Fatal Domestic Abuse (2021) *Advocacy After Fatal Domestic Abuse.* Available at: https://aafda.org.uk/ (Accessed: 8 March 2021)

Benbow, S. Bhattacharyya, S. and Kingston, P. (2018) Older adults and violence: an analysis of Domestic Homicide Reviews in England involving adults over 60 years of age. *Ageing and Society*, 39(06), pp.1097-1121.

Be Safe Bolton Strategic Partnership. (2019) *Domestic Homicide Review Michelle Overview Report.* Available at: https://www.bolton.gov.uk/downloads/file/2143/domestic-homicide-review-michelle-overview-report (Accessed: 10 July 2021)

Bolton Council. (2021*) Domestic abuse and violence*. Available at: https://www.bolton.gov.uk/community-safety-anti-social-behaviour/domestic-abuse-violence/4?documentId=376&categoryId=20041 (Accessed: 10 July 2021)

Bridger, E. Strang, H., Parkinson, J. and Sherman, L. (2017) Intimate Partner Homicide in England and Wales 2011–2013: Pathways to Prediction from Multi-agency Domestic Homicide Reviews. *Cambridge Journal of Evidence-Based Policing*, 1(2-3), pp.93-104.

Chantler, K. Robbins, R. Baker, V. and Stanley, N. (2019) Learning from domestic homicide reviews in England and Wales. *Health & Social Care in the Community*, 28(2), pp.485-493.

Cleaver, K. Maras, P. Oram, C. and McCallum, K., 2019. A review of UK based multi-agency approaches to early intervention in domestic abuse: Lessons to be learnt from existing evaluation studies. *Aggression and Violent Behavior*, 46, pp.140-155.

Cleveland Police. (2021) *Cleveland Police Force Policies*. Available at: https://www.cleveland.police.uk/foi-ai/cleveland-police/publication-scheme/our-policies-and-procedures/force-policies/ (Accessed: 19 September 2021)

College of Policing. (2020) *Identification, assessment and management of serial or potentially dangerous domestic abuse and stalking perpetrators.* Available at: https://library.college.police.uk/docs/appref/Serial-dangerous-domestic-abuse-stalking-perpetrators-principles.pdf (Accessed: 20 September 2021)

College of Policing Authorised Professional Practice. (2015) *Intelligence Management. Governance*. Available at: https://www.app.college.police.uk/app-content/intelligence-management/governance/ (Accessed: 10 July 2021)

College of Policing Authorised Professional Practice. (2020) *Major investigation and public protection. Potentially dangerous persons.* Available at: https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/potentially-dangerous-persons/?highlight=PDP?s=PDP (Accessed: 10 July 2021)

College of Policing Authorised Professional Practice. (2021). *Major investigation and public protection. Multi-agency agency public protection arrangements (MAPPA)*. Available at: https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/mappa/#categories (Accessed: 10 July 2021)

Crime and Disorder Act 1998. Available at: https://www.legislation.gov.uk/ukpga/1998/37/contents (Accessed: 10 July 2021)

Criminal Justice Act 2003. Available at: https://www.legislation.gov.uk/ukpga/2003/44/contents (Accessed: 10 July 2021)

Dowrick, A. Kelly, M. and Feder, G. (2020) Boundary spanners: Negotiating connections across primary care and domestic violence and abuse services. *Social Science & Medicine*, 245, p.112687.

Freedom of Information Act 2000.Available at: https://www.legislation.gov.uk/ukpga/2000/36/contents (Accessed: 6 January 2021).

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service. (2019) *Police effectiveness, efficiency and legitimacy 2018/19. An inspection of Cleveland Police.* Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-assessment-2018-19-cleveland.pdf (Accessed: 19 September 2021)

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service. (2021) *Integrated vulnerability inspection post-inspection review*. Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/publications/integrated-vulnerability-inspection-post-inspection-review/ (Accessed: 19 September 2021)

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service. (2021) *PEEL Assessment Framework 2021/21*. Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/publication-html/peel-assessment-framework-2021-22/ (Accessed: 19 September 2021)

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service. (2021) *Police response to violence against women and girls – Final inspection report.* Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/publications/police-response-to-violence-against-women-and-girls/ (Accessed: 25 September 2021)

Hartlepool Borough Council. (2021) *Domestic Homicide Review*. Available at: https://www.hartlepool.gov.uk/info/20006/emergencies_safety_and_crime/1057/domestic_homicide_review (Accessed: 10 July 2021)

Hartlepool Borough Council. (2019) *Domestic Violence Homicide Review Overview Report, Death of Annie*. Available at: https://www.hartlepool.gov.uk/downloads/file/7014/domestic_homicide_review_-_annie_-_overview_report (Accessed: 10 July 2021)

Home Office. (2010) *Child sex offender disclosure scheme guidance*. Available at: https://www.gov.uk/government/publications/child-sex-offender-disclosure-scheme-guidance (Accessed: 19 September 2021)

Home Office. (2015*) Policy Paper. 2010 to 2015 Government Policy: Crime Prevention*. Available at: https://www.gov.uk/government/publications/2010-to-2015-government-policy-crime-prevention/2010-to-2015-government-policy-crime-prevention#issue (Accessed: 20 March 2021).

Home Office, (2016) *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf (Accessed: 6 January 2021).

Home Office. (2016) *Domestic violence disclosure scheme: guidance*. Available at: https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance (Accessed: 19 September 2021)

Home Office. (2016) *Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf (Accessed: 6 January 2021).

Home Office. (2020) *Domestic Abuse Bill 2020: factsheets*. Available at: https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets (Accessed: 10 July 2021)

Home Office. (2021) *Ask for ANI and Safe Spaces schemes: training toolkit*. Available at: https://www.gov.uk/government/publications/ask-for-ani-and-safe-spaces-schemes-training-toolkit (Accessed: 10 July 2021)

Home Office. (2021) *Domestic Abuse Act 2021: overarching factsheet*. Available at: https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-abuse-bill-2020-overarching-factsheet#will-these-measures-apply-across-the-united-kingdom (Accessed: 1 September 2021)

Human Fertility and Embryo Authority. (2019) *Human Fertility and Embryo Authority Code of practice*. Available at: https://portal.hfea.gov.uk/media/1605/2019-12-03-code-of-practice-december-2019.pdf (Accessed: 10 July 2021

Ingala Smith, K. (2021) *Counting dead women*. Accessed at: https://kareningalasmith.com/ (Accessed: 8 March 2021).

Jaffe, P. Dawson, M. and Campbell, M. (2013) Developing a National Collaborative Approach to Prevent Domestic Homicides: Domestic Homicide Review Committees. *Canadian Journal of Criminology and Criminal Justice*, 55(1), pp.137-155.

Jeyasingham, D. (2017) Soft, small, malleable, and slow: Corporeal form and movement in social workers' and police officers' talk about practice in a Multi-Agency Safeguarding Hub. *Child & Family Social Work*, 22(4), pp.1456-1463.

Local Government Association. (2013) *Adult safeguarding and domestic abuse. A guide to practitioners and managers*. Available at: https://www.adass.org.uk/adassmedia/stories/Adult%20safeguarding%20and%20domestic%20abuse%20April%202013.pdf (Accessed: 14 July 202)

Long, J. Wertans, E. Harper, K. Brennan, D. Harvey, H. Allen, R. Elliott, K, (2020). Femicide Census. Available at: https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf (Accessed: 16 December 2020).

Manchester Community Safety Partnership. (2017) *Domestic Homicide Review Report: 'Shawn'*. Available at: http://www.makingmanchestersafer.com/downloads/file/160/dhr_shawn (Accessed: 10 July 2021)

Manchester Community Safety Partnership. (2018) *Domestic Homicide Review in the case of 'Jenny'*. Available at: http://www.makingmanchestersafer.com/downloads/file/157/dhr_jenny_march_19 (Accessed: 10 July 2021)

Manchester Community Safety Partnership. (2018) *Domestic Homicide Review Report: 'Sarah'*. Available at: http://www.makingmanchestersafer.com/downloads/file/140/dhr_8_-_june_2018 (Accessed: 10 July 2021)

Making Manchester Safer. (2021) *Domestic Abuse*. Available at: http://www.makingmanchestersafer.com/homepage/12/domestic_abuse (Accessed: 10 July 2021)

Mental Health Act 1983. Available at: https://www.legislation.gov.uk/ukpga/1983/20/contents (Accessed: 10 July 2021)

Middlesbrough Community Safety Partnership. (2020) *Domestic Homicide Review Overview Report, Jean*. Available at: https://www.middlesbrough.gov.uk/sites/default/files/DA-DHR4-report.pdf (Accessed: 10 July 2021)

Middlesbrough Community Safety Partnership. (2020) *Domestic Homicide Review Overview Report, Jessica*. Available at: https://www.middlesbrough.gov.uk/sites/default/files/DA-DHR2-report.pdf (Accessed: 10 July 2021)

McGarry, J. (2016) Domestic violence and abuse: an exploration and evaluation of a domestic abuse nurse specialist role in acute health care services. *Journal of Clinical Nursing*, 26(15-16), pp.2266-2273.

