Home Office

Updating the Domestic Homicide Review Statutory Guidance

Government response

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Contents

Introduction 2
Complaints or comments 2
Background 3
Summary of responses 5
Executive summary 5
Consultation overview 5
Key questions 7
Methodology 8
Responses to specific questions 9
Government response 16
Consultation principles 18

Introduction

This is the government's response to the Domestic Homicide Review (DHR) Statutory Guidance consultation, which launched on 1 May 2024 and ran for 8 weeks, concluding on 29 July. The consultation was open to the public and invited feedback from a range of stakeholders, including specialist violence against women and girls' organisations, professional bodies, services and agencies, and individuals bereaved following domestic abuse related deaths

This document provides an overview of the responses received, summarising the key themes that arose and highlighting the specific outcomes of the consultation.

We are grateful to everyone who took the time to respond to this consultation, particularly those who have been personally affected by fatal domestic abuse.

If you wish to provide any comments regarding this response document, the public consultation or the guidance amendments, please contact the Home Office at the following address:

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Alternative format versions of this publication can also be requested from dhrenquiries@homeoffice.gov.uk

Complaints or comments

If you have any complaints or comments about the consultation process, you should contact the Home Office at the above address.

Background

Domestic abuse is the most prevalent form of violence against women and girls (VAWG). In the year ending March 2025, just under 1 in 3 women aged 16 and over reported experiencing domestic abuse since the age of 16 (29.6%) as well as just over 1 in 5 men (21.8%)[1]. Domestic abuse can have fatal consequences, with 111 domestic homicides taking place in the year ending March 2025.[2] The Government is committed to tackling VAWG as a national emergency, as outlined in the "Freedom from Violence and Abuse: a cross-government strategy to build a safer society for women and girls", which sets out the Government's plan to halve VAWG in a decade.

Every death linked to domestic abuse should be considered for a Domestic Abuse Related Death Review (DARDR), to ensure that national and local agencies, local communities and society as a whole learn lessons from domestic abuse related deaths and treat every death as preventable. DARDRs are multi-agency reviews that seek to identify and implement lessons learnt from deaths of those aged 16 or over which have, or appear to have, resulted from domestic abuse.

DARDRs are legislated for under the Domestic Violence, Crime and Victims Act 2004, which was amended by the Victims and Prisoners Act 2024 to align the definition of domestic abuse to that of the Domestic Abuse Act 2021 and amend the term 'homicide' in DARDRs to reflect the range of the deaths which fall within the scope of a review.

Additionally, it has now been ten years since the DARDR Statutory Guidance was updated in 2016, and fifteen years since the first guidance was published and DARDRs were operationalised in 2011. Over this time, we have learnt a great deal about the strengths of DARDRs and the areas for improvements, to maximise their potential for better understanding and preventing domestic abuse related deaths.

To address the discrepancies between the existing DARDR Statutory Guidance and the amended legislation, and to ensure the guidance better reflects current processes, the Home Office held a public consultation inviting views on updating the DARDR Statutory Guidance.

The revised DARDR Statutory Guidance proposed a number of amendments and additions, including:

- The inclusion of guidance and information for reviews that cover where a victim has died by suicide, neglect or in unexplained circumstances;
- Details on how and when perpetrator engagement should be conducted;
- Details on how to ensure a DARDR uses a trauma-informed approach;

[1] Crime in England and Wales: Annual supplementary tables - Office for National Statistics

[2] Homicide in England and Wales - Office for National Statistics

- Details on how to ensure the DARDR takes a victim-centred approach;
- An outline of the role and responsibilities for the Domestic Abuse Commissioner and Police and Crime Commissioners;
- The introduction of a new ‘Scoping Review’ process to ensure all potential DARDRs are progressed; and
- The inclusion of a ‘DARDR Toolkit’, which includes templates to support those completing DARDRs.

Summary of responses

Executive summary

Overall, the majority of consultation responses were supportive of the revised DARDR Statutory Guidance. There was positive feedback on the inclusion of a 'DARDR Toolkit', the additional details on how to ensure DARDRs take a trauma-informed, victim-centred approach, and the overall clarity with which the purpose of DARDRs is conveyed. Respondents also shared areas in which they felt more detail was required, such as on reviews that cover where a victim has died by suicide, neglect or in unexplained circumstances and on children as victims of domestic abuse in their own right.

