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To: Police Accountability Board

From: Detective Chief Superintendent Adam Gallop

Date: 21 September 2026

Domestic Homicide Reviews

1. Purpose

This paper provides the Police Accountability Board with assurance on how Cambridgeshire Constabulary identifies,
implements, embeds and monitors learning from Domestic Homicide Reviews (DHRs). It updates the April 2026 paper using the safeguarding review rolling log as at September 2026, with particular focus on the operational response to recommendations, evidence of embedding and the remaining risks.

2. Recommendation

The Board is asked to note the progress made, the assurance mechanisms in place and the outstanding priorities set out in section 9. The Board is also invited to support continued senior oversight of the small number of actions where completion depends on cross-force, national or partnership arrangements.

3. Headline Assurance

- The September 2026 DHR log contains 58 DHR records, including 39 published reviews and a developing pipeline of new and submitted reviews.
- The log contains 72 actionable police recommendations: 53 are marked complete, 15 in progress and one not started. Three have no populated status, which is an assurance and data-quality issue requiring correction. Two further entries are explicitly recorded as requiring no police action.
- Recent learning continues to centre on dynamic risk assessment, professional curiosity, holistic investigation, safeguarding when victims disengage, cross-border information sharing, sudden-death practice and communication with families.
- The strongest assurance is available where learning has been converted into force-wide processes, training or system controls, including DARA, secondary MASH triage, Risk Assessment on Retraction, Week 40 DA training, revised sudden-death training and established MARAC arrangements.
- Evidence of activity is stronger than evidence of outcome. As our involvement in DHR reviews continues, focus will place greater emphasis on audit results, compliance trends and victim-safety outcomes to demonstrate impact rather than completion alone.

4. Background and current position

The Police and Crime Plan Early Intervention and Prevention pillar commits to learning from reviews and recommendations to prevent future victimisation. DHRs provide an important opportunity to identify learning in safeguarding, risk management and investigative practice, including deaths by homicide, suicide and other deaths linked to domestic abuse.

Since the April paper, three new DHR records have been created. The wider pipeline includes five reviews submitted to the Home Office, five to be written, three awaiting confirmation and two open out-of-force reviews.

Portfolio position	Number	Assurance interpretation
Published reviews	39	Learning available for implementation and thematic analysis
Submitted to Home Office	5	Actions may remain subject to quality assurance or final publication
Draft / to be written	5	Future learning pipeline
Awaiting confirmation	3	Threshold decision outstanding
Out-of-force open or closed	3	Cambridgeshire involvement depends on cross-force scope
Pending publication, no outstanding actions	2	Operational actions closed before publication
Closed, not published	1	Learning retained locally

5. Key recent reviews and policing themes

This section focuses on the reviews that currently carry the most relevant policing learning. For each review, the emphasis is on what the recommendation was seeking to change, what update has been recorded against it, and what further assurance is still required.

Ava

The Ava recommendations focus on the identification and communication of domestic abuse history, including how prior risk, patterns of behaviour and safeguarding concerns are made visible to practitioners and decision-makers. The local updates record completion of MARAC information-sharing expectations and progress in clarifying the criminal justice pathway for remanded domestic abuse defendants. This provides assurance that local partnership processes have been strengthened. The outstanding recommendation relates to national warning-marker capability on PNC/LEDS. This is outside sole Constabulary control and should remain visible as an external dependency until there is a clear national position or alternative local mitigation.

Miles

The Miles recommendations are operationally practical and relate to the quality of first-contact and investigative decision-making. One recommendation requires all relevant missing-person information to be recorded on COMPACT so that risk, history and decision-making are available to those managing the incident. A second recommendation reinforces the need for professional curiosity when deciding whether house-to-house enquiries are required at domestic incidents. Both are recorded as in progress and awaiting gaps within the current response CPD training curriculum. Action has been taken by DCI Yorke to deliver Domestic Abuse training at Detective Constable and Detective Sergeant CPD training event, specifically covering Evidence Led Prosecutions. A Safer Together newsletter has been instigated by the Op Soteria lead. Further assurance will be required to ensure that recording quality and investigative enquiry decisions have improved in live practice – dip sampling and audits will take place to achieve this.

