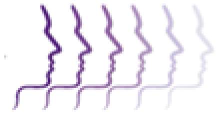
Leicestershire & Rutland
Safer Communities Strategy
Board
Making Leicestershire & Rutland Safer



LEICESTERSHIRE AND RUTLAND SAFER COMMUNITIES STRATEGY BOARD

Thursday, 26 March 2026 at 10.00 am

Sparkenhoe Committee Room, County Hall, Glenfield

Agenda

1.	Introductions	
2.	Minutes of previous meeting.	(Pages 3 - 8)
3.	Matters arising	
4.	LRSCSB Action Log	(Pages 9 - 10)
5.	Declarations of interest	
6.	Re-offending rates of prisoners following Early Release Scheme. *Bob Bearne, LLR Probation Delivery Unit Head, will give a verbal update in follow-up to the report considered by the Board on 21 November 2025: https://democracy.leics.gov.uk/documents/s193107/Probation%20report.pdf*	
7.	Leicestershire Fire and Rescue Service update. *Ben Bee, Assistant Chief Fire Officer, will present this report.*	(Pages 11 - 16)
8.	Domestic Abuse Related Death Reviews. *Holly Wells, Domestic Abuse Related Death Review Support Officer, will present this report.*	(Pages 17 - 20)
9.	CSP Domestic Homicide Review Contributions. *Gurjit Samra-Rai, Community Safety Team Manager, Leicestershire County Council will present this report.*	(Pages 21 - 52)

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10. Anti-social Behaviour Case Management System (ECINS). (Pages 53 - 58)

Gurjit Samra-Rai, Community Safety Team Manager, Leicestershire County Council, will present this report.

11. Safer Communities Performance 2025/26 Quarter 3. (Pages 59 - 64)

Gurjit Samra-Rai, Community Safety Team Manager, Leicestershire County Council, will present this report.

12. Other business

13. Date of the next meeting

The next meeting of the Board will take place on Thursday 25 June 2026 at 10.00 am via Microsoft Teams.

Agenda Item 2

Minutes of a meeting of the Leicestershire and Rutland Safer Communities Strategy Board held via Microsoft Teams on Friday, 21 November 2025.

PRESENT

Mr. C. Pugsley CC (in the Chair)

Cllr. L. Blackshaw	Community Safety Partnership Strategy Group Chair – Charnwood Borough Council
Cllr. L. Phillimore	Community Safety Partnership Strategy Group Chair - Blaby District Council
Cllr. M. Wyatt	Community Safety Partnership Strategy Group Chair – North West Leicestershire District
Cllr. Christine Wise	Rutland County Council
Joshna Mavji	Public Health, Leicestershire County Council
Ch. Insp Lindsey Madeley-Harland	Leicestershire Police
Sajan Devshi	Office of the Police and Crime Commissioner
Kay Knowles	Probation Service
Ashraf Hajat	Leicestershire Fire and Rescue Service
Wendy Hope	Integrated Care Board
Sharon Cooke	Leicestershire County Council

Officers

Lindsey Kirby	Leicestershire County Council
Gurjit Samra-Rai	Leicestershire County Council
Anita Chavda	Leicestershire County Council
Euan Walters	Leicestershire County Council
Andy Cooper	North West Leicestershire District Council
Giuseppe Vassallo	Charnwood Borough Council
Lee Mansfield	Charnwood Borough Council
Leye Price	Harborough District Council
Mark Smith	Oadby and Wigston Borough Council
Carol Parker	Blaby District Council

	Apologies for absence
Cllr. S. Butcher	Community Safety Partnership Strategy Group Chair – Melton Borough Council
Cllr. D. Woodiwiss	Community Safety Partnership Strategy Group Chair – Harborough District Council
Cllr. K. Loydall	Community Safety Partnership Strategy Group Chair – Oadby and Wigston Borough Council
Cllr. S. Harvey	Rutland County Council (Fire Authority)
Rachel Burgess	Hinckley and Bosworth Borough Council

27. Introductions

The Chairman welcomed everyone to the meeting.

28. Minutes of previous meeting.

The minutes of the meeting held on 25 September 2025 were taken as read and confirmed as a correct record.

29. Matters arising

There were no matters arising from the minutes of the previous meeting.

30. LRSCSB Action Log

The Board considered the LRSCSB Action Log, a copy of which, marked 'Agenda Item 4', is filed with these minutes.

It was noted that most of the actions were on the agenda for the day's meeting or were longer term actions that would be completed at future meetings.

With regards to Action no. 4 – report on Home Office Sub Threshold Pilot, it was explained that the Home Office had just begun their review of the Pilot and locally Leicester, Leicestershire, and Rutland would be feeding into the review. When the review was complete and published a report on it would be brought to the Board.

With regards to Action no. 8 – DarDR Support Officer post it was explained that conversations were taking place about extending that post and where the funding would come from. Once a decision had been made the Board would be updated.

RESOLVED:

That the status of the Actions in the Log be noted.

31. Declarations of interest

The Chairman invited members who wished to do so to declare any interests in respect of items on the agenda for the meeting.

No declarations were made.

32. Office of the Police and Crime Commissioner update.

The Board considered a report of Sajan Devshi, Performance and Assurance Officer, Office of the Police and Crime Commissioner, which provided an update on the work of the Office. A copy of the report, marked 'Agenda item 6', is filed with these minutes.

It was noted that the government had announced that they intended to abolish the role of Police and Crime Commissioners when the Commissioners' current term ended in 2028. In areas with a directly elected mayor the mayor would take on the powers of the Police and Crime Commissioner. In areas without mayors, police oversight would transfer to new policing boards made up mainly of local authority representatives. The specific police governance structure that would be in place in Leicestershire was unclear at the moment as a decision had yet to be made on local government reorganisation for the area and whether there would be a Strategic Authority with a mayor.

RESOLVED:

That the contents of the update on the work of the Office of the Police and Crime Commissioner be noted.

33. HMIP Inspection of Probation Service.

The Board considered a report of Kaye Knowles, Interim Head of Leicester, Leicestershire and Rutland (LLR) Probation Delivery Unit (PDU) regarding His Majesty's Inspectorate of Probation (HMiP) inspection of LLR PDU and the subsequent action plan. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

Arising from discussions the following points were noted:

(i) HMiP had carried out their inspection in March 2025 and identified strengths of LLR PDU and areas for improvement. HMIP made 6 recommendations and an action plan had been developed to address the areas for improvement. Amongst the areas for improvement was the ability of LLR PDU to identify risks and mitigate against those risks. There was also an issue with LLR PDU staff having insufficient professional curiosity to look into offenders being dealt with in more detail. Another issue was whether the LLR PDU was taking the appropriate action in response to information received from the Police about offenders.

(ii) One of the other issues identified by HMiP was the use of middle manager's time and the amount of oversight they were having. It was felt that they were getting too involved in operational decisions and having to counter sign assessments when they would be better off focused elsewhere. A quality assurance cycle had been introduced which reduced the amount of oversight on the written assessment by the middle managers.

(iii) Prison capacity issues had impacted on LLR PDU delivery because the Early Release Schemes had to be prioritised. In Leicestershire a multi-agency approach had been used to manage the Early Release Schemes and an Early Release Hub had been set up. The work involved partners relevant to victims, accommodation and drug treatment. The multi-agency work had been successful and was unique to Leicestershire. In response to a question as to what was the reoffending rate of prisoners released early under the scheme, it was agreed that a report on this would be provided at the next Board meeting.

RESOLVED:

That the update regarding Leicester, Leicestershire and Rutland Probation Delivery Unit be noted.

34. Community Safety Partnership Domestic Homicide Review contributions.

The Board considered a report of Gurjit Samra-Rai, Strategic Lead – Safer Communities, Leicestershire County Council, which proposed an increase in contributions to the Domestic Homicide Review (DHR) management process provided by Leicestershire County Council Safeguarding Partnership Board Office (SPBO). A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Board noted that the statutory duty to carry out DHRs was on Community Safety Partnership (CSP) Chairs. However, DHRs in Leicestershire and Rutland were managed by Leicestershire County Council on behalf of the CSPs. A number of specialist Leicestershire County Council officers supported the process including legal services, children and family services, adults and communities and safer communities. Leicestershire County Council did not charge a management fee. On an annual basis Leicestershire County Council contributed £30,000 towards DHRs, the Office of the Police and Crime Commissioner (on behalf of Leicestershire Police) contributed £16,000 and each Community Safety Partnership contributed £2,500. The number and complexity of DHRs in Leicestershire was increasing therefore in order to cover the increased costs it was proposed that each District partner and Rutland County Council should be invoiced £5,000 per annum.

Members raised concerns that it was only the CSPs that were being asked to increase their contribution and not Leicestershire County Council. Members requested more data and information showing the costs and breakdown between CSPs and Leicestershire County Council of the work carried out with regards DHRs. In response it was explained that the alternative was that CSPs became responsible for managing their own DHRs.

It was agreed that a further report on this matter would be brought to the next meeting of the Board containing the extra detail, and a decision on the funding contributions would be postponed until then.

RESOLVED:

(a) That the update regarding Domestic Homicide Reviews be noted;

(b) That officers be requested to provide more data detailing the breakdown of work on Domestic Homicide Reviews in a report for the next meeting of the Board.

35. New Anti-social Behaviour recording system - ECINS

The Board received a verbal update from Gurjit Samra-Rai, Strategic Lead – Safer Communities, Leicestershire County Council, regarding the new anti-social behaviour recording system known as ECINS.

Arising from the update the following points were noted:

(i) Some progress had been made with ECINS and integration of the Police Storm system had gone well. A survey had been undertaken and the majority of users were happy with the system. Dip sampling had taken place and some user error had been identified.

(ii) There were still some problems with the database for example in relation to the police input form, and the Genie search was only partially functioning. Regular meetings were taking place with ECINS, and ECINS were looking into the issues. One of the issues was a high turnover of staff.

(iii) Whilst a number of areas in the country had moved to using ECINS for their ASB recording, other authorities were not having the same problems with ECINS as in Leicestershire and Rutland. This was because the ASB partnership in Leicestershire and Rutland was much more advanced than in other areas and used much more data sharing between agencies. Other areas saw Leicestershire and Rutland as a model of where they wanted to get to. The downside of this was that ASB recording was not as straightforward as it was elsewhere.

(iv) It was intended that in future ECINS would be used for collecting more detailed information about individuals but at the moment the focus was on embedding the basics. Further development would take place in due course.

RESOLVED:

That the update regarding ECINS be noted.

36. Safer Communities Performance 2025-26 Quarter 2.

The Board considered a report of Anita Chavda, Projects and Planning Officer, Community Safety Team, Leicestershire County Council, regarding Safer Communities' performance for 2025-26 Quarter 2. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

RESOLVED:

That the 2025-26 Quarter 2 performance be noted.

37. Date of the next meeting

RESOLVED:

That the next meeting of the Board take place in person on Thursday 26 March 2026 at 10.00am in Sparkenhoe Committee Room at County Hall, Glenfield.

