Consultation on updating the Domestic Homicide Review Statutory Guidance: Written submission from the Domestic Abuse Commissioner for England and Wales

Role of the Domestic Abuse Commissioner

The Domestic Abuse Act establishes in law the Office of the Domestic Abuse Commissioner, with the purpose of providing public leadership on domestic abuse issues and to play a key role in overseeing and monitoring the provision of domestic abuse services in England and Wales. The role of the Commissioner is to encourage good practice in preventing domestic abuse; identifying adult and child victims and survivors, as well as perpetrators of domestic abuse; and improving the protection and provision of support to people affected by domestic abuse from agencies and government. As the Domestic Abuse Commissioner for England and Wales, I welcome the opportunity to feedback on the draft updated Domestic Homicide Review statutory guidance and would be pleased to discuss the contents of this response further, if requested to do so

This response will set out the Commissioner's overarching observations of the review process and key recommendations, before responding in more detail to address the consultation questions for each section.

The consultation on the draft statutory guidance is welcome and the Domestic Abuse Commissioner is encouraged to see the feedback from those involved within the Domestic Abuse Related Death Review (DARDR) process already reflected in the guidance. It is encouraging to see consideration of trauma informed practices, included in the guidance, and greater emphasis on the inclusion of family and wider testimonial networks. The Domestic Abuse Commissioner supported the change in naming reviews from Domestic Homicide Reviews to Domestic Abuse Related Death Reviews and would recommend that the guidance is amended to reflect this since the passing of the Victims and Prisoners Act 2024.

Since Domestic Homicide Reviews (DHR) were first implemented in 2011 the review process has contributed to identifying where change is needed to prevent future deaths and demonstrated commitment at local level to the exploration of how

agencies can improve practice. The Home Office has acknowledged in the introductory statement to this guidance that since DARDRs (DHRs) were operationalised a lot has been learnt about the strengths of the reviews. This includes where they can be improved to maximise their potential for better understanding and preventing domestic abuse related deaths.

The Domestic Abuse Commissioner believes that this is a significant reflection of the wealth of information the Home Office holds with regards to reviews. Whilst the annual analysis is welcome and informative, it does not address the continuous improvement which could be achieved by considering how the statutory guidance is reviewed and implemented. A mechanism for regular review of how guidance is interpreted and implemented would be welcome to better inform practice and achieve the aims of the Domestic Abuse Related Death Reviews in preventing future deaths. The Domestic Abuse Commissioner believes that the Home Office should provide ambitious leadership to ensure learnings are embedded locally and nationally, this should start with creating a space in the guidance for continuous development and improvement of the review process.

Learning from other review processes is helpful to ensure there is sufficient direction on areas of uncertainty and inconsistency. The Child Safeguarding Practice Review (CSPR) guidance for safeguarding partners 2022 refers to feedback from partners and a two-way dialogue with the system. This is taken into account when undertaking future updates to the guidance. There have been no updates to the DHR statutory guidance since 2016, and in that time differing practice and recurring issues have emerged. These missed opportunities have created a space in which reviews lack adaptability and are outdated in their approach. This could be more effectively resolved by adopting better flexibility to the guidance. Moreover, the Home Office has reflected on the plethora of information held as a result of overseeing the review process, which is not usually shared, and therefore cannot be embedded into local practice.

The Domestic Abuse Commissioner feels that a more dynamic response is needed to ensure guidance can be regularly updated or clarified. This would allow for the process to develop, incorporating the views and experiences of key stakeholders in a more timely way, and would better support future iterations of the statutory guidance. This has been achieved in other review processes, for example the guidance for CSPRs sits alongside the relevant Working Together to Safeguard Children 2018 statutory guidance. It would be pertinent for the Home Office to consider adopting a similar approach to this in supplementing this guidance. The Domestic Abuse Commissioner believes a more dynamic process for reviewing the statutory guidance would allow it to reflect and respond to emerging issues. As it

currently stands the guidance does not go far enough to address these practice issues that are so often raised in the conduct of reviews.

Recommendation 1: The Home Office should develop options for continuous review or clarification of the statutory guidance to ensure it can be flexible to emerging issues and needs. This should include specific thematic pieces of non-statutory guidance.

Recommendation 2: The Home Office further consults with key stakeholders to develop thematic supplementary, non-statutory guidance.

Capacity and Resourcing

The lack of dedicated funding has been a recurring theme in the Domestic Abuse Commissioner's scoping to establish an oversight mechanism for implementation or recommendations. This funding issue stretches across the process itself and for partners working to contribute to reviews including:

- **Lack of a prescribed funding model:** The Domestic Abuse Commissioner hears about difficulties experienced by Community Safety Partnerships for commissioning DHRs, and this is particularly difficult for Local Authorities experiencing financial difficulties or subject to S114 notices. This has also been thwarted in recent years by the lack of a prescribed model or dedicated funding, and frustrations in the process from some partners. This has led to some key partners withdrawing funding contributions and ultimately rendering local funding models at risk.[1] In many areas, the burden sits heavily on local authorities and Community Safety Partners and there is varying perception of the role of Police and Crime Commissioners (PCCs) in contributing towards DHR costs. In the recent survey conducted by the Local Government Association in partnership with the DAC office, only 47% of respondents had a formal partnership arrangement governing which agencies contribute to the costs of DHRs.[2]

- **Funding for independent chairs:** The majority of costs associated with DARDRs related to commissioning independent chairs. From 2018/19 to 2022/23, inclusive, local authorities responding to a joint survey between the LGA and DAC with regards to resourcing of DHRs indicated that £2,436,467 was spent on the costs of DHR chairs. This rose from £428,711 in 2018/19 to

[1] See DAC letter to communities secretary Letter to Communities Secretary on local authority financial crisis - Domestic Abuse Commissioner

[2] Domestic homicide review survey 2024 | Local Government Association

£704,869 in 2022/23.[3] With the increasing concerns around availability and quality independent chairs the lack of funding is a growing concern.

- **Funding the costs required to conduct reviews and manage the subsequent action plan:** This includes increasing legal costs, especially relating to reviews of domestic abuse related suicides as the recognition of domestic abuse as a key factor continues to increase. The Domestic Abuse Commissioner is piloting a model for national rollout for the oversight of implementation of recommendations, which requires strong local governance arrangements and capacity at the local level to effectively monitor the implementation of actions across all agencies. Full consideration of, and greater attention to, what is truly required to achieve the aims of reviews and prevent future deaths is needed. The Commissioner would urge the Home Office to review the Local Government Association recently published joint report with the Domestic Abuse Commissioner which identifies the increasing costs associated with DARDRs.[4]

- **Funding for expert panel members, 'by and for', and specialist services:** The engagement of expert panel members has increased in more recent years. However, there remains a gap in identifying specific issues, partly due to the funding available for reviews. Specialist services are often at maximum capacity and so are unable to take on additional unpaid work. This is particularly relevant to specialist 'by and for' services who are not always able for reasons stated or always invited to support this process. Some organisations, such as Imkaan and CWJ, Beyond the Streets and Standing Together, advocate for the value that expert panel members can bring to the review process. However, this has been something that has often been overlooked, particularly where there are cost implications. This is explored in more detail in response to question 11 on expert panel members and with regards to intersectionality.

- **Funding for specialist services to support bereaved families and children bereaved by homicide, which supports a trauma informed approach to reviews:** This is addressed in more detail within the children's section and responses to trauma informed approaches in reviews. However, greater consideration is needed in the review process to ensure there is adequate provision for bereaved families. Consideration should also be given to the family members of perpetrators who may be involved in the review process, acknowledging that their needs differ and will often be complex and

[3] Domestic homicide review survey 2024 | Local Government Association

[4] Domestic homicide review survey 2024 | Local Government Association

intersecting depending on the circumstances. In addition, consideration should be given to how specialist services may have a role in supporting survivors of domestic abuse, including children. This includes victims who are subject to a review either having been identified as the perpetrator in the domestic abuse related death review, or a victim of domestic abuse which has been a contributory factor in a death, for example where the primary perpetrator of abuse has died by suicide.

Recommendation 3: The Home Office provides dedicated funding for domestic abuse related death reviews which should include costs related but not limited to:

- Chairs and authors
- Expert panel members
- Specialist service engagement (as experts) including by and for services
- Coordination, management and governance of reviews
- Support for families to engage with the process
- Dissemination of learning

This would be in line with the Domestic Abuse Commissioner's recommendation to specifically fund 'by and for' sector organisations in order to strengthen their capability and capacity building. The Commissioner has called for the establishment of a sustainable, cross-governmental pot of funding dedicated to 'by and for' sector service providers serving domestic abuse survivors from marginalised communities, namely BME, LGBT+ and disabled (including deaf). As such, a funding pot for domestic abuse related death reviews would be in alignment with the Commissioner's consistent ask to financially support specific issues within the domestic abuse sector.

