Statutory Review – Executive Summary

On behalf of Safer MK Community Safety Partnership

REPORT INTO THE DEATH OF CHRISTOPHER
January 2019

Report produced and chaired by Peter Stride:
Foundry Risk Management Consultancy

Report Published November 2023

Table of Contents

1. The Review Process

1.1 This summary outlines the process undertaken by Safer MK Partnership, in reviewing the circumstances of the death of Christopher who was a resident in their area.

1.2 The following pseudonyms have been in used in this review for the deceased and other parties, to protect their identities and those of their family members:

Referred to in report as	Relationship to Christopher	Ethnic Origin	Faith	Immigration Status	Disability Y/N
Christopher (38 years)	Deceased	White British	Christian	British Citizen	N
Harriet	Previous Partner	White British	Unknown	British Citizen	N
Isabelle	Partner	White British	Unknown	British Citizen	N
Henry	Deceased's Father	White British	Unknown	British Citizen	N
Louisa	Partner's Mother	White British	Unknown	British Citizen	N
Child 1 (Ch1)	Deceased's Child	White British	Christian	British Citizen	N
Child 2 (Ch2)	Deceased's Child	White British	Christian	British Citizen	N
Child 3 (Ch3)	Partner's Child	White British	Christian	British Citizen	N

1.3 Inquest: On 16 December 2019 the Coroner concluded that Christopher had died by suicide, with the medical cause of death being recorded as 'suspension from a ligature around the neck'.

1.4 Police Investigation: Detectives from Thames Valley Police investigated the circumstances surrounding the finding of Christopher's body and confirmed that there was nothing to indicate foul play or third-party involvement in his death. Consequently, the matter was formally classified as an 'unexplained death' and closed.

1.5 Following the discovery of Christopher's body in January 2019, Thames Valley Police made a referral to Safer MK. On 31 January 2019 contact was made with the Home Office confirming the Partnership's intention to carry out a DHR. This referral was agreed on 4 February 2019.

1.6 All agencies that potentially had contact with Christopher, Harriet, and Isabelle prior to Christopher's death were contacted and asked to confirm whether they were involved with them.

2. Contributors to the Review

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Review reports (IMRs) for all the organisations and agencies that had contact with Christopher, Harriet, and Isabelle. A total of four agencies responded saying they had no contact.

- Central and North West London NHS Foundation Trust (CNWL)[1]
- The National Probation Service and Community Rehabilitation Company
- MK Adult Social Care
- Milton Keynes Housing

2.2 Five agencies responded saying they did have contact with various members of the family and details of these contacts are recorded within the Combined Chronology. Each of the following agencies prepared a chronology and IMR report.

Agency Name	Known to Agency	Chronology	IMR
Thames Valley Police	Yes	Yes	Yes
GP Surgery	Yes	Yes	Yes
MK-ACT	Yes	Yes	Yes
Milton Keynes University Hospital Trust	Yes	Yes	Yes
Children's Social Care	Yes	Yes	Yes

2.3 Quality and Independence of the IMR authors. The IMRs were prepared by authors who were independent of any service delivery or case management of any of the parties involved in this process. The IMRs were comprehensive and allowed the panel to analyse the contact with Christopher, either of his former partners or their immediate family (where relevant). The detail ensured that Panel members were able to identify learning and recommendations for this review and, where necessary, follow-up questions were sent to agencies and responses received, prior to, or at subsequent panel meetings.

2.4 The authors assisted the panel further, answering follow up questions as necessary.

[1] CNWL was never provided with the details of Harriet and therefore no searches were carried out to identify if contact or engagement took place. As Harriet has never engaged with this review or provided any permission to access her medical records, this was not pursued by the review process. CNWL did receive a referral for Isabelle however for similar reasons as Harriet no research or disclosure was made by CNWL.

