Learning from loss

Ensuring the lessons from domestic homicide reviews lead to change

domestic abuse commissioner

July 2025

Dedication to victims and their families

Every review, recommendation and action featured in this report stems from a tragic loss of life at the hands or through the acts of someone close to the victim(s).

Every life lost, whether taken in a homicide or a death by suicide, leaves behind a legacy, and family, friends, and communities whose lives will never be the same. Some families are left waiting, with no formal review or investigation into the death of their loved one in the context of abuse and many families must relentlessly campaign for much needed policy change.

At the heart of this work is the deepest respect for the victims who are no longer with us and an effort to honour and remember them by telling their story. But in addition to memorialising victims, we must act on the learning from domestic abuse-related deaths to better safeguard victims in the future and hold perpetrators to account.

Establishing an Oversight Mechanism is one part of that effort. This report fundamentally outlines the need to learn from domestic abuse-related deaths to safeguard and protect future life.

This report is a dedication and testament to those who have been killed or who have died by suicide as a result of domestic abuse and the vital changes needed and brought to the collective consciousness by their deaths.

This report features tributes to individual victims from those who knew and loved them in the hope that it provides insight into their lives and gives voice to their experiences. We remain steadfast in our commitment to families bereaved by domestic abuse and are dedicated in bringing about the change needed to prevent future harm.

Our sincerest sympathies are with every family, friend, child and loved one of someone who has lost their lives through domestic abuse.

Acknowledgements

I am grateful to those areas who gave their time and commitment to piloting the oversight mechanism and helped to shape a process which truly demonstrates the change domestic homicide reviews can bring. These areas include:

Police and Crime Commissioners

- Southend Essex and Thurrock (SET)
- Norfolk
- Cleveland
- Merseyside
- Isle of Wight and Hampshire
- South Wales
- Gloucestershire
- Greater Manchester Combined Authority
- Northumbria
- Dyfed Powys (withdrawn)

Community Safety Partnerships

- East and West Sussex
- Warwickshire
- London Borough of Lambeth
- Westmoreland and Furness
- Leeds
- Cornwall
- London Borough of Bexley
- Manchester (City Council)
- Northumberland
- North East Lincolnshire
- Hertfordshire

Foreword

Dame Nicole Jacobs

Domestic Abuse Commissioner

Last year, 108 people were killed by a partner or family member, while the number of victims of domestic abuse dying by suicide overtook domestic homicide for the second year in a row.

When someone loses their life to domestic abuse, it is an appalling failure of our society, the state and the systems designed to keep us safe. That is why, when the unimaginable happens, there must be no stone left unturned in the search to understand how a life was cut short and determine how we ensure measures are put in place, so it never happens again.

Yet, vital opportunities to prevent future deaths are being routinely missed across England and Wales.

For over 13 years, domestic homicide reviews have been gathering critical learnings from too many lives tragically lost. But despite bereaved families, the domestic abuse sector and myself calling for better accountability in our response to domestic abuse, there remains no process to ensure the important changes highlighted in these reviews are being implemented at a national and local level.

This report – which summarises a pilot project by my office to explore how we best monitor the implementation of recommendations and delivery of actions stemming from these reviews – has unearthed some stark and concerning findings.

Heartbroken families are having to face a three-year wait on average for reviews to conclude, while others get no formal answers or even a formal investigation into the death of their loved one.

When domestic homicide reviews conclude, my office uncovered how many of these potentially lifesaving recommendations, carefully considered over many years, are being left to languish in government departments.

Similarly, others had to be abandoned by local agencies because of a lack of resource or guidance that can only come from national leadership. It is time for this to change.

“When we think of Lucy we smile and we remember her as loving, caring and putting others first. She was a dedicated mother who lived for her boys, they were her life.” *DHR 3*

Within this report is an opportunity to honour every life lost, by better safeguarding victims into the future and holding perpetrators to account.

By harnessing the power of new technology and AI, we can ensure that local and national agencies can accelerate the learning that is drawn out from a tragic loss of life and turn it into action – whether that be implementing best practice locally or national policy change.

In the face of an ambitious target to halve violence against women and girls within a decade, the government must harness every lever it has – and establishing a robust oversight system for domestic homicide reviews must be part of that. The cost of failing to act is not one we can afford.

"Nothing will bring my daughter back, but if lessons can be learnt from this review, it can stop this happening to another vulnerable person." DHR MS A

Foreword

Frank Mullane

CEO of Advocacy After Fatal Domestic Abuse

I was delighted to be asked to write a foreword to this compelling case by the Domestic Abuse Commissioner for oversight of the implementation of recommendations in Domestic Homicide Reviews (DHRs).

Nearly ten years ago, after the last upgrade of the statutory guidance for DHRs, Dame Nicole Jacobs and I discussed the need for increased focus on ensuring that the findings from these powerful reviews were being converted into improved services for domestic abuse victims.

Following prolonged domestic abuse and death threats directed at my sister, she and I made unsuccessful, desperate, and repeated attempts to get effective help, principally from the police. After the murder of my sister Julia and nephew William, my brother-in-law Mike Mason said:

> ***"Something is broken here, and we can't walk away until we have had one hell of a go at fixing it."***

Despite my family bringing determined and organised pressure onto primarily the police, and a subsequent inquest, it took a DHR (The Pemberton Review) to uncover all that we needed to know and generate the findings that would provide impetus for significant change. Professor Neil Websdale, who introduced this type of reviewing into the US and other countries, described the Pemberton Review as a gold standard.

My family was doing something that felt like active democracy, citizens bringing legitimate challenges and questions to public service providers. The Pemberton Review was important for these reasons: it adequately answered the questions my family had; it laid out in rich detail what it is like to live under coercive control; it revealed serious flaws in public protection and gave impetus, in particular to the police, on the need for services to improve. The Pemberton Review illuminated the past to make the future safer.

I first met Nicole over ten years ago and was struck by her knowledge, groundedness and common sense. What stood out

> ***"Despite being small, Nicola was described by a friend as a strong and feisty with a 'sweet heart'. Another person described her as a lively and bubbly person."*** *DHR Nicola*

was that she was not shackled by dogma and she brought an open mind to every exchange. It means that when she draws firm conclusions, as expressed in this critical document, they are well considered and tested, and so should be heeded. A key conclusion of this report is that if the government is to achieve its ambition of halving Violence Against Women and Girls within a decade, it will be critical to ensure that learning from DHRs is embedded both locally and nationally.

The section on pilot findings is alarming as it includes reasons why actions generated from DHRs were not completed. These include a lack of resources. As a common action from DHRs is around training, this is particularly concerning. All victims of domestic abuse seeking professional help should reasonably assume that those assigned to help them are professionally competent.

With typical thoroughness, the Domestic Abuse Commissioner calls for the full resourcing of the Oversight Mechanism so that there is "interrogation of completed actions with as much detail and consideration as those which are not completed."

The report helpfully suggests why we struggle to measure the changes instigated by DHRs. An unsettling example is the absence of a process for coordinating recommendations (for national application) across government. But it also includes the many benefits the Oversight Mechanism will bring, and a standout benefit is "utilising one central tool to share learning locally, across regions and nationally". DHRs are not about blame, but about accountability and this report unveils how the Oversight Mechanism can both challenge and support local areas, where recommendations are not being implemented.

DHRs should reduce domestic abuse and fatal domestic abuse. Achieving these outcomes requires committed activity to convert review findings to changed practices in others and in systems. The Domestic Abuse Commissioner sets out in this crucial report how that can be achieved.

Frank Mullane is CEO of Advocacy After Fatal Domestic Abuse (AAFDA), which provides specialist advocacy and support to families bereaved by all forms of domestic abuse, offers extensive professional training, including training Chairs of DHRs and influences national policy and legislation. Frank worked closely with the Home Office to develop the DHR model and has continued this work ever since. He became a Home Office appointed reader of reviews and AAFDA sits on the Quality Assurance Panel. In those roles, he has read around 1,200 DHRs.

"If they mattered to you, then you mattered to them. I feel incredibly lucky to have had them as my parents. They were loving, kind, generous and such a big part of my life, I just can't imagine them not being here anymore." *DHR Marjorie*

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"She was an independent and proud woman unwaveringly loyal and had a strong personality. She was very funny, making us smile when she laughed at her own jokes, even the bad ones. We are all absolutely heartbroken, and devasted by her death. You always think you have time to put things right – she mattered." *DHR Martine*

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"Amber was a free spirit and loved all music... from classical to drum and bass." *DHR Amber*

domestic abuse commissioner

Introduction

Domestic homicide[1] remains unacceptably high in our society. There were 108 domestic homicides in England and Wales between April 2023 and March 2024. This equates a quarter of all homicides during this period and is a figure relatively unchanged in the last 10 years.[2]

In addition to recorded homicides, the loss of life due to domestic abuse is likely to be even higher, and recent studies show that the number of victims of abuse who take their own lives following domestic abuse exceeds the number of domestic homicides. Since 2016, domestic abuse-related deaths by suicide have also been subject to Domestic Homicide Reviews.[3] The Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicide Project recorded 1,012 deaths in the four years between April 2020 and March 2024, which included 501 domestic homicides and 354 suspected victim suicides following domestic abuse.[4]

There is also a growing concern about the number of 'hidden homicides' – where a death is sudden, unexpected, or unexplained, under suspicious circumstances, but no charges are ever brought.[5]

Domestic homicide and domestic abuse-related suicide disproportionately impact women. Research into femicide[6] more broadly nationally and globally continues to highlight the stark reality of deaths of women at the hands of partners or family members. UNODC state that some 51,100 women and girls were killed at home by people closely related to them in 2023, an average of 140 each day and accounting for 60 per cent of all female homicides.[7] In too many cases, victims of femicide had previously reported violence and with intervention their killings could have been prevented. In the UK, the Femicide Census released in June 2024 shows that at least 147 women were killed by 144 men in 2021. Out of the 147 women, 105 (71%) were killed by a current or former partner or a family member.[8]

"Diana was the person that many people turned to if they had problems, she was always there for her family and friends and no matter what people were going through she always put it aside and dealt with the people that needed her. She will be sadly missed." *DHR Diana*

In England and Wales, the majority of domestic homicide victims are women, with most men killed by homicide occurring outside the home, in circumstances unrelated to domestic abuse. The circumstances and typologies of abuse tend to differ between men and women – with men likely to have been killed by another man (either a family member or within a same-sex relationship), compared with women who are more likely to be killed by a male partner or ex-partner. Of the 108 victims of domestic homicide in the 12 months to 31 March 2024, 83 victims were female and 25 were male. Most perpetrators (93 of 108) were male and 64% (16) of male victims were killed by another male.[9] While representing a minority of victims, it is crucial to have an understanding of the distinct experiences of male victims of abuse. Domestic Homicide Reviews (DHRs) offer insight into male experiences of abuse, and research published in 2021 illustrates themes emerging from male deaths as a result of domestic abuse through intimate partner violence,[10] including where the perpetrator was female.

The Centre for Women's Justice highlight in their report[11] that official statistics give a limited picture of the circumstances of men killed by their female intimate partners, and the circumstances of these killings. It is worth noting that their analysis of 92 cases over a 10-year period found evidence to suggest that, in 77% of those cases, women had experienced violence or abuse from the deceased. The experiences of men killed in domestic abuse remain under-examined and there is a need for further research in this area.[12]

Domestic abuse does not exist in a single form and domestic homicide should be viewed through an intersectional lens. This is a powerful focus that enables us to understand victim/survivor experiences as a whole and identify systemic oppression and marginalisation. There is a notable gap in considering intersectionality in DHRs. Research by the Centre for Women's Justice and Imkaan (2023) found a lack of investigation following suicides of Black and minoritised women, suggesting that these deaths remain unexamined and invisible.[13] This research noted that reviews often take place only when families push for them, but that at the same time many Black and minoritised families may not engage with this process.

Scope of the report

This report will provide an overview of the DHR process, highlight the need for accountability and central oversight, and outline the work undertaken by the Domestic Abuse Commissioner to test an approach to do this. It will also set out a recommended blueprint for national rollout of an accountability and oversight mechanism, and the benefits this could bring in improving the wider response to domestic abuse.

This report provides a summary of the work carried out by the Commissioner to establish a robust oversight mechanism and an overview of what is required to deliver national roll out.

"She was described by her sons as a lively, sociable person but that she had become more insular after meeting [perpetrator of abuse]." DHR 9

The Commissioner, through this report, highlights:

- The need for oversight and accountability centrally for implementation of DHRs.
- The benefits such work would bring to unlock learning and support evidence-based strategic and operational planning.
- The ability of new technology to enable effective oversight and embed learning.
- That a second year of piloting is needed to help test and embed a system for data collection and analysis.
- The importance of managing the impact on local resourcing.

Methodology

This report is informed by a range of sources from across external and internal research, practice insight, and input from individuals working on DHRs at a local level. The Office of the Domestic Abuse Commissioner has considered:

- A review of academic literature and research on DHRs.
- Data collected through the local oversight mechanism pilot.
- Surveys and input from pilot areas about their experiences of the oversight mechanism and DHR processes.
- National government responses to DHR recommendations.
- The Domestic Abuse Related Death Reviews forum (DARDR Forum);[14] a collaborative approach bringing together those leading on DHRs in local authorities, Community Safety Partnerships (CSP) Police and Crime Commissioners (PCC) offices and health bodies. The Commissioner jointly formed the DARDR Forum with the Local Government Association (LGA) and Association of Police and Crime Commissioners (APCC) to bring together those leading on DHRs within Local Authorities, CSPs, PCCs, with local health representatives also in attendance. The forum established its own terms of reference.
- Expert input on new technology to analyse data.
- Learning from DHRs themselves.

Given the range of input into this report, it necessarily includes a mixture of practice, research and policy commentary and recommendations.

“Maria has been described as a kind and considerate person who cared immensely for the welfare of her family particularly her children.” DHR 4

Notes

1. In England and Wales, this includes murder and manslaughter by either a former or current intimate partner or family member. This is not a legal definition and DHRs have also included lodgers or flatmates. With upcoming changes to Domestic Homicide Reviews, lodgers and flatmates will no longer be included in DHRs, to align with the definition of domestic abuse within the Domestic Abuse Act 2021.
2. Office for National Statistics (2025). *Homicide in England and Wales Articles*.
3. Rowlands, J. et al (2023). 'The Challenges and Opportunities of Reviewing Domestic Abuse-Related Deaths by Suicide in England and Wales'. *Journal of Family Violence*, pp.723–737.
4. The VKPP works within the College of Policing to deliver projects that develop the evidence base for vulnerability and related serious crime, across police forces in England and Wales, driving practice improvement. Hoeger et al (2025). *Domestic Homicides and Suspected Victim Suicides 2020-2024, Year 4 Report, Vulnerability Knowledge and Practice Programme (VKPP)*.
5. BBC News (2025). *Mum of murdered teen wants 'hidden homicide' data to be gathered*. BBC News.
6. The UN defines femicide (or feminicide, as it is referred to in some contexts) as an intentional killing with a gender-related motivation. It is different from homicide, where the motivation may not be gender related. Femicide is driven by discrimination against women and girls, unequal power relations, gender stereotypes or harmful social norms. UN Women (2024). *Five essential facts to know about femicide*. UN Women – Headquarters.
7. United Nations (2024). *Femicides in 2023: Global estimates of intimate partner/family member femicides*.
8. Femicide Census (2021). *Femicide Census: 2021 Report*.
9. Office for National Statistics (2025). Appendix Tables: Homicide in England and Wales, Table 34.
10. Hope, K. et al (2021). 'What can we learn from Domestic Homicide Reviews with male victims?' *Partner Abuse*, 12(4), pp.384–408.
11. Centre for Women's Justice (2021). Women who kill: How the state criminalises women we might otherwise be burying.
12. Rowlands, J. (2022). 'The Potential and Limitations of Domestic Homicide Review: A Response to Hope et al'. *Partner Abuse*, 13(3), pp.316–325.
13. Imkaan & Centre for Women's Justice. (2023). *Life or Death? Preventing Domestic Homicides and Suicides of Black and Minoritised Women*.
14. The purpose of the DARDR forum is to support those responsible for managing the domestic abuse-related death review process at an operational and strategic level. The forum provides a space to share learning and practice, raise issues and concerns, receive updates and keep up to date with, and informed of, work related to domestic homicides and other domestic abuse-related deaths, including suicides.

"She [Lucy] had a giggly little laugh, which we heard a lot when she was in a happy place. We miss her." *DHR 3*

Chapter 1

Domestic Homicide Reviews: context and history

This chapter outlines the background to and purpose of Domestic Homicide Review (DHRs), including what a DHR is and does, developments to date and the future of the review process.

1.1 What is a Domestic Homicide Review?

A DHR is a review into the circumstances around a death following domestic abuse. Community Safety Partnerships (CSPs) have overall responsibility for a DHR, and implementation of any learning that arises. The criteria for when a review should take place, and what the review should contain are set out in statutory guidance, which is due to be updated in Summer 2025.[15]

Crucially, the aim of the DHR is to understand what was missed in the statutory and community response before the death, and typically the review will not consider any activity or involvement of agencies that took place after the death. The spirit of reviews is to learn, rather than to blame organisations or individuals, and focus on constructive action that can be taken in the future to prevent future deaths.

1.1.1 Process

When a death meets the criteria for a DHR, a notification is made to the CSP, usually by police but sometimes by other agencies, or bereaved families who have advocated for a review. Upon receiving this notification, a CSP will start the process for commissioning a review. Statutory guidance stresses that families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder – this should be at all stages of the process and families should be engaged in reviews as soon as possible.[16] It is important that families are offered specialist, and where required, culturally competent advocacy and support as soon as possible.[17] Upon notification, the CSP will gather relevant information to determine with multi-agency partners whether to conduct a DHR and notify the Home Office of that decision. In instances where a CSP has decided not to commission, the Home Secretary can direct a CSP to conduct a review if a review is deemed necessary.

The CSP has responsibility for ensuring a DHR is completed but will appoint an independent Chair and convene a panel made up of representatives from local statutory and voluntary organisations who either had contact in a case or bring specific expertise. The panel then reviews the circumstances of the death and the response of statutory and other agencies to domestic abuse to identify what lessons need to be learned, and how the response of statutory and other agencies to domestic abuse could be

“Laura was 52 years of age when she died, and of white British heritage. She had been a successful business women, married and had two children.” DHR Laura

improved, as well as highlighting good practice. Organisations who had contact with the individuals involved are asked to provide an Individual Management Review (IMR). An IMR is an in-depth analysis of their involvement with the victim, perpetrator or alleged perpetrator and their families supported by a chronology. The Chair should wherever possible engage with the bereaved family, friends and other networks, such as employers, colleagues and neighbours, to gain understanding of what happened and hear any concerns or issues they wish to raise. Where possible, the Chair may also engage with the perpetrator/alleged perpetrator.

Once all the information has been gathered and analysed, the Chair will author a full 'overview' report, along with an executive summary. Before a report can be finalised, a draft must be shared with the Home Office Quality Assurance Panel (QAP). The QAP includes representatives from relevant statutory agencies as well as the voluntary sector, who receive reports along with feedback from a core group of 'readers' who review the DHRs in detail and highlight pertinent issues for consideration. The panel has responsibility for quality assuring all overview reports for DHRs. If the panel finds that a final report is inadequate, they will feedback directly to the CSP responsible for the review to explain why the report requires amendments.[18] This can require several changes and further review from the QAP before a report is considered ready for publication. Once ready, the overview report and executive summary will usually be anonymised and then in many cases published on the CSP or another local partnership website, as well as the national repository (the Home Office DHR library).[19] Some DHRs are not published in full, or at all, if there are concerns over the safeguarding of remaining family members or friends. The report contains the facts of the case, what lessons need to be learned, recommendations to address these and an action plan to take the recommendations forward.

1.1.2 DHR recommendations, action plans and implementation

Recommendations are developed by the independent Chair and agreed by the DHR's panel and should be tailored and address the learning. Recommendations should be SMART[20] and focused on improving the response to domestic abuse, either at the local, regional, or national level.

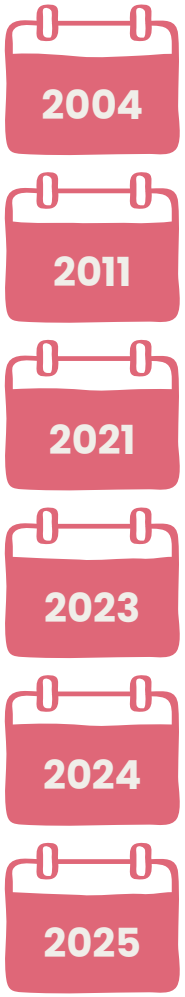
Following publication of a review, CSPs develop an action plan to support implementation of recommendations at a local and national level. CSPs are expected to track the progress of actions related to recommendations within reviews through multi-agency action plans. The draft revised statutory guidance states that action plans and recommendations are a vital part of the DHR process, and it is crucial that sufficient focus to ensure learning is meaningful, relevant and achieves change to prevent further abuse and homicide.

1.2 Why were DHRs introduced?

DHRs were introduced to establish what lessons could be learned from domestic homicide and how this could be acted upon to improve service responses, contribute to the understanding of domestic violence and abuse and to develop and highlight good practice.[21]

Following the tireless campaigning of Frank Mullane in advocating to elevate the voices of his sister Julie Pemberton and nephew William Pemberton posthumously, the first DHR, pre statutory guidance, was conducted by West Berkshire Safer Communities Partnership and published in November 2008. The review considered the deaths of Julia and William and was debated in Parliament.[22] In the debate, Dr. Carolyn Hoyle, was quoted as having commented in the review that Thames Valley Police **"must ensure that the tragic deaths of Julia and William Pemberton are embedded into its institutional memory in order that current commitment to helping victims of domestic violence does not wane"**.[23] From their very inception, families and parliamentarians have been concerned with how to ensure the learning leads to change.

1.3 History and development of DHRs



"They described Adele as a very bubbly person who was very happy most of the time and who would love to speak to people ." *DHR Adele*

While legislated for by Section 9 of the Domestic Violence, Crime and Victims Act in 2004, it was only in 2011 that DHRs were formally implemented in England and Wales through the introduction of statutory guidance. Domestic abuse-related suicide was not included within DHRs until 2016 when changes were formally introduced in the revised statutory guidance.

The revised statutory guidance states that role of reviews is to **"illuminate the past to make the future safer"**[24] by bringing to light the many forms of domestic abuse-related deaths, including intimate partner homicide, adult family homicide and victims who die by suicide, and where opportunities to intervene were missed.

In 2022, the Tackling Domestic Abuse Plan committed to introducing a more formal role for the Domestic Abuse Commissioner in oversight of implementation of DHRs and provided £100k to support the development of a pilot.

In 2023, the Home Office created a DHR library,[25] the aim of which is to bring together published DHRs in one central online location. These reviews are available to the public.

In 2024, the Welsh Government piloted and introduced Single Unified Safeguarding Reviews. While the statutory guidance for DHRs applies to England and Wales, Wales has piloted and formally implemented the Single Unified Safeguarding Review (SUSR). This process means there is one review to encompass all safeguarding reviews in Wales,[26] with the aim of ensuring that the affected family is at the heart of an expedient and rigorous review process. The SUSR is in its first year of delivery and is governed by statutory guidance,[27] which includes reference to the statutory guidance for DHRs.[28] Oversight of this process sits with the SUSR Ministerial Board for Wales and includes the SUSR Strategy Group and Victim and Family Reference Group. Alongside the SUSR process is a repository that collates reviews, recommendations, and actions. By June 2025, it is expected that registered users will be able to extract learning from Welsh SUSRs. The SUSR seeks to improve approaches to review learning so that policy makers, academics, local and national government will use the SUSR, and this will help improve the evidence base to bring changes to practice.

In January 2025, the Home Office reformed the QAP by appointing members through a more formal public appointments process. This aims to bring greater rigour to the QAP.

The Home office have committed to formal training of chairs and commissioned Advocacy After Fatal Domestic Abuse (AAFDA) to deliver this over a two-year period starting April 2024, to improve the quantity and quality of available Chairs for DHRs. The Commissioner's team feeds directly into the steering group for this training programme. It is anticipated that once the pool of trained Chairs is large enough, only those who have completed the training will be allowed to chair DHRs.

Section 19 of the Victims and Prisoners Act 2024 introduced a change in the naming of reviews to Domestic Abuse-Related Deaths and amendments to Section 9 DVCVA 2004 to include the definition of domestic abuse within the Domestic Abuse Act 2021 with regards to when a notification for a review should apply. These changes are to be formally introduced in 2025 alongside revised statutory guidance.[29]

Notes

15. Home Office (2016). *Domestic homicide reviews: statutory guidance*.
16. Home Office (2016). *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*.
17. Home Office (2017). *Domestic homicide review: leaflet for family*.
18. Home Office (2013). *Terms of reference: Domestic Homicide Review Quality Assurance Panel*.
19. Home Office (2025). *Domestic Homicide Review Library*.
20. SMART refers to specific, measurable, achievable, relevant and time-bound.
21. Home Office (2016). *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*.
22. Hansard (2009). *House of Commons Debate: Pemberton Homicide Review*.
23. Hansard (2009). *House of Commons Debate: Pemberton Homicide Review*.
24. Mullane, F. (2017). 'The impact of family members' involvement in the domestic violence death review process' in M. Dawson (Ed.), *Domestic homicides and death reviews: An international perspective*. UK: Palgrave Macmillan.
25. Home Office (2025). *Domestic Homicide Review Library*.
26. This includes Adult Practice Reviews, Child Practice Reviews, Domestic Homicide Reviews, Mental Health Homicide Reviews and Offensive Weapons Homicide Reviews.
27. Welsh Government (2024). *Single Unified Safeguarding Review: statutory guidance*.
28. The DHRs are still required to follow the DHR statutory guidance. However, Wales are piloting an alternative approach to quality assurance outside of the Home Office QA panel.
29. *Victims and Prisoners Act (2024)*: Section 19.

