

# Learning from loss

Ensuring the lessons from domestic homicide reviews lead to change

EXECUTIVE SUMMARY



domestic  
abuse  
commissioner

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# 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- Dyfed Powys (withdrawn)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

# Introduction

**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. Domestic homicide remains unacceptably high in our society, and every homicide and suicide represent a failure to protect victims and stop perpetrators.**

Between April 2023-March 2024, there were 108 domestic homicides in England and Wales, which equates to a quarter of all homicides during this period, and is a figure relatively unchanged in the last 10 years.<sup>1</sup> The cost to families cannot be truly quantified, but the Home Office estimate the financial cost to society and the public purse of a single domestic homicide is £2.9m, totalling £313m in a year.<sup>2</sup> 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 lives following domestic abuse exceeds the number of domestic homicides.

Reduction in domestic abuse-related deaths will be an essential measure of this governments commitment to halving Violence Against Women and Girls. To achieve this, we must be sure that the learning identified in Domestic Homicide Reviews (DHRs) is heeded.

A DHR is a review into the circumstances around a death following domestic abuse. These reviews were formally introduced in 2011;<sup>3</sup> however, the first review, into the killing of Julia and William Pemberton, was published by West Berkshire Safer Communities Partnership in November 2008. DHRs were designed to establish what lessons could be learned from domestic homicide and support local areas to develop action plans that improve responses – as well as highlighting any national learning that needs embedding into government policy. Community Safety Partnerships (CSP) have overall responsibility for the DHR locally, and the implementation of any learning that arises.

These reviews present a critical opportunity to ensure that local areas, as well as national government, implement learning to prevent this devastating loss of life from ever happening again. However, too often, agencies, government departments and other public bodies are not held to account in the implementation of the recommendations made to them. We currently have no idea of the extent to which recommendations and action plans are being implemented on a national level. This is a huge opportunity missed.

**“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**

## History and development of DHRs



2004

Section 9 of the Domestic Violence, Crime and Victims Act



2011

DHRs implemented in England and Wales through the introduction of statutory guidance



2021

Domestic Abuse Act – The Commissioner receives all reviews



2023

The Home Office created a DHR library



2024

Wales and Single Unified Safeguarding Reviews commenced



2025

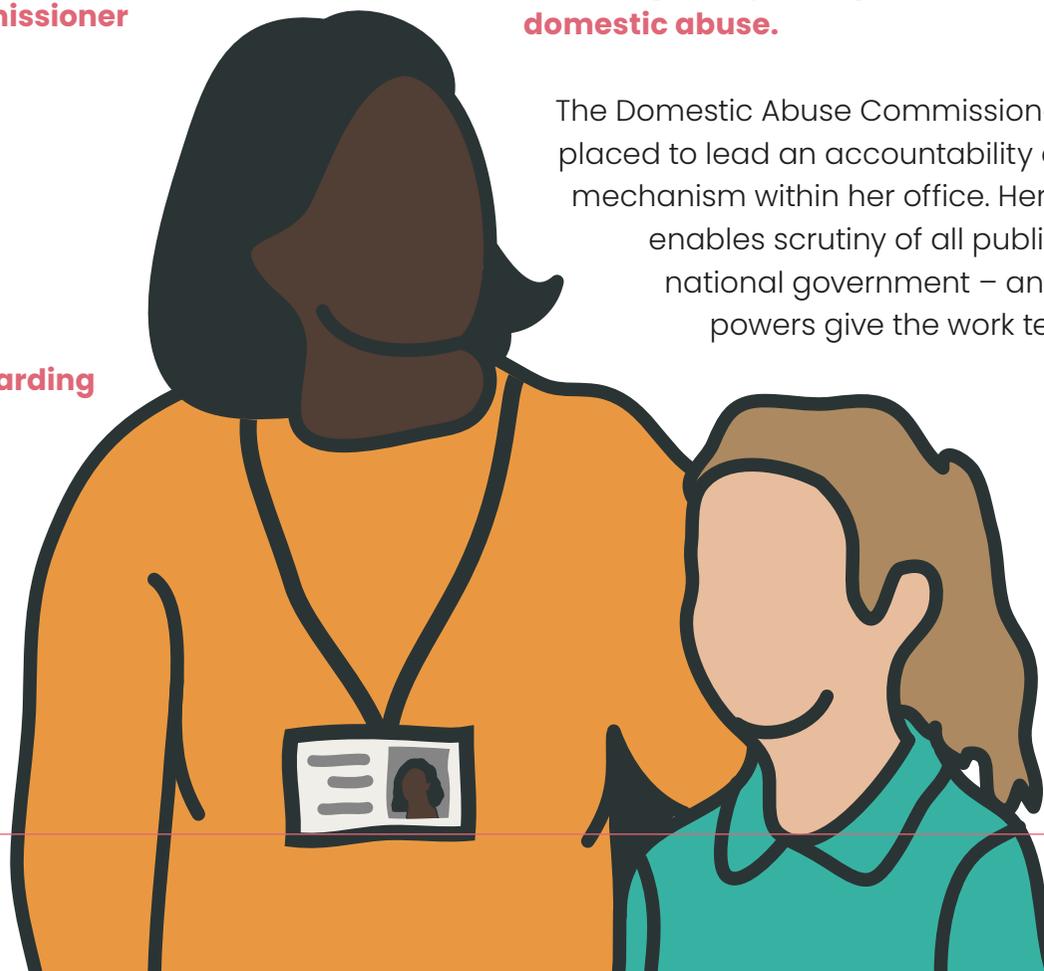
It is expected registered users will be able to extract learning from the Welsh SUSRs

