Never again. Again.

A REVIEW OF HEALTH RECOMMENDATIONS FOLLOWING A DOMESTIC ABUSE RELATED DEATH.

Research and Analysis from all Domestic Abuse Related Death Reviews published in 2024.

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STANDING TOGETHER
against domestic abuse

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RECOGNITION AND ACKNOWLEDGEMENTS

Standing Together Against Domestic Abuse (STADA) wishes to acknowledge that for every domestic homicide and domestic abuse related death, a loved one - someone's mother, father, daughter, son, brother, sister, aunt, uncle, or friend - has died.

STADA recognise the pain and anguish at losing a loved one and it is with victims at the front of our mind that STADA continues our push for system-wide change.

The annual report from the national Domestic Homicide Project published in March 2025 identified that of the 262 deaths recorded between 1 April 2023 and 31 March 2024, 98 were suspected suicide following domestic abuse, it is of note that this is the second consecutive year that suspected suicides following domestic abuse have overtaken the number of intimate partner homicides.[1] This report looks at reviews of all domestic abuse related deaths, including suicides.

[1] College of Policing, National Police Chiefs Council, Vulnerability Knowledge and Practice Programme, *Executive Summary: Domestic Homicides and Suspected Victim Suicides 2020-2024 Year 4 Report*, (2025).

REPORT SUMMARY

STADA reviewed all Domestic Homicide Reviews/Domestic Abuse Related Death Reviews published in 2024 and has found that 89% of them had at least one recommendation for health professionals or the health system.

The reviews related to deaths over a period of nearly ten years. Many recommendations were repeated across several DHRs/DARDRs suggesting a lack of learning over time and between locations. STADA categorised the various recommendations and found that almost a quarter related to the need for 'training and learning' related to domestic abuse amongst healthcare professionals.

The need for improved practice in the intersection between mental health and domestic abuse was another common theme.

STADA is committed to working with survivors, the voluntary and statutory sectors and central government to address these gaps and help ensure the health system provides a reliable route to safety for those experiencing abuse.

89%

of Domestic Abuse Related Death Reviews had at least one recommendation for health professionals or the health system.

22.5%

of all 316 recommendations related to the need for 'training and learning' related to domestic abuse amongst healthcare professionals.

CONTEXT

Year after year, death after death, case reviews are published pointing out missed opportunities by healthcare professionals to spot and respond to the signs of domestic abuse.

2025 is the year to change that. The government will publish its 10 Year Health Plan as well as a new Violence Against Women and Girls (VAWG) Strategy. The two must complement each other.

This paper seeks to give government the latest analysis of domestic abuse related death reviews and shine a light on what is and is not working in the healthcare response.
This review and analysis draw on all Domestic Homicide Reviews (DHRs) which are now known as Domestic Abuse Related Death Reviews (DARDRs), published in 2024.

It seeks to:

- Further understand the key areas of recommendations for the health systems and health professionals from DHRs/ DARDRs.
- Inform the current policy work undertaken by STADA and contribute to Government thinking as it seeks to halve violence against women and girls in a decade.
- Inform STADA's own best practice in the 'Whole Health' field, specifically its health accreditation work.

STADA also hope this report will be used by health sector colleagues, public health colleagues, specialist domestic abuse services and commissioners as further evidence of the need for specific domestic abuse responses and interventions within health settings.

The change of terminology from DHR to DARDR reflects a growing recognition that many domestic abuse victims are driven to take their own lives.

STADA endorses the calls of the 'Domestic Abuse Related Suicide Campaign' [2] – set up by bereaved families to ensure links between suicide and domestic abuse are addressed consistently across the statutory and specialist sectors involved in multi-agency responses to any such case of suicide.

This is an issue that the new VAWG strategy and the 10 Year Health Plan – which will recognise suicide as one of the nation's biggest 'killers' - must also address.

Health settings have a unique position as a universal service accessed by victims and perpetrators. 80% of women experiencing domestic abuse seek help from health services and these are often women's first and only point of contact. [3]

This was echoed by the Domestic Abuse Commissioner's 'Patchwork of Provision' report which found that victims and survivors were most likely to tell a health professional about their abuse before other professionals. [4]

We appreciate the current context of an NHS in crisis and the uncertainty that the recent announcements about the abolition of NHS England (NHSE) and cuts to Integrated Care Boards (ICBs) has created. It is not yet clear what this will mean for the valuable Domestic Abuse and Sexual Violence (DASV) work that has been undertaken by colleagues at NHSE and across the health sector.

However, this research once again points to the importance of a strong and consistent health response to domestic abuse – guided by a strategy - and the fatal costs of the failure to institute this across England and Wales.

[2] Domestic Abuse Related Suicide Campaign - Suicide is Homicide Campaign — PROJECT RESIST
[3] Department of Health, *Responding to Violence against women and children – the role of the NHS,* (2010).
[4] Domestic Abuse Commissioner, *A Patchwork of Provision*, (2022).

PREVIOUS RESEARCH

In 25%
of DHRs GPs had missed opportunities to enquire about Intimate Partner Violence (IPV).

This research builds on almost ten years of studies of domestic homicides, that point to the need for changes in the health system regarding how it responds to domestic abuse.