10.00 - 10.36 am
21 November 2025

CHAIRMAN

Leicestershire and Rutland Safer Communities Strategy Board Action Log

No.	Date	Action	Responsible Officer	Comments	Status
1.	20.6.25	Police led CTLP training to be offered to County Councillors	Anita Chavda	Training took place on 5th January 2026	Green
2.	13.12.24	Further updates on ASB Case Management System to be brought to the Board when there is further information to report.	Gurjit Samra-Rai	Ongoing.	Amber
	20.6.25	ECINS lessons learnt report to come to future Board meeting	Gurjit Samra-Rai	On agenda for Board meeting on 26 March 2026	Amber
3.	21.11.25	Early Release Scheme - further report requested on reoffending rate of prisoners released early.	Kay Knowles/Bob Bearne	Verbal update to be provided by Bob Bearne at meeting on 26 March 2026	Amber
4.	20.6.25	Report on Home Office Sub-Threshold Pilot to come to future meeting	Gurjit Samra-Rai	Home Office have just begun review. Report will be brought to Board when results of review published.	Amber
5.	20.6.25	Check if data can be obtained regarding whether the over-representation in the criminal justice system seen in Leicestershire is mirrored in other parts of the country.	Carly Turner	To be confirmed	Amber
		The next time a report comes to the Board regarding Youth Justice it should contain data on neurodiversity.	Carly Turner	Updates from Youth Justice will be annually – next report will be brought in June 2026.	
6.	25.9.25	A report to be submitted to the Board in 12 months' time regarding use of Community Protection Notices in the LLR area.	Chief Inspector Craig Smith-Curtis/Anita Chavda	Likely to come to meeting on 25 September 2026	

No.	Date	Action	Responsible Officer	Comments	Status
7.	25.9.25	A report submitted to a future meeting of the Board regarding the proposed extension to the DArDR Support Officer post	Holly Wells	Report from Holly Wells on the agenda for the meeting of 26 March 2026	Amber
8.	21.11.25	Further report on Domestic Homicide Review contributions to come to next meeting setting out detailed data on costs and work carried out.	Gurjit-Samra Rai	Report on agenda for meeting on 26 March 2026	Amber

Leicestershire & Rutland
Safer Communities Strategy
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LEICESTERSHIRE & RUTLAND SAFER COMMUNITIES STRATEGY BOARD

26th MARCH 2026

LRSCSB UPDATE: LEICESTERSHIRE FIRE AND RESCUE SERVICE

Purpose of report

1. The purpose of this report is to provide an overview to the Board on the work that is currently being undertaken by Leicestershire Fire and Rescue Service (LFRS).

Background

2. LFRS has a dedicated Community Safety department within the organisation. The department focuses on two main areas of Protection (buildings) and Prevention (people).

3. The Protection element allows for community and business engagement. This is a statutory duty of fire and rescue services and LFRS is the local enforcement agency of the Regulatory Reform (Fire Safety) Order 2005. This applies to commercial premises and buildings where members of the public may gather. It does not apply to single private domestic dwellings.

4. The Prevention element engages with a wide community audience across Leicester Leicestershire and Rutland (LLR) and uses a blended approach of resolute Community Educators and operational firefighters. This includes entering people's homes and providing them with specific advice or equipment relative to their needs; referred to as a Home Safety Check (HSC).

Proposals/Options

5. The Board is asked to consider the report and provide comment regarding the issues raised within the section 'Key issues for partnership working….'

Notable developments and challenges:

Past Year

6. Fire Protection activity continues to be delivered through a Risk-Based Inspection Programme (RBIP) focused on higher-risk premises. Between April and December 2025, LFRS completed 737 targeted fire safety audits under the

RBIP, towards the annual target of 1,040. In addition, 114 officer-generated audits were undertaken following concerns raised by members of the public, operational crews, partner agencies, and post-fire activity, ensuring emerging risks were addressed outside of planned inspection activity.

7. During this period, 137 audits resulted in unsatisfactory outcomes, leading to the issue of 61 Enforcement Notices and 73 Action Plans. A total of 132 follow-up inspections were completed to monitor progress and secure compliance. This represents an increase on previous years, reflecting both a rise in unsatisfactory outcomes and an increase in appropriate referrals from partner agencies.

8. Where an immediate risk to life was identified, prohibition action was taken. 11 Prohibition Notices were issued during the reporting period, including action taken in higher-risk premises. These cases required multi-agency coordination to manage the impact on occupants and ensure appropriate safeguarding and alternative arrangements were put in place.

9. Fire Protection teams have worked closely with District Councils in relation to premises used for homelessness and emergency accommodation. Inspections have been conducted across all identified premises to provide assurance on fire safety standards and support safe occupation.

10. Joint working with local authority partners has continued to develop. Joint training has been delivered with licensing teams, contributing to improved awareness of fire safety requirements and an increase in appropriate concern referrals. LFRS has also undertaken joint inspections with Trading Standards and Immigration, where fire safety deficiencies have been identified alongside wider regulatory issues.

11. LFRS continues to use prosecution where serious or sustained non-compliance is identified. During the reporting period, one prosecution was successfully concluded, with two further cases currently progressing through the court process and one additional prosecution initiated.

12. From April 2025 the Service completed a total of 7,903 Home Safety Checks (HSCs). Of these, 1,193 high-risk HSCs were delivered by Community Educators comprising 976 successful initial visits, 159 follow up visits and 58 Vulnerable Person Home Safety Checks. Operational crews completed the remaining HSC as part of their local targets.

13. The Community Safety Facebook page remained the main channel for promoting key safety campaigns in Q3, achieving notable public engagement—particularly for Electrical Safety and Christmas safety messages. Regular radio and television interviews ensure key safety messages are shared everywhere.

14. In quarter 3, Community Safety visited 47 primary schools and delivered presentations to 4,573 children. The schools programme for the 2025/26 academic year is focused on areas with higher rates of accidental and deliberate fire incidents, as well as greater deprivation. Community Safety is actively promoting the Staywise learning resource to schools not receiving in-person

visits this year.

15. LFRS continue to support the city centre-based Warning Zone by providing an employee to the children's safety centre. With 10–11-year-old young person's attending across LLR they receive fire, road, online, rai, water safety as well as a range of other immersive activities.

16. LFRS HQ hosted the launch of our new virtual reality film, 5 in 5, created in partnership with Bedfordshire Fire and Rescue Service. Designed for young and new drivers, the film educates viewers about the hazards and risks they face.

17. Road safety expert Liz Box spoke at the event, highlighting that while fear-based interventions can attract attention, they do not always result in safer behaviour and may sometimes encourage risky actions, particularly among young males who are most at risk on the roads. The film is now integrated into our road safety programmes for schools and colleges and will also feature at community events and open days across the County.

18. Three LFRS Fire Cadets spoke eloquently and passionately to 150 Fire Sector professionals at the NFCC Fire Prevention Conference held in November. They represented all UK Fire Cadets by putting forward the views of children and young people that will shape NFCC policy.

19. LFRS fire investigators help the Police with arson cases. In 2025, two people were sent to prison for arson—one for 12 months and one for five years. Both cases came from joint work with the Police and Crime Scene Investigators, involving Field Interrogation. It is important to note that these cases can take years to conclude, and updates are only provided once sentencing happens.

Key issues for partnership working or affecting partners

20. Assistive technology provision varies across local authority areas. Within Leicestershire County, there are recognised challenges in the provision of assistive technology for individuals with hearing impairments, particularly hard-of-hearing equipment and silent alerters. By contrast, Leicester City and Rutland have established funding arrangements with charitable partners, including Action Deafness and Amplius, enabling broader access to devices such as silent alerters, amplified doorbells, and phone and TV equipment for vulnerable residents.

21. Fire service provision supports but cannot substitute for commissioned services. In Leicestershire County, LFRS can provide deaf smoke alarms (DSAs) to eligible residents; however, this offer is criteria-based and capacity-limited and cannot meet county-wide demand in isolation. Where a silent alerter is clinically or practically more appropriate than a DSA, LFRS has no mechanism to provide this equipment, and referral pathways remain limited.

22. A coordinated approach would help reduce unequal risk for residents. The absence of commissioned assistive technology pathways in the County means

residents experience a different level of protection compared with those living in City and Rutland areas. This presents an opportunity for local authorities and partners to collectively consider how existing good practice could be adapted or scaled, ensuring a more consistent safeguarding offer and reducing avoidable risk for vulnerable residents across all communities.

23. Housing and Accommodation Pressures. With the phasing out hotel-type accommodation for asylum seekers, there is an anticipated increase in referrals and complexity in managing vulnerable individuals. This could require stronger partnerships with charities and local authorities to address risks, language barriers, and onward placement.

24. Emerging legislative requirements and building safety reform continue to shape Fire Protection activity. Residential Personal Emergency Evacuation Plan (RPEEPS) requirements and the acceleration of external wall cladding remediation both require close coordination between building owners, managing agents, local authorities and LFRS to ensure risks are appropriately managed while longer-term solutions are delivered.

25. There has been an increase in the use of houses and Houses in multiple occupation (HMOs) to meet housing demand, including for the accommodation of asylum seekers. Under existing Memoranda of Understanding, local authority licensing teams take the lead role for HMOs, with LFRS providing fire safety input and enforcement where required.

26. The data currently being provided by private companies and managing agents to LFRS does not have any vulnerability evaluation or risk prioritisation added. Therefore, evaluating priorities is not possible and the volume is significant. LFRS has reached out to the relevant group who meet quarterly; other partners present may be able to assist.

27. An increasing number of these premises are now being managed privately as part of immigration accommodation contracts. Given the growth in numbers, the capacity of managing agents to maintain effective fire safety controls, and the potential vulnerability of occupants, a coordinated and consistent approach between local authorities, managing agents and LFRS is essential to ensure risks are identified, managed, and reduced effectively.

Recommendations for the Board

28. It is recommended that the board:

- Note the content of the report
- Consider how the themes impact their areas of activity and where closer partnership working opportunities can be explored.

Officer to contact

Ben Bee
Assistant Chief Fire Officer

Leicestershire Fire and Rescue Service

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Agenda Item 8

Leicestershire & Rutland
Safer Communities Strategy
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LEICESTERSHIRE & RUTLAND SAFER COMMUNITIES STRATEGY BOARD

26 MARCH 2026

L&R DOMESTIC ABUSE RELATED DEATH REVIEWS

Purpose of report

1. The purpose of this report is to provide an update for Board Members on the current Domestic Abuse related Death Reviews (formerly known as Domestic Homicide Reviews) within Leicestershire and Rutland.

Background

Domestic Homicide Reviews

2. Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004. Under section 9(1) of the 2004 Act, domestic homicide review means 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 he2 was related or with whom he was or had been in an intimate personal relationship, or
   (b) a member of the same household as himself,
   held with a view to identifying the lessons to be learnt from the death.

3. The purpose of a DHR is 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. An Action Plan is created based on the Recommendations and lessons highlighted as part of the review. These lessons could result in changes to national and local policies and procedures as appropriate.

