Learning from loss

Ensuring the lessons from domestic homicide reviews lead to change

Appendix

National recommendations

domestic abuse commissioner

July 2025

Recommendations have been RAG rated based on the status of the recommendations as reported by departments:

Complete (green)

In progress (amber)

Incomplete (red).

Those in grey represent recommendations that were not taken forward.

Recommendations made for Ministry for Housing, Local Government and Communities (MHCLG)

DHR	Recommendation	Government department/ public body responding	Response
Magda, 2021	**Recommendation 1:** The Department for Levelling Up, Housing and Communities should review with wider Central Government departments and the Domestic Abuse Commissioners Office the impact the statutory duty to provide support within safe accommodation has on community-based provision to ensure Local Authorities have adequate resource to commission wider support such as therapeutic support and specialist support for marginalised communities (particularly who may have limited safe accommodation options and thus only ever seek support within the community).	**MHCLG**	The Ministry of Justice (MoJ) has responsibility for the provision of community-based support to victims of domestic abuse, and provides funding through Police and Crime Commissioners (PCCs). The Victims and Prisoners Act 2024 includes a new duty to collaborate which, once implemented, will introduce new responsibilities for PCCs, local authorities, and integrated care boards (ICBs). This duty will require PCCs, local authorities and ICBs to collaborate in the commissioning of community support services in England for victims of domestic abuse, sexual abuse, and serious violence. This includes a requirement to develop a joint needs assessment and local strategy which demonstrates how they will collaborate to deliver and improve relevant community-based support services, such as therapeutic support and specialist support for marginalised communities. MHCLG is supporting MOJ as they lead development of statutory guidance for the implementation of the new duties, working with DHSC and other relevant government departments in developing statutory guidance for the implementation of the new duties. This will include ensuring that the new duty complements local authorities' delivery of their duties under Part 4 of the Domestic Abuse Act 2021 regarding the provision of support in safe accommodation.

			MHCLG statutory guidance on safe accommodation support includes clear expectations on local authorities to review the impact of their strategy, including on the provision of other local authority-funded domestic abuse support in their area, and is clear that MHCLG does not expect the provision of support in safe accommodation to result in cuts to community-based domestic abuse support.
Louise, 2020	**Recommendation 17.4:** Home Office: The panel further recommends that the Home Office encourage all Local Authorities to ensure that their assessment and strategy for accommodation-based support takes into account people with complex needs, including the risk of suicide.	**MHCLG**	Part 4 of the Domestic Abuse Act 2021 requires local authorities to assess and meet the support needs of domestic abuse victims within safe accommodation. The MHCLG statutory guidance specifies that local authorities must ensure their strategies account for the diverse needs of individuals, including those with mental health issues, which includes those at risk of suicide.
Salma, 2019	**Recommendation 3:** The Ministry of Housing, Communities and Local Government (MHCLG) to review the learning from this case and issue appropriate guidance nationally to ensure housing providers can be informed of safeguarding concerns at the tenancy nomination stage.	**MHCLG**	On 25 January 2022, the Government updated statutory guidance for Local Housing Authorities to have regard to the allocation of social housing, under Part 6 of the Housing Act 1996. This included amending Chapter 5: Allocation scheme management paragraph 5.7 and adding new paragraphs 5.8, 5.9, 5.10, and 5.11. Paragraph 5.8 states: "Local housing authorities should consider whether it is appropriate to share information regarding safeguarding concerns, including, but not limited to concerns about domestic violence and abuse, with other agencies (such as housing associations and GP surgeries)." Paragraph 5.10 of the guidance states: "Local authorities should consider the following case study when determining how to work with other agencies to keep victims safe: Overview Report into the death of Salma (January 2019). This Domestic Homicide Report examines agency responses and support given to Salma, a resident of Tower Hamlets, prior to her death. In this example, information could have been shared at the tenancy nominations stage to safeguard the victim.

			Authorities should have regard to the following sections of the report in particular: 'Summary of Information known to the Agencies and Professionals involved' and 'Analysis of Agency Involvement'." The relevant statutory guidance is available at paragraphs 5.7 to 5.11 of the Allocation of accommodation: guidance for local authorities https://www.gov.uk/guidance/allocation-of-accommodation-guidance-for-local-authorities/download-this-guidance

Recommendations made for Department for Education (DFE)

DHR	Recommendation	Government department/ public body responding	Response
Andrea, Jordan, Sammy, 2015	**Recommendation 3:** The Department of Education require parents who are home educating to register this with their local authority's Education Services. That the Department of Education provide guidance on when and with whom local authority Education Services can share this information with other agencies.	**DFE**	The landmark Children's Wellbeing and Schools Bill which was introduced on 17 December 2024, contains measures to introduce compulsory registers of children not in school in every local authority in England. These registers, along with the accompanying duties on parents and out-of-school education providers to provide information for them, will support local authorities to identify all children not in school in their areas, including home educating children, and to take prompt action to ensure they receive a suitable and safe education. Local authorities can also provide information from their registers to certain persons or organisations if they believe it appropriate to do so for the purposes of promoting or safeguarding the education or welfare of the child to whom the information relates, or any other person under the age of 18. Those persons or organisations are those listed in Section 11(1) of the Children Act 2004 and Ofsted.

Recommendations made for Department for Work and Pensions (DWP)

DHR	Recommendation	Government department/ public body responding	Response
Sarah, 2017	That Citysafe explore with the Department for Work and Pensions, Liverpool Clinical Commissioning Group and Liverpool Adult Social Care the feasibility and circumstances of when the Department for Work and Pensions could make referrals to those organisations for people in receipt of carer's allowance.	**DWP**	DWP already has well established national processes and guidance in place to deal with vulnerable customers if, of course, they are made aware of this vulnerable status. For example, staff are provided with the following advice: • If you have a genuine concern about the safety, behaviour or wellbeing of someone you are allowed to share this information with the relevant authorities. This includes situations where people may pose a risk of harm to themselves or others. • Data protection laws do not prevent you from disclosing personal data to the relevant authorities when you are acting in good faith about a genuine safeguarding concern. • You should only disclose personal data that is relevant and necessary for the relevant authority to deal with the situation. DWP regularly raise awareness of the processes with their staff and will continue to do so going forward. As such, there is no need to set up specific local arrangements as suitable national ones are already in place.

Recommendations for Ministry of Justice (MOJ), Her Majesty's Prison and Probation Service (HMPPS) and National Probation Service (NPS)

DHR	Recommendation	Government department/ public body responding	Response
Edie, 2021	**Issues for National Policy 1:** Consider whether further guidance is required on multi-agency risk management when remanding to prison following a domestic abuse offence. **Note that this case involves contact with a victim while someone is remanded in custody.**	MOJ	The Prison Public Protection Policy Framework (published November 2024) sets out the expectation that prisons are required to restrict unconvicted (including remand) prisoners' contact with victims or witnesses. This includes those who the police or CPS have identified are at risk of witness intimidation, prisoners remanded for offences under the Protection from Harassment Act 1997 or for the offence of controlling or coercive behaviour under Section 76 Serious Crime Act 2015; prisons must restrict prisoners from making unauthorised contact with their victims from within prison until the end of their trial. Requirements to risk asses all prisoners on entry to custody, and share information between healthcare partners, and prison and probation services are in place in the supporting Early Days in Custody policy, the Prison Public Protection Policy Framework, and the Continuity of Healthcare for Prisoners policy, as detailed in the recommendation related to Issues for National Policy 2. Further work is underway to drive improvements in the use of information for the purposes of risk assessment on reception, and as part of this work we will consider how we may be able to improve the use of information from Delius (probation information system).
Edie, 2021	**Issues for National Policy 2:** The Home Office should consider whether further national policy and practice guidance is indicated on prison reception processes in checking probation and community health system.	MOJ	Prison Service Instruction (PSI) 07/2015, Early Days in Custody – Reception in, first night in custody, and induction to custody (available online), already places a requirement on prisons to make use of all the information available for the purposes of risk assessment on reception. Paragraph 2.18 of the PSI specifically mentions Delius (probation information system) as a potential source as follows: "The PER and any other available documentation including Suicide & Self Harm Warning Forms, ACCT documents and CSRAs, must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm or harm to others by the prisoner, or harm

			from others. All available, relevant information must be considered including that held on OASys/Delius. Staff should liaise with the OMU where necessary. Assessments must also be made of prisoners who by-pass some Reception processes owing to their late arrival or disruptive behaviour, and those whose status and demeanour may change after a court appearance via video link." Whilst the policies are clear, we are aware that practice is not uniformly in line with them, as is apparent from this tragic case. We are currently scoping a national project to drive improvements in the use of information for the purposes of risk assessment on reception, and as part of this work we will consider how we may be able to improve the use of information from Delius. All health treatment in custody is the responsibility of NHS England and NHS Wales. HMPPS is committed to working in partnership with health and social care partners so that people in prison can access the equivalent standard and range of health and social care services as they would receive in the community. We continue to work closely with healthcare partners on information sharing issues, including through the HMPPS/NHSE Information Sharing Advisory Group, and will involve them in shaping and taking forward the new project. The Continuity of Healthcare for Prisoners policy is currently under review and we will ensure that the findings of this DHR are considered as part of the review. NHS partners are being consulted as part of the review.
Nicky, 2020	**Recommendation 7:** Managing offenders subject to immediate release: The Ministry of Justice to consider how those offenders who are subject to immediate release after serving a period on remand, are flagged for risk management, considered and their management resourced.	**MOJ**	HMPPS is committed to enhancing communication processes for cases where there is an unplanned immediate release of prisoners who remain subject to Probation Supervision. New processes will ensure that practitioners are well-informed and equipped to implement measures that effectively manage public protection.