3. The Review Panel members

3.1 The Review Panel comprised of the following agency representatives.

Name	Job Title	Agency
Peter Stride	Chair	Foundry Risk Management Consultancy Ltd
Andrew Thompson	Detective Inspector	Thames Valley Police
Sue Burke	Chief Executive Officer	MK Act Domestic Abuse Intervention Service
Nadean Marsh	Head of Nursing Quality and Safeguarding	Milton Keynes University Hospital Foundation Trust
Lisa Johnson	Lead Nurse Safeguarding Adults	Milton Keynes University Hospital Foundation Trust
Susie Payne	Quality and Performance Manager	Milton Keynes Council Adult Services
Amanda Derbyshire	Designated Nurse for Adult Safeguarding	Milton Keynes Clinical Commissioning Group
Lesley Mellor	Partnerships Officer	MK Together Partnership
Jo Smart	Programme Manager	MK Together Partnership
Julia Roberts	Safeguarding Manager	Milton Keynes Council Children's Social Care

3.2 The Review Panel met a total of six times, with the first meeting of the Review Panel on 5 June 2019. There were subsequent meetings on 1 October 2019, 29 January 2020, 25 August 2020, 12 November 2020, and March 2021. Draft reports were reviewed at the latter meetings with the Review Panel subsequently receiving updates from the Chair.

3.3 The chair of the review wishes to thank everyone who contributed their time, patience, and cooperation in this process.

4. Author of the Overview Report

4.1 Peter Stride was appointed by the Safer MK Partnership as Independent Chair of the review panel and author of the report. He is a retired Metropolitan Police Officer and has over 30 years of detective experience in the field of Domestic Abuse, Public Protection and Safeguarding in London. His experience includes specialist and generic investigative roles at New Scotland Yard and the boroughs of Westminster, Brent, and Harrow. Peter has been the vice chair of various Local Safeguarding Adult and Children Boards and was responsible for the creation and implementation of MASH[2] and MACE[3] panels as well as chairing MAPPA[4] and MARAC[5] meetings.

4.2 Since retirement Peter has established his own consultancy business, which focuses on child and adult safeguarding within the public sector. He has completed Home Office approved Training and has attended subsequent Training by AAFDA (Advocacy After Fatal Domestic Abuse). Peter is an experienced review chair and has completed a wide variety of statutory reviews concerning adults and children. The Chair has no connection with Safer MK and has never been an employee within any of the partnership agencies represented in this review.

5. Terms of Reference

5.1 Details of the Terms of Reference are recorded in Appendix 1.

6. Chronology Summary

6.1 The chronology was prepared for the eight years prior to Christopher's death. During the review period Christopher had two partners, he was in a relationship with Harriet during the earlier part of the scope period and later with Isabelle.

6.2 Involvement with various agencies during the review period is summarised below:

- There were several calls to the police during which Christopher was treated as both an alleged perpetrator and a victim of domestic abuse. Following various investigations, no prosecution ever took place.
- There were several calls to Children's Social Care from family members and anonymous sources reporting concerns about Harriet and Isabelle and the care they provided to their children.
- Christopher attended the Emergency Department of the Milton Keynes University Hospital Trust as the result of various incidents including an eye injury, soreness to his neck and injuries to his hand.

[2] Multi Agency Safeguarding Hubs
[3] Multi Agency Child Exploitation
[4] Multi Agency Public Protection Arrangements
[5] Multi Agency Risk Assessment Conference

- During attendances at the GP surgery Christopher reported difficulties regarding work-related stress. Christopher was prescribed various medication and spent a significant amount of time off work sick.

7. Agency Engagement

7.1 Thames Valley Police

Christopher was known to the police and involved in several incidents where he was viewed at times as being the perpetrator and other times the victim of domestic abuse. At no point was Christopher or either of his partners ever charged with a crime relating to incidents recorded in this review.

7.2 Medical Centre

The Practice saw Christopher regularly over two separate periods during the time frame of the Review. The first of these periods was following a marital breakdown, between 17 October 2011 and 28 May 2012. There are no details submitted as to the exact nature of the discussions or issues raised by Christopher on these visits. The second was between 22 July 2016 and 29 March 2017 for an episode of depression.