Middlesbrough Community Safety Partnership. (2021) *Domestic Homicide Reviews*. Available at: https://www.middlesbrough.gov.uk/community-support-and-safety/domestic-abuse/domestic-homicide-reviews (Accessed: 10 July 2021)

Ministry of Housing, Communities & Local Government. (2021) *The charter for social housing residents: social housing white paper*. Available at: https://www.gov.uk/government/publications/the-charter-for-social-housing-residents-social-housing-white-paper/the-charter-for-social-housing-residents-social-housing-white-paper (Accessed: 17 August 2021)

Monckton Smith, J. (2021) *In control. Dangerous Relationships and How They End in Murder.* London. Bloomsbury Publishing Plc.

Monckton Smith, J. (2019) Intimate Partner Femicide: Using Foucauldian Analysis to Track and Eight Stage Progression to Homicide. *Violence Against Women*, 26(11), pp. 1267-1285.

NHS England. (2015) *Serious Incident Framework*. Available at: https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf (Accessed: 10 July 2021)

NHS England. (2021) *Independent investigation reports*. Available at: https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports/ (Accessed: 10 July 2021)

Office for National Statistics. (2019) *Police workforce, England and Wales: 30 September 2019*. Accessed at: https://www.gov.uk/government/statistics/police-workforce-england-and-wales-30-september-2019 (Accessed: 1 September 2021)

Office for National Statistics. (2021) *Homicide in England and Wales: year ending March 2020*. Accessed at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2020 (Accessed: 20 March 2021)

Oldham Community Safety and Cohesion Partnership. (2018) *Domestic Homicide Review: Catherine*. Available at: https://www.oldham.gov.uk/downloads/file/5099/catherine_-_overview_report_july_2018 (Accessed: 11 July 2021)

Oldham Community Safety and Cohesion Partnership. (2019) *Domestic Homicide Review in the case of James*. Available at: https://www.oldham.gov.uk/downloads/file/6134/james_-_overview_report_-_september_2019 (Accessed: 11 July 2021)

Oldham Council. (2021) *Domestic Violence and Abuse*. Available at: https://www.oldham.gov.uk/info/200321/crime_and_safety/859/domestic_violence_and_abuse/4 (Accessed: 10 July 2021)

Redcar and Cleveland Community Safety Partnership. (2019) *Domestic Homicide Review: Annie*. Available at: https://www.redcar-cleveland.gov.uk/resident/neighbourhoods/community-safety-partnership/Domestic%20Homicide%20Review/Redcar%20DHR%202%20-%20Ex%20Summary%20Post%20HO%20Feedback.pdf (Accessed: 11 July 2021)

Redcar and Cleveland Council. (2021) *Domestic Homicide Review*. Available at: https://www.redcar-cleveland.gov.uk/resident/neighbourhoods/community-safety-partnership/Pages/Domestic-Homicide-Review.aspx (Accessed: 10 July 2021)

Rochdale Borough Council. (2021) *Domestic Homicide Reviews*. Available at: http://www.rochdale.gov.uk/council-and-democracy/policies-strategies-and-reviews/reviews/Pages/domestic-homicide-reviews.aspx (Accessed: 10 July 2021)

Rochdale Borough Council. (2021) *Domestic violence and abuse*. Available at: http://rochdale.gov.uk/health-and-wellbeing/domestic-violence-and-abuse/Pages/domestic-violence-and-abuse.aspx (Accessed: 10 July 2021)

Rochdale Borough Safeguarding Adults Board. (2021) *Domestic Abuse*. Available at: https://www.rbsab.org/professionals/domestic-violence/ (Accessed: 10 July 2021)

Rochdale Borough Safeguarding Adults Board. (2021) *Multi-agency Policy and Procedures*. Available at: https://www.rbsab.org/professionals/multi-agency-policy-and-procedures/ (Accessed: 10 July 2021)

Rochdale Safer Communities Partnership. (2019) *Domestic Homicide Review into the death of Ethel*. Available at: http://www.rochdale.gov.uk/pdf/2020-01-15-domestic-homicide-review-november-2019-v2.pdf (Accessed: 12 July 2021)

Safe Lives. (2018) *For police: Domestic Abuse Matters*. Available at: https://safelives.org.uk/training/police (Accessed: 1 September 2021)

Safe Lives. (2021) *Resources for identifying the risk victims face*. Available at: https://safelives.org.uk/practice-support/resources-identifying-risk-victims-face (Accessed: 10 July 2021)

Safe Lives. (2021) *Resources for Marac meeting*. Available at: https://safelives.org.uk/practice-support/resources-marac-meetings (Accessed: 10 July 2021)

Safer Stockport. (2021) *Domestic Homicide Reviews*. Available at: http://www.saferstockport.org.uk/project/domestic-homicide-reviews-new/ (Accessed: 10 July 2021)

Salford and Manchester Community Safety Partnerships. (2019) *Domestic Homicide Review in the case of Niki*. Available at: http://www.makingmanchestersafer.com/downloads/file/180/dhr_niki (Accessed: 11 July 2021)

Salford Community Partnership. (2021) *Domestic Homicide Reviews*. Available at: https://www.partnersinsalford.org/salford-community-safety-partnership/domestic-homicide-reviews-dhrs/ (Accessed: 10 July 2021)

Saxton, M. D. Jaffe, P. G. and Olszowy, L. (2020) 'The Police Role in Domestic Homicide Prevention: Lessons From a Domestic Violence Death Review Committee', Journal of Interpersonal Violence. doi: 10.1177/0886260520933030.

Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Reviews (DHR) Case Analysis. Report for Standing Together*. Available at: https://www.standingtogether.org.uk/blog-3/domestic-homicide-review-dhr-case-analysis (Accessed: 9 March 2021).

Sheehan, B. Murphy, S. Moynihan, M. Dudley-Fennessey, E. and Stapleton, J. (2014) Intimate Partner Homicide. *Violence Against Women*, 21(2), pp.269-288.

Shorrock, S. McManus, M. and Kirby, S. (2019) Practitioner perspectives of multi-agency safeguarding hubs (MASH). *The Journal of Adult Protection*, 22(1), pp.9-20.

Sohal, A. Feder, G. Boomla, K. Dowrick, A. Hooper, R. Howell, A. Johnson, M., Lewis, N. Robinson, C. Eldridge, S. and Griffiths, C. (2020). Improving the healthcare response to domestic violence and abuse in UK primary care: interrupted time series evaluation of a system-level training and support programme. *BMC Medicine*, 18(1).

Stanley, N. Chantler, K. and Robbins, R (2018) Children and Domestic Homicide, *The British Journal of Social Work*, Volume 49, Issue 1, January 2019, Pages 59–76.

UK Government (2021) *When a death is reported to a coroner*. Available at: https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner (Accessed: 20 March 2021)

UK Government (2014) Multi-agency public protection arrangements (MAPPA): Guidance. Available at: https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance (Accessed: 20 August 2021)

UK Government. (2021) *Tackling violence against women and girls strategy*. Available at: https://www.gov.uk/government/publications/tackling-violence-against-women-and-girls-strategy (Accessed: 20 September 2021)

Wigan Building Stronger Communities Partnership. (2018) *Domestic Homicide Review into the death of Susan*. Available at: https://www.wigan.gov.uk/Docs/PDF/Council/Strategies-Plans-and-Policies/Building-Stonger-Communities/DHR-Executive-Summary-Feb-2020.pdf (Accessed: 12 July 2021)

Wigan Council. (2021) *Domestic Homicide Review*. Available at: https://www.wigan.gov.uk/Council/Strategies-Plans-and-Policies/Domestic-Homicide-Review.aspx (Accessed: 10 July 2021)

Appendix A – Breakdown of Domestic Homicide Reviews examined

CSP Code	CSP	DHR Code	DHR Name	Perpetrator Gender	Victim Gender	Total number of recommendations	Recommendations at CSP	Recommendations at individual organisations
A	Hartlepool Borough Council	A1	Annie	Male	Female	20	7	13
B	Middlesbrough Council	B1	Jessica	Male	Female	7	4	3
B	Middlesbrough Council	B2	Jean	Male	Female	30	9	21
C	Redcar & Cleveland Borough Council	C1	Annie	Male	Female	7	6	1
D	Bolton Council	D1	Michelle	Male	Female	47	5	42
E	Manchester City Council	E1	Sarah	Male	Female	23	1	22
E	Manchester City Council	E2	Jenny	Male	Female	3	2	1
E	Manchester City Council	E3	Shawn	Female	Male	19	7	12
E	Manchester City Council and Salford City Council	E4	Niki	Male	Female	2	2	0
F	Oldham Council	F1	James	Female	Male	3	3	0
F	Oldham Council	F2	Catherine	Male	Female	7	4	3
G	Rochdale Council	G1	Ethel	Male	Female	6	4	2
G	Rochdale Council	G2	Olivia	Male	Female	25	7	18
H	Wigan Council	H1	Susan	Male	Female	5	5	0
			Totals	**Male = 12** **Female = 2**	**Female = 12** **Male = 2**	**204**	**66**	**138**