A 2016 analysis of DHRs by STADA identified:

- Just over half (13/24) of the interpersonal homicide reports note that the GP missed opportunities to ask the victim about Intimate Partner Violence (IPV). Most frequently observed was a lack of professional curiosity about relationships with partners/children's fathers. [5]

- In a quarter (6/24) of the DHR reports, missed opportunities for GPs to enquire about IPV with perpetrators are noted. [6]

The reviews' recommendations for practice focused on GPs having a 'Whole Surgery' approach to training that is intersectional, as well as recommendations around enquiry about DVA and training needing to be complemented by a surgery-wide domestic abuse policy separate from the safeguarding policy.

There were also several recommendations around record keeping. Of specific note was the recommendation that GPs and mental health services need to be better 'carer aware' and to develop joint strategies in relation to carers in line with *The Care Act (2014)*.

The analysis went on to note that:

- Mental health was recorded as the second most common health-related theme in the DHR reports (15/24). [7]

- Mental health problems may increase vulnerability to IPV or develop because of it. [8]

- Nearly two thirds (15/24) of Intimate Partner Homicide (IPH) victims had support needs related to their mental health. [9]

- The same number of IPH perpetrators also had a history of mental health problems. [10]

[5] London Metropolitan University, Standing Together Against Domestic Abuse, *Domestic Homicide Review: Case Analysis,* (2016).
[6] *Domestic Homicide Review: Case Analysis*, (2016).
[7] *Domestic Homicide Review: Case Analysis*, (2016).
[8] *Domestic Homicide Review: Case Analysis*, (2016).
[9] *Domestic Homicide Review: Case Analysis*, (2016).
[10] *Domestic Homicide Review: Case Analysis*, (2016).

Again, recommendations directly from the homicide reviews focused on all staff receiving training, a recommendation that all staff should be expected to enquire about DVA, having a Trust-wide policy and recommendations on integrated working.

A further analysis by STADA in 2019 specifically focused on analysis of DHRs in London. [11]

This analysis again identified recommendations direct from the reviews for GPs centred around an intersectional, 'Whole Surgery' approach to training.

It noted several recommendations around enquiry about domestic abuse and the need for a surgery wide domestic abuse policy that is separate from the safeguarding policy.
There were also recommendations that GPs and mental health services need to be more 'carer aware' of the possibility that carers might be either victims or perpetrators of domestic abuse and develop joint strategies in relation to carers in line with the *Care Act (2014)*.

This study identified:
"A large proportion of cases, totalling 78% (14/18) involved a caring relationship between the victim and perpetrator. These cases often involved a wide range of agencies providing numerous services and with varying levels of awareness of the risks presented. In some cases, safeguarding concerns were raised but information was rarely shared among agencies, allowing a true picture of risk to emerge." [12]

The analysis continued with recommendations for mental health replicating the 2016 study.

***The Pathfinder Report 2020*,** in its recommendations for ensuring a 'Whole Health System' response to domestic abuse, reflected the value of co-location, and the need for domestic abuse policies, training, and informal coaching as well as effective referral pathways. It noted that the function of domestic abuse coordination within health systems (for example roles to facilitate connections between primary care, acute care, mental health trusts and voluntary sector) is critical for an effective response. [13]

An academic study by ***Knipe et al (2024)*** found that despite *National Institute for Health and Care Excellence (NICE) Guidelines* recommending that everyone attending hospital for self-harm should be asked about domestic abuse, many clinicians were not asking due to the fear of making things worse or not knowing how to help. [14]

[11] Standing Together Against Domestic Abuse, *Executive Summary London Domestic Homicide Review (DHR): Case Analysis and Review of Local Authorities DHR Process,* (2019).
[12] The Mayor's Office for Policing And Crime (MOPAC), Standing Together Against Domestic Abuse, Executive Summary London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process, (2019), pg. 24.
[13] AVA, Imkaan, IRISi, SafeLives, Standing Together Against Domestic Abuse, Pathfinder, (2020).
[14] Knipe et al, 'Once you've opened that can of worms': qualitative study to understand why liaison psychiatry staff are not asking about domestic abuse following self-harm, (2024).

The Domestic Abuse Commissioner's 2023 Summary Report on the Domestic Homicide Oversight Mechanisms for Health (Physical and Mental Health) drew on the analysis of fifty-eight DHRs published between 2017 and 2019, and their recommendations relating to the Health Sector. The report reflected that recommendations related to training and development appeared in 72% of the DHRs, with a reference in the key messages that routine inquiry is absent in a range of health settings. The analysis identified a lack of multi-agency working and poor information management in 67% of the DHRs. Critically, there was also a key message around the failure to recognise carers' needs and complete carers' assessments. [15]

The evaluation of the **STADA Whole Health Project (Crossing Pathways Key Findings Report)** noted the ongoing gaps in partnership approaches, limited co-located coordinator roles embedded in acute trusts and limited DVA interventions in Primary Care were revealed in the project mapping exercise. It also identified that just 14% of mental health trusts in the mapping employed a mental health Independent Domestic Violence Adviser (IDVA). [16]

In February 2025, Tim Woodhouse published his Churchill Fellowship report ***"66 Ways to Reduce Domestic Abuse Related Suicides"***. [17]

In the report he estimates that over 1800 lives are being lost in domestic abuse related suicides every year amongst victims and perpetrators. His 66 recommendations include many aimed at the health sector and at health professionals. They include embedding mental health clinicians in domestic abuse services and vice versa, better domestic abuse training at all stages of training for health professionals and including measures to reduce the risk of suicide on every domestic abuse safety plan.

