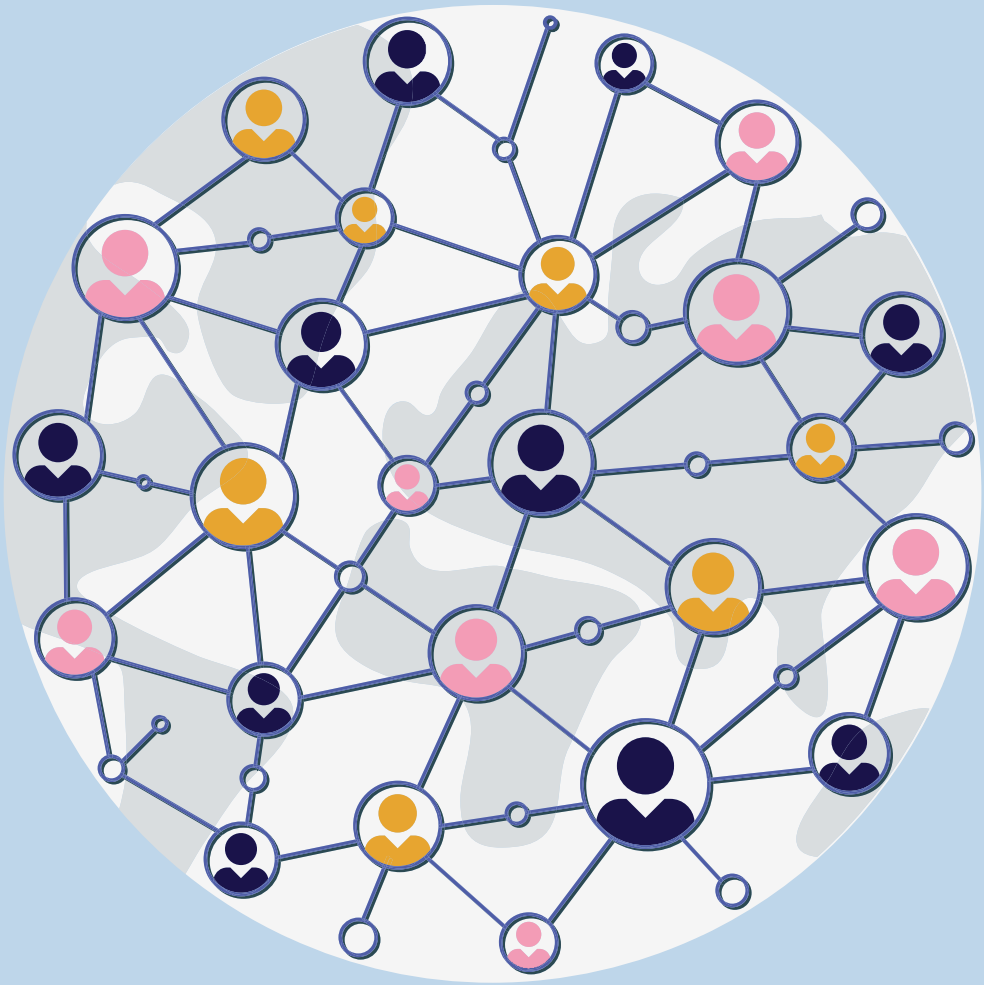
Domestic Homicide Reviews:
The role of family, friends and community - ‘A hierarchy of testimony’?

Report Author: Sarah Dangar | March 2024



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Foreword

WWIN Domestic Abuse Service is privileged to present this report which we hope will kickstart long overdue conversations regarding the vital role families, friends, and communities can play in tackling domestic abuse.

WWIN has been at the forefront of this work for over forty years, delivering victim services across Wearside as a member of the Women's Aid Federation England (WAFE) national network of providers, and working in partnership with a wide range of services across sectors. WWIN is proud of the strong community relationships we have developed over the years but, as we see the number of domestic abuse incidents continue to rise, we question who holds 'agency' in this field.

The increase in Domestic Homicide Reviews and the wider domestic abuse statistics demonstrate we need to do more, do things differently, and importantly, listen to wider voices that can help reduce this endemic crime and we are grateful to the many bereaved families, and practitioners, who have shared their knowledge and experience in this conversation.

The Covid 19 pandemic shone a light on communities, on our resilience, but also on our vulnerability and lack of 'agency' when situations are outside of our experience and knowledge. That's when the concept of our Findaway project took on an urgency; agencies have a duty to act but communities also have a critical role, and that role needs to be enabled, heard, and acted upon. Our partnership with Advocacy After Fatal Domestic Abuse (AAFDA) on this project, out of which this research and report has come, has been invaluable.

This model of providing wider support is just beginning to gain momentum in identifying the important role family, friends, and communities can play; how to turn this into positive action that changes outcomes is the challenge that starts here. We hope this report highlights those challenges and pushes forward practical, effective solutions that reduces the significant harms of domestic abuse.

Becky Rogerson MBE
Director, WWIN

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Acknowledgements

A Domestic Homicide Review, whilst being a critical tool for learning about agency and societal responses to victims (and, in some cases, perpetrators) of domestic abuse, is so much more. These reviews offer a lasting narrative of individuals' lives and deaths, and of the experiences of those that are left behind. In compiling this report, we remember those whose lives have been lost to domestic abuse.

Our sincere thanks to the families who have given their time, shared their experiences and worked supportively with us to make a safer future for others who may be at risk of harm. We are also grateful to the Domestic Homicide Review Chairs and Community Safety Partnership representatives whose experience and expertise have enhanced this report.

Special thanks are due to AAFDA for their help and support in facilitating this research, especially in facilitating engagement with, and enabling input from, family members and the Domestic Homicide Review Network. Finally, we thank those who have provided editing and wider contributions.

> *"You are the voice of the dead person, and you have a huge responsibility to ensure their story is recorded correctly. How can we learn from the past if it is not represented accurately?"*
>
> Frank Mullane MBE, CEO AAFDA, 2018

Introduction

Findaway is a project created by WWIN, a specialist domestic abuse service in Sunderland together with Advocacy After Fatal Domestic Abuse (AAFDA), Angelou Centre, Respect, The Alice Ruggles Trust, Northumbria Police and Crime Commissioner, and Surviving Economic Abuse.

The project aims to support those that are worried that someone they know is being controlled, scared, or hurt by their partner, ex-partner or a family member. Findaway offers an anonymous phone line and is working with people who have supported their family and friends through controlling and dangerous relationships to put together helpful information and resources for anyone worried about someone else's relationship.

Findaway is based within a well-established specialist service in Sunderland supporting people across the North East. This project was made possible due to support and funding from Comic Relief and the Northumbria Office of the Police and Crime Commissioner.

As part of the development of the Findaway project, the partners agreed to undertake research into learning from family contributions and engagement with Domestic Homicide Reviews, both to understand recommendations from reviews but also families' experiences of the DHR process.

> *"Families, friends and neighbours - you are often the first to learn about abuse and can be best placed to offer support. You are the first line of protection for people subjected to abuse, not services."*
>
> Becky Rogerson, Director, WWIN

Research Aims

1. To understand the scale and scope of recommendations from published Domestic Homicide Reviews[1] (DHRs) relating to communities and testimonial networks.

2. To explore these recommendations in order to:

- **a.** Identify good practice to enhance services for families and friends of individuals being subjected to domestic abuse
- **b.** Amplify the voices of family members and other relevant third parties
- **c.** Open pathways for third party reporting
- **d.** Guide campaign strategy and focus.

1 Further information on Domestic Homicide Reviews can be found at www.gov.uk/government/collections/domestic-homicide-review

Background and Context

Domestic Homicide Reviews (DHRs) came into force in April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be 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 he was related or with whom he[2] was or had been in an intimate personal relationship or
- **b** A member of the same household as himself, with a view to identifying the lessons to be learnt from the death.

In December 2018, the guidance was extended to include cases where a victim takes their own life: "Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable." [3]

The purpose of a DHR is to:

- **a** 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 safe guard victims;
- **b** identify clearly what those lessons are, both within, and between agencies, how, and within what timescales they will be acted on, and what is expected to change as a result;
- **c** apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- **d** prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- **e** highlight good practice.[4]

2 Section 6 of the Interpretation Act 1978 - words importing the masculine gender includes the feminine.
3 Home Office (2016a) 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' at: assets.publishing.service.gov.uk/media/5a80be88e5274a2e87dbb923/DHR-Statutory-Guidance-161206.pdf
4 Home Office (2016a) 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' at: assets.publishing.service.gov.uk/media/5a80be88e5274a2e87dbb923/DHR-Statutory-Guidance-161206.pdf

Scale

The Domestic Homicide Project [5] is a Home Office funded research project led by the National Police Chiefs' Council (NPCC) and delivered by the Vulnerability Knowledge and Practice Programme (VKPP) in collaboration with the College of Policing. Across the two-year period from 1 April 2020 to 31 March 2022 the project reported 470 deaths in total which took place in a domestic setting or following domestic abuse, including 43% intimate partner homicides, 24% suspected victim suicides, 22% adult family homicides, 8% child deaths, and 3% 'other' [6].

In 2023, a Freedom of Information request submitted to the Home Office revealed four and a half years' worth of data relating to the number of DHRs being commissioned. In 2019, the Home Office received 99 DHR notifications (that is to say notifications from Community Safety Partnerships that they had commissioned a Domestic Homicide Review), in 2020 this rose to 130 notifications, in 2021 to 173 and in 2022 to 192 notifications [7]. In the first six months of 2023 (January to July), 128 notifications had been received. This demonstrates an increasing number of reviews being commissioned to critically reflect on these deaths and to commit to identifying lessons and forming recommendations and action based on this learning.

Involvement of family, friends and wider testimonial networks

The Home Office Statutory Guidance on the Conduct of Domestic Homicide Reviews is clear that families should be integral to reviews, it explicitly states: 'The review panel should recognise that the quality and accuracy of the review is likely to be significantly enhanced by family, friends and wider community involvement. Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder. The chair/review panel should make every effort to include the family and ensure that when approaching and interacting with the family the panel follows best practice'. The Community Safety Partnership should also provide families with a Home Office leaflet that sets out the process of a DHR, how families can take part and signposts to support.[8]

DHR Chairs and panel members should seek to involve families in the way, and by the means that best suits that family. They should update families regularly, should offer families the opportunity to attend a panel meeting and meet its members. Families should see drafts of the terms of reference and final report and crucially, have the opportunity to feedback on them. Ultimately there should be no 'hierarchy of testimony' where the views of professionals within DHRs are weighted more heavily than the views and experiences of families and friends.

> *"Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder."*
>
> Home Office Statutory Guidance

5 Domestic Homicide Project - VKPP Work
6 Bates, L. et al. (2022) 'Domestic Homicides and Suspected Victim Suicides 2021-2022'
7 Home Office confirms steep rise in suicide related domestic homicide reviews - Tortoise (tortoisemedia.com).
8 Domestic Homicide Review Information - Leaflet for Family Members (publishing.service.gov.uk)

Relevant Literature

In 2016, Standing Together Against Domestic Violence (now Standing Together Against Domestic Abuse or STADA) commissioned a Domestic Homicide Review: case analysis[9]. This analysis, from a sample of 32 DHRs, was undertaken by the Child and Women Abuse Studies Unit (CWASU) at London Metropolitan University. The report provides an overview of Intimate Partner Homicide and Adult Family Homicide cases drawing out the similarities and differences in these cases. It identified six key themes: contact with General Practitioners (GPs); mental health; safeguarding adults; safeguarding children; the role of informal networks in the DHR process and what informal networks knew; and risk assessment. It then made recommendations around GP practices, mental health services, health services, adult safeguarding, children's social care and schools.