7.3 MK ACT

The IMR from MK ACT Domestic Abuse Intervention Service informed the review that in March 2014 a referral named Christopher as an alleged perpetrator. MK ACT state that a safety plan for the victim was put in place after the risk was assessed as being Medium. The incidents were reported to the police and following the interaction with MK ACT a Non-Molestation Order was granted against Christopher.

As this review has been unable to get the permission from either Harriet or Isabelle to reveal the details of their involvement with MK ACT no more information has been disclosed by this agency.

7.4 Children's Social Care

There were several involvements with Christopher's family primarily focused upon reports of domestic abuse, and the wellbeing of the three children. Christopher and Harriet are the parents of Child 1 and 2, Isabelle is the mother of Child 3, from a previous relationship which does not form part of this review. Referrals were made to the Children and Family Practice on two occasions, during Christopher's relationship with Harriet, following an assessment it was deemed that sufficient support was being provided to both parents and children. Additionally, there were several contacts when the children were not living with Harriet, these resulted in advice and support leaflets being provided but no further action being taken as the children were not deemed to be at any immediate risk.

There was one contact relating to Isabelle. There was a referral to the Multi Agency Safeguarding Hub (MASH) in February 2017. Mental Health Services at Milton Keynes University Hospital had assessed Isabelle following her presenting with low mood and suicidal ideation. She reported being in an abusive relationship and that she was partly to blame for the problems. Children's Social Care visited Isabelle, concerned over the impact of this on her child. She denied that the relationship was abusive and stated that

Christopher was not living with her and Ch3 at that time. The case was closed following this assessment.

7.5 Milton Keynes University Hospital Trust

Christopher made several visits to the Emergency Department for treatment following injuries to his eye, wrist, hand and neck. These visits were dealt with promptly with no subsequent admissions. On one occasion Christopher left the hospital prior to treatment as he had to collect one of his children. He was advised to return to the hospital afterwards, but he didn't, and despite the efforts by the hospital to contact him there was no further treatment.

8. Key Issues Arising from the Review

8.1 Domestic Abuse/Violence

The impact of any domestic abuse during either of Christopher's relationships is impossible to confirm. Tragically it was not possible to build a picture from Christopher's perspective and neither Harriet nor Isabelle took part in the review process. Whilst there were various reports to the police of domestic incidents, visits to the medical centre by Christopher regarding anxiety and stress, and attendances at hospital with various injuries no cause or link has been made to Christopher's death. Christopher never reported any domestic abuse concerns and as there was no direct contact between the review and either of his partners it is inappropriate to make any conclusions.

8.2 Male Victims of Domestic Abuse

No allegations of domestic abuse were ever made by Christopher, however there were five incidents, reported by various parties where Christopher was deemed to be the victim of such abuse. These provide an opportunity to consider the role and availability of services for male victims of domestic abuse. Agencies were invited to consider their processes and policies on this subject, including victim referrals and highlighting this subject to the community.

8.3 Routine Domestic Abuse Questioning within Health Care

The NHS has produced a briefing document relating to Domestic Abuse[6], titled '*Domestic Violence, A Briefing for Healthcare Professionals'*. Its content provides advice and guidance for those engaging with victims and those vulnerable to such incidents. Its content was reviewed by the panel and a recommendation produced encouraging relevant agencies to introduce the options contained within it. These include:

- Commit to begin routine assessments for domestic abuse within their health setting
- Place victim safety cards in bathrooms and examination rooms and place domestic abuse posters within waiting areas
- It was also suggested that healthcare providers wear lanyards or badges that highlight their support against domestic abuse

[6] https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiqmdvMp7XzAhUClFwKHV8YDP8QFnoECAMQAQ&url=http%3A%2F%2Fsosvics.eintegra.es%2FDocumentacion%2F01-Medico%2F01-03-Documentos-trabajo-prof%2F01-03-001-EN.pdf&usg=AOvVaw1SVohR48NqPLyv93O3vIhd

- Introduce resource tables and distribute patient education material including phone numbers of local shelters, hotlines and community resources.
- The creation of a domestic abuse protocol or review to ensure all practical and appropriate measures and resources are dedicated to the subject
- Ensure the training is organised and up-to-date with regards to domestic abuse assessment and intervention
- Work with domestic abuse programmes in your community to let patients and the community know that the clinic, health care facility or health association cares about addressing domestic abuse
- Document assessment of domestic abuse in Vision or Emis and use an abbreviation such as DVA in any record of consultation.