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Recommendation 4: That the Home Office identifies the additional resourcing requirements needed to accompany this guidance, which, reflects the scope, requirements and ongoing commitments involved in Domestic Abuse Related Death Reviews.

Recommendation 5: That the Home Office designates funding to support the conduct of DARDRs and works with CSPs and PCCs to determine the most appropriate funding model.

Recommendation 6: That any funding model ensures the Home Office core team is adequately funded to deliver their roles and responsibilities in the review process. This should include funding which enables effective oversight of local and national recommendations and adequately resourced the Domestic Abuse Commissioner's oversight mechanism.

Beyond capacity and resourcing, the Domestic Abuse Commissioner often hears from Community Safety Partnerships (CSPs) and those close to the review process about a number of key challenges including;

- The legal implications surrounding reviews where there is no criminal conviction, and relevant parties object to the review or the inclusion of certain information.

- Delays, at all stages of the review process which often result in recommendations and actions being out of date at the time of publication or superseded by legislation or wider organisational change. These delays are observed across the review process from notification to quality assurance, they hinder learning and engagement with agencies, families and wider networks. Furthermore, they undermine any trauma informed practice particularly with regards to family members.

- Multiple DARDR reviews which run concurrently to each other, drawing out similar lessons, involving the same panel members and yet are not cohesive to the wider learning or feeding into reviews which may follow soon after or during the process. This is also relevant to parallel reviews such as Mental Health Homicide Reviews, Child Safeguarding Practice Reviews, Safeguarding Adult Reviews.

- Engagement with bereaved family members. It cannot always be assumed that families will support the review process, and this can present further considerations for CSPs in meeting the expectations of the statutory guidance. Where families are engaged, they face what has been described as a hierarchy of testimony.[5] CSPs experience further challenges in engaging with families post publication of the review and the guidance could better address the expectations with regards to this, by setting out the need for clear engagement plans for families at scoping review stage.

Designated Responsibilities

The Domestic Abuse Commissioner believes that the guidance should give greater power to CSPs to ensure that the process is managed and progressing. The current guidance assigns this role to the Chair. The Commissioner believes that this takes control from the Community Safety Partnership who are often held accountable for delays, without any authority to influence Chairs who are not conducting a review

[5] Domestic Homicide Reviews: The role of family, friends and community - 'A hierarchy of testimony'? - AAFDA

in a timely manner. A clear distinction needs to be made between the management of the panel meetings and the management of the overall review. The role of the chair should rightly be to manage the panel meetings, to ensure all relevant information required to conduct the DHR is available to the panel. The role of the CSP should be to ensure that the review is managed and coordinated to meet all of the expectations set out in the statutory guidance for the conduct of reviews.

It would also be beneficial to consider supplementary guidance on the commissioning and management of the DARDR process, providing greater clarity on key milestones and dates for progressing reviews, whose role it is to ensure they are adhered to, and an expectation on chairs and CSPs to work together to reduce the length of time in which reviews remain in an indeterminate state with little or no feedback to bereaved families.

Children

Since the Domestic Abuse Act 2021 recognised children as victims in their own right there is little consideration or reference to their needs in the guidance. The Domestic Abuse Commissioner believes that the guidance should emphasise the need for those conducting a review to commit to ensuring the voices of children and young people are heard in reviews and that there is an opportunity for children and young people to contribute. Their input can provide unique insight and help produce a review that is accurate and meaningful.[6] This requires support from professionals and specialist services.

Research carried out in 2017 concluded that children and young people can be articulate, strategic and reflexive communicators, and that good support for families struggling with domestic violence must enable space for children and young people's voice to be heard. This is possible only in an integrated framework able to encompass multiple layers and perspectives, rather than privileging the adult point of view.[7]

This should include taking a trauma informed approach and following referral pathways to specialist support. The guidance should also address the need to

[6] Resource for professionals (aafda.org.uk)

[7] The Management of Disclosure in Children's Accounts of Domestic Violence: Practices of Telling and Not Telling Callaghan, Fellin, Mavrou, Alexander and Sixsmith (2017) The Management of Disclosure in Children's Accounts of Domestic Violence: Practices of Telling and Not Telling - PMC (nih.gov)

consider how children are impacted by a domestic abuse related death and the implications of the review on their health and wellbeing, ensuring that there is adequate support which takes into consideration how a criminal trial and publication of reviews may be triggers and cause trauma to resurface. [8]

Research demonstrates that children may see, hear or intervene in episodes of violence or abuse prior to a homicide. They may also be present at the time of the homicide. These experiences have been found to have a wide ranging and enduring effect of children which is mirrored in the findings from the HALT research project.

Intersectionality

Domestic abuse does not exist in a single form. It is unique to each person's situation and history. Different forms of domestic abuse, including controlling and coercive behaviours, coexist in most contexts and it is important to understand how power and control manifest in these situations. 'Race'/ethnicity, age, gender, religion, sexuality, socio economic status, immigration status, disability status and other ways in which victims/survivors identify plays a crucial role in their experience of abuse, its impact and their ability to access pathways of support and recovery.

Specialist pathways of support as well as any attempt to understand victim/survivor needs should be responsive to the multiple contexts of oppression and vulnerabilities that they experience. Intersectionality, a term coined by Kimberley Crenshaw, is firmly located in Black women's experiences of racism and multiple forms of oppression, including domestic abuse.[9] This is a powerful lens that enables us to understand victim/survivor experiences as a whole and identify systemic oppression and marginalisation.

In respect of the DHR statutory guidance there is a notable gap in the consideration of intersectionality when conducting a Domestic Homicide Review. Research by the Centre for Women's Justice and Imkaan (2023)[10] found a lack of post-death

[8] Professional support for children bereaved by domestic homicide in the UK, Gomersall, Alisic et al 2024 Professional Support for Children Bereaved by Domestic Homicide in the UK (springer.com)

[9] Columbia Law School (2017). Kimberlé Crenshaw on Intersectionality, More than Two Decades Later. [online] www.law.columbia.edu. Available at: Kimberlé Crenshaw on Intersectionality, More than Two Decades Later | Columbia Law School

[10] Life or Death? Preventing Domestic Homicides and Suicides of Black and Minoritised Women Life or Death? Preventing Domestic Homicides and Suicides of Black and Minoritised Women — Imkaan

investigation following suicides of Black and minoritised women, suggesting that these deaths remain unexamined and invisible. This research noted that reviews often take place when families push for them and speculates that many Black and minoritised families do not engage with this process. The research also reflects the need for so called 'cultural experts' to ensure victims' voices are centred and the review is analysing context and information through and intersectional lens. This includes considering how a perpetrator's narrative can be persuasive and manipulative.

In the conduct of reviews, it is also important to consider intersectionality in the commissioning process, ensuring that Community Safety Partnerships recruit chairs who are able to evidence an understanding of intersectionality but are also representative across all protected characteristics and minoritised groups. Panels should also be encouraged to ensure a broad representation.

It is of note that the by and for sector face additional barriers to engagement in the development of policy across the domestic abuse sector, this is due to their size, limited funding and the disproportionate effect on by and for services of the challenges faced by the wider sector. Such gaps in elevating the contributions of the by and for sector prevents DARDRs from being comprehensively diverse and inclusive.

Recommendation 7: That the guidance be amended to require greater consideration and demonstrations of intersectionality beyond references to equality and diversity.

Recommendation 8: That the Home Office actively engages with the by and for sector to co-produce and ensures that any future iterations of the guidance will include meaningful consultation with the by and for sector.

Further feedback is provided below in response to the questions posed in this consultation.

Do you have any comments on 'Section 1.1 Purpose of a DHR' in terms of content or clarity?

The Domestic Abuse Commissioner agrees with the purpose of the DARDR with regards to being clear that this is not an inquiry into how a victim died or who is culpable. The Commissioner supports the reference to understanding what lessons can be learnt. However, the language in this section could be stronger, for example rather than solely referring to 'learning' the guidance could place greater emphasis

on implementing actions which result in changes in policy and/or practice to prevent future deaths.

Paragraph 1.2 is very clear about what the DARDR is not, with regards to investigation, culpability and inquiries into how the victim died. This could be emphasised so that it stands out to anyone referring to this guidance. It would also be helpful in this paragraph to outline how a DARDR might inform coroner's inquests and police investigations. There is reference to how a review might identify evidence which had not been recognised in other processes but not how it might uncover information that is relevant to other processes. The guidance needs to refer to the relevant sections in the guidance that explore this further namely 1.10 Criminal Investigations and 1.11 Coronial Inquests.