In relation to informal networks the report found that victims of Intimate Partner Violence are more likely to seek help from friends or family than from a formal agency, that professionals should consider that these informal networks hold vital information about risk and that prevention initiatives should involve wider communities and create 'circles of support' for victims. Recommendations focussed on increased public awareness.

In 2020, commissioned by the Mayor's Office for Policing and Crime (MOPAC), STADA extended this work and published a further analysis[10] of DHRs focussed on reviews in London. The report analysed 84 DHRs between 2011 and 2018 and reviewed local authorities' DHR processes. The report identified key themes in eight areas: the DHR process, intimate partner DHRs, adult family homicide DHRs, Black minority and ethnic groups, lesbian, gay, bi-sexual, transgender +, mental health, older people and themes across all DHRs.

This report found that 50% of friends and families in the cases analysed had contributed to the review and noted that uptake of specialist advocacy and support was low and that further opportunities to access support should be offered.

> ***"the report found that victims of Intimate Partner Violence are more likely to seek help from friends or family than from a formal agency"***
>
> **Standing Together Against Domestic Abuse, 2016**

Across the range of deaths that this report analysed, there were key recommendations that emerged around friends and family members. As with the 2016 report, it was highlighted that victims will, most likely, disclose to family and friends are required to ensure that communities understand the dynamics of domestic abuse and the services that are available for support. As with the earlier report, public awareness was highlighted, particularly to challenge victim blaming attitudes, specifically tailored to minority communities that might face multiple barriers to accessing services and support, and around third-party reporting.

In 2022, the Home Office published its most recent analysis of Domestic Homicide Reviews[11] (October 2019 to September 2020) which presents key information from 124 DHRs following consideration within the quality assurance process.

9 cwasu.org/resource/domestic-homicide-review-dhr-case-analysis/
10 www.standingtogether.org.uk/blog-3/london-dhr-case-analysis-and-review-launch-2020
11 www.gov.uk/government/publications/ key-findings-from-analysis-of-domestic-homicide-reviews

Across the reviews, there were 127 victims (14 of which had taken their own lives). The youngest victim was under 18 and the oldest 94, with the average being 41 years old. The oldest perpetrator was 89 years old, and the average age was 40. Similarly, to the findings of this report, the majority of victims (80%) were female, and the majority of perpetrators (83%) were male. Again, reflecting our findings, 73% of those perpetrators were identified as the partner or ex-partner of the victim and 27% as family members.

This analysis found that the average time between the victim's death and the submission of the DHR to the quality assurance process is two years. Enabling family participation was cited as an 'influence' on this timeline alongside other influences including completion of criminal justice outcomes, Community Safety Partnership sign off and the coroner's inquest. This Home Office analysis reports that families contributed to 77% of the DHRs analysed. Support from an advocate was noted in 32 of the 124 DHRs.

In 2023, a Home Office funded project, co-produced by AAFDA and University of Warwick, 'Learning Legacies: An analysis of domestic homicide reviews in cases of domestic abuse suicide'[12] was published. Whilst focussed specifically on DHRs relating to deaths by suicide, the project had significant contributions from bereaved families (including through a steering group, interviews, and a focus group) and offered insights into what they wanted and expected from the DHR process.

Like the studies above, this research found that the majority of victims were female, and the majority of (alleged) perpetrators (where stated) were male, most commonly current or ex partners. The majority of victims were white British; however, ethnicity was not stated in 20% of the cases reviewed. Victim ages varied, but 40% were aged between 24 and 34 years old at the time of their deaths.

This work identified five key themes: Parties' profiles, vulnerabilities and needs, agency engagements and responses, the context and aftermath of death, the commissioning and commencing of DHRs and running successful DHRs.

The 32 DHRs in this sample were assessed in terms of the level of family involvement and coded as none, limited or significant. There was an even spread of levels of involvement across the DHRs. Through their participation in the project, some families expressed that the DHR process was a largely positive experience and allowed them to be heard and to ensure that the voice of their loved one was heard in the review. However, others felt 'misled' by the DHR process which had claimed that they were integral but instead produced a review which did not, in reality, attach importance to their input and subsequently made recommendations and designed actions plans that did not respond to, or acknowledge their contribution, experiences and expertise.

> ***"Some families expressed that the DHR process was a largely positive experience [...] However, others felt 'misled' by the process which had claimed that they were integral but instead produced a review which did not, in reality, attach importance to their input"***
>
> **Learning Legacies, AAFDA & University of Warwick, 2023**

12 wrap.warwick.ac.uk/174206/

Methodology

Domestic Homicide Reviews (DHRs) were collated from Community Safety Partnership websites between November 2022 and early February 2023. Initially, the project focused on reviews from 2019 onwards, however this yielded a relatively small sample, and the decision was taken to extend the temporal scope to reviews relating to deaths that occurred from 2018 onwards. This extended the sample from 51 reviews to 123 reviews. As reviews were collated from public websites, there are no unpublished reviews in the sample.

DHRs were anonymised and data was extracted from case files to both a spreadsheet and, where applicable, reflective notes for quantitative and qualitative analysis. Initial analysis highlighted reviews that offered insight into the project's research questions, namely those with recommendations that related to Findaway themes. These reviews were further analysed to produce findings and recommendations.

The draft report was presented to the Findaway Project Family Reference Group[13], made up of six family members bereaved by fatal domestic abuse. Families shared their thoughts on the report findings and the draft recommendations in a one and a half hour facilitated session (conducted by Zoom and recorded) in November 2023. All responses were anonymised, and all quotes are shared with consent. This discussion helped to shape this final report and its recommendations.

In January 2024, a survey was sent to all members of the AAFDA DHR Network[14] and network members were invited to submit their responses to ten questions (see Appendix 2). These questions were designed following the Findaway Project Family Reference Group session and encompass their questions and concerns. Ten survey responses were received. Two DHR Chairs also chose to submit a free text written response to the network via e-mail. All responses were anonymised and all quotes are shared with consent. A one-hour focus group session (conducted by Zoom and recorded) was also held in January 2024 with DHR Chairs and representatives from Community Safety Partnerships, this was organised and facilitated through the DHR Network. 24 individuals attended. The questions posed in this session mirrored the survey questions.

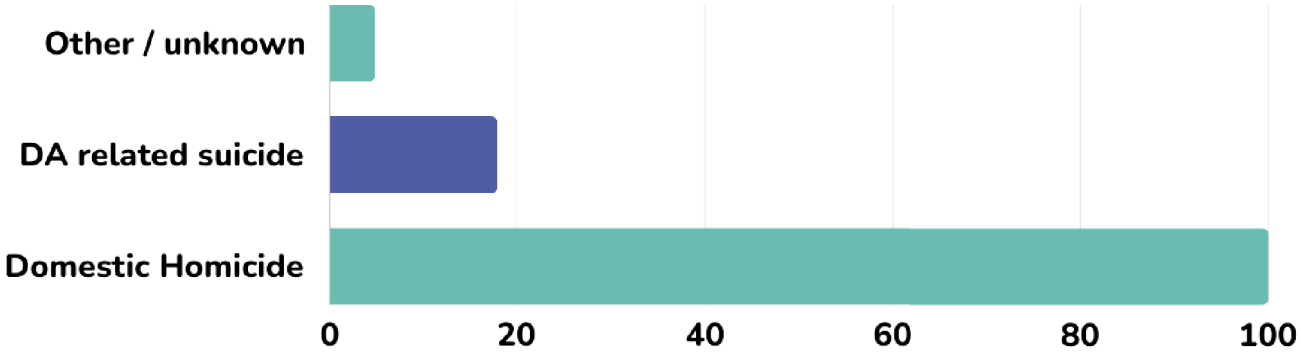
Final report recommendations were drawn from findings from the DHR sample and learning from the Findaway Project Family Reference Group and the DHR Network focus group.

13 The Findaway Reference Group are a group of family members who have lost a loved one following domestic abuse. The purpose of the group was to feed thoughts and ideas into the development of the Findaway project.
14 The DHR Network was established by AAFDA in 2021 with the aim of raising the standard of DHRs nationally. DHR Network members are primarily made up of DHR Chairs and representatives of Community Safety Partnerships. Its goal is to create a high standard of DHRs and offer resources to support key professionals in the DHR process. More information is available at: aafda.org.uk/dhr-network.

Key Findings

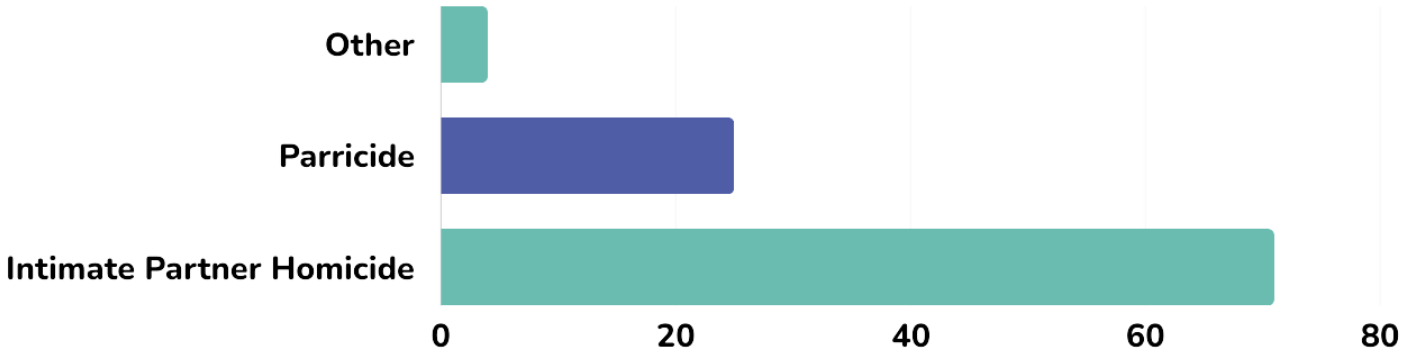
This report considers 123 Domestic Homicide Reviews (DHRs) of victims who died in 2018 (59%), 2019 (32%) and 2020 (10%). This reflects the delay between the death, the commissioning and undertaking of the review, the quality assurance process and subsequent publication of the DHR.