8.4 Impact of Domestic Abuse upon Children

The review considered, holistically, the impact on children living in a family environment where domestic abuse was an issue. It considered Safelives research which included details of how children are affected, including behavioural and emotional vulnerability.

Children's Social Care (CSC) analysis records that engagement with the family was limited and assessment of risk was low. The review records that this is a surprising outcome bearing in mind the nature and detail of initial reporting from various family members. Therefore, the author has identified a learning point and recommendation around seeking reassurances regarding risk assessment processes.

The review also recognised the work done by the CSC along with the health visitor, schools, and nurseries which the children attended. During engagement in March 2014 and November 2015 various options were discussed, including attendance at summer activities, held by the local Children's Centre. In both cases the conclusion of these involvements was recorded as 'matters addressed' and no more detail was available to this review.

The review also recognises the services of Operation Encompass which encourages a line of communication and support between the police and educational settings and is an ideal opportunity for children in a similar position to those within this review to receive support throughout each day whilst at school. This process has been in place, via the local MASH, for the last three years and therefore no recommendation is created.

8.5 Information Sharing

This subject has been raised previously and it remains something which the review feels is crucial in the successful identification and reduction of domestic abuse and keeping people safe. Practitioners who encounter domestic abuse victims, perpetrators and their families often need to assess whether and how to share personal information, regarding their clients with other professionals. The review considered the key benefits and lawful basis for sharing information.

The chronology of events in this review was also considered and various opportunities discussed, including the use of the Multi Agency Risk Assessment Conference (MARAC) to provide a better information sharing pathway and legal options available to family members concerned for the well-being of Christopher, his partners, and their children.

Therefore, a recommendation was raised for all panel agencies to review their information sharing policies and protocols.

8.6 DASH risk assessment questionnaire and professional judgment

The review considered these two areas using the principles of the MARAC process to provide context. The use of the DASH checklist allows professionals to get an immediate snapshot from the victim's point of view and can highlight immediate areas of risk, however professionals are also encouraged to use their experience, reflection, and deliberation to make an informed decision. Escalation can be based upon professional judgment alone and this can include raising concerns to a multi-agency forum such as MARAC.

Panel agencies were invited to review their own use of professional judgement in the assessment of risk and whether a DASH checklist-style questionnaire would support this.

9. Conclusions

9.1 The interview with Christopher's family and employer confirmed he was a caring, loving son and father. He was a loyal and popular friend and employee who was well thought of by those around him. His death was a tragedy and has deeply affected friends and family.

9.2 But for those close to Christopher this tragedy is made even more difficult because it appears that there were no clear indicators as to its likely happening. His family knew that Christopher had been involved in two difficult relationships with Harriet and Isabelle and this appears to have affected him quite deeply and whilst he never discussed or disclosed issues of domestic abuse several reports and records clearly document the challenges Christopher faced in each of these relationships. It has been a challenge for the review panel to understand the emotional and psychological impact that these incidents and challenges had on Christopher. As the chronology and analysis shows, there were several occasions in each relationship where the police and other agencies were involved, not just with Christopher and his partners, but also their children. There is no definitive link between Christopher's death and the issues of domestic abuse. We do not seek to find or lay blame at the door of either Harriet or Isabelle however the impact upon men, of domestic abuse, is a subject which is in need of urgent review, analysis, and wider acknowledgement. Whilst recognising that domestic abuse against any person is unacceptable and abhorrent this review recognises the impact of being in a relationship where it is a regular issue can be significant and potentially cause those involved to make the ultimate sacrifice.

9.3 The chair and panel wish to be explicit that they do not want to suggest or infer, in any way, that they believe either Harriet or Isabelle were responsible for the death of Christopher.

