



Home Office

Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004

June 2006

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MINISTERIAL FOREWORD

The Government takes domestic violence very seriously and is committed to addressing the challenge of a crime that not only devastates individual lives but affects society as a whole.

The Government definition of domestic violence is:

“Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.”¹

The changes in the legislation and the development of our National Delivery Plan set out key outcomes and objectives that we are committed to delivering at both a national and local level, and clearly demonstrate the Government’s commitment to tackling this devastating crime.

A key outcome for the National Delivery Plan² is:

“...to reduce the number of domestic violence related homicides.”

Our work has already made a difference in that the number of women who are killed as a result of domestic violence has fallen by 14 per cent over the last two years. Currently around 103 women and 36 men are killed as a result of domestic violence,³ which highlights that we need to do more to prevent these deaths. A systematic review in the case of a domestic violence homicide is one way that we can learn lessons to prevent assault, significant injury and, ultimately, murder.

Section 9 of the Domestic Violence, Crime and Victims Act 2004 introduces a statutory basis for local bodies to establish homicide reviews for victims of domestic violence. This will bring the procedure into line with current practice for serious case reviews following the serious injury or death of a child.

During the passage of the Act through Parliament we agreed to a full three-month consultation period to give key stakeholders the opportunity to comment on the exact process and methodology that domestic homicide reviews should take.

We recognise that there is still further work to do and we need to work together to provide support to help local agencies analyse their policy and practice to ensure that they provide a co-ordinated community response to domestic violence. This consultation sets out the areas that the Government feels need full consideration in the development of guidance for these reviews.

We all need to take responsibility to bring about change and keep our family, friends and communities safe from domestic violence. I want to thank you all for the work you have done and will do to make domestic violence part of our history and not our future.

We very much look forward to hearing your views.

Rt Hon Baroness Scotland QC

¹ This was revised from the previous Home Office definition to include violence between family members over 18 as well as adults who are, or were, intimate partners. This ensures that those issues of chief concern to black and minority ethnic communities, for example honour-based violence, forced marriage and female genital mutilation, are properly reflected. This reflects concerns voiced by many in responses to the safety and justice consultation paper.

² www.crimereduction.gov.uk/dv01.htm

³ Coleman, K., Hird, C., and Povey, D. (2006) Violent Crime Overview, Homicide and Gun Crime 2004/2005 (Supplementary Volume to Crime in England and Wales 2004/2005). *Home Office Statistical Bulletin*, 02/06.

EXECUTIVE SUMMARY

This consultation paper sets out proposals for the format that domestic homicide reviews should follow. As part of their statutory duty under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 local bodies will be required to have regard to the guidance when establishing reviews.

Under section 9(1) of the Act a domestic homicide review is defined as “a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- (a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship; or
- (b) a member of the same household as himself/herself,

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

This guidance covers different aspects of the review methodology from the initial stages of determining whether a review should take place and the level of involvement from family members to the production of the final report.

The statutory purpose of a review is to learn lessons from the death. In practice this will include:

- identifying the lessons to be learnt, in particular about how local professionals and agencies work together to safeguard victims;
- identifying how those lessons will be acted upon and what is expected to change as a result; and
- improving inter-agency working and improving protection for domestic violence victims.

Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

This guidance is based on that already in use for serious case reviews (SCRs) of the death or serious injury of a child where abuse or neglect is or is suspected to be a factor.⁴ The 11 sections of this guidance identify particular themes that need to be addressed by the agency which eventually takes on responsibility for conducting the review. Therefore, it is important that we hear from as many people as possible to make sure that we are learning everything we can to ensure better services for future victims.

We recognise that domestic violence may have different consequences for victims from different communities. Victims in some black and minority ethnic communities may be discouraged from speaking out about violence for fear of bringing dishonour upon their family or community.

We acknowledge that domestic violence and abuse can also manifest itself through the actions of immediate and extended family members through the perpetuation of activities, such as forced marriage, honour-based violence and harmful traditional practices. Extended family members may condone or even share in the pattern of abuse.

We also know that the dynamics, and therefore the indicators, might be different for people who are lesbian, gay, bisexual or transgendered, and different again for male victims when there are female perpetrators. All of this will need to be considered when reading this guidance.

We would also like to hear your views and comments on whether any aspects of the review process will have an impact on equality and diversity issues. Questions covering diversity issues have been posed throughout this guidance.

⁴ *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children.* HM Government 2006. London: The Stationery Office.

YOUR VIEWS

Please write with your comments,
by 13 September 2006, to:

Domestic Violence Team
Violent Crime Unit
Home Office
4th Floor Peel Building
2 Marsham Street
London
SW1P 4DF

Or send to:
DVHRGConsultation@homeoffice.gsi.gov.uk

For additional hard copies please contact us
at the address above. Electronic copies of this
document can be found on the crime reduction
website at www.crimereduction.gov.uk

You should also contact the Domestic Violence
Team should you require a copy of this
consultation in another format e.g. Braille,
large print or audio.

The Home Office expects to publish a summary
of responses received within three months of the
closing date for this consultation. This summary
will be made available on the crime reduction
website. Ultimately, the responses will form
the basis of the guidance which is published and
will bring into effect section 9 of the Domestic
Violence, Crime and Victims Act 2004.

SECTION 1: INTRODUCTION

PURPOSE OF THIS CONSULTATION

Status of this guidance

1.1 The Domestic Violence, Crime and Victims Act 2004⁵ establishes a statutory basis for domestic homicide reviews.

1.2 Under section 9(1) of the Act a domestic homicide review is defined as “a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- (a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship; or
- (b) a member of the same household as himself/herself,

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

1.3 Under section 9(3) specified persons and bodies (listed within section 9(4)) establishing or participating in a review are under a duty to have regard to this guidance. The following persons and bodies have a duty to have regard to this guidance:

For England and Wales:

- Chief Officers of Police for police areas in England and Wales;
- local authorities – for England that means the council of a district, county or London borough, the Common Council of the City of London and the council of the Isles of Scilly; for Wales, that means the council of a county or county borough;
- local probation boards;

- strategic health authorities;
- primary care trusts;
- local health boards; and
- NHS trusts.

For Northern Ireland (separate guidance will be issued):

- the Chief Constable of the Police Service for Northern Ireland;
- the Probation Board for Northern Ireland;
- health and social services boards; and
- health and social services trusts.