Of the 123 DHRs analysed, 100 related to domestic homicides[15], there were 18 cases where a victim had taken their own life, and the remaining five reviews were categorised as 'other or unknown' domestic abuse related deaths



Breakdown of Domestic Homicide Reviews by type of death

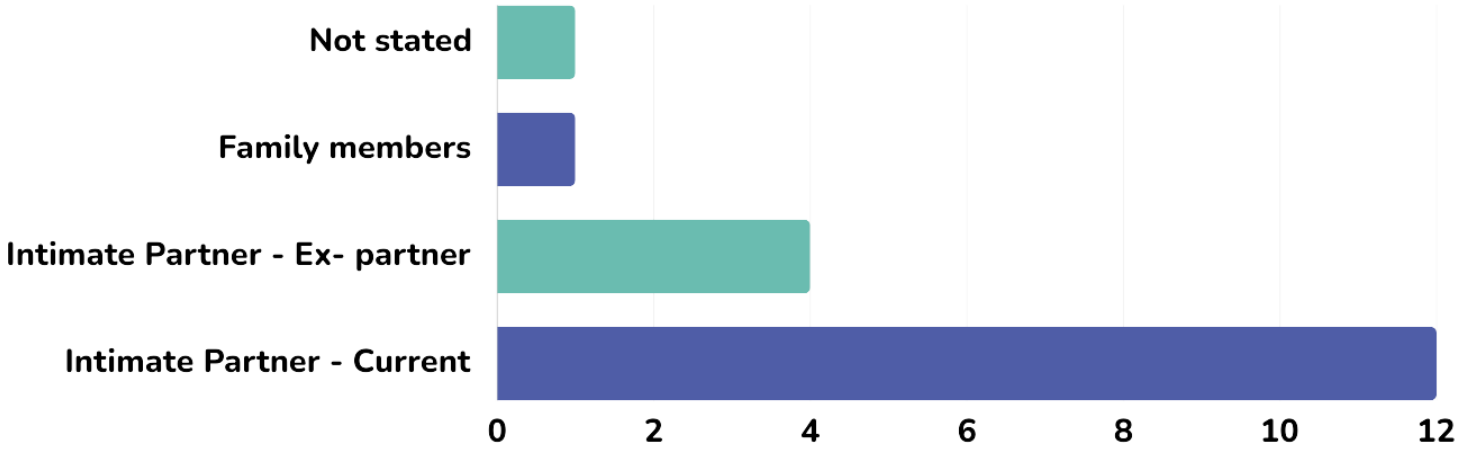
Among the 100 domestic homicides covered by the sample, 71 were Intimate Partner Homicides[16], 25 were parricides[17], and the remainder were other deaths (for example individuals living in the same household but not related or intimate partners).



Breakdown of domestic homicides by type

15 Domestic homicide occurs when a victim is killed by a current partner, ex-partner, relative or an inhabitant of their home at the time (Home Office, 2018).
16 Intimate partner homicide (IPH) refers to the killing of a person by their current or former intimate partner.
17 Parricide is the killing of a parent or other near relative.

Among the 18 reviews where individuals took their own lives in the context of domestic abuse, in 16 of these cases the alleged abuser was an intimate partner, with 12 being current and four being ex-partners. In one case of a young British Pakistani woman, the alleged abusers were her brother and father, a case that appears to be so-called honour-based abuse including the threat of forced marriage.



Deaths by suicide – breakdown of alleged abuser

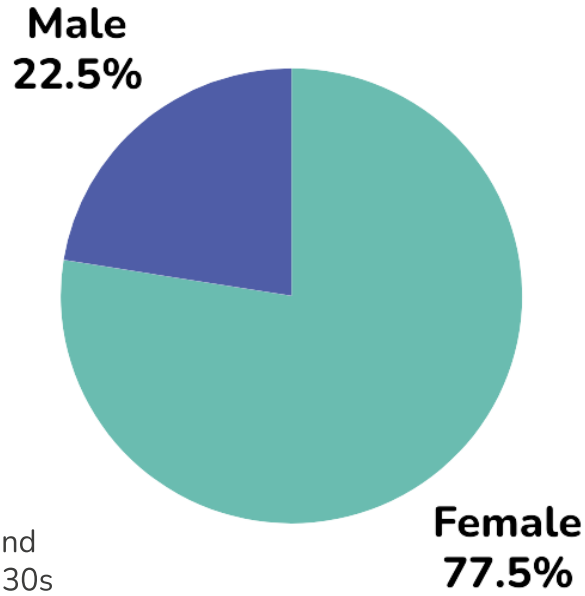
Victim profiles

Within the 123 DHRs, there were 129 victims who lost their lives to domestic abuse, three of whom were children and in one case a woman died carrying her unborn child.

In four cases there were multiple victims – two mothers were killed alongside their children and in two cases both parents were killed by their adult sons.

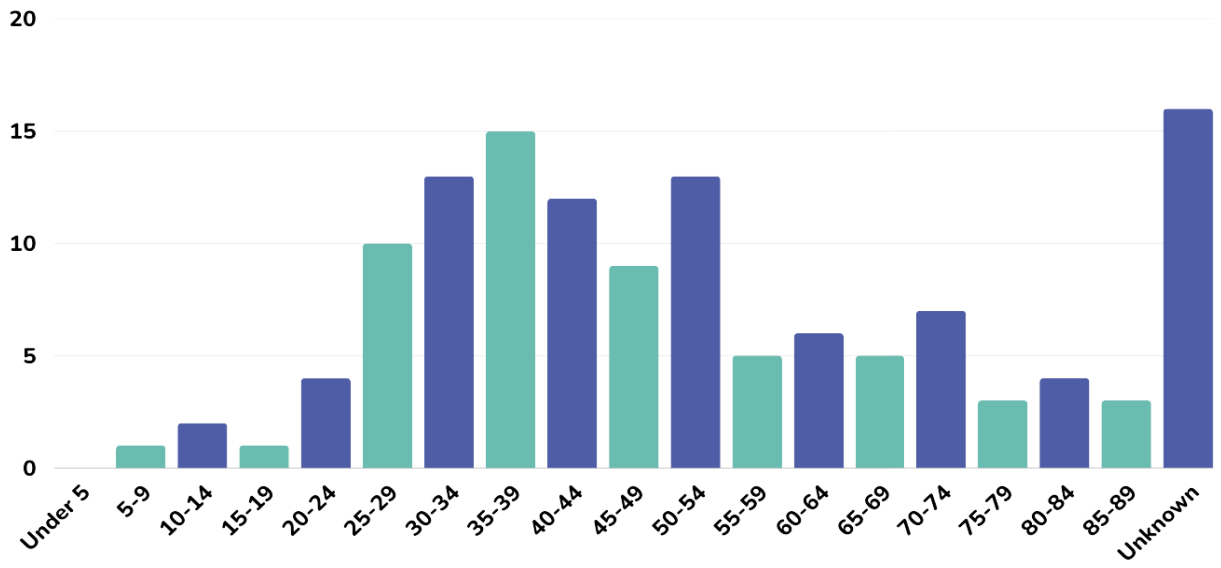
Of the 129 lives, 77.5% were female and the remainder were male.

In 16 of the reviews in the sample, the age of the victim was not stated or was stated in a range (for example; 60-70). In order to analyse the given ages of both victims and perpetrators within the reviews collected, ONS population age categories were used[18]. The victims within the reviews analysed were aged between 7 and 89 years old. The majority of victims (49/129) were in their 30s and 40s (38%). 28 victims (21%) were over the age of 60 years old.



Victim profiles by sex

18 Principal projection - UK population in age groups - Office for National Statistics (ons.gov.uk)



Victim profiles by age

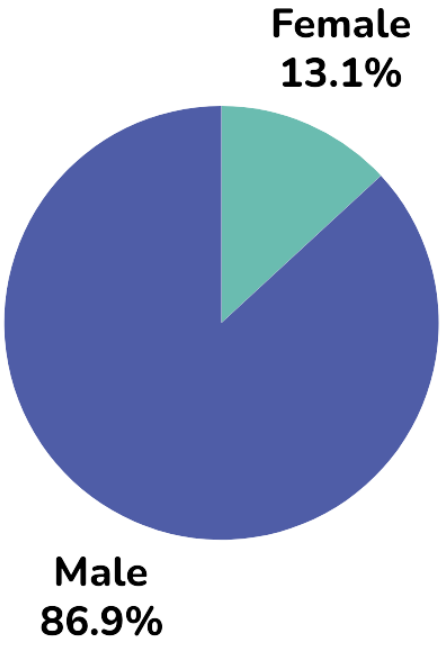
Ethnicity was only reported in 104 of the DHRs collated and analysed for this report, in 19 reviews it was not stated. Where ethnicity was stated, reviews did not offer consistent recording of ethnicity according to accepted recording elsewhere. For the purposes of this report, ONS ethnic group categories (high level) were used [19] and professional judgement applied to allocate the ethnicity stated in reviews against ONS ethnic group categories. This is not a robust method, and it is therefore likely that this report cannot provide an accurate or complete analysis of the ethnicity or nationality of the victims or abusers within the analysed reviews.

Ethnicity of victims was not stated for 19 of the 129 victims within the 123 reviews that were analysed. With the caveat above, the following ethnicities were reported in relation to victims:

- **Asian, Asian British or Asian Welsh – Ten individuals**
- **Black, Black British, Black Welsh, Caribbean or African – Four individuals**
- **Mixed or Multiple Ethnic groups – Five individuals**
- **White – 82 individuals**
- **Other ethnic groups – Nine individuals**

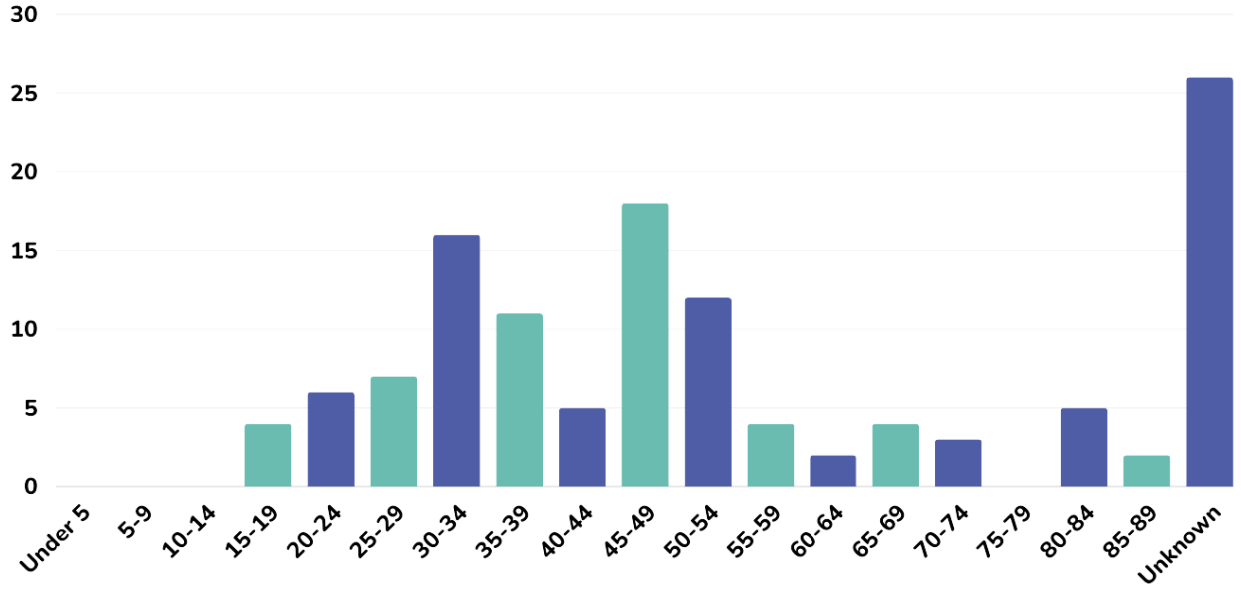
Abuser profiles

There were 125 perpetrators of abuse across the 123 DHRs in the sample. In two cases, there were two perpetrators in each case (in one a woman and her male lodger and in the second a father and his son). Of these 125 abusers, the overwhelming majority, 106 offenders (85%), were male, with 16 being female. The sex of the offender was not stated for three individuals.