The **Domestic Homicide Project** in its Year 4 recommendations published in March 2025 makes two recommendations for police and public health, the first related to police, mental health services and substance misuse services improving information sharing and mapping local provision for appropriate referrals to help improve safeguarding and prevent future deaths. It also recommends that police work with partners such as Health to raise awareness about risks posed by non-fatal strangulation and its prevalence in cases of suspected victim suicide following domestic abuse. [18]

1800 LIVES
ARE LOST TO DOMESTIC ABUSE RELATED SUICIDES EACH YEAR.

[15] Manchester Metropolitan University, Domestic Abuse Commissioner, *Summary Report: Domestic Homicide Oversight Mechanism for Health (Physical and Mental Health)*, (2023).
[16] Standing Together Against Domestic Abuse, *Crossing Pathways: Key Findings*, (2025).
[17] Tim Woodhouse, *The person most likely to kill a victim of domestic abuse… is themselves*, (2025)
[18] *Executive Summary: Domestic Homicides and Suspected Victim Suicides 2020-2024 Year 4 Report*, (2025).

SURVIVOR PERSPECTIVES

STADA has undertaken recent work to include and embed survivor voice in our understanding of gaps and barriers in the health system, identifying opportunities and recommendations.

The Survivor Voice Network that engaged with STADA throughout the Crossing Pathways Project co-produced a set of recommendations which can be viewed in full in the Centring the Survivor Voice: Phase Two 2024 report. [19]

The themes relating to health include:

- Training and professional development
- Accessible and flexible services
- Communication and confidentiality
- Multi-agency collaboration
- Trauma-informed and person-centred care
- Streamlining referrals and treatment
- Safety and confidentiality
- Addressing neurodivergence and disabilities

METHODOLOGY

Using the government library of DHRs (DARDRs) STADA undertook a search of reviews published in 2024 with health recommendations.

Further filters were used to identify sex, age, and relationship of victim to perpetrator and then-informed by STADA's professional working experience of working across health - recommendations were grouped into broad categories. [20]

The remainder of this report will use the term 'DHR' to reflect how the reviews are named and presented on the government library.

[19] Standing Together Against Domestic Abuse, *Centring the Survivor Voice: Phase Two,* (2024).
[20] Home Office, *List of Domestic Homicide Reviews (DHRs),* Accessible at: https://homicide-review.homeoffice.gov.uk/

KEY FINDINGS

Ongoing criminal proceedings or delays in identifying a death as domestic abuse related can prevent swift reviews and so these reviews relate to deaths occurring in different years to that of publication.

In 2024 there were a total of 47 DHRs published in the library.

Of these, 42 (89%) had at least one recommendation relating to the health sector or health professionals. Of the 42 reviews with health recommendations:

- Deaths ranged from 2014 to 2022.
- 9 victims were recorded as dying by suicide (21%).
- 73% of victims were identified as female (31 females and 11 adult males plus 1 male child as the DHR was done jointly with a child safeguarding practice review).

Age ranges of the victims were as follows:

16 - 19	0
20 - 24	2 (5%)
25 - 34	7 (17%)
35 - 44	8 (19%)
45 – 54	9 (21%)
55 - 64	7 (16%)
65 and above	3 (7%)
No age recorded in review	6 (14%)

The victim to perpetrator relationships were as follows:

Intimate partner	32 (76%)
Family	8 (19%)
Co-habitant	1(2%)
Other non-relative	1(2%)

- 5 reviews recorded the victim as a carer for the perpetrator, as categorised using the filter on the library, however, STADA's review of the reports identified 1 additional victim carer, totalling 6 victim carers.

- 6 reviews recorded the perpetrator as carer for the victim, as categorised using the filter on the library.

- Including the additional carer identified by STADA's review, analysis shows that 28% of deaths reviewed, with a health recommendation, involved a carer.

- 29 cases (69%) in the library categorised victims as having multiple disadvantage via filters including (but not limited to) a range of mental health issues, vulnerabilities including alcohol misuse, housing issues and physical disability.

STADA's review of reports identified an additional 4 cases: 1 with a physical health issue and learning disability, 1 with alcohol use, 1 with a physical health condition and 1 with a physical disability. This brings the total number of victims with multiple disadvantages to 33 (78%).