Gill, 2020	**Recommendation 1:** Ministry of Justice: The existing practice of prohibiting domestic abuse interventions from being offered to victims and perpetrators of domestic abuse whilst on remand in H.M. Prison be changed and such interventions be encouraged.	**MOJ**	There is an expectation that referrals are actioned where a need is identified. When Pre-Release teams interview people on remand and they request support, for women they can be referred to CRS women's services. For men or women, they can be advised to access counselling via the prison mental health services and supported to find community based services they can access on release. OMUs complete a screening process including identifying domestic abuse perpetrators so appropriate safety measures can be put in place. Interventions to address domestic abuse would form part of the Court process at the PSR stage or be included after conviction and sentence. Eligibility for accredited programmes is based upon an assessment of risk and need. Prisoners on remand are unlikely to have a full assessment of risk inclusive of any current alleged offence therefore unless they have a proven pre convictions history, there is no reliable assessment of current risk without 'assuming' their guilt to produce one. Additionally, offering interventions to those on remand could increase the risk of non-completion and associated reoffending risks. International reviews (McMurran & Theodosi, 2007) and our own evaluations in HMPPS (McGuire et al., 2008; Hatcher et al., 2012; Travers et al. 2013) have consistently shown that non-completers reoffend at higher rates than those of equivalent risk who were not assigned to a programme. This effect appears most pronounced for community programmes (McMurran & Theodosi, 2007). Evidence is however based on studies which mostly report on voluntary (participant-led) non-completion, which can include staff decisions to remove people due to them not complying with engagement rules, or other infringements which lead to them no longer being able to participate (e.g., breach, prison transfer). Putting people on a programme who do not have enough time to complete before the end is not recommended. Interventions teams are therefore cautioned about offering places to those on remand as it cannot be guaranteed that they will have sufficient time to complete the intervention.

William, 2019	**Recommendation 7 (concerning MoJ & HO):** The Dorset Community Safety Partnership reviews the Data Sharing Agreement with the Ministry of Justice - which would enable Magistrates Courts to contribute to future DHRs - when the agreement is complete and shares it with the Home Office.	**MOJ**	Dorset Community Safety Partnership was working with the MoJ to develop a Data Sharing Agreement which would enable Magistrates Courts to share relevant information with DHRs commissioned in this region. Following discussion with the DA Commissioner's Office, it was concluded the work should be paused to explore the wider issue of the need for Information Sharing Agreements with a range of organisations and agencies not currently listed in the statutory guidance. Ministry of Justice officials will pick this up with the Domestic Abuse Commissioners office.
Siobhan, 2019	**Recommendation 4:** The CSP should write to the Ministry of Justice to seek assurance that reviews into the effectiveness of domestic abuse offender behaviour programmes are in place to ensure that resources are effectively targeted and positive outcomes can be demonstrated.	**MOJ**	HM Prison and Probation Service (HMPPS) currently offers five Accredited Programmes that may be undertaken by those convicted of domestic abuse offences. These are the Building Better Relationships programme, Becoming New Me +, New Me Strengths, Building Choices (available in prisons and probation), and Kaizen (available in prisons only).
Salma, 2019	**Recommendation 6:** The Ministry of Justice to consider the learning from this case and review and / or issue appropriate guidance nationally to ensure consideration of domestic violence and abuse in the Pre-Action Protocol.	**MOJ**	Domestic abuse already has to be considered in civil litigation. The Domestic Abuse Act 2021 required new rules of court to make a special measures direction in relation to victims, which includes those victims of domestic abuse. The power to make rules or practice directions lies with the independent Civil Procedure Rule Committee (CPRC). The MoJ will work the CPRC to explore whether they consider that further amends are required.

Unpublished, 2019	**Recommendation 9.4:** The Home Office share this DHR with the Ministry of Justice in light of information available at Bail hearings as our understanding is the file size for Body Worn Camera footage cannot be currently accommodated in the Courts IT system.	**MOJ**	There are no IT issues around playing this evidence, providing the Prosecutor has downloaded it onto their laptop, rather than streaming via the CPS cloud-based evidence systems. This will enable the Prosecution Advocate to present it through their laptop via the Courts EPS. EPS (Evidence Presentation System) is a solution for the presentation of multimedia evidence which allows advocates to connect their laptops to the in-court display screens in the same manner as they would connect to an external monitor.
Adult K, 2018	**Recommendation 4:** Pre-Sentence Reports for Domestic Abuse Offences: The Ministry of Justice is asked to consider whether a standard should be set for pre-sentence reports involving domestic abuse, including those presentence reports which are required verbally and 'on the day', to routinely include evidence of police reports, necessitating the time being allocated for them to be carried out.	**MOJ**	The HMPPS Domestic Abuse Policy Framework was published in April 2020. It sets out the expectation that Probation Court staff seek information from police and Children's Services in all cases, where domestic abuse is a feature of current or previous behaviour, and where it is considered, the information will significantly affect the sentence. If it not available in time, probation staff can request an adjournment, but this is a matter for the Court.
Julie, 2018	**Recommendation 7:** That the report is shared with the Ministry of Justice in order that: • The implications of shortages of probation officers on professional standards are noted.	**MOJ**	Improving the quality of practice, particularly around protecting the public, is one of the Chief Probation Officer's top priorities, including through steps to improve Learning & Development and long-term transformative change to the way we assess risk, needs and strengths. However, much of that improvement relies on increasing staff capacity. We are undertaking record levels of recruitment and are positive that as staffing capacity increases, further improvements in the quality of our delivery and therefore in our inspection results will be seen.

	• Consideration is given, within the restructure of the probation services, to the professional registration of probation officers to ensure that individual standards of professional practice can be regulated. • Consideration is given to providing a list of internationally commensurate probation qualifications.		Following unification in 2021, significant staffing issues and poor practice was identified (to note, prior to unification, the performance of the private Community Rehabilitation Companies (CRCs) was judged by HMI Probation to be below standard). This coincided with the service starting to move out of alternative delivery regimes put in place to adapt to COVID-19 which also had significant impacts on core functions, creating backlogs and hampering the improvements unification was expected to deliver. Though a challenging baseline was inherited, and then compounded by COVID, delivery is now starting to stabilise with signs of improvement as the unified service is still maturing. Recruitment has seen significant improvement in staffing levels for the Service as a whole, with a 979 FTE increase in Probation Officers from June 2021 – September 2024, however recruitment and retention remain challenging in certain areas such as London and the South East against a competitive job market. Statutory guidance on the qualifications for Probation Officers has always applied and is published here: Statutory Guidance: Core probation roles and qualification requirements - GOV.UK. In terms of overseas qualified Probation Officers, we do not have or use a list of recognised overseas qualifications. Instead, we have a list of recognised qualifications awarded in England and Wales (E&W). We require anyone applying to a Probation Officer role who has an overseas awarded qualification to apply to ENIC - Home (European Network of Information Centres – UK) for a Statement of Comparability, to evidence that their qualification is the equivalent of the Professional Qualification in Probation (PQiP), which is the current recognised qualification for Probation Officers in E&W. HMPPS has introduced an internal probation professional register and professional registration standards to demonstrate the commitment of probation qualified staff to high standards of professionalism, and to provide assurance that those individuals authorised to assess and manage the risk of people on probation have the right qualifications, knowledge and skills to do so. On 30 September 2024, we made registration requirements mandatory for staff working in roles where there is an essential requirement to hold a probation officer qualification. To maintain and renew registration staff are required to keep learning and skills up to date. For the first year they will be required to have completed key learning on child and adult safeguarding

			and domestic abuse, and to reflect that learning in their practice. We have introduced the Probation Professional Register Panel to provide challenge and scrutiny to the operation and impact of the internal probation professional register's operation. The Panel membership includes external and internal subject matter experts and is chaired by an academic. The impact and effectiveness of professional registration will be quality assured as it embeds in its first full year of operation, through both qualitative and quantitative monitoring.
Scott, 2018	National recommendation 1: The National Criminal Justice Board use this case to review with multi-agency partners how people in Scott's situation – in and out of prison, with mental ill health, using substances, a history of homelessness and domestic abuse - get identified and supported by the system, including getting consistent proactive support for their mental health and ensuring they are housed appropriately.	MOJ	Other existing boards may provide a more appropriate forum for reviewing how effectively those with multiple complex needs are identified and supported. For example, the cross-government Reducing Reoffending Board brings together key departments and agencies to coordinate efforts to address the underlying causes of offending. The board promotes collaboration across government to ensure offenders can access the tools they need to move away from crime. It provides a forum for departments to strengthen multi-agency partnership working, building on learning from initiatives like the MHCLG-led cross-government Changing Futures programme, which seeks to test innovative approaches to improving outcomes for people experiencing multiple disadvantage. We will explore whether the recommendation could be considered as part of a future board.
Kayll, 2020	**Recommendation 7:** That the Home Secretary and Justice Minister duly consider the public's concerns in relation to serious crimes committed by prisoners unlawfully at large and maximise opportunities to prevent this before a finite period has elapsed. This is particularly important where previous convictions relate to either	MOJ	The Ministry of Justice takes the management of offenders in the community very seriously. There are risk assessments and strict licence conditions. We use Electronic Monitoring to closely monitor perpetrators of domestic abuse across the criminal justice system. We recently launched the DAPO pilot which allows for the use of GPS and Radio Frequency (RF) tags to monitor compliance with requirements of the new DAPO civil order in pilot areas. Separately, for individuals on release from prison, the Domestic Abuse Perpetrators on Licence (DAPOL) project tests the use of EM to monitor compliance with licence conditions in 8 probation regions, including London. RF, GPS and Alcohol tags are all available to the courts for community-based sentences to protect existing and future victims of VAWG.