9.4 There has been concern raised by several panel agencies, throughout this review process, that blame could be inferred by the commissioning or content of this review. It is not the role of these statutory reviews to apportion blame or find fault. The content of the report simply reflects the findings of panel agencies and seeks to identify

opportunities for learning and recognition of good practice. Harriet and Isabelle chose not to participate in this review and the chair wishes to point out that this fact must not be seen in a negative light. There is no obligation for individuals to take part and their decision is seen as a reasonable one.

9.5 Neither the police investigation nor coronial process found any link between Christopher's death and these relationships. This review supports these outcomes.

9.6 Information provided by the agencies involved in this review would appear to demonstrate that there are several themes that need to be considered because of Christopher's death. The report acknowledges that the more historical incidents outlined above would now be dealt with differently and we thank agencies for providing accounts of how systems have changed due to self-evaluation and improvement.

9.7 There are various themes within the review including men as victims of abuse, the effects of domestic abuse on children, the sharing of information among statutory and non-statutory agencies, and professional curiosity. Each of these have been explored during this process and the various learning points and recommendations are intended to support families facing similar difficulties and challenges as Christopher, his partners and children.

9.8 In approaching these learning points and recommendations the Review Panel has sought to understand what happened and recognise the issues in the lives of Christopher and his family that might help to explain why he died.

9.9 The Review Panel would like to extend their deepest sympathy to all those affected by Christopher's death.

10. Lessons to be Learned

10.1 During the review and analysis period various opportunities for learning were identified. These were shared and agreed with the review panel.

Learning Point 1: The panel feels that the Home Office needs to consider the way in which incidents similar to this are reviewed and a more bespoke process introduced.

Learning Point 2: The review feels that there is an opportunity to enhance the support provided to male victims of domestic abuse and that men should be offered greater encouragement to come forward when they feel they are the victims of domestic abuse and/or coercive control.

Learning Point 3: When a report is made of domestic abuse by, or on behalf of, a male victim then a relevant referral should be offered.

Learning Point 4: The options highlighted in the NHS document '*Domestic Violence, A Briefing for Healthcare Professionals*' give clear guidance about the pathway to promote the subject of domestic abuse and support victims.

Learning Point 5: Considering the volume and severity of the previously reported incidents the assessment of the level of risk is surprising and the review is seeking reassurances that current risk assessment processes within CSC are dynamic and robust and are based upon information whose provenance and accuracy are considered and assessed.

Learning Point 6: With regards to Christopher, it is also worth noting that there were three opportunities for a DASH risk assessment to be carried out, but it appears that on each occasion no such process was completed. This was discussed by the panel and concern was raised about how all people in similar circumstances *e.g.,* those making 'counter allegations' were treated. Thames Valley Police provided reassurances the Crime Data Integrity (CDI) process[7] now identifies cases where allegations are made by both parties following an incident (particularly involving domestic abuse) and ensures compliance with regards to the recording and reporting of such allegations. Therefore, this review will be making a recommendation to reassure itself that the CDI process is working appropriately.

Learning Point 7: Police Officers must be aware of the stance taken within the new Domestic Abuse Bill 2021 in treating children as victims of domestic abuse in a similar way to adults. Therefore, children must receive the same care consideration and be treated in a similar fashion.

Learning Point 8: Any learning regarding the interviewing of children by police officers has already been identified however, the review feels it is important that reassurance is sought that operational guidance is being put into practice.

Learning Point 9: The effects of domestic abuse are discussed throughout this report and the DASH risk assessment process is crucial in recording the details of those present at the scene of any such incident. Therefore, its accuracy and content are crucial, particularly when considering that such reports are shared across the multi-agency forum.

Learning Point 10 Currently there is no process for discussing domestic abuse concerns when patients register at a GP surgery. The introduction of a questionnaire could provide confidence to patients in coming forward to report such matters.

Learning Point 11. Perhaps there is a need to enhance the training around domestic abuse for front line MKUHFT staff and to develop some questions into clinical templates.

[7] https://www.thamesvalley.police.uk/SysSiteAssets/foi-media/thames-valley-police/policies/policy---crime-recording.pdf

11. Recommendations from the Review

11.1 Various recommendations were proposed as a result of the analysis and the identification of the 'Lessons to be Learned'. These recommendations were discussed and agreed with the review panel.

