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Commissioning Pathways for Domestic Homicide /Abuse-Related Death Reviews: Are All Deaths Counted?

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Domestic homicide reviews (being renamed domestic abuse-related death reviews) have been undertaken in England and Wales since 2011. However, relatively little is known about the commissioning process for these reviews, including where notifications come from, if the types of cases being referred are changing, and the outcomes. Our knowledge is also limited about who is involved in these decisions and who is informed when a decision is made.

For this project, data were requested from the partnership bodies responsible for commissioning domestic homicide / abuse-related death reviews about notifications and decision-making between January 2017 and December 2024. Our findings highlight the changing profile of cases, variability in decision-making, and gaps in communication and oversight. This research was funded by a British Academy/Leverhulme Small Research Grant (SRG24\240681).

Research background

In England and Wales, domestic homicide reviews (DHRs) - being renamed domestic abuse-related death reviews (DARDRs) - are undertaken into the "death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect". (1) For clarity, in this document, we refer to DARDRs.

DARDRs were introduced in 2011 in the Domestic Violence, Crime and Victims Act 2004. **(1)** The deaths examined by DARDRs include domestic homicides, as well as domestic abuse-related deaths by suicide, and can involve former or current intimate partners as well as family members. **(2)** Led by an independent chair, DARDRs are multi-agency statutory reviews that bring together a range of stakeholders. In a DARDR, these stakeholders examine the circumstances of a domestic abuse-related death to identify learning and recommend practice, policy, and system changes. Between 2011 and 2022, estimates suggest that over 1000 DARDRs have been completed. **(3)**

The DARDR process begins with a notification to a local Community Safety Partnership (CSP) of a death where domestic abuse is known or suspected to have been involved. Having been notified, the CSP must decide whether the case falls within scope and, if so, whether to commission a DARDR. According to the statutory guidance governing DARDRs, this decision should be taken by the chair of the CSP and should include consultation, not least with local domestic abuse specialists. After a CSP has made its decision, the Home Office provides an additional layer of oversight and must be informed. The deceased's family should also be notified of the decision to commission. **(2)**

There has been very little research into this commissioning pathway. However, there is evidence to suggest that notifications and commissioning decisions have changed over time, including for police notifications of potentially in-scope deaths. **(4)** Additionally, research has suggested that, despite meeting the criteria, some domestic abuse-related deaths may not be subject to a DARDR. **(5, 6, 7)**.

This knowledge gap is particularly important given the challenges of commissioning and delivering DARDRs. For example, a recent survey by the Local Government Association (LGA) and the Office of the Domestic Abuse Commissioner for England and Wales highlighted the need for clearer and more robust Home Office guidance on the commissioning of DARDRs following suicide. **(8)**

To address this gap, this study aimed to improve understanding of the commissioning pathway and decision-making processes for DARDRs when notifications are received by CSPs.

Specifically, we set out to understand:

- Where notifications of potentially reviewable deaths come from.
- Who is involved in decision-making about whether a DARDR should be commissioned.
- Whether there are differences between the deaths that are reviewed and those that are not.
- Who oversees this process.

"Each review is an opportunity to defeat domestic abuse – so this research is critical because it unveils the improvements needed to ensure the notification and decision-making process is as good as it can be for bereaved families and all victims of domestic abuse"

Frank Mullane, AAFDA

What did we do?

Methods and data

We requested data on all notifications of deaths received by CSPs from January 2017 to December 2024, irrespective of the commissioning outcome. Data was first requested through a survey sent via the LGA to local authorities. This was followed by Freedom of Information requests to local authorities that had not responded to the survey. We requested two types of data:

- An aggregate information request for the total number of notifications received during the study period, and information on the local process.
- An individual case information request: de-identified data about individual cases, including: case type (homicide, suicide, unexpected death, e.g., fall from height, or other, e.g., neglect); victim and (alleged) perpetrator characteristics; decision-making criteria and outcome; who was involved; and whether families and the Home Office were notified.

Stakeholder engagement

During the project, we consulted extensively with stakeholders to understand challenges and concerns in commissioning DARDRs and to inform the development of our data collection tools. We:

- Spoke with CSPs, usually the local authority officer responsible for commissioning DARDRs, as well as chairs.
- Established a stakeholder group. Among others, this included the LGA, the Association of Police and Crime Commissioners, the Office of the Domestic Abuse Commissioner, and the Vulnerability Knowledge and Practice Programme (based within the new National Centre for VAWG (Violence Against Women and Girls) and Public Protection (NCVPP). Advocacy After Fatal Domestic Abuse (AAFDA) was also represented.
- Engaged with families bereaved by homicide or suicide via AAFDA and met with AAFDA's family advocacy team.
- We also piloted the data collection tools; our thanks go to five local authorities involved, including Bradford Council, Warwickshire County Council, Westmorland and Furness Council, and Wokingham Borough Council.

We identified 318 CSPs across England and Wales. Our final sample included 200 responses. As some responses were submitted jointly/collaboratively, these responses equated to data from 262 CSPs (or 82.4%). Of these 200 responses, 162 were usable, yielding a sample of 1,437 cases for which notifications were received between January 2017 and December 2024.

Key findings

Notification source and case type

Notifications are most often made by the police
The police made 82.4% (n=1208) of notifications. Otherwise, 10.6% (n=156) of notifications were made by other statutory agencies or partnership bodies.

Notably, family members, either directly or indirectly, made notifications in 2.5% (n=37) of cases, and an advocacy or victim support service did so in 2.7% (n=39) of cases. The source of the notification was unknown in 1.8% (n=26) of cases.

