June 2024

A written response from Dr James Rowlands, Dr Elizabeth Cook and Sarah Dangar to:

Open consultation on *Updating the domestic homicide review statutory guidance*, from the Home Office and Laura Farris. Available at: https://www.gov.uk/government/consultations/updating-the-domestic-homicide-review-statutory-guidance

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1. Executive Summary

We welcome the draft revised statutory guidance for the conduct of Domestic Homicide Reviews. Since the last iteration of the statutory guidance was issued in 2016, there have been considerable changes to the domestic abuse policy landscape, including:

- The completion of some 1000 reviews, which means we have a better sense of what works and what does not.
- The launch of the government's own reform agenda (HM Government, 2012) – including the introduction of a DHR library, the change to the definition and naming of reviews, the roll-out of training for chairs, and the development of an oversight mechanism by the Domestic Abuse Commissioner – meaning that there is an ever-developing framework to support the conduct of reviews.
- An expanding evidence base on reviews. This includes a better picture of case profiles, learning, and recommendations, and an increasing amount of research into how reviews are undertaken.

Considering these changes, it is positive that the revised statutory guidance includes some valuable changes. These changes include:

- introducing more detailed templates for completion;
- a commitment to underlying principles, including learning and implementing change, the importance of being victim-centred and trauma-informed, and the role of family and others who knew a victim;
- the new requirement of a rationale from Community Safety Partnerships (CSPs) where a decision is made not to commission a review is a very positive step in increasing the transparency of commissioning processes at a local level;
- added detail on what it means to be an Independent Chair in practice;
- as well as movement towards acknowledging the Panel as 'co-producers' in the final review report

However, there is still more to do. In this submission, we make extensive recommendations. These recommendations address a range of areas that require further development. These include:

- Adding a working definition and clarity to the scope of domestic abuse-related deaths that fall within the remit of domestic homicide review (in particular, suicides);
- Adding further detail to the processes of implementation following completion of a review (i..e, 'what comes after') including roles and responsibilities;
- Adding a requirement for local commissioners to resource the participation of specialist domestic abuse and by-and-for services which provide specific expertise on Panels;
- Adding explicit guidance around identifying, contacting and engaging with the networks of victims and perpetrators; and
- Improved collaboration between domestic homicide reviews and parallel review systems (in particular, Coroners).

Given reviews are a response to profound trauma for families and communities, as drafted, the changes proposed do not match the importance of the task. Consequently, we make recommendations for a more ambitious programme of reform to ensure we can work together

to honour victims, hold perpetrators accountable, identify and share learning, and drive meaningful change.

To progress this work, we make a simple call: we would encourage the Home Office to adopt the spirit and practice of review. To do that, we make two important recommendations. First, the Home Office should review its mechanisms for oversight and accountability to date. This means undertaking an appraisal of its responsibility over reviews since 2011 and what has changed since this point. Second, the Home Office should engage in meaningful co-production as it moves forward, ideally by establishing a taskforce that includes representation from key stakeholders to complete the work to finalise the revised statutory guidance.

2. Questionnaire

1. Are you responding as an individual or on behalf of an organisation?

☒ Individual

☐ Organisation

[if 'Individual then Q2, if Organisation then Q3]

2. If you are responding as an individual, please select the option which best describes your status.

☐ Family member or friend bereaved by domestic homicide

☐ Family member or friend bereaved by another type of domestic abuse related death (not a homicide)

☐ DHR Chair or Panel member

☒ Academic / researcher / student

☐ Other (please specify):

3. If you are responding on behalf of an organisation, please select the option which best describes the type of organisation.

☐ Law enforcement agency (police, policing body, Crown Prosecution Service)

☐ Healthcare organisation

☐ Local Authority

☐ Community Safety Partnership

☐ Educational institution or student body

☐ Violence against women and girls charity / service provider

☐ Other (please specify):

4. What is the name of the organisation?

n/a

5. From the list below, where are you or your organisation based?

☐ National

☐ South West

☐ South East

☐ North West

☐ North East

☐ Yorkshire and the Humber

☐ East of England

☐ West Midlands

☐ East Midlands

☒ London

☐ Wales

☐ Another part of the UK

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

☒ Yes

☐ No

Recommendation 1

We support the stated purpose as proposed and the emphasis on reviews being 'victim-centred' and conducted in a 'trauma-informed' way (see Section 1.5).

We recommend, however, that the revised statutory guidance be amended to make explicit that reviews must also seek to learn lessons about "work to hold perpetrators to account and prevent them from causing further harm". In addition, further clarity is needed to understand the practical implications of *doing* 'trauma-informed' and 'victim-centred' reviews (e.g., training on principles of 'trauma-informed' practice, additional operational guidance, etc.).

Recommendation 2

We support the recognition and reference to the involvement in reviews of those that a victim was "close to", including families, friends, neighbours and colleagues, i.e. testimonial

networks (see Section 1.5). Testimonial networks should be central to reviews, given their potential contribution to and benefit from this process (Rowlands and Cook, 2022).

We recommend, however, that the language be amended from "can be utilised" to "must, wherever possible, be utilised" (see Section 1.3).

Recommendation 3

We recommend, similarly, that the language used to refer to testimonial networks be clarified and used consistently. Currently, different terminology is used to refer to some or part of different testimonial networks.

Recommendation 4

We recommend that the revised statutory guidance includes a clear definition of the different membership of testimonial networks, including families, but also friends, neighbours, and colleagues, as well as wider communities (including, where appropriate, faith communities). We also recommend that this be amended to also refer to those who knew the perpetrator, i.e. their family and other testimonial network members.

Recommendation 5

We recommend that there is explicit reference to children as prospective members of testimonial networks. There is currently no reference to the involvement of children as victims in their own right (in line with the *Domestic Abuse Act 2021*).

Recommendation 6

We recommend that the language that refers to testimonial networks' potential contributions should be strengthened to recognise that testimonial networks have a role in review "by virtue of *connection*". This includes contributing by:

- Sharing *information* (about both the victim and/or perpetrator, including relating to them as a person, concerning their contact and experience of agencies, and the impact of the death).
- *Shaping learning* (including by identifying the questions they want to be answered or providing feedback and challenge throughout the review process).
- *Being part of change* (by being part of the process of implementing recommendations and ensuring accountability).

Recommendation 7

We support the reference to the need for national learning and the role of the relevant Government departments and organisational bodies.

We recommend, however, that this section be strengthened by summarising how recommendations should be routed and responded to by these bodies, as well as the role of the Domestic Abuse Commissioner.

Recommendation 8

We recommend, in addition to Sections 1.3 and 1.4 referring to local and national learning, that 'regional learning' is added given that a formal role for Police and Crime Commissioners (PCCs) has been proposed, as well as other changes in sectorial governance (for example, the establishment of Integrated Care Boards).