Appendix B – Domestic Homicide Review recommendations and Freedom of Information responses

DHR A1 - Annie	
Breakdown of recommendations	**FOI response / research result**
Cleveland Police 1. Review their domestic abuse training for officers and staff to satisfy themselves and the Safer Hartlepool Partnership that it effectively encompasses and addresses the hidden signs of domestic abuse. 2. Ensure that the decision-making rationale for prioritisation of investigations is clearly recorded. 3. Review the governance and oversight of investigations with regard to timeliness and ensuring all available evidence is captured. 4. Engage with partner agencies, particularly the National Probation Service, in reviewing multi-agency knowledge and where appropriate involvement in the identification and management of a PDP.	1. Cleveland Police has embarked on a force wide training programme with regards to Domestic Abuse and intends on of training all operational officers and staff. The force has invested in the Safe Lives DA Matters accredited College of policing training programme which has seen in excess of 800 officers currently trained and 60 DA Specialist Champions. The champions work in all disciplines throughout the organisation and will received continued professional development in areas of domestic abuse and will cascade to the wider force. 2&3. Cleveland police has reviewed its crime allocation policy and introduced the CAAF in addition it has updated its supervisor's crime management procedures which clearly outline supervisor responsibilities and times scales for review. All incidents and investigations are recorded on the NICHE system for transparency and auditable purposes. The force has also invested in raising of investigative standards (RIS) for all officers and staff this has included interactive magazines and N'Calt college of policing training packages, along with Toolkits, and aide memoires. All of the above is monitored through a robust performance framework. 4. Cleveland Police has reviewed and updated its PDP policy in line with APP and the College of Policing working with partners to integrate local policies and procedures.
Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) 1. Ensure all frontline staff attend Domestic Abuse training focussing on staff always considering potential vulnerabilities of other members of the household when undertaking assessments of a patient's mental health and associated risks encouraging the adoption of a think family approach. 2. Provide guidance to staff when working with the perpetrator of domestic violence and including this within the Domestic Abuse policy. 3. TEWV to ensure effective supervision processes are in place so that when a carers assessment is offered that it is completed. 4. When there is multi-agency involvement in a patient's case, TEWV to ensure open channels of communication should be maintained with all agencies involved.	1. A Domestic Abuse training package was devised and has been delivered as part of the Trusts level 3 Safeguarding Children's Mandatory update training. This package ran from October 18 to September 19. The current Level 3 Mandatory update for this year's topic is focused on the Think family approach and County lines. Domestic Abuse continues to feature in all Safeguarding Adults and Children's training and a stand –alone non -mandatory training package for Basic Awareness of Domestic Abuse is also available. 2. A Domestic Abuse Audit was completed in January 2020. A subsequent action plan was produced and all actions were completed by April 2020. The Domestic Abuse Procedure was completed December 2020 (delayed during the COVID period. In addition a briefing was circulated to managers to share with their team members the learning as a result of the review. The Trusts

5. When there is multi-agency involvement in a patient's case, TEWV to ensure any alerts pertaining to potential risks should be shared across all agencies. 6. All safeguarding concerns should be recorded in line with TEWV processes, policies and procedures. 7. TEWV to review their risk assessment arrangements to ensure it captures new information and intelligence.	Intranet was updated with the DOH guidance for Health professionals working with perpetrators of Domestic Abuse. 3. Using the SBARD process a briefing was circulated to all Trust staff. This has shared the learning from this review. 4. The Trusts safeguarding Adult and Children's training (Including safeguarding adults level 1 and 2 and Safeguarding children's level 2 and 3) has been reviewed to reflect the need for information sharing with the multi-agency network to ensure risks are shared and safeguarding is prioritised. 5. All staff have been made aware of the need to maintain channels of communication with all agencies involved and all safeguarding concerns should be recorded in line with TEWV processes, policies and procedures. Risk assessment arrangements have also been reviewed. 6. Using the SBARD process a briefing has been devised to communicate with All Trust staff. This included guidance of record keeping standards. In addition reports are produced for the Trust Safeguarding & Public protection subgroup of the board which captures adherence of record keeping. This is a quarterly report. The Trust Safeguarding team is linked in with ongoing work for the new electronic patient records to streamline the recording process . Dip Sampling has been introduced for safeguarding Adults concerns for quality assurance and findings fed into the auditing process. Processes for staff recording safeguarding concerns are also monitored though the Trust Safeguarding & Public protection subgroup. 7. The Trust has reviewed its risk assessment arrangements and their ability to react to dynamic information and intelligence and as a result the current risk assessment does include current dynamic risks.
NHS England (North) share the MHHR report when finalised with the Safer Hartlepool Partnership to ensure co-ordination between relevant recommendations.	The Domestic Homicide Review (DHR) conducted by Hartlepool Community Safety Partnership following the murder of 'Annie' was received following publication by NHS England on 21st June 2019. The Independent Investigation commissioned by NHS England was undertaken in parallel with DHR, to reduce the impact of investigative processes on family members and staff. The resultant independent investigation report was published by NHS England on the 4th May 2021 and has been shared with the Community Safety Partnership, the wider NHS and with appropriate professional forums. NHS England commissioned mental health expertise to assist the Independent DHR Chair and to inform the mental health component of the DHR report, the mental health expert also formed part of the commissioned independent investigative team to ensure that the findings which led to the formulation of recommendations were aligned.

	NHS England is committed to openness and transparency and in the interest of learning, publishes and shares the findings of independent investigations in the public domain. It is generally accepted that there is a public benefit in the facts and circumstances of cases such as these being independently reviewed and any learning for the wider NHS being shared. This is done by publishing the report on the website of NHS England and NHS Improvement. The Trust and the Clinical Commissioning Group (local commissioners of NHS services) are also required to publish the report on their websites. There is no specific policy directing the sharing of the learning from investigations however the Serious Incident Framework (2015) https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf is clear and promotes the ever increasing need to work collaboratively in an effort to draw lessons to inform systematic learning and improvement.
Home Office to consider placing the guidance for the identification and management of PDP's on a statutory footing to mirror MAPPA to prevent differing practices across England and Wales	During the passage of the Domestic Abuse Act 2021 we have committed to refreshing and strengthening the MAPPA Statutory Guidance to make clear that convicted offenders who demonstrate a pattern of offending behaviour that either indicates serious harm or an escalation in risk of serious harm, related to domestic abuse or stalking but which is not reflected in the charge for which they were actually convicted, should be considered for management. The Domestic Abuse Act also places a duty on the Government to prepare and publish a comprehensive perpetrator strategy that aims to bring more perpetrators to justice and reduce reoffending. In the Strategy we will set out our approach to: • detecting, investigating, and prosecuting offences involving domestic abuse; • assessing and managing the risks posed by individuals who commit offences involving domestic abuse, and including domestic abuse related stalking; and • reducing the risk that such individuals commit further offences involving domestic abuse. The College of Policing Authorised Professional Practice also has guidance on potentially dangerous people which can be accessed via this link: https://www.app.college.police.uk/app-content/major-investigation-and-publicprotection/managing-sexual-offenders-and-violent-offenders/potentially-dangerouspersons/?highlight=PDP?s=PDP

DHR B1 – Jessica	
Breakdown of recommendations	**FOI response / research result**
The Human Fertility and Embryo Authority [HFEA] ensure that health professionals working in this sector have policies, systems and training in place that ensure staff proactively look for risk indicators of domestic abuse and ask direct questions when appropriate opportunities are available.	When the recommendation was considered there was already guidance addressing safeguarding issues such as this, so no further guidance or new policy was introduced. Sections 25.33 – 25.36 of our Code of Practice detail safeguarding practices that should be in place at licenced clinics.
NHS England considers issuing guidance to GP practices to ensure patient care is not impacted upon by other relationships that may exist, for example, were there is also a business or commercial relationship.	Nil response.
Home Office work with the Employers Initiative to create best practice policy for small family owned and run businesses [such as pharmacies] that provides guidance on how staff and employers deal with disclosures, suspicions or indicators of domestic abuse.	We have recently introduced the Ask for ANI codeword scheme nationally. This was launched in January 2021 to provide direct support to victims of Domestic abuse through their local pharmacy. Pharmacies can sign up voluntarily to the scheme and we have worked with pharmacy chains and the National Pharmacy Association to provide pharmacies with information on the scheme. The full training materials provided are available at this link: Ask for ANI domestic abuse codeword scheme: pharmacy materials - GOV.UK (www.gov.uk).