1.4 Although not defined as such in the Act, ‘local authority’ includes mental health trusts and social services. In addition, section 9(2) states that the Secretary of State may in a particular case direct a specified person or body to establish, or participate in, a review.

DOMESTIC VIOLENCE NATIONAL DELIVERY PLAN

1.5 The Government’s response to domestic violence has been to develop a National Delivery Plan.

1.6 The focus of the National Delivery Plan has identified five key outcomes which the Government, its respective agencies, local partnerships and the statutory and voluntary sectors are all working towards. These are to:

- reduce the number of domestic violence homicides;
- reduce the prevalence of domestic violence, particularly in high incidence areas and/or communities;

⁵ Domestic Violence, Crime and Victims Act 2004, available at: www.opsi.gov.uk/acts/acts2004/20040028.htm

- increase the rate of reporting of domestic violence, particularly in high incidence areas and/or communities;
- increase the rate at which domestic violence offences are brought to justice, particularly in high incidence areas and/or communities, as well as in areas with high attrition rates; and
- ensure victims of domestic violence are adequately protected and supported nationwide.

1.7 These outcomes are underpinned by seven key workstreams/objectives that will lead to the delivery of the outcomes. We will shortly be publishing an update on our progress over the last year and our commitments for the coming year, and these objectives may be subject to change.

SECTION 2: STYLE AND DEFINITION OF REVIEWS

2.1 Domestic homicide reviews are designed to complement the existing serious case reviews (SCRs) that take place when a child dies or is seriously injured and abuse or neglect is known or suspected to have played a part in the death or serious injury. It is intended that a similar template for domestic violence related homicides of persons aged 16 or over should be adopted. Most agencies should already be familiar with the format used in SCRs and, to provide consistency with the processes, it may prove beneficial to use a similar standardised format for domestic homicide reviews. Local agencies should also have regard to mental health investigations, which may provide learning. Learning and common best practice from homicide reviews conducted internationally have also been considered when drafting this guidance.

2.2 The statutory purpose of a review is to learn lessons from the death. In practice this will include:

- identifying the lessons to be learnt from the death, in particular about how local professionals and agencies work together to safeguard victims;
- identifying how those lessons will be acted upon and what is expected to change as a result; and
- improving inter-agency working and improving protection for domestic violence victims.

2.3 Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

Q1 – What format do you think would be appropriate for domestic homicide reviews? Though they have commonality with the SCRs, are there any issues that may arise if this process and style is adopted?

TIMING AND PROPORTIONALITY

2.4 Section 9(1) of the Act sets out the definition of a domestic homicide review.

2.5 When a person dies in these circumstances, the local review body (see Section 3) should consider whether a homicide review is necessary. There is a presumption that there will be a review in every case; however, the final decision on whether a review is necessary may need to be determined by the chair of the local review body. If the review body makes a decision not to hold a review, it will need to make a case to the appropriate government department (to be determined), stating the reason why it has reached this decision.

2.6 It may not be necessary for there to have been a criminal conviction or prosecution before a review can take place. However, where there is a related criminal investigation and prosecution, this will need to be discussed and agreed as early as possible with the relevant criminal justice agencies to ensure that the review does not prejudice these proceedings. It may be necessary to agree that where proceedings are taking place, the review is conducted on the basis that the final report of the review is not published until after the outcome of any criminal proceedings, unless new evidence which may have a bearing on these proceedings comes to light. This, however, should not mean that none of the recommendations arising from the review can be taken forward. The review body will need to consider if any of the recommendations identified would jeopardise the proceedings if they were to be taken forward. Nevertheless, all decisions should be made based on the circumstances of each individual case and at a local level.

2.7 Although not within the terms of the Act or governed by this guidance or another statute, local agencies may also wish to carry out a review in cases of suicide that are related to domestic violence, cases of serious physical or sexual violence linked to domestic violence, or cases where an unborn child is killed in circumstances of domestic violence. Where local agencies decide to take this forward, similar consideration will need to be given and the ultimate purpose should again be to learn lessons.

2.8 Local agencies will also need to consider whether there is an overlap with an existing or proposed SCR into the death or serious injury of a child where abuse or neglect is a factor and whether a separate domestic homicide review is needed. This may arise particularly in cases involving a victim aged between 16 and 18 which might be suitable for either system of review, depending on the facts, or in cases of familicide. Similarly, agencies will also need to consider if there is an overlap with an existing mental health investigation. In general, agencies should avoid duplicating reviews of the same case, unless it is felt that there are further issues that need to be considered in a second review. Agencies are therefore free to combine reviews into a single process and final report, depending on the facts of the case. If there are combined reviews, the terms of reference should make it clear that both procedures are fully addressed and specific actions included. Local agencies need to decide which review process will best suit the circumstances of the case. The key thing is that deaths – either of adults and/or of children – are considered for review.

Q2 – A process for deciding when a review should take place is needed. What procedure can be used to ensure that the process is effective, and who should take that decision?

Q3 – What are your views on the possibility of holding reviews before the outcome of any legal proceedings or investigations? Do we adopt the same procedures as the SCRs and decide on a case-by-case basis?

Q4 – What are the equality and diversity impact issues that should be considered under this section?

SECTION 3: WHICH BODY SHOULD TAKE THE LEAD RESPONSIBILITY FOR INSTIGATING THE REVIEW?

3.1 In SCRs, the local safeguarding children board sets up the process. For domestic violence homicides it is questionable who should lead. Although the obvious candidate is the local CDRP or its equivalent, it is arguably only suitable for those CDRPs and equivalents which have responsibility for education and social services to conduct a homicide review. It has also been suggested that, where appropriate, there should be scope for the CDRP or equivalent to delegate responsibility for the review to a local strategic domestic violence partnership. Ultimately, ownership of the review will need to be defined.

3.2 It is proposed that the local review body (CDRP or equivalent) with responsibility for establishing a review should first contact the persons and bodies listed in section 9(4) of the Act who are under a duty to take account of this guidance and establish a domestic homicide review body. At this stage the review body should also consider the implications if an SCR process or a mental health investigation is also being taken forward. The review body should then determine whether a case falls within the criteria in section 9(1) of the Act and whether a review should therefore take place. If the review body makes a decision not to hold a review, it will need to make a case stating the reason why it has reached this decision. It may be beneficial for local areas to set up quality assurance panels to act as advisers, so that any issues regarding the reviews and their processes could be addressed by them. The quality assurance panels could be drawn from relevant organisations and other departments.