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

☒ Yes

☐ No

Recommendation 9

We recommend explicitly referencing the different types of homicides that fall into scope to ensure clarity in commissioning. This is because there are differences between intimate partner and adult family homicides (Bracewell *et al.*, 2022).

Recommendation 10

We support the recognition that other types of death are in scope (including deaths by suicide, as well as deaths involving neglect or unexplained circumstances).

We recommend, however, that a working definition of what constitutes a domestic abuse-related death be developed and that Section 8e be integrated into the revised statutory guidance rather than being a stand-alone section. We are concerned that little consideration has been given to the decision-making process around commissioning or how to ensure consistency in this respect. Concerning deaths by *suicide*, Sections 3.9 and 8e do not assist decision-makers in determining what cases should be reviewed. Evidence shows that the lack of a working definition in the 2016 statutory guidance prevents a consistent understanding of what constitutes an in-scope death because these deaths are under-conceptualised and lacking in terms of operationalisation (Rowlands and Dangar, 2024). Consequently, there have been calls for additional guidance (Hoeger *et al.*, 2024).

Recommendation 11

We recommend that a working definition of what would constitute a death "from neglect or in unexplained circumstances" be developed. Concerning deaths involving *neglect or unexplained circumstances*, we are concerned that the errors made in introducing an under-conceptualised and little operationalised definition for deaths by suicide are being repeated in this category.

Recommendation 12

We recommend, to bring these points together, that the revised statutory guidance is amended to be clear that, in making decisions about scope, the key consideration is whether a death was "*caused by, related to, or somehow traceable to*" domestic abuse (Websdale, 2020, p. 1). The use of this language would enable a recognition that causality can be complex. Such a recognition is essential to identify domestic abuse-related deaths by suicide, where direct attribution may not be possible (Dangar, Munro and Young Andrade, 2024). This is particularly important given, for example, that Section 3.11 states that there is no expectation that the "victim's death was directly a result of domestic abuse".

Recommendation 13

We recommend, linked to this, that the statutory guidance be amended to be clear that decision-makers can exercise discretion to consider reviewing deaths that might otherwise fall outside of the "personally connected" definition of the *Domestic Abuse Act* 2021. This would enable reviews to be considered where deaths:

- Occur outside of normative family and intimate relationships, measured in terms of temporality, status and/or perceived closeness (e.g. dating relationships, relationships where status may not have been disclosed or be unclear or not defined, as well as extended kinship, and caregiving).
- Involve corollary victims.
- The perpetrator has or appears to have been motivated by gender-based violence, including sexual jealousy, and this has occurred in a domestic setting.

For a complete summary, please see a previous consultation response in 2023: https://lawpoliticsandsociology.wordpress.com/wp-content/uploads/2023/07/domestic-homicide-review-legislation-consultation-response.pdf.

Recommendation 14

We recommend amending Section 3.10, which currently describes "factors to consider when commissioning a DHR", as this is currently underdeveloped. Additionally, there is similar but different content elsewhere in terms of establishing Terms of Reference (in 7a), in the IMR template (Annex D, in the "analysis of involvement"), and in the context of compiling a review (Section 8.1). This lack of alignment, repetition and underdevelopment limits the utility of the framework that the revised statutory guidance will offer to review.

Recommendation 15

We recommend that the revised statutory guidance embeds an ecological model, emphasising consideration of personal/individual, microsystem/relationship, exosystem/community, and macrosystem/societal levels (Heise, 1998). An ecological model involves asking, as one participant noted in a recent study:

> 'Did we do enough? Should we have done more? What could we have done more and were there individual, you know, [organisational], service, government, policy issues that got in the way of us doing that?' (Rowlands, 2023, p. 159).

Therefore, we recommend that the revised statutory guidance is developed to provide a framework to guide how an ecological model can inform the scoping, analysis, learning, and recommendations from reviews.

Recommendation 16

We recommend that the singular reference to the "coordinated community response" (in Section 1.3) is further developed, particularly in so far as it can inform identification of learning, the development of recommendations, and the implementation of action plans. There is existing guidance that could usefully inform this development (e.g., Standing Together, 2020).

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

☒ Yes

☐ No

Recommendation 17

We support the provision of a process map that summarises the conduct of a review, and one that captures the relationships between the stages of review.

We recommend, however, that the process map be revised to include:

- In 'Notification Process': a reflection of who is involved, including family.
- In 'Scoping Review': a reflection of what other action may also be taken, either in terms of running a parallel review or if a decision is made not to conduct a review.
- In 'Commissioning & Conducting': undertaking the review and creating an action plan are combined in the figure. However, these are separate stages.

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

☒ Yes

☐ No

Recommendation 18

We support the clarification on the referral sources for a review in Section 4.2.

We recommend that Section 4.2 be separated as follows:

- First, to acknowledge that the police will typically be the source of referral while confirming that any other agency may also make a referral if they become aware of a death that may meet the criteria, and to refer to the requirement to have links with Real Time Surveillance to identify deaths by suicide (currently in Section 8.22). Within this revised section, we recommend placing an expectation on all agencies to make a notification as soon as reasonably possible.
- Second, to emphasise that family and other testimonial networks may also raise their concerns and outline the process for doing so (either directly to the CSP or via another statutory agency or specialist support service). Within this revised section, place an expectation on all agencies to respond to such a concern and facilitate a notification as soon as reasonably possible. The guidance should be clear that these agencies must not gatekeep and that they must also provide information on and offer to make a referral to specialist advocacy services at the same time.

Recommendation 19

We recommend that Section 4 also be amended to clarify the process for commissioning reviews where a victim and/or perpetrator resided in more than one area. This would include the following amendments:

- Explicitly state that overall responsibility for establishing review rests with the relevant local CSP.
- Set out a process for agreeing responsibility where a victim was known in more than one area, emphasising that (a) the CSP where the victim was predominantly residing is responsible for commissioning the review but (b) that there is a duty on other connected CSPs to collaborate.
- Explicitly include domestic abuse-related deaths abroad where the parties primarily reside and have accessed services/are known to agencies in England and Wales. The local where the victim was normally, or last, resident should be responsible for establishing the review.

Recommendation 20

We recommend that this section sets out model(s) for sustainable funding, given concerns in this respect (Montique, 2019), including (a) contributions from the responsible authorities that make up a CSP along with the PCC and (b) the circumstances when more than one CSP should share the cost of commissioning a review.

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

☒ Yes

☐ No

Recommendation 21

We support the introduction of a scoping process, as this clarifies the initial stages of a review, and **we support** the timeframe of four weeks. We anticipate that for deaths involving homicides, the primary function of the Scoping Review will be to identify immediate actions and inform the convening of the review. In contrast, for other domestic abuse-related deaths, this process will also likely inform the commissioning decision-making process. Many local areas already undertake a process of this kind, including asking agencies to provide a 'summary of engagement', which could inform the completion of the Scoping Review template.