Abuser profiles by sex

19 style.ons.gov.uk/house-style/race-and-ethnicity/



Abuser profiles by age

The youngest perpetrator in the sample was 18 years old and the oldest was 88 years old. Where stated, this is in line with the victim profiles, the majority (50 of 125) perpetrators of abuse were also in their 30s and 40s. However, the age of the perpetrator was not stated for 26 of the offenders within the cases in the sample – a fifth of offenders.

Ethnicity of perpetrators of abuse was not stated in 32 of the 123 of the reviews that were analysed. As with victim profiles, where ethnicity was stated, there was little consistency in recording. Having used ONS high level ethnicity categories for the purposes of this report, the following ethnicities were reported for the 125 abusers identified in the 123 reviews:

- **Asian, Asian British or Asian Welsh – 11 individuals**
- **Black, Black British, Black Welsh, Caribbean or African – Nine individuals**
- **Mixed or Multiple Ethnic groups – One individual**
- **White – 64 individuals**
- **Other ethnic groups – Eight individuals**

Bereaved children

The 126 adult victims represented in the reviews were survived by over 165 children[20]. In five of the cases, these were adult 'children' (11 bereaved adults). In seven cases, the children were no longer in the care of the victim at the time of their death.

20 In 30 cases, it was either not stated if the victim had children or how many children they had.

Analysis and Discussion

Recommendations from Domestic Homicide Reviews

Across the 123 DHRs in the sample, there were 1602 recommendations made, of which 601 were single agency recommendations[21]. Only 117 recommendations (7% of total recommendations) related to Findaway themes despite the fact that testimonial networks were involved in 92 of the 123 reviews in the sample (75%). Contributions came from a range of family members including parents, spouses, siblings, children, grandchildren, nieces, nephews and cousins. There were also contributions in 22 cases from friends of the victim, in five cases from work colleagues, one from a sports club that the victim was a part of, one vicar and neighbours contributed to one case. In eight of the reviews where friends and family were involved, it is not clear from the reviews who exactly participated.

There were also four reviews that had contributions from the perpetrator's family and one with a contribution from the perpetrator's employer.

The level and nature of contributions from family, friends and wider community members and narratives within the reviews suggested that recommendations should/could have been made for learning.

In DHR01, the murder of a woman by her husband, the review noted "The fact that some of her friends and family had knowledge of what she may have been going through demonstrates yet again that more has to be done to afford people the confidence to speak to others about their concerns."

And in DHR05, a review of a women murdered by her partner, the family reported that "we don't doubt she kept elements of the abuse she suffered at his hands secret from us as she was afraid of what might have happened to us had we further challenged him and tried to protect her and their child"

However, in neither of these reviews, were there recommendations that spoke to the concerns raised and highlighted by the family members that took part, so whilst the review has identified learning, there has been no action or response to this learning.

> *"more has to be done to afford people the confidence to speak to others about their concerns"*
>
> DHR01

21 Single agency recommendations are those made by organisations/agencies within their Individual Management Reviews that are submitted to the DHR panel as part of the DHR process.

In DHR101, where a man was killed in 2019 by his partner's son, the family specifically asked for their comments to be noted in the review:

1. **"The family thought that [victim's] admissions to hospital with head injuries and his later attendance to see his GP when he complained of low mood were red flags for abuse and should have been recognised as such.**

2. **[Victim] lived in a three-bed flat and after the two other people living there left he fell into rent arrears as he was unable to pay the 'bedroom tax'. His family thought that if he had been moved to a one bedroom flat at this point then problems would have been avoided as he would not have built up the arrears that led to his eviction. They also think that it may have been in part the pressure of his housing situation which caused him to move in with [alleged perpetrator]."**

Again, there were no panel recommendations that specifically addressed the family's concerns, the closest was a generalist recommendation around routine enquiry being embedded in domestic abuse training. This is made even more disappointing in that the Home Office, in their published feedback to the Community Safety Partnership noted: "The review features good analysis on why the GP never completed a routine enquiry with the victim, despite abuse indicators being known, good discussion on the impact of toxic masculinity and there is also a comprehensive overview of interactions with services and missed opportunities."

In DHR106, an intimate partner homicide, "The family did provide a file in which they had detailed key events in [victim's] life and a series of questions they had of agencies surrounding the care and support [victim] had received prior to her murder. The questions focussed upon the duty of care and a lack of action afforded to [victim] when incidents had been disclosed by [victim] to care agencies, and when matters were raised with those services by the family themselves.". Despite two family members participating in this review, there were no recommendations in this review that addressed the issue of families raising concerns to services (in their loved one's lives) and seemingly not being heard – a considerable opportunity for learning in this review that was missed.

> ***"This suggests a significant disconnect between what families are sharing with review teams and how this is (or is not) being translated into recommendations"***

In the cases highlighted here, and in many more, the knowledge, narratives and experiences of family members did not translate into focussed, robust recommendations. This suggests a significant disconnect between what families are sharing with review teams and how this is (or is not) being translated into recommendations. It would appear that some panels are not taking a wider lens and considering the role of friends, families and wider communities in reporting and responding to domestic abuse. They are instead focused primarily on the responses of agencies. This might suggest a hierarchy of testimony where the views of agencies are given more weight than the experiences, knowledge and reporting from victims' wider testimonial networks.

> *"This might suggest a hierarchy of testimony where the views of agencies are given more weight than the experiences, knowledge and reporting from victims' wider testimonial networks"*

Themes

Five key themes emerged from recommendations relating to families, friends and wider community networks:

1. **Public Awareness**
2. **Learning from and engagement with families**
3. **Support for families/carers/wider communities**
4. **Involving families in risk assessment**
5. **Post-death recommendations**

Public Awareness

This area attracted the most recommendations covering a wide range of public awareness activity.

Firstly, there was a range of recommendations focussed on raising awareness around domestic abuse itself for victims and for the wider community including what it 'looks like' and increasing understanding of coercive control specifically.

In one local area, the Domestic Abuse Strategy Group committed to "public awareness raising about coercive and controlling behaviour. As a minimum there should be an action appended to the current action plan which lays out a publicity campaign around coercive control using existing media platforms." (DHR02). Having searched for any campaigning in this local area, there is some information on coercive control on the local Domestic Abuse Board's website. The website also highlights a range of abusive behaviours with some short videos to support descriptions, however it is not clear if the 'publicity campaign' went beyond this.

A Community Safety Partnership (CSP) in Wales committed to ensure "that information is available to the wider community on the dynamics of domestic abuse, including coercion and control, and how they can report concerns or seek access to support." (DHR80). In this case, there is evidence of coercive and controlling behaviour being highlighted in the area's Domestic Violence and Abuse Strategy 2021-2024 however, again, it is not clear how this was translated into a wider information campaign or how communities might report domestic abuse and/or access support locally.

Review recommendations also highlighted the importance of raising awareness with victims and family/friends in the services available (both locally and nationally) and how to access these services.

In DHR19, a review examining the murder of a man by his brother, the CSP aimed to "carry out a leaflet drop providing information highlighting domestic abuse and the referral pathways to leisure facilities and community centres within their district." and in a review of the murder of two parents by their adult son with significant recommendations around housing, local Neighbourhood Management planned "To include information about DA and access to support in the Residents Handbook and Housing Matters newsletter. This information to also draw attention to abuse from adult children to parents. To put notice/display key messages on physical or digital noticeboards where present in blocks of flats, about DA and how to access support. Include information about abuse from adult children to parents." (DHR86).

Further, this area was committed to ensuring "that information is accessible to those who do not speak or read English with confidence" recognising, in part, the diversity of the communities they serve. Whilst it does appear that the named council here have taken steps, for example the 'Tenants Handbook' which does highlight domestic abuse (and is available in seven languages), has created a factsheet and has signposted in a housing newsletter to a domestic abuse organisation, it is not clear if this was focussed on abuse from adult children to parents which was specifically highlighted in this review.

Another review, the drug related death of a woman, highlighted the often-overlooked area of post-separation abuse[22] recommending that the "Partnership should undertake a focused piece of work to raise awareness of the risks posed in relation to domestic abuse and recent separation of partners" (DHR114).

There were also a number of recommendations relating to specifically raising awareness in communities around familial abuse – supporting both victims and the general public to understand adult child to parent violence specifically as well as abuse within families. Notably though there were no specific recommendations around so-called honour-based abuse despite a review into a domestic abuse related suicide where the victim had disclosed numerous times about the coercive control and threat of forced marriage she was experiencing from her father and brother.

22 Post-separation abuse can be defined as the ongoing, wilful pattern of intimidation of a former intimate partner including legal abuse, economic abuse, threats and endangerment to children, isolation and discrediting and harassment and stalking.

In DHR103 "[The victim's] family have advised the review that they were aware that [victim's son and perpetrator] was physically abusing his mother from his teenage years or even earlier. It became more difficult for them to intervene after she and [the perpetrator] moved away from the town in which [the victim's] wider family lived, but they do not appear to have perceived [the perpetrator's] violence towards his mother as domestic violence until the [date in 2019] incident. Some of the barriers which prevent the victims of familial domestic abuse from seeking help may also be present within the wider community. Therefore, there may be a case for promoting public awareness of familial domestic violence and abuse. It is therefore recommended that [the Safer X Community Safety Partnership] make use of the learning from this review to raise public awareness of familial domestic violence and abuse."

It is worth noting here that whilst it is encouraging to see that a recommendation focussed on this important area of domestic abuse, the recommendation itself lacks robustness and is both ambiguous and vague. Regrettably, there was no action plan published alongside this review, so the detailed actions around this recommendation remain unclear.

Review recommendations recognised the need for focussed awareness campaigns for specific groups and communities, including older people, young people (including the student population), faith groups, minoritised/racialised communities (for example: Polish, Lithuanian, African Caribbean, and Traveller communities) and employers, job centres and solicitors.

"whilst it is encouraging to see that a recommendation focussed on this important area of domestic abuse, the recommendation itself lacks robustness and is both ambiguous and vague"

The area that commissioned DHR117, a 2020 matricide, outlined that: "As part of the refresh of the local domestic violence and abuse strategy, the CSP should develop a targeted domestic abuse education campaign to the local African and Caribbean community, this should involve community representatives in designing education and support." Critically here, there appears to be aspiration to co-create this campaign with the community, demonstrating perhaps a genuine aspiration to deliver action on this recommendation.

"Critically here, there appears to be aspiration to co-create this campaign with the community, demonstrating perhaps a genuine aspiration to deliver action on this recommendation"

Another Partnership also recognised the importance of co-design and committed to "working with local specialist service providers who have experience of supporting Eastern European women experiencing domestic violence/abuse, to identify the most effective way to increase awareness of domestic abuse, and support services, within that community and to develop an action plan to implement this." (DHR113).