3.3 Under section 9(2) of the Act, the Secretary of State has a reserve power to direct a specified person or body within section 9(4) of the Act to establish, or participate in, a review. It is envisaged that this power might be used where a local decision has been taken not to conduct a review of a case that clearly falls within the terms of section 9(1) of the Act, or where a particular person or agency has refused to

participate in a review and their involvement is considered essential to the review.

Q5 – How effective would CDRPs or equivalents be in taking the lead responsibility for reviews, and are there any other agencies/partnerships that could do this?

Q6 – Are CDRPs or equivalent in two-tier authority areas with responsibility for education and social services the only bodies that could conduct reviews?

Q7 – How can local areas incorporate quality assurance steps into the review process, and who should advise on quality assurance assessment of reviews?

Q8 – What are the equality and diversity impact issues that should be considered under this section?

WHO SHOULD CONDUCT REVIEWS?

3.4 Section 9(4) of the Act sets out those persons and bodies who are under a duty to take account of this guidance in respect of the establishment and conduct of reviews.

3.5 The review bodies' initial meeting to determine the scope of the review should consider whether there are other persons or bodies who could have a useful role to play in the review and who should be invited to do so. The voluntary sector may have valuable information on the victim or may have been in direct contact with the victim or perpetrator. Information may become available through criminal proceedings which may be relevant to the review.

3.6 Each agency should undertake a separate management review of its involvement with the victim/perpetrator. This should begin as soon as a decision is taken to proceed with a review, and sooner if a case gives cause for concern within the individual agency. Independent professionals

(including GPs) should contribute reports of their involvement. Those conducting management reviews of individual services, or producing the final report, should not have been directly concerned with the victim/perpetrator or family, or have been the immediate line manager of the practitioner involved. Agencies should be mindful of seeking consent from the victim's family and, where appropriate, the perpetrator's family before information is shared between agencies. Agencies will also need to ensure that any information is shared within the agreed protocols. There is an expectation that all relevant agencies will take part in, and fully co-operate with, the review process.

3.7 The review body may wish to consider appointing a chair to take responsibility for managing and co-ordinating the review process. This may be an independent chair or an internal chair. Careful consideration will need to be given to both of these options as, although an independent chair may be desirable, there may be potential cost implications in appointing one. Similarly, if the review body decides to use an internal chair, it will need to be mindful of the potential conflict of interests if the chair were also responsible for conducting interviews and drafting reports. Within SCRs, the overview report is commissioned from a person who is independent of all the agencies/professionals involved. The decision to appoint the chair should be based on issues relevant to the case in question and should be made by the appropriate local agencies. Consideration needs to be given to the skills and expertise needed by the potential chair. The following skills are desirable for the chair and can be used as a guide; however, these are not definitive:

- having relevant knowledge of domestic violence issues, research, guidance and legislation with regard to adults and children;

- understanding the role and context of the main agencies likely to be involved in the review;
- managerial expertise;
- report-writing skills;
- investigation skills;
- interviewing and communication skills; and
- other expertise where appropriate.

DETERMINING THE SCOPE OF THE REVIEW

3.8 The review body will need to consider the scope of the review and draw up clear terms of reference, bearing in mind the intention of the reviews as set out in section 9(1) of the Act. The following is a checklist of the issues that local bodies may wish to consider. The list is not exhaustive, but relevant issues may include the following:

- What are the most important issues to address in learning the lessons from this specific case?
- A decision should be made regarding the time period of events reviewed, for example how far back the review should go and determining an appropriate and sensible cut-off point. The time period will need to be decided on a case-by-case basis. Consideration of family history or background information will help to gain an understanding of events.
- Which agencies and professionals should contribute to the review, and who else should be asked to contribute? This could include agencies which have not come into contact with the victim but could have been expected to do so (i.e. to see if there are any barriers to seeking help).

- Where more than one local authority area has knowledge of the victim, it should be made clear which CDRP/local review body will have primary responsibility in the review and how the other areas are to be involved.
- How are family members to be invited to contribute to the review and in what ways? Consideration needs to be given to the fact that the wishes of the family can change over time, and their views need to be taken into account throughout the process.
- Will the case give rise to other investigations, for example a SCR, mental health investigations, inquests, police inquiries or suicide inquiries? If so, how can a co-ordinated review process best address all the questions in the most economical way? How can the review process take account of a coroner's inquiry and any criminal investigation or proceedings related to the case? Is there a need to liaise with the coroner and the Crown Prosecution Service?
- Consider how to involve agencies or professionals (including the voluntary sector) in other areas and what the roles and responsibilities of the different agencies with an interest should be.
- Who will make the link with interests outside the main statutory agencies, for example independent professionals and voluntary organisations?
- Consider how any public, family and media interest should be handled before, during and after the review. As cases will differ, this will need to be determined at a local level and on a case-by-case basis (see Sections 5 and 6).

- The review body will need to consider obtaining independent legal advice about the review (see Section 7).
- Consider publicising the fact that the review is taking place so that individuals can come forward with information that might not otherwise be available.

Q9 – What other factors need to be considered?

Q10 – What are the equality and diversity impact issues that should be considered under this section?

3.9 Some of these issues may need to be re-visited as the review progresses and new information emerges.

TIMEFRAME FOR CONDUCTING THE REVIEW

3.10 Reviews will vary in their breadth and complexity, but in all cases lessons should be learned and acted upon as quickly as possible. It is recommended that a decision on whether to hold a review or not is taken within one month of a case coming to the attention of the potential local review body. The terms of reference for the review will also need to be drawn up and agreed within this time. Individual agencies should secure case records promptly and begin work quickly to draw up a chronology of involvement with the victim and family.

3.11 It is recommended that the review's final report should be completed within three months of the commencement of the review. This may not involve three whole months of actual work on the review, for example it may be structured as ten days' work spread over this period. This procedure falls in line with SCRs. However, there may be particular reasons why this is not appropriate in some cases, and the review body may decide to agree an alternative timescale.

3.12 In some cases, criminal proceedings may follow the death. Those co-ordinating the review should discuss with the criminal justice agencies how the review process should take account of such proceedings. For example, how does this affect timing, the way in which the review is conducted (including interviews with staff), who should contribute and at what stage. In some cases, it may not be possible to complete or to publish a review until after an inquest or criminal proceedings have been concluded; again this should not necessarily prevent early lessons from being learnt and implemented.

Q11 – Do you have any views on the proposal of a maximum duration of three months for a review?