Figure 1: Proportion of Domestic Homicide Reviews with Health Recommendations

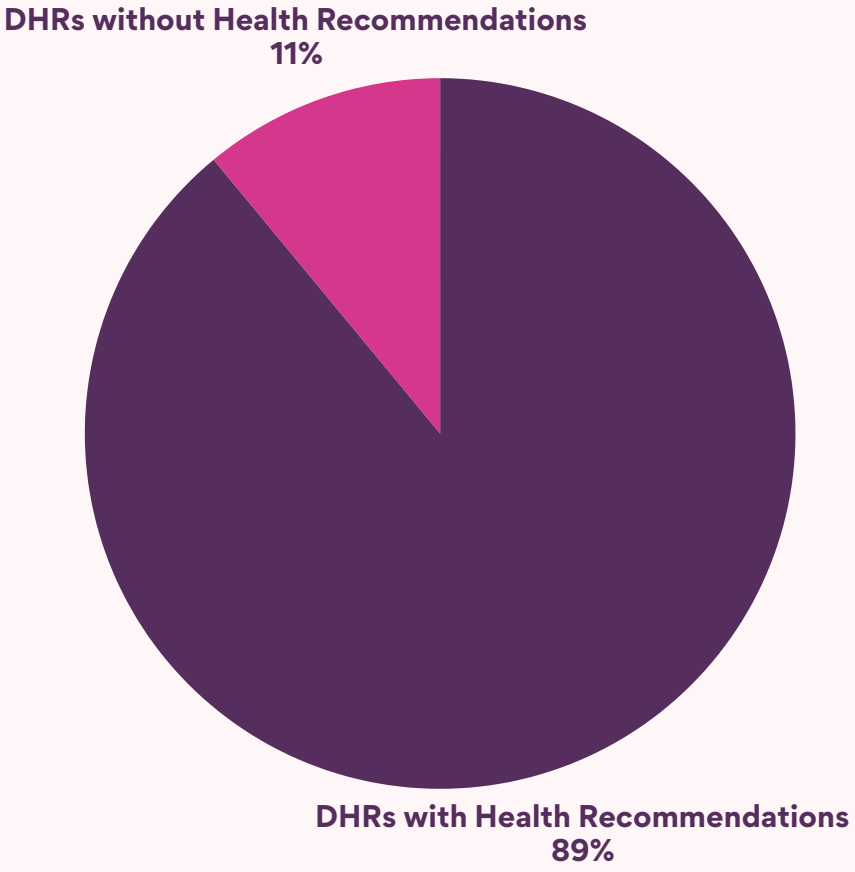
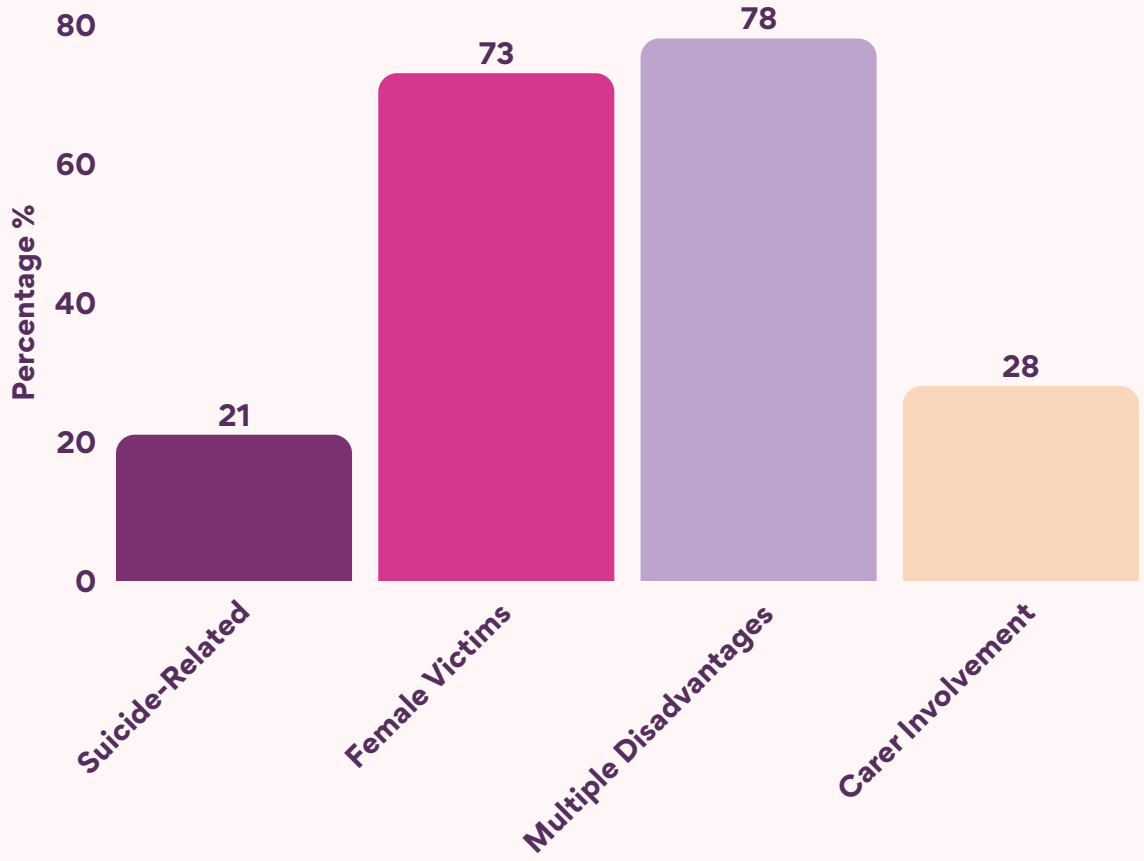