Consultation overview

The DARDR Statutory Guidance is relevant to those organising, conducting and participating in a DARDR. This includes but is not limited to Community Safety Partnerships, the DARDR Chair and Panel, the Domestic Abuse Commissioner, Police and Crime Commissioners, organisations working with victims and perpetrators, commissioners of services (including the police, local authorities and the NHS) and the family, friends and community of the victim. Some of these organisations may also have statutory duties to safeguard victims of domestic abuse.

The Home Office sought to engage with the following groups through the consultation:

- Criminal justice agencies (police, policing bodies, Crown Prosecution Service, HMPPS);
- Healthcare organisations;
- Local Authorities (including Community Safety Partnerships);
- Local Government bodies (including the Local Government Association);
- Educational institutions and academics;
- Specialist violence against women and girls organisations and organisations specialising in supporting those impacted by domestic abuse related deaths;
- Families and friends bereaved by a domestic abuse related deaths; and
- Organisations or individuals that contribute to the DARDR process (including the Domestic Abuse Commissioner and DARDR Panel/Board members).

The consultation was publicly available and as such, members of the general public who held a particular interest in the subject matter were also able to respond. The consultation received responses from a variety of organisations and individuals. The majority were submitted via the online survey, but written submissions were also accepted. In total, there were **254 complete responses** (208 via online survey and 46 written). The majority of responses were from or on behalf of organisations (216; 85%), with the remainder from individuals (38; 15%). Of those responding as or on behalf of an organisation, the majority

of organisations were Local Authorities (27%), with the second largest category was healthcare organisations (19%).

Table 1: Organisations represented in the consultation responses

	Response total (of non-blank responses)	Response percent
Local authority	58	27%
Healthcare organisation	40	19%
Community safety partnership	39	18%
Law enforcement agency (for example, the police, a policing body or the Crown Prosecution Service)	25	12%
Violence against women and girls' charity or service provider	21	10%
Other charities	3	1%
Educational institution or student body	1	0%
Other	29	13%
Total (non-blank responses)	216	100%

The online consultation responses were received from all regions of England and Wales. For the question 'Where do you live?', 208 responses in total were given. The most common comment answer was South East England (23%). It is important to note that responses received offline, via email and letter, were not included in the location breakdown, as not all respondents provided demographic information. The full breakdown was as follows:

Table 2: Online respondent locations

Location	Response total (of non-blank responses)	Response percent
National	20	10%
North East	8	4%
North West	18	9%
Yorkshire and the Humber	21	10%
East Midlands	20	10%
West Midlands	16	8%
East of England	19	9%
London	11	5%
South East	47	23%
South West	17	8%
Wales	11	5%
Scotland	0	0%
Northern Ireland	0	0%
Total (non-blank responses)	208	100%

Key questions

The consultation sought feedback on the updated version of the DARDR Statutory Guidance. The online survey included a total of 30 questions. Questions 1-5 and 27-30 were about the respondent, as summarised in the 'Consultation overview' section. Questions 6-26 were about the guidance, and used a range of open and closed questions, with the option to provide further comments or clarifications in a free text response.

Methodology

Analysis consisted of developing coding frameworks for free text responses, through which key themes were established for each question. The themes captured the overarching views about the revised guidance and any proposed amendments shared by respondents; these were then used as the basis for further updates to the guidance.

The majority of the written responses submitted followed the structure of the online survey, however, this was not a requirement. Offline responses were combined with online responses prior to analysis.

Percentages highlighted throughout the consultation response document have been rounded to the nearest whole number. Each question may have received a different number of responses, based on the type of question and the respondent's choice of whether to answer.

The consultation findings can only be used to record the various opinions of the participants who have chosen to respond to the consultation proposals. Due to the self-selecting nature of the public consultation method, findings should not be considered statistically representative of group or sector opinions.

Responses to specific questions

This section will outline the responses to the individual online survey questions (Questions 6 to 26), followed by a summary of the offline responses.

Question 6: Give any comments you have on the content or clarity of 'Section 1: 1 Purpose of a DARDR'.

There was a notable number of positive responses to this question, and respondents generally felt the purpose of a DARDR was clear, focusing on understanding lessons to be learnt rather than apportioning blame. Respondents also stated that the victim-centred nature of the review was clear.