Q12 – What are the equality and diversity impact issues that should be considered under this section?

SECTION 4: INDIVIDUAL AGENCIES' MANAGEMENT REVIEWS

4.1 Once it is known that a case is being considered for a review, each agency should secure records relating to the case to guard against loss or interference. Each of the persons or bodies listed in section 9(4) of the Act should carry out an individual management review, unless it had no involvement with the victim or the perpetrator. The individual agency reviews form part of the main domestic homicide review.

4.2 The purpose of the management reviews is to allow agencies to look openly and critically at individual and organisational practice, to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about. Management review reports should be accepted by the senior officer in the agency who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon. The aim should be to focus on agency and multi-agency practice and expectations of good professional practice within them, rather than individual practice or any attribution of blame.

4.3 Upon completion of the review report, there will need to be a process for feedback to the staff involved. There may also be a need for a follow-up session if the final report raises new issues for the agency and its staff. Decisions on the process that is used will need to be agreed by the local review body on a case-by-case basis.

4.4 Agencies' reviews are not a part of a disciplinary inquiry, but information that emerges in the course of reviews may indicate that disciplinary action should be taken under established procedures. Alternatively, reviews may be conducted concurrently with disciplinary action. That would be a matter for agencies to decide in accordance with their disciplinary procedures.

4.5 The following outline format provides a guide for the preparation of management reviews to

help ensure that the relevant questions are addressed. It should also help ensure that information is given to the review body in a consistent format, to help with preparing its final report. The questions posed are not a comprehensive checklist for all situations. Each case may give rise to specific issues that need to be explored, and each review should consider carefully individual cases and how best to structure the review in the light of those particular circumstances. Where staff or others are interviewed by those preparing management reviews, a written record of such interviews should be made and this should be shared with the interviewee.

OUTLINE FORMAT FOR INDIVIDUAL MANAGEMENT REVIEWS

Agency involvement with the victim, perpetrator and their families

4.6 The review should include a comprehensive chronology of the involvement of the agency with the victim, perpetrator and their families over the period of time set out in the review's terms of reference. It should summarise the events that occurred; the decisions reached; the services offered and provided to the victim, perpetrator and their families; and any other action taken. Those responsible for conducting the review should have no previous links with any of the parties or have been the line manager of any practitioner with any such links.

Analysis of involvement

4.7 The review should consider the events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken which indicate that practice or management could be improved, the review should consider not only what happened, but why. The following are the areas that will need to be considered:

- Were practitioners sensitive to the needs of the victim, knowledgeable about potential indicators of domestic violence, and aware of their agencies' policies and about what to do if they had concerns about a victim or perpetrator? *Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?*
 - Did the agency have policies and procedures for risk assessment for domestic violence victims/perpetrators acting on concerns about their welfare, and were those assessments used in the case of the victim/perpetrator? Do the agencies have policies and procedures in place for dealing with concerns over domestic violence? *Are these assessment tools, procedures and policies professionally accepted as being effective?*
 - Did the agency comply with its agreed domestic violence related protocols with other agencies, including any information sharing protocols?
 - What were the main points or opportunities for assessment and decision making in relation to the victim/perpetrator and family? Do assessments and decisions appear to have been reached in an informed and professional way? *Is it reasonable to assume with hindsight that these points would have been apparent at the time?*
 - Did actions fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made, in the light of the assessments, given what was known/should have been known at the time?
 - Where relevant, was a case conference held and the reviewing processes complied with?
 - When, and in what way, were the victim's wishes and feelings ascertained and considered? *Is it reasonable to assume that the wishes of the victim should have been known?*
 - Was anything known about the perpetrator? For example, were they being managed under Multi-Agency Public Protection Arrangements (MAPPA)?
 - Was this information recorded?
 - Were procedures sensitive to the racial, cultural, linguistic and religious identity of the victim/perpetrator and family?
 - Were senior managers or other agencies and professionals involved at the appropriate points?
- Good practice*
- Are there ways of working effectively that could be passed on to other organisations/individuals?
 - Are there lessons from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or to identify perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision and working in partnership with other agencies and resources?

Recommendations for action

- What action should be taken, by whom, and by when? What outcomes should these actions bring about, and how will the agency review whether they have been achieved?

Q13 – Are there any other areas that could be included here, and are the questions that are outlined relevant?

Q14 – What are the equality and diversity impact issues that should be considered under this section?

SECTION 5: FAMILY INVOLVEMENT

5.1 The involvement of family members will be important to the review, and they should be invited to contribute as part of the process. The contribution that they can provide may be vital and invaluable to the case. International research on domestic violence homicide reviews shows that emphasis is usually placed on taking into account the needs of surviving family members. The review body will need to consider carefully whether involvement comes only from the victim's family or whether contributions should also be sought from the perpetrator's family. Decisions will need to be made at local level and on a case-by-case basis. Awareness of domestic violence within families and extended families will also need to be taken into account during this process.

5.2 In most cases family members will want to have some involvement in the review process. However, if initial contact or involvement is turned down, further attempts will need to be made to contact family members and keep them informed of the progress. The review body should, therefore, as far as possible, develop, agree and follow a liaison strategy for each stage of the review. The following is a checklist of points that the review body may wish to consider when involving family members. The list is not exhaustive, and the review panel may want to include other issues:

- Talk with the family to check to what extent they want to be involved, and find out what their needs are. The nature and extent of the involvement the family may wish to have with the review may change over time, so regular communication with the family is critical.

- Be aware of violence within families, for example the forms of violence that affect victims from black and minority ethnic communities.
- Consider how evidence will be gathered.
- Consider whether someone should be appointed to act on behalf of the family during the review.
- Consider whether support services should be made available to the family.

5.3 In all cases, the involvement of the family needs to be proportionate and balanced against the wider aims of the review.

Q15 – Are there any areas not covered that you think would be helpful?

Q16 – What are the equality and diversity impact issues that should be considered under this section?

SECTION 6: MEDIA INVOLVEMENT

6.1 Once a review has been decided upon, there will be a need to establish a media handling strategy. Where possible, a common approach to communications should be taken with the media, with a single point of contact. One option could be to establish a communications working group with representatives from relevant agencies, which could report to the quality assurance panel. The following are suggestions of the issues that the review body may wish to consider:

- Identify the point of contact.
- Consider what the scope of the review will be, the timeframe and what the outcomes will be.
- Consider how information will be communicated and the timing and sequencing of communication to the family before the media.
- Consider how to establish a compilation of chronological events so far and obtain a consensus from all interested parties.
- Identify key points and ensure that they are communicated in a relevant and concise manner.
- Set out a list of what the organisations did and, if practices and procedures have already been changed since the incident took place, list those changes. This all helps to put the incident into context and look to the future.