Figure 2: Characteristics of DHRs with Health Recommendations in 2024



DHR RECOMMENDATIONS

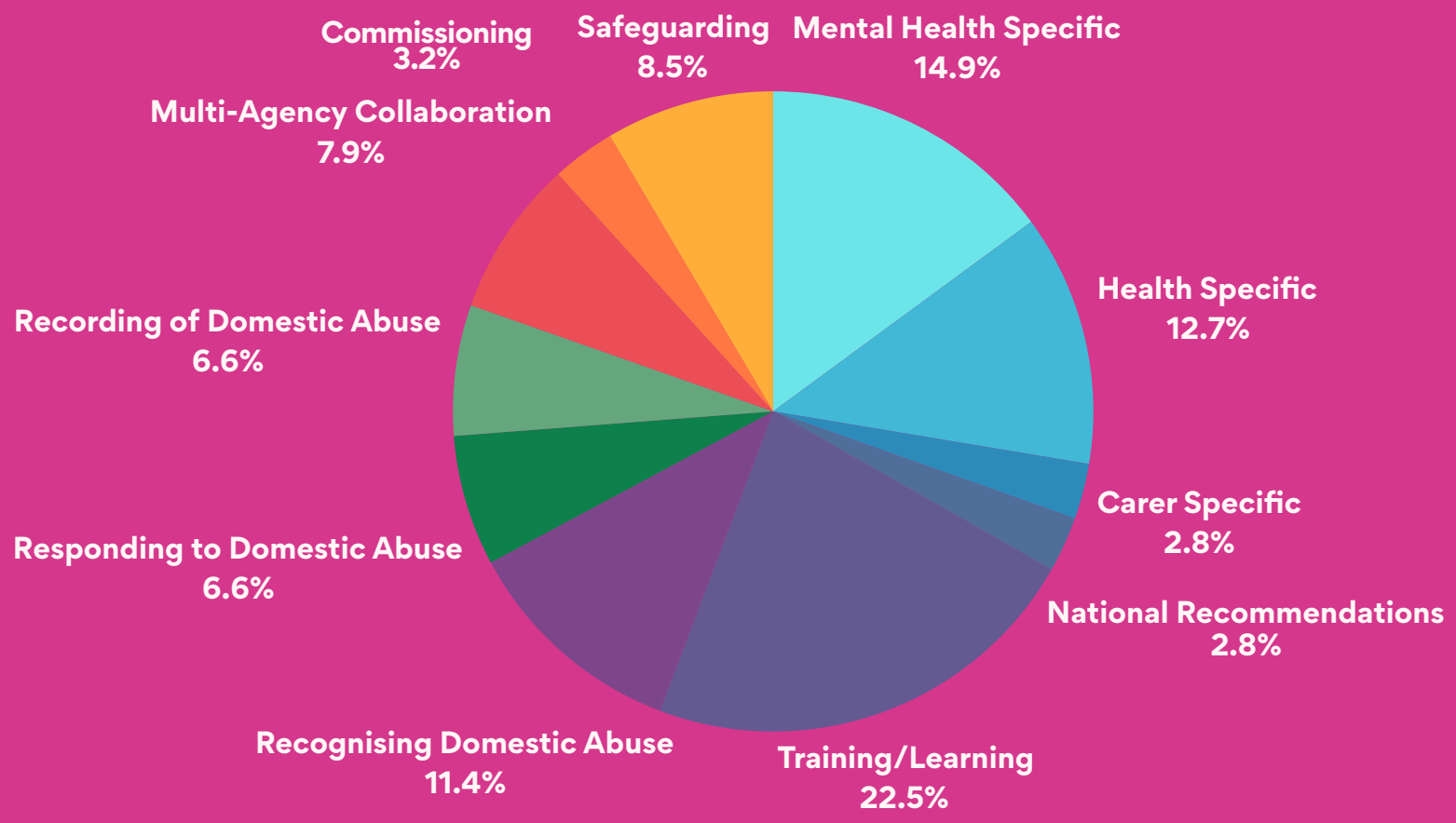
A total of 316 health recommendations were identified, with an average of between 7 and 8 actions per case, with the actual range spanning from 1 recommendation to 33 recommendations.

DHR processes involve different authors, chairs and professionals from across England and Wales. Identifying and categorising recommendations has proved challenging due to different styles of writing and recording and varying quality in defining recommendations. This review categorised the recommendations based on the themes in the table below:

Category	Total number of recommendations per category	Percentage of all health recommendations made	DHRs the category featured in*
National recommendations	9	2.80%	7 (16%)
Training / learning	71	22.50%	28 (66%)
Recognising domestic abuse	36	6.60%	24 (57%)
Responding to domestic abuse	21	6.60%	13 (30%)
Recording of domestic abuse	21	6.60%	16 (38%)
Multi-agency collaboration	25	7.90%	15 (35%)
Commissioning	10	3.20%	6 (14%)
Safeguarding	27	8.50%	15 (35%)
Mental health specific	47	14.90%	13 (30%)
Other health specific responses	40	12.70%	29 (69%)
Carer specific	9	2.80%	6 (14%)

***(% of all DHRs with a health recommendation)**

Figure 3: A Percentage Breakdown of all Recommendations by Category



ANALYSIS

This section considers the recommendations presented in the DHR reports by category. 'Training and learning' and 'mental health' were the categories with the most recommendations.