The Domestic Abuse Commissioner often hears from bereaved family members about the importance of their involvement in the review process and feeling their voice is both heard and valued. The language referring to the insight from family, friends, neighbours and colleagues in paragraph 1.3 could be stronger to demonstrate that they are equal partners in the process as referenced in section 8c which clearly states that families should be treated as a key stakeholder. The Commissioner supports the recommendation in the recently published 'A hierarchy of testimony' report which says that Chairs and Panel members must hear the voices of families, friends and wider testimonial networks. The Commissioner recognises the benefits of using the term testimonial networks to determine where information about the victim's experience and life may inform learning in the review. However, the Commissioner would also suggest that such networks would be best framed in the context of a Coordinated Community Response (CCR), emphasising their role as support networks and often the first point of disclosure for victims. [11]

Framing engagement across all networks and agencies in the context and principles of the Coordinated Community Response (CCR) places the victim at the centre, with the aim of holding perpetrators to account. This is underpinned by a full understanding of the perpetrator's behaviour and the impact this had on not only the victim leading up to and including their death but also any child victims or survivors.

The emphasis on victim centred reviews, conducted in a trauma informed way is welcome however this could be reflected more robustly in the reference to 'engaging with perpetrators' in this section. Engagement with perpetrators should have a focus on the individual responsible for the abuse to ensure learning relates

[11] In+Search+of+Excellence+2020.pdf (squarespace.com)

to all potential interventions that could prevent future harm. Rowlands 2024[12] analyses the use of perpetrator testimony in DHRs. Participants in this research emphasised that without perpetrator involvement there might be less focus on the individual responsible for the abuse. It is also important to note in considering a trauma informed approach that perpetrators within a DARDR may have experienced abuse themselves, whether that is related to the victim of the homicide/death or others. Conducting a DARDR in a trauma informed way requires exploration and understanding of trauma in the wider context of domestic abuse, including coercive and controlling behaviour. The purpose of engaging with perpetrators should be made clear within the guidance and should be included within the principles of the CCR.

Recommendation 9: Paragraph 1.3 be amended to say 'this learning should inform and improve local responses to tackling domestic abuse

Recommendation 10: That the guidance be amended from 'can be utilised' in reference to family, friends, neighbours and colleagues be changed to 'must, wherever possible, be utilised'

Recommendation 11: That the section on engagement with perpetrators is further developed to provide:

- Clarity on the purpose of engaging with perpetrators and how this should be reflected in reviews so that the victim remains central in line with the principles of a Coordinated Community Response.
- Further emphasis on remaining trauma informed in considering engagement with perpetrators in reviews.
- Engagement with family, to ensure they are fully informed of any intention to engage perpetrators in the review and understand the purpose of doing so. This should include taking into account the views of the victim's family and making informed decisions about when and how to include perpetrators narrative which gives due weighting to the victim's family.
- Guidance which allows the perpetrators narrative to be redacted where families feel strongly about this in respect of publication but where it is felt that engagement with perpetrators contributes to learning which could prevent future deaths.

[12] Perpetrator Involvement in Domestic Homicide Reviews in England and Wales - James Rowlands, 2024 (sagepub.com)

Recommendation 12: That the Home Office ensures appropriate training is promoted and included within chairs training and for panel members with regards to:

- Trauma informed approaches
- Engagement with family members of victims and perpetrators
- Engagement with perpetrators
- The voice of the child in reviews.

National Recommendations:

The Domestic Abuse Commissioner supports the reference to addressing national recommendations to the relevant Government department and organisational body. **Contact details should be provided** for the relevant government departments and national bodies as an appendix to the guidance. This should include shared mailboxes to ensure the information does not go out of date.

The Commissioner's office often hears of the challenges for Community Safety Partnerships in identifying the appropriate person or department to direct reports and recommendations to. Delays in raising national recommendations hinders the progress of action plans at local level and does not support the ethos of the review process.

Having an open and transparent process with regards to national recommendations is vital to demonstrate the Home Office expectations of all government departments and national bodies. This would validate and respect the contributions of panel members and bereaved families, who invest their time and often takes an emotional toll.

Given the overarching governance role of the Home Office it is essential that the expectations of public bodies set out in this guidance are modelled and reflected in the Home Office and other Government department responses to national recommendations. Responses to national recommendations should be shared with Community Safety Partnerships directly and promptly. There **should be a formal process** in which actions taken to implement recommendations can be shared with Community Safety Partnerships when requested, including when a recommendation will not be taken forward or implemented.

Recommendation 13: The Home Office consider a model across government departments which not only brings together recommendations at an inter-ministerial level with regards to oversight, but actively engages designated DADRD

leads across government departments to deliver on the policy considerations made within recommendations at an operational level.

Recommendation 14: The Home Office invites government departments and national bodies who receive recommendations to share the appropriate contact details for those departments and public bodies and that these are published alongside the guidance. To avoid the need for frequent updates this should be appropriate departmental inbox addresses which can direct recommendations to the appropriate responsible person who can respond in a timely way.

7. Do you have any comments on 'Section 1.2 Criteria and definitions for a DHR' in terms of content or clarity?

The Domestic Abuse Commissioner welcomes the inclusion of the definition of domestic abuse within the Domestic Abuse Act 2021 in this guidance. Simply including this definition is not enough to make clear that there are a range of domestic abuse related deaths which would meet the criteria set out in paragraphs 2.1.

The guidance should include a clearer reference to where a death 'appears to have resulted from domestic abuse'. This should include incorporating the description of deaths which may have been 'caused by, related to, or somehow traceable' to domestic abuse (Websdale, 2020, p.1). A narrative here which contextualises the change in definition and broader remit of the review process is essential to ensure that partners understand the circumstances in which a notification can and should be made to CSPs.[13]

The statutory guidance should address the gap which is created by the change in definition and provide clarity about the expectations for reviews which may have previously met the criteria, for example those living in the same household. The guidance should also address circumstances where it may be unclear as to whether a review would apply, which the Commissioner has commented on in her previous consultation response regarding the change of definition and naming of reviews. We recommend that the Home Office review the Commissioner's previous consultation response on this issue. [14].

[13] Domestic Homicides and Suspected Suicides 2021-2022 Year 3 Report[Title] (vkpp.org.uk)

[14] Consultation_questions_DHR_Legislation_Amendments-1-DAC-Response.pdf (domesticabusecommissioner.uk)

Clarity is needed in this section on reviews where the death occurs outside of England and Wales, but the abuse occurred in the UK as the victim's place of habitual residence. We have heard from some bereaved families that victims are removed from, or leave the country, a short time before their death and a review has not been commissioned as a result, despite the victim's habitual residence being in the UK.

Section 3.9 should be moved to a section that relates to suicide, neglect or unexplained circumstances as this appears to relate only to the Single Unified Safeguarding Review process. The later reference to 'cases not ruled as homicide' in 8e is disjointed with regards to providing clarity on the differences in approach to a review depending on the circumstances of the death. Whilst the guidance applies to all domestic abuse related deaths, there are some considerations for Community Safety Partnerships which are most likely or only apply in the case of deaths which are not ruled as a Homicide and most frequently where the death is ruled a suicide, due to the absence of a charge, conviction or criminal history. These considerations, such as information sharing and appropriate timescales related to terms of reference, should be addressed more clearly and transparently in the guidance in relation to those reviews which are not ruled a homicide to better support the delivery of reviews.

The Domestic Abuse Commissioner supports the statement at paragraph 3.9 which makes it clear that due to the possible number of cases that will meet the criteria it will not be possible for every case to progress to a DHR. However, the factors listed in 3.10 require further consideration. This would ensure they are robust enough to support Community Safety Partnerships in their decision making and rationale. This should also take into consideration who is likely to refer to the guidance, including bereaved family members so that anyone referring to the guidance can be sure of the parameters in which a decision not to conduct can be made.

Recommendation 15: That the guidance adopts the agreed terminology of 'Domestic Abuse Related Death Reviews'

Recommendation 16: The guidance should identify the types of homicide which fall into scope so that there is consistent language across reviews, for example, Intimate Partner Homicide and Adult Family Homicide. In addition, a shared language should be referenced in the DHR library

Recommendation 17: The guidance should specify that a Domestic Abuse Related Death Review should take place no matter which country or where the death took place if the victim was habitually resident in their CSP area**.**

Recommendation 18: The guidance should clarify that a notification should be made to the CSP where the death is 'caused by, attributable or somehow traceable to' domestic abuse (Websdale 2020, P1).