We recommend, however, that clarification be added that there must be a process for consultation, including an identified forum where this will occur. Currently, this section does not provide any guidance on how a commissioning decision should be made or who should be involved, despite a question about this in the 'Scoping Review Template' (question 8). We also recommend adding that the requirement to consult with local partners who work with victims of domestic abuse is strengthened from "should" to "must"; and that the reference should be to consulting specialist domestic abuse *and* led-by-and-for services to address the circumstances of any given case.

Recommendation 22

We support including notification of family for the Scoping Review, as set out in Section 5.2.

We recommend, however, that:

- The Home Office update and expand the existing leaflets for family, friends, employers and colleagues, and also create a suite of letter templates for CSPs, with these developed in collaboration with bereaved families. This would recognise that notifications are sensitive processes.
- That the statement that specialist advocacy should be offered "at the earliest opportunity" be strengthened to read "at notification and, as appropriate, re-offered at later stages".
- That the victim's family be updated on the outcome and be offered the opportunity to receive the Scoping Review (with guidance also provided to address what can be shared in this context and how). Currently, Section 5.5. does not include sharing the Scoping Review with the victim's family.

Recommendation 23

We recommend that the revised statutory guidance be explicit about what other action may be taken in parallel review processes. Such action may either be in terms of running a parallel review or some other action if a decision is made not to conduct a review (e.g. discharging the case into a parallel review process or deciding to undertake a lighter touch audit or learning review).

Recommendation 24

We recommend that the 'Scoping Review Template' in Annex C be revised as follows:

- *Question 3* - Separate sections on background for the victim and perpetrator, including a section on any children (where appropriate), with "background" clarified as referring to relevant case information and a summary of contact with agencies.
- *Questions 4 and 5* – To better assist with alignment and transfer to an IMR, in the learning and actions section, the same language to be used as in the IMR template.
- *Question 6* – To emphasise the importance of consistent decision-making regardless of the outcome, to be revised to set out the rationale for the commissioning decision, including why the case *does* or *does not* meet the criteria.
- *Question 9* – To be revised to capture the point above about running a parallel review or, if a decision is made not to conduct a review, how it is proposed to discharge the case.

Recommendation 25

We recommend, to enhance accountability, that CSPs are required to report on the source, number and profile of notifications received, the decision-making process, and the commissioning outcome.

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

☒ Yes

☐ No

Recommendation 26

We recommend that Section 6.2 be revised so that responsibility for the final composition of the Panel sits with the Independent Chair and the Panel itself. The revised statutory guidance currently places responsibility for convening the Panel on the CSP.

Recommendation 27

We recommend that Section 6.2 be revised from "relevant expertise" to read "including those who can contribute by virtue of *contact* (i.e., agencies that were involved with the victim, perpetrator and/or any children) or *specialist knowledge,* regardless of contact (i.e., specialist domestic abuse services, as well as other non-governmental organisations with issue or community-specific knowledge, including 'led-by-and-for' services)". While we support the emphasis on all "relevant expertise", this list is currently unclear.

Recommendation 28

We support recognition of the critical importance of specialists in Section 6.3, particularly given concerns about the adequacy of review reports into the deaths of victims from minoritised communities (e.g., Chantler *et al.*, 2022) and/or in terms of engagement with specific experiences (e.g., Hasham and Thorlby, 2023).

We recommend, however, revising the language of "marginalised" to "minoritised or minority" groups.

Recommendation 29

We recommend, to ensure access to expertise from specialist domestic abuse and led-by-and-for services which are often under or precariously funded (Domestic Abuse Commissioner, 2022), that the revised statutory guidance include a requirement for local commissioners to resource their participation.

Recommendation 30

Concerns have been raised about the appropriateness of some expert representation, including both in terms of selection or how expertise is input in reviews (e.g., Centre for Women's Justice and Imkaan, 2023).

We recommend, to ensure appropriate expertise, further clarity be provided regarding the experience, skills, and knowledge required of those appointed as experts.

Recommendation 31

We recommend in relation to intersectionality (referred to in the revised statutory guidance as “equality and diversity”) in the review process, that:

- The Scoping Process explicitly identifies whether the review will need to include experts, whether such expertise is available locally or needs to be sourced from elsewhere, and any resource implications.
- To align with this, the revised statutory guidance and relevant templates should be updated to reflect a requirement to set out how such specific case circumstances have been addressed, including through the appointment of expert representatives, and the steps taken during the review to ensure the Independent Chair and Panel are also mindful of these considerations.

Recommendation 32

We recommend that the section on panel membership be further developed so that clarity is provided regarding the experience, skills, and knowledge required of those appointed to the Panel. There is evidence that panel members often do not have access to training and support or the capacity to engage in the review process (Rowlands, 2023).

Recommendation 33

We recommend a requirement that, when making a nomination, agencies have a responsibility to ensure Panel members have (a) the capacity, (b) the training, and (c) the support to participate.

Recommendation 34

We support the continued emphasis on independence and the expectations around the Panel engagement (see Sections 6.4 and 6.5).

We recommend, however, that:

- It is clarified that the Independent Chair, in consultation with the Panel, should agree on the frequency of the meetings and that, as a minimum, this should include an initial meeting to decide on the scope and Terms of Reference; meeting(s) to discuss the information gathered (as well as a meeting, if requested, with testimonial networks); at least one meeting to discuss a draft of the report; and then an agreed process for further discussions, revisions and/or sign off the final draft.
- Instead of requiring at least quarterly meetings and updates, there should be a requirement for the Independent Chair to provide “regular and timely updates”.
- The requirement to “provide feedback and constructive challenge throughout the process” (point 2) and “use their expertise to consider and constructively challenge …” (point 4) should be integrated into a strengthened point 3 about the Panel being “co-producers”.
- Point 4 be revised to add that, while working with the Panel as co-producers and attempting to seek agreement wherever possible, ultimately, the Independent Chair is the decision maker for the report.
- Other parts of the revised statutory guidance need to be revised to consistently reflect this emphasis on co-production.

Recommendation 34

We recommend that an escalation process be set out to manage disputes within a review (i.e. between the Independent Chair, Panellists and/or their agencies, and testimonial networks) and about a review (i.e. between the Independent Chair and the CSP). We recognise that it is not for the Home Office to arbitrate. However, there is evidence of the potential for conflict within Panels (Haines-Delmont, Bracewell and Chantler, 2022).

Recommendation 35

We support the emphasis on governance structure in Section 6.6

We recommend that there should be a requirement for CSPs to set out an escalation process.

Recommendation 36

We support the clarification provided within Section 6.7 regarding the independence of the Chair.