"Christopher was a white British Male. He lived in Hertfordshire all his life and was aged sixty-nine at the time of his death.." ***DHR Christopher***

Chapter 2

The need for oversight

Over the last 13 years, there has been a significant repetition in the nature and theme of recommendations. Alongside this, there has been no oversight of those repeated themes within recommendations that require national legislative changes, additional resources or guidance to enable consistent, embedded change at a local level.

This chapter will give an overview of the need for an oversight mechanism, outlining some of the main issues and challenges highlighted by CSPs, PCCs, statutory and voluntary agencies involved in DHRs. This includes issues observed by the Commissioner in scoping the need for an oversight mechanism and raised by families bereaved by domestic abuse-related deaths.

The benefits of national oversight are detailed in Chapter 3, with the Commissioner's recommended design for a mechanism set out in Chapter 5.

2.1 The problem: a lack of oversight of, or accountability for, implementation of DHR recommendations

There has never been any national oversight of or accountability for implementation of recommendations. In her designate role, the Commissioner stressed the need for independent scrutiny of DHRs. During the passage of the Domestic Abuse Act 2021,[30] she advocated for a legal provision to require CSP's to share their reviews with the Commissioner once published. The Domestic Abuse Act, therefore, requires all CSPs to provide the Commissioner with any finalised reviews, an important first step in establishing oversight.

The current statutory guidance, although due to be updated later in 2025, does not currently refer to oversight of or national accountability for implementation. The implementation of action plans has remained a local responsibility and, while CSPs have reported sharing national recommendations with the Home Office and/or other national bodies, it is unclear if and how these have been actioned. As a result, there is no collective understanding of whether recommendations and the subsequent actions have been completed and what impact they have had in preventing future harm.

"Anna was born in Poland and moved to England in 2006. She was a wonderful mum, wife, daughter, and sister." *DHR Anna*

Academics have critiqued the use and effectiveness of DHRs, noting the lack of scrutiny, oversight, and accountability with regards to the implementation of recommendations and lessons learned. Most recently, in his examination of the potential and peril of reviewing domestic abuse-related deaths, Rowlands[31] noted:

- Issues with the capacity of CSPs to consistently deliver the DHR process.
- A lack of consistent national oversight, including both to scrutinise CSPs but also to bring together and address learning nationally, meaning that there is not consistent assurance that reviews lead to action.
- A lack of clarity about the changes that results from reviews.
- Until recently with the launch of the DHR library in 2023, there was no means in which to access learning from other areas on a national scale besides specific academic projects.[32]

Analysis of reviews and the themes and trends within them has been piecemeal prior to the development of the DHR library. However, academics have generated important analysis about the circumstances and learning from these killings and deaths.[33]

Since 2020, the Home Office has commissioned annual qualitative analysis of DHRs.[34] The analysis examines trends based on location, demography, characteristics of victims and perpetrators and also considers family contributions to the review process. This and other analysis, such as that conducted by Homicide Abuse Learning Together (HALT) Project,[35] has shown consistent themes being repeated through reviews. This strongly indicates that lessons are not embedded or shared across areas.

While around 600 reviews are accessible through the DHR library, this allows for just comparison between areas of the recommendations – not how they have (or, more critically, have not) been implemented.

The Tackling Domestic Abuse Plan 2022[36] set out the previous Government's objectives and reform agenda for DHRs. This included the importance of implementation of learning from domestic homicides and a commitment to the creation of a stronger oversight mechanism. The Plan committed to introducing a formal role for the Domestic Abuse Commissioner in the oversight of implementation of recommendations from reviews and considered introducing a formal role for PCC's.

This government has committed to halve violence against women and girls within a decade.[37] This ambition is integral to meeting the wider Safer Streets mission.[38] A key measure of success will be tackling the highest harm, where lives have been lost. DHRs represent a wealth of insight and information – and yet we currently have no idea the extent to which recommendations and action plans are being implemented on a national level. This is a huge opportunity missed.

2.2 DHRs: current challenges

In developing proposals for an oversight mechanism for DHRs, the Commissioner sought insight from a range of sources to understand challenges in the production and implementation of DHRs. Some of these challenges are detailed below.

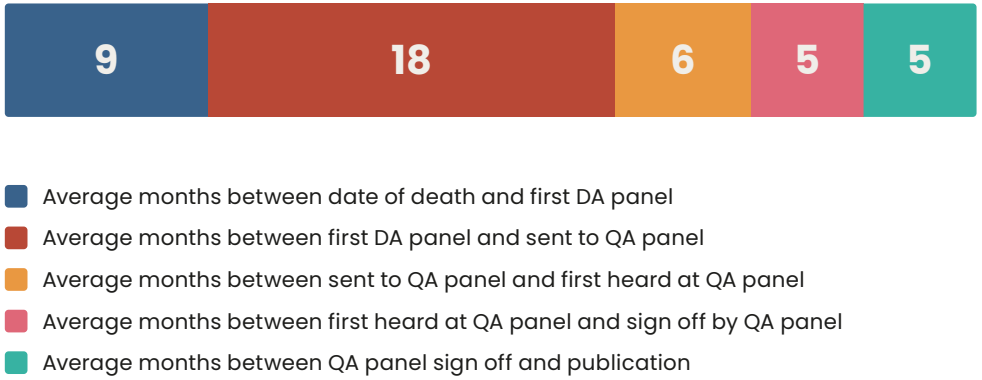
2.2.1 Timeliness of reviews

> ***"The whole process takes too long, far too long for families because you can't move on, you can't get to the inquest, you can't get anywhere until that DHR is done."***[39]
>
> Bereaved family member, in WWIN report, 2024

The time taken for a review to be completed and published was an issue for 71% of pilot sites surveyed by the Commissioner. The statutory guidance currently requires an overview report to be completed within six months of a decision to conduct a review; however, this timescale is almost never met.[40] There is no time requirement for the process of quality assurance to be completed. Local partnerships largely credited the QAP with frustrating delays, something the Home Office is seeking to address through the recruitment of public appointees to the panel.

Analysis from the survey of pilot areas reviews shows that, on average, the time between first panel meeting and the DHR being sent to the Home Office for quality assurance was **18 months**, ranging from two months to 55 months. On average, there were five months between the review first being heard by the QAP and being signed off by the QAP (Figure 1).

Figure 1: Average time periods across stages of the DHR process



From the date of the victim's death to publication, the average time for a review to complete, based on the pilot submissions, was 37 months.

> ***"She [Anna] was family-orientated, and loved her family greatly, always providing food for daily meals. She particularly loved to eat nuts and waffles.."*** *DHR Anna*

Home Office analysis of DHRs found that the time between a victim's death and the completion of the review is influenced by a range of factors including police investigation, criminal trial, coroner's inquest and contact with family, as well as CSP submission to the Home Office and the quality assurance process. CSPs also highlighted the increased volume of reviews as contributing to the time taken to complete them.

CSPs reported the following particular issues:

- Length of criminal proceedings.
- Difficulties in recruiting Chairs.
- Capacity of agencies to complete Individual Management Reviews (IMRs).
- Capacity of agencies to engage in the process.
- Ability to engage in the process, where capacity is stretched due to contributing to a number of review processes.

Consequently, some areas have been delayed in starting or progressing with their review. This has a significant impact on families, with one family member stating that "the whole process takes too long, far too long for families because you can't move on, you can't get to the inquest, you can't get anywhere until that DHR is done"[41] and there is no accountability for this on CSPs.

The ongoing issue of lengthy review processes affects confidence in the review process itself, particularly for family members, some of whom have fought for a review and have been involved in the process for many years.[42]

In her response to the statutory guidance consultation, the Commissioner recommended that updated statutory guidance is amended to impose a time limit on delaying a review rather than an expectation to complete within a six-month period, which is unrealistic. Guidance should clarify what constitutes a reasonable delay, such as protracted criminal proceedings or appeals.[43] The Home Office should also consider further reforms to the QAP, beyond the recruitment of public appointees, to address the gap in completion of overview reports and publications.

CSPs contribute a large proportion of funding for DHRs locally, and, in some areas, local authorities are the sole contributors to DHR costs.[44] The CSP also hold responsibility to maintain oversight of the DHR process. The Chair, working with the CSP has a responsibility for delivery. However, these two things often become confused or come apart, for example, due to the lack of capacity within CSPs, or because of the lack of consistency in how Chairs take on their responsibility to deliver DHRs, among other issues. Families have also expressed their concerns that some chairs take on too many reviews[45] and CSPs have reported challenges in recruiting chairs.

Delays at the point of quality assurance is also a problem. The DARDR Forum, highlighted concerns over delays at the point of quality assurance. These include backlogs in reviews for the QAP as well as inconsistent or unhelpful feedback, which require amendments before being resubmitted for quality assurance. The Commissioner also found that delays occurred right at the end of the process, between QAP approval and final publication.

To address this, many areas have instigated 'rapid review' processes enabling early learning to be identified by agencies and actioned as soon as possible before a comprehensive review begins. The Home Office outlined the components of a 'Scoping Review' within the draft revised guidance, which intended to support the management of increasing notifications. The 12 months since the draft guidance was published – with no final guidance confirmed – has led to inconsistent approaches across local areas in implementing effective rapid reviews.

2.2.2 Increasing number of reviews

Better identification of domestic abuse-related deaths, while welcome, does have a cumulative effect on the number of reviews being conducted at any one time. This is particularly the case for victims who die by suicide or 'hidden homicides'.

The number of DHRs that are heard at the Home Office QAP has increased year on year, with a 23% increase in the number of DHRs between September 2020 and September 2023.[46] Research is currently being undertaken jointly by Durham University and City St George's University of London to map the notifications received by CSPs and DHR commissions in order to track this increase in real time.

Despite this increase, the process or the resourcing for it, has changed little to accommodate this. The inclusion of deaths beyond those of homicide has not been sufficiently addressed or effectively managed within the statutory guidance.

The inclusion of domestic abuse-related suicide in the 2016 statutory guidance has had a particular impact here. While broadly supported, many feel the statutory guidance on these particular deaths is inadequate.[47] This has left the process fraught with inconsistency and uncertainty. These reviews raise questions and often require more complex legal considerations, such as in the absence of a charge for a domestic abuse perpetrator, or where a perpetrator retains parental responsibility for the children of the deceased. This means that there are often issues in the sharing of information and in engaging families, which can lead to reviews being further delayed.

The forthcoming changes to the naming of reviews, to clarify the scope of DHRs is a welcome change. However, without careful considerations about how to mitigate any additional resourcing issues, there is a risk of overwhelming CSPs as numbers of reviews could grow substantially.

The crux of this issue links back to capacity and a lack of clear guidance, not just for CSPs but also for the agencies, including specialist 'by and for' organisations and the wider specialist sector contributing to reviews, many of whom have a limited number of appropriate representatives who can carry out the panel role. This issue is exacerbated when multiple reviews accumulate at the same time and where the boundaries of agencies cross several

"Marie was a very much-loved mother, daughter, sister, and friend. Her mother describes her as "caring, funny, affectionate, bubbly and kind. She didn't have a bad bone in her body." *DHR Marie*

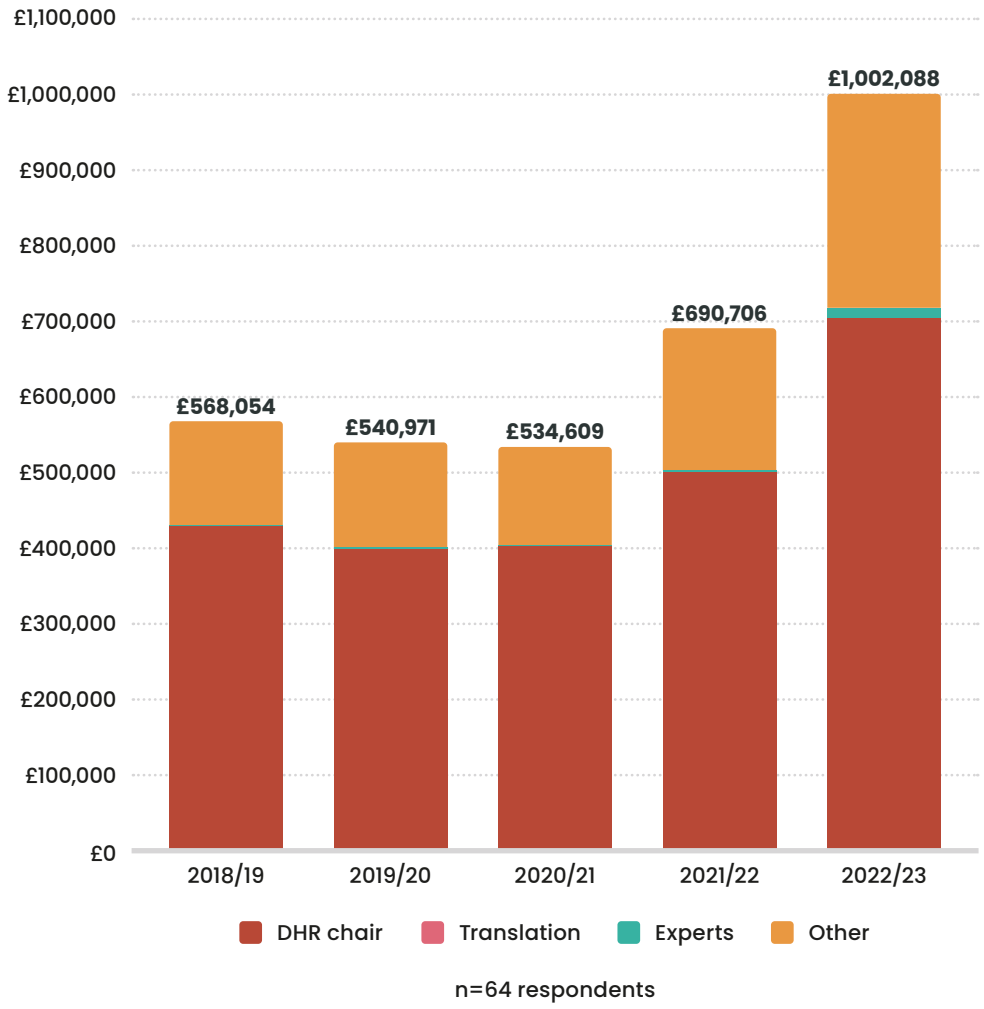
local authorities or NHS trusts. A DHR is a final opportunity to elevate the voice of a victim and to understand the circumstances that led to the death. It is imperative that anyone involved in a DHR panel feels able to give their uninterrupted attention to it and that families observing and contributing to this process feel that panel members are fully engaged.

The Commissioner trusts in the DHR process to 'illuminate the past to make the future safer.' However, where CSPs lack capacity to produce insightful, timely reviews (let alone implement recommendations), this represents a poor use of local resource, which should be maximised to learn lessons from loss.

2.2.3 Direct and indirect cost of undertaking reviews

Pilot areas have consistently reported that there is a lack of sufficient funding for Chairs, administrative support, and coordination, and not simply because the number of reviews had increased. A joint survey carried out in January 2024, between the Commissioner and Local Government Association (LGA) found that expenditure on DHRs has been steadily increasing in recent years. Local Authorities responding said they spent a combined total of £1m on DHRs in 2022/23, 45% more than in 2021/22, which in turn was 29% higher than in 2020/21.

Figure 2: Local Authorities total estimated expenditure on DHRs 2018/19 to 2022/23



n=64 respondents

Around three-quarters of that spending was on DHR Chairs. Respondents were also asked to provide the non-financial resource costs in FTE staff incurred in undertaking and implementing DHRs in 2022/23. Fifty-one responded, estimating a full-time equivalent of 81.6 FTE across all areas (or 1.6 FTE on average). Based on an average salary of £30k to represent the different roles involved, this equated to an annual cost of £2.4m in staff costs for the direct administration and delivery of DHRs.[48] This does not factor in the costs for the full panel members' time to prepare IMRs and take part in (often multiple) reviews, or wider agency capacity and time to engage with reviews.

Local authorities carry the financial burden of reviews, with the largest partnership contributions coming from PCCs and NHS Trusts. Ninety-six per cent of the respondents to the joint DAC-LGA survey reported their CSP was experiencing challenges in undertaking and implementing DHRs.[49] These challenges are a growing concern for CSPs who hold responsibility for conducting reviews with competing priorities for the same limited funding. It is imperative that action is taken to address these issues to ensure reviews remain of a high standard and can be effective in promoting change in policy and practice.

2.2.4 Difficulties in demonstrating impact

A study conducting an international comparison of Domestic/ Family Violence Death Reviews[50] found that all reviews examined in the study stated a reduction in death as a goal of the review process. However, none reported an actual reduction. Studies have shown that evidencing the impact of reviews on the number of deaths in this way is challenging, given the inability to establish a causal link between review recommendations and a reduction in deaths or harm.[51] It is particularly difficult to attribute the impact of DHRs on the number of domestic abuse-related deaths when improvements are being made in the identification of these deaths (especially suicides). This means that the number of domestic abuse-related reviews will rise, even as significant improvements to the system are made. A DHR and the recommendations made within them bring together multiple agencies to address gaps in responses and strengthen the coordinated community response to domestic abuse. The collective learning from reviews will be a driver for systemic change at a national level and, as such, contributions from reviews may take more time to be realised.[52] However, their importance in contributing to the reduction in future harm or the potential to elicit action that prevents a further incident in similar circumstances occurring again should not be underestimated. This is challenging not least because police and agencies have become better at identifying where domestic abuse may have been a factor – in suicide or hidden homicide cases – thus increasing the number of domestic abuse-related deaths recorded and reviewed.

The lack of national oversight or accountability contributes to these difficulties. Contributors to Rowlands' work describe how

> *"She was a unique, lovely, special and beautiful person Inside & Outside."* DHR Elaine

inconsistent leadership by the Home Office has contributed to the DHR being less than useable or useful.[53] A family advocate in the same research also expressed concerns about the length of time reviews have been embedded in practice, yet the same missed opportunities are repeated. Those interviewed by Rowlands felt that a lack of national oversight meant there was little assurance that reviews would lead to action.

Without a commitment to a mechanism that is primarily concerned with impact, we cannot know whether the investment both of resource for agencies and emotional capital of families, friends and those individuals working on a review is being best served.

The overarching aim from an oversight mechanism is to drive improvements in the local response to domestic abuse, building on the collective intelligence and insight from several hundred reviews. This may well reduce future deaths and suicides, and prevent domestic abuse, however more immediate benefits are:

- Improved local outcome-based action planning.
- Collective insight that leads to national policy change.
- A strengthened response to domestic abuse.

Notes

30. Domestic Abuse Act (2021): Section 17.
31. Rowlands, J. (2025). *The Potential and Peril of Reviewing Domestic Abuse-related Deaths*.
32. Sharp-Jeffs, N. and Kelly, L. (2016). *Domestic homicide review (DHR): case analysis report for Standing Together*; Chantler, K. et al. (2020). *Learning from domestic homicide reviews in England and Wales, Health and Social Care in the Community*, 28(2), pp.485-493.
33. Sharp-Jeffs, N. and Kelly, L. (2016). *Domestic homicide review (DHR): case analysis report for Standing Together*; Chantler, K. et al. (2020). *Learning from domestic homicide reviews in England and Wales, Health and Social Care in the Community*, 28(2), pp.485-493.
34. Home Office (2024). *Analysis of domestic homicide reviews*.
35. From 2019-2021, Manchester Metropolitan University ran a study of DHRs through their Homicide Abuse Learning Together (HALT) Project. The HALT project, with the help of Kings College London, collated a repository of 316 DHRs, and analysed 302 published from 2011-2019. These reviews had been collected via local authority web pages and reports were shared via HALT's websites. They have now been included in the Home Office Library. HALT | Domestic Homicide | Homicide Abuse Learning Together An innovative 3 year study aiming to address important gaps in existing knowledge of domestic homicide and to influence policy and practice.
36. HM Government (2022). *Tackling Domestic Abuse Plan*.
37. Labour Party (2024). *Labour Party Manifesto 2024: Our plan to change Britain*.
38. Prime Minister's Office (2025). *Safer Streets*.
39. Dangar, S. (2024). *Domestic Homicide Reviews: The role of family, friends and community – 'A hierarchy of testimony'?*

40. BBC News (2025). *Domestic abuse review delays are 'hell', bereaved families say* - BBC News.

41. Dangar, S. (2024). *Domestic Homicide Reviews: The role of family, friends and community – 'A hierarchy of testimony'?*

42. BBC News (2025). *Domestic abuse review delays are 'hell', bereaved families say* - BBC News.

43. Domestic Abuse Commissioner (2024). *Consultation on updating the Domestic Homicide Review Statutory Guidance: Written submission from the Domestic Abuse Commissioner for England and Wales*.

44. Local Government Association and Domestic Abuse Commissioner (2024). *Domestic Homicide Review Survey 2024: Research Report*.

45. Dangar, S. (2024). *Domestic Homicide Reviews: The role of family, friends and community – 'A hierarchy of testimony'?*

46. Home Office (2024). *Analysis of domestic homicide reviews*.

47. Rowlands, J. and Dangar, S. (2023). 'The Challenges and Opportunities of Reviewing Domestic Abuse-Related Deaths by Suicide in England and Wales'. *Journal of Family Violence*, 39, pp.723-727.

48. Local Government Association and Domestic Abuse Commissioner (2024). *Domestic Homicide Review Survey 2024: Research Report*.

49. Local Government Association and Domestic Abuse Commissioner (2024). *Domestic Homicide Review Survey 2024: Research Report*.

50. Bugeja, L. et al (2015). 'Domestic/family violence death reviews: An international comparison'. *Trauma, Violence and Abuse*, 16(2), pp.179-187.

51. Jones, C. et al (2022). 'Domestic Homicide Review Committees' Recommendations and Impacts: A Systematic Review'. *Homicide Studies*, 28(1).; Bugeja, L. et al (2015). 'Domestic/family violence death reviews: An international comparison'. *Trauma, Violence and Abuse*, 16(2), pp.179-187.

52. Bugeja, L. et al (2015). 'Domestic/family violence death reviews: An international comparison'. *Trauma, Violence and Abuse*, 16(2), pp.179-187.

53. Rowlands, J. (2025). *The Potential and Peril of Reviewing Domestic Abuse-related Deaths*.

"Luke was 23 years old when he died in April 2020. As a much loved member of his family, he is deeply missed." ***DHR Luke***

Chapter 3

Testing an approach to overseeing implementation

This chapter provides an overview of work to pilot an oversight mechanism, for implementation of DHRs, early evaluation, and recommended requirements for national roll out.

> ***"The Domestic Abuse Commissioner's 'Domestic Homicide Oversight Mechanism' seeks to add value, provide consistency, and improve the quality of DHR processes."***

3.1 Aim of the pilot

The purpose of the local oversight pilot was to test and learn about the best way for the Commissioner to oversee the implementation of recommendations and actions within DHRs, and to inform the development of the oversight mechanism for roll out nationally. While there are existing reporting mechanisms globally, none had been tested within the specific context of DHRs and with CSPs within England and Wales, and it was important to first test what resources might be needed, and identify how to overcome challenges, before rolling out.

The pilot was also the first time CSPs had been brought together in this way to focus on implementation of DHRs, and it provided an opportunity to learn from local practice and share between areas. The pilot provided an opportunity to understand the capacity and resource required to carry out effective oversight, the needs of local areas and how oversight can best support local implementation of recommendations and evidence impact.

The key considerations were:

- The tools needed to oversee implementation of DHR recommendations and action plans.
- Resourcing needed in terms of:
  - Analytical capability
  - Staffing input from local areas
  - Staffing within the DAC Office
- The challenges faced by CSPs and PCCs in participating in oversight.
- The ways in which national government currently consider recommendation and how they could participate in oversight.
- Best practice locally and/or nationally.
- The role of the Commissioner to support escalation of issues identified through DHR recommendations or implementation of actions.
- Sharing of good practice between local areas.
- The coordination of reviews locally and how this relates to oversight.