	violence, domestic violence, or coercive control, and introduction of further legislation, national protocols and operational guidance should be considered.		
William, 2019	**Recommendation 11 (concerning MoJ & HO):** That Safer Somerset and Dorset Community Safety Partnership write to the Home Office to alert them to the issue so that they can liaise with the Ministry of Justice and consider what action is necessary.	**HMPPS**	This recommendation is referring to the comprehensiveness of pre-sentence reports. HMPPS are working with the Home Office and the NPCC on exploring the feasibility and benefits of direct access for probation staff to the Police National Database (as part of HMPPS's Pathfinder to Improved Pre-sentence Advice (PIPA) project). The PND is a national information management system.
Mr E, 2019	**Recommendations for National Probation Service Recommendation 1:** Irrespective of the gender make up of victims and perpetrators active checks should be made with the police when writing reports for courts no matter what type of report or timescale. If the information cannot not be accessed in the time frame allowed, an adjournment should be requested to avoid re-victimisation.	**The National Probation Service**	HMPPS Domestic Abuse Policy Framework was published in April 2020. HMI Probation's report 'A thematic inspection of work undertaken, and progress made, by the Probation Service to reduce the incidence of domestic abuse and protect victims' noted the improvements to the leadership of domestic abuse work at a national level, and the comprehensive guidance on managing domestic abuse work provided by the Domestic Abuse Policy Framework. The Domestic Abuse Policy Framework sets out the expectation that Probation Court staff seek information from police for Pre-Sentence Reports where domestic abuse is a feature of current or previous behaviour and if the information cannot not be accessed in the timeframe allowed, an adjournment should be requested. HMPPS have continued to work with the police to improve access to domestic abuse information. This includes pursuing probation managed access to local police databases as well as a pilot to access the Police National Database (PND). HMPPS data in December 24 indicates that probation staff have significantly improved their performance in gathering information from police and children's services.

Mr E, 2019	**Recommendation 2:** The alcohol screening tool should be completed in all relevant cases at the report stage to ensure the correct targeting of provision takes place.	**The National Probation Service**	A revised Probation Service Court Services Policy Framework was published in January 2025. This sets out the requirement that the substance misuse screening tool should be completed during all pre-sentence report interviews where there are current or historic concerns around substance misuse.
Mr E, 2019	**Recommendation 3:** Report writers and court probation staff should give active consideration to continuing to protect the victim when there have been bail conditions to prevent contact between victim and perpetrator.	**The National Probation Service**	The HMPPS Domestic Abuse Policy Framework was published April 2020. This makes it clear that Probation Court staff must prioritise immediate action to protect victims and children, for example when protective bail conditions have been lifted after sentencing, establishing immediately where the individual is living, and consider any measures required, including restrictive requirements to protect victims and children.
Mr E, 2019	**Recommendation 4:** When probation officers are undertaking OASys assessments, where there is domestic abuse, regular contact with the police needs to be written into the risk management plan section and then regular checks undertaken.	**The National Probation Service**	The HMPPS Domestic Abuse Policy Framework sets out the expectation that practitioners must outline how they will monitor risk to identified and potential victims throughout the sentence within their Risk Management Plan. We have also developed a guidance document 'Domestic Abuse Four Pillars of Risk Management – A Quick Guide' in April 2020 to ensure staff specifically consider actions they need to consider to manage the risk of further domestic abuse. It specifically requires practitioners to detail the frequency and triggers for ongoing domestic abuse checks.
Mr E, 2019	**Recommendation 5:** When offenders attend the office with injuries, as well as active questioning in the interview, concerns should be triangulated with the police.	**The National Probation Service**	The Risk of Serious Harm Guidance published April 2020 identifies common themes related to escalating risk to support staff to recognise and be able to take prompt action under those circumstances. One of these specific circumstances is deterioration in the individual's lifestyle or presentation. The guidance encourages staff to share information and ask for updates from partner agencies as part of reviewing their risk management plan and determining appropriate actions.

			HMPPS has devised a new Continuous Professional Development risk learning product for experienced staff which is due to be launched in April 2025. This 2 day learning includes skills practice to have difficult conversations with offenders, challenge biases that may impact on our risk assessment and management and share information with managers and other agencies in order to have a more holistic understanding of the individual we are working with.
Mr E, 2019	**Recommendation 6:** When cases are assessed as medium risk of harm and there are concerns as to the safety of ongoing living arrangements home visits should be undertaken.	**The National Probation Service**	The HMPPS Home Visit Policy Framework was published in November 2021. This sets out the expectations for when Probation Practitioners should conduct Home Visits. A home visit should be conducted within 6 weeks of the start of supervision for individuals who are a medium risk of serious harm regardless of sentence type. It further outlines that where new or escalating concerns arise, a home visit should be undertaken at the earliest opportunity.
Mr E, 2019	**Recommendation 7:** When a case is escalated to high risk this should trigger a home visit automatically.	**The National Probation Service**	The HMPPS Home Visit Policy Framework was published in November 2021 and sets out the expectations for when Probation Practitioners should conduct Home Visits. This makes clear that a home visit must be conducted upon assessment of a high risk of harm if this occurs during the supervision period or within 15 working days if assessed as high risk of harm at the start of supervision.
Mr E, 2019	**Recommendation 9:** When offenders state they are attending various provisions in the community this should always be triangulated.	**The National Probation Service**	HMPPS Risk of Serious Harm Guidance was published in 2020 to support practitioners in their assessment and management of risk of harm and improve consistency of approach across HMPPS. The guidance covers the need to find good sources of information and verify information. It also sets out that that Risk Management Plans should involve all relevant agencies. HMPPS have revised the suite of risk and domestic required learning for all new and experienced practitioners. These revised products focus on the need to ask questions, gather information from a variety of sources and engage other agencies.
Mr E, 2019	**Recommendation 11:** NPS and police to discuss whether WWOB warrants can have a priority rating to ensure that those taken out on high risk of harm serious offenders are executed swiftly.	**The National Probation Service**	The role of HMPPS is to initiate a return to Court or a recall. Where a court issues an arrest warrant it is for HMCTS to determine whether it should be executed by HMCTS enforcement or the police. Where a warrant is allocated to the police the execution of arrest warrants is an operational decision for policing.

Edward, 2020	**Recommendation 1:** The Probation Service: The Probation Service National Team Steering Group - Assessing Risks, Needs and Strengths review OASys to ensure it reflects the learning and impact of the presence of ACEs on people on Probation and in Prison. As this case demonstrates that the assessment of factors linked to offending in OASys, which are: • Accommodation. • Education, training and employability. • Financial management and income. • Relationships. • Lifestyle and associates. • Drug misuse. • Alcohol misuse. • Emotional wellbeing. • Thinking and behaviour. • Attitudes. • Health and other considerations. and the Risk of Serious Harm section failed to capture the experience and impact of ACEs on all three brothers.	**The National Probation Service**	The Assessing Risks, Needs and Strengths (ARNS) project will deliver an organisational change in the approach to how assessments, risk management and sentence planning is undertaken in practice, enabled by a new digital service. The ARNS project launched their Minimum Viable Product (MVP) in December 2024 with 5 Probation Practitioners testing the new need assessment and sentence plan sections. The MVP currently retains the specific questions from OASys in relation to assessing individual's experiences of childhood and associated practice guidance. Further planned development work on needs sections and the risk section, within ARNS, will ensure that information is presented together to support staff to analyse key areas of risk holistically. The specific consideration of Adverse Childhood Experiences (ACEs) is embedded within the ARNS project plan as a discrete workstream for the post MVP project stage. To date, the project has begun early scoping activities which have included inputs from academics in relation to the evidence on ACEs and other difficult circumstances/ histories that people on probation and in prison might have. ACEs has also been considered as part of a broader considerations on enhancing the adoption of trauma-informed approaches as part of assessment and sentence planning activities. The project has also been consulting people with lived experience of prison and/or probation as part of this scoping work. Recommendations will also be considered alongside to take opportunities to enhance both the new digital service and the learning and development offer that supports desired practice changes.

Edward, 2020	**Recommendation 2:** The Probation Service: The Probation Service National Team sponsor ACEs training with learning outcomes that focus on i) the impact of ACEs on physical and emotional development, ii) identifying and evidencing the presence and impact of ACEs, iii) incorporating this information into NPS assessment documents - OASys, Parole Reports, PSRs etc. This to be targeted at all staff who supervise service users and their line managers.	**The National Probation Service**	We launched Trauma Informed Practice Awareness on 28 October 2024. This learning product contains content about Adverse Childhood Experiences and is required learning for all operational Probation staff.

Recommendations made for NHS England

DHR	Recommendation	Government department/ public body responding	Response
Unpublished, 2020	**Recommendation 7:** NHS England, as the commissioner of Child Health Information Services (CHIS) 0-19 should ensure that local commissioners and providers of the 0-19 service have an up-to-date position on the transfer of records when children move areas and any action that needs to be taken to ensure that important safeguarding information is not lost on transfer.	**NHSE**	For this report NHS England provided an update on the progress of recommendations. They could not however, provide a detailed response due to a lack of formal recording against individual recommendations at the national level. Each of the 42 Integrated Care Boards (ICBs) are executively accountable for the verification of health recommendations and feedback on pre-published DHRS as part of the local CSP's DHR process.