- Consider what is being done to minimise the risk of recurrence.
- Agree a holding statement for the media and keep this under constant review. Ensure appropriate legal advice is obtained.
- Share and decide who will talk to the media – speak with one voice where possible, and issue joint statements.

6.2 All communications should:

- meet the highest standards of accountability and transparency in public services;
- ensure legality; and
- ensure public safety is highlighted and consider interim steps to learn immediate lessons and improve services where possible.

6.3 The review body will also need to consider:

- what information should be disclosed before, during and after a review; and
- how it should be reported.

Q17 – What are the equality and diversity impact issues that should be considered under this section?

SECTION 7: **LEGAL ADVICE**

7.1 It is expected that all agencies will have access to legal advice as part of their day-to-day business. It is recommended that agencies contact their legal departments to inform them that they are proposing to conduct a review. It will also be worthwhile bearing in mind that agencies' actions could potentially be subject to judicial review.

7.2 Agencies should also be mindful of the fact that the family of the victim and/or perpetrator may also seek legal advice.

SECTION 8: EXPERT ADVISERS/WITNESSES

8.1 The review body should appoint appropriate expert advisers from the relevant agencies involved in order to assist with the review, for example an independent police officer from another force/national body and/or a health officer with expertise in the systems and policies of health agencies. Advisers should be strictly independent of any previous involvement with the case or any persons connected with it. The appointment of advisers will vary according to the nature of each individual case and should be decided by the local agency on this basis.

8.2 The advisers should be sufficiently qualified to review the performance of the relevant agency involved and to highlight any perceived shortcomings or good practice. The number of expert advisers required by a review will vary according to the number of agencies involved, and the review body should judge the number of expert advisers a review needs in order to give a thorough overview.

8.3 It is envisaged that expert advisers will be appointed by, and be accountable to, the review body.

Q18 – Do you have any views or comments on the appointment and use of expert advisers/witnesses?

Q19 – What are the equality and diversity impact issues that should be considered under this section?

SECTION 9: OTHER FACTORS

9.1 The review body should be aware of the potential sensitivity of any meeting prior to or during the review with any agencies involved, and a record of all meetings that are held during the course of the review should be made.

9.2 The review body may also wish to consider establishing administrative support for the review, as a designated review support person may need to work closely alongside the chair of the review and act as the first point of contact for the review.

Q20 – What other factors should be taken into consideration during the process of the review?

Q21 – What are the equality and diversity impact issues that should be considered under this section?

SECTION 10: COSTS

10.1 During the passage of the Act through Parliament, it was expected that the costs of the reviews would be absorbed into the daily working routines of the relevant agencies. In some areas, reviews are already taking place, and we would expect agencies to be considering reviewing cases where someone with whom they were in contact has been killed.

10.2 There should be a clear line on how the agencies involved in the review meet the costs. For example, the cost of the review could be met by contributions from all the relevant agencies concerned on the same basis as SCRs that are carried out by local safeguarding children boards.

Q22 – What are the issues that may arise from following this protocol, and do you have any suggestions on how costs may be met?

SECTION 11: PRODUCING THE FINAL REPORT

11.1 The review body should produce a concluding report that brings together and analyses the findings of the various review reports from agencies and others and makes recommendations for future action. Final reports should be produced according to the following outline format, although, as with management reviews, the precise format will depend upon the characteristics of the case. The review body may wish to use an independent author to produce the final report, but that is a matter for local discretion.

11.2 Consideration should be given to translating the final report into different languages, where appropriate.

OUTLINE FORMAT FOR THE FINAL REPORT

11.3 Below is an outline format for the final report. It is not prescriptive and the local review body may wish to use a different format. It will, however, be useful in highlighting the kind of issues that should be dealt with. The review body will need to bear in mind the importance of anonymising personal details within the final report.

Introduction

- Summarise the circumstances that led to a review being undertaken in this case.
- State the terms of reference of the review.
- List the contributors to the review and the nature of their contribution. List the review body members and the author of the overview report.

The facts

- Describe the membership of the family and household.

- Describe the chronology of the involvement with the victim/perpetrator and their families on the part of agencies, professionals and others who have contributed to the review process. Note the chronology of each occasion on which the victim or perpetrator was seen and the views and wishes that were sought or expressed.
- Provide an overview that summarises what information was known to the agencies and professionals involved about the family, perpetrator and the home circumstances of the victim/perpetrator.

Analysis

11.4 This part of the overview should examine how and why events occurred, decisions were made and actions taken or not. This is the part of the report in which reviews can consider, with the benefit of an overview of events and involvement, whether different decisions or actions may have led to a different course of events. The analysis section is also where any examples of good practice should be highlighted.

Conclusions and recommendations

11.5 This part of the report should summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action. Recommendations should include, but not be limited to, the recommendations made in individual agency reports. Recommendations should be relatively few in number, focused and specific, and capable of being implemented.

Accountability and disclosure

11.6 The review body should consider who might have an interest in the review and what information should be made publicly available.

There are difficult interests to balance, for example:

- the need to maintain the confidentiality of personal information on the victim, perpetrator, their family members and others;
- the accountability of public services and the importance of maintaining public confidence in the review process;
- the need to secure full and open participation from the agencies and professionals involved;
- the responsibility to provide information to those with a legitimate interest; and
- constraints on sharing information when criminal proceedings are outstanding and access to information may not be within the control of the review body.

11.7 It is important to plan for requests for information and how they should be met. For example, a lead agency may take responsibility for de-briefing family members or responding to media interest about a case in liaison with contributing agencies and professionals. In all cases, the review body's final report should contain an executive summary that includes, as a minimum, information about the review process, key issues arising from the case and the recommendations that have been made.

Learning lessons locally

11.8 Reviews are of little value unless agencies learn lessons from them. As much effort, if not more, should be spent on acting upon recommendations as on conducting the review. The following may help in getting maximum benefit from the review process:

- As far as possible, the review should be conducted in such a way that the process is a learning exercise.
- Consider what information needs to be disseminated, how and to whom, in the light of a review. Be prepared to communicate examples of both good practice and areas where change is required.
- Focus recommendations on a small number of key areas with specific and achievable proposals for change and intended outcomes.
- The local review body should put in place a means of auditing action against recommendations and intended outcomes.
- Convene a local annual training event on lessons learnt combined with a national report of findings.