DHR B2 – Jean	
Breakdown of recommendations	**FOI response / research result**
Cleveland Police 1. The process in which Clare's Law disclosure is made should be reviewed to ensure that requests are being processed in line with Home Office Guidance. 2. Message around the investigation golden hour to be disseminated. This is an action that is being replicated in the Crime Allocation and Improvement Rapid Response plan. 3.Training to be disseminated to all operational officers around evidence-led prosecutions. 4. All domestic abuse crimes should be reviewed by a supervisor prior to closure. 5. Training and guidance around the quality of supervisory reviews to be cascaded to all supervisors as part of the Crime allocation and Improvement Rapid Response plan. 6. Domestic abuse policy to be updated in respect to the handling of "no reply" domestic abuse incident, or those where only one party has been spoken with.	We have looked at the content of your request and some of the information is answered in the below links therefore we consider the Freedom of information Act 2000 Exemption 21 (Information Accessible by other means) is engaged in relation to this request this is a class based and absolute exemption, requiring no prejudice or public interest to be considered. https://www.justiceinspectorates.gov.uk/hmicfrs/publications/integrated-vulnerability-inspection-post-inspection-review/ In relation to polices there is also information available in the below link. https://www.cleveland.police.uk/foi-ai/cleveland-police/publication-scheme/our-policies-and-procedures/force-policies/

7. Review of control room management and tasking of domestic incidents. 8. Clear guidance to be created and circulated around the ongoing management of DA investigations where there is a suspect who still needs to be traced. Where a suspect has not been arrested for a DA incident the requirement to arrest/trace them should be handed over to the Investigation Team.	
HMICFRS *Following the response above from Cleveland Police, the researched submitted a FOI request* ***to HMICFRS, as follows****;* I would like to understand if and/or how HMICFRS utilise and/or engage in the Domestic Homicide Reviews to inform recommendations/professional practice. As such, please provide a response outlining the following; 1) Do HMICFRS review completed DHRs? If yes, how are these shared with HMICFRS? 2) If yes to above, how do HMICFRS utilise these reports to understand policing issues and assist inspections? 3) Is there relevant HMICFRS policy regarding review/utilisation of DHRs? If yes, please signpost. 4) Any relevant evidence and/or examples where DHRs have been utilised by HMICFRS to improve policing policy and/or practices. 5) Any other relevant information regarding this subject.	HMICFRS do not routinely review completed DHR's, as such there is no policy. Our PEEL inspection programme assesses the effectiveness, efficiency and legitimacy of police forces. Within the course of our inspection activity for PEEL, our Force Liaison Leads (FLL) may become aware of a current or recent DHR within the police force they are aligned to. This may be referenced by constabulary employees within interviews or focus groups. If the DHR has concluded, then the force representative may discuss the outcomes of the DHR and activity undertaken or planned within force to address any linked recommendations. This may then be referenced within our inspection evidence. The FLL may review a copy of the DHR dependent on the timescale in which it was completed, and whether it falls within the evidence gathering window for consideration. In cases where a DHR publication and HMICFRS inspection activity run in parallel but independently, concerns may be noted and suggestions made for improvement activity being aligned. Many of the improvement themes established with the DHR process are already considered within our PEEL inspection methodology.
National Probation Service 1. Details of domestic abuse history obtained from Police systems are routinely recorded in the Non-Disclosure Section of OASys, as well as in the Case Management System in order to ensure that this information is flagged to any member of staff who may need to access the case record. 2. Home Visit Guidance is reviewed and re-issued to all staff in order to reiterate the importance of home visits and the purpose of them in identifying and addressing risk factors, particularly where there is a history of domestic abuse. Staff should always be mindful of the potential risks to a victim when gathering information, making referrals, and recording and storing information. Systems and procedures must be put in place to ensure that risk to victims is minimised – which would include taking a cautious approach to discussing abuse directly with the victim and offender together in the same meeting.	With regard to the DHR concerning Durham and Tees Valley CRC; whilst this has been published there are ongoing matters which mean it would be inappropriate to comment at this time.

3. Information to be provided to staff in relation to the importance of clear and accurate recording on the case record of all offenders in order to ensure that all contacts and work undertaken are evident to any authorised individual accessing that record. 4. Guidance to be re-issued to staff in relation to caretaking cases and the importance of good communication between staff and the expectations around enforcement when caseholders are unavailable/on leave. In addition to the timeliness of requesting caretaking. (Caretaking means someone else has to look after the case in the absence of the allocated member of staff.) 5. National Standards guidance to be recirculated to staff in order to reiterate the level of contact expected and guidance around practice and expectations. 6. Guidance to be reissued to staff in relation to information sharing with other agencies in particular the police and MARAC to ensure appropriate information is shared in order to manage risk effectively.	
Durham and Tees Valley Community Rehabilitation Company (DTV CRC) 1. To improve DTV CRC's response and safeguarding of victims of domestic abuse 2. Improved response to safeguarding of adults. 3. Consistent response across DTV CRC team areas to MARAC. 4. Improved enforcement practice of Court Orders and defensible approach to absences. 5. Improved effective management oversight of practice 6. Improved Responsible Officer practice in regards to domestic abuse-related information and the overall context of risk and case management. 7. To enhance the skills of practitioners to recognise escalating and dynamic risk factors and respond to these effectively.	With regard to the DHR concerning Durham and Tees Valley CRC; whilst this has been published there are ongoing matters which mean it would be inappropriate to comment at this time.
DHR C1 – Annie	
Breakdown of recommendations	**FOI response / research result**
Cleveland police should use the learning from this case to review their processes and illustrate to officers the need to have a full understanding of a domestic abuse perpetrators offending history when completing a DASH RIC and considering whether disclosure should be made under the DVDS. This may be especially the case when a relationship is thought to be ending.	Nil response.

DHR D1 – Michelle	
Breakdown of recommendations	**FOI response / research result**
Bolton at Home 1. Ensure all operatives report any signs of vulnerability through to appropriate teams 2. Ensure all relevant information regarding relevant others (family/ friends/ partners) is recorded 3. Engage with relevant others where appropriate in the delivery of support interventions 4. Ensure cases are closed using a robust process 5. Ensure periodic contacts with other partner agencies for updates 6. Review current practice of refusing additional occupants at introductory tenancy stage 7. Ensure additional Police checks where offences/ risk is known	Bolton at Home website outlines 'We are a charitable Community Benefit Society. We do not constitute a public authority under the Freedom of Information Act 2000 (FOIA) and Environmental Information Regulations 2004 (EIR), and therefore, we are not obliged and we will not respond to, requests under such legislation as a matter of course.'
Joint Achieve Bolton and Bolton Clinical Commissioning Group 1. Systems and processes are in place between Bolton pharmacies and GMMH regarding the non-collection of methadone after 3 days. 2. Substance misuse provider to liaise with pharmacy contractors to ensure effective processes are in place. 3. GMMH to confirm the instruction to cancel or to continue the patient's prescription electronically by email enabling any authorised party may see clearly when that message was provided to the pharmacy. 4. An additional system for messages to be transmitted between pharmacies and Achieve Bolton in relation to concerns for the health and well-being of service users. 5. Staff should seek to identify relations / associations which may exist between service users in order to acknowledge such relationships in terms of risk assessment and care planning, including assessing the risk of the relationship, of each individual to each other and therefore, the risk of DAV 6. Achieve Bolton will work with GP's to improve information sharing and develop a clear procedure for the communication of concerns relating to service users. 7. All staff should be encouraged to question the information they receive, validate and clarify to ensure the information they have is accurate enough to inform robust risk assessment and care planning 8. Previous BIDAS Action's - All three organisations within BIDAS (previously commissioned service) should make greater efforts to work in partnership and to	1. This is covered via a prescription handling pathway and the service level agreement between GMMH and community pharmacies dispensing Opiate Substitution Therapy (OST). 2. The Achieve Bolton service has a clinical team who liaise with community pharmacies, supported by the Team and Operational Manager. 3. Requests to stop prescriptions are done by telephone with an entry added on the electronic record system to provide an audit trail. 4. Yes, there is a separate email specifically for pharmacies and a duty telephone line. 5. Following conclusion of this investigation and the organisational recommendations, a service wide learning event was held where this incident was discussed, and all were made aware of the recommendations. DV is covered as part of clinical risk training and is part of the assessment and review process. 6. Achieve Consultant Addiction Psychiatrist has engaged with Bolton GP's with training provided and this has contributed to improved communication. Achieve Bolton regularly ensure GP's are aware of how to make contact with the service, including during Covid lockdown, where communication went via the CCG. 7. This was covered in the learning event and features in regular staff supervision with triangulation of documentation, such as assessment, risk tools, multi-agency information, including MARAC.