We recommend, however, considering the profile of Independent Chairs and that the Home Office develop a workforce strategy alongside the revised statutory guidance. This would address the evidence of a lack of diversity to date and a preponderance of former police officers (Rowlands, 2023).

Recommendation 37

We recommend amending Sections 6.8 and 6.9 (referring to how the Independent Chair is responsible for managing the review process) as follows,

- In Section 6.8, instead of "managing", this is amended to that the Independent Chair is responsible for "leading" the review process "and agreeing with the CSP how it will be coordinated".
- In Section 6.9, clarifying the process for resolving any disagreement between the Independent Chair and the CSP; in particular, reflecting our earlier point, we **recommend** that it be clarified that the Independent Chair should co-produce the report with the Panel, and in line with the requirements of the statutory guidance, but is ultimately the decision-maker for the review itself (e.g. the conduct of the Panel and the report's content). At the same time, the CSP is the commissioner (e.g. in terms of oversight and decisions around action plans, publication, and dissemination).

Recommendation 38

We recommend adding 'victim-centred' to Section 6.11 to align with Section 1.1.

Recommendation 39

We recommend that "experience of writing formal reports" should be essential, albeit we suggest that this should not be restricted to prior experience of writing review reports to enable a more diverse workforce of Independent Chairs.

Recommendation 40

We recommend that the revised statutory guidance be amended so that the process of mapping, contacting, and engaging with family and other prospective testimonial network members is included in Section 6, i.e. from the start of a review. As drafted, the involvement of family and other testimonial networks is not detailed in this section but instead addressed in Section 7.

Recommendation 41

We recommend that Section 8 be revised to focus on the approach to analysing information gathered from testimonials networks. In this context, we are also concerned that, as drafted, the revised statutory guidance does not reflect the different testimonial networks that may be involved in a review or the potential complexity of practice in this area (Rowlands and Cook, 2022; Dangar, 2024). Consequently, we recommend providing more specific guidance on mapping family and other prospective testimonial network members. This could include, for example, where to gather information (e.g., the police inquiry or other agency records, with this then developed as testimonial networks are engaged and potentially identify other participants) and how to record this (e.g., the development of genograms).

Recommendation 42

We recommend that the revised statutory guidance and associated templates are further developed to provide explicit guidance around contacting, engaging, and involving:

- Different membership of testimonial networks (and specifying who these individuals are in a consistent manner).
- The victim or perpetrator's testimonial networks (including specifically in cases of Adult Family Homicides, given the dual role of families) instead of conflating the two.

Recommendation 43

We recommend including explicit guidance on ensuring the voices of children are heard in reviews and how to do this, including in terms of age-appropriate practice. We also recommend requiring that children are signposted to specialist and expert trauma-informed support. This is particularly important considering increasing recognition of children's potential involvement in review (Stanley, Chantler and Robbins, 2019) and concerns about the support available for children after a death (Dangar, 2024).

Recommendation 44

We **recommend** that the Home Office work with the Ministry of Justice to ensure that specialist advocacy support is available to victim and perpetrator testimonial networks (including children). This would enable the involvement of all testimonial networks asdiscussed elsewhere in this submission.

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

☒ Yes

☐ No

Recommendation 45

We recommend adding a specific requirement to ensure that, in so far as possible, the Terms of Reference answer any questions raised by testimonial networks. We recommend sharing the Terms of Reference and strengthening Section 7.1 as follows:

- Amending the text to read "and to identify any questions they may have and ensure that, where possible, these are included in the scope of the review".
- Adding a requirement that, where testimonial networks raise issues that are outside the scope of the review, the Independent Chair should ensure they are offered specialist advocacy support and/or signposted appropriately.

Recommendation 46

We recommend removing the Independent Chair's role in agreeing plans for briefing sessions or learning events in Section 7.5 – as these will happen *after* the production of the review report.

Recommendation 47

We support the inclusion of Section 7b.

We recommend that the guidance be amended to include a provision for 'Short Reports' in Section 7.6.1 (and that a template be developed for this purpose) where an agency had limited contact with a review's subject(s).

Recommendation 48

We are concerned that, while there are references to the development of a (combined) chronology in the revised statutory guidance, this is not included explicitly in this section, nor is a template provided. Having chronologies from all agencies that provide information – whether their reports are IMRs or Short Reports – is vital to building a picture of the contact timeline.

We recommend that this section be amended to be explicit about providing a 'Chronology' from each agency, then the development of a 'Combined Chronology', and that templates be created for this purpose.

Recommendation 49

We recommend including "Other evidence about a victim's life" in Section 7b to ensure a victim focus and/or minimise victim blame (Rowlands, 2023, p. 223-226). Evidence has supported the use of other evidence to help Panels to "hear from" or "come alongside"

victims, including the use of photos or other artefacts (such as a diary, social media, or some other communication by or to the victim).

Recommendation 50

We recommend that provision be made for 'Practitioner Learning Events' to be undertaken and that Section 7b addresses and provides a framework for such events. Other types of statutory review have developed practices around engaging frontline professionals involved in the case in a review. Such events can provide an opportunity for the professionals involved in a case to come together to consider the circumstances surrounding it and why actions were or were not taken, thereby informing the analysis, learning, and recommendations.

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

☒ Yes

☐ No

Recommendation 51

Section 8.1 refers to examining "how and why the death occurred". While we agree that understanding the trajectory to a death is essential, including identifying opportunities for intervention, we are concerned that this limits the focus to the death event. As stated in 1.1, the purpose of a review is to learn lessons and we believe that this must include more broadly consideration of experiences before the death itself.

We recommend that this be amended to be clear that the learning should take a broad lens, considering:

- Pathways to, and the history of, violence and abuse generally (which, in addition to enhancing reviews generally would also allow for the recognition and consideration of cases where, for example, a victim of abuse killed their partner, see: Centre for Women's Justice and Justice for Women, 2021; Rowlands, 2022);
- Any responses, individually and collectively over time (including the victim, perpetrator and any children's concerns about and/or experiences of agencies, as well as agency responses themselves);
- The death event itself;
- As appropriate, any relevant learning post-death (e.g. in terms of identification and notification, response to victim's family, etc.).

Recommendation 52

For Section 8.2.4, we agree that the review report should be clear about who is responsible for overseeing the action plan. However, we are unclear why the Action Plan is discussed here, given that the Independent Chair and Panel's role is to identify learning and develop recommendations, while the action plan and implementation will happen after the production of the review report.

We recommend this be removed.

For section 8a:

Please see our response to **Q.6** in relation to a trauma-informed approach.

For section 8b:

Please see our response to **Q.6** in relation to a victim-centred approach.

For section 8c:

Please see our response to **Q.11** in relation to family and other testimonial networks.