“Luke was 23 years old when he died in April 2021. As a much loved member of his family, he is deeply missed.” DHR Luke

## Scope and methodology

This report provides an overview of the DHR process, highlights the need for accountability and central oversight, and outlines 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 considerable benefits this could bring in improving the wider response to domestic abuse.

The Domestic Abuse Commissioner is uniquely placed to lead an accountability and oversight mechanism within her office. Her independence enables scrutiny of all public bodies – and national government – and her statutory powers give the work teeth.



# The need for accountability

**It is simply unacceptable that there is no accountability for implementation of recommendations that have been made following loss of life. 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. The Domestic Abuse Act 2021<sup>4</sup> requires all CSPs to provide the Commissioner with any finalised reviews – an important first step in establishing oversight.

Over the last 13 years, there has been 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. 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.<sup>5</sup> The Domestic Abuse Act 2021 requires public bodies to share a copy of any finalised report to the Domestic Abuse Commissioner, an important first step in establishing oversight.

**“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 devastated by her death. You always think you have time to put things right – she mattered.”** DHR Martine

Since 2020, the Home Office has commissioned a qualitative analysis of DHRs, analysing reviews annually from April 2019 to the most recent 2022–2023 report. This and other analysis, such as the Homicide Abuse Learning Together (HALT) Project,<sup>6</sup> has shown consistent themes indicating that lessons are not embedded or shared. In 2023, the Home Office created a DHR library<sup>7</sup> – this brought together published DHRs in one central online location, which are available to the public. While useful, this central repository is simply that – and provides no more of a sense to agencies or the public as to whether recommendations have been implemented or not.



# Moving to greater oversight and accountability

## Testing an approach to accountability and oversight

To address the lack of oversight and accountability for DHR implementation, the Home Office provided £100k for the Commissioner to pilot an independent oversight mechanism. This ran in 2024, and the Commissioner worked with 21 local areas: 11 Community Safety Partnerships (CSPs) and 10 Police and Crime Commissioners (PCCs) led approaches. The purpose of the pilot was to:

- Test the most effective methods of capturing data regarding recommendations and their progress.
- Assess how best the Commissioner can support local areas to implement and share learning.
- Hold national government and local agencies pilot areas to account in implementing their own recommendations.
- Assess resource required for effective accountability and oversight at a national level.