4. The responsibility for establishing a review rests with the local Community Safety Partnership (CSP). Within Leicestershire and Rutland, the agreement is that the Leicestershire and Rutland Safeguarding Partnerships Business Office (SPBO) conduct the review on behalf of the CSPs, who own the resulting report and action plan.

Domestic Abuse related Death Reviews.

5. The previous Conservative government carried out a domestic homicide review (DHR) legislation consultation in the summer of 2023. In their response to the

consultation the government announced that Domestic Homicide Reviews would be renamed as Domestic Abuse Related Death Reviews to better recognise deaths from domestic abuse related suicide. This change of name was confirmed in Part 1 Section 19 of the Victims and Prisoners Act 2024.

6. In readiness for the new statutory guidance and in line with the terminology used by the Domestic Abuse Commissioner and other Local Authorities, it has been agreed to refer to all new reviews moving forward by the new name of Domestic Abuse related Death Reviews. Those already in progress will continue to be referred to as Domestic Homicide Reviews (DHRs). For my report, I will use the new term.

7. There are currently eleven (11) Domestic Abuse related Death Reviews (DArDR) in progress at various stages across Leicestershire. The table below shows a breakdown of key data:

Sex of victim	Female	Male	
	9	2	
Type of Perpetrator	Familial	Relationship (includes ex-partners)	Other (friend / tenant etc)
	4	6	1*

**the victim and perpetrator were in a very short-term sexual relationship at the time of death*

8. There is also an out of area case (Warwickshire) which is being supported as necessary by Leicestershire agencies and the Leicestershire and Rutland Safeguarding Partnerships Business Office.

9. Key themes emerging from the eleven cases in progress include, but are not limited to:

- The link between Mental Health and Domestic Abuse, including diagnostic overshadowing
- Isolation in rural communities and whether this led to a lack of reporting / disclosure of Domestic Abuse
- Death linked to use of firearm, recorded in 2 of the 11 cases.
- Impact of adverse childhood experiences / trauma with regards to the perpetrator
- Multigenerational abuse / child to parent abuse – often starting in childhood and early teens. In 2 of the 11 cases, the death was matricide and in a 3rd case the victim was a grandparent.

10. Action Plans have been created for 6 of the cases, as they are either complete / nearing completion and actions are already being progressed, with some actions already having been completed.

11. The Home Office has returned one Overview Report shared with them in June 2025 with requests for a pen picture of the victim to be included: this has since been done and the report is to be resubmitted and discussions re publication will now take place.

12. It is hoped that at least 2 more Overview Reports will be submitted to the Home Office before the next Board meeting in June 2026.

Notable developments and challenges:

13. Upon completion of the review process, the lead Board Officer from the Safeguarding Partnerships Business Office submits the full, detailed Overview Report, a summarised version of the report (Executive Summary) and Action Plan to the Home Office. The report is then submitted to the Home Office's Quality Assurance Panel for review. The Panel are responsible for quality assuring all Overview Reports for DArDRs conducted under the statutory guidance. If the Panel finds that a final report is inadequate, the Panel Chair will feed back directly to the CSP (via the Safeguarding Partnerships Business Office) to explain the reasons why it is felt the report requires amendment.

14. The Quality Assurance Panel includes representation from all relevant statutory agencies, including

- Home Office
- National Offender Management Service
- Department of Health
- Crown Prosecution Service
- Department for Education
- Department for Communities
- Local Government Independent Police Complaints Commission
- Representation from the voluntary sector.

15. The Safeguarding Partnership Business Office have been notified that there are significant delays in terms of reports that are submitted to the Home Office being heard by the Quality Assurance Panel of up to several months. This delay has a knock-on effect with regards to publication of the Report and bringing a sense of closure to the families.

16. As noted above, action plans are being progressed without awaiting publication so that key learning can be shared and embedded across the service area and relevant CSP areas and effective changes can begin to be made.

17. We have also had instances where the Overview Report has been signed off by Panel and the Leicestershire and Rutland Case Review Group, but then agencies have requested further changes, delaying Home Office submission.

18. The Leicestershire and Rutland Safeguarding Partnership Business Office have shared this with the Independent Chair of the Safeguarding Adults Board, who

is helping to develop guidance for Case Review Group members, including sign off process and reminding them that there are families at the centre of the process, to help prevent unnecessary delays in the future.

Recommendations for the Board

19. To note the contents of the report and provide support to the DArDR Support Officer and Safeguarding Partnerships Business Office where necessary.

Officer to contact

Holly Wells
Domestic Abuse Related Death Review (DArDR) Support Officer
Leicestershire and Rutland Safeguarding Partnerships Business Office

Tel: 0116 3052730 Email: Holly.Wells@leics.gov.uk

Agenda Item 9

Leicestershire & Rutland
Safer Communities Strategy
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LEICESTERSHIRE & RUTLAND SAFER COMMUNITIES STRATEGY BOARD

26 MARCH 2026

CSP DOMESTIC HOMICIDE REVIEW CONTRIBUTIONS

Purpose of report

1. The purpose of this report is to propose an increase in funding contributions to the DHR management process provided by Leicestershire County Council (LCC) Safeguarding Partnership Board Office (SPBO) and other officers across the authority.

Background

2. A report on the issue was previously presented to the Board on 21st November 2025. https://democracy.leics.gov.uk/documents/s193131/DHRs.pdf
At that meeting Board members requested further information before they could make a decision and deferred the item to the March 2026 meeting.

3. Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). Responsibilities to facilitate reviews fell to local authorities and partners through Community Safety Partnerships.

4. The infrequency of DHRs, however, posed potential issues regarding capacity and capability to undertake such reviews efficiently and effectively. As a solution in 2013 the Leicestershire Safer Communities Strategy Board (now the Leicestershire & Rutland Safer Communities Strategy Board) agreed delegated local arrangements to assist in the management and production of DHR Reports.

Management of DHRs

5. The process and procedures governing DHRs is attached at Appendix A; the management of DHRs includes the management of actions and recommendations.

6. Current delegated arrangements for the management of DHRs involve the commissioning of expert support, the cost of which is rising, and assistance from the Safeguarding Partnership Business Office (SPBO) and there are

numerous meetings and Boards attended by LCC staff at varying grading bands. This culminates at the point of publication of the Domestic Homicide Review by the relevant CSP.

7. Recommendations and actions are identified within the DHR report, and they can be a combination of forms:
    - Directly for the relevant CSP;
    - For a single agency identified within the review process;
    - Broader cross-agency or multi-agency recommendations and actions.

8. Recommendations and actions require implementation, monitoring and sign-off and in some cases suitable remedial action and support to ensure completion. Given the purpose of a DHR it is crucial that the post DHR process is both timely and robust; this is not currently the case.

9. There is currently an LCC identified post who picks up and drives forward all of the actions arising from DHRs, the funding for which was originally taken from the partnership DHR budget as a pilot. Leicestershire County Council has now mainstreamed this post to support the partnership on a permanent basis.

10. The number and more notably the complexity of DHRs is increasing; even before a decision is made that a case meets the threshold for a DHR much work is undertaken by the SPBO. A number of specialist Leicestershire County Council officers support the process, from Director level through to administrative support, including legal services, children and family services, adults and community and safer communities, as well as representatives from health, police and voluntary sector. Specialists in the field are also consulted with on an ad hoc basis.

11. Furthermore, the Home Office challenged a Leicestershire CSP through a judicial review, the pooled partnership DHR funding was used to support this Borough in defending themselves.

12. Summary:

Total number of DHRs (since 2011)*	**Completed (including those not published)**	**Ongoing**
17**	11	6

* this figure covers only those which progressed to a full review.

** this figure includes 2 Alternative DHRs and does not include the cases from 2025 as some decisions have not yet been finalised.

Funding of DHRs

13. The Leicestershire Safer Communities Strategy Board (now the Leicestershire and Rutland Safer Communities Strategy Board) agreed current arrangements in 2013. The annual funding contributions agreed are set out below:

Leics. County Council	£30K +DHR post +officer time
OPCC	£16K
Districts & Rutland CC @ £2.5K Each	£20K

14. Contributions run in line with the financial year e.g., this year's contributions will be from April 25 – March 26 and is invoiced in Feb/Mar.

Outgoings:

- Recharge by the SPBO for their services. These are based on 0.5fte of a Grade 6 admin post and 0.6fte of a grade 12 post, this was £53,504.67 last financial year.

- Costs of DHRs, this includes engagement of independent Chair/Author and ancillary expenses. On average an annual estimate based on four DHRs per annum costs circa £15 -20K. However, DHR numbers are unpredictable.

- LCC do not currently charge for officer or management time.

15. During the Covid-19 pandemic both the number and progress of DHRs reduced and financial reserves increased. The table below shows the DHR costs by financial year, the lower costs have allowed reserves to build. As at the 1st April the available reserve was £70,788. It was the reserve that allowed for the funding of an additional pilot post for one year without a requirement to ask for additional funding from stakeholders.

Financial Year	DHR Costs (£)
2019/20	13,625.14
2020/21	4,288
2021/22	256
2022/23	8,677
2023/24	11,388

16. Factors which did impact the reserve:
    I. The additional post within SPBO, 0.5 FTE at Grade 9.
    II. Increase in number and complexity of DHRs. Projected costings for contribution purposes were based on an average of four DHRs per annum. We currently have six at panel or pre-panel stage.
    III. The costs for DHRs includes provision for appointment of an Independent Chair and an Independent Author. We have to date managed to run DHRs utilising a single person to undertake both roles

which has allowed for savings and consequent positive impact on the reserves. We do however need to maintain the option to utilise separate roles if required particularly for more complex cases.

IV. The Home Office has consulted on the statutory guidance for DHR's. The draft indicates DHRs will become broader in scope. Larger numbers will be accompanied by increased costs.

V. A Home Office Judicial Review

17. After detailed discussions with finance colleagues, it has been advised that in order to cover the costs of DHRs going forward each District partner and Rutland should be invoiced £5,000.

18. Due to the nature of Domestic Abuse, it is not possible to use demographic data, indices of deprivation, population figures or intelligence to identify areas of prevalence. DA can and does affect all members of society.

19. A further consideration is that each LA or CSP area undertake their own DHR process.

Recommendations for the Board

20. It is recommended that:

(a) The Board notes the content of the report;

(b) The Board approves the proposal of an increased contribution to £5,000 as stated in paragraph 17 above.

Notable developments and challenges:

21. Developments and challenges have been as follows:
- The number of cases has increased considerably since 2013;
- The complexity of cases has increased significantly;
- The funding arrangements have not been reviewed since 2013, despite numerous pay awards.

Officer to contact

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APPENDIX A

Leicestershire & Rutland Domestic Homicide Reviews: Local Procedures

This document outlines the procedures to be followed when considering and carrying out Domestic Homicide Reviews in accordance with the Home Office Guidance "Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)"

Authors: Chris Tew, Gary Watts, James Fox

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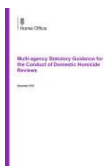
Introduction

Definition in the Home Office guidance:[1]

> "Domestic homicide review means 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 was related or with whom he was or had been in an intimate personal relationship, or
>
> (b) A member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death" (p. 5, para 5).