Recommendation 19: That the guidance must be further developed to include a specific section with clear guidance on domestic abuse related suicides and unexplained deaths. This guidance should cover:

- When legal advice should be sought for example where there are no criminal convictions.
- The appropriate timescales for considering domestic abuse as a contributory factor in the death.
- Issues of disclosure and publication pertinent to cases where a victim has died by suicide or their death is unexplained, for example where there is a cause for concern with respect of legal culpability, safeguarding or family court proceedings.
- Circumstances in which families become aware of information over the course of time which was not available or known at the time of scoping. The guidance should state that families can meet with the CSP, to reconsider the decision not to conduct a review.

***8. Do you think 'Figure 1: Domestic Homicide process map' is* useful?**

The Domestic Abuse Commissioner welcomes the addition of the process map to provide a visual step by step of the review process. Whilst it is helpful to see this mapped out at a high level, it would be beneficial to develop this further for each strand of the process. Doing so would better reflect the depth and span of the review process and provide a more transparent and informative picture for families in particular who will not be well versed in the process. The flowchart does not provide detail as to how family and wider networks' views are fed into the process. This could be resolved by adding in the relevant timescales. To improve accessibility all aspects of the guidance **should be available in easy read**.

The notification process suggests that a CSP is able to take a decision not to proceed with a DARDR on the basis that the circumstances of the death do not meet the DARDR criteria without notifying the Home Office of that decision or consulting with others. This appears to be a shift from previous guidance which stated that the decision should be taken in consultation with local partners. Given the wider scope of reviews it is important that consultation remains part of the process. It is essential that CSPs maintain documentation and records of decision making and the guidance should require this along with a specified time for which those records should be retained.

The term 'fatality' is also used in the process map and should be removed to reflect the agreed and most appropriate language of domestic abuse related death.

The process map only refers to national recommendations with regards to oversight of implementation and does not reflect oversight at the local level. This needs further development to ensure accountability of the implementation of actions and recommendations locally. The ministerial oversight section suggests that the expectation to act to implement recommendations on Government departments occurs following the DAC annual report. However, this is not the case, and Government Departments must consider recommendations immediately upon a DARDRs publication, and DAC oversight will only start when this is underway. The guidance should be clear that all agencies local or national should act to implement recommendations.

Recommendation 20: That the notification process is clear with regards to the need to consult with local partners on whether a death meets the criteria for all notifications.

Recommendation 21: That the guidance requires CSP to document their decision making and retain this record for a specified period of time.

Recommendation 22: That the ministerial oversight and publications strands of the guidance be further developed to reflect that upon publication, government departments and all agencies should be acting to implement recommendations and that they can be expected to update on their progress through oversight.

Recommendation 23: That the process map be further developed to reflect all aspects of the review process. This should be done in consultation with families with lived experience of the review process and those who have conducted reviews including CSPs and Chairs.

9. Do you have any comments on 'Section 2.4 Notification of a death to the Community Safety Partnership' in terms of content or clarity?

At paragraph 4.2, more affirmative language should be used to place greater responsibility on agencies to notify the CSP, rather than state a notification 'can' be made.

Section 4.3 should require CSPs to clearly indicate on their websites how a notification can be made to a CSP of a death which may meet the criteria for a review. This would ensure that the process is accessible to family and wider networks. The guidance should direct CSPs to outline the scoping review process to ensure transparency with regards to next steps. It should also be made clear that

specialist services or statutory agencies approached by a family member for this purpose should act to facilitate a notification not to determine if one meets the criteria.

Recommendation 24: That the guidance be amended that state agencies should notify the CSP, immediately and without delay, if they become aware of a death which may meet the criteria for a DARDR.

Recommendation 25: The guidance includes a requirement on CSPs to ensure information on how to notify the CSP of a death which is in scope for a review is publicly available and accessible on their websites, including information about the scoping review process.

10. Do you have any comments on 'Section 2.5 Scoping Review process' in terms of content or clarity?

The Domestic Abuse Commissioner welcomes the inclusion of the scoping review process and supports an early review which ensures that actions are implemented and monitored without delay. However, this section raises more questions than clarification and the Commissioner strongly believes that this section should be further developed to achieve the intent with which it appears to have been written.

For example, paragraph 5.1 states that the scoping review would assess whether a full DHR is needed, leaving it open to interpretation. If the intention of this is to allow CSPs greater flexibility in their decision making to take into account a wider range of factors than is already accepted in practice, then this should be made more explicit and those factors laid out in the guidance. The Domestic Abuse Commissioner often hears from CSPs about the time, resourcing and capacity issues related to multiple review processes, sometimes due to the delays at various stages of the review. Without greater clarification the Commissioner would be concerned that this will be open to interpretation with regards to when a review is 'needed' and result in unintended consequences and challenge, thus creating further unnecessary delays.

Paragraph 5.1 also states that the CSP must conduct a Scoping Review for all fatal incidents that meet the criteria for a DHR within four weeks of a notification. This implies that there would be a process by which a determination is made before the scoping review as to whether a notification meets the criteria. The Commissioner feels strongly that this would lead to gatekeeping by single agencies and is not in the spirit of the review process. The purpose of the scoping review should include; to assess whether the death meets the criteria for a Domestic Abuse Related Death Review.

Furthermore, the purpose of the scoping review states that the scoping review is a tool to determine the proportionality of the review required. This suggests that there is another route to delivering a review however this is not clear and will lead to inconsistencies in practice if not remedied. If a full review if not considered proportionate, the guidance should outline what the alternative/s would be.

The Domestic Abuse Commissioner believes that there should be an expectation on the CSP to consider all aspects of the purpose of a review which, as stated in section 1.1, is to understand what lessons can be learnt from domestic abuse related deaths. In addition to this, the purpose is also;

- to identify and implement local and national learning to better safeguard victims of abuse
- to consider any exceptional ethical or safeguarding considerations which may result from conducting a review, most significantly whether the harm caused by conducting a review outweighs the understanding, learning and change which can be gained.

The Domestic Abuse Commissioner supports the introduction of trauma informed approaches and would like to see this strengthened in the guidance to enable CSPs to apply these principles to their decision making so that the review process seeks to do no harm.

The Commissioner fully supports the involvement of family at all stages of the review process including the scoping review and the offer of specialist support at the earliest opportunity. There are some concerns with regards to the involvement of families in the scoping review process and engaging them at such an early stage in the decision-making process. For example, the timescale of the scoping review directly conflicts with a trauma informed approach.

To balance the need to treat families as equal partners in the process and remain trauma informed there would need to be much greater investment in specialist support. There are ethical considerations in the conduct of reviews which should be better reflected in the guidance so that Community Safety Partnerships can, where it is right and appropriate to do so, depart from the relevant timescale, provided, there is a clear engagement plan for families at an appropriate time.

Other considerations that might factor in decision making process are that:

- By conducting a review, the CSP feels that it is more likely than not that further harm will be caused to one or more parties. In these cases, the CSP can provide a clear rationale, following a scoping review, as to why this would outweigh the potential learning and understanding gained from

conducting the review. They must describe how they will draw out and implement relevant actions and learning.

- Where a review has the potential to cause further harm, but it is felt a DARDR should go ahead, the CSP should outline how they will mitigate against this and how any safeguarding will be addressed.

The thoughts, feelings and wishes of family should be included in any rationale regardless of whether it supports or conflicts with the CSPs decision.

The Domestic Abuse Commissioner supports the 4-week timeline to ensure that reviews are progressed without delay however the guidance must reflect circumstances, in which this may not be met, considering the relevant practice issues that have arisen in the conduct of DHRs. Such issues include the accessibility of some information, often related to health records, where the death is not explicitly homicide. In addition to this, the immediacy of actions related to reviews so soon after a death is vital and important to ensure that the information is safeguarded and appropriately managed.

The guidance should also include a requirement to notify the coroner of a scoping review so that inquests are not conducted without a full awareness of whether a DARDR will be commissioned. However, involving grieving families so early in the process, will inevitably contradict a trauma informed approach to the process for many. Rather than be prescribed to involve families at this early stage, the scoping review should be tasked with setting out a clear engagement plan for the victim's family and wider testimonial networks whether a decision is made to conduct a full review or not. The role of specialist advocacy and support is integral to this and in some instances, this may include early engagement in the scoping review, it is important to recognise here that it is not just immediate family who hold key information that might support the review but those who were close to the victims and/or perpetrator. The focus should therefore be on engaging testimonial networks in the scoping review.

There are a number of gaps in the guidance with respect to the timeline and the engagement of families including; Whose responsibility it is or should be to engage with families at this time given an independent chair is not yet appointed? Who provides aftercare to the bereaved family members should a decision be made not to conduct a review or where the period of time between the review and the first panel meeting is considerable? The Domestic Abuse Commissioner office has heard feedback from a number of Community Safety Partnerships and from bereaved family members that reviews are significantly delayed at the start of the process.