Neither action plans for the above reviews were published, this means there is little oversight (outside of the local area) to ensure that these recommendations, which appear to be positive, are indeed being actioned in order to truly learn from the deaths that led to them.

DHR30, which examines the death of a 72-year-old Asian Pakistani woman at the hands of her adult son in 2018, identified two specific recommendations around older people. The first aimed to "Review links with voluntary and charitable organisations having contact with older people to ensure engagement with training and awareness programmes. Particular attention should be paid to religious/cultural/social community-based organisations." and the second recommended that "DA Champions engage with relevant voluntary, religious, culturally and ethnically based community groups to raise awareness of the abuse of older people and seek to broaden the range/network of such organisations that are cognisant of the availability of training and/or support.".

Whilst the published report in this case was significantly redacted, the action plan was published. In relation to the first recommendation, there appears to be a number of targeted actions including identifying and signposting to relevant groups in the area's 'Resources guide' (although there is acknowledgment of a lack of identification of faith groups) and holding a community awareness domestic abuse event with faith leaders which would be followed by a programme of engagement and awareness events. It does appear that some work was undertaken to complete these actions, for example the local 'Resources guide' does signpost to the Hourglass[23] charity whose mission is to 'end the harm, abuse and exploitation of older people in the UK' and whose website has a focussed section on domestic abuse and states that: "For older victims, family members rather than intimate partners are most often the perpetrators of domestic abuse". The action plan also states that the event for faith leaders was held in March 2020, however it is not clear what outcomes were achieved as a result of this event. Disappointingly the local Domestic Abuse Strategy covering this time period does not appear to have been updated and does not mention older people as victims of domestic abuse.

In DHR80, where a young woman was killed by her boyfriend, the review made a recommendation "That X Community Safety Partnership, in conjunction with all higher and Further Education providers undertake a targeted communication strategy to highlight the dynamics of domestic abuse, including coercion and control amongst the student population." – again, here the action plan is not published alongside the review so it is not clear what specific steps were planned or indeed taken in order to ensure that the 'targeted communication strategy' was undertaken and measured for efficacy. The family were involved though in this review and the Home Office feedback letter published alongside the review specifically highlights that "The family tribute is extremely welcome and paints a vivid picture of who she was as a person, her hopes, dreams, and passions".

Finally, within this broad theme, there were a number of recommendations that clearly evidenced the need for projects and work that raise the understanding and awareness of what to do if a loved one is being abused, how to report it and how to seek support.

In DHR44 it was recommended that "That the Safer [X] Partnership reviews the existing Domestic Abuse Communications Plan to raise awareness of domestic abuse in [local area]. Ensuring it is reaching all aspects of the community, including family, friends and work colleagues, on how they can respond and report concerns and options available to them, including civil orders and how they can request information to inform their safety planning."

"there were a number of recommendations that clearly evidenced the need for projects and work that raise the understanding and awareness of what to do if a loved one is being abused, how to report it and how to seek support."

23 www.wearehourglass.org/aA

In DHR98, where a British Asian woman was killed by her husband, it was recommended that the CSP "should review the effectiveness and if necessary, strengthen the information provided to family, friends, neighbours and diverse communities about recognising the signs of domestic abuse and where they can go, if necessary anonymously, with such information."

One DHR, from the South of the England, following feedback from the Home Office DHR Quality Assurance Panel[24], updated its recommendations and action plan to specifically reference the then newly formed Findaway project: "The CSP to consider the recently launched service, Findaway which supports family and friends when they are concerned about a loved one who is experiencing abuse." (DHR97).

Learning from and engagement with families

Recommendations here largely focussed around 'professionals' and services listening to families who often hold information that is not held by agencies – hearing and valuing their experiences, essentially listening to families' expertise on their loved one to improve responses.

DHR16, in a single agency recommendation, noted that "When engagement is difficult and there are failed contacts, then consideration should be given to a more active engagement including face to face with families or carers, especially when there is a risk of harm to self or others." However, the resultant panel recommendation here lacked robustness "(X Community Safety Partnership) should seek assurance from its partners that Professionals seek to triangulate information which may help them to inform a more holistic assessment of a patient/client which is inclusive of information available from family and partner agencies.".

> ***"It fails to recognise the status of information from families and only aims to 'seek assurance'"***

It fails to recognise the status of information from families and only aims to 'seek assurance'. Whilst the action plan is not publicly available, feedback from the Home Office to this CSP noted "The action plan is not SMART. The three panel recommendations are not tangible and merely request for the CSP to "seek assurances". The family of the victim (a case of patricide) was involved in this review, and it is one of the rare examples where it appears that learning from the family contribution has resulted in recommendations.

DHR10, reviewing a case of matricide, was explicit in recommending that the NHS Foundation Trust "review how and when they gather information from family and friends who are carers for patients who present with mental health problems. Family and friends will have known the patient longer and be more aware of subtle changes in their behaviour and may provide valuable additional information to assist the mental health professional's evaluation.". In this case, there was limited publication in terms of the report itself. The action plan was published, however was only populated with the recommendations themselves rather than any actions, outcomes, named leads or timescales. This makes it nearly impossible to know if and how this recommendation resulted in any meaningful change.

24 www.gov.uk/government/publications/terms-of-reference-domestic-homicide-review-quality-assurance-panel

The Home Office in their feedback letter had acknowledged that "The voice, concerns and perspectives of the family came through clearly and the issues they raised were thoroughly examined", it is therefore even more disappointing that the subsequent action plan was not fit for purpose and did not enable oversight over the recommendations made in the review.

Support for families/carers/wider communities

There were a number of recommendations around support for families and wider communities. In a 2018 review conducted in the South of England it was recommended that "The Board should promote guidance available to friends, family or colleagues of someone they suspect is in an abusive or unhealthy relationship on how they could help them in an informed, supportive and non-judgmental way to identify possible options and solutions." (DHR61). In the South West, a similar recommendation from DHR60 "to raise awareness of...services for family members and friends who are worried about their loved ones being in an abusive relationship. And to promote the availability of the 'family and friends' booklet".

And in the review of an Asian woman who was killed by her husband, the review recommended that the "CSP should review the effectiveness and if necessary, strengthen the information provided to family, friends, neighbours and diverse communities about recognising the signs of domestic abuse and where they can go, if necessary anonymously, with such information." (DHR98).

There were also a considerable number of recommendations specifically around support for families/carers with loved ones experiencing mental ill health, drug and alcohol misuse and complex needs, particularly focussed on families' input into care planning, hospital discharge and carers' assessments. These recommendations were often, but not exclusively, seen in those reviews of parricides and were closely linked to recommendations around adult child to parent abuse and familial abuse.

A local area, reviewing a case where a man was killed by his half-brother, recommended that "A range of information resources (leaflets, websites etc) on specialist voluntary and statutory services which includes sources of support for family members should be given to the family of those living with mental ill-health and substance misuse, and also made available in waiting areas" (DHR28). The action plan was not published in this case, so it is not clear how it might have addressed this recommendation. The Home Office feedback letter published alongside the review highlighted the impact of the contribution from the victim's friend which included a pen picture.

Recommendations around support for families and carers often sat alongside concerns highlighted, and recommendations made around risk and risk assessment.

"Recommendations around support for families and carers often sat alongside concerns highlighted, and recommendations made around risk and risk assessment."

Involving families in risk assessment

Closely linked to the theme above around support for families/carers, there emerged a theme focused on risk, risk assessment and involving families in planning around risk. There were, again, a significant number of recommendations on this theme.

In DHR74, in a case where an adult son killed his mother and was convicted of manslaughter with diminished responsibility, there were four specific recommendations relating to care planning and risk assessment:

- **"The Trust must ensure that families and carers are appropriately involved in care planning and risk assessment".**
- **"The Trust must ensure that risk to families is considered as part of risk assessment and management, with collateral information from family members".**
- **"The Trust must ensure that where risk to family members is reported, risk assessment must be updated, and victim safety planning becomes part of the risk management plan".**
- **"The Trust must incorporate the understanding of potential risk of harm to parents into risk assessment training, policy, and procedure".**

The action plan was published alongside the review. The plan is well populated. Many of the action points have been completed and where this is the case, evidence has been presented.

In another case, where an elderly husband killed his wife and was subsequently subject to a hospital order, the review recommended that "a review of hospital discharges procedures will be undertaken to ensure where appropriate, voices of the next of kin and carers are included in discharge planning giving consideration to complexity and/or safeguarding issues". (DHR76). The action plan is available within the published overview report, whilst it is well populated, the actions are not SMART[25] and it is unclear if/when progress will be made against the action. The lack of identified timelines for actions was also identified in the Home Office's feedback letter to the CSP.

Post-death recommendations

Whilst DHRs are primarily focussed on examining responses up until a death itself, a number of DHRs in the sample extended their scope to helpfully identify learning through a range of recommendations aimed at improving responses to bereaved families, friends and wider communities after a domestic abuse related death, including with the statutory review process itself. These recommendations broadly highlighted learning around: support for bereaved children, media reporting, family involvement in the DHR process, employer's involvement in the DHR process and the publication of the review.

In relation to bereaved children three reviews made very similar recommendations around support for children following their traumatic loss. DHR39, a case where a young man killed his Aunt and was subsequently convicted of manslaughter on the grounds of diminished responsibility, recommended that the local "Partnership should liaise with [local area] Children's Social Care...and satisfy itself that Child A and Child B (as well as their families) are in receipt of trauma informed support to cope with both the aftermath of the homicide and the publication of the DHR." Critically the panel also made an important recommendation in relation to the children which might support their understanding of this death as they grow: "After publication of this DHR, the Safer X Partnership should liaise with X and X Children's Social Care respectively and ensure that this report is attached to Child A and Child B's records. This is so that, if they wish to read the DHR when they are older, it will be available to them.".

25 en.wikipedia.org/wiki/SMART_criteria

Here, there is limited publication, and the action plan has not been included, therefore we are not able to see what actions were identified to address these important recommendations that go beyond the scope of the review in order to consider the needs of the children bereaved and impacted by this tragic case.

DHR40, a case of intimate partner murder and suicide, specifically highlighted concerns over media reporting of learning from the DHR recommending "The Safer [local area] Partnership to engage with media outlets locally and regionally in relation to the learning from this case to encourage the adoption of best practice in relation to the reporting of domestic homicides." This review did identify the guidelines[26] published by Level Up[27] (and produced in partnership with AAFDA) and Zero Tolerance[28].

The action plan identified four action points in relation to this recommendation, largely focussed on internal discussions to identify further actions. This DHR made five 'post death' ecommendations, three of which were in a national context around DHRs and DHR processes. However, where the three recommendations were national, they were attributed to the Home Office with no actions attached and no oversight or commitment that they would be progressed beyond the recommendation within the review itself.

Family involvement in reviews was highlighted in a number of recommendations. DHR40 critically identified the need for "The Home Office to consult with those affected by domestic homicide, in particular families, to hear their views on a standard for the publication and the sharing of learning from DHRs", again as this was a national recommendation for the Home Office, there were no actions attributed to this recommendation. However, since this review was published the Home Office have engaged with bereaved families through organisations like AAFDA to better understand their experiences of the DHR process.