CSPs and PCCs were asked through a survey about their experiences of the pilot. Most notably, many areas involved in the pilot credited the Commissioner's pilot with improving accountability for DHR recommendations locally, having done the following as a direct result:

- Reviewed the process for dissemination learning across local boards 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 DHRs.

## What has piloting shown us?

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

**“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

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.

Through the pilot, both quantitative and qualitative data was collected and is summarised in the ‘key findings dashboard’ at the end of this document, along with a summary of the themes and trends in DHR recommendations. Overall, from 76 DHRs there were 1,129 recommendations and 1,815 actions relating to these recommendations. Where actions were not taken forward or

completed, this was often due to a lack of resource or capacity, organisational change or restructure, conflict with other processes or a national recommendation where there had been no feedback or update.

Implementation of recommendations was self-assessed to a set criteria provided by the Commissioner. As this was a retrospective review, areas had not anticipated this degree of scrutiny and so 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 and clearly demonstrates the value of DHRs in effecting change. For example, one pilot area reported that following an action relating to recording Domestic Violence Disclosure Scheme (DVDS) referrals at MARAC, they had seen an increase in referrals by 40% in the previous year. This clearly shows the impact of recording DVDS referrals at MARAC in raising awareness of the scheme – as a direct result of a DHR recommendation.

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

PCC pilot area, 2024



## Process findings

- **Nearly all pilot areas reported good partnership working and the vast majority had a desire to learn from DHRs and prevent future deaths.** This is something the Domestic Abuse Commissioner has seen reflected in the willingness to engage and participate in the pilot.
- **However, fewer (24%) felt they had evidence of significant change as a result of DHRs** or that there were strong funding arrangements to support recommendation implementation. There is clearly a stronger role needed nationally to support change at a local level.
- **Dedicated resource was key to supporting the process and implementation of recommendations.** This was particularly acute where a greater number of domestic abuse-related suicides were identified and subject to a review.
- **New technology is needed to harness the learning from the hundreds of reviews across England and Wales.** Existing data tools are unable to manage the large datasets produced by a pilot of 21 areas and would be rendered useless by a national dataset. 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. This method of data collation and analysis, if scaled up to a national roll-out, would be untenable.

**“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

- **Retrospective reviews of action plans limit the ability of local areas to interrogate and assure implementation as it happens.** 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.



- **Lack of clear responsibility for recommendations and actions locally hampered accountability.** In one-third of pilot areas, there was a lack of clear partnership arrangements for funding DHRs, and recommendations or actions were 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.

- **Variation in action plans and local assurance processes made data collection inconsistent.** Across areas, the format of actions plans varied, which made requesting action plans for review difficult as data could not be collated consistently. This was highly resource intensive, particularly where the Commissioner’s team needed to follow up for missing information.



## Self-assessment of implementation by local areas lacked independent scrutiny

**Data provided was largely based on self-assessment, and so variation or bias could creep in. Ideally, assessments should be made independently of the agencies delivering recommendations.**

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 and scrutinise individual returns.

**“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**

# National policy recommendations from DHRs

**Through the pilot, the Commissioner also 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 central 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.**

There were 110 national recommendations – the majority of which are 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:

- 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%). Not one government department could confirm that they had updated the CSP on implementation of their action.

**“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

- 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.

# From piloting to national accountability and oversight

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

Key requirements are:

1. A second year to pilot 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 Commissioner's Office to scrutinise returns and hold local areas and national government to account.

**“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

## New technology

The Commissioner procured specialist advice from Catch Impact on the development of a digital tool for any national mechanism. This would need to allow for secure, simple data input from multiple agencies, including the 300+ CSPs, analyse and track implementation, and support peer learning across regions.

**A comprehensive and future-ready digital tool** requires **£1m** for development and **£100k annually** to run. It would support up to **50,000 users**, allowing full integration of all partner agencies across all CSPs. It builds AI-assisted data processing, advanced analytics, benchmarking tools, and a learning library to truly transform how we access learning from reviews. This will be critical to maximise the benefits from DHRs. This would require 6-10 months for development.