Mr M, 2019	**Recommendation 15 for NHS England:** NHS England should share learning identified with the First Tier Tribunal (Mental Health) regarding providing guidance to families about how any confidential information they share may be used.	**NHSE**
Mr M, 2019	**Recommendation 20 for NHS England:** NHS England should gain assurance about the quality of private PICU provision following the principles of host commissioning arrangements. This is to ensure that the local CCG/ICS monitors and has quality oversight for providers in their locality. Quality issues should be raised via the quality system oversight groups.	**NHSE**
Mr M, 2019	**Recommendation 26 for NHS England:** NHS England should share the learning with the First Tier Tribunal (Mental Health) about parricide and risk to family members, and how sensitive third-party information is managed.	**NHSE**
Mr M, 2019	**Recommendation 25 for NHS England:** NHS England should share learning identified about parricide with the Home Office.	**NHSE**

Francis, 2019	**Recommendation 8.8 for Primary Care Services England:** Primary Care Services England should consider how GP2GP record transfers could be improved and the Black Country and West Birmingham CCG should also encourage as best practice direct conversations between GP practices where there are concerns that a vulnerable adult has changed practice.	**NHSE**	
Frank, 2019	**Recommendation 5.74:** The fourth recommendation is for the NHS England team to re-visit the Trust after six months. The aim is to examine reports and data relating to the above recommendations and discuss with the independent team.	**NHSE**	

Frank, 2019	**Recommendation 6.6.2:** The NHS England Independent Report makes comment and a recommendation about this issue and states: "It is not uncommon for misunderstandings (about protocols and the scope of the law) to occur in such circumstances. We would urge the Trust to work with the police to develop a policy or memorandum of understanding to cover the occasions when a patient detained under Section of the MHA (when a warrant for a S.135 would not be needed) has to be returned and is behaving in a threatening manner. This might usefully also clarify arrangements for detention under S.1363 of the MHA and the arrangements for removal to the Health Based Place of Safety (HBPOS)4."	**NHSE**	
Mrs D, 2019	**Recommendation 4:** Using Learning: Learning from the review may also be used for national learning purposes, communicated through the Home Office Public Protection Unit specifically:	**NHSE**	

	1. That all Health and Social Care support services to take a Think Family approach in their assessments and plans for service users, particularly when assessing risk to others. 2. For NHS England to reinforce the need for GPs, when treating depression, to be mindful of risks associated with domestic violence and abuse and to use professional curiosity when exploring high risk behaviours and emotional instability of patients. 3. Bodies such as National Institute for Health and Social Care Excellence should consider incorporating into relevant Quality Standards (such as suicide prevention and coexisting severe mental illness and substance misuse) a risk assessment process for use when people do not attend appointments. The risk assessment should include information from carers or family members of the individual who has not engaged and the impact on them of the person's mental ill-health and any coexisting substance misuse.		

Kelly, 2019	All NHS Safeguarding integration projects provide a solution for how risks presented to and by a patient are documented within clinical records, so that NHS staff do not inadvertently increase their patient's risk of harm from or to others.	**NHSE**
Scott, 2018	**National recommendation 2:** NHS England to ensure that, at regional and national level, patients with severe mental health issues (such as schizophrenia) requiring regular antipsychotic medication have clear and specific care plans that identify their regular medication needs. This information must be contemporaneous and should be visible across all healthcare systems, including prison, and accessible as patients are transferred and move across care locations. NHS England to update Safer Gloucestershire every six months until complete. As part of this, NHS England to consider the value and viability of a lead professional for this patient group who could follow up as a patient moves between institutions (e.g. mental health in-patient care) and the community. As the recommendation above will take time to implement, the following recommendations are included to improve the existing process.	**NHSE**

Scott, 2018	**National recommendation 3:** NHS England to ensure that community GPs promptly provide comprehensive details of a patient's health records when asked by a prison healthcare team for this information. This should include details of the prisoner's history of both physical and mental health problems.	**NHSE**
Scott, 2018	**National recommendation 4:** NHS England to develop capability for prison healthcare to access Summary Care Records for prisoners so that prisoners' healthcare needs are addressed immediately.	**NHSE**
Andrea, Jordan, Sammy, 2015	**Recommendation 2:** NHS England to ensure that health professionals giving a terminal diagnosis organise for immediate support to be available to patients to discuss the impact of their illness and the prognosis on their life, and the support likely to be needed and available.	**NHSE**

Recommendations made for Home Office (HO)

DHR	Recommendation	Government department/ public body responding	Response
Lucy, 2020	**Recommendation 21.1:** The Review recommends that the Home Office takes action to amend the wording of information leaflets and statutory Guidance relating to Domestic Homicide Reviews to reflect the increasing number of domestic abuse related suicides.	HO	The responses to recommendations suggesting changes to Domestic Homicide Reviews (DHRs) have been grouped together: The Home Office consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews, and we are currently analysing the responses received. We agree that additional information on domestic abuse related suicides was required, and this has been included in the draft guidance. Additionally, the Home Office amended the legislation underpinning DHRs via the Victims and Prisoners Act 2024 so that a DHR is commissioned when the death has, or appears to have, resulted from domestic abuse as defined by the Domestic Abuse Act 2021 and amends their name to **'Domestic Abuse Related Death Reviews'** to reflect the range of the deaths which fall within the scope of a review **(these changes are expected to commence in 2025).** Following the implementation of these changes, the language specific to homicides in relevant materials, such as the leaflets, will be revised to reflect the range of the deaths that fall within the scope of a review, including domestic abuse related suicides.
Lucy, 2020	**Recommendation 21.2:** As this review is not unique in finding that the families of the deceased and her partner were confused by the title of this review "Domestic Homicide Review" resulting in missed opportunities for the safety of future partners; it is recommended that consideration should also be given to changing the title to 'Domestic Abuse related Death Reviews'.	HO	
Patrick, 2020	**Multi-Agency Recommendation 1:** The Home Office should revise the statutory guidance to address the specific challenges of reviewing a death by suicide.	HO	

Patrick, 2020	**Recommendation 9:** Safer Somerset Partnership to request the Home Office consider updating the Multi-Agency Statutory Guidance for a Conduct of a Domestic Homicide Review 2016 to include specific guidance where a person may have taken their own life. This review to include recommended terminology to replace the DHR use of homicide/victim/ perpetrator to make it more transparent to a family why a review is required.	HO	
Daisy, 2019	**Recommendation 3:** For the Home Office to consider whether the methodology and guidance for a DHR could be modified for a more proportionate review, where the perpetrator is diagnosed as not of sound mind due to dementia and there is no evidence to suggest any historic domestic abuse.	HO	The Home Office consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews (DHR) and we are currently analysing the responses received. Further guidance on managing reviews that encounter issues with mental capacity and historic domestic abuse, or lack thereof, will be considered and provided where appropriate. The current statutory guidance sets out that the Chair and review panel should consider the scope of the review process for each homicide and draw up clear terms of reference which are proportionate to the nature of the homicide. Safeguarding Adult Reviews (SARs) can also be considered, instead of DHRs or joint reviews, as we recognise that undertaking multiple reviews can be burdensome. Where appropriate, the Home Office is supportive of a proportionate approach to undertaking statutory reviews. Additionally, the Ministry of Justice and Department for Health and Social Care collaborated on the Mental Capacity Code of Practice; this includes mental capacity assessments and codes of practice.

Andrea, Jordan, Sammy, 2015	**Recommendation 1:** Home Office to launch a campaign to help the public understand coercive control and to direct them to local sources of support. Campaign to target cultural and social norms that support, accept or disguise coercive control, particularly acknowledging the issue of shame.	**HO**	The response to recommendations regarding national campaigns have been grouped together: The Home Office has previously delivered a multi-year national campaign on violence against women and girls, which included information on domestic abuse and specifically controlling and coercive behaviour. A television advert for the campaign depicted specific scenarios highlighting and raising awareness of these types of abuse. This year, the government will deliver a programme of campaigns to prevent VAWG through awareness-raising and behaviour change communications. Consideration is being given to the scope for this campaign activity to address these specific behaviours. To Be Completed by end of 2025.
Stacey, 2021	**Recommendation (s) from Stacey's family:** Stacey's family believe that there should be a national campaign supported by the Home Office to provide more information on television about domestic abuse and in particular, coercive control to raise public awareness and tell victims where they can get support.		
Simran, 2019	**Recommendation 5 for Home Office/Designate Domestic Abuse Commissioner:** Research into barriers to engagement with - and reasons for disengagement from - police and domestic abuse services, from victims within Black and Asian communities to be undertaken.	**HO**	The response to recommendations regarding minority communities and barriers to reporting have been grouped together: This Government understands the additional barriers to accessing support that victims within Black and Asian communities can face. We are also considering in particular how best to support migrant victims and are engaging closely with domestic abuse services to identify initiatives which will support migrant victims to report to the police and improve the support migrant and asylum-seeking victims of VAWG receive from Immigration Enforcement. We are looking at the additional barriers to accessing support that Black and Asian communities face as part of the upcoming VAWG Strategy.

Olga and Viktor, 2019	**Recommendation viii:** Recommendation to the Domestic Abuse Commissioner to highlight the considerable fear some people have of reporting to the police, due to their history of a fraught relationship with the police either here or in other countries and the hostile environment created towards migrant communities, refugees and asylum seekers in this country. Also, to bring to the Commissioner's attention the issue of the police being 'weaponised' by perpetrators leading to increased fear of victims in engaging with support. To ask the Commissioner to consider these issues in relation to increased police and public awareness of DV and access to support for Black, Minority and Ethnic and migrant communities.		
Suzanne, 2021	**Recommendation 10:** That Manchester Community Safety Partnership writes to the Home Office to suggest that follow up interviews with perpetrators should take place outside the DHR process at a time when perpetrators may be better placed to make a more valuable contribution to the aims of DHRs.	**HO**	The Home Office recently consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews (DHRs) and we are currently analysing the responses received. The draft guidance includes a dedicated section outlining best practice for engaging with perpetrators in recognition of the need to set out more information on this area. This sets out that before approaching a perpetrator, the DHR Chair should discuss their plans with the family and friends of the victim and take their views into consideration. Further guidance on engaging perpetrators in the DHR process will be considered and provided where appropriate. Additionally, we will continue to engage with the domestic abuse sector, including those organisations who work with perpetrators, to develop policies to achieve the Government's ambition to halve VAWG over the next decade.