Polly

The Polly review resulted in several recommendations that have either been completed or substantially progressed. Completed updates include ensuring safe contact details are recorded and used within MARAC processes, reviewing Domestic Violence Disclosure Scheme practice, strengthening intelligence consideration for repeat perpetrators, and improving safeguarding arrangements for detainees who present with mental-health or suicidal concerns. These updates demonstrate a broad response across MARAC, disclosure practice, custody and intelligence. The remaining action concerns the consistent allocation of linked domestic abuse investigations to the same officer where practicable, so that related incidents are understood together and managed through a single, coherent safeguarding and investigative plan. Messaging has been shared with local Crime Managers and this practice is adhered to as far as possible, however there are still pockets of non-compliance which need to be addressed.

Jeanette

The Jeanette recommendations are significant because they cover several recurring and high-risk themes: evidence-led investigation where a victim is reluctant to support a prosecution, safeguarding for vulnerable adults assessed at standard risk, family-related domestic abuse, professional judgement, elder abuse and awareness of specialist support services. These recommendations will be addressed through a bespoke training session, aimed at response officers and investigators during their CPD sessions. This is the priority gap within the current portfolio because it cuts across risk assessment, investigation and safeguarding practice.

Sarah

The Sarah review contains completed learning on MARAC chairing (DI or above and having attended Safelives training) and out-of-court disposal decision-making, indicating that relevant practice expectations have been clarified. An outstanding recommendation concerns continuity of contact with families following a reported suicide where domestic abuse may be relevant. The BCH tri-force sudden-death policy does not fully specify the recommended arrangement, meaning local clarification is still required. Further assessment will

confirm who has responsibility for ongoing family contact, how this is recorded, and how oversight is maintained where domestic abuse, suicide and bereavement support overlap.

Siobhan

The Siobhan recommendations focus on accessibility, cultural knowledge and practical support. They require improved specialist awareness of Gypsy, Roma and Traveller communities, practical assistance to help individuals navigate processes, and accessible alternatives for people with educational needs or low literacy. Progress has been made against this recommendation, with awareness training delivered in August 2026, which is a positive implementation step. However, broader assurance is still required that single points of contact are available, that practical support routes are understood by frontline staff, and that accessible alternatives are embedded rather than dependent on individual officer knowledge.

6. Constabulary response to learning

- **First contact and identification of risk**

  DARA training has been rolled out across the force, with direction that a DARA is completed at every domestic abuse event and interaction. Child and adult safeguarding referrals are also mandated where relevant. The EIDAD and PVH functions provide research and advice to frontline staff, supporting recognition of history, escalation and cumulative harm.

- **Risk assessment and safeguarding**

  DARA is electronically transferred into Athena and available on the case record. Secondary triage within MASH provides quality assurance, and missing supervisory endorsement is tasked back to districts. The Risk Assessment on Retraction standardises consideration of safeguarding when support is withdrawn. MARAC arrangements use trained police chairs and presenters, with safe-contact information incorporated into practice.

- **Investigation standards**

The DA strategic delivery approach promotes holistic investigation, concurrent consideration of counter-allegations and stronger gatekeeping. Evidence-led investigation remains a live learning theme, particularly where victims are reluctant or disengage. Linked-investigation allocation to a single officer is still being progressed.

- **Supervision**
  Supervisory review is required for domestic abuse risk assessments, and MASH address breaches of the supervision procedure. Inspector ratification and gatekeeping arrangements provide additional challenge at key decision points. DA scrutiny and review activity are intended to test the quality of investigation and safeguarding rather than solely the presence of a form.

- **Training and workforce development**
  Learning has been incorporated into student-officer Week 40 DA training, DI/DCI CPD, sudden-death supervisor training, FLO inputs and specialist awareness sessions. Future vulnerability training will focus on professional curiosity, holistic problem solving, suicide prevention and support for vulnerable adults.

- **Information sharing and partnership working**
  Co-location and information-sharing through MASH, MARAC and partner agreements remain central. Cross-border sharing is supported through existing systems, but a specific reciprocal process for proactively sharing high-risk assessments with seven neighbouring forces remains challenging and incomplete.