Recommendation 1: The Home Office to review current methodology and consider introducing a stand-alone 'Suicide following Domestic Abuse' review process.

Recommendation 2: Safer MK to become more proactive in encouraging male victims of domestic abuse to come forward, and support service and advice lines should be advertised more widely.

Recommendation 3: Safer MK should review current policies and processes and ensure that there is a referral pathway available to all 'reported' or 'recorded' male victims of domestic abuse.

Recommendation 4: Healthcare agencies represented in the review should introduce the options contained in 'Domestic Violence a briefing for healthcare'.

Recommendation 5: CSC to ensure that current policies and procedures include suitable frameworks for the assessment of risk to all vulnerable children and that initial assessments are subject to regular, detailed review and management**.**

Recommendation 6: All panel agencies review their information sharing policies and protocols to ensure that, with due regard to the legislation mentioned in Paragraph 5.7.3 of the Overview Report, there is a clear pathway for the sharing of information.

Recommendation 7: Thames Valley Police to review counter allegations of domestic abuse over the previous 12 months and ensure that all 'counter allegations' were properly recorded and investigated.

Recommendation 8. Thames Valley Police to ensure that officers are suitably trained and assessed in treating children as victims and witnesses when investigating domestic abuse cases.

Recommendation 9: Thames Valley Police should review previous reports of domestic abuse involving the presence of children and ensure that their own operational guidance is being adhered to.

Recommendation 10: Police officers should be reminded of the need to record details of all persons present when attending reports of domestic abuse.

Appendix 1

Terms of Reference
Christopher Statutory Review

1 Commissioner of the Statutory Review

1.1 The chair of the Safer MK Community Safety Partnership has commissioned this review, following notification of the death of Christopher in the Milton Keynes area.

1.2 All other responsibility relating to the review commissioners Safer MK Community Safety Partnership namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the Overview Report will be the collective responsibility of the Partnership.

1.3 The resources required for completing this review will be secured by the chair of the Safer MK.

2 Aims of Review Process

2.1 Establish what lessons are to be learned from this death regarding the way in which local professionals and organisations work individually and together to safeguard victims.

2.2 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.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies.
  - the observations (and any actions) of relatives, friends, and workplace colleagues relevant to the review
- analyses and comments on the appropriateness of actions taken.
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

3 Timescale

3.1 Aim to complete a final overview report by 26 October 2019 acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the

independent chair. Additionally, the criminal justice process may impact on timescales, although the statutory guidance is clear a review should be commenced and concluded as soon as possible – and the Review Panel should be mindful of paragraphs 90 to 96 of the guidance.

4 Scope of the Review

4.1 To review events up to the domestic abuse related death of Christopher in January 2019. This is to include any information known about Christopher's previous relationships where domestic abuse is understood to have occurred.

4.2 Events should be reviewed by all agencies for a minimum of eight years (*i.e.,* 01 January 2011) preceding the domestic abuse related death. Unless it becomes apparent to the independent chair that the timescale in relation to some aspect of the review should be extended.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

4.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers Christopher faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 Review relevant research and previous DHRs (including those in Milton Keynes) to help ensure that the Review and Overview Report is able to maximise opportunities for learning to help avoid similar homicides occurring in future.

4.8 Key Lines of Enquiry

- Set out the facts of their involvement with Christopher, Harriet, Isabelle, Ch1, Ch2 and Ch3.
- Critically analyse the service they were provided, in line with the specific terms of reference.
- Identify any recommendations for practice or policy in relation to their agency.
- Consider issues of agency activity in other areas and review the impact in this specific case.

5 Role of the Independent Chair

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. *(Consider Home Office leaflet for family members, plus statutory guidance (section 6)).*
- Determine brief of, co-ordinate and request IMRs.
- Review IMRs – ensuring they incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses.
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel.
- Present report to the CSP (if required by the CSP Chair).

6 Liaison with Media

6.1 Safer MK as lead agency for domestic abuse for the Milton Keynes Partnership will handle any media interest in this case.

6.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.