Rosita, 2021	**Recommendation 1:** Home Office to provide a framework for CSP's to transparently demonstrate the timely delivery of recommendations and findings emerging from DHRs. Following a DHR, a structured Home Office framework would greatly assist CSP's to drive timely completion of action plans and the implementations of recommendations by all agencies.	HO	The Home Office has worked with the Domestic Abuse Commissioner to implement a Domestic Homicide Review (DHR) Oversight Mechanism, which will support areas to implement DHR recommendations and actions and escalate structural problems with implementation. It will also identify and analyse key themes within the recommendations, to improve the learning across England and Wales. Additionally, the Home Office recently consulted on an updated version of the statutory guidance that underpins DHRs, and we are currently analysing the responses received. Further information on national and local oversight and the implementation of learning has been included in the draft guidance.
Unpublished, 2021	**Recommendation 5:** Police National Database: The Home Office to review access to the Police National Database for domestic abuse cases where there is information that a perpetrator of domestic abuse has had police contact in another force area.	HO	The Home Office led Police National Database (PND) transformation programme will increase the number of concurrent PND users by Summer 2026. This will mean police forces will be able to assign access to better support all investigations including domestic abuse. In the meantime, the Home Office will continue to support the work of the PND national steering group to ensure effective allocation of licences. National policing assign PND licences according to policing priorities and meet several times a year to review the effectiveness of the allocation. This often includes groups of forces using pooled licences to make most effective use of PND capacity. This could include provision for forces to undertake appropriate checks routinely for domestic abuse. We are also aware of the lack of information sharing between different agencies across the criminal justice system and are considering solutions to improve information sharing between the courts and police on protective orders. **Plan to be completed by December 2025 and rolled out to align with capacity uplift in Summer 2026.**

Erin, 2021	**Recommendation 17.1.5:** For the purposes of DHRs, the Home Office should seek to achieve agreement with relevant authorities on the provision of pertinent information within the Common Travel Area.	**HO**	The Home Office is exploring potential levers for information sharing in order to strengthen collaborative working for Domestic Homicide Reviews going forward. However, any proposed changes to the Common Travel Area (CTA) would need to be put forward to the Cabinet Office, who hold responsibility for the oversight of the CTA policy.
Nicky, 2020	**Recommendation 6:** Serial domestic abusers: In the development of the national domestic perpetrator strategy, the Home Office considers commissioning research into whether a high-risk domestic abuser will be a high-threat domestic abuser to future partners and by virtue of their serial offending, are worthy of enhanced intervention, management and opportunities for change.	**HO**	Between December 2020 and March 2021, the Home Office launched a call for evidence to gather information to inform the Tackling Violence Against Women and Girls Strategy 2020-24 and the Tackling Domestic Abuse Plan which was published in 2022. The Plan committed to invest £75 million over three years into tackling domestic abuse perpetrators, which included funding for further research to improve knowledge of what works to reduce reoffending, and launched the Domestic Abuse Perpetrators Research Fund. Research on areas including "Key Lessons on 'what works' with Domestic Abuse Perpetrators" has been published on GOV.UK.
Lucy, 2020	**Recommendation 21.3:** 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	**HO**	The Home Office does not take the view that Domestic Homicide Reviews (DHRs) fall within the categories of inquests, investigations and inquiries mentioned in the judgement of R (On the application of the Secretary of State for Transport) v. HM Senior Coroner for Norfolk [2016] EWHC 2279 (Admin). As outlined in the DHR statutory guidance, DHRs "are not inquiries into how the victim died or into who is culpable, nor are the DHRs specifically part of any disciplinary inquiry or process." The Home Office acknowledges there may be some overlapping processes between Coroners' Inquests and DHRs. However, each have different purposes and outcomes. There is currently no framework through which an Inquest will act as the sole provider of information to DHRs, as such agencies must engage with both processes to provide information where appropriate.

	agencies need only to respond to the Inquest and the information will be shared with other statutory reviews. This issue is likely to come up again in Suicide DHRs so Legal clarity would be beneficial.		
Krystyna, Elzbieta, 2020	**Recommendation 6:** Increasing the evidence base around domestic abuse and domestic homicide in the Polish community: In view of the proportionally high number of domestic homicides involving Polish communities, the Home Office to consider undertaking a composite review of their corresponding domestic homicide reviews in order to share learning and best practice concerning this marginalised group.	HO	The Home Office is working to develop the evidence base on domestic abuse related deaths, including through funding research by the National Police Chiefs' Council's Domestic Homicide Project, which captures information from all 43 police forces in England and Wales. Across the three-year dataset (April 2020 – March 2023), the project highlighted the prevalence of Polish victims of domestic homicides as the second most common after victims of British nationality across the three-year dataset (24 out of 723 deaths, 4%). For more information on the project, please see https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/. The Home Office is also considering the additional barriers different groups of victims can face to accessing support such as ethnicity, disability or immigration status.
Maria, 2020	**Recommendation 4:** The Home Office and Government: That the Home Office and Government consider the learning from this case in relation to third-party disclosure of information when reviewing current legislation and guidance in relation to domestic abuse.	HO	The Home Office consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews (DHRs) and we are currently analysing the responses received. Further guidance on the disclosure of information will be considered and provided where appropriate.

Mary S, 2020	**Recommendation 10:** That the Chair of the Community Safety Partnership writes to the Home Office to request that any future revision of the statutory Domestic Homicide Review guidance considers further clarity in respect of the role of both GP's and any services commissioned to provide those.	**HO**	The Home Office does not have a record of receiving correspondence from the Chair of the Community Safety Partnership on this matter. However, the Home Office consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews (DHRs). The draft guidance includes some information on clinicians and health professionals, notably the importance of sharing all relevant information about the victim and, where appropriate, the perpetrator; this is supported by the Department of Health and Social Care. Further guidance on the role of GPs and any related services commissioned to provide information to DHRs will be considered and provided where appropriate.
Unpublished, 2019	**Recommendation 9.1:** Advice to be sought from the Home Office on the effectiveness of DASH as a risk checklist in cases where an adult child poses a threat to a parent.	**HO**	The Home Office recognises the challenges within the existing system to risk assessment and management and is committed to ensuring that the multi-agency approach effectively responds to victims. The Home Office are planning for a review of the way risk to domestic abuse and wider VAWG victims is assessed and managed which will include working with other Government departments, policing, domestic abuse sector specialists and ensuring that survivor voices and lessons learned from DHRs are represented.
Unpublished, 2019	**Recommendation 9.14:** That the Authority request that the Home Office commission the development of a brief and user-friendly Domestic Abuse assessment tool that can be used for non-intimate partner and inter family violence and abuse with confidence.	**HO**	

William, 2019	**Recommendation 5 (concerning Home Office):** The Safer Somerset Partnership and Dorset Community Safety Partnership jointly write to the Home Office to recommend a review of guidance in respect of MARAC to MARAC referrals to include consideration of such referrals when a perpetrator moves between areas.	HO	
Senai, 2020	**Recommendation 6:** Home Office: The Home Office to produce a briefing paper of guidance on how to better assess risk in family violence cases.	HO	
Daisy, 2020	**Recommendation 1:** That the Home Office consider research into the risk of suicide after separation for vulnerable victims where high level coercive control is present. If appropriate this could be included in domestic abuse risk assessments going forward.	HO	The Home Office recognises the challenges surrounding suicide following domestic abuse, particularly when reporting is less consistent and so, data is likely to underestimate. We are working to develop the evidence base on suicides that follow domestic abuse, including through funding research by the National Police Chiefs' Council's Domestic Homicide Project, which captures information on suicides with a known history of domestic abuse from all 43 police forces. Across the four-year dataset (April 2020 – March 2024), the project highlights that coercive or controlling behaviour is a significant risk factor in cases of suspect victim suicides following domestic abuse. For more information on the project, please see https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/ Furthermore, the Home Office are planning for a review of the way risk to domestic abuse victims is assessed and managed which will include working with other Government departments, policing, domestic abuse sector specialists and ensuring that survivor voices and lessons learned from DHRs are represented.

Marjorie, 2019	**Recommendation 4 (concerning Home Office):** The Safer Waverley Partnership endorses and supports the recommendation suggested in the draft guidance "Firearms Licensing Statutory Guidance for Chief Officers of Police", and recommends that the circumstances of this review are shared with those within the Home Office responsible for those consultation, to assist in the continuance with the consultations with other professional bodies and to reach a positive conclusion as soon as possible.	HO	Statutory Guidance to Chief Officers of Police on firearms licensing was issued on 1 November 2021. This followed a public consultation from July to September 2019. The Statutory Guidance details the assessment of suitability that the police must undertake before issuing or renewing firearms certificates, and it is designed to ensure greater consistency in licensing decisions taken by police forces. The Statutory Guidance was refreshed and re-issued on 14 February 2023 after a review following its first year of operation. The Statutory Guidance introduced the requirement that the police must be provided with relevant medical information from an applicant's GP or other GMC registered doctor at the time of making an application for the grant or renewal of a firearms certificate and, if not provided, the application will be refused. To strengthen and support these medical arrangements, the government has worked with the Department of Health and Social Care, NHS England and the British Medical Association to introduce a digital marker for use on GP medical records to support information sharing between doctors and the police. The digital marker supports the continuous monitoring of firearms certificate holders by the police, as it alerts the GP to relevant changes in a certificate holder's health, so that they can notify the police. The rollout of the digital marker to GP surgeries in England started in July 2022 and is now complete.
Emma and Child A, 2019	**Recommendation 1:** The Home Office to work with other government departments to develop a cross-government definition of AFV/CPV. This should include developing policy and practice guidance for AFV and refreshing the current CPV guidance (to include adult children).	HO	All situations with potential domestic abuse should be taken seriously irrespective of the relationship between perpetrator and victim. Sections 28-31 of the Domestic Abuse Statutory Guidance cover abuse by family members, which includes abuse by adult children towards parents or those in a parental role. The guidance highlights that patterns of abuse within the family may differ to those found in cases of intimate partner abuse, and that services should consider this and ensure assessment procedures are used appropriately to identify risk. The Home Office ran a consultation on the definition of child to parent abuse between November 2023 and February 2024, that sought to agree terminology where children under the age of 16 (and so outside of the statutory definition of domestic abuse) are displaying harmful behaviours towards parents and/or caregivers. The findings of the consultation will be considered in the upcoming VAWG Strategy, and a response to the consultation will be published in 2026. Due to be completed in 2026.