engage external agencies within assessment, risk assessment and review processes. All 3 organisations within BIDAS need to demonstrate improved levels of information sharing and joint working. 9. Previous BIDAS action – Lack of engagement in elements of the service provided by BIDAS should prompt timely intervention and review from Case Management and other areas of the service as appropriate. This should be a joint approach from all 3 organisations	8. BIDAS was replaced by Achieve Bolton, who sub-contract The Big Life Group to undertake an assertive outreach function. There is a shared electronic record system, incident reporting system and staff are co-located. Assertive Outreach includes home visits and welfare checks, which would have included 'Michelle', had this model been operational at the time of this incident. 9. See response above. It should be noted that this incident pre-dated the GMMH contract and the model in place now would mitigate for many of the shortfalls discussed in the investigation and highlighted in the recommendations.
Bolton Clinical Commissioning Group 1. A more robust additional system for messages to be transmitted between the pharmacy and substance misuse services). This may be by email or other electronic system to allow identification of the message with a date and timestamp. The message may be from a preselected list i.e. patient failed to collect for 3-consecutive days. 2. NHS commissioners seek assurance from providers, Bolton Foundation Trust and GMMH as to the immediate response to a patient disclosing recent suicide attempts and suicidal ideation 3. GP Practices should consider the benefits of obtaining more medical, psychological and social information when patients register with their service, although this cannot be mandated as National Guidance precludes this. Consideration should be given as to the pertinence of the social and medical history to on-going care and "Coded" on the significant past history screen in the records accordingly. 4. GP and clinical practice staff to enquire regarding suicidal ideation self-harm and risk of harm to self at every contact regarding mental health. GP practices to gain and document a clearer understand of a patient's psychosocial protective and risk factors when assessing mental health. 5. GP practices to encourage all members of a household to register with the same GP practice. 6. GP Practices to have a repeat prescribing policy which indicates the frequency of medication review for certain conditions. The Policy should make reference to the cross-provider process when a patient does not attend for Methadone prescribing and a practice's action when repeated attempts to contact a vulnerable patient regarding their medication fail and there are concerns about the patient's safety.	1. Bolton CCG shared and discussed the findings from this review with the Local Authority and NHSE who are the actual commissioners of Achieve and Community Pharmacy. The GM Care Record enables the GP record to be shared with community pharmacy where appropriate. 2. NHS Bolton CCG Safeguarding Team seek assurance as the lead commissioner within the NHS safeguarding contractual standards annually. 3. GP's would consider this on first consultation and apply as appropriate but it is not a pre-requisite or indeed a requirement of registration. 4. This is considered at every consult as part of an ongoing risk assessment but there are times when this may not be appropriate and may not be beneficial to the consultation. The individual practitioner will make this call in line with their GP training in such conditions. 5. This is down to individual choice and convenience and there may well be justifiable reasons for registering with a different Practice to others in the household. 6. GP's all have a repeat prescribing policy and the frequency of medication reviews will be guided by the BNF or shared care arrangements with providers. The vulnerability of the patient is often very complex and not dependent on Methadone alone. 7. Community Pharmacies will contact the Provider (Achieve) who in turn would contact appropriate services. 8. The CCG safeguarding team has a good working relationship with the IRIS Project and within GP Primary Care services. There is on-going training offered by the provider across the system.

7. In particular, where a patient fails to attend for their methadone there should be a liaison between the 3 providers to agree a plan of action to ensure the patient is safe and on-going prescribing is appropriate. 8. GP practices to continue to engage with the IRIS programme and enquire regarding DAV (in a safe manner) when appropriate.	
Cheshire & Greater Manchester CRC 1. Information Sharing Agreement with GMP regarding Domestic Abuse Call Outs is not functional and reliant on requests from CGM CRC to GMP. 2. CRC (Bolton) needs to ensure that all relevant issues identified are communicated to all practice staff.	With regard to Cheshire and Greater Manchester I can report that, as part of the DHR / IMR process, a Senior Probation Officer sat on all panels to contribute understanding and learning, with any actions set for the CRC having and oversight by the Community Director (CD), to ensure that they were completed in a timely manner. The CD reviews all DHRs and if learning was identified this would be shared across the organisation. This was built into Practice Development Days and/or further targeted training. In terms of Domestic Abuse, a full training package was delivered as a refresher between 2019 and 2020 to all practitioners in Cheshire & Greater Manchester. This was complimented by further e-learning. In respect of the specific action concerning information sharing, under Section 8 of the contract held by Cheshire & Greater Manchester, all cases, regardless of offence were required to have a check with the local police area for domestic abuse call outs. This was achieved through the Service Level Agreement with Cheshire and Greater Manchester Police. Performance with this was measured by the performance team and reported to the Senior Leadership Team on a monthly basis.
Department for Work and Pensions DWP will look to strengthen the instructions when ESA claims are suspended.	The instructions are available on the DWP intranet, which is an online information system, and are available to all benefit processing staff. Senior staff have engaged with all colleagues through telephone conferences to increase awareness and Team Leaders will promote these with their staff.
Greater Manchester Health and Social Care Partnership 1. To disseminate the anonymised details of the case to other NHS Contractors to consider their own operational systems for resilience and response to concerns in relation to Domestic Abuse 2. To update Safeguarding training for community pharmacies that provide Drug and Alcohol services. 3. To develop standards for the administration, prescribing and dispensing of controlled drugs by community pharmacy across Greater Manchester	1. The Greater Manchester Health and Social Care Partnership (GMHSCP) shared the findings with Community Pharmacists, Pharmacy Superintendents and we share at the Local Intelligence Network for controlled drugs 2. This was in progress pre COVID, the pharmacist has to be Level 2 trained. The Primary Care Team commissioned Safeguarding training and we recommend that Commissioners included in their contracts.

	3. We used the lessons learnt model to disseminate information. There are controlled drug Regulations and we have the controlled drug reporting system which pre-Covid was use widely by Community Pharmacies.
Greater Manchester Police The issues revealed by this IMR in relation to internal and external communication the recognition of vulnerability in missing person cases and prioritisation of FWINS where vulnerability is a factor are to be reported to GMP's Organisational Learning Board for assessment. Relevant learning from that assessment to be disseminated across GMP.	Nil response.
Lancashire Constabulary 1. Training to Contact Management staff on the importance of correctly classifying incidents from the outset or amending the classification as further information comes to light. 2. Golden hour tasks required to be undertaken on receipt of a Missing Person's Report to be conducted expeditiously. 3. Cross border missing person investigations and more complex investigations be allocated a SPOC on initial transfer. 4. Full and concise information be gathered upon deployment to a Missing Persons incident. 5. Training be delivered to all staff involved in Missing Person enquiries and this to be tailored to their role. For example-: Contact management, DRU, PC, Sgt, DRI and DI. 6. Undertake a review of the current procedures TO REVIEW A MISSING PERSONS RECORD, taking into account both timescales and role of the reviewer and ensure future IT systems running Missing Persons investigations have the capability to incorporate review timescales tailored to the specific investigation. 7. Ensure specialist skills and knowledge are available to Officers undertaking Missing Persons investigations so they can request the correct resource, to aid the investigation. For example-: POLSA; Missing Persons Manager; Digital Media Officer, in order to incorporate specific actions when and where necessary. 8. The Constabulary to adopt a Missing Persons management IT solution that assists in the delivery of an effective investigation. 9. Clear ownership of each investigation and an officer in the case allocated to the family	The Freedom of Information Act 2000 provides a general right of access to all types of recorded information held by public authorities, at the time a request is received. This right is outlined under Section 1 of the Act and has two aspects. Firstly, the public authority must (unless an exemption applies) confirm whether or not the information requested is held. Secondly, where information is held, the public authority must (unless an exemption applies) communicate that held information to the applicant - in other words disclose the held data. Section 84 of the Act additionally states, that the right of access is to recorded information. For example, an FOIA request would be for a copy of a policy document, rather than an explanation as to why a policy is in place. The Act does not cover general questions about, for example, a policy, instructions/guidance or decisions, or analysis, interpretations, explanations, assessments, opinions, comments or unrecorded discussions. We do not hold any recorded information in respect of these questions, however the explanation below provided outside of the FOIA may assist you. The recommendations were all included in an action plan created on behalf of the independent chair of the Domestic Homicide Review into the death as part of the Domestic Homicide Review process. Lancashire Constabulary completed, and implemented where necessary, all the organisational single agency recommendations assigned to them and they were marked as completed over a course of time on the action plan by the reviewer.