## Capacity to provide scrutiny and build capacity at the local level

In addition to resourcing to develop new technology, ongoing funds would be needed to staff a small team within the Commissioner's 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 brings the total funding required for a transformative national accountability and oversight mechanism to approximately **£1.45m** in Year 1, and £550k thereafter.



# Key benefits of the Commissioner's proposal

**The proposed model for national roll out of an accountability and oversight mechanism, making use of new technology, would bring huge benefits to the local and national work to tackle domestic abuse.**

These are through the ability to:

- **Unlock local lessons to help prevent future deaths and improve the wider response on domestic abuse across the country.** Currently, learning stalls at a local level. An oversight mechanism can utilise one central tool to share learning locally, across regions and nationally. The new digital platform, using AI, would enable local agencies to upload their actions and access others in real time and improve the response to domestic abuse locally. Building on local commitment, this would provide a cost solution to address the issue of under resourcing locally – and duplication – to improve responses to domestic abuse.
- **Transform domestic abuse strategic planning at a local level.** This tool could be used by local leaders to learn from tragedy to build their multi-agency response; without needing to wait

for another victim to die before implementing much-needed change. This will pre-empt learning and drive efficiency as local areas can make immediate use of a huge wealth of insight from across the country. Through this new tool, the Commissioner envisions a system whereby local strategic leads (and national policymakers) can input information about their local area and generate ideas for change on the basis of learning from DHRs in similar areas. This could transform the delivery of statutory requirements at a local level, such as through joint strategic needs assessments under the Victims and Prisoners Act, Police and Crime Plans, the Serious Violence Prevention Duty, and the Safe Accommodation Duty, among others.

- **Produce national annual thematic analysis of key trends from recommendations.** A new digital system that streamlines the review of data would allow the time of the Commissioner's team to focus on actions and 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.
- **Ensure that all national government departments are aware of their recommendations.** There is currently no mechanism in place to ensure that government departments are made aware of recommendations in a timely manner, nor held to account for implementation alongside local government. The proposed model would plug that gap.

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

- **Act as a blueprint for building future oversight mechanisms.**

Investment in a new technological tool to gather and share learning could be adapted for the Offensive Weapons Homicides Reviews, as well as Child Safeguarding Reviews helping drive further efficiencies both locally and nationally.

- **Creating stronger communities of practice to support local areas.**

The Commissioner has collaborated with the Local Government Association and Association of Police and Crime Commissioners to bring together those leading on DHRs within public bodies to share practice stemming from DHRs. 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.

The Local Government Association sums up by stating: *“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*

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

*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.”<sup>8</sup>*



# Recommendations

## 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.

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



- 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.<sup>9</sup>

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.

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

- 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.

“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

## 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 2021, 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.

**“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





## 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. Office for National Statistics (2025). [Homicide in England and Wales Articles](#).
2. Home Office (2019). [The economic and social costs of domestic abuse](#).
3. 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.
4. [Domestic Abuse Act \(2021\): Section 17](#).
5. Rowlands, J. (2025). [The Potential and Peril of Reviewing Domestic Abuse-Related Deaths](#).
6. From 2019–2021, Manchester Metropolitan University ran a study of DHRs through their Homicide Abuse Learning Together (HALT) Project. The HALT project created a repository of, and analysed, 322 domestic homicide reviews published from 2011–2019. These reviews had been collected via local authority web pages and reports were shared via HALT’s websites. These reviews have now been included in the Home Office Library.
7. Home Office (2025). [Domestic Homicide Review Library](#).
8. Councillor Heather Kidd, Chair of LGA’s Safer and Stronger Communities Board.
9. Domestic Abuse Commissioner (2024). [Consultation on updating the Domestic Homicide Review Statutory Guidance: Written submission from the Domestic Abuse Commissioner for England and Wales](#).

**“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



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