Agenda Item 9

Leicestershire & Rutland
Safer Communities Strategy
Board
Making Leicestershire & Rutland Safer

LEICESTERSHIRE & RUTLAND SAFER COMMUNITIES STRATEGY BOARD

25 SEPTEMBER 2025

L&R DOMESTIC ABUSE RELATED DEATH REVIEWS

Purpose of report

1. The purpose of this report is to provide an update for Board Members on the current Domestic Abuse related Death Reviews (formerly known as Domestic Homicide Reviews) within Leicestershire and Rutland.

Background

Domestic Homicide Reviews

2. Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004. Under section 9(1) of the 2004 Act, domestic homicide review meant a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—
   (a) a person to whom he2 was related or with whom he was or had been in an intimate personal relationship, or
   (b) a member of the same household as himself,
   held with a view to identifying the lessons to be learnt from the death.

3. The purpose of a DHR is to establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims. An Action Plan is created based on the Recommendations and lessons highlighted as part of the review. These lessons could result in changes to national and local policies and procedures as appropriate.

4. The responsibility for establishing a review rests with the local Community Safety Partnership (CSP). Within Leicestershire and Rutland the agreement is that the Leicestershire and Rutland Safeguarding Partnerships Business Office (SPBO) conduct the review on behalf of the CSPs, who own the resulting report and action plan.

Domestic Abuse related Death Reviews.

5. The previous Conservative government carried out a domestic homicide review (DHR) legislation consultation in the summer of 2023. In their response to the

consultation the government announced that Domestic Homicide Reviews would be renamed to Domestic Abuse Related Death Reviews to better recognise deaths from domestic abuse related suicide. This change of name was confirmed in Part 1 Section 19 of the Victims and Prisoners Act 2024.

6. In readiness for the new statutory guidance and in line with the terminology used by the Domestic Abuse Commissioner and other Local Authorities, it has been agreed to refer to all new reviews moving forward by the new name of Domestic Abuse related Death Reviews. Those already in progress will continue to be referred to as Domestic Homicide Reviews (DHRs). For the rest of the report, the new term will be used.

7. There are currently twelve (12) Domestic Abuse related Death Reviews (DArDR) in progress at various stages across Leicestershire. This figure includes one that is on hold pending a decision as to whether to conduct a DArDR, 10 cases in progress two of which have had final reports created and signed off by the Case Review Group, and one case that is outside Leicestershire but is being supported by local agencies and the Safeguarding Partnerships Business Office.

8. Of the total 12, 4 cases are in the early stages, 3 of which are currently out for commissioning of an Independent Author. In the fourth case, an Independent Author has been agreed and an information trawl has been circulated to agencies in readiness for an initial Panel meeting.

9. The case 'on hold' that is an out of area case concerns the death of an adult in Nottinghamshire, the individual however was previously a care leaver from Leicestershire. The case has been placed on hold at the request of the Nottinghamshire Coroner. No timescales have been shared with the Safeguarding Partnerships Business Office.

10. Action Plans have been created for the 2 cases signed off by the Case Review Group and are already being progressed. One of the action plans has been shared with the Home Office alongside the Overview Report, the second Report is anticipated to be shared with the Home Office in the coming weeks.

Notable developments and challenges:

11. Upon completion of the review process, the lead Board Officer from the Safeguarding Partnerships Business Office submits the full, detailed Overview Report, a summarised version of the report (Executive Summary) and Action Plan to the Home Office. The report is then submitted to the Home Office's Quality Assurance Panel for review. The Panel are responsible for quality assuring all Overview Reports for DArDRs conducted under the statutory guidance. If the Panel finds that a final report is inadequate, the Panel Chair will feed back directly to the CSP (via the Safeguarding Partnerships Business Office) to explain the reasons why it is felt the report requires amendment.

12. The Quality Assurance Panel includes representation from all relevant statutory agencies, including;

- Home Office
- National Offender Management Service
- Department of Health
- Crown Prosecution Service
- Department for Education
- Department for Communities
- Local Government Independent Police Complaints Commission
- Representation from the voluntary sector.

13. The Safeguarding Partnership Business Office have been notified that there are significant delays in terms of reports that are submitted to the Home Office being heard by the Quality Assurance Panel of up to several months. This delay has a knock-on effect with regards to publication of the Report and also bringing a sense of closure to the families.

14. As noted above, action plans are being progressed without awaiting publication so that key learning can be shared and embedded across the relevant CSP areas and effect changes can begin to be made.

Recommendations for the Board

15. To note the contents of the report and provide support to the DArDR Support Officer and Safeguarding Partnerships Business Office where necessary.

Officer to contact

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DHRs / DArDRs currently in progress

Cases arranged by year they were first presented at CRG:	Referrals to be discussed / decision to be made by CRG	Cases currently on hold by the CRG	CRG have agreed case meets the criteria, awaiting Home Office response	Out for commissioning of Independent Author	Panel meeting / Report being written by Independent Author	Report signed off by CRG	Review completed and with Home Office awaiting outcome	Case Updates (for June 2025 CRG)
2022								
January 2022						DHR Case X 2021		Presented at April CRG and signed off. Further amendments to the report requested and completed (Aug 2025), case not yet progressed forward to Home Office.
October 2022							DHR Case H 2022	Sent to the Home Office on 11/06/25. Action Plan is being progressed.

December 2022				Case J 2022				Judicial Review hearing took place July 2024 against original decision not to conduct a DHR. Appeal lodged. June 2025 CRG – agreed that case will now progress as a DHR
2023								
October					DHR Case U 2023			2nd draft report has been shared with Panel for feedback. Next Panel meeting TBC.
2024								
February 2024					DHR Case A 2024			2nd draft report has been shared with Panel for feedback. Now exploring contact with victim's family.
March 2024					DHR Case B 2024			3rd draft of the Overview Report is currently being

								prepared by the Independent Author following interview with the perpetrator.
April 2024					DHR Case D 2024			3rd draft of the report shared with Panel. Now exploring contact with victim's family.
June 2024		Case I 2024						No changes, case still on hold at request of Nottinghamshire coroner.
November 2024				Case M 2024				Expression of interest for author circulated
2025								
April 2025				Case Q 2025				Expression of interest for author circulated
June 2025				Case R 2025				Expression of interest for author circulated

Involvement in DHRs from other areas:	CSP / Area

Adult M	Warwickshire (Nuneaton and Bedworth Safer Communities Partnership)

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