11.9 Day-to-day good practice can help ensure that reviews are conducted successfully and in a way most likely to maximise learning:

- Establish a culture of audit and review; reviews may need to be included as a standing agenda item at CDRP or equivalent meetings.
- Have in place clear, systematic case-recording and record-keeping systems.
- Develop good communication and understanding between disciplines and members of the review body.
- Communicate with the local community and media to raise awareness of the work of services with domestic violence victims, so that attention is not focused disproportionately on tragedies.

- Make sure staff and their representatives understand what can be expected in the event of a domestic homicide review.

Lessons of national importance

11.10 The review body should send a copy of its report to the relevant government department highlighting the relevant points. Examples could include where the review has shown the need to reconsider the law in a particular area, or the need to revise or introduce national guidance or training.

Action on receiving the final report

11.11 On receiving the final report the review body should:

- ensure that contributing agencies and individuals are satisfied that their information is fully and fairly represented in the final report;
- translate recommendations into an action plan which should be endorsed and adopted at a senior level by each of the agencies involved. The plan should set out who will do what, by when, and with what intended outcome. The plan should set out how improvements in practice and systems will be monitored and reviewed;

- clarify to whom the report, or any part of it, should be made available, taking into account any obligations under the Freedom of Information Act 2000 and the Data Protection Act 1998;

- disseminate the report or key findings to interested parties as agreed. Make arrangements to provide feedback to staff, family members of the victim and the media, as appropriate; and
- provide a copy of the overview report, executive summary, action plan and individual management reports to the senior officer of each agency. A copy of the report should also be sent to the relevant government departments and government offices.

Q23 – Do you have any views on how the report should be made available – full report or executive summary and recommendations, etc?

Q24 – What are the equality and diversity impact issues that should be considered under this section?

ANNEX A: CONSULTATION QUESTIONS

STYLE AND DEFINITION OF REVIEWS

Q1 – What format do you think would be appropriate for domestic homicide reviews? Though they have commonality with the SCRs, are there any issues that may arise if this process and style is adopted?

TIMING AND PROPORTIONALITY

Q2 – A process for deciding when a review should take place is needed. What procedure can be used to ensure that the process is effective, and who should take that decision?

Q3 – What are your views on the possibility of holding reviews before the outcome of any legal proceedings or investigations? Do we adopt the same procedures as the SCRs and decide on a case-by-case basis?

Q4 – What are the equality and diversity issues that should be considered under this section?

WHICH BODY SHOULD TAKE THE LEAD RESPONSIBILITY FOR INSTIGATING THE REVIEW?

Q5 – How effective would CDRPs or equivalents be in taking the lead responsibility for reviews, and are there any other agencies/partnerships that could do this?

Q6 – Are CDRPs or equivalent in two-tier authority areas with responsibility for education and social services the only bodies that could conduct reviews?

Q7 – How can local areas incorporate quality assurance steps into the review process, and who should advise on quality assurance assessment of reviews?

Q8 – What are the equality and diversity impact issues that should be considered under this section?

DETERMINING THE SCOPE OF THE REVIEW

Q9 – What other factors need to be considered?

Q10 – What are the equality and diversity impact issues that should be considered under this section?

TIMEFRAME FOR CONDUCTING THE REVIEW

Q11 – Do you have any views on the proposal of a maximum duration of three months for a review?

Q12 – What are the equality and diversity impact issues that should be considered under this section?

INDIVIDUAL AGENCIES' MANAGEMENT REVIEWS

Q13 – Are there any other areas that could be included here, and are the questions that are outlined relevant?

Q14 – What are the equality and diversity impact issues that should be considered under this section?

FAMILY INVOLVEMENT

Q15 – Are there any areas not covered that you think would be helpful?

Q16 – What are the equality and diversity impact issues that should be considered under this section?

MEDIA INVOLVEMENT

Q17 – What are the equality and diversity impact issues that should be considered under this section?

EXPERT ADVISERS/WITNESSES

Q18 – Do you have any views or comments on the appointment and use of expert advisers/witnesses?

Q19 – What are the equality and diversity impact issues that should be considered under this section?

OTHER FACTORS

Q20 – What other factors should be taken into consideration during the process of the review?

Q21 – What are the equality and diversity impact issues that should be considered under this section?

COSTS

Q22 – What are the issues that may arise from following this protocol, and do you have any suggestions on how costs may be met?

PRODUCING THE FINAL REPORT

Q23 – Do you have any views on how the report should be made available – full report or executive summary and recommendations, etc?

Q24 – What are the equality and diversity impact issues that should be considered under this section?

Are there any other questions that arise from this guidance?

ANNEX B: PARTIAL REGULATORY IMPACT ASSESSMENT

TITLE OF PROPOSAL

GUIDANCE FOR DOMESTIC HOMICIDE REVIEWS UNDER SECTION 9 OF THE DOMESTIC VIOLENCE, CRIME AND VICTIMS ACT 2004

1. PURPOSE AND INTENDED EFFECT

Objective

Section 9(1) of the Domestic Violence, Crime and Victims Act establishes a statutory basis for local bodies to establish domestic homicide reviews of “the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship; or
- (b) a member of the same household as himself/herself,

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

The statutory purpose of a review is to learn lessons from the death. In practice this will include:

- identifying the lessons to be learnt, in particular about how local professionals and agencies work together to safeguard victims;
- identifying how those lessons will be acted upon and what is expected to change as a result; and
- improving inter-agency working and improving protection for domestic violence victims.

Under section 9(3) specified persons and bodies (listed within section 9(4)) establishing

or participating in a review are under a duty to have regard to this guidance. They include:

For England and Wales:

- Chief Officers of Police for police areas in England and Wales;
- local authorities – for England that means the council of a district, county or London borough, the Common Council of the City of London and the council of the Isles of Scilly; for Wales, that means the council of a county or county borough;
- local probation boards;
- strategic health authorities;
- primary care trusts;
- local health boards; and
- NHS trusts.

For Northern Ireland (separate guidance will be issued):

- the Chief Constable of the Police Service for Northern Ireland;
- the Probation Board for Northern Ireland;
- health and social services boards; and
- health and social services trusts.