Deaths by suicide are now the most common type of case
Reflecting rising national awareness of the link between domestic abuse and suicide, these deaths now outnumber homicides in DARDR notifications: in 2024, 43.5% (n=108) of notifications were for suicides, compared with homicides (34.7%, n=86).

In addition, despite not being recognised in the 2016 statutory guidance, **(2)** notifications for other non-homicide deaths have increased: in 2024, unexpected deaths accounted for 10.5% (n=26) of notifications, with 9.3% (n=23) 'other' deaths, e.g., neglect.

Victim, perpetrator and case characteristics

Victim characteristics
In line with domestic abuse prevalence generally, most (69.5%, n=998) notifications were for female victims; 22.7% (n=326) were for males. Victim ages ranged from under 19 to over 90, albeit with nearly half of the sample within the 30–49 age range (43.4%, n=624). Victim ethnicity was recorded as White in 62.8% of cases (n=902), then Asian, Asian British or Asian Welsh at 5.3% (n=76), Black, Black British, British Welsh, Caribbean or African at 3.3% (n=48), an other ethnic group (1.5%, n=21) or mixed (1%, n=15).

Perpetrator characteristics
A majority of perpetrators were male (66.9%, n=961), with 13.8% being female (n=198). Nearly half of the sample (39.9%, n=572) fell within the 30-49 age range, with ages ranging from under 19 to over 90. Many perpetrators were White (46.3%, n=666), followed by 4.6% Asian, Asian British or Asian Welsh (n=66), 3.5% Black, Black British, Black Welsh, Caribbean or African (n=51), 1.1% of mixed or multiple ethnic groups (n=16), and 1.7% from an other ethnic group (n=24).

Key information about notifications is often missing
At the point of notification, data for the victim and the perpetrator were often missing. However, this varied by characteristic. Data was often missing for ethnicity as well as other characteristics such as disability, gender identity, sexual orientation and faith. In some cases, perpetrator data was not provided.

Decision-making and communication

The wider partnership is often involved in decision-making
CSPs were asked to describe their DARDR decision-making processes, and in 80% of these responses, CSPs indicated partnership involvement in decision-making.

However, specialist services are often not consulted
Despite the statutory guidance requiring consultation, **(2)** when looking at all 1,437 notifications, specialist domestic abuse services were consulted in just 36.8% of cases (n=529). The absence of led-by-and-for services was notable, with only a handful of cases listed as involving them.

Families are often notified if there is a decision to commission
In 68.4% of all cases (n=983), families were informed of the commissioning decision. When a decision was made to commission a DARDR (including as a 'joint' review with some other form of statutory review), families were almost always notified (86.3%, n=883). However, they were far less often told if there was a decision not to commission (19.8%, n=66).

The Home Office is often notified if a DARDR is commissioned
Statutory guidance states that the Home Office should be informed of commissioning decisions. **(2)** This occurred in 88% of cases (n=1265). However, again, this varied depending on the outcome. When a decision was made to commission a DARDR (including as a 'joint' review with some other form of statutory review), the Home Office were notified in 98.2% (n=1005), with this dropping to 60.2% of cases in which a decision was made not to commission (n=201).

Commissioning outcomes

Almost three-quarters of notifications lead to a DARDR
Where the outcome was known, a statutory review was commissioned in 73.8% (n=1060) of cases. This included decisions where a DARDR (sometimes as a 'joint' review with some other form of statutory review) (71.2%, n=1023), or some other form of statutory review (2.6%, n=37), was commissioned. However, this means that in 23.2% (n=334) of cases, no statutory review was commissioned (although in 3.6% (n=52) of cases, another alternative process – such as a rapid learning review or a multi-agency professional forum – was used).

However, commissioning outcomes vary by case type
For *homicides*, a statutory review was commissioned in 84.1% (n=569) of cases (including a DARDR either alone or jointly in 82.9% (n=561) of cases). For other cases, a decision to commission was less common. For *suicides*, a statutory review was commissioned in 69.5% (n=374) of cases (of which, a DARDR either alone or jointly in 66.7%, n=359). For *unexpected deaths*, a statutory review was commissioned in 49.4% (n=43) of cases (of which, a DARDR either alone or jointly in 47.1% (n=41)). For *other deaths*, a statutory review was commissioned in 50.0% (n=53) (of which, a DARDR either alone or jointly in 38.7% (n=41) of cases)).

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Conclusion

This research has uncovered the changing profile of notifications being received by CSPs, with deaths by suicide now the single largest source of notifications, as well as considerable variations in whether a DARDR is then commissioned. Practices for informing families and the Home Office of the commissioning decision also vary considerably.

Improving our understanding of DARDR commissioning has significant implications. To ensure confidence in the DARDR system, further guidance, more consistent practice, and robust reporting are needed for notification and decision-making.

Recommendations

1. Provide working definitions of the types of domestic abuse-related deaths that are in scope for commissioning a DARDR.
2. Introduce a standardised template for notifications of potentially reviewable deaths that captures protected characteristics and other key information.
3. Clarify expectations about who is involved in decision-making at a local level, including the need to routinely consult specialist domestic abuse services (and led-by-and-for services, when appropriate).
4. Clarify expectations around engagement with families and ensure that they are informed of decisions to review/not review. In addition, provide clear timeframes for when families should be informed of the decision.
5. Clarify expectations around notifying the Home Office, particularly when decisions are made not to review.

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