National Probation Service 1. A short term piece of work should be undertaken to develop existing practice which ensures that all PSR (pre-sentence report) writers in the Bolton NPS Court Team are briefed and reminded of the need and importance of recording all relevant historical information in the ROSH analysis document, regardless of its inclusion or not within the PSR document 2. To improve the focus of 'Domestic Abuse' when report writers are preparing sentencing reports, despite the index offence not including any evidence of domestic abuse. To increase professional curiosity when preparing reports in terms of an individual's relationship status.	In response to the Action Plan contained in the DHR the following actions were taken to embed practice around domestic abuse (DA) in the relevant teams in Bolton: • There was an NPS Court Team briefing to discuss initial DHR findings • The NPS Court Team manager completed 10 PSR/ROSH assessment dip samples after the briefing to check if the learning had been embedded • There was an NPS 'All Bolton OM Briefing' in Feb 2019, in which the Case Study and DHR learning was discussed • The case study/learning was also discussed within the NPS Court Team In terms of implications for wider practice/policy; there is specific domestic abuse training for court practitioners/PSR authors supported by guidance on what safeguarding checks are required to prioritise the safeguarding of children and adults at risk. The guidance is available on EQUIP which is the Probation Service central repository for the organisation's business processes and can be accessed by all grades of staff. There are regular audits of PSRs - the performance team collate all cases assessed at Court for surety that DA/ safeguarding checks are completed so there is evidence of ongoing proactivity and learning to the actions. The refreshed "Touch Point" model and introduction of Quality Development Officers provides an improved quality assurance framework for risk assessment practice, in which the assessment and analysis of DA behaviours is part. As part of the unified model there will be a budget increase of 8 million pounds to strengthen probation's effectiveness in court with the improved use of PSR's to achieve better outcomes/sentences. In respect of CRC staff and the training they have/will receive it is important to note that CRC staff received broadly the same training as NPS staff pre-unification. As part of arrangements for unification, a training plan was implemented for CRC staff 12 months prior. This training included Domestic Abuse and Child Safeguarding training, both e-learning and classroom based training (2 days classroom training), and Adult Safeguarding eLearning and classroom based training (1 day classroom training). This training must be renewed every 3 years. As part of post-unification training former CRC staff will be required to undertake the following: • The mandatory, statutory training for Domestic Abuse and Child Safeguarding and Adult Safeguarding described above- if required • SARA v2 online training • Domestic Abuse Polygraph Training • Risk Assessment Steps 1-4 and the Four Pillars-contains information about the wider domestic violence context and different domestic violence offences • For Court staff including PSOs and PSR authors specific training referenced above

	• Skills for Relationships toolkit training. • Victim contact scheme training • 7-minute briefings on Forced Marriages; Disclosure; Honour Crime; DA as a driver to Women's' offending; • NPS risk training The above is further supported by the guidance on EQUIP and My Learning, which is the HMPPS digital learning platform, and has a significant range of domestic violence related learning which staff can access at the point of need.
DHR E1 – Sarah	
Breakdown of recommendations	**FOI response / research result**
National (This FOI was submitted to Home Office) There should be consideration of developing a process whereby information about high-risk domestic abuse offenders is shared across international boundaries.	Recommendations and actions made in DHRs need to be taken forward by the local CSP and the organisations and agencies to which they are relevant, as per sections 75, 76 and 77 of the statutory guidance. The CSP is in charge of monitoring the implementation of the actions set out in the action plan and formally concluding the review when the action plan has been implemented, as per sections 79 f and g of the statutory guidance. The Home Office does not tend to respond to national recommendations made in DHRs when writing to CSPs, however we do record all recommendations. We are currently considering how we can improve the oversight and implementation of national recommendations, including how we can provide feedback to local areas on actions taken in response to them.
Greater Manchester Police 1. To ensure that officers probe information provided by victims in relation to previous domestic abuse. This is particularly important in relation to incidents in other areas and the need to complete relevant checks, for example, the Police National Database (PND). 2. To ensure that all officers who have contact with victims of domestic abuse understand the importance of providing relevant helpline and support signposting. When it has been done, a record should be made as to what information has been provided to the victim. 3. To ensure that supervisors make proper use of an up to date induction package for newly appointed domestic abuse specialists when they start in post. 4. To ensure that whenever children are present during incidents of domestic abuse they are communicated with, listened to and their welfare considered.	Nil response.
Pennine Acute NHS Hospitals Trust (North Manchester General Hospital Accident and Emergency)	Nil response.

1. To conduct regular audits to ensure patients identifying signs of domestic abuse are supported appropriately. 2. To ensure that DVA training includes good practice around interviewing the victim and perpetrator separately. 3. To ensure that safe enquiry is conducted in the event of domestic abuse disclosure, regardless of whether the victim is the patient or partner, friend or relative accompanying them. 4. To carry out a risk assessment for any person disclosing domestic abuse in line with MSAB/MSCB guidelines 5. To ensure that lessons learned from this DHR are cascaded to staff as appropriate.	
Manchester Mental Health & Social Care Trust 1. To ensure that DVA training includes good practice around interviewing the victim and perpetrator separately. 2. To ensure that safe enquiry is conducted in the event of domestic abuse disclosure, regardless of whether the victim is the patient or partner, friend or relative accompanying them. 3. To carry out a risk assessment for any person disclosing domestic abuse in line with MSAB/MSCB guidelines 4. To cascade lessons learned from this DHR to ensure that clinicians consider the full facts rather than just responding to the presenting issue, e.g. domestic abuse as well as mental health issues.	Nil response.
Manchester Clinical Commissioning Group (GP) 1. To improve GP awareness of symptoms and behaviour associated with DVA through IRIS training 2. To disseminate learning from the DHR via Safeguarding Newsletter, CCG Website.	1. IRIS (Identification and Referral to Improve Safety) is a General Practice based Domestic Violence and Abuse (DVA) training, support and referral programme for General Practice staff which is commissioned by MHCC. All 85 Manchester GP practices have received IRIS training which includes identifying the symptoms and behaviour associated with DVA. The training is regularly reviewed to include learning from domestic homicides and other statutory reviews. The training is also provided as an update session every 3 years and any new starters can access training at 'mop up' sessions offered locally. The effectiveness of training is evidenced by increased referrals by Primary Care to IRIS over the years, last year GPs made 741 referrals. 2. The learning within the 7 minute briefing was circulated 26.11.2018 by the Director of Corporate Affairs MCCG and all learning from DHRs is included within the IRIS training delivered to practices.

North West Ambulance Services 1. To ensure that awareness raising with staff takes place in relation to the consideration of immigration status and to be curious why a patient may not have a GP.	The attached training slides are delivered to all patient facing staff, hear and treat managers, advanced paramedics, consultant paramedics, Frequent Caller Team, EOC managers and support centre staff.
Robert's (Sarah's son) school (This FOI was submitted to Manchester School Governance Unit) 1. The school should take action to ensure that staff are familiar with the possible indicators of domestic abuse and the impact on the child. 2. The school should consider accessing Healthy Relationships Awareness sessions for pupils, which looks specifically at domestic abuse and relationships. 3. To review the effectiveness of changes to the system where Deputy Head Pastoral reviews all counselling appointments every week to check who has attended and who hasn't. There should be a system of follow-up as necessary. 4. To ensure that all records relating to children are accurate and visits to the school nurse are included in the Head of House Meeting Minutes 5. To ensure that where children are concerned with their workloads, a referral is made to their personal tutor to discuss and plan support.	Response provided by Manchester City Council, Children's and Education Directorate. Q1 & 2. The school participates regularly in safeguarding networks and training on a range of topics arranged by the Local Authority. Training has included Domestic Violence and Abuse, mental health and also healthy relationships. This is evidenced by the completed annual Safeguarding returns as requested by the Local Authority which cover policies, procedures, staff training and curriculum. The school keeps their safeguarding policy up to date, which includes sections on staff awareness of the signs of abuse and relevant referral processes. Q 3,4 & 5. The actions for the school in the Domestic Homicide Review Action Plan were reviewed with the school at the time. The Safeguarding Lead for Education, together with the Domestic Homicide Review Lead, liaised with the Senior Leadership Team and visited the school. School had amended their processes around welfare and record keeping in line with the recommendations in the action plan.
DHR E2 – Jenny	
Breakdown of recommendations	**FOI response / research result**
Manchester Clinical Commissioning Group (CCG) The CCG should ensure that all appropriate staff in General Practice are IRIS trained and confident in making safe enquiry into domestic abuse where clinically indicated.	IRIS (Identification and Referral to Improve Safety) is a General Practice based Domestic Violence and Abuse (DVA) training, support and referral programme for General Practice staff which is commissioned by MHCC. All 85 Manchester GP practices have received IRIS training which includes making safe enquiry into domestic abuse where clinically indicated. The training is regularly reviewed to include learning from domestic homicides and other statutory reviews. The training is also provided as an update session every 3 years and any new starters can access training at 'mop up' sessions offered locally. The effectiveness of training is evidenced by increased referrals by Primary Care to IRIS over the years, last year GPs made 741 referrals.