7. Governance, oversight and assurance

The assurance model described in the April paper remains applicable: portfolio coordination through MASH ownership and operational activity, named review representatives, bi-monthly action review and quarterly senior governance through the VAWG Governance Board chaired by the Assistant Chief Constable.

Assurance layer	What it demonstrates	Current evidence	Assessment
Ownership	Named accountability for each review/action	Portfolio coordinators and review representatives; named owners in the log	Established
Tracking	Progress and ageing are visible	Rolling recommendation log and regular action review	Established, but status quality needs tightening
Implementation	Policy, process o r training has changed	DARA, RAR, MASH triage, Week 40 training, sudden-death and FLO inputs	Strong
Embedding	Change is reinforced in operational systems	Athena transfer, supervisory tasks, gatekeeping an d scrutiny	Moderate to strong
Impact	Practice and victim safety have improved	Some narrative assurance and audit mechanisms, but limited outcome measures in the log	Needs strengthening

8. Recommendations: progress and outstanding actions

The log records 72 actionable police recommendations. Fifty-three are marked complete and 19 are in progress.

Status	Number	Board interpretation
Complete	53	Action recorded as delivered
In progress	19	Active delivery or external dependency

Priority outstanding areas

- Cross-border high-risk information sharing:
  The Olivia recommendation remains incomplete because a reciprocal arrangement is needed across multiple neighbouring forces.
- National systems:
  The Ava warning-marker recommendation depends on national PNC/LEDS arrangements and should remain visible as an external dependency.
- Linked domestic abuse investigations:
  Implementation of a single-officer approach where practicable remains in progress and should be tested through audit.
- Suicide and family contact:
  Local clarity is still required on who maintains contact with families following suspected suicide where domestic abuse may be relevant.
- Gypsy, Roma and Traveller accessibility:
  Training has begun, but additional SPOCs and practical support for literacy and educational needs are not yet fully embedded.
- Missing-person information and professional curiosity:
  The Miles actions require evidence that reminders or training have changed recording and enquiry quality.

9. Evidence of impact

There has been demonstrable implementation and embedding activity in respect of the majority of recommendations to this point. DARA is integrated with Athena,

MASH has a secondary triage and task-back process, withdrawal of support prompts a structured risk assessment, MARAC roles and training are specified, and learning is incorporated into recurring training and CPD. These controls reduce reliance on individual memory and make expected practice more visible and auditable.

However, the rolling log mainly records actions taken to this point in time, rather than measurable outcomes. It does not consistently provide audit results, compliance rates, repeat-victimisation trends, changes in risk grading, victim feedback or evidence that the quality of investigations has improved. Consequently, assurance is strongest for implementation and embedding, but more limited for demonstrable impact on victim safety.

Over the next quarter, the following activity is proposed to provide assurance that measures implemented to this point are translating into operational improvements:

- Audit to examine DARA completion and supervisory endorsement compliance, including the proportion tasked back by MASH and repeat non-compliance by team.
- Audit to examine evidence of professional curiosity, assessment of cumulative harm, counter-allegations, evidence-led investigation and safeguarding after retraction.
- Audit to examine use and timeliness of protective measures, including DVDS, DVPN/DVPO and MARAC referrals, linked to risk and repeat victimisation.
- Audit of whether linked investigations are allocated and managed holistically, with clear victim contact and investigative plans.
- Quality audit of sudden-death, missing-person and family-contact records where domestic abuse history is present.
- Partnership engagement with IDVA service to examine victim outcome information, including repeat calls, escalation, safety-plan delivery and qualitative feedback where available.

10. Conclusion

The Constabulary can provide reasonable assurance that DHR learning is systematically identified, owned and translated into operational changes. The portfolio demonstrates significant progress, with most recorded police recommendations complete and several important changes embedded through systems, supervision and training.

Recurring themes nevertheless remain, particularly around dynamic risk, professional curiosity, victim disengagement, vulnerable adults, cross-border working and family contact after suicide.

The key improvement for the next reporting period is to move from assurance based mainly on completed activity to assurance supported by consistent audit and outcome evidence.