2. BACKGROUND

Statistically, we know that every year around 103 women and 36 men are killed as a result of domestic violence,⁶ which highlights the need to do more to prevent these deaths. A systematic review in the case of a domestic violence homicide is one way that we can learn lessons to prevent injury and, ultimately, murder.

⁶ Coleman, K., Hird, C., and Povey, D. (2006) Violent Crime Overview, Homicide and Gun Crime 2004/2005 (Supplementary Volume to Crime in England and Wales 2004/2005). *Home Office Statistical Bulletin*, 02/06.

Domestic violence accounts for 17 to 25 per cent of all violent crime across England and Wales and affects all sections of society, regardless of gender, sex or ethnic background. Figures from the British Crime Survey's inter-personal violence module 2001, which provides the most robust data for domestic violence, shows that one in four women and one in six men will suffer domestic violence in their lifetime. However, 89 per cent of those who suffer four or more repeated attacks and serious injury are women.⁷

The Government's definition of domestic violence in England and Wales is:

*"any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality."*⁸

In June 2003, *Safety and Justice: The Government's Proposals on Domestic Violence* was published.⁹ This set out the Government's strategy for tackling domestic violence through prevention, protection and justice and support, and included proposals for legislative and non-legislative changes to the way domestic violence is dealt with in England and Wales.

The consultation of the Government's proposals ended in September 2003, and responses have helped inform our way forward, including the measures in the Domestic Violence, Crime and Victims Act, which received Royal Assent in November 2004.

During the passage of the Act through Parliament we agreed to a full three-month consultation period on the guidance that will be issued to local bodies, to give key stakeholders the opportunity to comment on the exact process and methodology that domestic homicide reviews should take.

In March 2005 the Home Office published *Domestic Violence: A National Report*.¹⁰ This report provides an overview of our achievements to date, while understanding that for this positive momentum of change to continue, we must set new objectives. This is reflected and underpinned in our National Delivery Plan with recommendations and mechanisms put in place for tackling domestic violence through early identification, prevention and improved response.

A domestic attack that results in the death of the victim is often not a first attack. Many people and agencies may have known of these attacks – neighbours, for example, may have heard violence, a GP may have examined injuries, the child's teacher may have suspected abuse, the police may have been called, there may have been previous prosecutions, and so on.

We believe that there is a great deal to learn from domestic violence homicides to inform risk assessments, understand where systems failed, why the involvement of agencies or professionals did not lead to effective interventions, and what can be done to put the system right and avoid future deaths.

The Government wants to ensure that the reviews do not simply become a bureaucratic exercise. We will want to ensure that local agencies learn the lessons and implement any recommendations made by the reviews, and that findings with national relevance are shared and acted upon.

The cost to society of one domestic violence murder is approximately £1.1 million.¹¹ This is calculated on the cost to public funds and loss of earnings and emotional trauma. This needs to be multiplied by 140 to understand the full cost to society each year.

⁷ Walby, S. and Allen, J. (2004) *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*. Home Office Research Study No. 276. London: Home Office.

⁸ This was revised in 2004 from the previous Home Office definition to include violence between family members over 18 as well as adults who are, or were, intimate partners. This ensures that those issues of chief concern to black and minority ethnic communities, for example honour-based violence, forced marriage and female genital mutilation, are properly reflected. This reflects concerns voiced by many in responses to the safety and justice consultation paper.

⁹ Home Office (2003) *Safety and Justice: The Government's Proposals on Domestic Violence*. London: The Stationery Office.

¹⁰ Home Office (2005) *Domestic Violence: A National Report*. London: Home Office.

¹¹ Brand, S. and Price, R. (2000) *The Economic and Social Costs of Crime*. Home Office Research Study No. 217. London: Home Office.

In 2001 in England and Wales domestic violence was estimated to cost a total of £23 billion.¹² £3 billion was spent on public services, including:

- £1 billion by the Criminal Justice System, nearly a quarter of its budget for violent crime;
- £1.2 billion by the National Health Service;
- £0.25 billion by social services;
- £160 million by local housing authorities and housing associations; and
- over £300 million in civil legal services.

In addition:

- Domestic violence costs employers and workers nearly £2.7 billion a year because of injuries.
- The cost of human and emotional suffering is put at £17 billion.

The proposals will have implications in terms of time and resources for all those local bodies listed under the Act, as well as for the voluntary sector. The expected benefits (both financial and intangible) will outweigh the projected costs.

3. OPTIONS

Option 1: Do nothing. This would mean that over 140 women and men will continue to be murdered in England and Wales and Northern Ireland each year. It would also result in limited changes to policy and practice at local level by local agencies because of the loss in lessons learned. This is not an acceptable option.

Option 2: Non-legislative measures. Following the safety and justice consultation paper the Government's response to domestic violence has been to develop a National Delivery Plan.

The focus of the national plan has identified five key outcomes which the Government, its respective agencies, local partnerships and the statutory and voluntary sectors are all working towards. These are to:

- reduce the number of domestic violence homicides;
- reduce the prevalence of domestic violence, particularly in high incidence areas and/or communities;
- increase the rate of reporting of domestic violence, particularly in high incidence areas and/or communities;
- increase the rate at which domestic violence offences are brought to justice, particularly in high incidence areas and/or communities, as well as in areas with high attrition rates; and
- ensure victims of domestic violence are adequately protected and supported nationwide.

These outcomes are underpinned by seven key workstreams/objectives that will lead to the delivery of the outcomes. We will shortly be publishing an update on our progress over the last year and our commitments for the coming year.

Option 3: Legislative measures. After careful consideration the Government has concluded that producing the guidance will fulfil its obligation under section 9 of the existing Domestic Violence, Crime and Victims Act 2004. Ultimately the final guidance will bring into effect section 9 of the Act and specified persons and local bodies are required to have regard to the guidance. This is the Government's preferred option. However, the content of the final guidance will be subject to the responses we receive from the consultation exercise.

¹² Walby, S. (2004) *The Cost of Domestic Violence*. Report to the DTI Women and Equality Unit. London: Department of Trade and Industry.

4. COSTS AND BENEFITS

During the passage of the Domestic Violence, Crime and Victims Act 2004 through Parliament it was expected that the costs of these reviews would be absorbed into the daily working routines of the listed agencies. In some areas, reviews are already taking place, and we would expect agencies to be considering reviewing cases where someone with whom they were in contact has been killed.