On the 7th December 2016, the Home Office published the revised "*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*", which was created as part of the framework of the over-arching "Domestic Violence, Crime and Victims Act 2004" (section 9(3)).



The purpose for undertaking Domestic Homicide Reviews (DHRs) is to:

a. *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;*
b. *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;*
c. *Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;*
d. *Prevent domestic violence and homicide and improve service responses for all domestic violence victims and their children by developing a co-ordinated multiagency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;*
e. *Contribute to a better understanding of the nature of domestic violence and abuse; and*
f. *Highlight good practice.*

…Reviews should illuminate the past to make the future safer. Reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions (para 8).

The narrative of each review should articulate the life through the eyes of the victim (and their children). And talking to those around the victim including family, friends, neighbours, community members and professionals… (Please see para's 9 & 10).

1. Background

The 8 Community Safety Partnerships (CSPs) in Leicestershire and Rutland have agreed, through the Leicestershire Safer Communities Strategy Board (LSCSB), to commission the Leicestershire & Rutland Safeguarding Boards to manage the review process through the joint Safeguarding Adults Board (SAB) & Local Safeguarding Children Board (LSCB) Safeguarding Case Review (SCR) Subgroup.

From the Home Office perspective, the CSP in the area where the homicide took place will remain the accountable body responsible for funding and commissioning the reviews; however, locally, all DHR activity is managed through the Safeguarding Boards Business Office (SBBO) which also acts as the single point of contact for the Home Office on DHRs.

The management of the multi-agency recommendations and the completion of actions, along with any resulting learning events, is the responsibility of the County Council Community Safety Team through the Domestic Abuse Partnership on behalf of the CSPs.

The Chair of the geographically relevant CSP will be responsible for individual DHR decisions including the need to hold a DHR, on the basis of recommendations from the LSCB/SAB conjoined SCR Subgroups meeting.

For updates from the Home Office, please visit their website:

https://www.gov.uk/government/collections/domestic-homicide-review

The following pages set out the local process for the completion of DHRs across Leicestershire & Rutland, which has been adapted from the revised statutory guidance published by the Home Office (December 2016).

2. Determining the need for a review

2.1. Notifications of deaths

When a domestic homicide occurs the police should inform the relevant Community Safety Partnership in writing of the incident. Where the deceased is aged 16 or 17 years, then the Child Death Overview Panel (CDOP) should also be made aware.

Any professional or agency/organisation may refer such a homicide to the CSP in writing.

In Leicestershire and Rutland the process is managed as follows:

- When the police or another agency/organisation are made aware of an adult death (this now includes 16 and 17 year olds) and where the circumstances may meet the criteria[2] for a DHR, there is an expectation that they will notify the SBBO manager or an officer within a reasonable time frame of the death occurring. The SBBO in turn notifies the head of the Leicestershire County Council Community Safety Team as soon as possible who will then liaise with the Chair of the relevant Community Safety Partnership (CSP)

- Although the initial information can be given verbally, a written report of the circumstances will be produced to comply with the national DHR procedures and to inform the relevant CSP Chair and SCR Subgroup

- Where a victim normally resides in Leicestershire or Rutland but their death occurs *outside* Leicestershire and Rutland and circumstances meet the criteria for a DHR, the responsibility for completing a DHR sits with the CSP where the victim's last known address was recorded.

- Where a victim normally resides outside of Leicestershire or Rutland but their death occurs *in* Leicestershire and Rutland and circumstances meet the criteria for a DHR, the responsibility for completing a DHR sits with the CSP where the victim's last known address was recorded.

2.2. Working with other areas

Where another CSP outside of Leicestershire and Rutland is completing a DHR within their area and they have reason to believe the individuals involved may be known to agencies within Leicestershire or Rutland, the CSP should write to the SBBO who will liaise with the Head of the Leicestershire County Council Community Safety Team. A trawl for information from local agencies/organisations will be conducted on behalf of the requesting CSP, and where possible, working to the requesting CSPs existing timescales.

2.3. Referring Cases for consideration

The case will be referred to the next planned Safeguarding Boards SCR Subgroup meeting unless the circumstances of the incident require a special meeting of the Subgroup to consider the case.

The SBBO will request an initial records check from members of the SCR Subgroup and domestic abuse specialist services. Agencies will share the outcome of their records check at the SCR Subgroup meeting where the case is considered.

Once it is known that a homicide is being considered for review, each agency with involvement with the victim, family or members of the household should promptly secure the agency's records relating to the case, to guard against loss or interference.

Following the meeting, a recommendation will be made by the group via the head of the County Council Community Safety Team to the Chair of the relevant CSP, stating if the criteria for a DHR have been met and whether a DHR or other learning process should be conducted.

[2] The definition of the circumstances surrounding a death to meet DHR criteria can be found on page 2.

The Senior Investigating Officer from Leicestershire Police may be invited to attend or contribute to the meeting to offer the latest information in relation to ongoing investigations and to provide any feedback from their initial contact with the family.

2.4. Joint DHR with Serious Case Review (SCR) and/or Safeguarding Adult Review (SAR) processes

If it is established that the deceased was under the age of 18 or the family unit includes children/young people under the age of 18, the Safeguarding Boards Business Office will ensure that the information is considered by the SCR Subgroup to establish if the case also meets the criteria for a children's serious case review.[3]

Alternatively, if it is determined that the case involves an "adult at risk", the SBBO will ensure that the information is considered by the SCR Subgroup to establish if the case also meets the criteria for a Safeguarding Adult Review (SAR).

A link to the relevant section of the Care Act 2014 is shown below:

http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

If it is determined that the criteria is met for a Child SCR or an Adult SAR (in addition to a DHR), the joint SCR Subgroup will consider the case and make a recommendation to the Chairs of the LSCB or SAB and the CSP, stating that the Chairs agree to undertake a jointly commissioned process whereby the Child SCR or Adult SAR terms of reference incorporate the DHR elements. This should reduce duplication of work for the organisations involved and provide an improved experience for families.

It should be noted that when victims of domestic homicide are aged under 18, a child SCR should take precedence over a DHR. However, it is vital that any elements of domestic violence relating to the homicide are addressed fully and the review includes representatives with a thorough understanding of domestic violence.

2.5. Timescale

The decision on whether or not to hold a DHR should normally be taken by the Chair of the relevant CSP within 1 month of a homicide coming to the attention of the SCR Subgroup. There may be circumstances where more information is required to determine the appropriate type of review.

The Independent Chair of the Safeguarding Boards must be informed of the decision to conduct a DHR and will provide independent advice to the CSP Chair as necessary throughout the process.

2.6. Options available to the SCR Subgroup

- To recommend that the CSP commission a DHR

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[3] The criteria for a Children's Serious Case Review are defined by the Department of Education under the statutory framework of "Working Together". For more information on the LSCB, please visit http://www.lrsb.org.uk/

- To recommend that the LSCB and CSP commission a joint DHR and child SCR
- To recommend that the SAB and CSP commission a joint DHR and adult SAR
- To recommend that a decision is put on hold until the criminal and coronial proceedings are completed
- To recommend that another type of review is commissioned (as defined in the Learning and Improvement Framework)
- To recommend that a review process is not undertaken.

2.7. SBBO Review Officer and Administration

When a decision has been made to undertake a DHR, the manager of the SBBO will appoint a SBBO Review Officer to the case and organise suitable administration support for the DHR process.

2.8. Notification of a decision to review (or not to review) a homicide

2.8.1. Home Office

The Chair of the relevant CSP, via the SBBO, will notify the Home Office of confirmation of either a decision to review or a decision not to review a homicide. This is placed in writing to:

The Home Office DHR enquiries: DHRENQUIRIES@homeoffice.gsi.gov.uk

A copy of this email will also be sent to the Independent Chair of the Safeguarding Board and the head of the County Council Community Safety Team by the SBBO.

As part of the Home Office internal processes the “decisions not to review” are reviewed by their Quality Assurance Group. This Group can request additional information about the case and also override the decision not to review. Whilst the Group meets quarterly, a response may not be received by the Group for some time after submission. During this time the SBBO will track the case until confirmation has been received by the Home Office that they are in agreement with that decision.

2.8.2. Coroner

The SBBO Review Officer will notify the coroner of the CSP’s intention to conduct a DHR or other review as a matter of courtesy.

2.8.3. Referrer

The SBBO Review Officer is responsible for providing feedback to the referrer of the decision made regarding a review.

2.9. Working with the criminal process and deciding when to suspend a review

Where there is an ongoing police investigation or an ongoing prosecution, the Police Detective Chief Inspector (DCI) responsible for Adult Safeguarding will inform the Senior Investigating Officer (SIO), the Disclosure Officer, Family Liaison Officer (FLO) and where necessary the Crown Prosecutions Service of the CSP’s intention to conduct a DHR or other review.

It may be appropriate to suspend a review due to ongoing criminal processes and investigations being undertaken. This is to ensure that the police are able to gather records and key witness information without interference from parallel legal processes. It is recognised that criminal proceedings take precedence and that, if the DCI for safeguarding wishes to make a recommendation to suspend the review, this should be done without delay and in writing with an explanation of their recommendation to the Chair of the SCR Subgroup.

It may be appropriate in some cases that portions of the review should be suspended: for example, internal agencies' reviews can be completed, but the bringing together of information into a multi-agency forum needs to be delayed. Alternatively the Review Panel may wish to delay contacting the family or interviewing key people as part of the review process. These decisions are taken in discussion with the Police DCI for adult Safeguarding.

In some instances processes are able to run parallel: for example, where the victim and the perpetrator are both deceased. This approach should always be cleared by the Police DCI for adult Safeguarding to ensure processes can run smoothly and without interference.

3. <u>Initiating the review</u>

3.1. Commissioning a Review Panel Chair/Overview Report Author

Once a decision to review has been made, the SBBO Review Officer will be responsible for securing the services of individuals to fill the roles of Review Panel Chair and an Overview Report Author (these are sometimes separate or dual roles). These persons should be independent of all the agencies/professionals directly involved in the particular case. A list of potential candidates will be drawn up and an individual chosen in conjunction with the SCR Subgroup Chair and a virtual panel of selectors.

When appropriate, the Chair of a DHR Panel may be a suitable employee of one of the local agencies not directly involved in the case.

Where an individual is externally commissioned, a legally binding contract will be put in place outlining their responsibilities in this role. The SBBO Business Manager will utilise Leicestershire County Council's legal services and comply with procurement rules when completing this task, due to the SBBO being hosted by Leicestershire County Council.

These appointments will be made with regard to their previous experience of such reviews and subject to satisfactory references from other Board Managers.

4. <u>The Review Process</u>

4.1. The agency information gathering process

After receiving agreement from the Chair of the CSP that they will conduct a DHR, the SBBO will issue a standard "Trawling letter" (Appendix 2) to an agreed list of agencies/organisations. This letter asks agencies/organisations if their services have a

record of the deceased person, their current or previous partners or any members of the same household.