Furthermore, there is no process included which sets out expectations on what should happen if the death does not meet the criteria for a review or a decision is made not to conduct a review. Support for families is lacking and considered underfunded in this respect. There is no formal process in which an agency, family member or individual can appeal to the Home Office where there is disagreement at local level, this should be clearly addressed in the guidance as to how representations can be made to the QA panel and/or the Home Secretary. More specifically, there should be a process for family members to advocate for a different decision, directly to the QA panel.

Providing some flexibility here for CSPs, taking into account the considerable delays already flagged to the Home Office for reviews and the requirement on agencies and families during this time following a death, would ensure due consideration can be given to taking a trauma informed approach to the scoping review. The guidance should be clear that families must be kept informed of any action being taken or not to review the death of their loved one, however the level of engagement at the scoping review will be subjective and should be carefully managed.

Recommendation 26: The Home Office should set out the circumstances in which a scoping review may reasonably be delayed.

Recommendation 27: The guidance should make clear that agencies should not wait for a scoping or full review following a death to act on any changes required which they have identified in reviewing their records and interactions with victims, perpetrators and families.

Recommendation 28: The guidance be amended to state that any information known to family members which is obtained at this stage should be given equal standing to that of agencies in the decision-making process.

Recommendation 29: Paragraph 5.4 should also include representations from family, friends and wider networks where it has been appropriate to obtain this information. Paragraph 5.4 is also inaccurate in referencing the relevant sections this should be amended to refer to section 9 and 10 when notifying that a DHR must be paused and include 'due to consideration of parallel review and/or criminal proceedings'. When referencing criminal proceedings, the guidance suggests that it is the chair who should liaise with the CPS, however it is unclear in the scoping review stage as to whether a chair should be appointed for this part of the process. If this is not the case this section should make clear who is responsible for seeking information form the CPS with regards to prosecutions.

Recommendation 30: The guidance is amended to include how a public body, family member or any other individual can contest a decision made by the Community Safety Partnership and Quality Assurance panel to conduct or not to conduct a review. This should also include how to make representations about failure to deliver on the statutory guidance in respect of a DARDR.

11. Do you have any comments on 'Section 2.6 Coordinating a Domestic Homicide Review at a local level' in terms of content or clarity?

There is variation in the way in which a DARDR is coordinated, managed and commissioned across England and Wales. In the Commissioner's work to establish and pilot a model for oversight of the implementation of recommendations within DARDRs, it has become clear that funding arrangements are varied, inconsistent, and resourcing and capacity is limited. Commissioning guidance should be included to make clear who should fund a review, how this might be funded, for example as a project cost, and what resource should be committed by partner agencies.

A recommendation made in the recent report, Domestic Homicide Reviews: The role of family, friends and community- 'A hierarchy of testimony' (Sarah Dangar, 2024),[15] published by Findaway and AAFDA, it states;

'Community Safety Partnerships (with the support of the Domestic Abuse Commissioner's Office) should develop a consistent model of commissioning Domestic Homicide Review Chairs in order to ensure a high standard, this should include consideration of the number of reviews a Chair is undertaking at any one time.'

The Domestic Abuse Commissioner supports this recommendation. However, the Home Office should consider how this can best be coordinated, supported and resourced to ensure that there is collaboration across Community Safety Partnerships in establishing a model. This should include engagement with the Local Government Association and the Association of Police and Crime Commissioners.

Furthermore, paragraph 6.8 states that the chair is responsible for managing the DHR process. The Domestic Abuse Commissioner would have some concern about this considering the scarcity of independent chairs and the number of reviews some chairs are undertaking at any one time. The Commissioner feels this should be a role for the CSP to ensure that the DHR is on track, that families are kept

[15] Domestic Homicide Reviews: The role of family, friends and community - 'A hierarchy of testimony'? - AAFDA

informed and to ensure the chair delivers as agreed. This should form part of commissioning guidance and may require further guidance for CSPs as to how to effectively manage the review process. The Commissioner agrees it is the role of the chair is to hold independent oversight of the panel meetings and to ensure that all avenues that may provide learnings to prevent future domestic abuse related deaths are explored. The guidance should include a pro forma for CSPs and Chairs in the toolkit which sets out the key responsibilities of each in the process.

The inclusion at 6.3 of expert representatives on marginal groups is welcome. However, the Commissioner would suggest this be amended from 'marginalised' to 'minoritised' groups. This section should also go further to include expert representatives on a range of issues and include more detailed guidance on the use of expert panel members. The guidance should cover information about when an expert might be appropriate and how an expert should be compensated for their time, taking into consideration the limited resources of By and For services.

There are various ways in which expert panel members can support the review process and inform the panel on key issues, including delivering training, contributing to the terms of reference, reviewing and providing feedback on Independent Management Reviews (IMRs), participating in panel meetings, providing a critical friend role for the draft report and in the dissemination of learning post review. Input may vary depending on the scope of the review; however, the guidance should provide more detail on how experts can and should be utilised appropriately and considered when commissioning a review.

The Domestic Abuse Commissioner supports the requirement in paragraph 6.7 that independent chairs must have completed the Home Office DHR Chair's training, however the impact this will have on the availability of chairs should be considered in resourcing the training.

Further clarification is needed as to what is meant by 'independence' this is often taken to mean that a chair has not worked operationally in an area however many chairs have specific experience in a particular profession which can be seen to be both helpful and conflicting. The Domestic Abuse Commissioner believes it is necessary to address this further in the guidance, this should also be included in more detail in any commissioning guidance. The Domestic Abuse Commissioner seeks further assurances that there will be robust quality assurance of chairs to maintain a high standard of review and to ensure that the outcome stated in paragraph 6.10 can be achieved.

Recommendation 31: Paragraph 6.3 be amended to reflect wider a coordinated community response which emphasises the importance of a victim's community and networks.

Recommendation 32: The Home Office adopts recommendation 8 of Findaway and AAFDA's recent report 'A Hierarchy of Testimony' and in doing so considers there is support, resourcing and appropriate collaboration.[16]

Recommendation 33: A pathway for escalation, holding chairs and authors to account, should be developed by the Home Office, including quality standards and assurance, so that where the QA panel notes consistent issues, inaccuracies or concerns in reports chaired and/or authored by the same person(s), there is a robust process and sufficient recourse to address this.

Recommendation 34: The guidance clarifies the meaning of independence with regards to the role of the chair and provides further detail on what should be considered when commissioning a chair.

Recommendation 35: The Home Office considers an accountability framework for chairs which seeks to maintain a high standard of review.

12. Do you have any comments on 'Section 2.7 Conducting the Domestic Homicide Review' in terms of content or clarity?

In setting the terms of reference, if family are truly equal partners, then they should also be referenced in setting the terms. Families often hold vital information about a victim's history and experience to inform this process. It is right that the terms of refence are shared with family, however this should be strengthened to say that family should have the opportunity to contribute to the terms of reference.

The statutory guidance should go further to address the need for better identification of minoritised groups within Domestic Abuse Related Deaths and as outlined in the paragraph on intersectionality at page 8 of this response, be more directive in ensuring that an intersectional lens is present throughout the review process. Practically, at point 7.3.6, whilst not legally considered a 'protected characteristic' it is important to include immigration status, as we know that this is a significant factor in domestic abuse, and it is something panels should be mindful of.

[16] Domestic Homicide Reviews: The role of family, friends and community - 'A hierarchy of testimony'? - AAFDA

The Domestic Abuse Commissioner supports the forward thinking in 7.5 with regards to briefing sessions and learning reviews. To ensure that there is synergy in the review process and implementation, the Commissioner would suggest including Police and Crime Commissioners in these discussions.

At paragraph 7.6.1, it would be helpful to ensure that IMRs include reference to any work being undertaken by agencies as a result of other reviews, as this may help inform the recommendation within a review where there are concurrent reviews at differing stages of the process.

As highlighted in the paragraph on Children at page 7 of this response, the statutory guidance should be reviewed to include greater emphasis on children bereaved by domestic abuse related deaths. At paragraph 7.6.2 of this draft guidance there should be greater consideration of children's voices in reviews. As recommended at question 11, a broader term should be adopted to extend the scope from family and friends to reflect the wider support networks and principles of the CCR. This paragraph should also go beyond interviewing testimonial networks to present a comprehensive picture of the victim's experiences and should state that this information should inform the learning and contribute to the development of recommendations to prevent future domestic abuse related deaths.[17]

13. Do you have any comments on 'Section 2.8 Compiling the Domestic Homicide Review' in terms of content or clarity?

Paragraph 8.3 should include the specific consideration given to children as witnesses to a homicide, victims of the abuse and future adult children who may revisit the review, when thinking about being trauma informed. The potential 'trauma' caused by a review process extends beyond the review itself. As such, the guidance should ensure that due consideration is given to the disclosure of personal information in the review that would not otherwise be in the public domain where it does not add value to the learning itself. Consideration should be given to the level and appropriateness of children's involvement in reviews and how this might be facilitated.