In terms of suggested amendments, respondents commonly asked for clarity regarding the change of name from 'Domestic Homicide Review' to 'Domestic Abuse Related Death Review'. Many respondents referenced the legislative changes in the Victims and Prisoners Act 2024 and asked when it would be appropriate to start using the new name.

Question 7: Give any comments you have on the content or clarity of 'Section 1: 2 Criteria and definitions for a DARDR'.

The most common response to this question asked for more information about the updated definition for DARDRs. Respondents suggested that the guidance should include specific information on suicide and other domestic abuse related deaths to support a common understanding across all parties referring cases and contributing to the reviews.

Additionally, some respondents queried the timeframe in which domestic abuse should be considered prior to the death occurring.

Question 8: Do you think 'Figure 1: Domestic Homicide process map' is useful? Explain your answer.

One hundred and seventy-two respondents (83%) answered 'Yes' to this question, indicating that the process map figure is useful. 29 respondents (14%) answered 'No' and 7 respondents (3%) did not provide either answer. One hundred and fifty-four respondents commented to provide further detail about their answer. Respondents shared positive feedback stating that the process map was clear and concise, which serves as a useful tool to explain the DARDR process to individuals with limited experience, such as new staff and bereaved families. Respondents also outlined potential areas for improvement, with the most common suggestions including:

- To reconsider the formatting of the infographic, as the font size and arrows are somewhat difficult to read.
- To add further steps to the infographic, to fully reflect the DARDR process, specifically in cases where the DARDR criteria is not met.
- To provide more detail regarding Ministerial oversight.

Question 9: Give any comments you have on the content or clarity of 'Section 2: 4 Notification of a death to the Community Safety Partnership'.

The responses to this question focused mostly on the notification process for families and friends and the route through which friends or family members of an individual can directly contact a CSP about a death that is believed to satisfy the conditions as set out in section 9 of the Domestic Violence, Crime and Victims Act 2004. Some respondents stated that guidance is required for the process to be understood and applied consistently across CSPs. For example, establishing expectations for communication with families at an early stage in the DARDR process, and outlining how to handle the notification. Some respondents raised concern that the guidance does not specifically reference that the CSPs hold final decision-making responsibility for whether a referral meets the DARDR criteria.

Question 10: Give any comments you have on the content or clarity of 'Section 2: 5 Scoping Review process'.

The most frequent theme was engagement with families and friends at the time of the scoping review process. The revised guidance provides opportunity for families and friends to engage with the DARDR process at this stage. There was a mixed response to this, with some respondents stating that the scoping review may be too early to engage both in terms of sensitivity, as it could place undue stress on grieving families, and practicality, as the police investigation could be underway which will then delay the commencement of the DARDR. However, other respondents stressed the importance of early engagement as families, friends and communities may have vital information about the victim that could be missed elsewhere.

The second most common theme was the practical application of the scoping review. Some respondents asked for additional guidance on how to adapt the process proportionately to each case, particularly where it is immediately clear that the DARDR criteria has been met.

Question 11: Give any comments you have on the content or clarity of 'Section 2: 6 Coordinating a Domestic Homicide Review at a local level'.

There was concern from respondents about the availability of suitably qualified DARDR Chairs. The revised guidance will place new requirements on DARDR Chairs, specifically

that all Chairs will be required to complete the training currently funded by the Home Office and run by the charity Advocacy After Fatal Domestic Abuse (AAFDA). Some respondents also suggested that there could be increased demand for commissioning DARDRs, following the legislative changes, which could potentially impact the availability of Chairs and delay the appointment of a Chair.

The second most common theme was requests for an escalation process to arbitrate issues and conflict. Respondents referred to examples for which an escalation process would be considered necessary – firstly, when disputes arise between local DARDR panel members and Chairs and secondly, when agencies refuse to take part in DARDRs.

Question 12: Give any comments you have on the content or clarity of 'Section 2: 7 Conducting the Domestic Homicide Review'.

The most frequent theme in this section was the importance of capturing the perspective of children in the DARDR, as they are now victims of domestic abuse in their own right under Section 3 of the Domestic Abuse Act 2021. Respondents suggested including guidance that outlines age-appropriate ways to involve children in the DARDR process, including signposting to the relevant specialist support services. There was also a wider theme on training, specifically suggestions for national training or e-learning for local DARDR panel members and the authors of Individual Management Reviews (IMRs).