If services have been provided to the deceased person, their partner(s) or any members of the same household, agencies/organisations are asked to give a brief summary of the nature and dates of their involvement. If there has not been any involvement with the deceased person, their partner(s) or any members of the same household, a nil return response is required.

The timescale for replies to the trawling request is usually 10 working days (the return date will be specified on the trawl letter sent to agencies). If an employee has a pre-declared interest in the case (i.e. family member or associate) then this should be made known to the SBBO Business Manager.

Where records exist they must be secured as previously noted and an A4 summary of involvement submitted; where no record exists, a nil return is required.

4.2. Chronology

This process compiles a picture of agency involvement. The “Chronolator” software tool is used to collate information.

4.2.1. Compiling a chronology of events

The SBBO “Chronolator” is the main software package to compile agencies’ chronologies.

The chronology must be completed on the pro-forma provided and be a record of the information known and recorded at the time. Where an agency became aware of information relating to earlier events outside of the scoping period, this should be recorded in summary form for the Review Panel. Should the Review Panel wish to retrieve the details this can be requested at a later date.

The chronology is not designed to be an accurate chronology of the family history, but of the agency knowledge and action (e.g. where a family moved house in April but the Social Worker found out in June, the chronology should record the date the Social Worker was informed, not the date the family moved).

The letter will provide timescales and formats for the provision of an Agency Chronology and Individual Management Report, together with guidance on their completion. These must be returned to the SBBO by a given date.

The chronology will need to be returned to enable the merged chronology to be created and the Review Panel to start work.

On receipt of the information returned by partner agencies/organisations, the SBBO Review Officer will write a report outlining the circumstances of the case. This report will be considered by the Review Panel at its first meeting.

The report may contain details of the case, guidance from the Home Office on decision making around reviews, a tentative schedule for the scope of any review process and some draft terms of reference.

Where appropriate, the report will reflect relevant issues in any ongoing, parallel processes:

- Criminal
- Coronial (including Coroners regulation 28 letters)
- Court/care proceedings
- SCRs or SARs,
- Health agency Serious Incident reports (SI) ➢ Agency disciplinary proceedings.

4.3. Establishing the Review Panel

The purpose of the Review Panel is to offer expertise and independence rather than representation. Its task is to give an independent overview of how agencies work together. It is important that different professional disciplines are represented to ensure that the relevant advice and perspective are available to the panel. Where a small number of agencies are involved in the case, other agencies will be asked to provide a representative to ensure appropriate challenge.

The minimum panel size is 4 and standing panel members are to include the Domestic Abuse Reduction Coordinator of the local authority, local CSP representative and SBBO Review Officer. Following the revised guidance in December 2016, the panel must also include specialist or local domestic violence and abuse service representation.

Administration for the panels will be provided by the SBBO.

The Review Panel will include individuals from relevant statutory agencies listed under section 9 of the Domestic Violence, Crime and Victims Act 2004. Those with a duty to cooperate with the review include:

- Chief officers of police for police areas in England and Wales
- Local authorities
- Strategic health Authorities
- Primary Care Trusts
- Clinical Commissioning Groups (also representing NHS England according to local agreement)
- Providers of probation services
- NHS trusts

There are other agencies which may have a key role to play in the review process but are not named in legislation, including representatives from Health provider agencies, housing associations and social landlords, HMP Prison Service, general practitioners (GPs), dentists, specialist domestic abuse services and teachers. Members from these agencies may be invited to join the panel.

The panel will produce draft terms of reference including the period of time the review will cover. These may be subject to change as the review progresses and further information becomes available.

Different services have different minimum and maximum adult record retention periods set against them: these can range from 2 years to 30 years, before they are destroyed. The Panel must bear this in mind when determining the length of the scoping period for the DHR and ensure this is proportionate.

As information comes to light through the review, it may be appropriate for the Review Panel to trawl additional agencies to understand their involvement. The responsibility for contacting these additional agencies sits with the SBBO Review Officer and is undertaken at the discretion of the Review Panel Chair.

Subsequent Review Panels are held over the period of the review to pull out key practice episodes, through information provided in Independent Management Reviews (IMRs), to enable the panel to derive areas of learning from the case. This then culminates in the Overview Report, completed by the independent author to the agreed template, addressing all areas stipulated within the agreed terms of reference.

It is the responsibility of the DHR Review Panel to ensure any early lessons are disseminated in a timely manner through the agreed methods in place.

Legal advice will be provided to the panel by Leicestershire County Council Legal Services.

4.4. Arranging a briefing for Independent Management Review (IMR) Authors

In consultation with the Review Panel Chair and the DHR Author, a date will be set for a briefing for IMR Authors.

This briefing provides an overview of:

- What DHRs are
- How the process works
- What the purpose of IMRs and their role as author
- What is expected of them and what they can expect from the Board Office during the process

The case is discussed and draft terms of reference circulated on the agreed IMR template. This session allows IMR authors to understand more about their role in the process, ask any questions they may have and make appropriate links with other agencies.

4.5. Role of an IMR Author

The purpose of an IMR is to allow agencies to look openly and critically at individual and organisational practice, and the context within which people were working, to see whether the homicide indicates that changes could and should be made to procedures and practice. IMR authors should identify how those changes will be brought about and highlight examples of good practice within agencies.

The IMR should begin once the terms of reference for the review have been set, and sooner if a homicide gives cause for concern within the individual agency. For those agencies with minimal involvement with the victim and their families, the panel may decide that a factual summary report of information is more appropriate than a full IMR report.

Those completing IMRs should not have been directly involved with the victim, the perpetrator or either of their families and should not have been the immediate line manager of any staff involved in the case. It should be recognised by the Review Panel that this may not be possible in smaller organisations due to capacity and existing organisational structures. If this is the case, the Senior Manager representing that organisation should notify the Review Panel Chair.

The IMR reports should be quality assured by the senior manager in the organisation who has commissioned the report. This senior manager will be responsible for ensuring that any recommendations from both the IMR and, where appropriate, the Overview Report are acted on appropriately.

4.6. Securing Data

As noted previously, once it is known that a homicide is being considered for review, each agency with involvement with the victim, family or members of the household should secure the agency's records relating to the case, to guard against loss or interference.

4.7. Use of interviews

It will be necessary for IMR authors to decide which staff had involvement in the case and need to be interviewed. The staff list should be sent to the SBBO Review Officer, who will share this with the SIO and obtain permission to conduct interviews. Interviews should be recorded and the record agreed by the interviewee.

Where staff or others are interviewed by those preparing IMRs, a written record of such interviews should be made. This should be shared with the relevant interviewee, who will then check the record for accuracy and will amend as necessary before signing the document as an accurate record.

Staff should be reminded that the review does not form part of a disciplinary investigation. If the review finds that policies and procedures have not been followed, relevant staff or managers should be interviewed to understand the reasons for this in accordance with the relevant agency procedures.

The view of the SIO and subsequent CPS advice must be sought prior to interviewing witnesses involved in any criminal proceedings to ensure this is appropriate and timely with parallel processes. All IMR reports may be made available to the Disclosure Officer during the process should they wish to call upon any of the information.

4.8. Timescales and extension requests

IMR authors must be aware of the timescales for completing the chronology and the IMR. Any difficulties in meeting timescales should be raised as early as possible with their agency's designated Senior Manager who in turn will notify the Review Panel Chair of any delay. (IMR authors need to be aware how their work fits into the whole programme: e.g. the timescales for creating the merged chronology being dependent on each agency's chronology being available.)

4.9. Templates

The Individual Management Review report and chronology should be written using the templates provided by the SBBO Review Officer. These templates will be based upon those suggested within the national Home Office. The templates will be created and signed off by the Review Panel.

The terms of reference for the individual case will have been added to the template which will contain supporting notes for completion.

The report should be a “standalone” document encapsulating information from the chronology in summarised form and sufficient for the facts of the family history and agency involvement to be clear. Where this has not been demonstrated, the Review Panel may ask the IMR author to complete further work on the report.

4.10. Creation of an anonymisation key for IMR Authors

The Review Panel will agree with authors how the IMR’s should be anonymised and will create an anonymisation key for partners to refer to individuals after a merged chronology and staff list has been provided. This process may not be completed until the conclusion of the Overview Report. This will be decided on a case by case basis by the DHR Panel.

4.11. Creation of single agency Action Plans

The IMR authors are requested to draw up a set of recommendations and Action plans as part of their role. These are scrutinised by the Review Panel and timescales set to them. It is expected that Senior Managers with the responsibility of signing off these IMRs, on behalf of their agency, initiate these actions without delay; this may mean that single agency actions are completed before the review is concluded.

4.12. Providing and receiving feedback

On completion of each IMR report, there will be a process of feedback and debriefing for the staff involved in the review prior to and post the publication of the Overview Report (i.e. those interviewed by IMR authors as part of the process). The management of these sessions are the responsibility of the senior manager in the relevant organisation on a single agency level.

DHRs are not part of any disciplinary inquiries, but information that emerges during the course of a review may indicate that disciplinary action should be taken under agencies’ internal procedures.

4.13. Interaction with the family, friends and associated persons

It is a vital part of the DHR process to involve key individuals that the deceased interacted with leading up to the event, such as friends, family and other informal support networks. This will enable the panel to gather rich data and first-hand information on the deceased from these people. As part of the Review Process, the panel members and chair must decide how best to interact with the family and who and how to involve other key people who would have formed part of the deceased’s life.

This will be done in collaboration with the Police Family Liaison Officer (FLO) and Police Senior Investigating Officer (SIO) to utilise existing advocacy services that the family may be accessing as part of police support and ongoing investigations. Timing is important when approaching the family; the panel will be guided by the FLO with this, bearing in mind ongoing parallel processes.

The panel Chair or the Overview Report author will make initial contact with the family members through the FLO, explaining to the family the DHR process and how they are able to be involved. During this engagement, the relevant Home Office information leaflet will be provided to the family.[4]

The panel Chair or the Overview Report author will then ensure there is regular engagement and updates on progress from the panel (through an advocate if appropriate), including the timeline expected for publication. This will explain clearly how the information disclosed will be used and whether this information will be published.

If the family decline involvement in the Review Process, the Chair or the Overview Report author will maintain links and notify when the review is completed and ready for publication. The panel Chair will also highlight any potential consequences of publication: for example, media attention and renewed interest in the homicide.

The Review Officer will assist with the process of contact with families on behalf of the panel if agreed by the panel Chair and Overview Report author.

4.14. Sharing information

4.14.1. Seeking Consent

During the DHR process, agencies are required to check their records for information they hold on the adults and children within the family unit. They may also be required to “trawl” for information on the perpetrator’s previous partners. It is the “trawling” agencies’ responsibility to ensure the relevant information sharing agreements are in place, and that their agency seeks relevant consent for the information that they are sharing with the Review Panel.