> ***"Andrea was quirky, her dress sense was kooky, and she was the first person I knew to eat organic food (long before it became fashionable) and to adopt a holistic life style."*** *DHR Andrea*

3.2 Methodology

Figure 3: Pilot timeline – year 1

Phase 1 January to April 2024

January to February

- Initial meetings and testing of data collection
- HALT webinars
- Oversight forms shared with pilot areas

March to April

- PCCs and CSP complete oversight forms
- DAC review of oversight form and early analysis
- Identify good practice examples (PCCs/CSPs and DAC)
- Joint learning event: APCC and DAC – DHRs and oversight
- Local Oversight Pilot: Stakeholder group (pilot sites)

Phase 2 May to September 2024

May to July

- DAC analysis and oversight forms
- Engagement meetings with pilot areas (dependent on oversight form responses)
- Action plan updates shared with DAC

August to September

- Learning event
- Early finding thematic reports dissemination of findings from DHR (Themes and trends)

Phase 3 October to December 2024

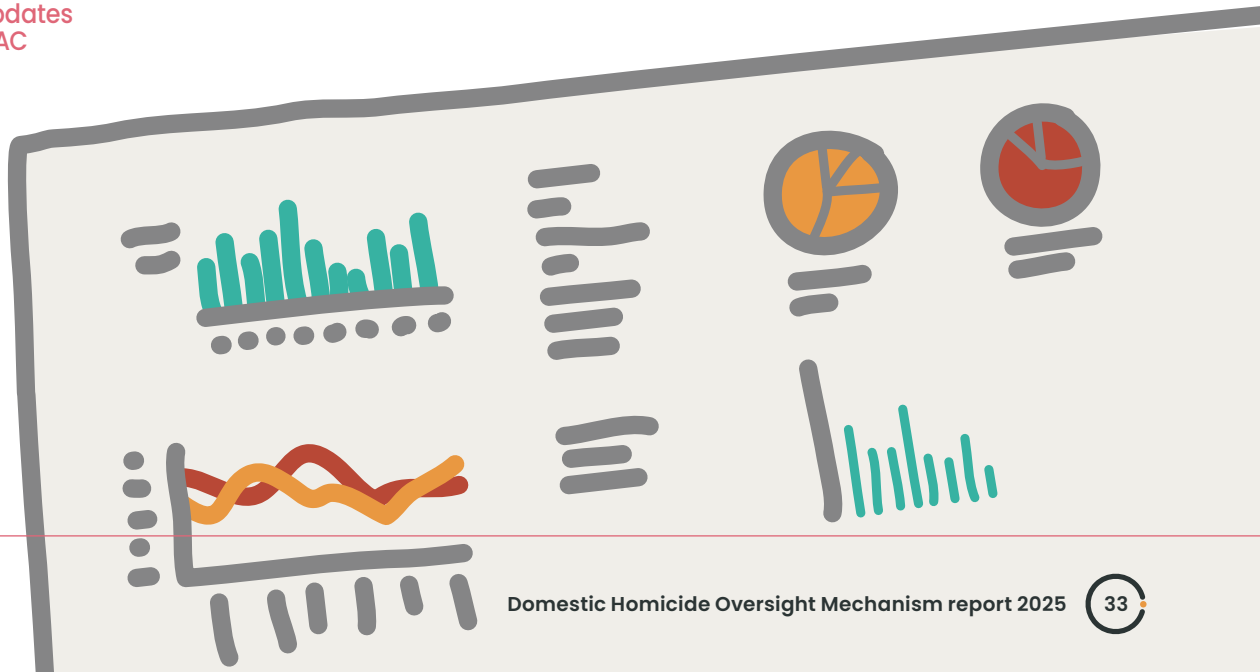
October to December

- Evaluation and pilot sites
- Feedback of findings to key stakeholders
- Learning event

Phase 4 January to April 2025

January to April

- DAC annual report
- National roll out of agreed model and process to all areas



"Charlie grew up in a secure family home and was described by her family as a kind and gentle soul who always looked for the good in people." DHR Charlie

3.2.1 Pilot design

The aims and objectives of the pilot were set out in the terms of reference, which can be found in Appendix A. This was developed in close collaboration with statutory and non-statutory partners, taking into account the considerations set out at 3.1. In considering the mechanics of oversight, two models for local participation, which can be found in Appendix B, were developed. One was led by PCCs, and the other by CSPs, with the purpose of determining which organisation would be best placed to coordinate at a local level.

This was to reflect the already embedded practice or significant involvement in some areas in the management and/or or sharing of learning from reviews, which is led by the PCC – for example, Greater Manchester Combined Authority (GMCA), Norfolk, Northumbria, Southend, Essex and Thurrock and Hampshire & Isle of Wight.

It was important to test a CSP-led model against a PCC-led one, given the Home Office's consideration of options for a more formal role for PCCs in DHR oversight. The APCC responded to the Home Office's consultation expressing support in having an oversight role, as their local responsibilities align with the intended outcomes of DHRs. It will also be crucial to consider the role of PCCs in light of the Government's devolution agenda, and how changing governance structures may influence the role, responsibilities, and functions of PCCs in relation to DHRs.

3.2.2 Recruiting pilot sites

During Autumn 2023, local areas were invited to express their interest in taking part in a pilot to test the two proposed approaches, bringing together CSPs and PCCs. To take part, areas were required to have at least one published DHR within the last three years, to ensure areas could fully engage with the pilot by sharing data on implementation from those completed reviews. The pilot examined reviews retrospectively, sometimes more than 12 months after publication.

Expressions of interest were received from 24 areas. Eleven CSPs and 10 PCCs were invited to participate in the pilot over a 12-month period. Only one area (Dyfed Powys) withdrew from the pilot, due to capacity issues.[54] They did, however, engage in the early process and provided feedback on their experiences.

3.3 Testing

The two models were tested from January 2024, and local areas were asked to provide information to the Commissioner at the start of the project (January 2024), at six months (June 2024) and at the end of the project (December 2024). Areas submitted their initial oversight forms on request from the Commissioner in March/April 24.

"Andrea was loyal and loving to family and friends, but had all the attributes of an actress, she could be demanding of herself and others, but gave as much as she demanded." *DHR Andrea*

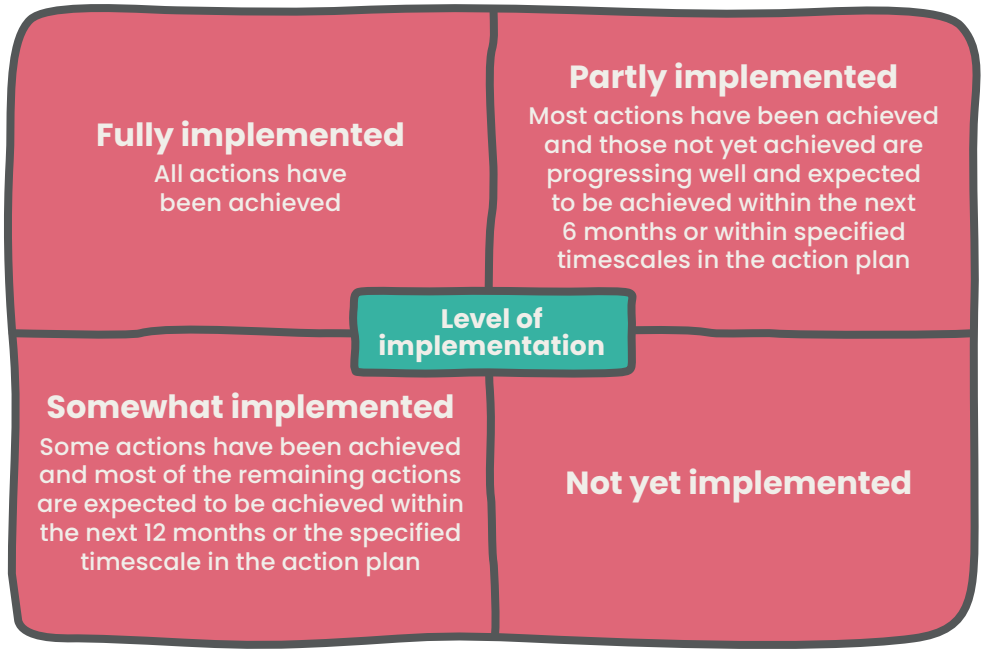
3.3.1 Gathering data on implementation

Pilot areas were asked to provide data to the Commissioner through an oversight form (see Appendix C) setting out progress against individual recommendations and their subsequent actions. This included an assessment of how well recommendations had been implemented.

Returned forms were amalgamated for detailed analysis. Across 21 pilot sites (which for some PCC areas related to multiple CSPs), there were a total of 76 DHRs, which made a total of 1,129 recommendations and 1,815 actions.

The Commissioner asked CSPs and PCCs to determine, through self-assessment, the level to which recommendations had been implemented, whether fully, partly, somewhat, or not yet implemented.

CSPs and PCCs were also asked how well they felt they had implemented the recommendations in terms of quality using a Gold, Silver, and Bronze standard, with guidance provided by the Commissioner to assist in this. The detailed criteria for each, can be found in Appendix D. Guidance for completing the oversight form, recognised that not all recommendations would fit neatly into the pre-determined categories, and that some recommendations may only be assessed against one or two elements of the criteria. There was no expectation that all



criteria must be met for a determination of a particular quality assessment to be made. However, a rationale was required.

Where possible, self-assessment returns were expected to be agreed with the partnership, recognising that this was a retrospective review of action plans that may have already been through partnership meetings and were no longer part of active discussions or agendas. How this agreement should be achieved was not specified for the purposes of the pilot. Some CSPs and PCCs found this retrospective look at recommendations meant it was more difficult to make an accurate assessment. However,

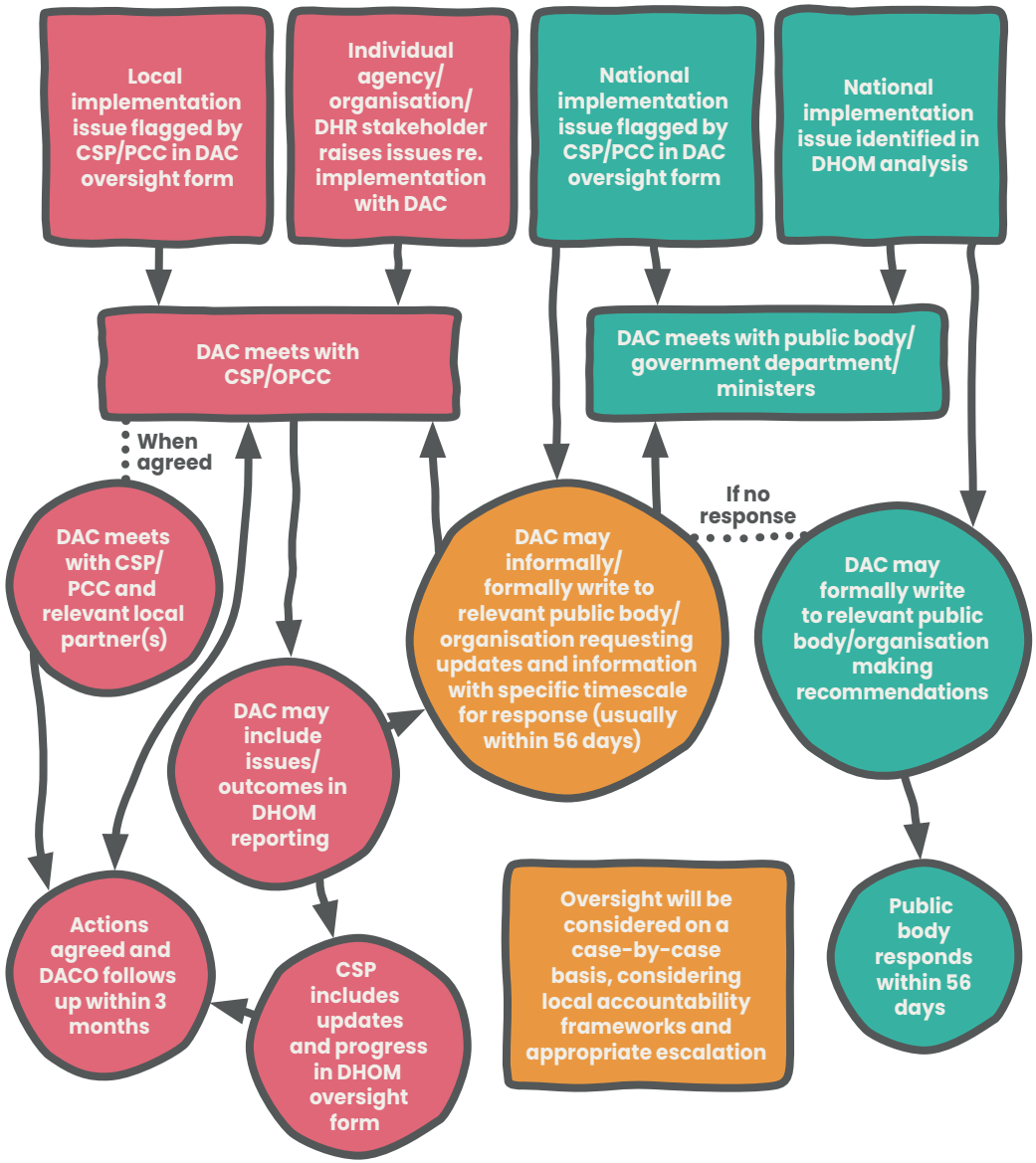
the Commissioner would not anticipate a similar delay between review publication and providing an update on implementation in any future national roll-out.

Data was also collected in relation to specific actions related to the overall recommendation. Action plans provide CSPs with oversight of agencies' progress against actions. Whether there was explanatory information on implementation varied across pilot sites, and few had existing processes for determining impact or outcomes.

The oversight form was designed to allow local areas to provide an explanation where recommendations were not implemented, or actions not completed. This was so that it could be understood in more detail and, where there were clear examples of agencies not fulfilling their responsibilities or recommendations, this could be escalated.

This was a key element of the pilot as the Commissioner wanted to understand why recommendations were not taken forward and create space within the mechanism to ensure the process itself is able to provide a feedback loop to Chairs, authors, and other interested parties. This would ensure the system can continuously improve.

An escalation process, as seen here, was designed to support local areas in highlighting barriers to implementation that could not be resolved through local governance. This process could be triggered by CSPs themselves or through analysis of oversight form data. This was not applied and tested in Year 1 of the pilot.



"[LINDA] was a beloved relative and friend. It is clear that the suffering caused by her death has been profound." DHR Linda

3.3.2 Building networks and sharing learning

Through the pilot, the following methods were implemented to share learning:

- A 'Domestic Abuse-Related Deaths Newsletter' was established sharing research and notable best practice.
- The Commissioner collaborated with the LGA and APCC to convene the Domestic Abuse Related Deaths Review Forum, a quarterly event, with a growing membership of those leading on the conduct of DHRs across CSPs, Local Authorities, PCCs and health.

3.4 Findings from pilot site data

There were considerable challenges in collecting and analysing data for the local oversight pilot, which are set out in more detail below. Of the data that was able to be analysed, findings are set out in a dashboard at the end of section 3.5.

3.5 Quantitative findings

Despite these challenges, the data provided by local areas provided significant insight into the implementation of DHRs, which is critical to the work to improve the response to domestic abuse. Equally, the process provided the Commissioner with an understanding of what is needed to truly support and hold agencies to account in the implementation of reviews.

Data provided within the oversight forms enabled analysis of the 76 DHRs.

There were 1,129 recommendations, with a summary shown in dashboard 1 at the end of section 3.5. The key findings from these recommendations were as follows:

- **Who recommendations were for:** 81% of recommendations were made at the local level, with 6% made at a regional level and 4% being national. Twenty-five per cent of recommendations were made for the CSP. As the pilot site data collection broke down recommendations by their actions, and which agencies the actions were for, analysis was conducted at the action-level rather than the recommendation level in order to present the most detailed overview of the DHR action plans. Separately, however, themes and trends analysis (shown in dashboard 2, at the end of section 3.7) of the DHRs themselves did explore recommendations made to specific agencies, albeit this was the DAC office's interpretation of DHR reports.

- **The level of implementation:** 975 recommendations (86%) were given an implementation assessment by the local area, 154 (14%) were not and have been categorised as missing/blank. Of these 975 recommendations, 671 (69%) were fully implemented and 158 (16%) partly implemented. Therefore, 829 (85%) of assessed recommendations were either fully implemented or were expected to be fully implemented within six months of submitting the oversight form. Fifty-eight (6%) were somewhat implemented and 88 recommendations (8%) were not yet implemented. For 154 (14%) recommendations, the CSP could not confirm a level of implementation. We anticipate that this may be down to the resourcing and capacity required to monitor implementation and to provide this information at the local level.
- **The quality of implementation:** Quality assessments were provided for a total of 899 (80%) recommendations, while for 230 (20%) of recommendations a quality assessment was not provided. Of the 899, 725 (81%) were assessed as Gold, Silver or Bronze – 281 (31 %) were assessed Gold, 263 (29%) Silver and 181 (20%) Bronze. One hundred (11%) were at an early stage of implementation and 74 (8%) were not met. Effective resourcing of the oversight mechanism would allow for greater independent scrutiny of these ratings.
- **The quality of implementation relative to the level of implementation:** When including the missing data, 59% of recommendations were identified as fully implemented, of which 42% of those were implemented to a Gold standard. This suggests local areas consider a fully implemented recommendation is more likely to be at 'Gold Standard', i.e. provided strong evidence of change. For the 158 partly implemented recommendations (14%), Bronze standard was the most frequently reported (35%).

There were 1,815 actions, relating to 1,129 recommendations, which were analysed to determine:

- **Which agencies actions were for:** There were 275 actions for the CSP and the only singular agency with over 200 actions was Police (215). Local Health Trusts, Domestic Abuse Partnership Boards, Integrated Care Boards, Adult Social Care, Mental Health Services, and Domestic Abuse Services all had over 100 actions each. These are set out below in dashboard 1.
- **The number of actions that were not completed:** There were 25 occasions where actions were abandoned, across 12 agency types. As an action could apply to more than one agency, this figure is higher than the 21 actions that were abandoned overall. There were 138 occasions where actions were incomplete across 29 agency types. Again, actions could apply to more than one agency, so this figure is higher than the 72 actions that were assessed as incomplete. CSPs provided reasons for abandoned and incomplete actions in their responses, and this is explored in more detail later in this chapter.
- **The number of completed actions:** In total, 1,288 actions were completed. The Commissioner was pleased to see the proportion of actions completed within reviews and is keen to ensure that the development of the mechanism for national roll out is fully resourced to allow for interrogation of completed actions with as much detail and consideration as those that are not completed.

"Storm's sister said that Storm was a loving, passionate person who was really kind to others." *DHR Storm*

DASHBOARD 1

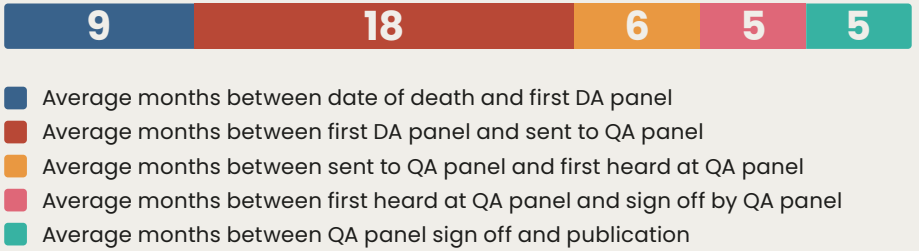
DHR action plan data return analysis from pilot sites

DHR action plan data return analysis

76 **DHRs** included

70% had been **published** at the time of collection

37 **months** average from date of death to publication of DHR



Recommendations

1,129 **recommendations** included

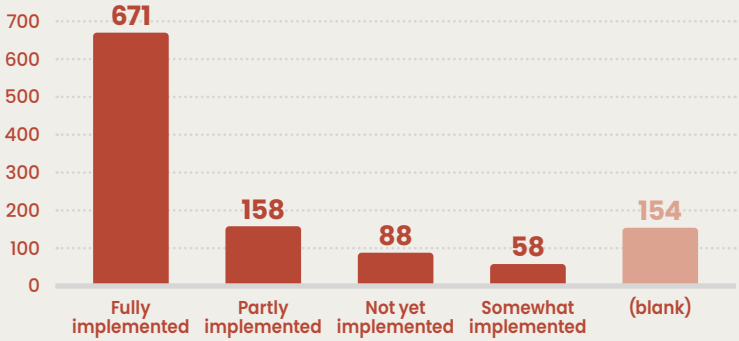
25% of which were made for the **CSP**

81% of which were made for the **local level**

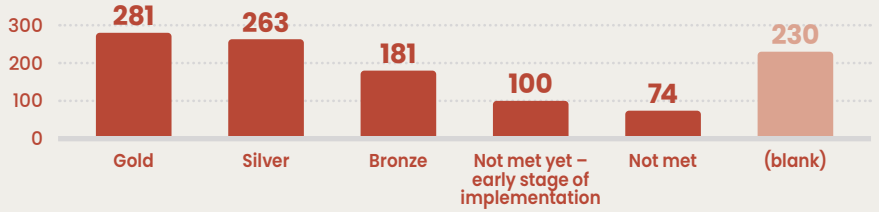
59% of recommendations were assessed as **fully implemented**

42% of those fully implemented were assessed as **gold quality**

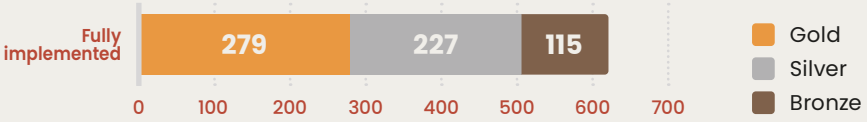
Implementation assessment of recommendation



Quality assessment of recommendation



Note: 'Not met yet', 'not met' and 'blank' have been excluded from this chart so data will not sum to 671.



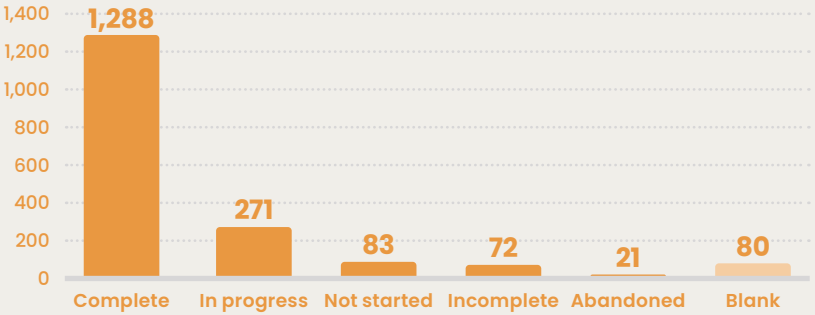
Actions

1,815 actions

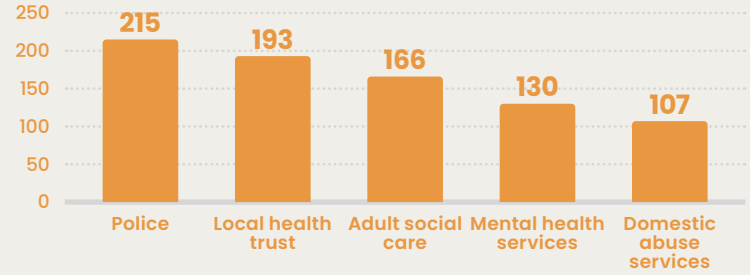
71% of actions had been **completed**

15% were **in progress**

Progress status of actions

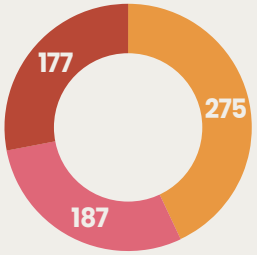


Actions for individual statutory agencies and DA services



Note: An action can be made for more than one agency so summing all agency-based actions will total more than 1,851.

Actions for CSPs, DA partnership boards and ICBs

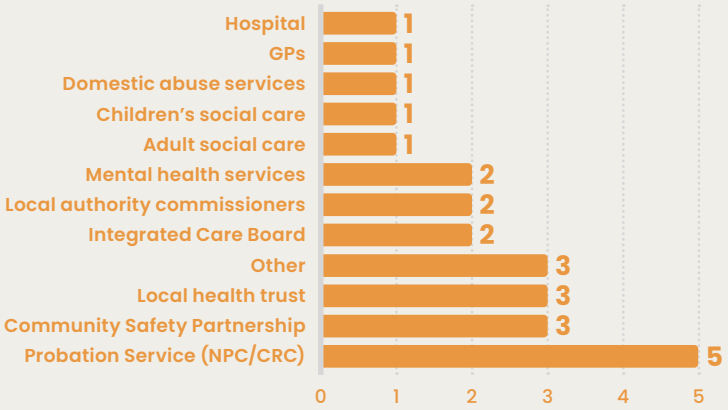


- Community Safety Partnership
- Domestic Abuse Partnership Board
- Integrated Care Board

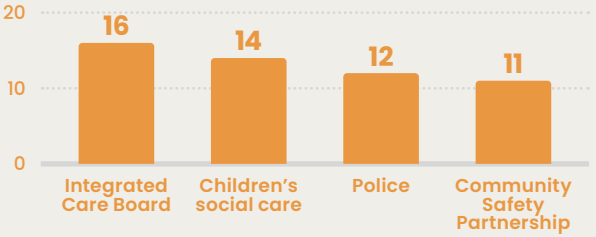
10% were for **local health trusts**

12% were for **police**

Abandoned actions by agency



Incomplete actions by agency (for those agencies with more than 10 incomplete actions)



domestic abuse commissioner

3.6 Qualitative findings

While the pilot lacked resource to report on and analyse every recommendation response, some interesting and excellent practice was identified. Particularly notable practice has been drawn out and is included in Appendix E.

The data also provided further context for the actions that were abandoned or incomplete, and insight into how to quality-assure self-assessment of implementation.

Reasons for abandoned actions included:

- A lack of resource and capacity.
- Organisational change or restructure.
- Instances where a recommendation was superseded by organisational change.