DHR E3 – Shawn	
Breakdown of recommendations	**FOI response / research result**
Manchester Health and Care Commissioning 1.The findings from the review are shared with Primary Care with the expectation that all presenting needs of patients are considered and that professional curiosity is exercised to contribute to risk assessment. Ensure that GPs inform patients of services they can access during the period they are waiting for a mental health outpatient appointment. 2. Review how GP practices can engage with those patients that are traditionally difficult to engage including review areas of best practice and consider how an outreach approach may be implemented. 3. Primary Care to be updated on self-neglect as a safeguarding issue and equipped to make a social care referral for self-neglect/vulnerability rather than only considering a mental health referral.	Nil response.
Clinical Commissioning Group (CCG) (GP Practice 1) Ensure that patients with a drug dependency have a medication review at least annually.	The majority of patients with a drug dependency are now supported by Change Grow Live in Manchester who prescribe and monitor, regularly review medications used in drug treatment, offer referrals to rehabilitation services, sign post to needle exchange and provide holistic advice and support.
Equity Housing 1. Using this case to issue a reminder to colleagues about the importance of maintaining detailed and accurate records 2. Give consideration to providing potential witnesses with written information about domestic abuse and advice about timely contact with appropriate agencies such as Domestic Abuse helplines, the Police, Crime Stoppers etc. 3. Review the Domestic Abuse policy and procedure in the light of any recommendations and actions flowing from this case review.	At present, Housing Associations such as ourselves are not subject to the Freedom of Information Act 2000. This is because we are not a public authority as defined under s3(1) of the same. Therefore, we do not have a statutory obligation to respond to requests for information made under this legislation. Equity Housing Group merged with Great Places Housing Group on 1 April 2020. Customers can find information relating to Domestic Abuse on our website (www.greatplaces.org.uk). We can also confirm that we are currently reviewing policy documentation, in addition to training and resources for colleagues and customers, in line with the Domestic Abuse Bill and Social Housing White Paper. We have a Strategic Safeguarding Group who oversee the implementation of training, policies and procedures (including recording systems), and our response to Domestic Abuse is kept under constant review to ensure best practice.
GMMH 1. Review the caseloads of the outpatient Consultants in order to reduce the waiting time for initial none urgent outpatient appointments	Nil response.

2. Specialist Consultant to be made aware of the requirements of the Adults of Working Age SOP	
Wythenshawe Community Housing Group (WCHG) 1. Ensure further referrals are made into MASH and/or Mental Health services where there have been numerous failed attempts to engage and where there are multiple risk factors. 2. Case closure will also be subject to a management case review and where appropriate the number of contact attempts will increase from 3 to 6 visits. 3. Seek to improve links between WCHG and GP practices via the Local Care Organisations and other partnership working, with the aim of agreeing a process for information sharing between housing provider and GP where appropriate.	1. WCHG takes a holistic approach to the way it delivers its services based on the 'Our Manchester' model of an asset based approach to core agencies and local communities. We work with the local community together to tackle issues and build on the strengths of our neighbourhoods through upskilling and engaging local residents to make a difference in their local community. Based on this approach WCHG has developed our 'Wythenshawe Integrated Neighbourhood Service (WINS) team. This team specifically focuses on high demand service users regularly presenting themselves to the Greater Manchester Police, NHS and Manchester City Council/social services for support. The WINS team review cases of mental health, safeguarding issues, crime, ASB, domestic violence and alcohol misuse to provide a bespoke and tailor made support package to the user. The team meets every week with associated partners to discuss each support package for individual users. 2. Due to the Coronavirus restrictions, since March 2020 WCHG has restricted the number of visits carried out to tenants' homes in line with Government guidance. Teams across the business are re-starting home visits as the lockdown is eased, but are following appropriate health and safety procedures. During the pandemic, for cases at key stages or where urgent contact was needed colleagues in Assure 24 (community safety) team were asked to make visits, and anything untoward noted on these visits would be proactively reported as a safeguarding issue, via our 'If in doubt, shout' safeguarding procedure, which all teams working either over the phones or making home visits follow. As part of returning to normal the Rents team is completing home visits before starting legal action or evictions proceedings. There are also checks with other teams to see if they have had any contact with the client; for example, Tenancy Management or Tenancy Support. 3. WCHG currently meets once a week with the Local Care Organisation (LCO) to discuss what's happening, any hot topics, demands, challenges, initiatives within our localities. Information is shared and acted upon if necessary with all necessary parties. The LCO has had many changes since

	the review, and the pandemic has brought significant challenges to working practices. We will continue to share information in order to bring about stronger partnership working that benefits the residents of Wythenshawe. We share this information by way of the WINS data sharing agreement and within the terms of section 17 of the Crime and Disorder Act 1998 & 11 2(b) and of the Care Act 2014.
DHR E4 – Niki	
Breakdown of recommendations	**FOI response / research result**
Nil single agency recommendations.	Not applicable.
DHR F1 – James	
Breakdown of recommendations	**FOI response / research result**
Nil single agency recommendations.	Not applicable.
DHR F2 – Catherine	
Breakdown of recommendations	**FOI response / research result**
Greater Manchester Police 1. That, if it comes to light a victim has been a perpetrator, or vici versa, there is a process for revisiting and, if necessary, reclassifying the roles; 2. The Oldham Community Safety and Cohesion Partnership request Greater Manchester Police take steps to raise awareness of domestic abuse services to persons who are in custody as perpetrators of domestic abuse; 3. Greater Manchester Police consider, when a caution is to be administered for domestic abuse, that if practicable, the case is first discussed with a specialist domestic violence officer.	Nil response.

DHR G1 – Ethel	
Breakdown of recommendations	**FOI response / research result**
Greater Manchester Police should determine whether their current domestic abuse policies and practices are a barrier to victims reporting domestic abuse in cases where physical injuries are absent.	Nil response.
That Pennine Care NHS Foundation Trust audits health visiting records for compliance with 'Routine Enquiry.'	Nil response.
DHR G2 – Olivia	
Breakdown of recommendations	**FOI response / research result**
Heywood, Middleton and Rochdale Clinical Commissioning Group (CCG) 1. When a disclosure or threat of violence is identified this must be recorded immediately. 2. GP's will consistently record, flag and chronologies on EMIS (Electronic Patient Record system) disclosures of domestic abuse. Records will clearly evidence discussions held including patient's capacity, risk assessments undertaken and resulting referrals. 3. Bespoke GP training made available for GPs and Practice Staff 4. GP's and GP Practice staff will have an increased knowledge base of domestic abuse, risk factors, risk assessment, local support services available and responsibilities for sharing information	This DHR was later removed from the CSP website; therefore, the data gathered has been used in this research, however, the content was not analysed further.
North West Ambulance Service Hold a learning review with the Support Centre Managers.	This DHR was later removed from the CSP website; therefore, the data gathered has been used in this research, however, the content was not analysed further.
Pennine Care NHS Foundation Trust Early Intervention Team 1. To ensure robust assessment of domestic situations within the patient profile of mental illness, alcohol use and aggressive behaviour. 2. To consider current training needs of mental health practitioners working for PCFT. 3. Establish closer links between EIT and CMHT services. 4. Review of PCFT policies and procedures relating to complex case management ~~5.~~ Review of multiagency processes in place within Rochdale that facilitates joint assessments and effective care planning.	This DHR was later removed from the CSP website; therefore, the data gathered has been used in this research, however, the content was not analysed further.

Rochdale Borough Council Adult Care 1. All duty staff should consider the needs of all household members, along the "Think Family" ethos and ensure that appropriate signposting takes place for other household members. 2. Staff should not make presumptions that other teams are involved without checking. 3. To review management oversight of EDT in relation to quality of practice, training needs and supervision. ~~4.~~ Learning from this review and lessons learnt to be disseminate to the wider workforce	This DHR was later removed from the CSP website; therefore, the data gathered has been used in this research, however, the content was not analysed further.
Greater Manchester Police 1. The issues revealed by this IMR in relation to the recognition of Disability and Mental health problems; Inter-agency communication and information sharing and Resources are to be reported to GMP's Organisational Learning Board for assessment. Relevant learning from that assessment to be disseminated across GMP 2. Professionals need to recognise all the factors that are present that may impact upon the levels of risk of domestic abuse including mental health and pregnancy. Narrative: GMP were called to a domestic incident at address involving an argument between Mario and Olivia. The incident was recorded as domestic abuse and a DASH completed. However there appeared to be no cognisance of the fact that Mario suffered from mental health problems or that the cause of the argument might have been Olivia's pregnancy. 3. All disclosures concerning incidents of domestic abuse should be explored. There may be evidence of a crime that requires investigation. Professionals need to ask questions, establish all the facts and recognise the appropriate response to take when they receive such information. Narrative: When police officers attended address one on 18 November 2016 they were told that Mario had attacked Olivia and had used a knife. Olivia showed a police officer a computer tablet with a document she had written that contained information that she had been subjected to domestic abuse, this included controlling behaviour. There was also information that Mario had wounded her with a knife, that he had assaulted her by throwing her to the floor and that he had tried to exercise control over her. The police officers who received the information about the use of the knife erroneously believed the matter had already been dealt with. The officer who read the document stated they only skim read it. 4. Professionals need to recognise when there may be a risk to life and ensure that an appropriate response is provided. Narrative: When GMP received the initial call from NWAS they delayed the response on the basis that there were	This DHR was later removed from the CSP website; therefore, the data gathered has been used in this research, however, the content was not analysed further.

insufficient police resources and that the matter was a medical issue rather than one that involved a risk to Olivia.	
DHR H1 – Susan	
Breakdown of recommendations	**FOI response / research result**
Nil single agency recommendations.	Not applicable.

Appendix C – Ethics Approval Form

ETHICS CHECKLIST FOR STUDENTS (approved February 2013)

This form is intended as an initial checklist for students proposing to undertake ANY research.