Agencies may wish to refer to the information sharing principles and exemptions as outlined by the Information Commissioner’s Office, the Data Protection Act (1998) the “Caldicott guidance” (DH 1997), and case law in relation to Human Rights legislation. Where in doubt, agencies are requested to refer to the Board’s procedures and their internal information governance teams for advice.

4.14.2. Disclosure

The Review Panel will work closely with the nominated Disclosure Officer responsible for the case within Leicestershire Police. The panel will ensure that all IMR reports are made available during the process should the police wish to call upon any of the documentation to support their investigations.

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[4] Information Leaflet compiled by the Home Office for Family members: http://www.homeoffice.gov.uk/publications/crime/DHR-leaflet2?view=Binary

4.14.3. Anonymisation

The content of the Overview Report and Executive Summary will be suitably anonymised in accordance with the key created by the SBBO Review Officer in order to protect the identity of the victim, perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998. This means preparing Overview Reports in a form suitable for publication, or redacting them appropriately before publication.

Only the Review Panel members and the panel Chair's name will be provided on the report, along with the contact details of the SBBO.

4.14.4. Freedom of Information Act Requests (FOIA)

The CSP will utilise the relevant Information Governance team to process any FOIA requests received regarding the DHR.

4.14.5. Accessibility

If the Review Panel is working with a family or organisation which would benefit from documents being translated or meetings and telephone calls being interpreted, this will be arranged by the SBBO Review Officer through the Leicestershire County Council Interpreting and Translation Services.

Where appropriate, the CSP will consider translating the executive summary in readiness for publication into different languages and other formats, such as Braille or British Sign Language, for the benefit of those involved in the review. This will be reviewed on a case by case basis.

4.14.6. Media Inquiries

Within the review process, the SBBO Review Officer will coordinate a multi-agency media planning group to coordinate the publication of the final Overview Report and executive summary.

During the review, especially at times of criminal trial and Coroner's inquests, there may be media inquiries to agencies about the case. If such an inquiry comes through to agencies, it is the receiving agency's responsibility to bring this to the attention of the Review Panel Chair and SBBO Review Officer.

If the inquiry is specifically about the DHR process or published report, this needs to be forwarded to the SBBO who will liaise with the Leicestershire County Council Community Safety Team Manager, who will, in turn, coordinate responses on behalf of the partnership. No comments about the DHR should be made without agreed partnership consent.

4.15. Drawing up the Overview Report, Executive Summary, Recommendations and Action Plans

The purpose of a DHR Overview Report is to bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports and associated documentation submitted to the review.

The Overview Report is completed by the independent author and will be anonymised in regard to any person identifiable information, with the agreed anonymisation key.

An Executive Summary will also be produced by the author designed as an "easy reference" version of the Overview Report.

The Overview Report will be written in line with Home Office guidance and to a high standard.

4.16. Action planning

The Overview Report will outline a set of recommendations for action which the Review Panel and CSP should translate into a specific, measurable, achievable, realistic and timely (SMART) Action Plan, which will be provided on the agreed template.

Any "early learning" lessons identified by individual agencies should be actioned promptly by the relevant agency and their progress and outcomes should be recorded as part of their IMR and the Overview Report.

Single agency Action plans must be agreed at senior level by each of the participating organisations. They should set out who will do what, by when, with what intended outcome, setting out how improvements in practice and systems will be monitored and reviewed.

The multi-agency Action plan is completed following the recommendations arising from the Overview Report. These actions are drawn up by the Review Panel with input from the relevant partnership (e.g. CSP, Safeguarding Board, or Domestic Abuse Partnership), reviewed by the SCR Subgroup and finalised by the relevant community safety partnership.

4.17. Consultation and re-drafts

Until publication any version of the Overview Report should only be circulated to:

- Those agencies participating in the review
- Members of the SCR Subgroup
- Members of the Leicestershire Safer Communities Strategy Board
- The Chair and members of the relevant CSP
- The Independent Chair of the Safeguarding Board
- Any other agencies agreed by the panel Chair.

The report will also be shared with family members through the panel Chair. The timing of this will take account of any ongoing criminal or coronial proceedings.

Any disputes with the contents of the review or factual inaccuracies should be raised in the DHR panel or SCR Subgroup meetings and formally minuted. This will enable the Overview report Author to make any necessary re-drafts and provide an audit trail of amendments.

For example:

If contributing agencies or individuals are not satisfied that their information is fully and fairly represented in the Overview Report

or

If they wish to bring context to a particular action or provide the Chair with missing information.

It will also allow the panel and the SCR Subgroup to ensure that the terms of reference have been addressed fully.

If re-drafts are necessary these will be noted through version control of the Overview Report. Once the Overview Report is agreed, the Review Panel should provide a copy of the Overview Report, Executive Summary and the Action plan to the Chair of the relevant CSP and the Independent Chair of the Safeguarding Board.

Following the agreement of the contents by the CSP Chair, this will then be submitted to the Home Office Quality Assurance Panel by the SBBO Review Officer.

This will be submitted via secure email to:

The Home Office DHR enquiries: DHRENQUIRIES@homeoffice.gsi.gov.uk

5. Concluding the Review

5.1. Publication Arrangements

There is an expectation that all Overview Reports and Executive Summaries compiled through the DHR process will be published. (Exceptions to publication can be explored in para 81 page 24). These will be uploaded onto the Leicestershire and Rutland Domestic Homicide Review website:

www.LRDHR.org.uk/

The purpose of publishing the reports is for the lessons learnt within the case to be shared widely. The aim in publishing these reviews is to ensure public confidence, and to improve transparency of the processes across all agencies and to protect potential future victims.

In certain circumstances, there may be reasons relating to the welfare of any children or other persons directly concerned in the review which mean it is not appropriate to publish the reports or that partial redaction of the report is necessary. The panel Chair will present these potential issues to the SCR Subgroup for consideration.

Where reports are to be published, this will be planned after any criminal or coronial processes have been completed and the Home Office Quality Assurance Panel has given approval of the documents. This will be planned and coordinated by a “small publication” meeting that will be attended by relevant media and safeguarding leads.

The small publication meeting will determine the lead agency for publication and media enquiries.

Where relevant Leicester City Safeguarding Boards Business Offices should also be informed of potential publication dates.

This process will ensure that agencies are fully prepared for the issues associated with the publication of the case and relevant Chief Officers are briefed and available to comment on the day of publication.

Domestic Homicide Reviews will normally remain on the DHR website for one year, before being removed, and are only available by direct request to the CSP or County Council Community Safety Team.

5.2. Supporting the family

The DHR panel will ensure that relevant family members are fully briefed on the report and understand its potential impact on them (e.g. media interest). They should be provided with the opportunity to ask any questions. Where appropriate, the media planning group will provide relevant media support for the families involved during this process.

The family will also be asked for any feedback on their experience of the process; this will be arranged by the Review Panel Chair. The DHR Panel Chair will signpost families to the National Homicide Service[5] and other specific charities set up to support families through incidents of domestic homicide.

5.3. Dissemination of the learning

After the document has been published, the Community Safety Partnership may organise the dissemination of multi-agency learning. This can be done through a variety of methods available:

- Publicising the report through the newsletters
- Utilising existing distribution networks amongst partners to notify agencies
- Utilising intra and internets/news-feeds amongst partners
- Incorporating learning into training sessions as case examples
- Publicising the review through conferences and display stands
- Holding learning workshops for practitioners
- Providing “stock” presentations for safeguarding leads to utilise in internal training sessions
- Sharing at regional/local safeguarding and domestic violence forums
- Providing a presentation to the Leicestershire Safer Communities Strategy Board and local Community Safety Partnerships.

5.4. Monitoring the Action Plan/Audit processes

The monitoring and audit of Action plans is the responsibility of the Community Safety Team on behalf of the Community Safety Partnership.

[5] https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service

6. Version control and summary of amendments

Date	No	Consultation Method
16.10.14	0.01	First draft: Gary and Chris from City procedures
04.02.15	0.02	Second draft: Gary and Chris
04.02.15	0.03	Transferred to new template
06.02.15	0.04	Part reviewed by Gary with tracking
09.02.15	0.05	Fully reviewed by Gary with tracking
31.03.15	0.06	Further review to James for consultation
21.05.15	0.07	Reviewed by James Fox
27.05.15	0.08	Revisions and further comments: Gary/Chris
28.05.15	0.09	Responses and minor revisions by James
03.12.15	1.0	Finalised
15.04.17	2.0	Reviewed and updated following revised DHR guidance published December 2016
28.6.17	2.0 FINAL	Published on www.lrsb.org.uk following CSP consultation May/June 2017

7. Signatory

Role	Name	Signature
Community Safety Officer on behalf of Leicestershire & Rutland CSPs	Rik Basra	via email 19.6.17

8. Review Periods

Procedures:
6 months after publication, then 3 yearly unless changes are made at a government level.
Templates:
6 months after publication, then 3 yearly unless changes are made at a government level.
Funding Arrangements:
To be reviewed annually between the LSCSB and the Safeguarding Boards.

9. Acronyms list

DHR	Domestic Homicide Review
DV/DA	Domestic Violence/Domestic Abuse
SCR	Serious Case Review
SAB	Safeguarding Adults Board
LSCB	Local Safeguarding Children Board
CSP	Community Safety Partnership
LSCSB	Leicestershire Safer Communities Strategy Board

HO	Home Office
IMR	Individual Management Report
FLO	Family Liaison Officer
SIO	Senior Investigating Officer (police)
SEG	Safeguarding Effectiveness Group
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
ToR	Terms of Reference
SMART	Specific, Measurable, Achievable, Realistic, Timely
CPS	Crown Prosecution Service
BME/BAME	Black and Minority Ethnic or Black, Asian and Minority Ethnic are the terminology normally used in the UK to describe people of non-white descent (Institute of Race Relations).
FOIA	Freedom of Information Act
FGM	Female Genital Mutilation
VCS	Voluntary and Community Sector
IDVA	Independent Domestic Violence Advocate/Adviser – Specialist support for those at high risk from harm from domestic abuse
CAADA	Coordinated Action Against Domestic Abuse – Now Safe Lives
DASH	Domestic Abuse Stalking and Harassment (Common Risk Indicator Tool for DA)
MHI	Mental Health Investigation
CCG	Clinical Commissioning Groups
LCC	Leicestershire County Council
ACPO	Association of Chief Police Officers replaced in April 2015 by NPCC National Police Chiefs Council
SBBO	Safeguarding Boards Business Office

10. Definition of Terms

- **Domestic Violence/Abuse (terms used interchangeably)**: any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over, who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

  - psychological
  - physical
  - sexual
  - financial
  - emotional

- **Controlling behaviour** is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

- **Coercive behaviour** is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim. (This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.)[6] In December 2015, a new domestic abuse offence to tackle coercive and controlling behaviour was commenced in legislation. More information about controlling and coercive behaviour in an intimate or family relationship can be found in the statutory guidance: https://www.gov.uk/government/publications/statutory-guidance-frameworkcontrolling-or-coercive-behaviour-in-an-intimate-or-family-relationship

- This definition, which is not a legal definition, includes so called 'honour' based violence, **female genital mutilation (FGM)** and **forced marriage**, and is clear that victims are not confined to one gender or ethnic group

- So called **"Honour" Based Violence**: "honour crimes" and "honour killings" encompasses crimes or incidents which are committed to protect or defend what is considered to be an 'honour' of the family or community. Victims may be 'punished' for not complying with what the family and/or community believe to be the 'correct' code of behaviour and therefore viewed as bringing 'shame' or 'dishonour' on the family or community. It is important to note that notions of 'honour' may not be obvious; victims may not identify or perceive what has happened as 'honour-based' violence.