Reasons for incomplete actions included:

- A lack of resource or capacity.
- Conflict with other processes.
- The action being related to a national recommendation with no feedback or update.
- Other reasons including an IT issue that could not be fully resolved.

PRACTICE EXAMPLE

Lack of resource/ capacity

The following recommendations were made by DHRs involved in the pilot:

1. *"Probation to reinstate daily meetings between CPS prosecutors and Court officers (and, where appropriate, the court IDVA)."*

   The subsequent action for both services stated that Probation was to reach out to CPS prosecutors, Court officers and Court IDVAs to set up the meetings. This action was abandoned due to a lack of resource and capacity. It was noted that meetings were reinstated informally and were happening when possible given staff shortages within both organisations.

2. Multiple agencies to conduct an audit of content and frequency of training to agencies involved with this case, to ensure that learning from the review is incorporated.

   The action was marked as 'incomplete' and the reason provided that *'No capacity in training to provide a comprehensive package covering all these areas, therefore some were prioritised'.*

"Her children were the biggest loves of her life. She was a lioness where they were concerned getting help with the children's needs, when there was little help being offered. She was so proud of their achievement." *DHR Angela*

While it is clear from the local response that agencies are doing their best within their resources to implement change, the sporadic implementation of such actions has the potential to lead to further gaps in response and does not enable prevention focused recommendations to be realised.

One of the limitations in the pilot has been the capacity and resource to implement escalation processes. While it is the role and remit of the CSPs to escalate such issues locally, there is currently little capacity to escalate issues with a wider reach (such as training) to a national level.

In some instances where an action was abandoned due to other influencing factors, areas were making efforts to bridge the gap in practice or policy until such a time as actions may be completed.

To quality assure local areas' self-assessment, areas would ideally provide evidence where relevant to validate their Gold, Silver, or Bronze assessment. Since this was a retrospective review, where an existing expectation had not previously been set in DHR statutory guidance, there were fewer examples of clear evidence. However, some were able to support their assessment with data, which provided insight into how DHR recommendations are implemented locally.

PRACTICE EXAMPLE

Organisational change

A recommendation stated that the Joint Commissioning System Optimisation Group (JSOG) were to:

"Develop an integrated approach to mental health support including integrated teams and pathways for those with mental anxiety and distress that don't meet current thresholds."

The action for mental health services, Local Health Trust, Local Authority Commissioners and JCSOG was:

"JCSOG were to develop an integrated approach to mental health support including integrated teams and pathways for those with mental anxiety and distress that don't meet current thresholds."

The action was abandoned due to organisation change or restructure as this recommendation was reliant on mental health transformation, which was considered slow and cumbersome. Instead, this area was drafting dual diagnosis principles in place of a strategy at this time.

> *"He described Suzanne as a beautiful young woman."* DHR Suzanne

PRACTICE EXAMPLE

Assessing quality of implementation

Evidencing the effectiveness of an action in recording Domestic Violence Disclosure Scheme (DVDS) referrals at MARAC, one oversight form response said that in response to the implementation of a DHR recommendation:

"MARAC has seen an increase in referrals for DVDS in the last year (Nov 2019-Nov 2020) by 40%, demonstrating an increase in awareness of DVDS and referrals."

There were also examples of where areas could not evidence improvement through audit or specific tracking but could, however, provide some assurance through supervision and feedback.

In one CSP area, the recommendation stated:

"The [Police] to audit the 'Strengthening Local Policing' programme' to ensure it enables a consistent and robust process for the supervision of all domestic abuse incidents/crimes."

In this case, Police had taken action to incorporate focused supervision into their BCU model and ensure investigation by dedicated safeguarding teams. In reviewing the implementation of this recommendation for oversight, the CSP noted that Police in their feedback said that there is more improved supervision and better focus on crimes examined. Police input reflected that:

"There does, from work I have reviewed since, appear to be more focused and targeted supervision of crimes."

In assessing the quality of implementation, the CSP stated that their review panel agreed with Police feedback that there had been a change in practice and culture due to this recommendation and other work already being done to improve supervision within the [Police]. While they did not feel able to apply the Gold standard as they had not conducted an audit to measure factors that would result in a Gold rating, there was consensus and the opportunity to challenge Police self-assessment locally as part of the oversight process.

3.6.1 Variation in recommendation objective

The number and quality, and objectives of recommendations varied considerably between reviews – with some including over 40 across a range of activities. The recommendations ranged from significant, organisational change to straightforward agency actions.

3.6.2 The CSP's role

There are a high number of actions for CSPs and domestic abuse partnership boards, raising potential conflict given their role in quality assuring and overseeing actions at a local level.

In evaluating the pilot, CSPs reflected that they did not consider it their role to judge quality of implementation. Instead, theirs was to challenge each agency on the status of recommendations and report on outcomes within action plans. They felt that governance of quality of implementation was the responsibility of each agency's oversight processes and internal auditing.

3.7 Thematic findings

Some thematic analysis was carried out looking at reviews from pilot areas, building on work conducted by HALT research and commissioned by the DAC. A summary of HALT's work can be found in Appendix F. The recommendations were coded against themes including which agencies they were for and the broader, often recurring, themes they related to. This is shown in dashboard 2.

Capacity, resource and the availability of the appropriate data and systems in which to extract that data meant that this analysis was restricted to a summary of the themes without the broader context of the reviews. This meant the analysis was unable to consider demographic data relating to victims and perpetrators or whether the review related to a homicide or domestic abuse-related death.

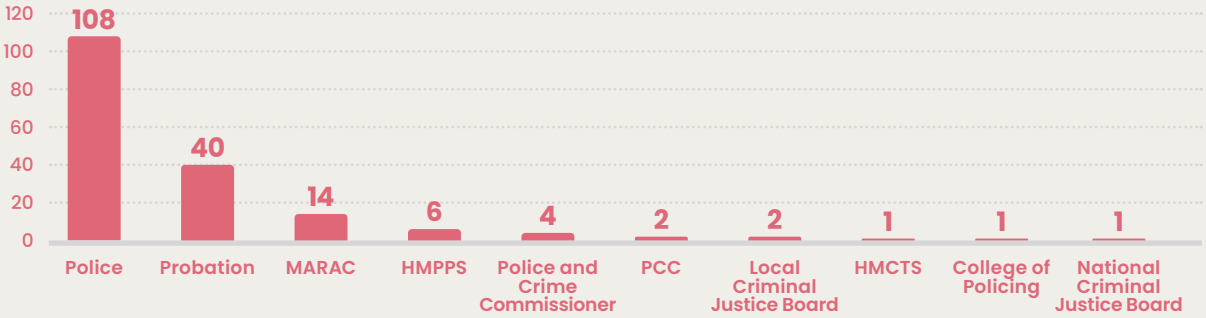
"As a family we have sadly lost our mam who was a great caring loving woman who would go out of her way to help anyone." DHR Mrs C and Miss A

DASHBOARD 2

Pilot sites themes and trends analysis

Recommendations identified within DHRs for...

Criminal justice



Adult services

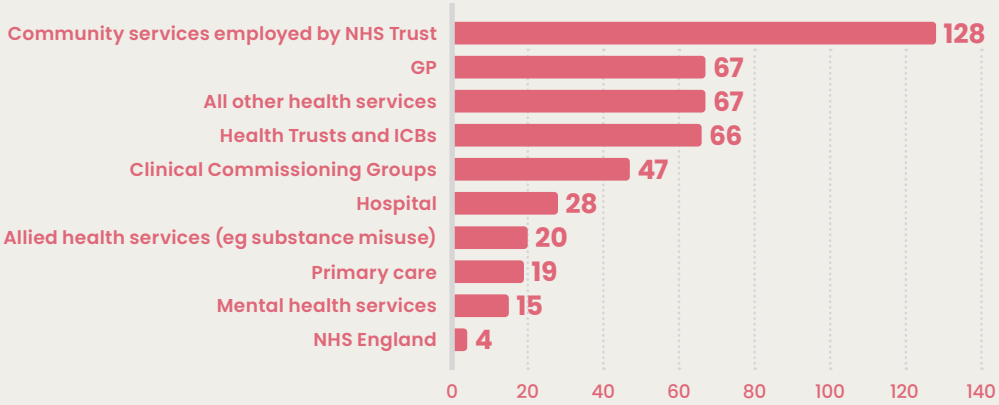
46

recommendations for **adult social care**

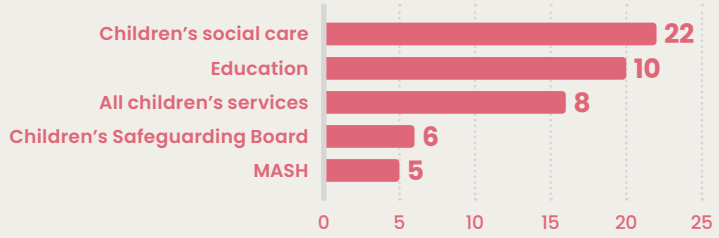
29

recommendations for **adult safeguarding boards**

Health

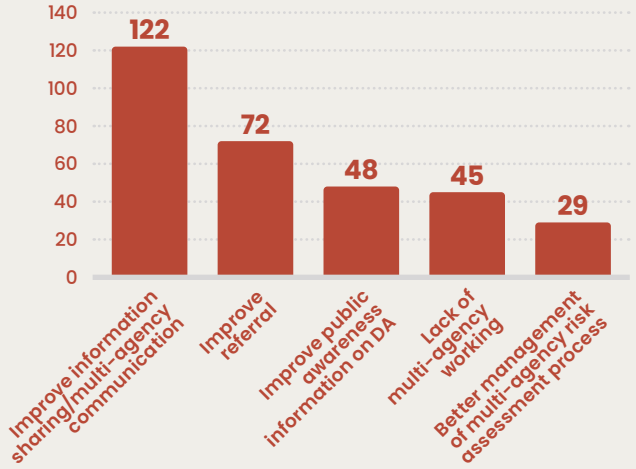


Children's services

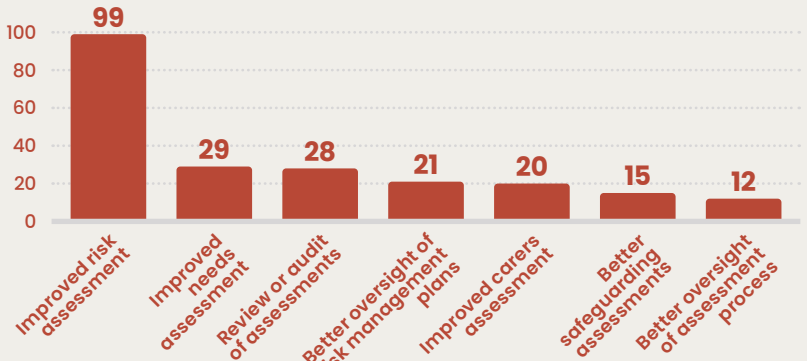


Improvements DHRs identified as needed

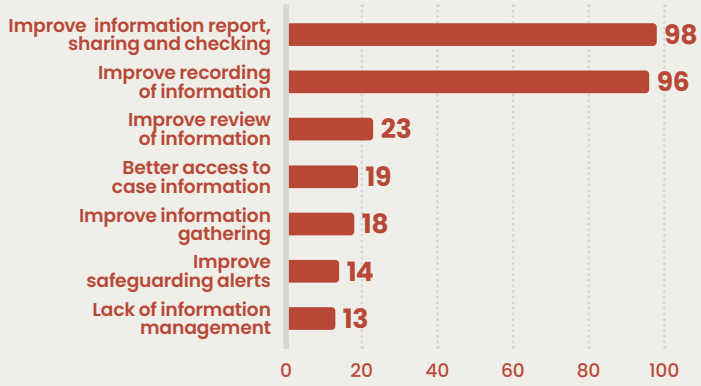
Multi-agency working



Improving assessments



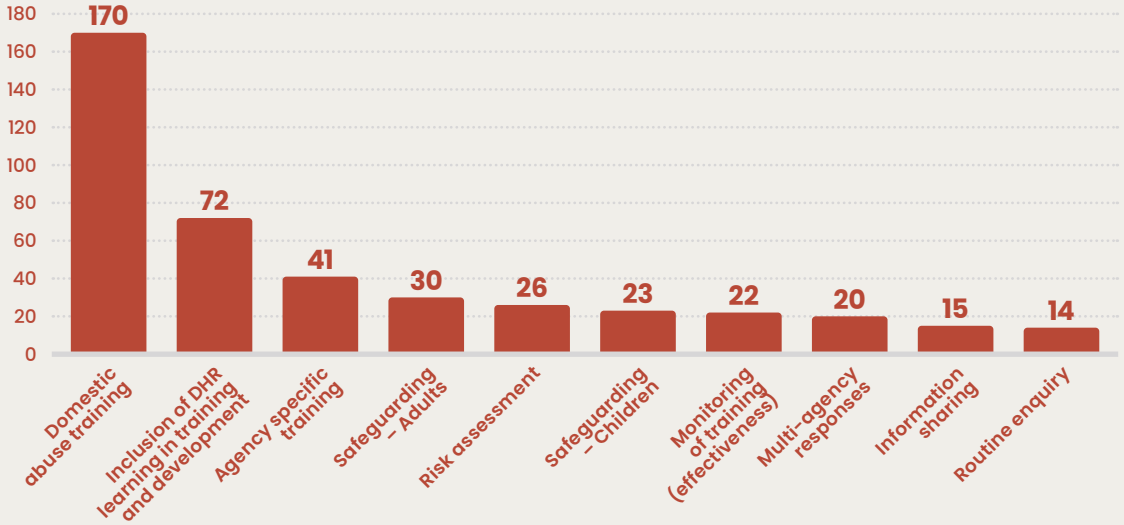
Information management



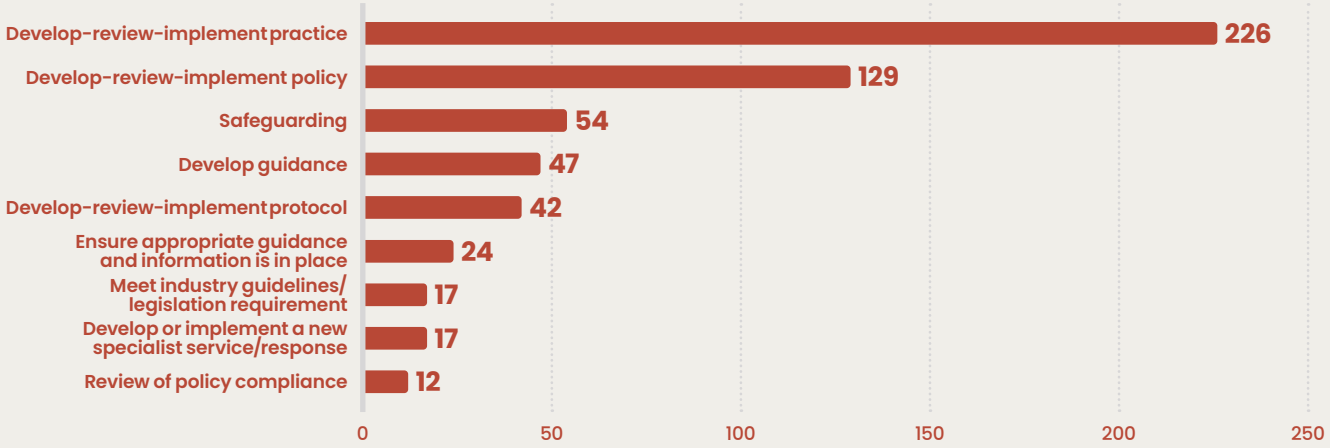
Developing practice

Improvements DHRs identified as needed (continued)

Training and development of staff



Policy and process



3.8 Process findings

At six months from the start of the pilot, the Commissioner undertook a survey of pilot areas. The findings from this can be found in dashboard 3. The evaluation sought views on the CSPs and PCCs experiences of the pilot, their views on data collected and any learning/challenges within the proposed model and wider DHR process.

Experience of the pilot indicates that CSPs and agencies are committed to achieving change with support for DHR processes and implementation locally.

3.8.1 Completion of data requests

In the absence of a fully developed IT system for the pilot and to test the level of information that might need to be gathered, a Microsoft Excel form was designed and shared with local areas. For the majority, the form was considered either easy or very easy to complete, and enabled gathering of data in a consistent format. However, where a local area was responding for several DHRs, this proved more difficult.

> ***"This was challenging as each of the CSPs taken differing administrative approaches to the oversight and action monitoring, which made it difficult to standardise within the document. But I feel this could be resolved if CSPs agree to implement this process to monitor future DHRs so the standardisation would be established for future DHRs."***
> [OPCC pilot area]

Guidance was provided to enable local areas to implement the quality standards, the majority found this useful and provided helpful feedback for improvement. Some of the issues with the form related to its functionality. Those with a high number of recommendations found the form to be time consuming. One suggestion was to **develop an online form that multiple partners could access and update simultaneously to reduce the time and duplication**. This is a key element of scoping for the Commissioner in developing a digital system.

3.8.2 Local prioritisation

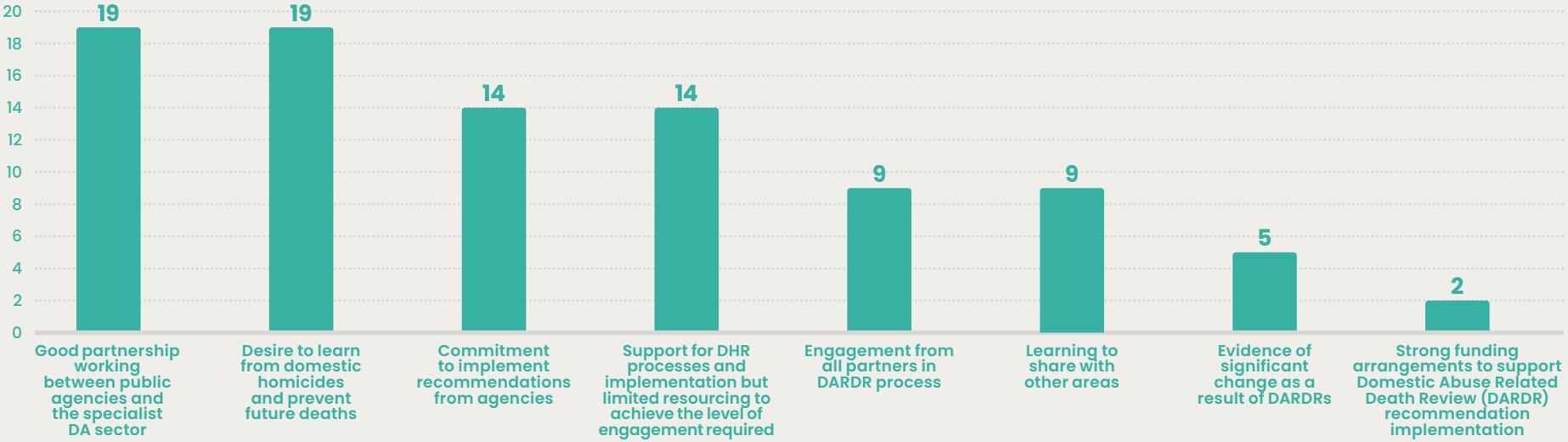
Pilot areas reported that their participation in the Commissioner's oversight pilot increased interest in the implementation of DHRs within their area, and the consideration of systemic change needed. Areas responding to the pilot evaluation survey noted that the process of oversight had itself promoted more outcome-based thinking, and half of all pilot sites said this resulted in greater engagement in reviews.

"Rachel was described as outgoing and active, loved animals, kept, and rode horses, and trained her dog in agility." *DHR Rachel*

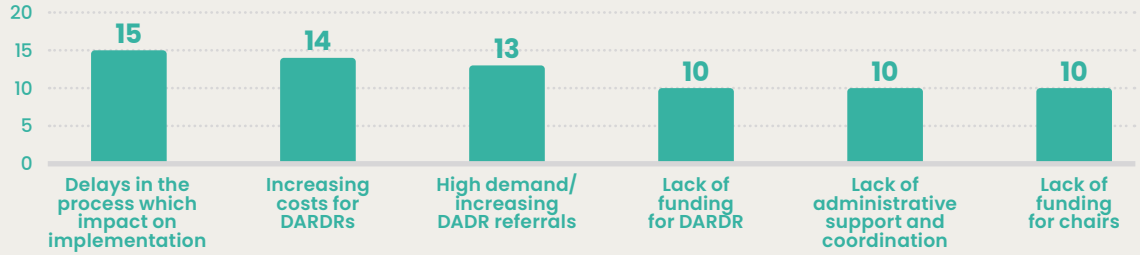
DASHBOARD 3

Pilot site evaluation of their involvement with the project and data collection processes

What have you learnt is working well in your area?



Main challenges identified



Implementation

76% of areas felt DHRs were being implemented **well or very well**

However, **almost half** of areas had issues or concerns they wanted to raise with the DAC office

Has understanding changed from taking part in the pilot?

90%

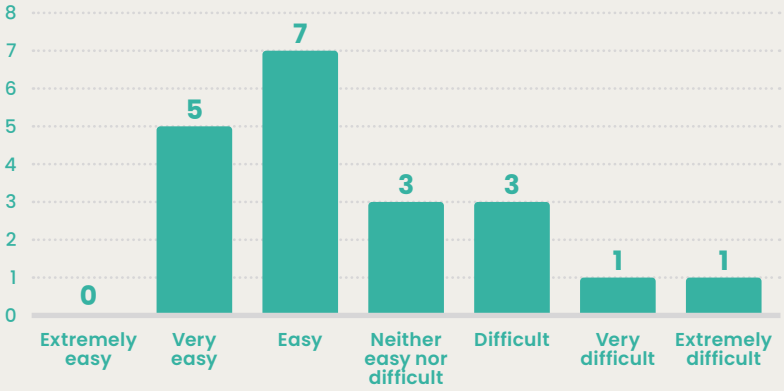
of pilot sites said their **understanding of the DHR process and implementation** had changed as a result of taking part in the pilot

How easy were the quality standards to assess?

35%

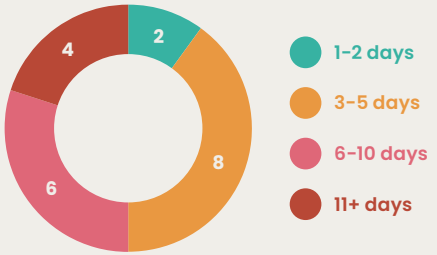
of pilot sites had **difficulties in assessing the quality standard of the implementation** of the action or recommendation

How easy was the oversight data collection form to complete?

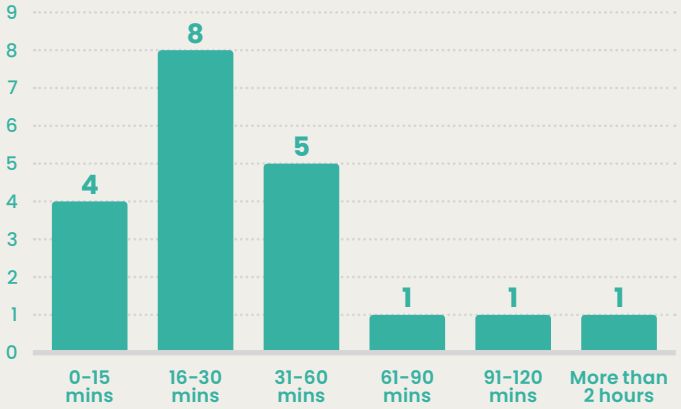


How long did it take to complete?

The whole oversight data collection form



An individual recommendation tab with up to 10 actions



For areas in which the involvement in the pilot had improved accountability, they identified having done the following as a result:

- Reviewed the process for disseminating learning across local boards and for sharing learning across a police force area.
- Considered who will be responsible for the management of the action plan.
- Implemented new processes and reviewed legacy work around recommendations to ensure they have been progressed appropriately.
- Implemented rapid review processes and oversight procedures with key stakeholders to ensure recommendations are progressed in a timely manner and learning is shared and implemented.
- Established routes to share learning, concerns, and updates across DARDRs.

3.8.3 Local resourcing

As set out in Chapter 1 of this report, the Commissioner's team observed problems with capacity and resource constraints among pilot sites. Twenty-three per cent of pilot sites stated capacity limited their ability to engage and progress actions in a timely manner. Some areas commented on the disconnect between panel members and those tasked with implementation within organisations.

3.8.4 Challenges in data analysis

There were considerable challenges in piloting an approach to oversight with the tools and resources available. In particular, the Commissioner's office encountered problems with collection and data analysis, which are summarised below.

1. **Existing technological tools were unable to manage the volume of data:** The data collection forms completed by the pilot sites resulted in a large dataset of nearly 1.4m cells in Microsoft Excel. Interrogating this data, for analysis purposes, in Excel spreadsheets was problematic. Both formula and pivot table functionality were vulnerable to processing limitations and the risk of human error. This method of data collation and analysis, if scaled up to a national roll-out, would be untenable.
2. **Subjective assessment of implementation locally:** Data provided was largely based on self-assessment, and so variation or bias could creep in. Different perspectives can impact on assessment and areas may be viewed as 'marking their own homework.' The Commissioner's office lacked capacity or resource to fully interrogate individual returns.
3. **Retrospective review of action plans:** For the pilot, this was unavoidable but did mean that areas were less likely to speak to agencies individually to seek their views on implementation. If the processes were to be rolled out nationally, some pilot areas said they would include this assessment as part of their assurance mechanism and obtain the views of other agencies, suggesting this might happen through their DHR subgroup.