In relation to reviews examining deaths by suspected suicide, DHR06 recommended that the "Home Office... develop and make available a leaflet about Domestic Homicide Reviews for friends and family of those deceased through suicide.". AAFDA subsequently (independently of this recommendation and based on feedback from families) published a leaflet specifically aimed at families bereaved by domestic abuse related suicide[29]. The Home Office also provided guidance to Chairs regarding support for families, which included those bereaved by domestic abuse related suicide[30].

The notification to families about the commissioning of a DHR led to a number of recommendations. In DHR102, a 2019 case of a woman who took her own life, the Partnership committed "to review how it informs, families of the deceased that a Domestic Homicide Review will take place. This will include protocols for homicides and unexpected deaths.". This recommendation came as a resultof a review where the family were not notified of the DHR until six months after the victim's death by suicide contrary to the requirements of the Home Office's Multi-agency Statutory Guidance for the conduct of Domestic Homicide Reviews[31].

"However, where the three recommendations were national, they were attributed to the Home Office with no actions attached and no oversight or commitment that they would be progressed"

26 Level Up (2019) Dignity for dead women: Media guidelines for reporting domestic violence deaths. Available at: www.welevelup.org/media-guidelines
27 Level Up is a feminist community campaigning for gender justice in the UK – more information available at: www.welevelup.org/
28 For more information, go to: www.zerotolerance.org.uk/work-journalists/29 Available here: aafda.org.uk/public/storage/Leaflets%20English/AAFDA_leaflet_A5_2023.pdf.
30 www.gov.uk/government/publications/guidance-for-domestic-homicide-review-chairs-on-support-for-families/guidance-for-domestic-homicide-review-chairs.support-for-families
31 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

The father in this case expressed anger that the review was taking place "as the family had just started to move on and come to terms with [the victim's] death. The process brought it all back.". The family subsequently took the decision not to contribute to the review.

There were also a number of recommendations relating to support for bereaved families living outside of England and Wales with DHR07 recommending that "The Home Office to review funding arrangements for the provision of specialist and expert advocacy for the families of victims who reside outside of the UK.". This was also highlighted in DHR107 with the firm recommendation that: "Families should be integral to DHRs and be treated as a key stakeholder. This is because their participation is likely to increase the quality of a DHR and out of respect for their loss. To facilitate this, families should have access to specialist and expert advocacy. The fact that a family resides outside of the UK should not be a barrier to accessing specialist and expert advocacy concerning the DHR process.". In this case the Chair also reflected that they had previously made the same recommendation in an earlier DHR. Despite these recommendations being made in relation to deaths in 2018 and 2019 respectively, there remains no specific funding or commissioned service provision for these bereaved families, despite them having to navigate the DHR process.

> ***"the family had just started to move on and come to terms with [the victim's] death. The process brought it all back."***

Employers were mentioned in a small number of reviews. This is an area that is often not considered or explored when reviews are gathering input from testimonial networks. Two reviews in the sample did make recommendations about the role of employers in the statutory review process. The first, in DHR40, was a national recommendation for the Home Office to "engage with the Corporate Alliance Against Domestic Violence and the Employers' Initiative on Domestic Abuse[32] to review existing guidance and support for employers in order to promote involvement in DHRs.". As with other national recommendations, there are no actions in relation to this recommendation, so it is not clear how, or if this recommendation will be progressed.

This recommendation was repeated by the same Chair in DHR107. In this case, where a British Pakistani woman was killed by her brother, the DHR Chair and panel attempted to contact an employer in order to collect more information to better understand the circumstances of this case. This, however, proved challenging and the review made a further, case specific recommendation around this and the review, undertaken by an experienced Chair, reflected that "there is a wider challenge relating to employer engagement in DHRs".

Finally, concerns and recommendations around publication emerged from a number of reviews in the sample. Two recommendations centred around support for children and families, DHR42 suggested the "Partnership...satisfy itself that Child A and B (and [the victim's] family) are offered support in relation to the publication of the DHR.", with DHR108, the case of a woman murdered by her husband, echoing that "Child A, B and C (as well as their kinship carers) are offered support in relation to the publication of the DHR.".

> ***"there remains no specific funding or commissioned service provision for these bereaved families, despite them having to navigate the DHR process."***

32 For more information, go to: www.eida.org.uk

DHR51, the case of a 76 year old woman killed by her elderly husband, raised concerns around publication in small communities, they asked that "The Home Office considers how to protect the anonymity of the DHR report for small rural communities.", they went on to observe that "Section eight of the Statutory Guidance (81) states: All overview reports and executive summaries should be published unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen. And the content of the overview report and executive summary must be suitably anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the Data Protection Act 1998. As explained in this report, it is challenging to anonymise a case in a small rural community, particularly when the story has been shared through the media. It would be impossible for a Domestic Homicide Report to remain anonymous as the story would be known to local people and would attract local interest.". No action plan was published alongside this report so it is not clear what the review felt was the best mechanism to better support anonymity or indeed what practical action they might like the Home Office to take.

As previously noted, DHR40, in one of the review recommendations, specifically called for "The Home Office to consult with those affected by domestic homicide, in particular families, to hear their views on a standard for the publication and the sharing of learning from DHRs.".

Findaway Project Family Reference Group Learning

What was clear from the outset of the session with the Findaway Project Family Reference Group, was that group members have had very different experiences of the DHR process. For some, it was a positive experience and, at the end, was a review that they were satisfied with. For others the experience has been exceptionally difficult, disappointing and has had (and is having) a significant impact on them and their wider families. One family member, whose daughter died by suicide, said "I think DHRs are appalling, I am part of a peer group and I don't think I'm a minority, I think I am more the majority who are disappointed with them" (Family Member 5), whilst another said "It's hugely disappointing that the calibre of DHRs hasn't been as good as the experience that we've had" (Family Member 4).

Whilst their experiences have been varied, some common themes emerged from their discussion of the report findings and from their own experiences of being a part of the DHR process.

> "It's hugely disappointing that the calibre of DHRs hasn't been as good as the experience that we've had"
>
> Family Member 4

Reflections on DHR Chairs

Family members in the Findaway Project Family Reference Group reported a range of experiences with the DHR process, for some it had been positive, however for others it has been and continues to be a negative experience. The one point that family members unanimously agreed on, was that "it's the Chair, you need a good Chair" (Family Member 1). One family have experienced the DHR process twice. The original DHR has now been superseded by a re-commissioned review. The family's first DHR was an extremely negative experience for them – the family did not perceive the Chair as independent, they did not feel listened to, they felt that whilst they could not say that agencies had lied, their sense was "that they weren't telling the truth" (Family Member 1). However, the second review (that is in progress) has been a far more positive experience.

The Chair communicates with them regularly (which they feel is of critical importance), the Chair seeks information from them, asks for their support to connect them to other potential testimonial networks, and overall has made the family feel a part of the review. They therefore feel more confident that the review will tell their loved one's story and lead to change.

Many also felt that capturing the voice of the victim depends on the quality of the Chair, with one family saying that they "need to be skilled in asking the right questions because they can spark memories and conversations", that "the family need to be given the opportunity to speak but without someone skilled at asking the right questions, they might not know where to start or what to say, it's got to be a two way process but it's got to be facilitated by a skilled, a very skilled, person, skilled in questioning and bringing out things in people and making them feel comfortable enough to say what they want to say" (Family Member 4).

One family asked in the session who regulates Chairs and quality assures their performance. They were concerned that there is no regulation, no quality assurance, no quality standard and no performance framework for DHR Chairs who are undertaking this critical and sensitive work. They were also concerned at the lack of consistency in the informal and formal mechanisms used by CSPs to recruit Chairs and felt that this may be contributing to the inconsistent quality of Chairs.

Reflections on DHR panels

> ***"one of my disappointments... is that nobody represented my daughter...nobody actually understood how to put the voice of that person in"***
>
> **Family Member 5**

Many of the families in the group session also had concerns about DHR panels and their composition. Family Member 5 said "one of my disappointments...is that nobody represented my daughter...nobody actually understood how to put the voice of that person in, they say they hear the voice of that person but I am a strong believer that they should have somebody independent on that panel to represent the person themselves", someone who "can understand the pain of that abuse, the psychological impact of that abuse". The family member suggested that this might be a survivor, a family member or a psychologist that is independent of the agencies involved.

This family member also felt concerned that panel members are required to be sufficiently senior, whilst they understood why distance was required between practitioners who might have worked with or been in contact with the victim, they felt that this offered too much distance and an over reliance on documentation rather than the experiences of the practitioner. They felt that individuals that had worked directly with the victim might have more insight to bring to the panel that might not always come through the Individual Management Review process.

A family member also expressed that "there has to be a lot of trust around the table (DHR panel)" and asked "how can you challenge if you don't know what has been done wrong?" (Family Member 4). Another family member had concerns over the authority of the DHR panel to request information from non-statutory organisations, citing specifically an employer who had not responded to the Chair's attempts to seek information. In their loved one's DHR, it was only when an ex-colleague of their sister had seen a documentary about the case that they were contacted on Facebook and the family member was able to connect the colleague with the Chair. They said "you're not getting the true picture if you are not able to speak to everybody that was involved in that person's death or had involvement with them" (Family Member 6) – this highlights the importance of reaching out to wider testimonial networks and how panels need to look beyond families to draw in as much information as possible.

Families also recounted different experiences of meeting the panel, again some of which were very negative and others that were largely positive. One family described meeting the panel for the first time early in the DHR process, she said she sensed some unease from panel members in meeting the family and so felt the need to reassure them and was clear with them about her hopes and expectations and told them "We just need everybody to be on the same page. There's been mistakes made by everybody and if we all put out heads together, I'm sure we can come up with something that will help everybody" (Family Member 2). She then felt that they engaged, many came to speak with the family in the meeting breaks and "the Chair made sure that they (the panel members) were there for us".

Another family, however, had a very different and very upsetting experience - "it was like the biggest interview of my life, I was sat in front of a panel of eight people, all sat in front of me on this big table and I was sat there and I had 45 minutes to say what I wanted to say to that panel and that was it". This family member felt unheard throughout the review process and did not feel that their daughter had a voice. It is clear that there does not appear to be any real consistency across practice, and this inconsistency means that families are having vastly different experiences of the same process.

> *"It was like the biggest interview of my life"*
>
> Family Member 5

Family engagement and the hierarchy of testimony

Families highlighted good communication as being key to their engagement in the review process. They expressed the importance of being regularly updated, even if there was little or no update to give. One family member said "no communication is just terrible, we're just thinking you're not doing anything " (Family Member 6), Family Member 5 agreed and said "it's horrible not knowing what is going on...you are just sat there waiting for that information, not knowing is worse than knowing sometimes", they felt that early in the process "it's the Chair's duty to find out what level (of update, information etc) families want". Families also stressed that when they felt that they were working with the Chair and panel "we feel like we've been involved in this DHR" (Family Member 6).

Families also discussed the hierarchy of testimony: the importance of family input holding the same weight as that of professionals and the principle of victims and their families being central to DHRs, one said "that was the purpose of it, you know and that seems to have been watered down constantly and its hugely disappointing." (Family Member 4).