Question 13: Give any comments you have on the content or clarity of 'Section 2: 8 Compiling the Domestic Homicide Review'.

The most frequent theme surrounded family and friends of the victim attending DARDR panel meetings. It was suggested that involving bereaved families and friends directly in this way and "[treating them] as a key stakeholder" (para 8.11) could compromise the ability of panel members to remain objective.

The second most common theme was the use of language. Some respondents expressed caution about the appropriate terminology to use in a DARDR when referring to a death – domestic homicide, domestic abuse related death, or fatality – and how to refer to a perpetrator, particularly in suicide cases where a criminal charge or conviction has not been established.

Additionally, some respondents raised the view that the references in this section to probing for evidence and examining how and why the death occurred were at odds to the purpose of a DARDR – "DARDRs are not inquiries into how the victim died" (para 1.2). Respondents stated that it was important to clearly differentiate the DARDR and criminal justice processes, to avoid confusion and manage expectations.

Question 14: Give any comments you have on the content or clarity of 'Section 2: 9 Parallel Reviews'.

Respondents shared positive feedback regarding the guidance on parallel reviews, stating that it is notable improvement and provides vital clarity on the process.

There were some concerns raised about the potential for duplication of work and learning, as well as the impact on staff contributing to both reviews running in parallel. Consequently, some respondents expressed a preference for joint reviews to streamline the process.

Question 15: Give any comments you have on the content or clarity of 'Section 2: 10 Criminal investigations'.

Some respondents suggested that DARDRs should take place after a criminal investigation has concluded, to avoid interfering with or complicating the investigation if both were conducted at the same time. Furthermore, respondents highlighted the importance of sharing any early learning gathered before a DARDR is paused for criminal proceedings, to ensure vital lessons are not lost during the time lapse before resuming the DARDR.

Question 16: Give any comments you have on the content or clarity of 'Section 2: 11 Coronial Inquests'.

A number of respondents suggested that more information about the coronial process was needed within the guidance. The suggestions included clarification on the correct channels of communication to notify coroners of a DARDR, outlining the training coroners receiving on domestic abuse and establishing a sequencing protocol for coroners' inquests and DARDRs to create a cohesive approach across regions.

Question 17: Give any comments you have on the content or clarity of Section 1: 3 and Section 2: 12 'Conducting a DARDR in Wales: The Single Unified Safeguarding Review (SUSR)'.

A number of respondents noted that they would be keen to see the Single Unified Safeguarding Review (SUSR) expanded into England, to streamline the current review process. It was commonly stated that a unified review process would overcome some of the barriers currently experienced when attempting to conduct joint reviews, as difficulties arise when attempting to work collaboratively across distinctly different review processes.

Question 18: Give any comments you have on the content or clarity of 'Section 2: 13 Anonymisation'.

There was a notably positive response from respondents to this section, who welcomed the addition of anonymity for members of the DARDR panel; many stated that this is essential to prevent unnecessary risks to the individuals and encourage open dialogue amongst panel members.

Respondents also raised concerns regarding anonymisation for DARDRs that contain specific or unique circumstances and could therefore be easily identified.

Additionally, it was common for respondents to request guidance for the purpose of risk assessing and on communicating the implications of including the victim's real name; which families sometimes request.

Question 19: Give any comments you have on the content or clarity of 'Section 2: 14 Data Protection'.

A number of respondents from healthcare organisations shared their views regarding data sharing for DARDRs, including on the disclosure of personal medical data, particularly in cases where individuals are not subject to criminal investigations and no criminal convictions have been issued for the victim's death. It was therefore suggested that the guidance should include further information on this issue.

More generally, respondents commonly asked for further information in relation to data protection, particularly the lawful basis for sharing data.

Question 20: Give any comments you have on the content or clarity of 'Section 2: 15 Home Office Quality Assurance Board'.

Some respondents stated their dissatisfaction with the delays in receiving feedback. Several respondents expressed that they do not feel the QA Board is sufficiently independent or transparent, which creates distrust at the local working level. Secondly, respondents shared anecdotal experiences wherein feedback from the QA Board was not returned for several months and subsequently delayed the publication of the final report. The delays were also noted to cause further distress to bereaved families and friends awaiting the finalised review.