Recommendation 53

We recommend that the language of "crucial" to refer to families be amended to the previous language of "integral". This would also reflect the recommendation from a recent report that the Independent Chair and Panels "must hear the voices of families, friends and wider testimonial networks" (Dangar, 2024, p. 40).

Recommendation 54

We support Section 8.12 which refers to awareness of the risk of ascribing a hierarchy of testimony.

We recommend, however, strengthening this section to recognise that *all* information gathered in a review, regardless of the source, should be subject to the same level of scrutiny. This is because testimonial networks, like agencies, are "one of [the] many different and potentially contested voices that are sought, brought together, and interrogated through the alchemy of deliberative dialogue within a DHR" (Rowlands, 2024b, p. 20). We believe recognising that agencies' information must also be scrutinised will help strengthen the importance of avoiding a hierarchy of knowledge.

Recommendation 55

We recommend that the language for disagreement with testimonial networks should be brought in line with that of agencies, i.e. as detailed in Section 6.5.

For section 8d:

Recommendation 56

We support the development of guidance about the involvement of the (alleged) perpetrator. There is evidence that involving (alleged) perpetrators in reviews may be valuable and enhance learning, but, at the same time, this practice is both uncommon and of considerable concern to stakeholders (Rowlands, 2024b).

We support that the revised statutory guidance identifies issues like the risk of repeating a victim-blaming narrative and the importance of considering the perspective of, and possible risks to, a victim's testimonial networks before any contact attempts.

We recommend, however, further developing the frameworks covering (alleged) perpetrator engagement. Currently, there is a reference to the importance of "set[ting] boundaries" in this context, but there is no further explanation of what the issues might be or how to manage them. Additionally, the guidance does not adequately address what is different in the context of deaths other than homicides for which particular barriers have been identified (Rowlands and Dangar, 2024). We also recommend linking this to the experience, skills, and knowledge of the Independent Chair in Section 6.11.

Recommendation 57

We recommend that a separate section is added relating to the involvement of the (alleged) perpetrator's testimonial networks. As already noted, within the current draft, the involvement of the (alleged) perpetrator's testimonial networks are often overlooked or conflated with the discussion of the involvement of those who knew the victim. Given the specific challenges that can arise in this context (Rowlands, 2024b), and reflecting our response to question 11, further detail is required.

For section 8e:

Recommendation 58

We recommend, in line with a response to Q.7, that Section 8e be integrated rather than left as a stand-alone section.

For section 8f:

n/a.

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

☒ Yes

☐ No

Recommendation 59

We recommend that the reference to 'relevant boards' in Section 9.1 be amended to read 'boards or bodies' as, for example, Mental Health Homicide Reviews are commissioned by NHS England.

Recommendation 60

We recommend that Section 9.2 should be amended to clarify that reviews may be conducted jointly or in parallel and, in so doing, considerations should include (a) the terms of reference, (b) the process of gathering agency information, (c) the process of testimonial network engagement (d) the process of perpetrator engagement (e) the production of the report, and (f) the publication of the report and dissemination of learning.

Recommendation 61

We recommend that the Home Office should work with the other government departments and bodies that sponsor parallel review processes to more fully consider the intersections and learning across these systems. Research reveals some similar learning and challenges between these parallel review systems (Robinson, Rees and Dehaghani, 2019).

Recommendation 62

We recommend clarifying that there is an expectation that any underlying single agency review report (e.g., a Serious Incident Investigations Report conducted by an NHS organisation, a Serious Further Offence Report conducted by the Probation Service, or reports by the Independent Office for Police Conduct) must be shared on request to inform the review process, albeit this may be subject to appropriate restrictions.

Recommendation 63

While this is beyond the question of parallel reviews, we note that the revised statutory guidance only partly addresses the interface with the criminal justice system (in terms of early consultation with the Crown Prosecution Service) and does not address the family court system at all. However, in some cases, information will be required from the criminal or family court systems because they played a significant role in a case, for example, around bail conditions or the progress of contact. We recognise that this is a complex area given judicial independence.

We recommend the Home Office and Ministry of Justice undertake to manage the interface between reviews and the criminal and family courts and develop protocols to do so.

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

☒ Yes

☐ No

Recommendation 64

We recommend that the statement in Section 10.5 referring to "delay progressing" be amended to refer to a decision to delay the review "in whole or in part". This would ensure that stakeholders are clear that they can, in agreement with the appropriate justice agencies, undertake parts of the review that would not compromise any proceedings in addition to the currently listed "preliminary work". While we agree that there may be occasions where a review will need to be paused if there is an ongoing criminal investigation, this must be balanced with ensuring the process is timely.

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

☒ Yes

☐ No

Recommendation 65

We recommend that the relevant local Senior Coroner and the Chief Coroner is notified at the commencement of a scoping review. Currently, this section does not provide sufficient clarity, particularly in respect of domestic abuse related deaths by suicide/other domestic abuse-related deaths. This would enable coroners to decide about the continuation or adjournment of the inquest and to discharge their broader duty to seek out as "many facts concerning the death as the public interest requires" (Naftalin and Munro, 2023),

Recommendation 66

We recommend that a protocol for inquests and reviews to work in parallel be established between the Home Office and the Chief Coroner to ensure consistency throughout England and Wales. This would mitigate the current problem of the 'postcode lottery' by enabling consistency and ensure that coroners have access to as much information as possible for the inquest and subsequent decision making.

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

☒ Yes

☐ No

Recommendation 67

We recommend that further consideration be given to how to integrate the requirements for the SUSR in the revised guidance. While we welcome the inclusion of guidance around the SUSR process, as incorporated currently, this does not aid readability.

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

☒ Yes

☐ No

Recommendation 68

We recommend further clarification regarding pseudonym selection, including who makes this choice and how. Decisions around the choice of pseudonyms are more complex than they might appear, including issues like who gets to be involved and how, as well as what

pseudonyms are chosen and the associated risks, such as the erasure of ethnic/cultural differences (Rowlands, 2024a).

Recommendation 69

More broadly, we are concerned that this section sustains a false narrative that reviews are anonymous. Yet, upon publication, reviews can be cross-referenced to media reports and identified (Websdale, 2020). The statutory guidance fails to address the ease by which assurances of anonymity (and so confidentiality) can be overcome, and so also fails to address the numerous consequences that flow from this and the potential impact on contributors (Rowlands, 2024a). Linked to this, while we understand that a victim's family may wish to see the victim's real name used, a decision to do so underlines that the anonymisation of the other subjects in the report is a fiction.

We recommend, therefore, that the revised statutory guidance addresses:

- Gaining informed consent from testimonial networks about their participation, including how any information they provide will be used, as well as other rights (such as the right of withdrawal or their opportunity to inform pseudonym selection).
- Making decisions about the nature and detail of information included in the review's report.
- Making decisions about any restrictions around publication.