"You could talk to her about anything. She loved life to the max and would often throw house parties. There were many good times when we went on holiday with families and friends." *DHR Barbie*

4. **Shared responsibilities locally:** In one-third of pilot areas, there was a lack of clear partnership arrangements for funding DHRs and recommendations or actions simply made for 'all agencies'. While these do not represent high quality recommendations (which the statutory guidance states should be SMART and targeted), they nonetheless exist, which limits the ability of the Commissioner to hold individual agencies to account.
5. **Inconsistent action plans:** Across areas the format of actions plans varied, which made requesting action plans for review difficult, as data could not be collated consistently. Therefore, a bespoke form for data collection had to be used.

3.8.5 Creating stronger communities of practice to support local areas

It is clear from pilot sites' responses in the evaluation that sharing good practice is much needed. It should take several forms, from face-to-face networking either virtually or in person, to online forums, training, and newsletters.

Efforts made by the Commissioner's Office to bring pilot areas together to share their experiences were hugely welcomed by CSPs and PCCs. Network meetings and learning events were very well attended, with local areas expressing a real need for these kinds of connections and strong desire for the Commissioner to facilitate them.

3.8.6 Comparison between CSP and PCC-led areas

Of the 21 local areas participating in the pilot, 11 were led by CSPs and 10 by PCCs. Evaluation of the process found that, in general, CSP-led models were more efficient than PCC-led models, although there were some benefits to a PCC-led approach.

There is a consensus among PCCs that they should have a role as their responsibilities align with the desired outcomes of DHRs. Therefore, their involvement in the process is key to improving local responses to prevent domestic abuse and homicide.[55]

However, they did express concerns around delivering oversight on DHRs with regards to the operational independence of partners. While PCCs do hold power to convene, there is no existing broad ranging governance arrangement that gives powers to PCCs to hold agencies accountable for action on recommendations.

Equally, all data generated – regardless of model - relied on CSPs to provide information. During the pilot, PCC-led areas completed the oversight forms and acted as a single point of contact with the Commissioner's team. The benefits of this were that the PCC was able to coordinate across CSP areas and convene partners in discussions about implementation. However, from a data collection perspective they relied on CSPs to provide the data, adding inefficiencies to the process.

> *"Bethany spent a lot of time with, and was close to her immediate family. When it came to their relationship as mother and son; DJ and Bethany were said to be, 'two peas in a pod' and 'best friends'."* DHR Bethany and Darren

Through oversight, the reach of PCCs into DHR-related meetings, panels and steering groups is expanded, increasing their understanding of reviews and bridging the gap between CSPs and PCCs locally in relation to DHRs.

Notes

54. During the pilot, the SUSR process for Wales was formally launched. This is likely to have some bearing on how the Commissioner engaged with CSPs and PCCs in Wales.

55. Association of Police and Crime Commissioners (2025). *APCC consultation response: Updating the domestic homicide review statutory guidance*.

"She loved her sustainable garden and loved finding new places to visit." ***DHR Angela***

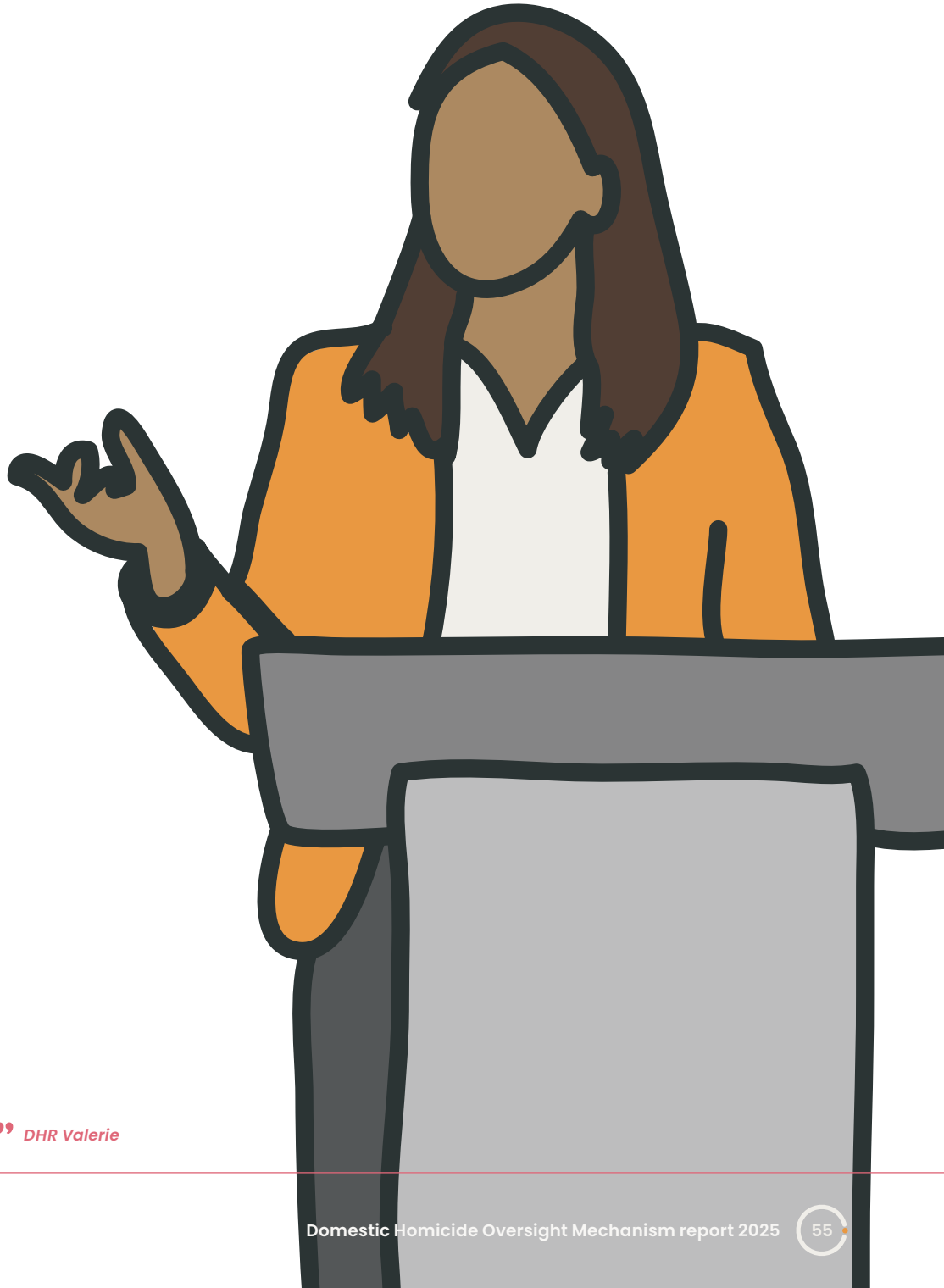
Chapter 4

National policy recommendations from DHRs

The Commissioner examined the extent to which recommendations made to national government had been implemented, and her findings were deeply concerning. Just as we expect local areas to take DHR recommendations seriously, so too must national government, equipped as it is with the resources and levers to effect change. It is simply not acceptable that recommendations made to national government, after careful consideration and the loss of human life, are left to languish.

Until now, national recommendations have been largely perceived as ignored or disregarded, and reviews considered a local endeavour.[56] However, they do often contain recommendations for national agencies and national government, which can lead to significant change at national level. There is also a role for national government in considering those consistent themes that emerge from DHRs, indicating a systemic issue that needs addressing nationally.

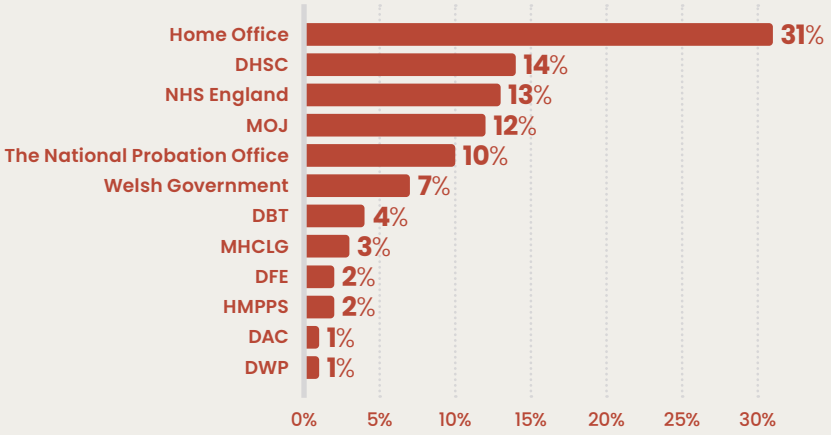
For the first time, formal responses to national recommendations were sought for all national recommendations made by available DHRs on the library from 2019-2021. These are being shared publicly by government departments and are provided in full on the Domestic Abuse Commissioner's website[57] and summarised below in dashboard 4.



"She was a very kind lady, who wanted to see her children happy and cared for." *DHR Valerie*

DASHBOARD 4
National recommendations

Government departments requested to respond to national recommendations



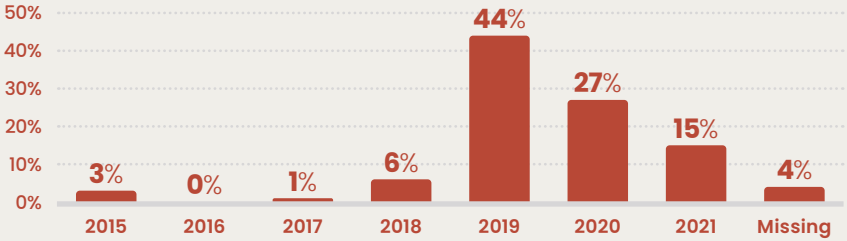
The Home Office

had the **most national recommendations** and were asked to respond to

31%

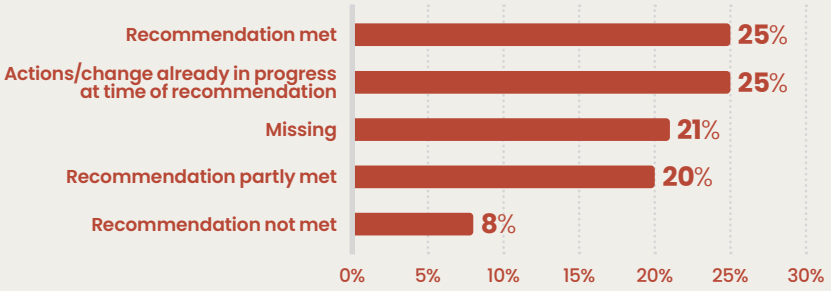
of the recommendations made

Year national recommendations made



A total of **110 national recommendations** made between 2015 and 2021

Implementation of recommendation

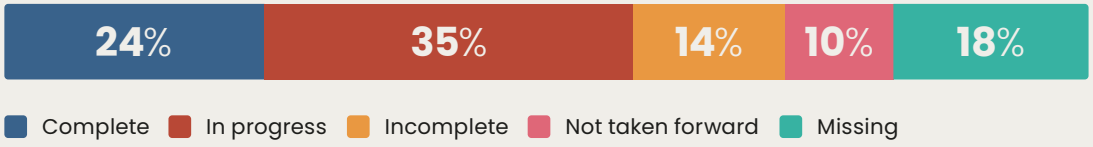


Note: Due to rounding, charts do not always appear to sum to 100%

24%
of recommendations have been **completed**

25%
of recommendations have been **met**

0%
of areas could confirm that they had **updated the CSP** on the outcome of the recommendation



domestic abuse commissioner

There were 110 national recommendations – the majority of which were for the Home Office – and, since 2019, the number of national recommendations has reduced year on year.

In examining national recommendations, the Commissioner found that:

- There are delays in recommendations reaching the Home Office.
- Recommendations are often simply shared with the DHR team within the Home Office, and not always with the team most relevant for implementation.
- Some recommendations are made to the Home Office by default, when they should be made for other departments.
- There is no coordination across government for analysis or implementation of recommendations.
- There is no mechanism for DHR chairs to engage with government departments when setting recommendations. Some chairs do make efforts to engage with government departments, but this is not always straightforward.
- There is no routine communication with local areas on the implementation of their recommendations. Government departments or other national bodies either had not or could not confirm whether CSPs had been updated.

Most shockingly, in the majority of reviews, the national body or government department was not aware of the recommendation made for them or was unable to confirm that they were aware (56%). Government departments could not confirm that they had updated the CSP on implementation of their action.

To ensure there was a response to each recommendation where possible and with agreement of the Home Office, the Commissioner sought responses from the government departments who held responsibility for that policy area on any work they may have done related to the recommendation.

There were two examples in which recommendations would have been better placed with the Department for Business and Trade (DBT). However, they did not feel able to respond, having no prior knowledge of the recommendation and at this late stage in the process.

Despite the considerable concerns outlined above, there are a number of examples of learning from DHRs that have been implemented and led to national policy change. It is vital that this becomes the norm, and not the exception, and information fed back to CSPs and to families on progress.

“She had bundles of life and liked to be the life and soul of the party. Diana was rarely happier than when she was on the dance floor with her friends and sister.” *DHR Diana*

PRACTICE EXAMPLE

National implementation

Example 1: The learning from the review into the death of Salma in 2019 has been referenced in the updated statutory guidance for local housing authorities[58] as a case study example when determining how to work with other agencies to keep victims safe.

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.

In this instance, the department were aware of the recommendation and able to ensure the learning from the review was embedded within the guidance.

Example 2: A recommendation for DWP stated:

"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."

In response to the recommendation, the DWP stated that they already have well established national processes and guidance in place to deal with vulnerable customers if they are made aware of this vulnerable status. They provided examples of advice given to staff and described how they regularly raise awareness of the processes with their staff and will continue to do so going forward. On this basis, they did not feel it necessary to set up specific local arrangements as suitable national ones are already in place. This highlights the disconnect between the local and national learning.

"Gerald has always been a very popular and likeable person. Gerald has always been the level headed and sensible one." DHR Gerald

4.1 Local recommendations of national relevance

As set out already, there are frequent instances where similar recommendations are made across multiple DHRs, indicating a systemic issue that could merit intervention from national government, were they to know of it. Often, local areas seek to circumvent national inaction through their own implementation, but this lacks coordination and can be inefficient.

This example provides evidence of the disjointed nature of DHR recommendations in the absence of a national oversight mechanism. The recommendation to introduce routine enquiry should be uncontroversial and if a DHR found it could prevent future harm then there is no reason other local areas might not introduce a similar scheme. However, the lack of national coordination, guidance, and ability to escalate implementation, holds this back.

There were multiple examples of actions relating to health records or GP systems that could not be implemented, often because the technology did not have the capability. In other instances, actions were not taken forward due to a lack of resource and capacity, such as a regional action to *'revisit training and share information to health professionals regarding the importance of routine screening and asking the question of patients whether they are experiencing domestic abuse, as set*

PRACTICE EXAMPLE

National guidance

An action for GPs for routine enquiry about domestic abuse whenever a patient indicates anxiety or depression could not be completed due to an IT issue (to introduce prompts on GP systems) that could not be fully resolved. Partners sought assurance that the issue was being raised nationally, particularly given the prompt worked in some GP practices and not others. Meanwhile, GP safeguarding leads were updated on the problem and informed that whenever anxiety or depression are disclosed by the patient, the GP should ask about domestic abuse regardless of whether the prompt appeared or not.

The CSP provided further assurance that the local Trust continues to incorporate this instruction into training and reinforce the messaging regarding positive enquiry around domestic abuse on disclosure of anxiety and depression. It appears in this instance that the action as it stands cannot be completed. However, the CSP has sought to implement regardless, albeit less robustly than if IT systems were adjusted at a national level.

out in NICE guidelines.' As above, national intervention could be both more efficient and more effective.

There were also examples of actions being abandoned because they were made at a local level for agencies but require national leadership, mandate, or guidance to ensure a consistent policy across all areas.

4.1.1 Cross-border learning

As DHR processes are soon to be introduced in Scotland, the Commissioner welcomes opportunities to ensure shared learning across the United Kingdom. Cross-border learning has been highlighted in reviews and should form part of any national oversight model in terms of ensuring recommendations made outside of England and Wales, where responsibility lies with national government level are not missed.

4.2 NHS England (NHSE) and Integrated Care Boards (ICBs)

The majority of recommendations for other national or regional public bodies were for NHSE, who also play a role in bringing together recommendations for ICBs locally (as well as sitting on the national QAP). Of the 107 national recommendations, the Department for Health and Social Care (DHSC) received 15 (14%) and NHSE received 14 (13%), collectively representing 27% of all national recommendations. A recent report from Standing

PRACTICE EXAMPLE

Action beyond borders

A cross-border recommendation was made, recommending:

"A cross-border process is agreed with key stakeholders to facilitate domestic abuse checks by the Probation Responsible Officer for perpetrators residing in Scotland."

The action for Police and Probation was as stated in the recommendation and was abandoned on the basis that:

"Work in this area was commenced 2019. Initial efforts by agencies to progress this action as a part of that work have shown ***it is not achievable at a local force or probation delivery level – it is one that requires national consideration.*** *Agencies will forward the action for progression at national level."*

"Bob was an exceptionally loyal man; notably caring, warm, and kind, with an inherent desire to protect those he loved and who loved him, he was the gentlest, most loving, and loyal person." *DHR Bob*

Together Against Domestic Abuse[59] found that in 2024, there were 47 DHRs published on the DHR library, of which 42 (89%) had at least one recommendation relating to the health sector or health professionals. For this report, NHSE provided an update on the progress of these recommendations. They could not provide a detailed response due to a lack of formal recording against individual recommendations at the national level, and there is no expectation that they do so through current statutory guidance.

Each of the 42 ICBs are executively accountable for the verification of health recommendations and feedback on pre-published DHRS as part of the local CSP DHR process. Collectively, they received 177 national recommendations.

NHSE has a unique role in the DHR process as they have been represented at the Home Office QAP since 2018. In this role, NHS Safeguarding provide feedback on draft recommendations, which are shared with local DHR panels and CSPs via the Home Office DHR QAP minutes.

Simultaneously, NHSE supports regional and ICB safeguarding colleagues in non-personally identifiable data collection of safeguarding statutory case reviews, including DHRs, on a Serious-Case Review Tracker (S-CRT), which forms part of their Safeguarding Integrated Data Dashboard.

NHSE has distinct ways of responding to DHR recommendations. They noted that any recommendations relating to the sharing of information across parts of health is subject to existing data sharing legislation and GDPR. Equally, they noted that recommendations relating to mental health would be subject to an operational and commissioning review by the ICB mental health lead and would be scrutinised by NHSE and DHSC strategic mental health leads.

Recommendations to share learning will happen via the National Safeguarding Steering Group (NSSG) and will continue to do so until updated statutory guidance is published. Since 2022, learning is also shared by FutureNHS, a platform for health and care professionals.

From October 2026, these duties and responsibilities will sit directly with the Department of Health and Social Care, as NHS England will cease to exist. All 42 ICBs have also been mandated to make a 50% operating cost efficiency from December 2025 and every NHS Trust a 15% operating cost reduction on their management overheads.[60] Cuts in public spending can only hamper the ability of agencies to implement their actions and report on progress. Consideration must be given to how NHSE, ICBs and DHSC feed into the DHR process at both the national and local level to ensure thorough and consistent implementation of recommendations and broader learning.

The role of health agencies is critical at both a national and local level. At a local level, from 21 pilot areas, local health trusts and mental health services received 323 actions.

4.3 Additional national policy recommendations

DHRs have a specific purpose in identifying learning and implementing change in practice. However, domestic abuse-related deaths raise vital issues for policy and national change outside of the scope of a DHR.

From the pilot year alone, the Commissioner has been able to demonstrate evidence of the need for change in a number of published reports and government consultation responses. However, there are still outstanding policy matters that require urgent reform that relate more obviously with DHRs, domestic homicides and domestic suicides specifically.

4.3.1 Firearms licensing

A DHR finalised in March 2024 following the deaths of two adults and two children in 2020 made six recommendations to the Home Office regarding firearms licensing (see government responses to national recommendations at www.domesticabusecommissioner.uk).

Between the time of deaths, and the publication of the DHR, the previous Government ran a public consultation from June–August 2023 to seek views on firearms licensing following two further tragic fatal shootings by licensed shotgun holders. During this time, bereaved families have lobbied tirelessly to ensure action is taken to prevent future harm and further loss of life. The Government published their response to the consultation in February this year.[61] The reforms to firearms licencing are welcome; in particular, the changes to the Statutory Guidance for Chief Officers of Police that now requires that the police conduct continuous assessment of certificate holders during the duration of a certificate, supported by the new digital medical marker enabling GPs to flag medical concerns that may impact upon the risk a licence holder poses.[62] The Commissioner was concerned to see that stronger action was not taken regarding integrity and dishonesty of applicants and encourages national government to ensure that 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 Commissioner encourages national government to monitor the impacts of changes against firearm-related crime rates, the rising or lowering of firearms-related homicides or increases or decreases in illegal arms. Recommendations from and characteristics of DHRs where a firearms licence was granted or featured in the review must be incorporated into continuous review. Similarly, any future changes should continue to be informed by engagement with the domestic abuse sector, survivors of domestic abuse, bereaved families and domestic abuse leads within statutory organisations.

"Mary often spoke warmly about her teaching career which she had loved, and she was described as highly knowledgeable about horses." *DHR Mary*

4.3.2 Hidden homicide and unexplained deaths

In its current form, DHR processes do not enable consistent learning to be drawn from circumstances where victims of domestic abuse have died by suicide, or whose deaths remain unexplained. Further, the delivery of the oversight mechanism and engagement with bereaved families has confirmed the Commissioner's concern for the response to circumstances where victims of domestic abuse have lost their lives in so-called 'hidden homicides.'

The recently published VKPP Domestic Homicides and Suspected Victim Suicides 2020-2024 Year 4 report, funded by the Home Office, recorded 1,012 deaths in 979 incidents. Of these, 354 were suspected victim suicides following domestic abuse, 71 were unexpected deaths and 25 deaths were classified as 'other'. The report repeatedly speaks to the increased identification and reporting of suicide following domestic abuse and unexpected deaths throughout and makes a recommendation for further scoping, research and review of the policies and emerging practice associated with the police response to unexpected deaths.[63] The Commissioner is supportive of this VKPP recommendation and is keen to see this workstream develop in alignment with the delivery of her recently accepted recommendation to the Home Office, along with policing leads, to elevate the status of domestic abuse within policing. However, more must be done to ensure that policies and practice associated with investigations into suicides and unexpected deaths fully explore the potential context of domestic abuse.

Although newly updated College of Policing guidance[64] on the identification and reporting of domestic abuse and associated investigations cases is positive, this cannot be utilised if domestic abuse is not consistently identified, as is the case in so-called 'hidden homicides.'

A DHR published in 2022 by Safer West Sussex Partnership[65] into the death of 'Laura' who died in April 2011, and discretional review into the death of 'Rachel', a former partner of the perpetrator (who died in 2006) well evidence the critical importance of thorough investigation that considers domestic abuse. At the time of Laura's death, a police investigation found she had died from accidental causes and there was no prosecution. Laura's family led a lengthy campaign, which led to a re-investigation and further independent pathology review in 2016; both of which led to a conviction for murder. The perpetrator in this case was also convicted of manslaughter at the same trial having also being found guilty of killing Rachel five years prior to Laura's death. Rachel's death was also treated as non-suspicious at the time.

There are many more bereaved families who are still campaigning for justice in cases of so-called 'hidden homicide' and action must be taken to ensure that domestic abuse is automatically considered in routine lines of evidential inquiry to rule out potential homicides. **Therefore, the Commissioner recommends that any unexpected death or suicide investigation or inquest must actively consider whether there is any evidence of ongoing or historic domestic abuse.** Professional curiosity and an inquisitive approach are

critical, and police forces must consider whether domestic abuse was a causal or contributing factor to the death.

4.3.3 Suicide and bringing perpetrators to justice

In tragic cases where victims have died by suicide because of their experiences of domestic abuse, perpetrators must be held accountable. Recent landmark inquest outcomes have explicitly drawn the links between domestic abuse victimisation and suicide, following the tragic deaths of Jessica Laverack (2022), Roisin Hunter Bennett (2022) and Kellie Sutton (2024).[66] Most recently, Keina Dawes's (2025) perpetrator was charged but acquitted of manslaughter and found guilty of coercive and controlling behaviour and assault. Change is needed to secure justice for families bereaved by domestic abuse-related suicide. The Commissioner welcomes the homicide review by the Law Commission and supports any work to develop manslaughter or other criminal offences to better secure justice in these cases.

More broadly, the Commissioner has long called for wholesale reform of homicide sentencing, as we continue to see cases where domestic homicides receive more lenient sentences than other homicides. Concerns over sentences have been consistently raised by bereaved families.

In addition, alongside a stronger criminal justice response, more must be done to ensure that CSPs have clear guidance on when to convene a domestic abuse-related death review in circumstances where deaths are unexplained, or victims have died by suicide or suspected suicide.