The Domestic Abuse Commissioner welcomes the inclusion at paragraph 8.6 of the impact on professionals engaging in DHRs. This could be strengthened to include consideration of multiple reviews, particularly where it is likely the same panel members would represent an organisation. As a result, professionals can experience vicarious trauma but also unconscious bias and compassion fatigue, which may impact on the critical analysis in some reviews. This also speaks to the

[17] Recommendation 1 'A Hierarchy of Testimony' Domestic Homicide Reviews: The role of family, friends and community - 'A hierarchy of testimony'? - AAFDA

importance of expert panel members who can directly contribute to the discussion with regards to professional challenge and promoting professional curiosity.

The Domestic Abuse Commissioner supports the inclusion of a victim centred approach at 8b.

The Domestic Abuse Commissioner welcomes the inclusion of section 8c with regards to involvement of family and friends particularly the statement that families should be treated as a key stakeholder. In order to validate and strengthen this, the reference in paragraph 8.12 to panels having an awareness of the risk of ascribing a hierarchy of testimony should be amended to say that panel members should commit to ensuring there is no hierarchy of testimony within reviews.

The Domestic Abuse Commissioner recommends the inclusion of a paragraph which outlines that panels should consider the weighting they give to agency and family testimony and how this translates into recommendations. Wearside Women in Need's Findaway report identified that family information does not always translate into recommendations. The testimony of families and testimonial networks often provide the missing pieces and, as such, can and should inform recommendations.

At figure 2, the requirement to refer to a specialist and independent advocacy service is noted at the point of commissioning a DHR. Given the intention is to inform and involve family at the point of a scoping review, this should also be included at step 1.

With regards to 8d 'Involving Perpetrators' we refer to comments at page 11 of this response.

In addition, it would be helpful at paragraph 8.17 to state whether the term 'perpetrator of domestic abuse' should still be used where there is no conviction for domestic abuse related offences and if not, then what the acceptable term to be used in law should be referenced.

At paragraph 8.20, the guidance should specifically reference 'safeguarding', being clear that this would take precedence rather than simply stating concerns for safety.

Clearly stating the purpose of engaging perpetrators would provide consistency across the guidance in this section, particularly with regards to paragraph 8.21.

The guidance appears to address the specific considerations of domestic abuse related deaths, including where a victim dies by suicide in section 8e. However, the Domestic Abuse Commissioner believes that this should be stronger and provide clarity of where it may not be appropriate for a review to proceed. This 'non-exhaustive' list should address some of the common reasons why CSPs report challenges, delays and legal issues with the review process which differ from those where the death is a homicide.

It is not enough to state at paragraph 8.23 that CSPs need to establish strong links with Public Health partners and local Real Time Suicide Surveillance (RTSS) processes. The principles for deciding to commission a review in the case of a victim who dies by suicide, or any unexplained death, should be made clear.

Recommendation 36: That the Home Office consult with relevant partners and experts, to produce supplementary non-statutory guidance to provide greater details and clarity on key issues such as cases where a victim has died by suicide, or their death is unexplained deaths

14. Do you have any comments on 'Section 2.9 Parallel Reviews' in terms of content or clarity?

This revision of the statutory guidance provides an opportunity to consider the overlapping aims and objectives of parallel and multiple reviews, many of which capture learning and recommendations which are similar and intersect. The Domestic Abuse Commissioner is not satisfied that section 2.9 addresses some of the issues raised by Community Safety Partnerships about the challenges of parallel review processes and duplication of effort. Furthermore, there is a need to clarify the expectations of agencies in sharing information across reviews and this is detailed further in response to question 16.

This section could be developed by drawing on learning from local areas, such as Cornwall, who have streamlined their approaches to reviews by integrating statutory reviews and taking a trauma informed approach to this. This has improved efficiency, resourcing and costs, but more importantly it is much more person-centred for family members, as well as garnering much more comprehensive learning, better accountability and joined up actions and improvements across all relevant directorates and services.

The purpose of the scoping review at section 2.5 included reference to determining *'the most appropriate form of review',* suggesting that a decision may be made not to progress a DHR in preference of other review processes. The Domestic Abuse Commissioner seeks clarity in the guidance about whether this is likely and on what

basis, for example, if it is felt that another review takes precedence or is more appropriate. If the intention is to provide exceptions, then both sections 2.5 and 2.9 should outline how CSPs will ensure that the dynamics, cause and effect of domestic abuse in relation to the death is not undervalued or diminished in other review processes, as well as how families would be supported.

With regards to Serious Further Offence Reviews and other independent reports, the Domestic Abuse Commissioner believes that the guidance should be more prescriptive in the sharing of reports with appropriate restrictions and safeguards so that the DHR analysis can be fully informed on practice issues.

The Home Office may want to consider how the Single Unified Safeguarding Review process may provide insight into greater connectivity of reviews, from decision making to learning.

Recommendation 37: Sections 2.5 and 2.9 be further revised to include clarity on the statutory duties to share information and in what circumstances a parallel review might take precedence over a DHR.

Recommendation 38: The Home Office and the Ministry of Justice consider how parallel reviews are integrated and streamlined to ensure trauma informed approaches are best achieved across all reviews and learning which translates into action is consistently implemented and carries equal weighting.

15. Do you have any comments on 'Section 2.10 Criminal investigations' in terms of content or clarity?

Section 10.2 on the scoping review with criminal justice agencies does not include the Police, although they are named at paragraph 10.3.

There is little reference to how at the scoping review stage, evidence not already known to the Police may come to light, particularly where families are engaged in this process.

It is relevant to this section to ensure that families are engaged in discussions with regards to whether they are pursuing a criminal investigation which may not have been opened, as this can have evidential implications later.

At paragraph 10.9 there is reference to notifying the Police where a DHR is anticipated to run in parallel to a criminal investigation or prosecution - this should also include the Crown Prosecution Service.

16. Do you have any comments on 'Section 2.11 Coronial Inquests' in terms of content or clarity?

The introduction of the scoping review process adds a layer of process which is not referenced in this section but is highly relevant to the coronial inquest. The decision in the case of R(Maughan) v HM Senior Coroner for Oxfordshire [2006] increased the possibility of inquest conclusions of unlawful killing for suicides that follow domestic abuse, if it can be shown on the balance of probabilities that the elements of the offence of unlawful act manslaughter are made out. The subsequent conclusions in the death of Kellie Sutton, Justine Reece and preventing future death report following the death of Jessica Laverack, highlight the importance of notifications of any scoping review being made to the coroner at the earliest opportunity to ensure that regardless of the decision made within the scoping review the coroner is in possession of all the information relevant to the death. The presence of domestic abuse can be a significant factor in determining the conclusion of an inquest. This has been further highlighted in the recent High Court ruling which stated 'emotional abuse' led to Roisin Hunter Bennett taking her own life in March 2022[18]. Whilst it is not the purpose of the DHR to determine how someone died or who is responsible, the DHR and inquest should work in parallel to ensure the coroner has access to as much information as possible for the inquest.

In clarifying the requirements to share information for the purposes of the DHR, the Domestic Abuse Commissioner would draw your attention to recommendations made within a DHR which states;

That the Home Office seeks clarity from the Dept. of Justice and/or Lord Chancellor's Office if the judgement in the R (Sec of State for Transport v HM Senior Coroner for Norfolk) includes DHRs. That is whether Domestic Homicide Reviews are considered to be a statutory Review within the meaning of the judgement which states that to avoid duplication agencies need only to respond to the Inquest and the information will be shared with other statutory re- views.[19]

Clarification that domestic abuse related death reviews are considered a statutory review within the meaning of *R (Sec of State for Transport v HM Senior Coroner for Norfolk)* would be appropriate in this section to support CSPs and review chairs in ensuring agencies share information for consideration by the panel.

[18] https://www.gazettelive.co.uk/news/teesside-news/battling-parents-win-landmark-ruling-29369032#ICID=Android_GazetteLiveNewApp_AppShare

[19] Cornwall DHR3 Amended Overview Report 5:1:23 (safercornwall.co.uk)

Recommendation 39: The guidance be amended to include a requirement for CSPs to inform Coroners when a scoping review is taking place.

Recommendation 40: The guidance clarifies that any agency listed in the statutory guidance which refuses to participate in a domestic abuse related death review would be in breach of their statutory duty.