- **Suicide** – where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

- **Intimate personal relationship** includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

- A **member of the same household** is defined in section 5 (4) of the Domestic Violence, Crime and Victims Act [2004] as:

    - a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it

    - where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

- **Victim:** a person harmed, injured or killed as a result of crime, accident or other event or action.

[6] http://www.homeoffice.gov.uk/media-centre/news/domestic-violence-definition

11. Contacts and further information

For more information on this local process, please contact the SBBO Business Manager on:

SBBO@leics.gov.uk or securely on SBBO@leics.gcsx.gov.uk Telephone: 0116 305 7130.

For more information on the Leicestershire Safer Communities Strategy Board and local Community Safety Partnerships, please contact the Leicestershire County Council Community Safety Team on:

Telephone: 0116 305 8077.

For more information on the Leicestershire and Rutland Safeguarding Adults and Children's Board, please visit:

http://www.lrsb.org.uk/
Or contact the Boards Business Manager on 0116 305 7130.

For up to date information on the national DHR guidance and national domestic violence strategies, please visit:

http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domesticviolence/domestic-homicide-reviews/

For more information on local domestic abuse services and to seek support if you are experiencing domestic abuse, please visit:

http://lrsb.org.uk/domestic-abuse

Domestic Abuse Helplines in Leicester, Leicestershire and Rutland:

Domestic Abuse & Sexual Violence in Leicestershire and Rutland - Advice and Services

Single public helpline number: 0808 802 0028
Single business line for professionals: 0116 255 0004

Helplines are open to both **men** and **women** affected and provide information, emotional support and signposting to local face to face support.

Remember, in an emergency you should always dial 999.

12. Summary of the DHR process

1	The police should inform the relevant Community Safety Partnership in writing of the incident The SBBO is notified of a death where circumstances suggest it could meet the criteria for a DHR It is determined whether this could also meet the criteria for a child SCR. If so a joint approach is agreed with the SBBO Business Manager
2	SBBO initiates initial information gathering from agencies
3	The initial case detail is presented by the police to the Leicestershire & Rutland Joint Adults and Children's Safeguarding Case Review Subgroup and a recommendation is made by the Subgroup to the relevant Community Safety Partnership via the Community Safety Team
4	Within a month of being informed, the relevant CSP has to decide on whether to carry out a DHR. The Home Office is notified and the timeframe for the process agreed
5	Further information gathering carried out if required
6	An Independent Chair is identified and an independent Overview Report writer is commissioned. Agencies are invited to participate in the review Templates for the chronology are circulated with return date
7	DHR Panels are convened and timescales to obtain information agreed – taking into account other parallel processes (criminal/coronial) The perpetrator/victim/families/employers and friends of the family are invited to participate in the review by the panel Chair
8	IMR Briefings are provided and templates for the report are circulated. A return date is communicated to IMR authors
9	An Overview Report is completed using information from agency IMRs and recommendations drawn up An Executive Summary is produced Subsequent SMART Action plans are drawn up (single agency and multi-agency)
10	Publication of the report is planned for a date agreed following completion of all legal processes

11	The report is submitted to the Home Office for quality assurance Following feedback the report is published if appropriate
12	The Leicestershire Safer Communities Strategy Board ensures that Action plans are monitored until completed, then actions are tested for effectiveness

Appendix 1: Template letter requesting a trawl of information held by agencies

Dear Safeguarding lead,

RE: Serious Incident Trawling Request

Background and Request

The Leicestershire & Rutland Safeguarding Boards Serious Case Review Subgroup has been informed of a death concerning an individual who may be known to your agency.

This initial information trawling exercise will enable the Board to make an informed decision on the best course of action to take, following the death of this adult. This could result in the undertaking of a Domestic Homicide Review (DHR). The Board recognise that gathering information from records can be a time consuming task. To ensure we identify agencies that have had involvement and relevant facts quickly, the following guidance is recommended:

Check all known records including electronic and paper based, including historical records. If the person is known to your agency then records and access must be secured.

Use a combination of names/spellings, any known aliases, dates of birth and addresses to ensure all records are searched.

An initial A4 side summary of your agency's contact/involvement with the individuals needs to be provided at this stage however your agency may be requested to provide a more indepth chronology at a later stage, if a DHR is initiated.

If there are no records of any contact then this confirmation is also required by providing a nil or negative response.

The deadline for you providing the Leicestershire and Rutland Safeguarding Boards Business Office with the A4 page summary, outlining your agency's involvement with this person OR a nil return, is DD/MM/YYYY (10 working days).

Legislation

A Domestic Homicide Review (DHR) is a statutory review of the circumstances in which the death of a person appears to have resulted from violence, abuse or neglect by:

a. A person to whom he was related or with whom he was or had been in an intimate personal relationship

   or

b. A member of the same household.

The Reviews are carried out in accordance with Home Office statutory guidance.

The purpose of the Review is 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
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

It is the duty of any of the bodies specified below to have regard to the Guidance issued by the Secretary of State as to the establishment and conduct of Domestic Homicide Reviews:

- ➢ Chief Officers of Police
- ➢ Local Authorities
- ➢ NHS Commissioning Board (NHS England)
- ➢ Clinical Commissioning Groups ➢ Providers of Probation Services ➢ NHS Trusts.

Information sharing guidance

As stated above, one of the purposes of the Domestic Homicide Review is the prevention of domestic violence homicide and it is considered that the sharing of information in connection with a Review is exempt from the non-disclosure provisions of the Data Protection Act. In addition there is an overriding public interest in disclosing the information requested and justification for doing so, although it is appreciated that you will wish to satisfy yourself that the disclosure is necessary, proportionate and restricted to material that is relevant to the purposes referred to above.

Any material that is disclosed pursuant to this request will (if referred to in the Review) be anonymised to protect the identity of any third party. The panel has considered whether there is any other effective means of obtaining this information and is satisfied that there are no other means available.

If you have any concerns about the contents of this letter can I suggest that you discuss these with your Information Management Compliance Officer and/or your legal advisers?

For more information on the DHR process and your agencies responsibilities, guidance can be found on the following webpage:

https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-ofdomestic-homicide-reviews

Please see overleaf for information trawl details. If you have any questions at this stage, please contact me using the details below.

Yours sincerely

(Name and contact details of SBBO leading).

Details of deceased:

Name:

DOB:

Deceased's address at time of death:

Period of involvement to initially scope:

Other significant individuals for scoping:

Name:

DOB:

Address:

Relationship to deceased:

Period of involvement to initially scope:

Name:

DOB:

Address:

Relationship to deceased:

Period of involvement to initially scope:

Name:

DOB:

Address:

Relationship to deceased:

Period of involvement to initially scope:

PLEASE ENSURE WHEN YOU SEARCH AGENCY RECORDS THAT YOU SEARCH USING ALTERNATIVE SPELLINGS OF FIRST NAMES AND SURNAMES FOR ALL FAMILY MEMBERS.

Known spellings for the family:

Known previous addresses of family members:

If you find you had contact with these individuals outside of the scoping period, please note this in your response.

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Leicestershire & Rutland
Safer Communities Strategy
Board
Making Leicestershire & Rutland Safer

LEICESTERSHIRE & RUTLAND SAFER COMMUNITIES STRATEGY BOARD

26th MARCH 2026

ANTI-SOCIAL BEHAVIOUR CASE MANAGEMENT SYSTEM (ECINS)

Purpose of report

1. The purpose of this report is to provide an overview of the project to implement a new Anti Social Behaviour (ASB) Partnership Case Management System (SMS) across Leicester, Leicestershire and Rutland (LLR) one year after implementation.

Background

2. The Crime and Disorder Act 1998 places a statutory duty on responsible authorities (including local police bodies and local authorities including district, borough, and county councils) to work together to reduce crime and disorder in their areas.

3. The ASB recording and management system, Sentinel, was introduced across LLR in 2011 after learning was taken from national and local serious case reviews around the importance of and requirement to share relevant information.

4. In 2023 a request was made by two members of the ASB Partnership, which is made up of 10 local authorities across LLR and Leicestershire Police, to review the suitability of the existing system, Sentinel. A desktop review was undertaken, which included researching other relevant products on the market. A Working Group was convened with members of the ASB Partnership and a workshop was held to discuss the forward plan. A report was taken to the ASB Strategy Group who requested a full business case to provide more detail on a potential system change.

5. Partnership agreement was gained at Chief Officer level through the Strategic Partnership Board, to look to procure a new case management system in 2024. In early 2025, the ASB Partnership procured ECINS, an ASB recording system which it was identified would best meet the needs of the partnership and the people they serve. Leicestershire County Council led the procurement process at the request of the Partnership.

6. Implementation of the system across a well embedded Partnership has been an important and at times challenging journey. However, the team working to embed the system have worked tirelessly with all partners and with the system owners to train users, embed processes, review practice and usage and work to further develop the system to best meet the needs of the partnership. Leicestershire County Council has also been driving the work to ensure the project is compliant with legal and GDPR frameworks.

Developments Underway

7. Work is progressing with ECINS on several system improvements. This includes creating a custom data-export specification to meet partnership needs and developing a Power BI dashboard to streamline data collection, visualisation, and hotspot mapping.

8. Completed developments include:

- A 40% increase in file storage capacity;
- New address-search functionality for easier case filtering;
- Custom Leicestershire actions and categories to support detailed ASB casework;
- An automated review, retain, dispose (RRD) process ensuring data deletion after six years.

Future Developments

9. Future planned developments include streamlining the local authority process of transferring referrals from multi-agency operating procedures (MOPs) to ECINS, auto populating fields, and incident beat codes. This will bring local authority and police data in closer alignment.

10. There are also plans to merge any remaining profile duplicates on the system and reduce the creation of these in future via technical tweaks to the Police's 'Storm' system integration. Information management support is needed to navigate the GDPR implications of merging profiles owned by different organisations.

11. The Partnership has also recently received updates from ECINS on a list of potential 'phase 2 developments' and are reviewing these internally to balance feasibility/ costs/ impact etc.

Notable developments and challenges:

Past Year

12. A number of partnership documents have been drafted and signed off, including legal documents governing the contractual arrangements, GDPR

documents ensuring compliance, Information Sharing Agreements, Memorandum of Understanding.

13. Partners have collaborated on a shared process and the range of custom tools that have been added to the ECINS System; as an example, in bi-weekly, ECINS change group meetings, partners have discussed and agreed amends to the Partnership custom actions and ASB categories, as well as changes to the publicly accessible Smartform.