Recommendation 70

We recommend that further consideration be given to the issue of anonymity, including the viability of alternative approaches, such as not associating reports to a given CSP area and publishing them at a regional or national level via the DHR library.

Recommendation 71

We support the recognition of potential risks to Panellists and the removal of their names from reports.

We recommend that, to provide assurances as to the appropriateness of these Panellists, and in addition to still naming the respective agencies, the job titles of Panellists should continue to be included (subject to any risk, whereby a generic role title may be appropriate).

Recommendation 72

We recommend that, as for Panellists, these considerations should also be extended to Independent Chairs. Where there are concerns about risk, there should be an option for the Independent Chair not to have their name published. Linked to this point, we also recommend that in these circumstances, the Chair's independence statement can be revised before publication to be generic for their previous roles.

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

☒ Yes

☐ No

Recommendation 73

We recommend that, given a CSP is ultimately the commissioning body, it is clarified in this section that CSPs are the data controller, and should seek appropriate legal advice as needed, including with respect to publication.

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

☒ Yes

☐ No

Recommendation 74

We support the refinement of the Quality Assurance process, including updating the Terms of Reference in Annex H and the standardisation of the Board's feedback in Annex E.

We recommend, however, the following amendments and considerations for the Quality Assurance process. We are concerned that there does not appear to have been any consideration of a root and branch review of quality assurance, particularly given general concerns about the effectiveness of national oversight (Haines-Delmont, Bracewell and Chantler, 2022) and the timing and quality of feedback from this process (Rowlands, 2023). As proposed, the Quality Assurance Board is neither independent (given that the Home Office chairs the board) nor transparent (in terms of appointment). Moreover, the proposed approach does not learn from best practices in other parallel review systems (e.g. the national Child Safeguarding Practice Review Panel). Finally, how the quality assurance process will report on learning is unclear.

To address independence and transparency and reflect best practices elsewhere, the Quality Assurance Board should:

- Have a defined membership, with members bringing expertise thematically, including:
    - Adult safeguarding.
    - Child safeguarding.
    - Family advocacy services.
    - Service/user family voice.
    - Specialist domestic abuse service provision.
    - Specialist led-by-and-for service provision.
    - Suicide prevention.
    - Serious incident/fatality review systems.
    - Academia.
- Have an Independent Chair.

- Have a membership (including the Chair) appointed through a transparent public appointment process, with remuneration and a term limit.
- Nominated advisors from relevant statutory organisations (criminal justice, child and adult safeguarding, health, housing, etc.) to provide information and advice on their respective service areas.
- PCC and DAC representatives are also nominated and have ex officio membership.

Recommendation 75

We support the role of the Home Office in terms of a secretariat.

We recommend that, to improve the quality assurance process itself:

For individual reviews:

- Review reports at submission to be considered by the DHR Readers Service, with the reader's report then provided directly to the commissioning CSP and Independent Chair. This would allow for the timely identification of any issues or areas for clarification and then a response by the Independent Chair in consultation with the Panel and CSP, including amendments or further work as necessary (in effect, our proposal would mean that readers would act as peer reviewers, and perhaps the term 'peer review' is also more appropriate than 'reader').
- Review reports to be re-submitted with an accompanying template completed to indicate the changes made in response to the reader's report. This would include noting both changes but also areas of disagreement with the reader.
- The Quality Assurance Board to consider the reports on re-submission, meaning that their feedback can be focused on substantive issues which require consideration against the statutory guidance and their professional expertise.

For national learning:

- Aligning this report with the Oversight Mechanism's reporting process.
- Reconsider the need for the QA Board to produce an *additional report*. The DHR Readers Service produces a report. Looking forward, the Domestic Abuse Commissioner's Oversight Mechanism will also include an annual report. Finally, the revised statutory guidance suggests that a non-statutory member of the Quality Assurance Board will have the "additional task of the annual report writer for the chair". Having multiple reporting mechanisms is a poor use of resources and will blunt the capacity of the review system to drive meaningful change. Consider the reporting process from the DHR Readers Service and Quality Assurance Board being combined into a single annual report producing aggregate data on the profile of reviews completed, recommendations identified, and learning from quality assurance.

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

☒ Yes

☐ No

Please see our response to the next question.

22. Do you have any comments on 'Section 3: Implementation of Learning – Making the Future Safer' in terms of content or clarity? Please specify which subsection you are referring to or enter 'No' if no further comment.

☒ Yes

☐ No

'Roles and responsibilities' Section:

As drafted, this section is too descriptive of the roles and responsibilities of the Independent Chair, the CSP, the DAC, and the Home Office. Moreover, this and the previous section currently set out what happens after a review – including publication and the delivery of action plans – but do not match the importance of the task with a vision for dissemination of learning or driving meaningful change.

For the Independent Chair:

Recommendation 76

We recommend revising Sections 18.1 and 18.4 more broadly, but also specifically to remove the Chair's responsibility for the action plan development (see **Q.12** and **Q.13**).

Recommendation 77

We recommend integrating Section 18.3 into Section 6a (as part of the discussion of the role of the Panel).

For CPSs:

Recommendation 78

We recommend that Section 19.1 is integrated into Section 4. It is currently unclear as to why there is a discussion of the establishment of the review at this point in the guidance.

Recommendation 79

We recommend that there is a requirement for the PCC (or Office of) to be represented as a Panellist on all reviews, either because the PCC is, in some way, a contributing agency (e.g. as a commissioner of a local service) or as an ex-officio member (i.e., so they are sighted). We agree that the PCC has a role in developing the draft action plan and they should be involved in reviews from the outset.

For PCCs:

Recommendation 80

We recommend that the roles and responsibilities of CSPs versus PCCs are clearly defined. We agree that PCC's roles in reviews should be formalised and have suggested examples of this (e.g. see our response below in relation to collation of learning). However,

the language of “strategic oversight” is ambiguous, given the revised statutory guidance empowers individual CSPs as the commissioning body.

For the Domestic Abuse Commissioner:

Recommendation 81

We support the proposed annual reporting (see **Q.20**).

We recommend that the process for reviews to make recommendations to Government departments and organisational bodies is clarified. While we welcome the formalised role for the Domestic Abuse Commissioner, and the development of the Oversight Mechanism, as for PCCs, this section is ambiguous. For example, as drafted, it suggests the Domestic Abuse Commissioner will be responsible for local learning, yet this is properly the responsibility of CSPs in the first instance and for which, presumably, the Commissioner is not otherwise resourced.

For the Home Office:

Recommendation 82

While we believe reviews have made an important contribution, and recognise the Home Office’s role in this respect (and particularly the contribution of the small but dedicated team of Civil Servants undertaking the day-to-day work in this area), it is important to acknowledge the sustained criticism of the consistency and robustness of national oversight to date (Neville and Sanders-McDonagh, 2014; Haines-Delmont, Bracewell and Chantler, 2022; Rowlands, 2022a). Thus, given this criticism, it seems extraordinary that of all the bodies named in this section, the Home Office has the least defined roles and responsibilities.