Student:	Laura Robinson
Email:	ROBL5_19@UNI.WORC.AC.UK
Instititute:	School of Psychology
Student Status:	Current Student
Supervisor:	Beverley Gilbert
Tutor:	Beverley Gilbert
Module Leader:	Holly Taylor
Reference	01191021310
Project Title:	How have the findings from Domestic Homicide Reviews in England and Wales from 2017 to 2019 impacted professional practice?

No.	Question	Answer
1.	Does your proposed research involve the collection of data from human participants?	No
2.	Does your proposed research require you to gain access to secondary data or documentary material through an organisation or individual?	No
3.	Does your proposed research involve the use of data or documentary material which (a) is not anonymised **and** (b) is of a sensitive or confidential nature **and** (c) relates to the living or recently deceased?	No
4.	Does your proposed research involve participants who are particularly vulnerable or unable to give informed consent? *(If your project involves adults who lack capacity to consent, please refer to the Guide to the Ethics Checklist as it may need to be reviewed by an NHS Research Ethics Committee)*	No
5.	Will your proposed research require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited?	No
6.	Will financial inducements be offered to participants in your proposed research beyond reasonable expenses and/or compensation for time?	No
7.	Will your proposed research involve collection of data relating to sensitive topics?	No
8.	Will your proposed research involve collection of security-sensitive materials?	No
9.	Is pain or discomfort likely to result from your proposed research?	No
10.	Could your proposed research induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	No
11.	Will it be necessary for participants to take part in your proposed research without their knowledge and consent at the time?	No
12.	Does your proposed research involve deception?	No
13.	Will your proposed research require the gathering of information about unlawful activity?	No

14.	Will invasive procedures be part of your proposed research?	No
15.	Will your proposed research involve prolonged, high intensity or repetitive testing?	No
16.	Does your proposed research involve the testing or observation of animals?	No
17.	Does your proposed research involve the significant destruction of invertebrates?	No
18.	Does your proposed research involve collection of DNA, cells, tissues or other samples from humans or animals?	No
19.	Does your proposed research involve human remains?	No
20.	Does your proposed research involve human burial sites?	No
21.	Will the proposed data collection in part or in whole be undertaken outside the UK?	No
22.	Does your proposed research involve NHS staff or premises? *(If yes, before completing this application it is important you refer to the further guidance in the Guide to the Ethics Checklist)*	No
23.	Does your proposed research involve NHS patients? *(If yes, before completing this application it is important you refer to the further guidance in the Guide to the Ethics Checklist)*	No

Details of Research
Outline the context and rationale for the research, the aims and objectives of the research and the methods of data collection. This should draw on the previous literature and should be more than simply a set of aims and objectives. The methods of data collection also need to be justified, and the selection of specific measures or tests should be justified in relation to their validity for the population in question.

A Domestic Homicide Review (DHR) is a multi-agency 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 person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves (Home Office, 2016). Since 13 April 2011 there has been a statutory requirement for local areas to conduct a DHR following a domestic homicide that meets the criteria. The purpose of a DHR is outlined in the Statutory Guidance (Home Office, 2016). Broadly, these purposes are; to identify lessons, improve practice, inform local and national policies, prevent domestic violence and homicide and improve service responses, better understand DV, and highlight good practice (Home Office, 2016).

In December 2016, the Home Office published a report, entitled, Domestic Homicide Reviews: Key findings of analysis from Domestic Homicide Reviews. Analysis was conducted of 40 DHRs published between 2013 to 2016 in England and Wales. The report broadly outlined common themes and trends and identified learning that emerged across the sample of DHRs. The purpose of which was to promote key learning and trends from the sample of DHRs with the aim of informing and shaping future policy development and operational practice both locally and nationally (Home Office, 2016).

Extensive research has been undertaken utilising information from DHRs; much of which seeks to identify patterns and trends in respect of perpetrator behaviour and public authority responses. The purpose of my research is to conduct a documentary analysis and comparison of a sample of DHRs between 2017 and 2019 (post previous Home Office research) to identify whether similar issues continue to occur, or not and draw out evidence of whether DHRs findings improve policy and practice to prevent domestic violence and homicides. I will approach this research through the pragmatic paradigm, using mixed methods to establish conclusions. To select the DHRs for review, I will select up to three Community Safety Partnerships where DHRs are easily accessible through their websites and use all relevant DHRs published over the prescribed period, therefore up to 20 DHRs will be reviewed.

The majority of domestic homicides are perpetrated within an intimate partner relationship, rather that the familial or other domestic arrangements (Home Office, 2016), therefore I will only include DHRs relating to intimate partner homicide (including ex-intimate partner homicide); the same criteria was set in the Home Office research in order to avoid conflating issues within the findings. No other criteria will be applied; therefore, all genders of victims and perpetrators will be included.

Where DHRs provide findings and recommendations in respect of public authority policy and/or practice improvement, I will utilise the Freedom of Information Act 2000 to submit requests to measure compliance. The research conducted by the Home Office in 2016 concluded that training was consistently the highest proportion of recommendations; using this conclusion as an example, my research will seek to establish whether the same conclusion can be drawn

from later DHRs samples, or whether there appears to be improvement in this area. Freedom of Information requests can be utilised where a similar recommendation has been made, to establish how the recommendation has been taken forward by agencies. I will also make use of relevant Government Publications, national and local policy in respect of relevant issues identified in the DHRs and examine existing literature to inform my research.
Who are your participants/subjects? (if applicable)
N/A
How do you intend to recruit your participants? (if applicable)
This should explain the means by which participants in the research will be recruited. If any incentives and/or compensation (financial or other) is to be offered to participants, this should be clearly explained and justified. The sample size should be justified either on the basis of a power analysis, or on the basis of previous studies. Please ensure that you include in your application copies of any poster(s), advertisement(s), emails or letter(s) to be used for recruitment.
N/A
How will you gain informed consent/assent? (if applicable)
Where you will provide an information sheet and/or consent form, please append this. The University of Worcester Participation Sheet and Privacy Statement template must be used. If you are undertaking a deception study or covert research please outline how you will debrief participants below
N/A

Confidentiality, anonymity, data storage and disposal (if applicable)
Provide explanation of any measures to preserve confidentiality and anonymity of data, including specific explanation of data storage and disposal plans. Plans for data storage and disposal must be feasible given the nature of the study. Please use the following headings: 1. **Confidentiality:** will participants be identified *(directly or indirectly)* in any study outputs or their identity disclosed to any third party? If yes, please provide further details and justification. 2. **Anonymity:** are the data being collected fully anonymously i.e. the identity of participants *(directly or indirectly)* will not be known at any point to the researcher? If the data **are not** being collected anonymously will it be stored in an identifiable format, or after data collection will it be anonymised *(permanently de-identified to the researcher) or pseudonymised (process whereby all identifiers are removed and a unique reference is assigned to each participant to which the researcher retains the key, in a separate secure location and is therefore still able to identify a participant's data)?* Please give full details. 3. **Data storage:** where will the data *(paper and electronic)* be stored including consent forms? Who will have access to the data? If applicable, include details of level of encryption on portable devices. 4. **Disposal:** how long will the data be stored? What arrangements will be in place for the secure disposal of data? **For guidance please refer to the current UW Policy for the Effective Management of Research Data and the Undergraduate & Post Graduate Taught Data Storage Guidance**
N/A
Potential risks to participants/subjects (if applicable)
Identify any risks for participants/subjects that may arise from the research and how you intend to mitigate these risks. Potential risks to the researcher must also be considered. Risks may include physical, practical, psychological and emotional consequences of participation.
N/A
Other ethical issues
Identify any other ethical issues (not addressed in the sections above) that may arise from your research and how you intend to address them.

I consider that this research is justified to understand if current statutory guidance is working and whether professionals and organisations are acknowledging lessons identified and taking forward to improve professional practice. I do not require volunteer participation during this research and DHRs are anonymised and are accessible as public information through Community Partnership Websites and/or on request, therefore I am not requesting ethical approval. I do not assess that there are any Health and Safety or safeguarding concerns during this research. Although this research does not require participation or consent, and personal details will be widely publicly available; it is critical that the research remains sensitive and avoids drawing reference to any particular case or person.
How specifically are you working to mitigate the transmission of COVID-19
Please include reference to any specific protocols or subject-specific guidance that you are following. This should include all stages of the research, but particularly recruitment of participants and data collection. Please also consider whether the risk to participants is increased due to their potential direct or indirect experience of COVID-19.
All my research will be conducted at my home address and participants are not required.
Published ethical guidelines to be followed
Identify the professional code(s) of practice and/or ethical guidelines relevant to the subject domain of the research.
Home Office, 2016. Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance161206.pdf (Accessed 6 January 2021). Freedom of Information Act 2000. Available at: https://www.legislation.gov.uk/ukpga/2000/36/contents (Accessed 6 January 2021).

Comments

If you encounter any technical difficulties when completing this form please contact SOLEhelp via the (IT Service Desk). If you have any ethics related queries when completing this form please consult the Ethics Guide for Staff and Students or your supervisor.