Olga and Viktor, 2019	**Recommendation vi:** Recommendation to the Home Office and the Domestic Abuse Commissioner, to further consider measures to identify adult child to parent abuse and to advise all (non-DA specialist) Helplines on training staff in adult child to parent abuse.	**HO**	All situations with potential domestic abuse should be taken seriously irrespective of the relationship between perpetrator and victim. Sections 28 – 31 of the Domestic Abuse Statutory Guidance cover abuse by family members, which includes abuse by adult children towards parents or those in a parental role. The guidance highlights that patterns of abuse within the family may differ to those found in cases of intimate partner abuse, and that services should consider this and ensure assessment procedures are used appropriately to identify risk. The Home Office is currently reviewing its helpline provision for victims of VAWG, this review includes understanding how VAWG helplines are situated within the wider system as part of the upcoming VAWG Strategy, expected in summer 2025.
Olga and Viktor, 2019	**Recommendation vii:** In responding to DA, including recognising, and giving safe and accurate advice. Helplines to include those for older people, general advice, and mental health helplines.	**HO**	The Home Office is currently reviewing its helpline provision for victims of VAWG, this review includes understanding how VAWG helplines are situated within the wider system. The Home Office currently funds Hourglass, a specialist helpline for older victims of abuse and the Department for Health and Social Care currently provides funding for a 24/7 suicide prevention helpline (https://www.gov.uk/government/news/10-million-to-support-suicide-prevention).
Sajwa, 2019	**Multi-Agency recommendations:** Recommendation 1: The Home Office to review funding arrangements for the provision of specialist and expert advocacy for the families of victims who reside outside of the UK.	**HO**	Given wider funding pressures, it is not possible to fund support for families outside the UK at this time. The Home Office provides signposting to resources here: Domestic abuse: how to get help - GOV.UK and the Ministry of Defence provides signposting to support for members of the armed forces and their family here: https://www.gov.uk/government/collections/domestic-abuse-guidance-and-support-for-the-armed-forces-community.

Chiman, 2019	**Recommendation 8:** The Home Office should consider what policy and training implications are raised through the review in respect of: a. Level of knowledge about honour-based abuse. b. Provision of specialist advice about honour-based abuse to Tribunals dealing with requests for permission to remain in the UK when there are allegations about honour-based abuse. c. Recording and linking information about perpetrators and victims of domestic abuse and so called honour-based abuse. d. Clarifying arrangements for risk screening and safeguarding oversight when responding to requests for relocation as a consequence of honour-based abuse.	**HO**	The Home Office takes seriously its responsibility to raise awareness about 'Honour'-Based Abuse (HBA), including to increase levels of understanding in affected communities and to train the relevant front-line professionals. To meet these goals, the Home Office has been working closely with the HBA sector and communications specialists to deliver a national campaign to raise awareness about 'Honour'-Based Abuse. The campaign concluded in March 2025 and included community events run by community advocates, paid social media content and special programmes on regional radio and podcasts. The Home Office has also reviewed the range of materials it issues on FGM and forced marriage to support professionals to help them understand these crimes and support victims and survivors. This includes publishing statutory muti-agency guidance and making available free e-learning for frontline staff in healthcare, police, Border Force, and children's social care. Over 54,000 people completed the free FGM eLearning course in 2023. We also have a range of materials to raise awareness of forced marriage with professionals, including free eLearning, which over 6,000 professionals have completed in 2023, and a forced marriage resource pack which is available. Additionally, the joint Home Office-FCDO Forced Marriage Unit (FMU) also continues to deliver awareness raising and training workshops to communities and professionals. For instance, the FMU carries out regular training sessions for police officers and for social workers. In 2023, the FMU also introduced bespoke workshops for registrars of marriages and their staff. In 2023, the FMU delivered awareness raising to 3,656 professionals in England and Wales. The Home Office engages closely with policing and the criminal justice system to create conditions that improve prospects for assessing HBA risk and evidencing as well as prosecuting HBA-related offences. To support the police and Crown Prosecution Service in investigating and prosecuting HBA, a joint CPS and Police Joint Protocol is in place. The CPS are also able to provide early investigative advice to the police in FGM cases. Lastly, HBA officials continue to work alongside immigration colleagues in the Home Office to scope measures to improve detection and safeguarding where there are HBA risks are present in the immigration system or can be mitigated via immigration measures.

SWO3	**Recommendation 10:** The Home Office review how MARAC intelligence is stored and used prior to a subject already known to Police and other Agencies being sentenced by a Criminal Court.	**HO**	The Home Office recognises the challenges within the existing system to risk assessment and management and is committed to ensuring that the multi-agency approach effectively responds to victims. The Home Office are planning for a review of the way risk to domestic abuse victims is assessed which will include working with other Government departments, policing, domestic abuse sector specialists and ensuring that survivor voices and lessons learned from DHRs are represented. – to be addressed in the VAWG Strategy, 2025.
SWO3	**Recommendation 11:** The panel asks that the Home Office to explore a process for the multi-agency management of repeated threats to kill and harm.	**HO**	The Home Office recognises the challenges within the existing system to risk assessment and management and is committed to ensuring that the multi-agency approach effectively responds to victims. The Home Office are planning for a review of the way risk to domestic abuse and wider VAWG victims is assessed and managed which will include working with other Government departments, policing, domestic abuse and VAWG sector specialists and ensuring that survivor voices and lessons learned from DHRs are represented. The Government have been clear that the most prolific and harmful perpetrators will be relentlessly targeted, using tactics normally reserved for terrorists and organised crime. From February 2025, offenders convicted of coercive and controlling behaviour who are sentenced to 12 months or more, will automatically be managed under Multi-Agency Public Protection Arrangements (MAPPA). This new change places coercive and controlling behaviour on an equal footing with serious and/or violent offenders and creates greater consistency in how these domestic abuse offenders are managed in the community. The Home Office is also working with the National Police Chiefs' Council and College of Policing to develop a national framework for utilising data-driven tools and algorithms to track and target high-harm offenders involved in domestic abuse, sexual assault, harassment, and stalking. These tools, used alongside police officers' expert judgment, will help law enforcement prioritise and pursue the most dangerous offenders, enabling a more effective allocation of police resources. The technology aims to assist in building risk profiles for both perpetrators and victims, enabling law enforcement and partner agencies to implement robust management plans that disrupt offenders' behaviour and enhance victim safety. Further measures to tackle domestic abuse perpetrators, including the most dangerous, serial perpetrators, will be included in the upcoming VAWG Strategy.

Kayll, 2020	**Recommendation 8:** That the Home Office in its forthcoming review of DHR statutory guidance gives consideration as to clarification in relation to the sharing of parallel review reports with DHR Chairs to reduce duplication and assist in expediting reviews.	HO	The Home Office recently consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews (DHRs) and we are currently analysing the responses received. The draft guidance includes a dedicated section outlining best practice for conducting DHRs in parallel with other reviews, including Mental Health Homicide Reviews, Safeguarding Adult Reviews, Child Safeguarding Practice Reviews and Serious Further Offence Reviews. Further guidance on parallel review will be considered and provided where appropriate.
Adult A, Child 1 and Child 2, and Adult B, 2024	**Recommendation 8:** The current timescale of holding a gun license for 5 years without any form of updating information, monitoring or refreshing of holder's circumstances, should be reviewed - it is too long. The Safer West Sussex Partnership request that the Home Office, in collaboration with Police authorities and the British Medical Association, should work towards creating an annual system whereby licensed gun holders should verify their suitability to own a gun. Any system introduced should not only be Page 2 of 5 consistently applied across all applicable jurisdictions, but its effectiveness evaluated. Home Office guidance should be amended to reflect these changes. The applicant or licensee should be required to pay a processing fee that allows full costs to be recovered.	HO	The Government ran a public consultation between 29 June 2023 and 23 August 2023, to seek views on a number of recommendations that had been made to the Home Office for changes to firearms licensing. The consultation followed the deaths of those shot and killed by a licensed shotgun holder in Keyham on 12 August 2021 and the fatal shooting of John MacKinnon on the Isle of Skye on 10 August 2022 (Firearms licensing: recommendations for changes - GOV.UK (www.gov.uk). The consultation included a question on the length of firearms certificates and whether interim medical checks should be made on licensed firearms holders between the grant of the certificate and any application to renew. The Government published its response to the consultation on 13 February 2025 (Recommended changes to firearms licensing: government response (accessible) - GOV.UK).The Government's view is that a careful balance has to be struck between the length of certificates and the imperative to ensure the safety of certificate holders, their families and the wider community. While a certificate duration of less than five years would seem to offer the advantages of more frequent suitability checks on certificate holders, the Statutory Guidance for Chief Officers of Police now requires that the police conduct continuous assessment of certificate holders during the duration of a certificate. This is supported by the new digital medical marker, which has been rolled out to all GP surgeries in England since 2023, which allows for a GP to alert the police should a certificate holder start to suffer from a relevant medical condition and are seen by their GP, which then ensures that consideration can be given by the police to whether it is safe for the individual to continue to have access to firearms. The Government is clear that public safety must be the paramount consideration and is of the view that no changes should be made to the duration of certificates at this time. On 5 February 2025, increased fees for firearms certificates came into effect to provide full-cost recovery for firearms licensing applications processed by police forces.