17. Do you have any comments on Section 1.3 and Section 2.12 'Conducting a DHR in Wales: The Single Unified Safeguarding Review (SUSR)' in terms of content or clarity?

The Domestic Abuse Commissioner does not have any specific comments in relation to this section of the guidance.

However, the Commissioner believes that, given the timing of this guidance, implementation of the SUSR and announcement in the King's Speech of bills to consider devolution at a regional level, there may be wider considerations for the Home Office in respect of the SUSR and some elements of the DARDR process, particularly oversight.

Recommendation 41: The Home Office considers how the governance and oversight of implementation of recommendations may be impacted by any regional arrangements.

18. Do you have any comments on 'Section 2.13 Anonymisation' in terms of content or clarity?

The Domestic Abuse Commissioner supports the anonymisation of reviews. However, the Commissioner also shares concerns of those delivering reviews that it is not possible to protect anonymity if other aspects of the statutory guidance are to be adhered to. This in turn leads to contradictions within the guidance and is further exacerbated by the reporting of reviews in local and national media where it is clearly linked to local cases.

The public facing information within a domestic abuse related death review could be better protected to ensure anonymity is preserved. This could include redacting the specific CSP or region for publication on the library.

The Domestic Abuse Commissioner agrees that it is not necessary to name individual panel members. However, the guidance should make clear that CSPs must maintain a record of the individuals involved in reviews, reporting only on their job role and organisation. This would allow for a level of transparency within reviews

as to who is included in the panel and their relationship to the victim, perpetrator or family.

There should be a clear distinction about what information is recorded and remains unpublished and that which is appropriate to be in the public domain.

Recommendation 42: That the guidance makes clear the data (including the scoping review rationale) must be retained by the CSP and specifies the period of time for which this must be retained.

19. Do you have any comments on 'Section 2.14 Data Protection' in terms of content or clarity?

Paragraph 14.5 may be problematic in the context of domestic abuse related deaths where an individual has not been 'held responsible' or 'criminally culpable' for the death. The guidance needs to explain that there is an assumption that any health information deemed relevant should be disclosed. This should further clarify that private medical information, particularly about the victim, should not be published if the detail is not pertinent to learning. References should be made to considering a victim's dignity in death and preserving their memory for children and families.

Recommendation 43: The guidance should be updated to include a paragraph which states that any health information deemed relevant should be disclosed.

Recommendation 44: A paragraph should be added to the guidance which outlines the ethical considerations with regards to including information which has been shared, where it is not pertinent to learning in order to prevent future deaths, or in the public interest to include.

20. Do you have any comments on 'Section 2.15 Home Office Quality Assurance Board' in terms of content or clarity?

The purpose of the QA board as referenced at 15.1 should reflect the purpose as stated in the terms of reference at annex H.

In considering whether a DARDR is ready for publication at paragraph 15.2, the guidance should be aligned with the terms of reference at annex H. To do so the guidance needs to state that the views of family, friends and community are included, have been actively sought and are reflected in the review. This should go further to be satisfied that their testimony has been given equal weight to statutory

agencies, and learning from them has been translated into robust recommendations and actions[20].

Where testimony from family has not resulted in any actions the guidance should require the review to include a rationale as to why. The criteria should also include reference to children in paragraph 15.1 so that the QA panel can be satisfied that where there are children, they have been given the opportunity to contribute and their voices are reflected in the review[21]

The reasonable criteria for when a review may not be commissioned is unclear throughout the guidance and this is further evident in this section. It is not clear whether the guidance expects CSPs to hold a DHR if the criteria within the Domestic Violence, Crime and Victims Act 2004 is met or whether there are circumstances in which, despite meeting the criteria for a review, it would be reasonable not to conduct one. This is essential to ensure that CSPs are providing enough information within their rationale to inform the QA panel and ensure that where there is a differing view or challenge from QA to the CSP that this can be communicated with minimal delay to the review or communication of the decision not to conduct to family.

Recommendation 45: Paragraph 15.1 of the guidance be amended to reflect the purpose as stated in the terms of reference

Recommendation 46: Paragraph 15.2 of the guidance be amended to be clear, that the views of family, friends and community are included, have been actively sought and are reflected in the review. This should also make reference to children so that the QA panel can be assured that they have been given the opportunity to contribute to reviews and their voices are reflected.

Recommendation 47: That the guidance includes reference to the testimony of family, friends and community to given equal weight to statutory agencies and learning from them has been translated into robust recommendations and actions. This should also require rationale for when their testimony does not result in recommendations or actions

Recommendation 48: That the guidance includes criteria to be considered by the QA panel when a decision is made not to conduct a review. This should include

[20] Recommendations 1 and 4 'A Hierarchy of Testimony' Dangar 2024 Domestic Homicide Reviews: The role of family, friends and community - 'A hierarchy of testimony'? - AAFDA

[21] Recommendation 7 'A Hierarchy of Testimony' Dangar 2024 Domestic Homicide Reviews: The role of family, friends and community - 'A hierarchy of testimony'? - AAFDA

- Safeguarding and public interest
- Parallel reviews which will provide a more appropriate forum to review the death and it is agreed by all partners that conducting a DARDR would delay or would not add value to the parallel process
- Alternative options for learning from the death
- The views of family members

The Community Safety Partnership should also be expected to retain this documentation for specified period of time

21. Do you have any comments on 'Section 2.16 Publication' in terms of content or clarity?

The Domestic Abuse Commissioner supports transparency and accountability in the publication of reviews. However, more detail is needed on the purpose of publishing action plans on CSP websites which are 'live' documents and subject to change. Given the considerable resource required and demand on CSPs in the conduct of reviews it seems an additional burden to expect this to be continuously updated. However, it may be of greater value to require CSPs to publish actions taken as a result of DARDRs on an annual basis.

It is also worth noting that the DA Commissioner's Oversight Mechanism will support holding CSPs to account in delivery of their actions on a more ongoing basis. The Commissioner suggests allowing the completion of the pilot of this mechanism before considering whether to require CSPs to publish Action Plans.

22. Do you have any comments on 'Section 3: Implementation of Learning – Making the Future Safer' in terms of content or clarity?

National and local oversight and implementation of learning

The Domestic Abuse Commissioner believes that all recommendations should be responded to in a timely manner, whether national or local. Therefore, paragraph 17.2 should be amended to remove the reference to recommendations being collated, analysed and presented to the Home Office by the Domestic Abuse Commissioner. It must be clear that the Commissioner is not a conduit between CSPs and the Home Office. The guidance should be clear that there is an expectation that all national recommendations are responded to by the relevant Government Departments or public bodies where a recommendation is made. The guidance must be clear that Government departments and public bodies must take responsibility for their own actions and the Home Office leads on the central government role in coordinating this.

The Commissioner will collate and analyse recommendations made in DHRs – and will determine how to analyse these recommendations depending on the content of those DHRs. This will form part of her annual report but will not be a precursor or replacement for Government taking responsibility for responding to DHR recommendations.

Recommendation 49: The guidance be amended to remove reference to recommendations being collated, analysed and presented to the Home Office by the Domestic Abuse Commissioner.

Recommendation 50: The guidance states that all national recommendations are responded to by the Home Office and other Government Departments or public bodies where a recommendation is made. The guidance must also state that Government departments and public bodies must take responsibility for their own actions and the Home Office will have responsibility for leading the coordination of this.

Role and Responsibility of the DHR Chair

It is helpful to see that the responsibility for management of the DHR process is made clear in paragraph 18.1. However, where this responsibility sits solely with a Chair this will likely impact on the timescales in which a review progresses, particularly where the availability of chairs is limited, and their capacity stretched. Further clarity is needed in the guidance to define the role of the CSP in managing the DHR process and the role of the Chair in overseeing the panel and information required to inform the review. Clearly defined roles should enable CSPs and Chairs to work collaboratively to ensure reviews are conducted in a timely manner in line with the statutory guidance requirements.

Paragraph 18.3 and 18.4 should be amended to remove the responsibility of the Chair to develop the action plan. This may be an oversight, in which case 'actions' should be replaced with 'recommendations'. The guidance should be clear that the development of recommendations should be done in consultation with the panel and the CSP, however the decision as to which recommendations are made remains with the independent chair.

It is unclear at 18.3 how the specific responsibilities for leading on engagement with friends and family of the victim relate to the scoping review process as the guidance on the scoping review suggests that engagement should begin with family and friends but does not include the appointment of a chair at this stage. It

is also important to specify what might constitute a conflict of interest for a chair. There is also no process in which a conflict arising during a DHR can be raised either by the Chair, CSP, panel or individuals.