Status was highlighted as being important too - one family had felt very dismissed when a meeting that was due to take place the following day (for which access and childcare arrangements had been made by a number of family members to attend) had been cancelled late in the evening with no explanation or indeed opportunity to speak with anyone about the cancellation. They felt that this showed a lack of respect and empathy for them and the impact the cancellation might have which is not in the spirit of families being key stakeholders in the review process.

> *"no communication is just terrible, we're just thinking you're not doing anything"*
>
> Family Member 6

The importance of independent advocacy

A theme of independent advocacy was highlighted throughout the Findaway Project Family Reference Group session by nearly all of the family members present. One family member said "the report only went well for us because of X (advocate's name), it's something everyone should have the opportunity to have" (Family Member 2). Others agreed, Family Member 1 said "Families need expert advice and they need funding for that". A number of family members expressed the importance of this advocacy at the stage of the process when they are presented with the draft review. One family member, when talking about reviewing the draft report, said that families needed "the right to reply with proper advocacy" (Family Member 3), particularly to address inaccuracies or points of contention. The group also discussed the idea of families having the opportunity to contribute something akin to a victim impact statement to share their thoughts on the review and the impact of their loss on them and their family which would also allow them to highlight anything in the report that they disagreed with or was contentious, particularly if their requests for changes had not been made, as in the case of Family Member 5 who had submitted 16 pages of comments and corrections that were not taken into account, considered or acknowledged in the final report.

The voices of children

One family in particular highlighted the plight of children, not only in the DHR process but in the lack of support in place for them after their traumatic bereavement. Family Member 1 described how they "had to get specialist experts in and we had to pay money, thousands of pounds to get that and there was absolutely no funding available at all from anywhere". The family were told "children tend to tell lies and they don't know what the truth is and that came out a few times. Children don't always tell lies" (Family Member 1). When their grandchild was at a point, after considerable specialist support, to share their experiences the Police and the Coroner's Court would not believe her because "children tell lies". This child was silenced in both the investigation and statutory review processes and was not seen as an important source of information and learning about their experiences and the experiences of their mother. Having been through such trauma, to then not believe children when they have shared their experiences is to potentially further traumatise them and to encourage silence.

> *"Families need expert advice and they need funding for that"*
>
> Family Member 1

Media reporting

Families expressed the devastating impact of media reporting on them, with Family Member 5 saying "the media have such a strong impact on how they can portray how things have been going that I think families need more control and say in that and are protected more in that", they described at times being "hounded by the media". Another family member said "There was stuff going out into the media...that we hadn't approved, we hadn't seen. There were photographs, where the devil they got them from, we don't know", they added "social media has overtaken red tape, people aren't afraid to put it out there" and Family Member 1 responded by saying "and once it's on the internet, it's there forever". Family Member 5 provided the press with a statement following the inquest into their daughter's death, they felt that "it was very important that I had my say and not just what the reporters said and to keep her dignity, because you know they weren't very good in life at keeping her dignity and they certainly didn't keep it in death for her". Despite previous work being done around media reporting guidance in cases of domestic homicide, this appears to still be an issue that continues and brings distress to families who are already managing traumatic grief and navigating statutory review processes.

DHR Recommendations, action plans and scrutiny

Families in the reference group felt that there should be a statutory requirement for updates to be given on recommendations and actions (with evidenced outcomes) from DHRs and that this should also be part of a feedback mechanism to the families involved in the review. Indeed, this accountability might increase the likelihood of recommendations being implemented.

They felt that where there were recommendations there is a lack of visibility of how this translates into actions and if actions were identified, if they have been completed and what outcomes have been achieved. Family Member 3 said "given that DHRs are supposed to be about learning lessons and not about apportioning blame, how can we ever get that result if they (the actions) are not followed through?", another said "how do we know it's implemented (the action plan)" (Family Member 6) and "how do we know in a year's time that it has been implemented, that it's being done? Should a DHR be done and then reviewed in six, 12 months' time to see where agencies have implemented what has been recommended with the failings that have been found and who's responsible to follow them up?" (Family Member 6).

One family member said that it was another member of the family that had chased the CSP for updates but "it shouldn't have to be a family member reviewing that (the status of the actions), it's so disappointing that there is no review process on the recommendations" (Family Member 3). One family shared their scepticism around recommendations and action plans "when they put recommendations and they use the word 'ongoing', 'ongoing' means 'we are never going to do that'" (Family Member 5). Another was concerned that there appears to be a lack of oversight of recommendations saying "how are we going to improve or move forward unless we have that level of scrutiny?" (Family Member 4), although they were heartened by the Domestic Abuse Commissioner's oversight role and hoped that this would bring progress and improve practice.

There is also a clear disconnect (highlighted also through the analysis of DHRs in this report) between what families are saying and reporting into reviews and how their testimony is being translated into recommendations and real action. One family said "although we felt heard and we could see our voices and hear our voices and hear our sister's and nephew's voices in the review, who's checking all those things now?".

> *"given that DHRs are supposed to be about learning lessons and not about apportioning blame, how can we ever get that result if they (the actions) are not followed through?"*
>
> Family Member 3

> *"it shouldn't have to be a family member reviewing that (the status of the actions), it's so disappointing that there is no review process"*
>
> Family Member 3

Timescales

Converse to the view of DHR Chairs (see below), families in the group expressed concerns at the length of time reviews can take. Family Member 5 said "the whole process takes too long, far too long for families because you can't move on, you can't get to the inquest, you can't get anywhere until that DHR is done. It documents, it says in the legal things, it takes about six months, well you know anyone that gets it done in six months is such a miracle because ours was three and a half years/four years and it should have gone on longer, it's only because I closed it to go to the inquest but that period of time is too long for families, too long...it is an unacceptable time frame for families and it has to stop".

> *"the whole process takes too long, far too long for families because you can't move on, you can't get to the inquest, you can't get anywhere until that DHR is done"*
>
> Family Member 5

They went on to clarify that it was not the Quality Assurance process which they understood and accepted takes time (there are considerable delays in this process, discussed further by Chairs below), "it's the actual point from starting for the family member, once it goes off to panel (the Quality Assurance panel) we've accepted it and seen that, it's because that first bit is taking three and a half/-four years....that's the bit, I don't care how long it takes after that, but it's that first bit to get it to families to see, that's the important bit". Whilst DHR Chairs, panel members and Community Safety Partnerships cannot control the length of the Quality Assurance process, they can control the time taken to conduct the review itself and families are highlighting that this part of the process is too slow and is negatively impacting on their experience of the DHR process and what it means for their lives.

Some felt that one of the issues was "Chairs take on too many cases and they have them all juggling up in the air but they don't commit to finish one...again there is nobody to check that, so often their DHR (Chairs) have a job themselves and they have maybe four or five DHRs on the go so actually everybody gets such a long time but again there is no scrutiny of them is there?" (Family Member 5). Family Member 1 agreed "she's (the DHR Chair) a lovely lady, she is a doing a really good job but it's taking too long because she's got other commitments and I think really if you are going to take a DHR on and do it properly, um, I think maybe one or two at a time but no more than that because it does, it just drags on and on and on and that doesn't do anybody any good".

> *"she's (the DHR Chair) a lovely lady, she is a doing a really good job but it's taking too long because she's got other commitments"*
>
> Family Member 1

This feedback from families creates a real challenge for CSPs commissioning Chairs and the whole process. Firstly, there do not appear to be enough quality Chairs and in order to be timely in their commissioning, CSPs are recruiting Chairs that are working on multiple reviews at one time. Secondly, Chairs often have to take on other work and other reviews to sustain their own businesses in order to continue to be available to Chair reviews. It is clear though that families are feeling the impact of these tensions.

Whilst the families in the reference group highlighted some of the very real concerns they hold and of the process, some did express "how important DHRs are at getting into the nitty gritty of things, which in the early days probably didn't happen but I think it's getting better" (Family Member 1). Despite some negative experiences they do appear to largely see the value of reviews and their experiences can not only enhance reviews that they are engaged in but also the DHR process and mechanism more widely. However, what is clear from the following section is that there appears to be a disconnect between what professionals and DHRs Chairs think they are doing well and families' experiences of the process.

> *"there appears to be a disconnect between what professionals and DHRs Chairs think they are doing well and families' experiences of the process"*

Learning from the DHR Network Focus Group and Survey Responses

Overwhelmingly what was clear, from both the group of Chairs/CSP representatives that contributed to the focus group and those that responded to the survey, is that Chairs want and aspire to meaningfully engage with families, friends and wider testimonial networks[33]. Some, though, felt that, at times, they are hampered by DHR panel members who are resistant and CSPs who are concerned about the additional time that might be required for such engagement.

Best practice and challenges in engaging with families and friends

In both the focus group and survey responses, Chairs reflected on best practice in engaging with families, friends, employers and wider testimonial networks. Many, whilst not in specific terms, outlined much of the practice outlined in AAFDA's 7 step model[34] in working with families, most notably in ensuring that families are able to contribute to the DHR in the way that best suits them, are regularly updated and have the opportunity to help to create change after the review (addressed later in discussions around recommendations and action plans). Interestingly, families in the reference group also highlighted these key elements. Chairs spoke of the importance of building trust with families and managing expectations and that this was best achieved when early initial contact was made. Many Chairs highlighted that good relationships with families (that subsequently supported engagement throughout the review) require time, effort and ultimately resource to build. One Chair noted that "meaningful engagement with a family can lead into days not just the odd hour here and there or for an update. Meaningful engagement, I think, we are talking about days rather than hours". (DHR Chair 14).

33 It is worth noting however that this group of Chairs and CSP representatives are members of the AAFDA DHR Network, so are engaged in professional development and best practice reviewing. Their views might not be wholly representative of ALL practicing Chairs.
34 More information on AAFDA's 7 step model in working with families through the DHR process is available at: aafda.org.uk/help-for-families.

DHR Chair 13 also highlighted the importance of accessing other support for families (for example Family Liaison Officers and advocacy services) for "emotional support and supporting us (Chairs) with engagement so that the family have trust in us as a Chair and as an independent Chair", better enabling Chairs to maximise the time they have available for the review without neglecting family involvement, they noted "we shouldn't be, sort of, putting it (family engagement) to the end of the queue in that other engagement is more important than engagement with the family".

Aside from the challenge of Chairs having adequate time to meaningfully engage with families and wider testimonial networks one Chair (DHR Chair 14) described 'push back' from DHR panel members who "don't necessarily like the proactive family members who want to come to the party with some of their own information", they went on to say "Certain panel agencies (mostly statutory organisations) really do not like it and push against it based on their own bias and hierarchical attitude. They criticise chairs and argue against meaningful engagement. This is particularly apparent with closed agencies that do not feel that they should be held accountable to or by a family"– this is further explored in the discussion below around the 'value' of family testimony and agency 'professional' testimony. Other challenges around family engagement specifically highlighted by Chairs and CSP representatives included understanding and responding to family and cultural dynamics and consideration of the involvement of the perpetrator and their family in reviews. CSP Representative 1 was clear that a DHR should not "discount one set of voices because the other shouts loudest, that we give a fair representation of everybody's thoughts".