			This gave effect to a commitment in the Government's manifesto. The fees were previously increased in 2015 and they no longer met the cost of the service provided. It is essential for both public safety and police efficiency that the fees provide full-cost recovery so that service improvements can be made. The fees include the cost to the police of the continuous assessment of a certificate holder's suitability to continue to possess firearms across the duration of their certificate.
Adult A, Child 1 and Child 2, and Adult B, 2024	**Recommendation 10:** The Safer West Sussex Partnership request that the Home Office should revise the gun licensing guidance to state that all Police Licensing authorities, when seeking references for an applicant, should make it clear to referees the responsibility they have to supporting public safety. This should include a statement which refers to the public safety consequences of failing to disclose relevant information which may indicate unsuitability. All referees should be formally written to when seeking a reference, with a standard template document for them to return which specifically addresses the relevant issues, as already outlined in licensing guidance, about intemperate habits and unsound mind, and risk factors such as drug and alcohol use, domestic abuse and mental health difficulties. Telephone follow up should take place on a random basis, but not be seen as the main method for obtaining references.	**HO**	The public consultation in 2023 contained a number of recommendations made about the role of referees in the firearms licensing process. The Government accepted the recommendations relating to referees provided in support of firearm and shotgun applications. At present, the name of only one referee is required to support an application for a shotgun certificate, while two referees are required to support an application for other firearms certificates, for example, those covering sporting rifles. Both the Coroner in the Keyham inquest and the Scottish Affairs Committee recommended moving to two referees for shotgun applicants and we support this recommendation. It will provide the police with more information about those applying for shotgun certificates and will support the important checks on suitability which are undertaken by the police. We will introduce new guidance for referees as part of a revised application form explaining what is required of them when supporting an application. In addition, the Statutory Guidance to Chief Officers of Police on firearms licensing that the police must follow will be strengthened in relation to the information police need to obtain from referees and this refreshed version of the guidance will be issued shortly. The Statutory Guidance will also make it clear that the police should look at the circumstances when referees are changed between an application for the grant of a firearm or shotgun certificate and an application to renew that certificate. The police already make enquiries on this where appropriate, but we will make this more explicit in guidance.

Adult A, Child 1 and Child 2, and Adult B, 2024	**Recommendation 12**: The Safer West Sussex Partnership request that the Home Office should revise the gun licensing guidance to state that all Police Licensing authorities, when seeking health/ medical information about an applicant, should be sent a standard proforma for GPs to complete. The proforma should not only include standard personal details, but specifically request information about any relevant issues (past or current) which may indicate unsuitability i.e., drug/alcohol use, domestic abuse, child abuse, mental health difficulties, acute stress as a result of trauma, suicidal or self-harm thoughts, degenerative diseases or conditions, personality disorder, terminal illness, life changing event e.g., loss of limb or serious car accident. Reference to any relevant issues should include dates, treatment/care, and monitoring.	**HO**	The application form completed by the applicant, both for the grant of a firearms certificate or for renewal, includes a medical proforma to be completed by the applicant's GP or by another suitably qualified doctor registered with the General Medical Council with access to the applicant's medical records. The Statutory Guidance for Chief Officers of Police on firearms licensing states that an application for a firearms certificate received by the police must not be granted without the medical information provided by the proforma. The medical proforma asks the applicant's doctor to confirm whether the applicant has ever been diagnosed with, or treated for, any of a number of medical conditions considered to be relevant to fitness to have access to firearms. The relevant medical conditions are listed in paragraph 2.33 of the Statutory Guidance. The proforma also asks the doctor whether there are any other mental or physical conditions, or combination of conditions, relevant to the applicant which may affect their safe possession of a firearm. As indicated above, the digital firearms medical marker will ensure that the police are informed if a certificate holder begins to suffer with a relevant medical condition during the lifetime of their certificate.

Adult A, Child 1 and Child 2, and Adult B, 2024	**Recommendation 13:** The Safer West Sussex Partnership request that the Home Office should revise the gun licensing guidance to make it not possible for first time applicants to transfer their application to another Police authority mid-way through the process if the applicant has decided to move home address, thereby reducing the likelihood of a different approach being taken by Police authorities and promoting continuity.	**HO**	The Firearms Act 1968 requires that an application for a firearms or shotgun certificate must be made to the police force in which the applicant resides. This should be the police force for the area in which the applicant resides at the time of application. This enables that police force to make use of any local intelligence it may have in relation to the applicant, and to make the necessary home visit or visits to assess the security of where firearms will be stored, and to interview other members of the applicant's household and other persons as appropriate. It can of course happen that an applicant moves house while the application is being processed. In these circumstances, it should be the police force where the person currently resides who issues the certificate, but we would expect there to be good liaison between both forces who have been involved in consideration of the application. The Statutory Guidance to Chief Officers of Police on firearms licensing has introduced greater consistency in how forces consider applications, so any move of address should not now impact significantly on the decision taken. However, we will amend the statutory guidance to make clear that good liaison should take place between forces where an applicant moves home address during the course of an application or renewal.
Adult A, Child 1 and Child 2, and Adult B, 2024	**Recommendation 14:** The Safer West Sussex Partnership request that the Home Office should revise the statutory guidance to reflect the need to keep GPs informed about the outcome of a license application.	**HO**	The Statutory Guidance to Chief Officers of Police on firearms licensing already provides, at paragraph 2.42, that when a firearm or shotgun certificate is granted or a person is registered as a firearms dealer, the police will contact the applicant's GP to ask them to place a firearms marker on the applicant's medical record to indicate that they have been issued with a firearm certificate so that a 'firearms held' marker can replace the 'application made' marker. The police must also advise the GP in all cases when an application is refused, revoked, cancelled or expires, so that the firearm marker can be removed.

Adult A, Child 1 and Child 2, and Adult B, 2024	**Recommendation 17:** The Safer West Sussex Partnership request that the Home Office should revise the gun licensing guidance to strengthen the wording in the section about 'suitability checks' to specifically include a statement 'and any other information which, when considered as a whole, raises questions about the applicant's integrity and overall suitability to own a gun. Where an applicant is found to have been deliberately dishonest or knowingly or recklessly made a false statement, the application process should be terminated.' The issue of integrity should have similar explicit weight and importance to that of dishonesty.	**HO**	The Statutory Guidance sets out, at paragraph 3.1, that when assessing suitability the primary consideration should always be whether the applicant can be permitted to possess a lethal-barrelled weapon without danger to public safety or to the peace and that, at paragraph 3.10ii, evidence of dishonesty is a factor that may be suggestive of the existence of a danger to the public safety or the peace. However, we will strengthen the wording in the Statutory Guidance in relation to integrity and dishonesty and we will make it clear that this is relevant to a person's suitability, including when they have made a false statement.

Recommendations re-allocated to a different government department

DHR	Recommendation	Government department/ public body responding	Response
Linda, 2020	**Recommendation 7:** Employers Role in Responding to Domestic Homicide Review: That the Home Office considers strengthening the expectations of private sector employers to engage with domestic homicide reviews.	**HO – directed to DBT**	Home Office response: These recommendations have been flagged to the Domestic Abuse Commissioner's office for the Department of Business and Trade (DBT) to respond. As such, the response to recommendations regarding employers have been grouped together. The Home Office work closely with Employers' Initiative on Domestic Abuse (EIDA) and, as a Beacon member, is a prominent advocate for culture change among UK employers. This includes actively engaging with a range of private sector employers. We also fund the Survivors Trust to deliver training on domestic abuse to employers around the country in order to raise awareness and equip staff to be supportive of the challenges that domestic abuse victims may have in relation to the workplace and to recognise, respond and signpost victims to the most appropriate support. Additionally, the Home Office consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews (DHRs) and we are currently analysing the responses received. We encourage DHR panels to engage with the victim and perpetrator's employers where relevant, and this has been included in the draft guidance.
Sajwa, 2019	**Recommendation 3:** The Home Office to engage with the Corporate Alliance Against Domestic Violence and the Employers' Initiative on Domestic Abuse to review the effectiveness of existing guidance and support for employers in order to promote involvement in DHRs.	**HO – directed to DBT**	
Adult A, 2019	**Recommendation 1:** The Home Office and the Domestic Abuse Commissioner's Office should ensure that all employers are made aware of the Domestic Abuse Act 2021 guidance and employers responsibilities laid out within this. Employers should be directed to the Employers' Initiative for Domestic Abuse (EIDA), a business network which empowers employers to take action against domestic abuse, for their staff, and their sector.	**HO – directed to DBT**	

Adult A, 2019	**Recommendation 2:** The Home Office and the Domestic Abuse Commissioner's Office should ensure that all employers should be referred to the Public Health England & Business In The Community Domestic Abuse Employer Toolkit. This toolkit helps employers of all sizes and sectors make a commitment to respond to the risk of domestic abuse and build an approach that ensures all employees feel supported and empowered by their workplace to deal with domestic abuse.	**HO – directed to DBT**	
DHR Q, 2018	**Recommendation 2:** Explore awareness raising and deliver a public / employer / education (including secondary or University education) focussed campaign on the risks that may be present during the period leading up to and including separation in a relationship.	**HO - redirected to DFE**	

Recommendations for Department of Health and Social Care (DHSC)

DHR	Recommendation	Government department/ public body responding	Response
Jack, 2021	**Recommendation 1:** Policy and protocol to reflect that an individual should not be left alone until further assistance has arrived when high risk/immediate safeguarding needs are identified and this should be built into the commissioning of homecare providers. Having stated that he was going to kill himself and it being perceived as a 'real' threat, the carer then left Jack and the premises prior to an assessor from the company arriving, to go and attend to a patient at a different location. This will prevent this situation occurring in the future, whether the person identified as high risk is the specified patient or not.	**DHSC**	If there is immediate risk of harm or someone is in immediate danger or a crime has been committed, the police should be contacted. The Right Care Right Person (RCRP) model is a police led initiative designed to ensure the most appropriate police involvement in cases where people have health or social care needs, and ensure that people receive support from the right person, with the right skills, training, and experience to best meet their needs. The RCRP approach provides a threshold to assist police make decisions about when it is appropriate. Under RCRP, police will continue to respond in cases where there is a duty to investigate a crime and protect people when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm. Safe implementation of RCRP requires a collaborative approach between health, social care and police at a local level and risks are monitored at a national level through an Oversight Group which includes representation from social care partners.