We recommend that the Home Office:

- Undertake an appraisal of its responsibility over reviews since 2011 and the learning from this.
- Explicitly identify its roles and responsibilities in the revised statutory guidance.

Recommendation 83

We recommend that Section 3 be broken into two distinct sections, with the first relating to “Publication and Dissemination of Learning” and the second relating to “Implementing Recommendations and Developing Action Plans”. We suggest that these two sections are then developed to set out a more ambitious framework for dissemination and change.

Recommendation 84

In terms of “Publication and Dissemination of Learning”, **we recommend**:

The inclusion of a requirement for CSPs to:

- Host a dedicated page relating to reviews on the relevant partnership website, including:

    - Information on the local review process (including notification process and commissioning decisions, as well as escalation).
    - Information on each published review.
- For each review, to develop a publication strategy and, as a minimum, on the relevant partnership website to provide the following information for each published review:
    - A stable link to the DHR Library and the completed report.
    - A 'lessons learned and actions taken' summary.
- For each review, to develop a dissemination strategy to reach all relevant stakeholders in a variety of mediums, including:
    - Family or other testimonial network briefing sessions.
    - Professional learning events (as currently detailed in 19.4).
- For reports that are not published, in addition to Paragraph 16.4, we believe there should nonetheless be the requirement to develop a summative 'lessons learned and actions taken' summary to ensure learning is not lost. We also recommend the DHR Library have the capacity to also hold this record.
- We recommend that learning from reviews be brought together regularly. While the Domestic Abuse Commissioner's Oversight Mechanism will produce an annual report, we also recommend that there is a requirement to regularly collate learning and recommendations locally. It may be that this responsibility is best discharged at a regional level and that it would, therefore, be best for PCCs to lead this in partnership with local CSPs (this would help effect the requirement to consider learning from local DHRs, as detailed in Paragraph 7.3.8). This should include cross-review learning dissemination.
- This process should align with the Domestic Abuse Commissioner's Oversight Mechanism.

Linked to this point, the revised statutory guidance could better identify the importance of research in this area. There is increasing knowledge about domestic homicide and domestic abuse-related deaths as a result of the analysis of reviews, but, at the same time, a reoccurring finding has been data gaps in reports (e.g., Sharp-Jeffs and Kelly, 2016; Chantler *et al.*, 2020). It has also been reported that there is no consistent understanding of the link between the production of reports and subsequent research (Rowlands and Bracewell, 2022). This section should address the importance of research and clarifies expectations around reviews in terms of data reporting.

Recommendation 85

In terms of 'Implementing Recommendations and Developing Action Plans', as drafted, the revised statutory guidance does not substantively address the challenges that can arise in developing recommendations (Rowlands, 2023), including the emerging evidence about the best way to frame and direct recommendations (Buxton-Namisnyk and Gibson, 2024). Nor does this section address the mixed evidence around impact (Jones *et al.*, 2022). To address these issues, the revised statutory guidance should be developed in terms of the development and implementing of action plans. We **recommend**:

- That the revised statutory guidance more fully articulate the process of developing recommendations, including balancing tensions (such as resources versus ambition) and focus (including, as detailed in response to question 7, addressing both personal/individual but also microsystem/relationship, exosystem/community, and macrosystem/societal level change, as well as the Coordinated Community Response).

- This guidance should be included in Section 8, as this activity properly takes place while compiling the review.
- In this section, there needs to be more explicit guidance on how to implement recommendations through the development and delivery of action plans, including the appropriate governance arrangements, as well as the responsibilities of those bodies subject to recommendation(s).

Recommendation 86

We recommend that the section to be revised to acknowledge that ensuring the opportunity to be actively involved following the conclusion of a review is vital:

- Explicitly address testimonial networks (as currently noted in Figure 2)
- And that this is more than simply updating on implementation but includes opportunities for involvement if sought and as appropriate.

23. Do you think the DHR Toolkit is useful?

☒ Yes

☐ No

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

☒ Yes

☐ No

Recommendation 87

We support the inclusion of the DHR toolkit, which will be a valuable aid for conducting reviews.

We recommend template changes to align them with our previous recommendations as detailed in this submission.

Recommendation 88

We recommend that the revised statutory guidance is explicit as to whether these templates are required or can be amended to local areas and/or specific cases.

Recommendation 89

We recommend the following issues are addressed within the Annex A:

Annex A:

- There are references to homicide throughout, which should be revised to include the other types of death that are in scope (e.g. suicides, neglect or unexplained circumstances).

- The current sections risk repetition and overlap and should be revised as follows:
    - That ‘Background Information’ should additionally address equality and diversity, as well as key information such as employment and housing status.
    - That ‘Agency Overview’ and ‘Analysis’ are integrated so that there is a section that addresses (a) what was known about domestic violence and abuse broadly, including any learning (b) what was known to professionals and agencies, an analysis their involvement, and any learning (c) any outstanding considerations from the Terms of Reference.
    - Within this integrated analysis section, for clarity, recommendations to be included following the associated learning
    - To emphasise that ‘Lessons Learnt and Recommendations’ section is intended to be a high-level summary to bring together the learning and all recommendations.
- The ‘Scoping Review’ is not attached to the DHR: this risks both repetition and inaccuracy (for example, if the information gathered has been updated or expanded). This section should instead be integrated into the ‘Terms of Reference’ and set out a short narrative as a ‘Rationale for the Decision to Commission a Review’.
- Using this toolkit to centralise the collection of data on the victim, perpetrator, and incident characteristics, as well as service contact, victim/perpetrator relationship, should be considered here. This is particularly important considering the rich and in-depth narrative detail available within reviews (Cook *et al*., 2023).

Recommendation 90

We recommend the following issues are addressed within the Annex B:

- The inclusion of an additional column to detail how the outcome will be evidenced.
- Clarification that the ‘Key Milestones to Complete Actions’ are ‘Outputs’.
- To be revised so it can clearly act as a template for recommendations from the review itself, or from single agencies (see also comments on Template D).

Recommendation 91

We recommend the issues detailed in our earlier responses are addressed within the Annex C.

Recommendation 92

We recommend the following issues are addressed within the Annex D:

- A specific section be included relating to ‘Your Agency’ to capture a brief summary of the agency's role and service offer, as well as specific policies and training around domestic violence and abuse.
- A ‘Methodology’ section be included to summarise the methodology used to prepare the IMR (e.g. case file review, interviews, etc.).
- A specific section be included to consider ‘Equality and Diversity’, to bring together what was known to an agency and their actions at the time or any learning or reflection on the extent to which this affected agency involvement.
- A specific section be included to consider ‘Subject/s Voice’ to bring together what the agency knew about the victim/s as a person.
- That ‘Addressing Terms of Reference’ is integrated into ‘Analysis of Involvement’ to avoid duplication.