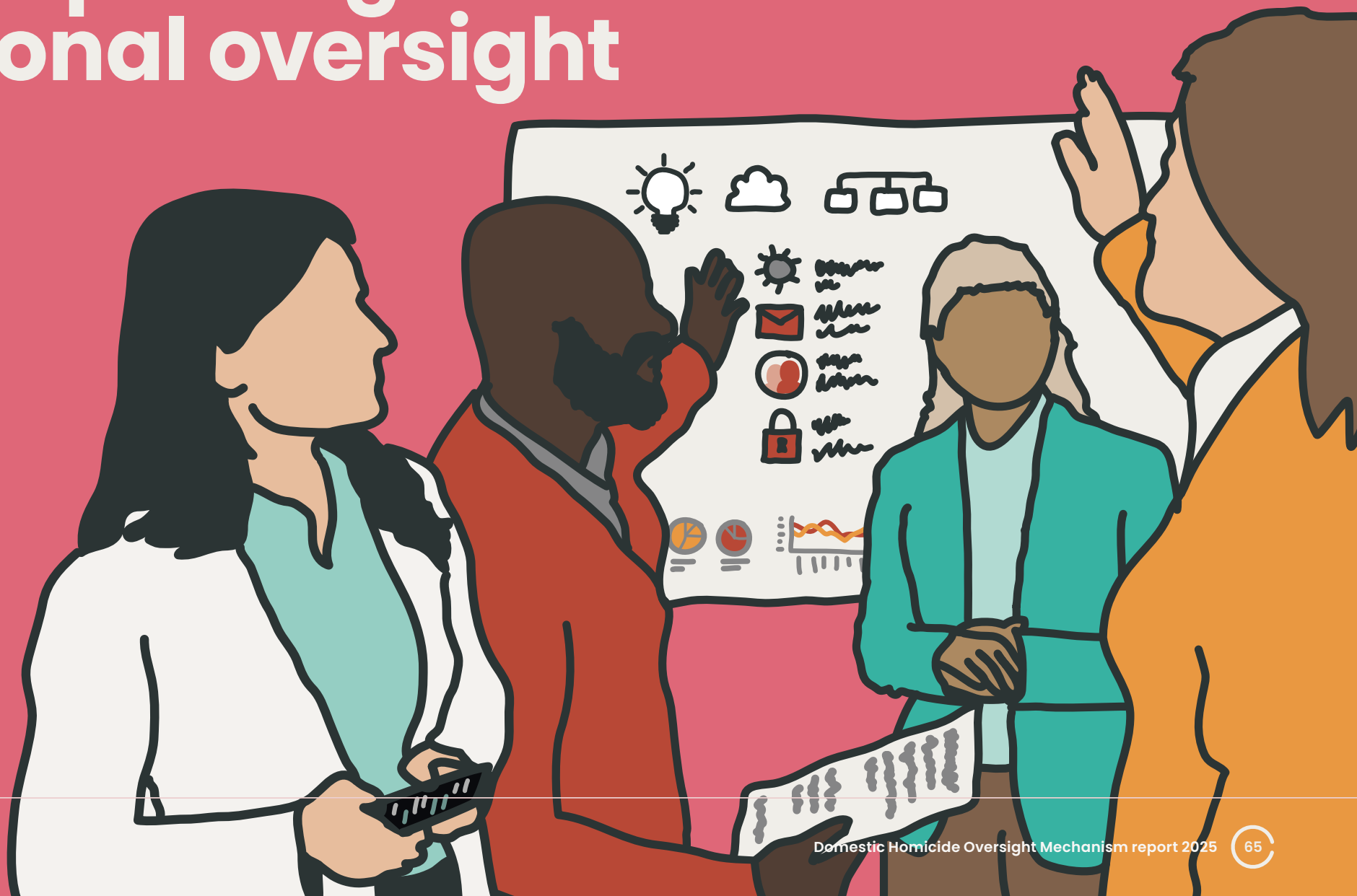
Notes

56. Rowlands, J. (2025). *The Potential and Peril of Reviewing Domestic Abuse-related Deaths*.
57. Domestic Abuse Commissioner (2025). Home - Domestic Abuse Commissioner.
58. Ministry of Housing, Communities and Local Government (2024). *Allocation of accommodation: guidance for local housing authorities in England*.
59. Standing Together Against Domestic Abuse (2025). *Never Again. Again: A review of health recommendations following a domestic abuse related death*.
60. NHS England (2025). *Working together in 2025/26 to lay the foundations for reform*.
61. Home Office (2023). *Recommended changes to firearms licensing: government response*.
62. Home Office (2023). *Statutory guidance for chief officers of police on firearms licensing (revised February 2023)*.
63. Hoeger, K. et al (2025). *Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides 2020-2024: Year 4 Report*.
64. College of Policing (2025). *Authorised Professional Practice: Identification, reporting and associated investigations*.
65. Safer West Sussex Partnership (2022). *Domestic Homicide Review: Laura*.
66. Keynejad, R.C. et al (2022). 'Domestic abuse is important risk factor for suicide', *British Medical Journal*, 379.

"Nicky was always a hard worker, often doing two jobs. She was truly the type of person that would do anything for everyone." ***DHR Nicky***

Chapter 5

From piloting to national oversight



This report has thus far set out a series of challenges to maximising learning from DHRs, an initial approach to oversight, and evidenced the clear need for greater accountability and oversight at a national level. It has demonstrated the Commissioner's initial efforts to pilot a local oversight mechanism, as well as findings from national recommendations made by DHRs over a two-year period.

The Commissioner has conducted extensive engagement with local agencies, specialist domestic abuse organisations, technology specialists and bereaved families. Through this, she has developed a proposed model for the national roll-out of an accountability and oversight mechanism for DHRs.

The proposed approach and resource required for national oversight is detailed in section 5.1, and section 5.2 sets out the benefits such an approach would bring.

5.1 Recommended proposal for national roll-out

The Commissioner's pilot year has demonstrated the need for national roll-out of an accountability and oversight mechanism for DHR implementation. The proposed model is detailed in this section, and broadly speaking will require the following:

1. A second year of piloting a local and national accountability and oversight mechanism.
2. The development of bespoke technology, enabled by AI, to collect, analyse and share the vast datasets and insight contained within several hundred DHRs and Action Plans.
3. Resourcing within the independent Domestic Abuse Commissioner's Office to scrutinise returns and hold local areas and national government to account.

A proposed model: CSP data collection

The Commissioner understands that a one-size-fits-all model will not be appropriate for national roll-out. However, there is a need for some consistency in approach where possible, and after testing the approach with both CSPs and PCCs, intends to plan for national roll-out to take a CSP-led approach for gathering data. This is following evaluation with pilot sites and consideration of the most efficient means in which to gather data about implementation.

"She was a beautiful outgoing sociable girl." DHR Elizabeth

That said, the Commissioner wishes to ensure accessibility in any digital system for all PCCs and allow flexibility for areas where a PCC already takes the lead on implementation of DHRs. For example, in one PCC area, the PCC's Domestic Abuse Board coordinates all reviews across 14 CSP areas, and funding is provided by the Police, Fire and Crime Commissioner (PFCC) and CSPs for this model. All recommendations are tracked across areas with county-wide follow-up on actions. In this area, there is a local escalation process through the domestic abuse board and work stems from the board to share learning, conduct local thematic reviews, deliver training and conferences and feed into strategic planning. The Commissioner's proposed model would not seek to disrupt this good work.

A second year of the pilot will enable the Commissioner and her team to work with PCC areas on how this works in practice, where a more flexible approach is needed. The model should be responsive to the size and scale of PCCs, including where they are part of a combined authority or a strategic oversight or delivery role in DHRs. CSPs have a responsibility in the conduct and commissioning of reviews and the implementation of subsequent recommendations and actions while PCCs have a unique convening role, which can ensure learning is shared and encouraged. Within the pilot, some PCCs were driving forward implementation and bringing together CSPs in their force area in a supportive and positive way. The Commissioner, in Year 2 would seek to establish pathways in which this was promoted nationally, within the context of a CSP-led oversight model for data collection. National roll-out should ensure that CSPs establish a local escalation process and governance arrangements for issues related to implementation of recommendations.

Meanwhile, further clarity is needed in the statutory guidance on the role of PCCs or Mayors and should be amended to say that PCCs should be invited to be involved in strategic oversight of DHRs across their areas and support knowledge sharing.

5.1.1 New technology

Exciting new technology, enabled by AI, could make the Commissioner's vision for DHR accountability and oversight – and transformation of the strategic response to domestic abuse, both locally and nationally – a reality.

Across multi-agency responses and safeguarding reviews, there are a range of ways in which progress against recommendations is tracked. The Commissioner does not seek to reinvent or duplicate systems that already exist – however, she recognises that technology requires considerable tailoring and significant development to meet the needs identified through the pilot. Efforts to identify and procure any existing off-the-shelf systems have been unsuccessful, as have efforts to develop a system through internal Home Office digital development teams.

The Microsoft Excel-based pilot was a valuable proof of concept, showing it is impossible to collect and combine data from multiple local areas to build a national picture of progress with this technology. As set out previously in Chapter 3 of this report, existing technology is unable to meet the demands of DHR accountability and oversight and would be unable to bring the additional benefits as set out later in this chapter (such as enhancing and streamlining the strategic response to domestic abuse more broadly).

Therefore, for national roll-out, the Commissioner has explored the potential for new technology, enabled by machine learning and AI, to future proof the delivery of oversight in DHRs and build with consideration of below emerging review processes, such as Offensive Weapon Homicide Reviews.

The case for developing a national digital oversight system is explored in detail in Annex A, developed by Catch Impact, a data and technology specialist organisation. This document demonstrates why such a system is essential, what problems it will solve and how it will work in practice. The core needs and design recommendations of the system can be found in part 4 of Annex A. Part 5 provides a rationale for investment and details how the system will make efficiencies by introducing a secure, scalable, and collaborative solution designed to address systemic challenges and support statutory obligations.

The benefits of such a system are set out in section 5.2, and the features of it outlined in detail in Annex A. These include:

- Unified digital workspace.
- Role-based, multi-agency access, with secure log-in links and tailored permissions.
- Streamline data ingestion (using AI-assisted import tools), allowing local areas to simply upload their DHRs and Action Plans, without the need for resource-heavy manual data entry.
- Automated notifications and escalation protocols, to provide reminders and ensure timely updates, reducing resource needed centrally by the DAC team.
- Standardised taxonomy for national consistency, ensuring data consistency and cross-area learning.
- Action level monitoring and quality assurance, facilitating detailed performance tracking and accountability.
- Partner centric dashboards, to provide a consolidated view for CSPs, PCCs and other local and national agencies.
- Multi-tiered reporting and benchmarking, with drill down capability for national to local levels.
- Knowledge management via e-learning library.
- Robust architecture for security, accessibility and scalability.
- AI-assisted join-up between CSP and PCC areas, highlighting most similar recommendations, actions, and implementation plans, for streamlined action implementation.

“Kelly was the kindest of souls facing insurmountable difficulties, as a family we love and miss her so much.” *DHR Kelly*

- AI-assisted programming to allow local areas to find most similar geographic and demographic areas, to draw from relevant DHRs and their implementation in the development of new strategies.
- Seamless authentication and interoperability, enabling secure access for internal and external stakeholders, with full audit trails for compliance.

5.1.2 Funding

Capital funding of £1m would be required to develop, build and deliver the new technology over a period of 6-10 months, and then up to £100k per annum for ongoing maintenance and running costs.

A "comprehensive future ready"[67] system requires £1m for development and up to £100k annually (dependent of the number of users the system supports) to run. This system uses AI-assisted data processing, advanced analytics, benchmarking tools, and a learning library. This version positions the Home Office to deliver long-term system-wide impact immediately.

5.1.3 DAC office resourcing

In addition to resourcing to develop new technology, ongoing funds would be needed to staff a small team within the DAC Office to provide independent scrutiny of DHR implementation and build capacity and capability at a local level.

Suggested resourcing needed to support full roll-out of a national accountability and oversight mechanism equates to approximately £450k, consisting of seven individuals comprising senior research officer, local engagement leads, admin staff and senior management. This staff team could be scaled-up over time.

The Commissioner's bolstered team would allow for detailed analysis of DHR findings, recommendations, and implementation, and combined with a new data tool would be able to provide in-depth data dashboards for national government and local agencies in real time.

Furthermore, additional resource would allow for:

- Rigorous scrutiny of self-assessment forms, including dip sampling across agencies, geographies, and government departments.
- Support for individual local areas where they are struggling with DHR implementation, providing expert advice on best practice.
- Establishment and delivery of the escalation process designed through the pilot and set out previously in Chapter 3 of this report, enabling continuous examination of emerging issues and holding agencies to account.
- Bolstering of existing mechanisms for cross-area learning and engagement, such as the Domestic Abuse Relate Deaths forum.

- Delivering a programme of learning events, reflecting learning from reviews as they are developed and implemented.
- Robust analysis of themes and trends in both recommendations and their implementation, and publication of annual in-depth reports.

TOTAL ANTICIPATED FUNDING - Year 2 (pilot): £1.45m

- £1m capital costs
- £450k resource costs

Year 3 (national roll-out): £550k

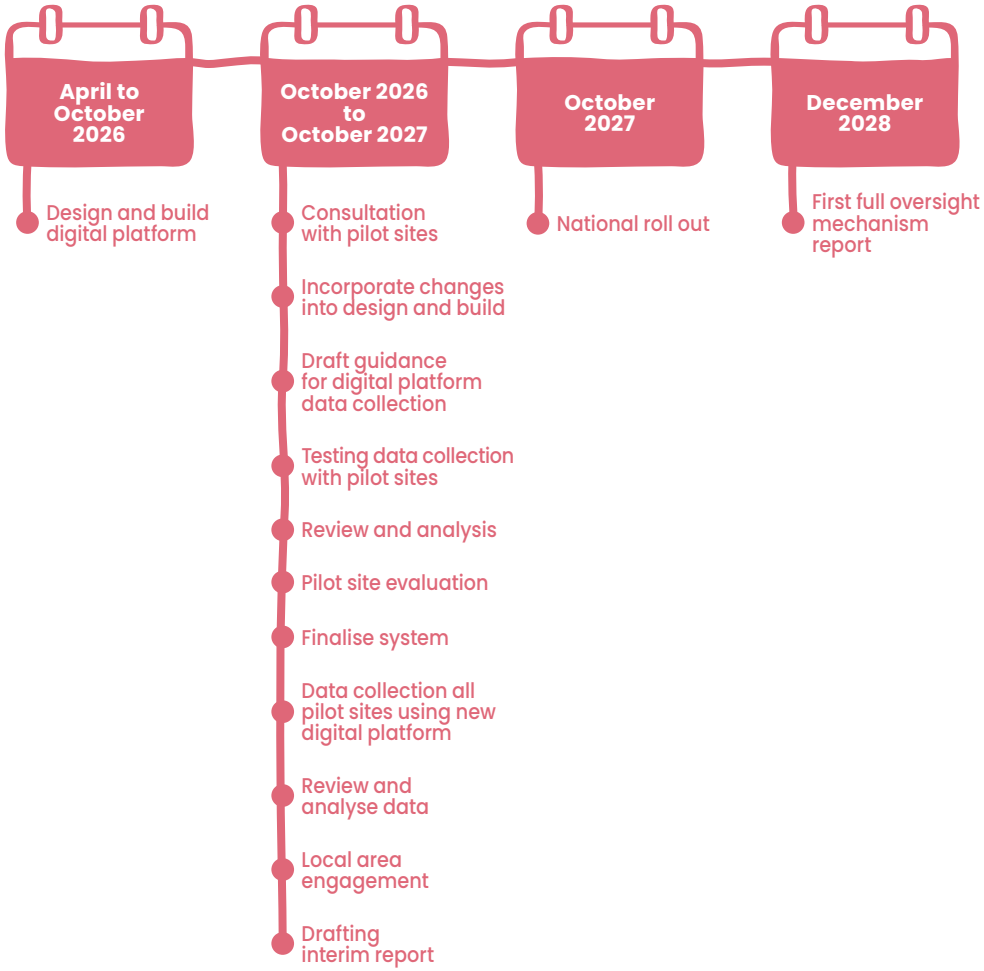
- £100k annual running costs
- £450k resource costs

Annual running thereafter: £550k

Domestic abuse is estimated to cost £88.9bn in a single year, and domestic homicides are estimated to cost society £2.9m per homicide.[68] We cannot underestimate the value of preventing a death in both financial and emotional terms. The ripple effect of taking someone's life is without bounds. The potential DHRs have to contribute to preventing future deaths is considerable and investment in the DHR process to ensure it is delivering on its aims to prevent domestic abuse and homicide is vital to achieving these aims.

5.1.4 Plan and next steps

If national government accept the Commissioner's recommendation to fund this, the anticipated timeline is:



"When I remember Daisy I remember the kind loving and generous child who grew into a funny gregarious life loving adult." *DHR Daisy*

Ahead of national roll-out, the purpose of the extended pilot will be to:

- Develop the new technology as set out earlier in this chapter, ready for national roll-out after 12 months.
- Test the escalation process as outlined in chapter 3.
- Review existing methods of shared learning and establish plans for national roll-out, utilising the online platform to identify practice.
- Undertake local engagement and host shared learning events.
- Work with national government to embed a process for oversight of national recommendations.

5.2 Benefits of oversight

"The LGA recognises the real value of the Commissioner's oversight of Domestic Homicide Reviews. It brings together learning from across the country and highlights what's working – and what isn't – in ways that central government alone can't see. This independent insight helps protect the integrity of the DHR process and builds confidence that reviews are leading to real change on the ground. Now's not the time to step back. With the right backing, this approach could be expanded further – helping to save lives, prevent future tragedies, and make better use of public money."[69]

The benefits identified of a Domestic Abuse Commissioner-led model for national oversight and accountability for implementation of DHRs were considerable. These are set out below and encompass learning from the local pilot, analysis of national recommendations, and engagement with specialist sector partners and bereaved families.

5.2.1 Accountability

"Having the lever of the DAC office oversight increases local accountability by introducing a mechanism for increased oversight and scrutiny."

PCC pilot area, 2024

What is abundantly clear is the vacuum of accountability in implementation of DHR recommendations and actions. Many local agencies – and some government departments – take their recommendations seriously and do their best to implement them well. However, there is no mechanism to ensure lasting change and consistency, particularly given the lack of resources at a local level.

Currently, there is no central location for England where implementation can be tracked, or for agencies to be held to account. The Commissioner's oversight pilot shows poor implementation of national recommendations, and difficulties in

implementation at a local level. Through national oversight, the Commissioner would use her powers to gather information on implementation of recommendations and actions and identify failures in implementation.

It is particularly concerning that so few government departments even knew they had DHR recommendations to consider.

Victims and their families deserve better. Progress has been made by the Home Office to collate DHRs into a library, which is an important first step, but does not allow routine aggregated data analysis or act as a tracking or monitoring tool for progress against actions plans, nor does it provide insight into how recommendations have been implemented.

The Domestic Abuse Act 2021 created the office of the Domestic Abuse Commissioner, whose role it is to hold national and local government to account. The Act gives the Commissioner distinct legal powers that would facilitate accountability for DHR recommendation implementation, namely a duty on public bodies to provide her with information and respond to her recommendations. Equally, the independent nature of the Commissioner's role would support robust accountability for local areas and national government, unencumbered by political or other allegiance.

5.2.2 Prioritisation, transparency, and status

The presence of oversight in the review process raises the profile of reviews as this presents a new layer of scrutiny that has been missing from DHRs since their inception. Strategic leads in pilot areas reported that oversight by the Commissioner empowered them to press for implementation of recommendations and actions to be prioritised.

Improved prioritisation is directly linked to raising the status of DHRs at a local and national level, as well as driving prioritisation through greater transparency. Any national accountability and oversight mechanism would necessarily require a high degree of transparency, driving prioritisation at a local and national level. A consistent and formal process for updating on progress would encourage greater emphasis on recommendations at a local and national level.

5.2.3 Family support and confidence

Clear accountability driven by the Commissioner would demonstrate to bereaved families that reviews are taken seriously. Even where all recommendations cannot be fully implemented, an oversight mechanism housed in the independent Commissioner's office will drive confidence in the process and reassurance that learning is not wasted.

"Louise, my daughter was the funniest, kindest girl. She didn't have the best childhood and struggled a bit, but she grew into a strong, loving, caring person." *DHR Louise*

5.2.4 Build understanding of domestic abuse, learning, and identify and escalate systemic issues

Currently, learning is often confined to the local level, with minimal sharing or thematic analysis conducted nationally. The Commissioner is uniquely placed to bring together local agencies, with national government, to facilitate this sharing of learning.

An oversight mechanism can support the sharing of learning, utilising one central tool to share learning locally, across regions and nationally. This will elevate local learning to a national platform in which local areas can consider where gaps in practice and development of policy have already been achieved or noted. Local areas could then consider any reviews in a progressive rather than a repetitive way, looking at what they could implement immediately from others' learning.

Through the pilot and testing on data collection, a high volume of information is required to be collected in order to draw out the systemic change elements of reviews, as well as the local thematic policy and practice issues. This demonstrates the importance of a new system that streamlines the review of data, relevant to the oversight of recommendations and allows the time of the Commissioner's team to be focused on those actions/recommendations that are critical to systemic change.

This will further assist national government to target policy change to most effectively reduce domestic abuse-related deaths and domestic abuse more broadly. CSPs involved in the pilot welcomed the opportunity to work with the Commissioner to raise issues they had identified on a national stage.

It could also enable areas to ensure training packages are well developed and address common issues. Equally, national thematic analysis of implementation should drive improvements in the quality of recommendations.

The Commissioner's annual oversight mechanism report will make recommendations to national bodies, allowing elevation and escalation of local recommendations with national relevance.

5.2.5 Transformation of local and national strategic planning and policymaking

National oversight, combined with the proposed technological tool, could truly transform how local and national government plan, and develop their response to domestic abuse.

It is a huge waste that the collective insight and intelligence from over a thousand DHRs – the loss of so many lives – has not been utilised effectively to date.

With exciting new technology, facilitated by AI, local and national agencies will be able to maximise the wealth of wisdom, both in recommendations themselves and in their implementation, to develop practice and policy. This will drive efficiency as local areas can make immediate use of huge amounts of information and draw on lessons from across the country, pre-empting any implementation challenges that might have previously occurred.

Through this new tool, the Commissioner envisions a system whereby local strategic leads (and national policymakers) can input information about their local area, the systems they work within, and the problem they are seeking to address. The combined wisdom of DHRs across the country will be utilised to develop not only suggested solutions, but information about which areas had already implemented similar systems.

This could transform the development of statutory requirements at a local level, such as Joint Strategic Needs Assessments (JSNAs) under the Victims and Prisoners Act, Police and Crime Plans, the Serious Violence Prevention Duty, and the Safe Accommodation Duty, among others.

5.2.6 Driving efficiencies and streamlining data collection

Currently, local review processes are highly inefficient, both in terms of data collection, sharing learning, and implementing change. Given capacity pressures highlighted earlier in the report, this will be crucial. A national oversight mechanism, supported through new technology, could enable:

- **Easier input of action plan data into a consistent national data collection tool.** This would assist local areas in quickly and easily uploading consistent datasets, tracking implementation, and using this across all CSP areas. This will help to identify duplicate actions for the same agency across different areas, and allow domestic abuse leads to focus on implementation.
- **Better sharing of learning to implement recommendations.** The consistency of themes across DHRs demonstrates the lack of effective sharing of learning between local areas. By easily sharing learning and best practice in implementing change, local areas can use existing best practice rather than reinventing solutions that may have already been developed elsewhere.
- **Easy and effective monitoring of timeliness,** by tracking timescales against implementation so that any correlation between delays and effectiveness can be addressed.

CSPs would also have the benefit of sharing with their review Chairs the consistent themes demonstrated across other reviews nationally, to better inform recommendations and join up common thematic learning within reviews themselves.

"She stood strong on her beliefs. I was so proud of her." *DHR Louise*

5.2.7 Enhance and support implementation of other relevant reviews

There is currently no mechanism in which to track and monitor change as a result of local multi-agency reviews, and to bring this learning together.

New technology offers the prospect of bringing together a wider range of statutory and non-statutory reviews, synthesising data and bringing benefits across a range of local and national priorities.

Other similar types of reviews already have a level of oversight to ensure that recommendations for change are properly embedded, and lessons are effectively learnt. This would be enhanced by the proposed new technology and linking in with DHRs. Scrutiny of serious incident reviews and reviews into deaths across social care and health have varying oversight arrangements for both the process and the implementation of the recommendations that they make. Offensive Weapons Homicide Reviews (OWHR) are currently being evaluated following a pilot and statutory guidance for those reviews outlines the role of the OWHR Oversight Board. Quality assurance of OWHRs occurs locally through the CSP or other agreed local arrangements.

With the establishment of the proposed accountability and oversight mechanism, this full range of local reviews could be brought together to great effect.

Notes

67. Annex A: *Development of a digital system for the Domestic Abuse-Related Deaths Oversight Mechanism*.
68. Home Office (2019). *The economic and social costs of domestic abuse*.
69. Quote from Councillor Heather Kidd, Chair of LGA's Safer and Stronger Communities Board.

Chapter 6

Conclusion and recommendations

The Commissioner strongly welcomes the government's commitment to halve Violence Against Women and Girls over the next decade. Reducing domestic homicides will be a critical test of its ability to achieve this.

Building on the lessons learnt through the pilot to date, this report sets out the important role that a national oversight mechanism would make in unlocking best practice and sharpening national policy making on what measures work more effectively to reduce the number of domestic abuse-related deaths.