Unpublished, 2021	**Recommendation 4:** Mandatory Health Training on Domestic Abuse The Home Offices is asked to consider consulting with the Department of Health and Social Care and the Royal Colleges over whether stand-alone domestic abuse training should be made mandatory for all front-line health professionals.	**DHSC**	DHSC work through the National Safeguarding Steering Group (NSSG) to assure the recommendations from DHRs are in place across the health system. This recommendation is partially met through the 2024 refresh of the intercollegiate safeguarding standards. These standards include mandatory DA training for all front-line health professionals, however they are part of a wider set of safeguarding standards and not delivered as stand-alone training.
Unpublished, 2020	**Recommendation 6.6:** Department of Health and Social Care: It is recommended that domestic abuse is included as a specific priority within the sixth annual progress report of the National Suicide Prevention Strategy36 (due in 2022).	**DHSC**	A 6th progress report was not published because a new 5-year cross-sector Suicide Prevention Strategy for England was published in 2023. For the first time, domestic abuse was included as a specific risk factor and area for further action in the strategy. Cross-government work to address the risk between domestic abuse and suicide is ongoing.
Unpublished, 2020	**Recommendation 17:** Domestic abuse is included as a specific priority within the sixth annual progress report of the National Suicide Prevention Strategy (due in 2022).	**DHSC**	A 6th progress report was not published because a new 5-year cross-sector Suicide Prevention Strategy for England was published in 2023. For the first time, domestic abuse was included as a specific risk factor and area for further action in the strategy. Cross-government work to address the risk between domestic abuse and suicide is ongoing.

Lucy, 2020	Public Health England will target the need for a better understanding of the links between self-harm and suicide. Self-harm is a way of communicating distress and may be used as a coping strategy. However, for some people it can be a risk factor in suicide. Self-harm in itself is not an indicator of suicidal intent.	**DHSC**	People who have self-harmed are a priority group in the 2023 Suicide Prevention Strategy for England. DHSC continues to fund the Multicentre Study of Self-Harm as part of this strategy. Self-harm has been identified as one of the biggest risk factors for suicide, and this research fed into NICE guidance on assessment, management and preventing recurrence of self-harm, as well as suicide. The project is currently exploring the feasibility of collecting additional data on the association between domestic violence and self-harm.
Krystyna, Elzbieta, 2020	**Recommendation 3:** Routine enquiry in secondary health care: The Department of Health and Social Care to consider commissioning research into the effectiveness of selective, routine enquiry into domestic abuse, where health indicators are present, in a range of secondary care services.	**DHSC**	Through the National Institute for Health and Care Research (NIHR), DHSC commissioned an independent research report summarising the evidence base on healthcare-relevant interventions which address violence against women and girls. DHSC will review the findings from this report to inform future policy development on domestic abuse.
Callum, 2020	**Recommendation 1 for National Policy:** The issue of accessing personal data held by general practitioners in the context of DHRs and reliance on consent rather than the legal obligation to be involved and contribute to the review and the substantial public interest to prevent domestic homicide.	**DHSC**	It is our expectation that GPs should share confidential patient information with a DHR, which they can legally do when there is an overriding public interest. Legislation requires ICBs to cooperate with information sharing for DHRs but there is no such requirement on GPs. A DHR should be able to seek information directly from a GP practice, which would generally be able to rely upon an overriding public interest justification to disclose any confidential patient information about both the victims and perpetrators of domestic homicide it believed would be relevant to the DHR. This is also supported by the 2012 guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences), Striking the Balance.

Daisy, 2020	**Recommendation 2:** That the Department and Health and Social Care and Home Office draft guidance on how to effectively manage joint Safeguarding Adult Reviews and Domestic Homicide Reviews.	**DHSC**	The Home Office recently consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews (DHR) and they are currently analysing the responses received. Further guidance on managing parallel or overlapping reviews will be considered as part of this process. Home Office will engage with other relevant departments, including DHSC, on these considerations.
Linda, 2020	**Recommendation 4: Domestic Abuse Training in Health:** The Home Office considers liaison with the Department of Health and Social Care and the Royal Colleges to provide a framework defining the level of domestic abuse education, awareness, competence correlating to job roles in health and social care, together with the domestic abuse training requirements for those roles.	**DHSC**	DHSC work through the National Safeguarding Steering Group (NSSG) to assure the recommendations from DHRs are in place across the health system. The inter collegiate standards have been refreshed in July 2024. The competency framework includes five levels of required safeguarding training to reflect best practice in adult safeguarding, and sets out minimum training and education requirements for staff working at all levels with adults at risk of abuse.

Frank, 2019	**Recommendations 5.7 for NHS England Independent Report Recommendation 5.71:** The first recommendation is designed to improve knowledge and practice when NHS and police staff overlap and when operational manners and procedures challenge patients. We urge the Trust and the police to discuss together (for example, in a workshop or a series of seminars focused on best practice) how they might consider developing knowledge, understanding and improve practice when patients need to be taken to the Health Based Place of Safety (HBPOS) under S.126 of the Mental Health Act and/or who are already detained under Section of the Mental Health Act and need help to be returned to hospital.	**DHSC**	DHSC is working through the National Safeguarding Steering Group (NSSG) to assure that the recommendation is in place across the health system.
Olga and Viktor, 2019	**Recommendation x:** Recommendation to Public Health England that they inform the public that coercive controlling behaviour needs to be reported to ensure vulnerable people are supported.	**DHSC**	DHSC through PHE and NHSE stood up a full range of resources/training materials re: information sharing on coercive control. These are consistently used to promote the 16 days of action for VAWG each December.

Mrs D, 2019	**Recommendation 4:** Using Learning: Learning from the review may also be used for national learning purposes, communicated through the Home Office Public Protection Unit specifically: 1. That all Health and Social Care support services to take a Think Family approach in their assessments and plans for service users, particularly when assessing risk to others. 2. For NHS England to reinforce the need for GPs, when treating depression, to be mindful of risks associated with domestic violence and abuse and to use professional curiosity when exploring high risk behaviours and emotional instability of patients. 3. Bodies such as National Institute for Health and Social Care Excellence should consider incorporating into relevant Quality Standards (such as suicide prevention and coexisting severe mental illness and substance misuse) a risk assessment process for use when people do not attend appointments. The risk assessment should include information from carers or family members of the individual who has not engaged and the impact on them of the person's mental ill-health and any coexisting substance misuse.	**DHSC**	Recommendation not for DHSCS.

Daisy, 2019	**Recommendation 1:** That the Department of Health and Social Care provide guidance and examples of good practice for practitioners on assessing risk of harm to others where someone affected by dementia exhibits or starts to exhibit, behaviours which are challenging, or which present an obstacle to the cared for person receiving the safe care they need.	**DHSC**	We suggest that the recommendation is not taken forward because: • Existing guidance on assessing the behaviour of people with dementia is already available; and • The recommendation does not align with the report's narrative. The report notes that at the time of the homicide, the husband/carer did not have a dementia diagnosis, and there was no indication that he posed a danger to his wife. However, the recommendation assumes a dementia diagnosis. There already are existing resources/ tools and guidance (e.g., NICE 1.13.2) available to support the assessment of behaviour in individuals with a confirmed diagnosis of dementia. It is important to recognise that different types of risk assessments have their strengths and weaknesses. Any assessment based solely on an actuarial tool should be approached with caution. Furthermore, even if a low risk is reported, this does not guarantee that behaviour will not change or escalate over time. An analysis of domestic homicide cases titled "Older adults and violence: an analysis of Domestic Homicide Reviews in England involving adults over 60 years of age" reveals that, of 14 adult family homicides, 16 intimate partner homicides, and five homicide-suicides, dementia was a factor in six cases. In four instances, a person with dementia was the victim, and in two cases, the perpetrator. The most common recommendation from this analysis was the need for a carer's assessment, though it often fails to fully address the complexities of many caregiving situations. The analysis underscores the importance of training for health and social care professionals to better understand the complexities of caregiving. It also highlights the need to challenge myths and stereotypes that can distort risk assessments of older adults, such as the misconceptions that people with dementia are inherently violent or that frail older adults are incapable of committing extreme acts of violence.

Unpublished	**Recommendation 17:** Domestic abuse is included as a specific priority within the sixth annual progress report of the National Suicide Prevention Strategy (due in 2022).	**DHSC**	A 6th progress report was not published because a new 5-year cross-sector Suicide Prevention Strategy for England was published in 2023. For the first time, domestic abuse was included as a specific risk factor and area for further action in the strategy. Cross-government work to address the risk between domestic abuse and suicide is ongoing.
DHR R Amanda, 2019	**Recommendation 9.1:** The Home Office should consider if the review indicates that further study of suicidal behaviour in partner-violent men or where there is controlling or coercive behaviour may inform the prevention of suicide and domestic homicide.	**DHSC**	We would highlight a completed National Institute for Health Research project in this area, that has measured both depressive symptoms and frequency of domestic violence: Advancing theory and treatment approaches for males in substance misuse treatment who perpetrate intimate partner violence (Programme ADVANCE) - NIHR Funding and Awards.

domestic
abuse
commissioner

The Domestic Abuse Commissioner for England and Wales
2 Marsham Street, London SW1P 4JA

commissioner@domesticabusecommissioner.independent.gov.uk

www.domesticabusecommissioner.uk