Recommendation 51: The guidance should be amended to say the Chair should consider what recommendations will lead to change and prevent future deaths either locally or nationally and consult with agencies and the CSP to identify what recommendations and actions will lead to measurable outcomes.

Recommendation 52: In composing recommendations the guidance should also state that Chairs must consider how the impact of recommendations should be measured and include these within reports.

Role and responsibility of the Community Safety Partnership

Paragraph 19.1 outlines responsibilities better placed in the section 1.4 onwards with regards to the notification of a review and subsequent role in establishing whether a review should be conducted.

Paragraph 19.2 places responsibility on the CSP to ensure that the action plan is implemented in a timely manner and is working to achieve the intended outcomes. To support the CSP in achieving this, the guidance needs to be more directive with regards to governance structures. This will not only ensure there are sufficient local levers for holding agencies to account but also support the oversight of implementation with regards to the responsibilities of the PCC and DAC.

There is no requirement within the guidance which includes feedback to family, friends and communities on the progress of actions. The Domestic Abuse Commissioner believes that this should be included in the CSPs' role and responsibilities.

Paragraph 19.3 could be refined to state that in agreeing relevant governance structures CSPs must engage with the Police and Crime Commissioners and that pre-existing local governance structures may be utilised. It is helpful to include the examples of structures which may be appropriate in agreeing the right structure locally.

It is not clear when CSPs should engage with PCCs in respect of a DARDR. It may not be sufficient to refer to PCCs at the post-publication stage, particularly where actions are immediate and relevant. This should be clarified in the guidance and the Commissioner would suggest the guidance includes a statement that CSPs can invite Police and Crime Commissioners to join the panel without prejudice (for

example where they are a commissioner of a service) as an interested party or unofficial panel member.

Since the PCC has been given a role at local level in governance arrangements for DHRs, it would seem appropriate to state at paragraph 19.4 that the PCC should be included in post publication learning events and it would be good practice to include the Domestic Abuse Commissioner rather than leave too much flexibility for CSPs to include PCCs as the guidance currently suggests.

Recommendation 53: That the contents of paragraph 19.1 be placed earlier in the guidance at section 1.

Recommendation 54: The guidance be amended to state CSPs 'must' develop a governance structure when working with partners to ensure effective delivery rather than 'should'.

Recommendation 55: Paragraph 19.4 be amended to state that CSPs should include PCCs in post learning events.

Recommendation 56: That the guidance is amended to include requirements for the Community Safety Partnership to agree appropriate feedback mechanisms for family, friends and communities on the progress of actions.

<u>Role and responsibility of the Police and Crime Commissioner</u>

It is helpful to clarify the wider role of the Police and Crime Commissioner. More could be said in this section about how this relates to accountability and oversight. Whilst PCCs can be involved and engaged in multi-agency strategic and governance structures, they are only able to hold police to account with regards to implementation of actions.

The reference to strategic oversight at paragraph 20.3 is unclear and contradictory to the broader governance arrangements outlined in the previous section. This would also conflict with the roles and responsibilities of the CSP. This should be amended as per recommendation 57 below. This would align more effectively with the last sentence in this paragraph which the Domestic Abuse Commissioner fully supports.

With regards to the role of PCCs in dissemination of learning, paragraph 20.5 should be amended to be consistent with previous paragraphs in terms of whose role and responsibility it is to lead post publication. The guidance clearly places this with the

CSP. This could be rectified by stating PCC should 'engage with CSPs' rather than 'engage CSPs'.

Recommendation 57: Paragraph 20.3 be amended to say PCC should be invited to be involved in strategic oversight of DHRs across their areas and support knowledge sharing.

Role and Responsibility of the Domestic Abuse Commissioner

Paragraph 21.3 may be misleading with regards to the functions of the Commissioner at a local level and may be considered conflicting with the role of the CSP and PCC locally to ensure dissemination of learning and insights. This should be removed.

The Domestic Abuse Commissioner would suggest that the reference to regional learning in paragraph 21.3 may be confusing where it has not been referenced previously. The Commissioner does agree that there is much to be gained from regional approaches which can feed into national learning. This would also enable opportunities for shared resource and to align with Governments plans for devolution. However, if regional learning is to feature in the guidance, then this should be further developed across all aspects of the review process (see also comments with regards to QA).

The Domestic Abuse Commissioner is currently piloting an approach to oversight with Police and Crime Commissioners and with Community Safety Partnerships. Whilst the evaluation of this work for national rollout will not align with timescales for this guidance, we refer to earlier comments with regards to the need to consider how this guidance is reviewed and updated and where supplementary guidance would be appropriate.

Of course, this oversight mechanism will necessarily support sharing of learning through annual reporting, and the Commissioner would welcome the opportunity to expand a programme of sharing learning if resourced to do so. However, responsibility must still lie with CSPs and PCCs to disseminate and share learning.

Recommendation 58: The guidance be amended at paragraph 21.3, to remove the sentence which states, 'At local level, the DAC will ensure the dissemination of learnings and insights through routine engagement with PCCs and CSPs, supporting partnership development and cross border learning networks'.

Recommendation 59: The guidance includes a paragraph which states that the Domestic Abuse Commissioner will develop a model of local oversight which will

include further detail on how the Commissioner will engage with PCCs and CSPs, an agreed pathway for escalation and establish mechanisms to share learning nationally. This will be subject to funding.

The role and responsibility of the Home Office

This section of the guidance is sparse in detailing the role the Home Office plays in reviews. It is surprising that this has been confined to one paragraph given the role that civil servants play in ensuring that some elements of the process are served. This section could be more explicit about the role the Home Office plays in reviews.

With regards to figure 3, it is not clear what is meant by 'aid implementation' in relation to the DAC local oversight structure. The DAC would suggest this be amended to 'support' so that there is clarity around the Commissioner's independence.

This figure also needs amending in line with comments about national oversight above and a further step which acknowledges how Government departments and public bodies should act in responding to recommendations.

Figure 3 does not make clear the role of the Domestic Abuse Commissioner in overseeing national recommendations and is misleading in terms of the role of DAC, PCC and CSP at local level.

Recommendation 60: The flowchart at figure 3 be reviewed and revised to better reflect the accountability structures and reflect the Domestic Abuse Commissioners role in oversight of implementation of all recommendations both local and national.

23. Do you think the DHR Toolkit is useful?

The Domestic Abuse Commissioner agrees that the toolkit is useful. However, it should be made explicit as to whether these templates are requirements rather than optional. It would also be helpful to include further standard letters to aid the process and consistency across areas.

A further review of the toolkit should be carried to ensure that any useful resources or existing toolkits to support review learning are included such as the AAFDA learning legacies toolkit.

24. Do you have any comments on the 'DHR Toolkit' in terms of content or clarity?

Annex A

The Commissioner would suggest some guidance on appropriately selecting a pseudonym.
There should also be a note with regards to the length of reviews. This does not need to be too prescriptive but should state that where a review is of considerable length Chairs and Authors should consider whether this is necessary and proportionate to achieve the purpose of a DARDR.

The Domestic Abuse Commissioner would also suggest that previous non-fatal strangulation and suffocation be added to the list of aggravating factors in section 10. In relation to previous abuse and children there should be inclusion of Childhood sexual abuse as well as ACE's.

In relation to contributor to the DARDR section 14 should also include what the role of/engagement with family was in the review.

Annex B

To align with the Domestic Abuse Commissioners oversight mechanism, we recommend this is amended to support any information requested by the Domestic Abuse Commissioner in the delivery of oversight. The relevant additions can be shared with the Home Office to support this development and include how agencies will evidence their progress towards achieving the outcome and the quality in which these recommendations were embedded in practice.

25. Do you think there are any ways that the guidance could be improved overall?

The guidance is difficult to follow and requires further review to ensure referencing is accurate. This will also need to be more accessible, see recommendations below.

Recommendation 61: A summary of the guidance be available in easy read format.

Recommendation 62: Translations of the guidance should be made available to ensure accessibility for families where English may not be a first language.

26. Is there anything missing in the guidance that you would like to see included?

The Domestic Abuse Commissioner would welcome further guidance on the expectations with regards to draft recommendations. This should be clear that there may be learning that does not result in recommendations or action but that there should be an agreed mechanism in the action plan for sharing key learning.

There should also be reference to how Chairs can and should engage with Government departments and national bodies when setting recommendations to ensure that recommendations are not negated by specific considerations the Chair would not be aware of. Including this should seek to strengthen recommendations, not evade them.

Recommendation 63: To include guidance in the annex for developing recommendations, with a focus on developing effective and targeted national recommendations.

Recommendation 64: To consider expanding the involvement of family, friends and community toolkit beyond a checklist – to include guidance for DHR Chairs, Panels and CSPs on best practice for engaging families, friends and communities.