The report also sets out in detail a blueprint, with the associated resource implications, required to expand the pilot into a second year with a view to national roll out in 2027.

The Commissioner is in a unique independent position to provide support at local level, garner practice and knowledge from local and regional areas, escalate issues or concerns about implementation and bring areas together nationally. Evidencing change and impact does not happen in a short period of time and the DHR process is already delayed in making efforts to address this.

Now is not the time to lose impetus in this process but rather to invest strategically in optimal resources at a moderate cost to achieve change as a result of domestic abuse-related death reviews.

6.1 Statutory recommendations

Under Part 2 of the Domestic Abuse Act, the Domestic Abuse Commissioner for England and Wales makes the following recommendations:

1. **Funding for the continued piloting and national roll-out of the Domestic Abuse-Related Deaths Accountability and Oversight Mechanism:** The Home Office should provide £1.45m in Year 1 and £550k per annum thereafter to develop and deliver a national accountability and oversight mechanism, housed within the Office of the Domestic Abuse Commissioner. This would fund:
    a. The development of a new digital platform which would:
        i. Enable CSPs to upload DHRs, including recommendations and action plans.
        ii. Enable local agencies and national government to directly update on implementation of their DHR recommendations and actions.
        iii. Through AI and machine learning, synthesise the combined learning from DHR recommendations, actions, and implementation progress.

"He was a kind and beautiful person and sadly leaves two children behind that will never get to know their daddy." DHR Finn

iv. Enable local agencies and national government, to effectively utilise this synthesis, to develop an evidence-based strategic response to domestic abuse with ready-made advice on good practice for implementation.

b. Resource within the Commissioner's Office and annual running costs. This would provide for the maintenance of the digital platform and a small team of practice experts and researchers, who would bring greater scrutiny and allow for escalation of systemic concerns.

2. Improving the Government's response to and implementation of its own recommendations from DHRs.

Just as local agencies are expected to learn from domestic abuse-related deaths and take their recommendations seriously, so too must national government. National government must act upon national recommendations, as well as recognise where consistent issues need a national response. Timely communication between government departments and CSPs, as well as coordination and communication between departments, is critical. The Commissioner has previously recommended a suite of proposals for improving how national recommendations are responded to in her response to the statutory guidance consultation, and these still stand.[70]

In addition, the Commissioner recommends that national government:

2.1 Respond immediately upon receipt of a DHR recommendation, with each individual government department taking clear responsibility for implementation of any recommendations made to them.

2.2 Share updates on implementation of their DHR recommendations with CSPs directly, promptly, and transparently. This should include:

2.2.1 The creation of a network of specific points of contact within government departments, with public mailboxes listed in guidance or on gov.uk to allow CSPs to easily contact relevant officials.

2.2.2 Establishing a formal process in which action taken to implement recommendations can be shared with CSPs when requested.

2.2.3 Notifying CSPs when a recommendation will not be taken forward or implemented.

2.2.4 Ensuring recommendations are received by the correct department and notifying CSPs when recommendations are transferred between departments.

"Erin was a good mum and completed her degree in criminal justice studies and had an ambition to be a lawyer." *DHR Erin*

2.2.5 Ensure responses to national DHR recommendations are considered within cross-government governance structures, such as the Violence Against Women and Girls Ministerial Board. This should also consider wider review processes and the potential for joint learning and implementation, such as SUSRs in Wales, Child Safeguarding Practice Reviews or Offensive Weapons Homicide Reviews. This should feed into the Safer Streets Mission Board.

2.2.6 Create an escalation process for where recommendations for departments are not being met.

2.2.7 Analyse consistent themes within DHRs to recognise systemic problems that warrant a national response – whether this is in the recommendations themselves or in implementation of these recommendations.

2.2.8 Provide guidance to DHR Chairs on how to best develop national recommendations.

2.2.9 Ensure Chair training builds an understanding of how national government recommendations might work.

2.2.10 Make use of the Quality Assurance process to correct recommendations that are for the wrong government department.

3. Improving capacity and resourcing to deliver DHRs locally:

The Home Office provides dedicated funding to local areas for DHRs, which should include costs related but not limited to the costs of:

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

The Home Office should work with CSPs and PCCs to determine the most appropriate models of funding.

"DJ also loved Mario games and everything to do with Mario." *DHR Bethany and Darren*

6.2 Practice recommendations for DHR Chairs, CSPs and PCCs

In addition to the statutory recommendations for government, laid under Part 2 of the Domestic Abuse Act, the Commissioner identified varying practice in delivery and development of DHRs, which warrant comment. Practice examples are included throughout this report, but particular recommendations for Chairs can be drawn out of this learning:

1. Chairs should avoid, where possible, making recommendations for CSPs to implement. CSPs should play more of a role in local oversight than delivery of actions, and recommendations for CSPs could represent a conflict of interest or confusion over statutory roles.
2. Chairs should ensure recommendations are focused and SMART, and actions should name the specific agencies expected to implement them.
3. Chairs should set out the importance and priority that should be given to different recommendations in their reviews and avoid individual short-term actions. This is to support local areas to prioritise limited resources on recommendations that will lead to meaningful change.

Notes

70. Domestic Abuse Commissioner (2024). *Consultation on updating the Domestic Homicide Review Statutory Guidance: Written submission from the Domestic Abuse Commissioner for England and Wales.*

"Linda was an intelligent and attractive lady, Linda was my precious sister, my only sibling – I loved her dearly and I miss her every day." *DHR Linda*

Glossary

Acronyms and initials

AAFDA	Advocacy After Fatal Domestic Abuse
APCC	Association of Police and Crime Commissioners
BME	Black and Minoritised Ethnic
CCB	Coercive and Controlling Behaviour
CCR	Coordinated Community Response
CSP	Community Safety Partnership
CSEW	Crime Survey for England and Wales
DAC	Domestic Abuse Commissioner
DAPB	Domestic Abuse Partnership Board
DADR	Domestic Abuse Related Death
DARDR	Domestic Abuse Related Death Review
DBT	Department of Business and Trade
DCMS	Department for Culture, Media and Sport
DfE	Department for Education
DHR	Domestic Homicide Review
DHSC	Department for Health and Social Care
DVDS	Domestic Violence Disclosure Scheme
DWP	Department for Work and Pensions
HALT	Homicide Abuse Learning Together (Research project)
HMPPS	His Majesty's Prison and Probation Service
HO	Home Office
ICB	Integrated Care Board
IMR	Independent Management Review
JSNA	Joint Strategic Needs Assessment
JSOG	Joint Commissioning System Optimisation Group
LA	Local Authority
LGA	Local Government Association
MARAC	Multi-Agency Risk Assessment Conference
MHCLG	Ministry of Housing, Communities and Local Government
MoJ	Ministry of Justice
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSE	National Health Service England
NSSG	National Safeguarding Steering Group (NHS England)
NPS	National Probation Service
ONS	Office for National Statistics
OPCC	Office of the Police and Crime Commissioner
OWHR	Offensive Weapons Homicide Review
PCC	Police and Crime Commissioner
PFCC	Police, Fire and Crime Commissioner
QAP	Quality Assurance Panel
SMART	Specific, Measurable, Achievable, Relevant & Time Bound
SR	Spending Review
STADA	Standing Together Against Domestic Abuse
SUSR	Single Unified Safeguarding Review
UNODC	United Nations Office on Drugs and Crime
VAWG	Violence Against Women and Girls
VKPP	Vulnerability Knowledge and Practice Programme

Terminology

Adult Family Homicide
Homicide of an individual aged 18 or over by an adult family member who is not an intimate partner.

'By and for' services
Organisations that are designed and delivered 'by and for' people who are minoritised (including race, disability, sexual orientation, transgender identity, religion or age). These services will be rooted in the communities that they serve, and may include wrap-around holistic recovery and support that addresses a victim/survivor's full range of needs, beyond purely domestic abuse support.

Coercive and Controlling Behaviour (CCB)
An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Controlling behaviours are used to make the person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. They are forms of domestic abuse, and a course of conduct offence under the Serious Crime Act 2015.

Coordinated Community Response (CCR)
The Coordinated Community Response enables a whole system response to individuals. This model of practice shifts responsibility for safety away from individual victims and survivors towards the community and services existing to support them. The process by which this multi-agency work is integrated and managed is known as the Coordinated Community Response. Founded by Standing Together Against Domestic Abuse (STADA).

Domestic abuse
For the purposes of this report, the statutory definition in the Domestic Abuse Act 2021 is used. Available at: www.legislation.gov.uk/ukpga/2021/17/contents

Domestic Abuse Related Death
Death that has, or appears to have, resulted from domestic abuse.

Domestic Abuse Related Death Reviews (previously Domestic Homicide Review)
Domestic Homicide Reviews (DHR) are soon to be renamed as Domestic Abuse Related Death Reviews to recognise deaths from domestic abuse-related suicide. The changes are brought into law via the passage of the Victims and Prisoners Act 2024. A DHR is a multi-agency review following a death of a person 16 or over that meets the criteria referenced in the Domestic Homicide Review statutory guidance (available at: www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews). The reviews were established on a statutory basis in 2013 under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

Femicide
The UN defines femicide (or feminicide, as it is referred to in some contexts) as an intentional killing with a gender-related motivation. It is different from homicide, where the motivation may not be gender related. Femicide is driven by discrimination against women and girls, unequal power relations, gender stereotypes or harmful social norms. UN Women (2024). *Five essential facts to know about femicide*. UN Women – Headquarters.

Intersectionality
A term coined by Kimberlé Crenshaw, is firmly located in Black women's experiences of racism and multiple forms of oppression, including domestic abuse. For more see: Columbia Law School (2017). Kimberlé Crenshaw on Intersectionality, More than Two Decades Later. See online at www.law.columbia.edu

Intimate partner homicide
Homicide of an adult aged 18 or over by a current or former intimate partner.

Protected characteristics
It is illegal for a person to be discriminated against because of a protected characteristic. There are nine protected characteristics under the Equality Act 2010: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Routine enquiry
Routine enquiry is a term used to describe asking all service users about their experience of domestic abuse. No signs of abuse or suspicions of abuse are needed as routine enquiry involves asking everyone. This can help making the enquiry easier because you can refer to it as just that – a question that everyone is asked.

Suspicious death
Where the death is suspected to have been caused by a criminal act.

Unexpected deaths
An unexpected death is when a person was not expected to die, meaning the death is not anticipated or related to a period of illness that has been defined as terminal. There is no obvious cause of death, or the person died from a notifiable cause for example this may be due to accident, apparent suicide or violent act.

Victims and survivors
We use this term to encapsulate both the legal framing of people who are subject to domestic abuse ('victims') and to account for the individual preferences of adults who have experienced domestic abuse ('survivors').

Appendices

Appendix A

Terms of reference: Domestic Homicide Oversight Mechanism: Local oversight pilot

Purpose of this document

The purpose of having terms of reference is to ensure that areas participating in the Domestic Homicide Oversight Mechanism (DHOM) Local Oversight Pilot understand:

- The aims, objectives and scope of the DHOM Local Oversight Pilot.
- The role and responsibilities of the Lead agency.
- The role and responsibilities of partners.
- The role and responsibilities of the DAC Office (DACO).
- The commitment that is expected in terms of engagement with DACO, information sharing, sharing good practice and participation in any evaluation of the pilot.

Terms of reference

Introduction

This document sets out the terms of reference for 'The Domestic Homicide Oversight Mechanism: Local Oversight Pilot', the participating areas and the resulting roles and responsibilities of those involved in testing both the CSP and PCC models.

The pilot is being delivered by the Domestic Abuse Commissioner.

The purpose of the DHOM is to bring independence to the Domestic Homicide Review (DHR) process post publication of reviews to ensure that there is local and national accountability for the implementation of DHR recommendations as well as identifying common themes and trends and supporting change at a national level. This includes ensuring that learning is shared nationally, improving the effectiveness of DHR recommendations, and demonstrating where there is change following those recommendations. The Domestic Abuse Commissioner's 'Domestic Homicide Oversight Mechanism' seeks to add value, provide consistency, and improve the quality of DHR processes.

The purpose of the local oversight pilot is to test and learn the best way for the DAC to oversee the implementation of recommendations and actions within DHRs, and to inform the development of the oversight mechanism for national roll out. This will provide an opportunity to understand the capacity and resource required to carry out effective oversight, the needs of local areas and how oversight can best support local implementation of recommendations and evidence impact.

Aims

- To test two models for local oversight in England and Wales, one led by PCCs and another led by CSPs, with a broad range of areas.
- To evaluate each approach and determine the model for national roll-out.

Objectives

- Shape rollout of DHOM nationally.
- Establish a process for escalating concerns about DHR implementation at national level.
- Share best practice and learn from other areas.
- Support local areas where challenges in areas arise, within the context of the DAC powers and independence.

Frequency of engagement/contact

- Local areas will be expected to provide information to the DACO at the start of the project (Jan 24), at 6 months (June 24) and at the end of the project (Dec 24).
- The frequency of engagement beyond information sharing will depend on each area, however this is not expected to be more frequent than once a month.
- There will be an expectation that pilot areas engage in learning events, of which there will be a minimum of 3 and no more than 6 throughout the year.
- Pilot areas will also be required to attend a stakeholder group as per the terms of reference for that group (to follow) which will meeting on a quarterly basis.

DAC role and engagement

The DACO will take a leadership role in terms of oversight, promoting shared learning across the pilot areas and working with local areas to design and implement appropriate sharing of good practice and outcomes.

The DACO will:

- Work with pilot areas to agree the most appropriate forum for sharing themes, learning and best practice.
- Convene a steering group of national oversight bodies to oversee the development of a local oversight model.

- Participate in some relevant local DHR meetings and learning events and where appropriate regional events in pilot areas.
- Identify and share themes and trends in DHR recommendations at a national level.
- Seek to understand local barriers/challenges and accountability frameworks for where DHR recommendations are not being implemented consistently.
- Provide support where appropriate. Where barriers to implementation are identified, the DAC Office will provide support and assistance to enable relevant agencies to implement their action plans effectively.
- Update Government Departments[1] and other national bodies on emerging issues or concerns and provide relevant updates to pilot sites as appropriate.

Role of CSPs and PCCs

- Share all completed and published DHRs and Action Plans from the previous 3 years.
- Complete returns to the DAC Office every 6 months on the implementation of their action plans.
- Complete an implementation form 6 months following publication of DHR, setting out progress.
- Contribute to and/or participate in national learning events.
- Promote good practice approaches across wider partnerships to ensure that DHR learning is embedded across all CSP/PCC areas.
- Nominate a designated lead for oversight who will liaise with the DACO.

By agreeing to participate in the Domestic Homicide Local Oversight Pilot you are also agreeing to the terms of reference as outlined above.

The terms of reference may be subject to change.

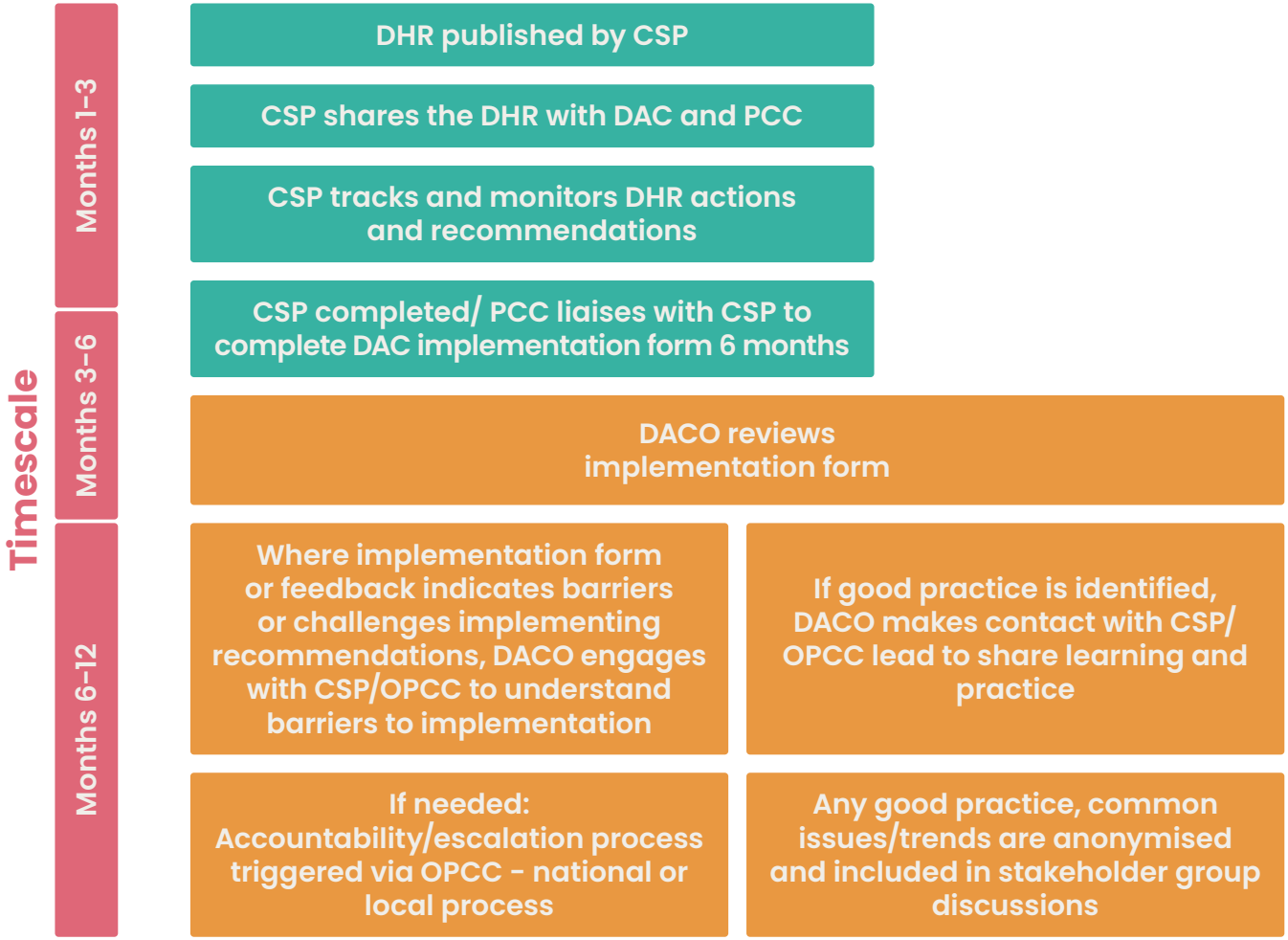
Addendum to Terms of Reference: Domestic Homicide Oversight Mechanism: Local Oversight Pilot

With regards to DAC role and engagement the following changes apply to reflect the role of Police and Crime Commissioners in oversight where existing processes exist or local processes are developed.

The DACO will take a leadership role in the promotion of shared learning across the pilot areas and work with local areas to support the design and implementation of appropriate sharing of good practice and outcomes where no such process currently exists or where areas are seeking to develop existing processes.

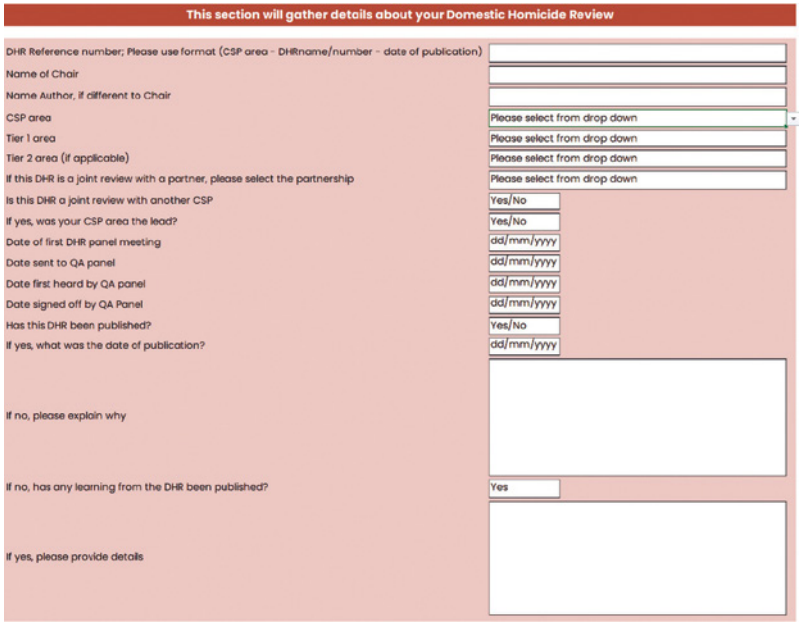
Appendix B

Model for delivery of local oversight mechanism CSP & PCC



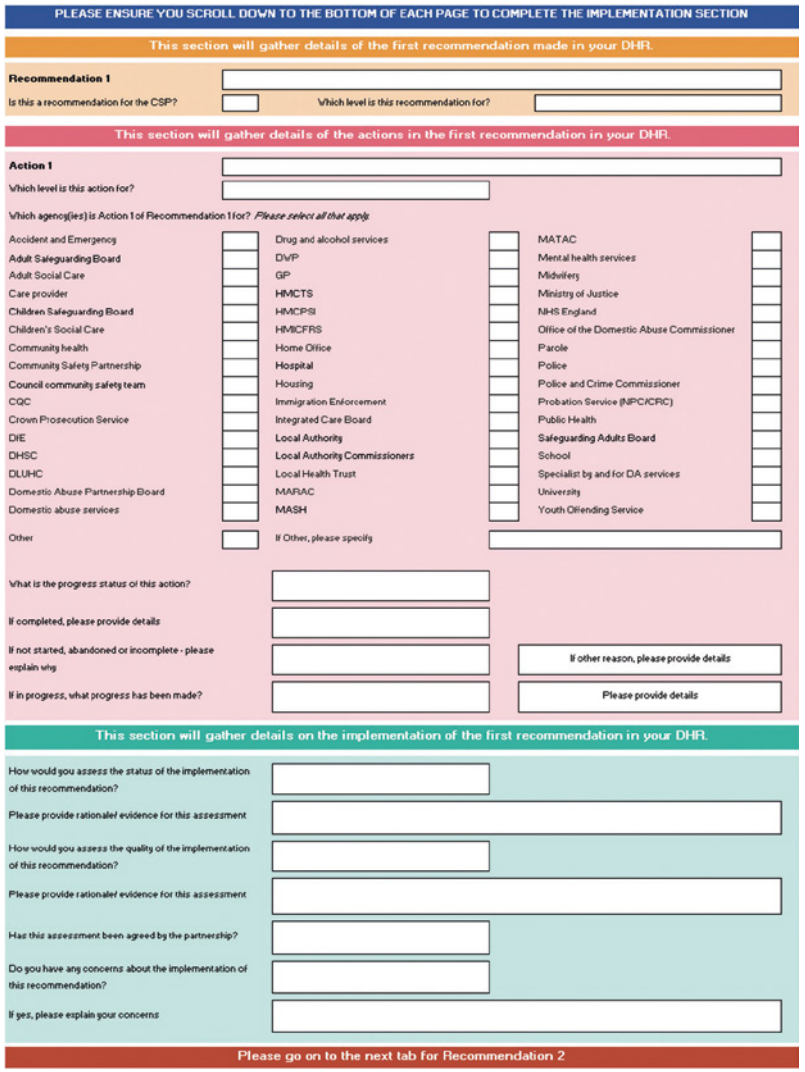
Appendix C

Pilot site oversight mechanism data collection form



This section will gather details about your Domestic Homicide Review

DHR Reference number; Please use format (CSP area - DHRname/number - date of publication)	
Name of Chair	
Name Author, if different to Chair	
CSP area	Please select from drop down
Tier 1 area	Please select from drop down
Tier 2 area (if applicable)	Please select from drop down
If this DHR is a joint review with a partner, please select the partnership	Please select from drop down
Is this DHR a joint review with another CSP	Yes/No
If yes, was your CSP area the lead?	Yes/No
Date of first DHR panel meeting	dd/mm/yyyy
Date sent to QA panel	dd/mm/yyyy
Date first heard by QA panel	dd/mm/yyyy
Date signed off by QA Panel	dd/mm/yyyy
Has this DHR been published?	Yes/No
If yes, what was the date of publication?	dd/mm/yyyy
If no, please explain why	
If no, has any learning from the DHR been published?	Yes
If yes, please provide details	



PLEASE ENSURE YOU SCROLL DOWN TO THE BOTTOM OF EACH PAGE TO COMPLETE THE IMPLEMENTATION SECTION

This section will gather details of the first recommendation made in your DHR.

Recommendation 1

Is this a recommendation for the CSP? | Which level is this recommendation for?

This section will gather details of the actions in the first recommendation in your DHR.

Action 1

Which level is this action for?

Which agency(ies) is Action 1 of Recommendation 1 for? *Please select all that apply*

Accident and Emergency		Drug and alcohol services		MATAC	
Adult Safeguarding Board		DVP		Mental health services	
Adult Social Care		GP		Midwifery	
Care provider		HMCTS		Ministry of Justice	
Children Safeguarding Board		HMCPSI		NHS England	
Children's Social Care		HMICFRS		Office of the Domestic Abuse Commissioner	
Community health		Home Office		Parole	
Community Safety Partnership		Hospital		Police	
Council community safety team		Housing		Police and Crime Commissioner	
CQC		Immigration Enforcement		Probation Service (NPC/CRC)	
Crown Prosecution Service		Integrated Care Board		Public Health	
DfE		Local Authority		Safeguarding Adults Board	
DHSC		Local Authority Commissioners		School	
DLUHC		Local Health Trust		Specialist by and for DA services	
Domestic Abuse Partnership Board		MARAC		University	
Domestic abuse services		MASH		Youth Offending Service	
Other		If Other, please specify			

What is the progress status of this action?