Question 21: Give any comments you have on the content or clarity of 'Section 2: 16 Publication'.

Respondents welcomed the inclusion of information on the DARDR Library. However, there were concerns noted around publishing the DARDRs in full. Some respondents

stated that families and other invested parties may experience distress from reading intimate details of the victim's life and as such, an alternative version of DARDRs should be published, to ensure a trauma-informed approach.

Respondents also enquired about updating DARDRs once the review process has concluded. The two most common questions related to whether a threshold needed to be met in order for new information to be considered an update, and whether there was a timeframe, following the conclusion of the DARDR, within which new information needed to be submitted.

Question 22: Give any comments you have on the content or clarity of 'Section 3: Implementation of Learning - Making the Future Safer'. Please specify which subsection you are referring to.

Respondents noted a lack of clarity relating to the role of the Police and Crime Commissioners (PCCs) within the DARDR process. Another common point of feedback related to recommendations, specifically respondents asking for further guidance on developing learning into recommendations. This included instructions on the best way to frame and direct recommendations, and the challenges that can arise when balancing resources and ambition.

Question 23: Do you think the DARDR toolkit is useful?

One hundred and ninety-four respondents (96%) answered 'Yes' and 7 respondents (4%) answered 'No', with 7 respondents not providing an answer. One hundred and forty-one respondents commented further, as prompted by Question 24, to explain their reasons.

Question 24: Give any comments you have on the content or clarity of the 'DARDR toolkit'.

As indicated in the previous question, the majority of respondents stated that the toolkit is useful and shared positive feedback to that effect, stating that it is comprehensive, easy to follow and supports consistency across CSPs. Several respondents also suggested establishing a timeframe for evaluating the toolkit following its formal introduction.

Other common suggestions included further guidance on reviews covering domestic abuse related suicides and on how to use the toolkit flexibly, for instance to accommodate joint reviews.

Question 25: Do you think there are any ways the guidance could be improved? If yes – how could it be improved?

One hundred and fifty-one respondents (73%) answered 'Yes' indicating that there are ways to improve the guidance, 45 respondents (22%) answered 'No' and 12 respondents (5%) did not provide either answer. One hundred and ninety-six respondents commented further to explain their reasons. The most common themes were suggestions to improve signposting to DARDR leaflets and resources, to incorporate more infographics as a way to improve the accessibility of the guidance, and to consider further detail on familial violence that meets the DARDR criteria.

Question 26: Is there anything missing in the guidance that you would like to see included? If yes – what is missing?

One hundred and twenty-four respondents (60%) answered 'Yes', 65 respondents (31%) answered 'No' and 19 respondents (9%) did not provide either answer. One hundred and twenty-three respondents commented further to explain their reasons. The most common theme was concerns about Local Authorities bearing much of the financial responsibility for DARDRs.

Respondents also suggested the following:

- More detail on the role of statutory domestic abuse partnership boards in DARDRs.
- Establishing a maximum number of recommendations per DARDR.
- Guidance on cases where victims of domestic abuse have killed abusive partners.

A summary of offline responses.

There were 46 offline responses to the consultation, which raised similar feedback to the online responses. The most common responses included the following themes:

- A need for Community Safer Partnerships to work together in a more productive way, particularly in cases of victims who lived in multiple CSP areas.
- By and for organisations shared experiences of being approached to contribute to DARDRs without formal invitations to join the panel.
- Concerns that DARDR Chairs and local panels do not have the appropriate training to work with perpetrators.
- Requests for more information on escalating complaints in relation to DARDR Chairs and Home Office decisions.

Government response

There were a number of areas in the consultation that received significant feedback, and we have therefore updated the Statutory Guidance accordingly.

The legislation underpinning DARDRs was amended by Section 19 of the Victims and Prisoners Act 2024. This changed the name of DHRs to 'Domestic Abuse Related Death Reviews' (DARDRs) and clarified the criteria for which DARDRs can be commissioned, so that going forward, DARDRs will be undertaken when a death has, or appears to have, resulted from domestic abuse as defined by section 1 of the Domestic Abuse Act 2021. This aligns DARDRs with the statutory definition of domestic abuse, which includes controlling or coercive behaviour, emotional abuse and economic abuse, as well as a definition of which relationships domestic abuse can occur within. The new legislation was commenced in September 2026. Consultation respondents asked that these changes reflected be in the next iteration of the Statutory Guidance. The guidance has therefore been updated accordingly, with additional information included on handling cases not ruled as homicide.