Recommendations have only been counted in one category, so for example where a recommendation talks about Mental Health Act training this is counted in 'mental health specific' and not 'training and learning.' This means that our figure of almost a quarter of all recommendations relating to the need for training or learning is likely an under calculation. However, where recommendations are specific to domestic abuse response and practice these have been added to the distinct categories of training/learning, recognising, responding, and recording of domestic abuse.

NATIONAL RECOMMENDATIONS

There were nine recommendations categorised as National recommendations, these could be considered as system-wide recommendations. The exact wording of the National recommendations pulled from the reports can be found at Appendix A.

Where a review made a National recommendation, this was counted in this category only and not in any other category, however, our analysis will show where National recommendations relate to other categories.

Many of the National recommendations related to information sharing and data, highlighting the lack of appropriate information sharing between health agencies has contributed to lives being lost.

There is an observation in one recommendation stated that "*Coordinating and collating information between individual GP practices and MARAC has resource implications.*" Whilst it is recognised that setting up IT systems which allow for easy transfer of data is technically difficult and expensive, STADA believe that it is worth doing given the price of not doing so will inevitably lead to more deaths.

As the NHS makes its shift from analogue to digital there is the potential for significant improvement here. But again, there will be resource implications and the need for training because IT systems can only ever be as good as the data entered into them.

TRAINING AND LEARNING RECOMMENDATIONS

This review identified seventy-one individual recommendations for the Health Sector in relation to 'training and learning', with this appearing in 66% of the DHRs, evidencing significant need for improvement in terms of the ability of health professionals to identify and respond to domestic abuse.

To identify recommendations in this category, specific reference to training or learning was looked for, but also recommendations which included reference to awareness raising amongst staff and promotion of practices or tools were also included, as it is recognised this is often done through learning and development practices.

The recommendations showed that there is a variance in whether domestic abuse training is standalone or incorporated into existing safeguarding training.

Recommendations included simple ones, such as the need for all staff understanding the definition of domestic abuse, as well as more detailed proposals. These include that all agencies should ensure domestic abuse training is clear on how professionals should respond to immediate and long-term risk; and the need for training to recognise the opportunity of perpetrator incarceration in engaging and safeguarding victims in the long term. Nuanced recommendations such as this demonstrate that efforts to improve staff awareness and responses to domestic abuse in recent times are proving successful.

One of the National recommendations was that the Home Office in consultation with the Department for Health and Social Care (DHSC) and Royal Colleges should consider whether standalone domestic abuse training should be mandatory for all front-line health professionals.

STADA believe that all health professionals in every discipline, should be required to undertake comprehensive domestic abuse training (including the related suicide risk) as part of their initial pre-qualification training and then at least once a year in order to maintain professional registration.

This is something that STADA continues to advocate for and was a part of the response to consultation roundtables held in advance of the anticipated 2025 VAWG strategy. STADA have also called for this as part of the consultation around the *Assisted Dying Bill.*

MENTAL HEALTH SPECIFIC RECOMMENDATIONS

Forty-seven recommendations were made about mental health responses. These included the need for a Mental Health Trust to review its website information to improve public understanding of mental health services, reminding GPs that a request for counselling should be accompanied by a review of mental health and any risks, recommendations related to implementing "Right Care, Right Person" and a variety of recommendations related to assessing and recording risk in relation to mental health.

Given the police report earlier this year which states that victims of domestic abuse are more likely to kill themselves than be murdered by their perpetrator, and Tim Woodhouse's Churchill Fellowship report which estimates that over 1800 people are dying in domestic abuse related suicides every year, it is clear that existing provision and practice is failing to support the mental health of people impacted by domestic abuse.

STADA support Tim Woodhouse's urgent call for a national task force to be established to explore all aspects of domestic abuse related suicides and agree a national action plan.

OTHER HEALTH SPECIFIC RECOMMENDATIONS

The category of 'other health specific' recommendations tended to be in response to specific elements of the DHR such as aspects of multiple disadvantage or response to specific health needs.

Examples of other health specific recommendations as worded in the reviews:

- 'Seek assurances from the NHS Integrated Care Board that the follow up of patients where there is a lack of engagement with services and where vulnerability is a feature is inherent within its policy.'

- 'Ensure that GPs are informed when patients have stopped taking prescribed medication.'

In one of the DHRs, there were two recommendations related to domestic abuse and epilepsy, highlighting the need for continued research into specific health issues and their comorbidity with domestic abuse.

[21] College of Policing, National Police Chiefs Council, Vulnerability Knowledge and Practice Programme, *Executive Summary: Domestic Homicides and Suspected Victim Suicides 2020-2024 Year 4 Report*, (2025).

There were eight recommendations related to where patients are deemed to be disengaging, non-engagement or not attending, there were also five recommendations which referenced drug and/or alcohol use or services.

STADA feel further research and best practice guidance for health responses to those with multiple disadvantage and domestic abuse is needed.