We recognise that figures from the SCRs, which are currently carried out following the death or serious injury of a child where abuse or neglect is or is suspected to be a factor¹³ suggests that each review is likely to cost in the range of a minimum of £4,984 to a maximum of £50,000 in terms of time and effort. It was envisaged that the costs of each review would be met from within the existing budgets of the responsible agencies.

There are currently some 140 domestic homicides each year, which suggests an approximate total cost to society of **£154 million**. However, each life saved through the lessons learned would save £1.1 million in public funds, costs to employers and human and emotional suffering.

5. SECTORS AFFECTED

Businesses

The Government believes that businesses will benefit from these reviews, as the proposals will not impose any additional costs or burdens on the private sector. Furthermore, any resultant reduction in domestic violence and domestic homicides will reduce the substantial losses firms currently suffer in the form of lost days, lower productivity and ultimately the loss of an employee due to domestic violence.

Public sector

We acknowledge that the reviews will create new ways of working in some areas. However, the long-term costs and the human and emotional savings demonstrate the benefits of establishing reviews to learn the lessons.

Charities and the voluntary sector

At this stage the proposals do not impose any direct costs. However, as part of the consultation exercise we will be asking about the involvement of the voluntary sector in domestic homicide reviews, where their involvement will be made on a local case-by-case basis.

6. CONSULTATION

The proposals for establishing domestic homicide reviews were widely consulted on following the publication of the safety and justice consultation paper. A partial regulatory impact assessment was produced for that document. We will now be going out for consultation on the exact process and methodology that domestic homicide reviews should take.

7. MONITORING AND REVIEW

The consultation exercise will be used to determine the best options for monitoring and reviewing domestic homicide reviews. Each review will also be open to scrutiny from central government departments to address issues of procedure and quality.

Rt. Hon. Baroness Scotland of Asthal QC
Minister of State for Criminal Justice and
Offender Management
Home Office

¹³ *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children.* HM Government 2006. London: The Stationery Office.

ANNEX C: INITIAL RACE EQUALITY IMPACT ASSESSMENT

Name of policy on which legislation is based:

Domestic violence

Lead policy official (including contact details):

Suzelle Dickson, Domestic Violence Team
Tel: 020 7035 3274

What is the purpose of the proposed policy (or the changes you want to make to a policy)?

Do not complete this section if you have already completed a partial or full RIA

A partial RIA has been undertaken.

What are you are trying to achieve through the proposed policy, and why? Do not complete this section if you have already completed a partial or full RIA

A partial RIA has been undertaken.

Who is intended to benefit from the proposed policy, and how?

Do not complete this section if you have already completed a partial or full RIA

A partial RIA has been undertaken.

We believe that there is a great deal to learn from domestic violence homicides to inform risk assessments, understand where systems failed, why the involvement of agencies or professionals did not lead to effective interventions, and what can be done to put right the system and avoid future deaths.

Are there associated aims of the proposed policy? What are they?

Do not complete this section if you have already completed a partial or full RIA

A partial RIA has been undertaken.

Is responsibility for the proposed policy shared with another department or authority or organisation? If so, what responsibility, and which bodies?

You should make every effort to involve partners or collaborators in a policy in the screening process, and in any subsequent assessment of the policy, if the screening shows it is relevant to race equality. In situations where your plans involve working in partnership with another public authority or contracting implementation of the policy out to another organisation, you will find the Commission for Racial Equality Guidance on partnerships helpful in this regard <http://www.cre.gov.uk/>.

Views are being sought from all our partners as part of the consultation process.

Will the proposed policy involve, or have consequences for, the people your authority serves and employs?

No. The reviews are intended to have a positive impact in that they will enable local agencies to learn lessons and ultimately bring about positive changes in policy and procedure.

Could these consequences differ according to people's racial group, for example, because they have particular needs, experiences or priorities?

Views are being sought from all our partners as part of the consultation process.

Is there any reason to believe that people could be affected differently by the proposed policy, according to their racial group, for example in terms of access to a service, or the ability to take advantage of proposed opportunities?

No. Local agencies will have to ensure that they comply with any regulations under the Race Relations Act 1976 and the (Amendment) Act 2000 and will need to be sensitive to the

diverse needs of those within their local area. However, views are being sought from all our partners as part of the consultation process.

Is there any evidence that any part of the proposed policy could discriminate unlawfully, directly or indirectly, against people from some racial groups?

No. It is important that the aims of the policy are communicated to all members of the community. Views are being sought from all our partners as part of the consultation process.

Is there any evidence that people from some racial groups may have different expectations of the policy in question?

No.

Is the proposed policy likely to affect relations between certain racial groups, for example because it is seen as favouring a particular group or denying opportunities to another?

No.

Is the proposed policy likely to damage relations between any particular racial group (or groups) and your authority?

No.

Results of initial screening:

Under every section contained within the consultation document readers will be prompted to comment on areas that may have an impact on equality and diversity. We will also monitor how the reviews are rolled out in cases involving victims from different racial groups.

ANNEX D: CONSULTATION CODE OF PRACTICE

This consultation follows the Code of Practice on Consultation, the criteria for which are set out below.

THE SIX CONSULTATION CRITERIA

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
2. Be clear about what your proposals are, who may be affected, what questions are being asked and the timescale for responses.
3. Ensure that your consultation is clear, concise and widely accessible.
4. Give feedback regarding the responses received and how the consultation process influenced the policy.
5. Monitor your department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.
6. Ensure your consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate. The full code of practice is available at: <http://www.cabinetoffice.gov.uk/regulation/consultation/index.asp>

CONSULTATION CO-ORDINATOR

If you have any complaints or comments specifically about the consultation process only, you should contact the Home Office consultation co-ordinator, Christopher Brain, by email at: christopher.brain2@homeoffice.gsi.gov.uk

Alternatively you may wish to write to:

Christopher Brain
Consultation Co-ordinator
Performance and Delivery Unit
Home Office
3rd Floor Seacole
2 Marsham Street
London
SW1P 4DF

ANNEX E: **RESPONSES: CONFIDENTIALITY AND DISCLAIMER**

The information you send us may be passed to colleagues within the Home Office, the Government or related agencies.

Furthermore, information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA) and the Data Protection Act 1998 (DPA)).

If you want the information you provide to be treated as confidential, please be aware that under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

Please ensure that your response is marked clearly if you wish your response and name to be kept confidential.

Confidential responses will be included in any statistical summary of numbers of comments received and views expressed.

The Department will process your personal data in accordance with the DPA – in the majority of circumstances this will mean that your personal data will not be disclosed to third parties.