- That ‘Effective Practice, Lessons Learnt & Recommendations’ are slit into ‘Effective Practice & Lessons Learnt’ and ‘Recommendations’, with the latter to be followed by an action plan template.
- The final section needs to enable agencies to report on the early learning and progress of actions based on the Scoping Review.

Recommendation 93

We recommend the issues detailed in our earlier responses are addressed within the Annex E.

Recommendation 94

We recommend the following issues are addressed within the Annex F:

- While we agree that this information is helpful, to ensure that each review is tailored to an individual case, it should be clarified that (a) this is guidance only and (b) it is expected that local data (e.g. from local needs assessments, advice from domestic abuse specialists and/or led-by-and-for services) or other sources (e.g. academic research) should be the primary source of information.
- In addition, it should be stated that intersecting inequalities and vulnerabilities such as those detailed in this section are not additive (Durfee, 2021).

Recommendation 95

We recommend the following issues are addressed within the Annex G*:*

- Include information on (a) whether specialist advocacy was taken up and (b) which agency offered specialist advocacy.
- Include information on whether and how someone wanted to be involved with the review following its conclusion (e.g. updates on action plan progression).
- Be explicit about how this form is to be completed, e.g. whether this is as a whole or for each member of the testimonial network(s) identified.
- Address issues as raised in response to question 18, e.g. informed consent.

Recommendation 96

We recommend the issues detailed in our earlier responses (see **Q.20**) are addressed within the Annex H.

Recommendation 97

We recommend the issues detailed in our earlier responses are addressed within the Annex I.

Recommendation 98

We recommend deleting Annex J as it appears to be a duplication of Figure 1.

Recommendation 99

We recommend the following issues are addressed within the Annex K:

- There are only references to homicide, but this annexe should be revised to include the other types of death that are in scope (i.e., suicides, neglect, or unexplained circumstances), and to include the appropriate support agencies.
- The list of other help and support contacts is partial (e.g. no reference to organisations that support specific communities) and should either be comprehensive or direct readers to an online, more easily updatable resource list.

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

☒ Yes

☐ No

Recommendation 100

We recommend the revised statutory guidance be reviewed for numbering and formatting.

Recommendation 101

Additionally, as already noted for specific sections, the revised statutory guidance needs to consistently encompass domestic abuse-related deaths, not, as currently, primarily homicides.

We recommend the revised statutory guidance be reviewed for consistency and accuracy of terminology.

Recommendation 102

It is critical that the revised statutory guidance is more regularly updated than it has been possible hitherto.

We **recommend** a commitment to regularly update the statutory guidance and to do so no less than every two years.

Recommendation 103

More broadly, the revised statutory guidance is a static document.

We recommend hosting the statutory guidance as an online document to enable easier updates. A platform supporting this would also need to include a mechanism to provide a summary of changes and allow stakeholders to sign up to be notified of any changes.

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

☒ Yes

☐ No

Recommendation 104

The review process, including the emphasis on accountability, not blame, is underpinned by the recognition that a culture of safety is the best way to identify learning and improve responses to domestic violence and abuse (Websdale, Town and Johnson, 1999).

To underpin this, **we recommend** that the revised statutory guidance should set out the expectation of candour, including openness and transparency by all stakeholders.

Recommendation 105

We recommend that a Statement of Ethics be developed to provide a framework to assist those involved in review in terms of their choices and decisions. There is currently no ethical framework for the conduct of review, either in England and Wales or globally (Cook *et al.*, 2023). Yet, as is evident from this submission and the research we have quoted, reviews are complex, particularly around 'decision-making moments' (Albright *et al.*, 2013, p. 437) that might go on to shape either stakeholder experience and/or findings.

While the statutory guidance will necessarily have to address specific aspects of practice within each section, a Statement of Ethics could better capture the principles currently identified in the revised statutory guidance, including being victim-centred and trauma-informed.

Recommendation 106

To progress this work, we would encourage the Home Office to adopt the spirit and practice of review. **We recommend** the Home Office should review its mechanisms for oversight and accountability to date. This means undertaking an appraisal of its responsibility over reviews since 2011 and what has changed since this point. Such an appraisal would aid in learning about review over the last 13 years.

Recommendation 107

We recommend that, to complete the revisions of the statutory guidance, the Home Office establish a task force that includes representation from key stakeholders.

While we support the development of revised statutory guidance, we are also conscious of the challenge of this task, particularly given the complexity of review. Consequently, we welcome the opportunity to provide feedback through the current consultation. However, as is evidenced by this submission – and no doubt others – there remain numerous areas where further work is required. Co-production would be a powerful tool to address these areas for further work. As an example, Scotland is currently developing its review mechanism. It has established a task force to provide national leadership for the development and implementation of a multi-agency domestic homicide and suicide review model for Scotland (https://www.gov.scot/groups/domestic-homicide-review-taskforce).

Recommendation 108

We recommend the Home Office commission an evaluation of review to better inform the conduct and development of this system. Such an evaluation could, importantly, also address a Theory of Change to underpin the efforts to learn from domestic abuse-related deaths.

Despite the resources being put into review, both in terms of direct and indirect costs, no evaluation has been undertaken. This means it is difficult to be confident about impact (Jones *et al.*, 2022), albeit research with stakeholders has identified a range of individual, intra-organisation, inter-organisation, and broader change can come about from review (Rowlands, 2023). In addition, while there is a developing evidence base about the doing of review, it remains incomplete (Cook *et al.*, 2023). Such a state of play is concerning given reviews have now been in operation for 13 years. Lastly, there is also little evidence of consistent knowledge exchange between reviews of domestic abuse related deaths and the other statutory review systems that operate in England and Wales, not least those involving children and adults, or mental health homicide (see **Q.14**).

About you

Please use this section to tell us about yourself.

Full name James Rowlands

Job title or capacity in which you are responding to this consultation exercise (for example, member of the public): Lecturer in Criminology

Date: 24/06/2024

Company name/organisation (if applicable): University of Westminster

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If you would like us to acknowledge receipt of your response, please tick this box: ☒

Address to which the acknowledgement should be sent, if different from above

n/a

If you are a representative of a group, please tell us the name of the group and give a summary of the people or organisations that you represent.

This submission is a joint response on behalf of Dr James Rowlands (Lecturer in Criminology at the Department of Criminology at the University of Westminster), Dr Elizabeth Cook (Senior Lecturer at the Violence and Society Centre at City, University of London), and Sarah Dangar (PhD candidate at City, University of London).

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