STADA recommend that the Department of Health funds new research into the needs of domestic abuse survivors with long-term physical health conditions and multiple disadvantages, with the aim of issuing new guidance to health professionals.

SAFEGUARDING RECOMMENDATIONS

STADA recognises that responsibility for domestic abuse responses often falls to safeguarding leads.

Whilst recognising and deeply appreciating the passionate and dedicated efforts of these individuals in driving local domestic abuse responses within the health sector, STADA believe that clinically based DVA specialists are essential. Such roles bring the expertise, skills, and focus needed to embed meaningful change. They can provide ongoing training tailored to a range of healthcare professionals across their local health system as well as links with voluntary sector specialist services.

Furthermore, STADA advocate for a national approach that addresses domestic abuse as an issue independent of safeguarding. STADA will continue to call for the provision of a domestic abuse coordinator (DAC) in every ICB.

The recommendations categorised as safeguarding across these DHRs ranged from: ensuring professionals are aware of statutory safeguarding duties; the need for the inclusion of specific issues in safeguarding training; to recommendations around safeguarding audits ensuring processes were being followed; and clinicians seeking advice, and support and use of case supervision via Adult and Child safeguarding leads.

MULTI-AGENCY COLLABORATION RECOMMENDATIONS

There were twenty-five recommendations related to multi-agency collaboration these included repeated references to MARAC (multi-agency risk assessment conference), sharing information with alcohol and mental health services and liaising with IDVA and other specialist services.

As noted earlier, there was a national recommendation which referenced MARAC - "*coordinating and collating information between individual GP practices and MARAC has resource implications.*"

Whilst this recommendation appears to be a statement rather than a tangible action it demonstrates the need for national directives. A further national recommendation reflected that - the absence of a consistent patient record system across different health providers is an issue when patients have accessed different services.

As part of the Coordinated Community Response (CCR) model pioneered by STADA we advocate that frameworks for coordination must be properly defined and resourced to enable robust partnership working.

RECOGNISING, RESPONDING AND RECORDING DOMESTIC ABUSE RECOMMENDATIONS

The three categories 'recognising,' 'responding' and 'recording' of domestic abuse each have twenty-one recommendations, showing there is more work needed in terms of practice, structures, and frameworks to embed these areas within Health. Domestic abuse health coordinators (clinically based DVA specialists) can help train and embed good practice.

In the recognising domestic abuse category, the need for routine enquiry was counted most frequently (thirteen recommendations). There were a further four recommendations advocating routine enquiry in the training and learning category. There was reference to recommendations for routine enquiry in emergency departments, assessment units, outpatient clinics, mental health, and substance misuse services.

There was also one National recommendation related to this topic: 'The Home Office and the Department of Health to engage with the Primary Care named GP network to promote and embed routine domestic abuse enquiry into GP working culture.' Programmes such as 'Enquiring about domestic abuse in general practice' have had a positive impact on the early identification of domestic abuse, but STADA have identified this needs to be within a system with robust training, support referrals pathways and domestic abuse coordination.

Professional curiosity (documented in one recommendation as inquisitiveness) was also mentioned repeatedly in the category of 'recognising domestic abuse' (five recommendations). It was also referenced in training and learning (four recommendations) and responding to domestic abuse (two recommendations) depending on the wording of the recommendation. Recommendations about professional curiosity were referenced for general practice, emergency departments and ambulance services.

Recommendations related to 'responding to domestic abuse' made repeated reference to use of the DASH (Domestic Abuse, Stalking and Harassment) risk assessment tool, exploring reasons for protective/ restraining/ police orders being in place, signposting and referral to specialist victim services and developing responses to perpetrators.

Regarding 'recording of domestic abuse' there were recommendations related to recording household members and relationships (there were six individual recommendations related to recording name or details about significant others / household members or those who attend with patients), GP practice staff documenting when they speak to a "partner", processes around adding a MARAC warning, use of alerts and flags on systems, consistency of recording risks related to domestic abuse and defined circumstances for linking of patients records.

STADA acknowledge the concern across the health sector around access to information in patient records and the additional work being done since the launch of patient access and nuances around proxy access to records. We are also aware of recent work by the Royal College of General Practitioners (RCGP) to review their guidance around recording of information related to domestic abuse for victims, perpetrators, and children. There was a National recommendation noted in this area - all NHS Integrated Care Boards to provide a solution for how domestic abuse risks presented to and by a patient are documented within clinical records, so that NHS staff do not inadvertently increase their patient's risk of harm from or to others.

COMMISSIONING RECOMMENDATIONS

It was positive to see ten recommendations related to commissioning with these being related to commissioning of hospital based Independent Domestic Violence Adviser (IDVA) services (four recommendations), IRIS* in general practice (five recommendations) and one recommendation about Health's role in commissioning a local third sector specialist service.

It was particularly positive to see various references to consideration of joint commissioning approaches between Health, local authorities and The Office of the Police and Crime Commissioner. STADA support the calls for commissioning of specialist roles such as domestic abuse coordinators (DACs) and Health Independent Domestic Violence Advocate's (HIDVA's)

**IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices and primary care settings. [irisi.org]*

CARER-SPECIFIC RECOMMENDATIONS

With only nine carer-specific recommendations identified even though 28% of the DHRs involved a carer, STADA feel this is an area for further research and practice development. The recommendations focused on recognising informal carers, utilising Care Act assessments and being aware of carers' support services and recommendations on how carers views are considered as part of assessments.

