Appendix 2

WIRRAL COUNCIL

WIRRAL COMMUNITY SAFETY PARTNERSHIP
(Date)

CHAIR OF DH REVIEW PANEL *(insert details)*

INDIVIDUAL MANAGEMENT REVIEW *(name of agency)*

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1. INTRODUCTION

Brief factual/contextual summary of the situation leading to the DHR including an outline of the TOR and date for completion:

- *Identification of person subject to review*
- *Date of Birth:*
- *Date of death /date of serious injury/offence*
- *Name, job title and contact details of person completing this IMR (include confirmation regarding independence from the line management of the case).*
- *Perpetrator / family Details if relevant*
- *Name / Date of birth / Relationship / Ethnic origin / Address*
- *Include family tree or genogram if relevant.*

2. TERMS OF REFERENCE

3. METHODOLOGY

- *Record the methodology used including extent of document review and interviews undertaken.*

4. DETAILS OF PARALLEL REVIEWS/PROCESSES

- *e.g. Criminal Justice process, MAAPA Review*

5. CHRONOLOGY OF AGENCY INVOLVEMENT

5.1 AGENCY INVOLVEMENT WITH THE VICTIM, THE PERPETRATOR AND THEIR FAMILIES

The review should include a comprehensive chronology that charts the involvement of the agency with the victim, the 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; intelligence and information known to the agency; the decisions reached; the services offered and provided to the victim, the perpetrator and their families; and any other action taken.

5.2 *State when the victim/child/family/perpetrator was seen including antecedent history where relevant.*

5.3 *Identify the details of the professionals from within your agency who were involved with the victim, family, perpetrator and whether they were interviewed or not for the purposes of this IMR.*

6. ANALYSIS OF INVOLVEMENT

6.1 *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, that indicate that practice or management could be improved, the review should consider not only what happened, but why. Each homicide may have specific issues that need to be explored and each review should consider carefully the individual case and how best to structure the review in light of the particular circumstances. The following are examples of the areas that will need to be considered:*

6.2 *Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of 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?*

6.3 *Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators, and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?*

6.4 *Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?*

6.5 *What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?*

6.6 *Did actions or risk management plans 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 or what should have been known at the time?*

6.7 *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 the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?*

6.8 *Was anything known about the perpetrator? For example, were they being managed under MAPPA?*

6.9 *Had the victim disclosed to anyone and if so, was the response appropriate?*

6.10 *Was this information recorded and shared, where appropriate?*

6.11 *Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?*

6.12 *Were senior managers or other agencies and professionals involved at the appropriate points?*

6.13 *Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?*

6.14 *Are there ways of working effectively that could be passed on to other organisations or individuals?*

6.15 *Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?*

6.16 *How accessible were the services for the victim and perpetrator?*

6.17 *To what degree could the homicide have been accurately predicted and prevented?*

6.18 *Assess practice against guidance and relevant legislation.*

7. ADDRESSING TERMS OF REFERENCE

7.1 *Consider further analysis in respect of key critical factors, which are not otherwise covered by the sections above.*

8. EFFECTIVE PRACTICE/LESSONS LEARNT

9. RECOMMENDATIONS

9.1 *Recommendations should be focused on the key findings of the IMR and be specific about the outcome which they are seeking.*