A new section has also been added to ensure that DARDRs are capturing and including the voices of children, where appropriate. As many respondents highlighted, children are now recognised victims of domestic abuse in their own right under Section 3 of the Domestic Abuse Act 2021, if they see, hear or experience the effects of abuse. The new Statutory Guidance therefore includes a dedicated section outlining best practice for how to engage children as part of a DARDR.

The revised guidance will implement the Scoping Review, as proposed in the consultation, to create a consistent approach across local areas and ensure learning can be drawn out and acted on before final publication. Respondents shared that local areas currently undertake different processes to gather information before deciding whether to conduct a DARDR or submit a decision not to conduct to the Home Office. As such, there are inconsistencies across regions, which can contribute to delays within the overarching review process. The Scoping Review will streamline this process by creating a single, unified approach across all local areas. The guidance outlines that a Scoping Review should be conducted for all deaths referred to the CSP for a DARDR, with a template provided to standardise the process. Respondents also stated that it can be difficult to act upon learning from DARDRs, as the relevant organisations only receive recommendations and actions following publication when the learning may then be outdated. As such, the guidance is clear that the Scoping Review should focus on identifying and disseminating early learning.

Additionally, the Government recognises the importance of embedding oversight to drive meaningful change for victims of domestic abuse. A number of consultation respondents also raised oversight as an area for improvement. That is why the section on oversight has

been revised to introduce new processes through which the sharing and implementation of national recommendations will be monitored across Government. This will ensure that national recommendations are acknowledged, recorded, and directed to the appropriate department or team. Going forward, national recommendations will then be shared with the Ministerial VAWG Board, to ensure that learning from DARDRs is overseen and considered by lead Ministers in all departments with recommendations to implement.

The Home Office has now committed to funding and delivering an oversight mechanism that will provide a digital platform through which recommendations can be tracked and monitored in real-time. By supporting the organisation and coordination of recommendations, this will ensure that learning is captured and translated into tangible action. Further detail on the oversight mechanism will be announced in due course. More information on implementing learning from DARDRs is provided in Section 18 of the guidance. These changes place a greater focus on sharing and implementing learning, to ensure lessons learnt taken on board to ultimately prevent future deaths.

The Home Office also introduced a new DARDR Quality Assurance (QA) Board in 2025, made up of public appointees and statutory agencies, who bring extensive expertise in domestic abuse and broader issues related to VAWG, to review all DARDRs prior to publication. This is intended to create a more streamlined process, whereby more reports are reviewed every month, and CSPs receive feedback in a more timely manner. The new guidance outlines the purpose, scope and membership of the Board and the Terms of Reference have been included to increase transparency as requested by respondents.

In response to the feedback provided on the infographics used in the document, these have been redesigned to ensure that they are easier to follow and fully reflect the DARDR process.

There were some areas of feedback that ultimately fell outside the scope of this consultation, such as implementing the Single Unified Safeguarding Review (SUSR) model in England and increasing the funding allocations for DARDRs.

The Government acknowledges the concerns raised regarding financial and resourcing challenges when undertaking DARDRs. The revisions made therefore aim to increase efficiencies and reduce delays in the overarching process. For example, the guidance provides instructions for CSPs on how to access to the register of qualified DARDR Chairs, in recognition of the concerns raised about the availability of suitably qualified DARDR Chairs. The DARDR Toolkit, consisting of templates and checklists, guidance for producing action plans, and key contacts, aims to ensure CSPs and DARDR panels are suitably equipped to undertake reviews.

Finally, we would like to reiterate our thanks all those that responded to this consultation, particularly those who have been personally affected by fatal domestic abuse.

Consultation principles

The principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation are set out in the Cabinet Office Consultation Principles 2018.

This publication is available at https://www.gov.uk/government/consultations/updating-the-domestic-homicide-review-statutory-guidance.

Any enquiries regarding this publication should be sent to us at vawgimplementation@homeoffice.gov.uk.