14. Partners have further agreed on the overarching shared process of collaborative case management, including adapting their methodologies to benefit the partnership, e.g. manually updating case beat codes and titles to aid police colleagues and manually sharing access where appropriate.

Barriers to Date

15. A number of challenges and issues have been resolved in the first year of implementing ECINS. By far the largest has been migrating legacy Sentinel data. This created several challenges, which have now been dealt with and no longer pose ongoing issues.

16. Accessing specific case files was problematic at times for some users. To overcome this, custom developments have been created, such as the address search filters which allow users to enter keywords, or even partial postcodes to more easily find cases.

17. There were a high number of duplicate profiles following data migration from Sentinel; approximately two thirds of these legacy duplicate profiles on the system have now been merged, increasing the ability to identify repeat victims.

18. User training and understanding of the system has been greatly improved following monthly monitoring reports to assess user errors. We have seen a steep drop off in these errors, with users better understanding how to utilise our custom categories and tools and share access with other organisations. Furthermore, weekly drop-in sessions have been delivered, regular training events and the ASB CMS Co-ordinator has been accessible throughout to support users with the new system.

Ongoing Issues

19. **GENIE**: For Police colleagues, this continues to be an issue, and Police IT are not confident that their GENIE system is accurately searching the ECINS database.

20. **Smartform Accessibility:** While significant improvements have been made to our Smartform, ECINS have raised that outstanding automated accessibility issues are false positives. Council IT support teams are supporting this issue by raising these to the report provider to guarantee the form’s accessibility.

21. **Data:** While work is ongoing to better extract and manipulate data from ECINS, at present, users have been struggling to get out anything more than basic data. We are still unable to hotspot map or get more sophisticated data points out of the system easily.

22. **System Glitches**: There have been several glitches or bugs with ECINS, such as CSRF (Cross-Site Request Forgery) tokens expiring and 500 errors kicking users out of the system, as well as faulty data exports. ECINS are aware of these issues and are investigating them.

Coming Year

23. Overall, we have overcome significant challenges since going live with ECINS. Local Authority users are getting on well with the system and are using the RMM and CMM platforms for efficient, partially automated, recording of ASB incidents.

24. Police users are struggling with frequent glitches surrounding the 'Police Input form' – a bespoke way for Police users to create cases on ECINS, although the frequency of issues has decreased over recent months. The GENIE software integration is still faulty but weekly technical meetings are in place to review this and other technical issues.

25. Once the custom data exports and Power BI dashboard are successfully in place, ECINS will function as required for the partnership in the most respects, with further work and system improvements required but less urgent / high risk than those we have overcome to date.

26. The partnership shall continue to review how the ECINS system is operating. Leicestershire County Council will continue to manage the contract to ensure the system is delivering what it was brought in to deliver.

<u>Key issues</u>

27. The key issues are as follows:

- As issues arise and are resolved at times it is unclear what the causal factor was, the Partnership continues to work with ECINS to address this.

- Case and report titling is a repeated issue with a partner agency; this means anyone on the system is able to access reports as they are not locked down.

<u>Issues in local areas</u>

28. This is a cross-partnership project and so does not affect one locality any more than another. Leicestershire County Council host a partnership ASB System Governance and Coordination Officer Post which is funded by, and responsible to, the partnership of 10 LLR Local Authorities and Leicestershire Police. This officer drives and supports the majority of the work on this project.

Recommendations for the Board

29. The Board is recommended to:

    (a) Note the contents of the Report;
    (b) To approve continuous review of ECINS to ensure it remains the best system for the LLR ASB Partnership

Officer to contact

Gurjit Samra-Rai – Community Safety Manager, Leicestershire County Council

Tel: 0116 305 6056
Email: gurjit.samra-rai@leics.gov.uk

Leicestershire & Rutland
Safer Communities Strategy
Board

Making Leicestershire & Rutland Safer

LEICESTERSHIRE & RUTLAND SAFER COMMUNITIES STRATEGY BOARD

26th MARCH 2026

SAFER COMMUNITIES' PERFORMANCE 2025/26 QUARTER 3 REPORT

Introduction

1. The purpose of this report is to update the Leicestershire & Rutland Safer Communities Strategy Board (LRSCSB) regarding Safer Communities performance for 2025/26 Quarter 3.

2. The Safer Communities dashboard has been updated and the whole process has been simplified by the Business Intelligence Team at Leicestershire County Council. The format that was formerly used was complex and led to capacity issues within the team. This simpler dashboard in Excel format includes all the information that was available via the drop-down options but is now shown on two pages. A key has also been provided for ease of reference for interpreting the data. The values that have been presented are based on rates per 10,000 per population, unless otherwise stated in dashboard.

3. The Safer Communities dashboard up to Q3 is attached to this report. Additional detail is available in the following complementary dashboards that are still uploaded to Tableau these areas include:
   - Domestic Abuse
   - Hate Incidents
   - Anti-Social Behaviour

4. The dashboard includes a rolling 12-month trajectory for each indicator. The table gives a district breakdown, where available.

5. It should be noted that the report presents broad county wide trends, and the accompanying narrative reflects this. Performance within localities can differ, sometimes dramatically, and the report should be read with this in mind.

Key points of the dashboard are summarised below:

6. **Protect and Support the most vulnerable in communities**
   The Multi Agency Risk Assessment Conference (MARAC) repeat referral:
   - Multi Agency Risk Assessment Conferences are regular meetings of professionals from partner organisations who meet to discuss how to help

individuals who are most at risk of serious harm due to domestic violence and abuse.

- The Indicator regarding MARAC repeat referrals is to be continued, with the following conditions noted:

    - The frequency of MARAC meetings held varies between MARAC's and local authorities. The repeat referral indicator is now calculated according to the 'SafeLives' guidance on what the repeat percentage should look like in their '10 Principles of a Good MARAC'. The guidance to this will be available in the updated MARAC Operating Protocol.

- The percentage of incidents which are repeat incidents is 30.2% which is lower than the previous year of 32.8 and this is within the Safe Lives recommended range of 28 – 40%.

7. **Continue to reduce Anti-Social Behaviour (ASB)**
    - ASB - Total figures have remained stable over the last year.

    - ASB - Nuisance and environment has now been combined as Community

    - Rise in rate of 'personal' ASB. This has risen significantly in the previous two quarters

8. **Ongoing Reductions in crime**
    - Total Crime and Violence with Injury has improved over the last two years.
    - Burglary Residential, Burglary Business & Community, vehicle offences have stabilised over the last year and are both now lower.
    - Overall crime and all crime statistics are all lower

    The Domestic Crime and Incidents:
    - The rate is higher than previous year, arrow indicated higher no polarity, neither good nor bad.

    The Domestic Violence with Injury:
    - The rate is lower than the previous year, arrow indicated lower no polarity, neither good nor bad.

    Sexual Offences:
    - The rate has remained stable.

9. **Preventing Terrorism and Radicalisation**
    - The number of hate crimes reported to the police remains low with a slight increase and is currently 1.4 offences per 1000 population. The current values is slightly higher worse when compared to the previous value (1.3).

- Racially or religiously aggravated crime for this quarter is 0.7, there is no previous year comparison, this is due to change in system from Sentinel to ECINS. It is anticipated this data will be available again in the future.

- A question from the Leicestershire Insight Survey asks residents how much they agree that people from different backgrounds get on well. Latest figures show % of people from different backgrounds who get on is also slightly down from previous year.

Recommendations

10. It is recommended that the Board notes the 2025/26 Q3 performance dashboard.

Officers to Contact

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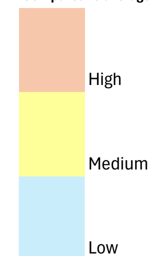
APPENDIX

Quarter 3 FY 2026 Safer Communities Performance Dashboard

Outcome	Indicator	Previous Value	Current Leics Value	Direction	Trend	Blaby	Charnwood	Harborough	H&B	Melton	NWL	O&W	Rutland
Protect and support the most vulnerable in communities	**MARAC** (repeat rate)	32.8%	**30.2%**	Lower no polarity									10.0%
	Domestic crime & incidents (rate per 1000 rolling 12 months)	15.8	**16.0**	Higher no polarity		14.9	16	12.6	16.5	16.3	18.4	18.1	9.1
	Domestic violence with injury (rate per 1000 rolling 12 months)	2.2	**2.1**	Lower no polarity		1.8	2.1	2.1	2.7	3	3	2.9	1.4
	Sexual offences (Domestic and non-domestic - rate per 1000 rolling 12 months)	2.8	**2.8**	Similar		3.0	2.9	1.6	2.1	2	2.2	2.8	2.1
	Hospital admissions for violence (per 100k pop)	n/a											
Contine to reduce anti-social behaviour	**ASB - Total** (rate per 1000 rolling 12 months)	10.0	**10.0**	Similar		9.7	12.5	6.9	8.7	9.3	11.9	8.0	5.0
	ASB - Community (new indicator replacing Environment and Nuisance)	n/a	**8.6**			8.2	10.8	5.9	7.3	8.1	10.3	6.6	4.1
	ASB - Personal (rate per 1000 rolling 12 months)	1.2	**1.5**	Higher - worse		1.5	1.7	1.0	1.5	1.2	1.6	1.3	0.8



- Higher no polarity
- Lower no polarity
- Similar
- Lower- good
- Higher - good
- Higher - worse
- Lower - worse

Outcome	Indicator	Previous Value	Current Leics Value	Direction	Trend	Blaby	Charnwood	Harborough	H&B	Melton	NWL	O&W	Rutland
Ongoing reductions in crime	**Total crime** (rate per 1000 rolling 12 months)	66.6	**62.7**			63.7	68.4	49.1	62.8	63.3	66.6	65.4	43
	Burglary residential (rate per 1000 rolling 12 months)	2.7	**2.2**			2.5	2.6	1.9	2.1	1.5	1.8	1.9	1.3
	Burglary Business and Community (rate per 1000 rolling 12 months)	1.7	**1.5**			0.8	1.8	1.5	1.8	1.7	1.3	1.4	1.5
	Vehicle offences (rate per 1000 rolling 12 months	5.4	**4.4**			4.5	5.1	3.7	4	3.8	5.2	4.6	3.7
	Violence with injury (rate per 1000 rolling 12 months)	7.7	**6.7**			6	6.7	5.4	7.6	7.5	7.7	7.3	5.3
PREVENT	**Hate Crime** (Police data- rate per 1000 rolling 12 months)	1.3	**1.4**			1.4	1.5	1.0	1.4	1.3	1.4	1.8	0.7
	Racially or religiously aggravated crime (crime and incident data)	n/a	**0.7**			0.6	0.9	0.5	0.6	0.5	0.7	0.9	0.1
	% agree people from different backgrounds (high is good)	89.1	**88.3**			83.2	87.0	90.7	90.1	92.2	91.1	86.4	n/a

Compared to average

High

Medium

Low

Higher no polarity

Lower no polarity

Similar

Lower- good

Higher - good

Higher - worse

Lower - worse