If completed, please provide details

If not started, abandoned or incomplete - please explain why | If other reason, please provide details

If in progress, what progress has been made? | Please provide details

This section will gather details on the implementation of the first recommendation in your DHR.

How would you assess the status of the implementation of this recommendation?

Please provide rationale/ evidence for this assessment

How would you assess the quality of the implementation of this recommendation?

Please provide rationale/ evidence for this assessment

Has this assessment been agreed by the partnership?

Do you have any concerns about the implementation of this recommendation?

If yes, please explain your concerns

Please go on to the next tab for Recommendation 2

Appendix D

Guidance for CSPs and PCC leads completing the DHR Oversight Form

Progress of actions

- Not started.
- In progress.
- Abandoned – by this we mean that the action is no longer necessary as alternative actions the actions have been taken which achieve the intended outcome or the action is no longer relevant.
- Incomplete – by this we mean the CSP has been unable to ascertain what steps have been taken to achieve this.

Level of implementation

- Fully implemented – all actions have been achieved.
- Partly implemented – Most actions have been achieved and those not yet achieved are progressing well and expected to be achieved within the next 6 months or within the specified timescale in the action plan.
- Somewhat implemented – Some actions have been achieved and most of the remaining actions are expected to be achieved within the next 12 months or the specified timescale in the action plan.
- Not yet implemented.

Framework for quality assessment of implementation

Gold

- There is strong evidence of change as a result of the actions for this recommendation.
- There is strong quantitative and qualitative evidence that this recommendation is achieving positive outcomes for survivors, children and families.
- The implementation of the recommendation is changing practice, attitudes and/or culture.
- There is systemic change as a result of this recommendation involving multiple or all partners within a co-ordinated community response.
- Organisational change has been achieved and the learning from the recommendation is embedded in practice.
- Learning has been shared in a range of formats including face to face delivery (in person or virtual), via briefing papers or shared materials and across agencies and geographical

boundaries, is formalised and is part of a longer-term training offer to all/relevant partners.

- There is quantitative evidence of progress against KPI's (this could include overarching DA strategy, the actions KPI itself or national KPI's).

Silver

- There has been change in practice as a result of the actions related to this recommendation.
- The implementation of the recommendation is changing practice, attitudes and/or culture.
- Learning has been shared in a number of ways and repeated/ there are plans to repeat within an agreed timescale.
- Organisational change has been achieved and is expected to be embedded within the next 6 months.

Bronze

- Of the actions that have been achieved there is evidence the learning has been disseminated through organisation or professional networks.
- Learning has been disseminated through briefings or stand-alone training/learning events.
- Organisational change has been achieved and is expected to be embedded within the next 12 months.
- Some actions may have been delayed or abandoned however alternative action was agreed at local level which directly addresses the recommendation.

Not met yet (Early stage of implementation)

- Organisations have taken prompt action to address this and evidence of implementation has been requested by the partnership. This is expected to be achieved/evidenced in the next 6-12 months or within the specified timescale in the action plan.

Not met

- There is no or limited evidence of this recommendation being implemented.
- Actions are incomplete or have been abandoned with no alternative action implemented by relevant partners.

Appendix E
Notable practice from the pilot

PRACTICE EXAMPLE

A review recommendation stated that the [CSP] *"should seek assurance that all health services in their area have implemented policies, pathways and staff training to support routine enquiry in domestic abuse."*

The subsequent action was for the [Health trust] *"to implement a rapid assessment tool in the emergency departments to support routine enquiry."*

In response to oversight the CSP updated that *"the rapid assessment tool went live as a mandated assessment for both Emergency Departments on 18th March 2024. This is also an active tool for community staff. Staff across Safeguarding, Emergency Dept and digital IT to enable this, the plan would be to audit in the future. It is early days."*

There are opportunities to draw out notable practice and to link areas to prior learning from reviews within a fully resourced oversight mechanism. While there was limited capacity to engage with areas on their completed actions, some actions of note were identified. However, in all cases their effectiveness could not be validated due to time and resourcing. This will only be achievable with a firm commitment from government to oversight as outlined in the summary of this report.

The Commissioner's office followed up with the CSP and health trust in March 2025 and was assured of ongoing review of progress against this recommendation by the inclusion of this action in cross-area planning through the local DARDR Oversight Group regarding health settings and domestic abuse practice, policy, and processes in the CSP area.

Despite actions being completed in relation to some aspects of the recommendation, agencies were candid in their responses, with one area noting *"Staff work at pace under considerable demands. Incorporating changes to practice, despite up-to-date policies and good training, does not guarantee a complete shift to new ways of working."*

This validates the need for oversight to be broader than a summary of performance measures at local level and speaks to the effort that real and embedded culture change takes to achieve within institutions. The longer-term ambition of a fully resourced oversight mechanism is to evidence change over time.

PRACTICE EXAMPLE

A recommendation and related action stated:

"[CSP] to consider the learning from this DHR in relation to meeting the needs of local communities, including the provision of culturally appropriate services, a diverse workforce and creating opportunities to build trust with communities."

This is a partnership of the voluntary and community sector, the NHS, local authority, and others, focused on improving health and wellbeing and reducing inequalities for people in the Local Authority area through an integrated health and care system.

The partnership considered this recommendation and action and subsequently set up a local Equalities Group, which undertook a specific piece of work on workforce representation and cultural competence. This was supported by an expert from a specialist 'by and for' service who sits on the Diversity, Equality and Inclusion Group.

The CSP described how this work had directly informed and contributed to the development of the Local Authority's plan to 2030. This was evident in the vision statement for this plan, which included significant commitments around equality, equity and justice and resulted in successful funding in the area related to addressing health inequalities. They also described this work as being significant for the Local Authority as an employer.

This has been reflected in local stakeholders' feedback to the Commissioner's team with regards to how this area is working to a well-coordinated community response. The CSP in this area has influenced the Local Authority plan and aims to have a domestic abuse-informed whole-systems approach.

Some recommendations are demonstrating notable practice in their implementation the example below highlights how recommendations can improve responses at a strategic and operational level informed by lived experience.

PRACTICE EXAMPLE

"As part of the refresh of the local domestic violence and abuse strategy, the CSP [Manchester City Council] should develop a targeted domestic abuse education campaign to the local African and Caribbean community, this should involve community representatives in designing education and support."

The action for the community safety team and third sector network locally was to:

"Research and learn from other examples of successful practice in this area (including CCR network). Work in partnership to design campaign and deliver campaign."

The Caribbean and African Health Network (CAHN), which includes BME survivors, were commissioned to develop a Victims Voice panel. While they had not developed a specific campaign, feedback from the panel has and continues to inform strategy and policy development. Tailored awareness campaigns for specific demographics were to form part of the new strategy refresh for 2024/25. The Commissioner has since followed up with CAHN network who said that.

The panel is commissioned by Manchester City Council and is open to people of all backgrounds and races (female, male, African, Caribbean, South Asian, Chinese, Polish, Caucasian, LGBTQ, young people, elderly, etc). Its primary aim is to help improve the local domestic abuse service provision.

The establishment of the Victim's Voice Panel (now called the 'Empowered Voices Panel') has acted as a driving force for fostering a more inclusive and culturally aware perspective on domestic abuse. By consistently engaging and providing input, the panel has highlighted the specific experiences of survivors from African and Caribbean backgrounds that were previously overlooked in local strategic planning and service delivery.

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The panel has made direct contributions to:

- Improving the cultural understanding of professionals within the CSP through shared experiences and reflective discussions.
- Influencing campaign messaging that aligns with the values, language, and real-life experiences of the target communities.
- Fostering trust between services and communities that have historically felt marginalised or misunderstood by traditional domestic abuse resources.

By centring lived experience, the Victim's Voice Panel has begun to close a critical learning gap – namely, the tendency of domestic abuse strategies to treat communities as homogenous, rather than appreciating the intersectional factors that shape vulnerability, access, and response.

The establishment of the Victim's Voice Panel has proven to be a significant and largely effective response to the recommendations set forth by the DHR. It has initiated the process of addressing long-standing gaps in understanding and engagement with African and Caribbean communities regarding domestic abuse.

"At CAHN (Caribbean and African Health Network), we prioritise culturally sensitive facilitation in our approach. We understand that discussing these topics can sometimes lead to re-traumatisation. Our efforts have led to the creation of a platform where individuals with lived experiences feel secure and empowered to share their valuable contributions."

The Commissioner feels that the inclusion of lived experience voices particularly in relation to minority groups should be commended and this provides an example of where recommendations can be instrumental to influencing approaches to developing strategy and improving practice.

Appendix F
Summary of thematic analysis conducted by HALT

In Autumn 2022, in preparation for the development of the oversight mechanism, the Commissioner commissioned the Homicide Abuse Learning Together, Manchester Metropolitan University (HALT) project to carry out four thematic reports related to DHRs. This was to help us better understand the types of recommendations made in DHRs across a range of practice areas, such as adult social care, health, criminal justice and children's services.[71] This work was intended to provide a better understanding of what an oversight mechanism could achieve with regards to thematic analysis. Consistent themes emerged from this research as had been drawn out of Home Office analysis. However, this analysis was also able to show which agencies these themes were most relevant to and recommendations therein commonly made for. The analysis in this study provides a rich, in-depth, context-specific analysis of recommendations, highlighting gaps in knowledge, policy and practice.

To put those recommendations into context, the HALT project was asked to consider key questions within reviews. The reports highlight the different types of homicide (intimate partner and adult family homicide and their characteristics, demographics, relationship type, living arrangements, risk and vulnerability factors, service contact and knowledge of domestic abuse, method of killing); a focus on protected characteristics,[72] older adults (in relation to adult social care report, see also Chantler et al, 2024); children and young people (in relation to children's services – see also children's services report[73]).

Each thematic report identified key messages from which there were recurring themes, such as the need for more assertive and enquiring practice, increased training and awareness across all aspects of abuse, improved assessment including carer and risk assessments, greater attention to equality and diversity issues and better recording and sharing of information. While the themes are familiar, the reports provide useful contextual information relating to that specific service area, thus providing relevancy. Such thematic, in-depth analysis is key to developing domestic abuse policy and practice.

Following publication, the Commissioner hosted a number of thematic webinars led by the HALT project and invited key partners across the four thematic reports to hear more about the findings from these reports. This brought together over 1,000 professionals, to share learning and practice, highlighting the appetite for strengthening responses to domestic abuse.

The prioritisation of resourcing and capacity afforded to the oversight mechanism has been focused on local action planning and recommendation implementation rather than thematic research. However, both have a role to play in facilitating change and the baseline provided by the HALT project provides an important measure from which to review progress periodically.

Notes

71. HALT (2023). *Domestic Homicide Oversight Mechanism briefings*.
72. Gunby, C. et al (2025). An Analysis of Gendered, Intersectional Dynamics in Domestic Homicide Reviews. *The British Journal of Criminology*.
73. HALT (2023). *Domestic Homicide Oversight Mechanism, Children's Services, Research report*.

Annex A

Development of a digital system for the Domestic Abuse Related Deaths Oversight Mechanism

Navigation

Sections 1-2: Pilot system: what the Excel pilot achieved, where it fell short, and how those lessons translate into recommendations for a new national system.

Sections 3-4: New DARDOM system: user groups, core needs and design recommendations.

Section 5-6: Rationale for investment and estimated cost/ timelines.

Purpose of this document

This document sets out the case for developing a national, digital Domestic Abuse Related Deaths Oversight Mechanism (DARDOM) system. Its aim is to demonstrate why such a system is essential, what problems it will solve, and how it will work in practice. It outlines the needs and goals of the professionals who will use the system – from local Community Safety Partnerships (CSPs) to national oversight bodies – and describes the limitations of the current, Excel-based approach.

Drawing on lessons from the pilot involving 20 areas, this document summarises both the successes and the barriers faced in tracking and learning from domestic abuse-related deaths. It then presents clear, practical recommendations for a future-proof system that can scale nationally. The ultimate goal is to improve accountability, support learning, and equip local and national stakeholders with the tools and insight needed to reduce domestic abuse-related deaths—and contribute to halving violence against women and girls within the next decade.

Pilot system: Challenges

The piloted Excel system is time-consuming, fragmented, and difficult to manage from a data output and oversight perspective. Preparing action plans after each domestic abuse-related death can take multiple staff days, and information must be manually copied between documents, increasing the risk of errors. Partner agencies, such as police or health services, can't access the system directly, so CSPs must spend time chasing them for updates. A lack of standardisation in how information is entered (like free-text entries or irregular follow-up cycles) makes national comparisons unreliable. Analytical insights are buried in cumbersome spreadsheets, and there's no robust audit trail to track who did what, when. In short, the current approach cannot scale to support national oversight or systematic learning.

Theme	Typical pain point
Manual workload	Excel action plans take 3-5 person-days per CSP, per review.
Duplication	CSPs copy partner updates into local sheets then into DAC template.
Partner agency engagement	Partner agencies have no direct access. CSPs must chase updates, manage interactions, escalate non-responses and log status changes.
Inconsistent taxonomy	Free-text classification of recommendations and actions hampers national aggregation.
Variable follow-up cadence	3-, 6-, or 12-month cycles make comparisons uneven.
Limited analytics	Pivot-table workarounds; trends and outliers hard to spot.
Weak audit trail	Quality ratings depend on self-declaration; evidence scattered.

Pilot system: Benefits, gaps and recommendations

The Excel-based pilot was a valuable proof of concept. It showed that it is possible to collect and combine data from multiple local areas to build a national picture of progress. By enforcing a shared template, the pilot brought consistency to what was previously fragmented work and allowed early insights into themes like training gaps or poor information-sharing. Perhaps most importantly, the pilot demonstrated the potential of national oversight, helping to build momentum among stakeholders.

Despite its success, the Excel pilot quickly revealed its limits. Entering over a thousand action items manually consumed weeks of staff time, and updates could become quickly outdated due to the lack of real-time access. Only CSPs could edit the files, leaving partner agencies on the sidelines. Differences in terminology across spreadsheets made national analysis unreliable, and the lack of an automated reminder system meant CSPs had to chase updates manually. While manageable for a small pilot, the Excel system cannot scale to a national level, where over 60,000 actions per year could be expected.

Pilot achievements

Benefit	How stakeholders used it
Proof of concept	Demonstrated it is possible to aggregate data from multiple CSPs and produce a national snapshot of implementation rates.
First shared template	Enabled 20 pilot CSPs to capture common fields (review type, recommendation, status).
Early analytics	Enabled DAC to publish preliminary themes (e.g., training gaps, info-sharing barriers) and quantify “complete vs in-progress” actions.
Momentum for change	Gave CSPs and DAC a common language and highlighted the value of national oversight, unlocking stakeholder interest.

Pilot shortcomings

Limitation	Impact
Labour-intensive data entry	1,129 recommendations and 1,815 actions took weeks of staff time to transcribe.
No real-time updates	Spreadsheets e-mailed quarterly; progress quickly out-of-date.
Single-editor bottleneck	Only CSP staff could open or edit the file – agencies remained passive recipients.
Free-text variance	Slight wording differences ("Police", "Constabulary") broke pivot-tables and trend analysis.
No audit or reminder engine	CSPs still relied on Outlook reminders and manual chasing.
Scalability ceiling	20 CSPs manageable; 300 CSPs could generate >60k actions/year – Excel becomes unstable.

New DARDOM system: Users and goals

The DARDOM system will serve a wide range of professionals, each playing a vital role in preventing future domestic abuse deaths. At the local level, **CSP leads** will use the system to log every domestic homicide review, coordinate recommendations, and track follow-up actions ensuring nothing is missed. **Partner agencies** such as police, health services, and housing teams will benefit from being able to update their assigned actions, reducing unnecessary admin and ensuring clearer accountability.

The Domestic Abuse Commissioner's Office **(DAC) oversight staff** will gain a bird's-eye view of how well actions are being implemented across the country, helping them spot systemic issues and push for improvement where needed. **Police and Crime Commissioners (PCCs)** can monitor DHRs in their CSP areas which can foster collaboration and target resources more effectively. It's also possible that **Independent Chairs** of domestic homicide reviews could access a central library of learning generated from data within the system. Finally, the **Home Office and other national bodies** will be able to monitor progress toward long-term goals like halving violence against women and girls within a decade by accessing reliable, up-to-date data that supports smart policy and funding decisions.

User group	Overarching goal(s)
CSP leads	Register every domestic-abuse-related death, coordinate recommendations, build & track action plans, evidence progress.
Partner-agency owners (police, health, children's services, housing, etc.)	Receive assigned actions, update status, supply evidence without repetitive admin.
DAC oversight staff	Monitor implementation quality, identify systemic barriers, escalate persistent non-compliance, publish national insights.
PCC viewers	View aggregate performance of CSPs in their police-force area to direct support and resources.
Independent DHR chairs	Access a central library of learning to support reviews.
Home Office / Other national bodies	Track progress toward halving VAWG in ten years; fund and shape policy based on defensible data. Respond to recommendations in a systematic way.

New DARDOM system: core needs and design recommendations

To be effective, the new system must provide a single, shared platform where all relevant agencies can contribute updates without duplication or delay. It should support automated data capture to potentially handle thousands of actions annually and allow partner agencies to take ownership of their tasks. Automated reminders and escalation processes will prevent delays, while a standardised structure will enable powerful national analytics and cross-area learning. The system must also allow detailed tracking of each action's status and quality, provide each agency with a consolidated view of its responsibilities, and offer clear dashboards and benchmarking tools for CSPs, PCCs, and national bodies to monitor and compare progress.

The future system must be web-based, multi-user, and scalable. It should guide users through structured data entry with standard drop-downs and offer quick ways to upload actions in bulk, cutting down entry time drastically. Agencies should be able to update their actions through simple, secure access, and automatic reminders should replace manual follow-ups. A strong audit trail and action-level scoring will support accountability, while intuitive dashboards at national, regional, and local levels will support targeted interventions. The system will also include a searchable learning library and exportable data for policy and reporting needs. It will feel familiar and user-friendly, while meeting accessibility standards and supporting long-term, high-volume use.

Need	Requirement	Why it matters	Design response
4.1 Single Source of Truth	One web-based action-plan workspace that replaces local spreadsheets.	Eliminates duplication and version-control issues.	**Low-code builder** provides rapid grid-style UI, single relational database, and built-in RBAC (Role-Based Access Control). Two portals: • **CSP Portal** (full CRUD). • **Partner Portal** (restricted self-update).
4.2 Role-Based, Multi-Agency Access	Secure, minimal-click login (or magic-link) for partner agencies; granular CSP/DAC permissions.	Shifts ownership to action leads; lightens CSP workload.	
4.3 Assisted Data Capture	Bulk PDF / CSV import with on-screen validation.	Reduces manual entry time from days to minutes.	AI-assisted PDF parser + bulk CSV loader; mandatory-field validator enforces completeness.
4.4 Automated Reminder & Escalation Engine	Configurable 3/6/12-month reminders; DAC escalation ladder for non-response.	Replaces manual chasing and ensures timeliness.	Scheduler triggers reminders; escalation ladder auto-emails CSP → PCC → DAC statutory letter.
4.5 Standardised Taxonomy	Controlled pick-lists for agency names, themes, status, quality.	Enables reliable national analytics and cross-area learning.	Central taxonomy tables editable by DAC Admin; pick-lists eliminate free-text drift.
4.6 Action-Level Status & Quality Scoring	Gold / Silver / Bronze with evidence upload and audit trail.	Provides granular accountability and supports systemic insights.	Inline status toggle; quality picker; evidence (file / URL / note); every change stamped to immutable audit log.
4.7 Consolidated Partner Workspace	Single dashboard listing every open action for each external agency.	Prevents "ten near-identical emails" fatigue.	"My-Agency" dashboard shows all actions owned by that agency across CSPs; CSV export.
4.8 Multi-Level Dashboards and Benchmarking	Drill-down views: National → PCC → CSP → Review, plus "most-similar CSP" comparator.	Lets all tiers spot gaps and target support.	Embedded BI layer of the chosen low-code suite powers dashboards across stakeholders adhered to national standards.
4.9 Learning Library	Optional 1-page summaries and artefacts, searchable across reviews.	Accelerates knowledge transfer for new DHR Chairs and CSPs.	File-store micro-service tagged to reviews; read-only to all CSPs, edit rights to originating CSP.
4.10 Audit, Security, Scale, performance	Full change log, WCAG-compliant UI, cloud architecture sized for 200 k+ actions over 5 yrs.	Meets governance, accessibility, and growth requirements.	UK/EU cloud hosting with auto-scaling; p95 page-load < 3 s; AES-256 and TLS 1.3 in transit; nightly encrypted backups; RTO ≤ 2 h, RPO ≤ 4 h.
4.11 Authentication and SSO	Simple and secure login for users.	Enhances security surrounding sensitive data.	Azure AD / Government SSO ready; external agencies can use passwordless magic-links (audit-logged).

New DARDOM system: rationale for investment

The current landscape of action planning and delivery across CSPs is fragmented and heavily reliant on local spreadsheets and manual processes. This results in inefficiencies, limited oversight, inconsistent data quality, and administrative burdens. The proposed digital platform introduces a secure, scalable, and collaborative solution designed to address these systemic challenges and support statutory obligations.

Unified digital workspace

The platform offers a single, web-based environment that consolidates action planning across agencies. By replacing disparate spreadsheets, it eliminates duplication, ensures version control, and supports real-time collaboration.

Role-based, multi-agency access

Granular access controls allow partner agencies to interact with the system via secure login/ links with permissions tailored to specific roles. This decentralises data entry, empowering action owners while reducing CSP administrative overhead.

Streamlined data ingestion

AI-assisted import tools could enable bulk upload of PDF and CSV data with built-in validation checks. This reduces manual data entry while ensuring data completeness and accuracy.

Automated notifications and escalation protocols

The platform includes a configurable reminder engine with escalation paths that align with statutory responsibilities. Automated workflows replace manual follow-ups and ensure timely updates across all tiers of governance.

Standardised taxonomy for national consistency

The use of controlled vocabularies for agencies, themes, statuses, and quality ratings ensures data consistency. This underpins reliable national analytics and enables cross-area learning.

Action-level monitoring and quality assurance

Actions are tracked using a Gold/Silver/Bronze classification system, with support for evidence uploads and a tamper-proof audit log. This facilitates detailed performance tracking and accountability.

Partner-centric dashboards

External agencies benefit from a consolidated view of their assigned actions across all CSPs, reducing information overload and enabling more effective task management.

Multi-tiered reporting and benchmarking

Interactive dashboards provide drill-down capability from national to local levels. Stakeholders can benchmark performance, identify gaps, and direct support efficiently.

Knowledge management via a learning library

The system could include a searchable repository of key documents and summaries, accelerating learning, particularly for new CSP leads and DHR Chairs.

Robust architecture for security, accessibility, and scalability

Hosted in UK/EU cloud infrastructure, the system is designed for scale (200k+ actions), with full WCAG accessibility compliance, end-to-end encryption (AES-256, TLS 1.3), and automated backups. Recovery objectives are aligned to business continuity standards (RTO ≤ 2h, RPO ≤ 4h).

Seamless authentication and interoperability

Integration with Azure Active Directory and Government Single Sign-On enables secure, passwordless access for internal and external stakeholders, with full audit trails for compliance.

Cost estimates

Briefly described below are two development options for the DARDOM system—one focused on delivering essential functionality quickly and cost-effectively, and the other offering a robust, future-ready platform that supports national scale and deeper insight.

Option A ('Lean / Minimum Viable') proposes a cost-effective route at **£500,000 for development** and **£15,000 annually** for platform hosting and licensing. It supports a limited number of users (up to 500 CSP and 20 DAC users), with external agencies accessing the system via secure links. This version delivers core capabilities: secure data entry, reminders, basic dashboards, and a 12-month pilot before national rollout. It's ideal for proving impact and functionality at a manageable scale.

Option B ('Comprehensive / Future-Ready') requires **£1 million for development** and **£100,000 annually** to run. It supports up to 50,000 users, allowing full integration of all partner agencies across all CSPs. It builds on the lean option's features, adding AI-assisted data processing, advanced analytics, benchmarking tools, and a learning library. This version positions the Home Office to deliver long-term, system-wide impact from day one, while remaining within the same delivery timeframe of **6-10 months.**

Both options are technically achievable within a year; the key decision is whether to start lean and scale up or invest upfront in a fully-fledged national infrastructure.

Conclusion

The Excel pilot proved the concept and galvanised stakeholders, but its manual nature, single-user design, and lack of automation underline the need for a scalable, role-based, cloud system. Investment in this platform represents a strategic step toward a more data-driven, transparent, and efficient approach to community safety. It ensures alignment with statutory duties, enhances inter-agency collaboration, and delivers measurable efficiencies across operational and reporting activities.

Meeting the needs and recommendations above will significantly reduce CSP workload, engage partner agencies directly, and give the DAC – and ultimately the Home Office – the real-time intelligence required to prevent domestic abuse related deaths.

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