

Leicestershire & Rutland  
Safer Communities Strategy  
Board



Making Leicestershire & Rutland Safer

## **LEICESTERSHIRE & RUTLAND SAFER COMMUNITIES STRATEGY BOARD**

**26 MARCH 2026**

### **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 means 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 as 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 my report, I will use the new term.
7. There are currently eleven (11) Domestic Abuse related Death Reviews (DArDR) in progress at various stages across Leicestershire. The table below shows a breakdown of key data:

Sex of victim	Female	Male	
	9	2	
Type of Perpetrator	Familial	Relationship (includes ex-partners)	Other (friend / tenant etc)
	4	6	1*

*\*the victim and perpetrator were in a very short-term sexual relationship at the time of death*

8. There is also an out of area case (Warwickshire) which is being supported as necessary by Leicestershire agencies and the Leicestershire and Rutland Safeguarding Partnerships Business Office.
9. Key themes emerging from the eleven cases in progress include, but are not limited to:
  - The link between Mental Health and Domestic Abuse, including diagnostic overshadowing
  - Isolation in rural communities and whether this led to a lack of reporting / disclosure of Domestic Abuse
  - Death linked to use of firearm, recorded in 2 of the 11 cases.
  - Impact of adverse childhood experiences / trauma with regards to the perpetrator
  - Multigenerational abuse / child to parent abuse – often starting in childhood and early teens. In 2 of the 11 cases, the death was matricide and in a 3<sup>rd</sup> case the victim was a grandparent.
10. Action Plans have been created for 6 of the cases, as they are either complete / nearing completion and actions are already being progressed, with some actions already having been completed.

11. The Home Office has returned one Overview Report shared with them in June 2025 with requests for a pen picture of the victim to be included: this has since been done and the report is to be resubmitted and discussions re publication will now take place.
12. It is hoped that at least 2 more Overview Reports will be submitted to the Home Office before the next Board meeting in June 2026.

**Notable developments and challenges:**

13. 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.
14. 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.
15. 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 bringing a sense of closure to the families.
16. As noted above, action plans are being progressed without awaiting publication so that key learning can be shared and embedded across the service area and relevant CSP areas and effective changes can begin to be made.
17. We have also had instances where the Overview Report has been signed off by Panel and the Leicestershire and Rutland Case Review Group, but then agencies have requested further changes, delaying Home Office submission.
18. The Leicestershire and Rutland Safeguarding Partnership Business Office have shared this with the Independent Chair of the Safeguarding Adults Board, who

is helping to develop guidance for Case Review Group members, including sign off process and reminding them that there are families at the centre of the process, to help prevent unnecessary delays in the future.

### **Recommendations for the Board**

19. 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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