There was a National recommendation that guidance is required relating to the potential requirement for a Carer's Assessment be undertaken when a person registers with their GP as a carer. This guidance could be provided via the Home Office 'Safe At Home' project which is considering the issues relating to both paid and family carers who are abusive to the person they care for.

CONSISTENT FAILURES TO IMPLEMENT LEARNING

The DHRs that were published in 2024 related to deaths that took place between 2014 and 2022. We looked at the DHRs relating to deaths at the beginning of this period, and then at the DHRs relating to deaths at the end, to see if there were notable differences.
However, the DHRs from 2022 included very similar recommendations (about training for health professionals and GP learning) to those made in the DHR from 2014. This suggests a very disappointing lack of progress over that time period.

CONCLUSION

STADA acknowledges there is a variety of guidance, practice directives and examples of good practice across Health provided via a range of mechanisms, through NICE, via the Royal Colleges and through forums such as domestic abuse leads networks and the Crossing Pathways meetings. However, we are concerned about the significant number of health recommendations within DHRs and repetition of recommendations across deaths occurring over multiple years, suggesting little systemic learning.

STADA recognise that every hour of every day, dedicated and committed health professionals are going above and beyond to support victims of domestic abuse. They are undoubtedly saving lives on a regular basis. Unfortunately, this best practice is not replicated consistently.

STADA believe this review of DHRs has demonstrated the ongoing gap in understanding of how health and domestic abuse issues intersect, and the urgent need for a more systematic approach. We endorse the calls of the 'Domestic Abuse Related Suicide Campaign' and would support further work to research the comorbidity of health needs and issues and multiple disadvantage and domestic abuse.

2025, with the new VAWG strategy and NHS 10-Year Plan, presents an opportunity for a national effort to embed models and practice which have been shown to be effective, such as standalone domestic abuse training and investment in domestic abuse health coordinating roles. The new 'Duty to Collaborate' (in the Victims and Prisoners Act 2024), should help bring partners together in the commissioning of services for the benefit of victims and it will be important for Health to be key partners in this.

The need for training comes across particularly strongly in this review of DHRs. Many specialist domestic abuse organisations can deliver domestic abuse training and have good evidence that it improves healthcare professionals' knowledge and confidence. We know survivors want professionals that are knowledgeable and confident in responding to domestic abuse and appreciate when they can link up with specialist services. We know early intervention saves lives and costs both financial and in terms of victim/survivor outcomes.

STADA is currently developing a health accreditation model called 'Pathways to Safety' with health colleagues, specialist domestic abuse services and key national partners, Respect and IRISi.

This will enable integrated care systems to be confident and accountable in their system-wide response to domestic abuse. The accreditation provides standards to be met across practice areas including workforce support and development, identification and early intervention, multi-agency collaboration, survivor voice and perpetrator accountability. This could be a model for a much-needed national approach.

CALL TO ACTION

This analysis illustrates the need for cross system approaches between Health and specialist domestic abuse services and a clear strategy. There is good evidence of the gaps and of effective interventions and models to address these issues, including cost/benefit data.

STADA calls on:

- DHSC to develop a national strategy for the funding and provision of clinically based DVA specialists; health care professional (HCP) training; and practice development that recognises DVA as a public health issue and its links with suicide and is 'carer aware.' This should be part of both the new VAWG strategy and the NHS ten-year plan.

- DHSC to develop central commissioning guidance for clinically based DVA specialists.

- DHSC to develop a strategy and guidance for a consistent approach to DVA data recording in Health.

It will take resources to make it happen. However carefully planned, sustained resourcing can be highly cost-effective and will save lives.

APPENDIX A:
All National Recommendations appearing in DHRs in 2024.

National - The Home Office is asked to consider consulting with the Department of Health and Social Care and the Royal Colleges over whether stand-alone domestic abuse training should be made mandatory for all front-line health professionals.

National - Coordinating and collating information between individual GP practices and MARAC has resource implications.

National - The absence of a consistent patient record system across different health providers is an issue when patients have accessed different services.

National - All NHS Integrated Care Boards to provide a solution for how domestic abuse risks presented to and by a patient are documented within clinical records, so that NHS staff do not inadvertently increase their patient's risk of harm from or to others.

National - A review into NHS systems and the functionality of information sharing needs to be undertaken. How to transfer medical notes between G.P. practices to ensure crucial medical information isn't lost should be considered.

National - Consideration needs to be given to the transfer of medical records between incompatible systems (such as EMIS and System One).

National - The Home Office and the Department of Health to engage with the Primary Care named GP network to promote and embed routine domestic abuse enquiry into GP working culture.

National - That the Department and Health and Social Care and Home Office draft guidance on how to effectively manage joint Safeguarding Adult Reviews and Domestic Homicide Reviews.

National - Guidance is required relating to the potential requirement for a Carer's Assessment be undertaken when a person registers with their GP as a Carer. This guidance could be provided via the Home Office 'Safe At Home' project which is considering the issues relating to both paid and family carers who are abusive to the person they care for