Engaging with wider testimonial networks

Engagement with wider testimonial networks (for example employers, faith and community groups) appears to feel more challenging than engaging with families for DHR Chairs. It is clear from the discussions and survey responses that Chairs are keen to "cast the net out as widely as possible" (DHR Chair 6), "scope far and wide" (DHR Chair 5) and look "for the stuff that is unknown and unknowable to the agencies involved" (DHR Chair 7) but DHR Chair 1 acknowledged that "the challenge is finding out who these people are and how to contact them"particularly when the family choose not to engage with the review (the Chair also made particular reference here to DHRs examining deaths by suicide). Another said "it can be incredably (sic) difficult to find and make these links with wider examples of information" (DHR Chair 10) and DHR Chair 6 said the challenge was in "identifying the different elements and individuals in the testimonial network". DHR Chair 3 highlighted the need for assessment when engaging wider networks to understand "what value will be added by their information/context v the potential harm of sharing sensitive information or adding further trauma to those affected by the death", DHR Chair 4 seemed to have experienced a similar challenge saying "Accessing wider testimonial networks is mostly hindered by an attitude of 'what can we learn' and 'what difference will it make to professional learning'?" However, DHR Chair 13 seemed to have a different perspective "you never speak to somebody who doesn't add some value to that understanding, if we hadn't reached out that far, that would be missed". However, DHR Chair 9 raised an important consideration when considering faith/community groups specifically noting "Engaging with some faith/community groups can take a very long time, in terms of managing trust, building relationships and this can prove challenging if there aren't already established networks and pathways in a district or borough. There is an example of this in one of our reviews that was altered to a learning review from a DHR but in which the community groups representatives didn't want the CSP or the Chair or others to raise the matter of the review as they were afraid of the review raising concerns of domestic abuse in the community, and what impact this might have on community tensions, and this highlighted how much work needed to be done to develop this trust and this was a much wider piece of work than could be done within the review timescale but was part of the action plan as a result." – this example demonstrates that engaging with wider testimonial networks can bring complexity and requires sensitivity, expertise and time.

Another Chair highlighted the challenge of seeking contributions and information from wider testimonial networks when there is "no statutory requirement to engage with the process" (DHR Chair 1), a concern also raised by families. A number of Chairs in the survey responses discussed the role of employers and their potential contribution to reviews. There appeared to be challenges that some had navigated successfully, and others had struggled with. One (DHR Chair 3) had "approached employers (especially when there are very few agency safeguarding contacts etc.). These had been useful, but it is a legal minefield about how/what to disclose and to ensure support for those approached.", one noted "in my experience especially with delays from murder to making contact, changes of roles or individuals can mean this brings a reduced output" (DHR Chair 10).

DHR Chair 1 however "had incidents when an employer did not want to engage with the process, but with gently diplomacy they shared some information (this required specific questions which were answered by their legal team) but it provided excellent insight into the pressures and lack of support available."

Another challenge that was clear through the survey responses and in the focus group discussion was the time that is required of a DHR Chair in casting that 'wide net'. There appeared to be variances in CSP's attitudes and approach/willingness to Chairs spending time (allocated to completing the review) reaching out to wider testimonial networks.

DHR Chair 3 noted "As use of the wider community network has expanded (more recently due to large number of suicide cases - many with much less pre mortem agency involvement), this requires significant additional work. The Independent Chair does not have a team of assistants and so it is the Chair...who needs to make the approach, travel, spend time with the contacts and write up the report. This can all be positive and is a very useful way of adding further information and context to a review but it takes time and therefore money.", they went on to note that "CSPs are already struggling to finance DHR Chairs and this simply adds to the number of days required to complete the review.".

> ***"CSPs are already struggling to finance DHR Chairs and this simply adds to the number of days required to complete the review"***
>
> DHR Chair 3

This tension between wanting to seek out testimony from wider networks and time/resource constraints was shared by a number of Chairs, DHR Chair 17 raised their concerns that "DHR Chairs are not being resourced, because CSPs are not being resourced so therefore are either having to limit what they do or end up doing things for free in their own time". It was clear that many of the DHR Chairs and indeed CSP representatives that contributed to this report want to deliver high quality reviews that draw upon a range of sources for learning but feel constrained and somewhat compromised in achieving that aim.

One CSP representative (CSP representative 1), a commissioner of DHRs and DHR Chairs, acknowledged that budgets are indeed finite (made more difficult by the current funding mechanism for DHRs where the financial responsibility and burden sits entirely with individual CSPs and is not supported by central government despite DHRs being a statutory requirement) and whilst they had not known this to be the case in their area (that a Chair was instructed to limit time and resource spent on family/wider testimonial engagement), they noted "we have to work within a budget and I do see that the potential for that to limit some CSPs, it's a real challenge the restrictions the finances play.".

The importance of the contribution from families and friends

The majority of Chairs and CSP representatives that contributed to this report were clear that meaningful engagement and contribution from family, friends and wider networks were of huge value to a review and to the learning that can arise from that review, with one Chair noting that this is "the only avenue that the voice of the victim can come through" (DHR Chair 11). DHR Chair 13 felt that DHRs can be "two dimensional" and recognised that information from agencies is important but that families can contextualise that information adding that family knowledge is "nuanced" and "really, really important". Others agreed that families and wider testimonial networks bring context of their loved one's engagement with services and DHR Chair 1 noted that families are "able to give the DHR a different lens and give invaluable vision into the circumstances and impact".

> *"families are "able to give the DHR a different lens and give invaluable vision into the circumstances and impact"*
>
> DHR Chair 1

Many Chairs referenced the importance of information from family members who "have been able to share incidents which were never reports to any agency and they provided insight into how the victim/perpetrator and the wider family/community responded" (DHR Chair 1), DHR Chair 4 felt that family input "is so important when mapping professional intervention/contact against significant life events." and that "Their knowledge often changes the narrative of attributing current events to a soundbite that is recorded in records as 'history of mental health', for example". They added that this knowledge "often provides a context as to why some people find it more difficult to engage or behave the way they do". The same Chair highlighted the importance and value of families sharing" personal diaries, letters, phone records, personal messages, bank statements and all kinds of documentation unavailable to professional agencies. They add such a rich information to the DHR if given the chance through meaningful engagement".

Chairs acknowledged that reviews without family or wider testimonial input "can leave a review devoid of a sense of person" (DHR Chair 9). DHR Chair 4 went as far as to say that "Without their voice, the review risks being dominated by professional perceptions" and can mean that reviews are a largely "paperwork exercise". Other Chairs echoed this idea of family engagement bringing humanity to a review, DHR Chair 8 said "The family can bring a picture of the deceased as a full person", DHR Chair 9 agreed noting family engagement in reviews brings "the 'real' person" and enables a Chair and panel "to gain a view into their world and life beyond that of them as a victim, as a person with a life. To know what they enjoyed, what was important to them, beyond the confines of the life and impact of their experiences as a victim. To know what they were like as a son, daughter, or brother, sister, friend etc.

> *have a heart as well as facts*
>
> DHR Chair 10

DHR Chair 10 felt that families bring reports "to life" ensuring reviews "have a heart as well as facts" adding "I have seen family inputs enable a lift of defensive or unconscious bias in agency responses/ discussions". DHR Chair 4 also added a point that was important to them in their practice, that "Families also uphold the principal of transparency – the greater their involvement, the more likely it is that Chairs will be held to account for conducting thorough and honest reviews".

(No) Hierarchy of testimony

Both focus group participants and survey responses reflected upon the 'hierarchy of testimony' and, to an extent, the idea of status when considering family contributions to DHRs. One Chair acknowledged that "Family and friends may not feel that their voice and the voice of the victim is heard enough, depending on what interaction they have had prior to and after the death" (DHR Chair 2), they appeared to want to redress this and to reassure families that their input is important and valued within the review process.

Chairs in the focus group were clear that the experiences and expertise of family members must hold the same weight as the input from agencies and recognised that "there needs to be balance but the panel can be too heavily focussed on statutory agency/vol agency involvement" (DHR Chair 9), there was an acknowledgement that without the input of family, friends and wider networks, the "full picture" (DHR Chair 2) cannot emerge. One Chair, when talking about their role and the role of Chair colleagues said "We need to be really careful of how we value the input of family and not seeing it as something lesser than the input from statutory partners for example, or specialist agencies" (DHR Chair 13), this was supported by a survey respondent who said "There should be NO hierarchy of testimony. The testimony of friends and family MUST be given the same weight, value and worth as professional testimony" (DHR Chair 4). DHR Chair 14 felt that the "principle of epistemic justice where we actually place the same value, weight and credibility on family member testimony as that of professionals" is "really important".

What felt unclear however was if this view, that appeared to be held by most of the Chairs in the focus group and that submitted survey responses, was supported by others in the DHR process, for example DHR panel members, one Chair reported "I have also been told, "You can listen, but we should apply our own professional knowledge to their account and refer back to IMRs.". This is particularly important if the testimony...does not correspond with the 'person' they identify with in statutory records" (DHR Chair 4). This example demonstrates that whilst Chairs in our group feel strongly that family and wider network testimonies are of equal value to any other testimony, this might not be the case more widely amongst other professionals and panel members and this can create some tension and ultimately impact on the review itself and a family's experience of the review process.

> ***"I have also been told, "You can listen, but we should apply our own professional knowledge to their account"***
>
> **DHR Chair 4**

Hearing the voices of children

There were some opposing views expressed in the focus group around the involvement of children in DHRs. It was widely accepted that decisions on inviting children to participate should be considered on a case-by-case basis and take into account the age of the child(ren). One Chair felt that "you have got to try to balance the value we might get out of their input against the damage we might do to already quite traumatised children" (DHR Chair 18), they felt that there might be an opportunity instead to access summaries from police or other interviews with children in order to get a sense of their experiences. Others however, disagreed. DHR Chair 12 said in response "There is a slight counter narrative...that obviously them not having a voice could equally be damaging".

Another DHR Chair who has also experienced domestic homicide as a child (their father was killed by their mother) added "you will never traumatise a child by asking them what happened, what we can learn from this, because I was silenced as a child, nobody spoke to me and it actually made life really, really difficult for me", they went on to say "don't ever think you should ignore a child because you can learn so much from every single DHR that you do where children are involved if you speak to them" and continued "if we are going to save lives and do our DHRs properly, we need to start talking to children". Chairs were also looking to the future, one highlighted that "children are not children forever and we need to think about the adult that might read this review in the future" (DHR Chair 14) and another said "to read a document (as an adult) that is cleansed of their presence or experience is a disservice to them and what they have suffered and endured" (DHR Chair 4).

> *"if we are going to save lives and do our DHRs properly, we need to start talking to children"*

> *"to read a document (as an adult) that is cleansed of their presence or experience is a disservice to them and what they have suffered and endured"*
>
> DHR Chair 4

DHR Chairs all agreed though that in order to engage with children in reviews a robust and holistic support package needed to be in place in order to make that engagement as safe and trauma informed as possible. DHR Chair 12 summarised their approach: "My key points are we have to, we have to take every case on its merits, we have to take assessment from the professionals within this, we have to make sure that there are support services available and lined up...but we have to work on the basis that the child's voice is just as important on this, you know children are victims of domestic abuse as defined by the 2021 Act (Domestic Abuse Act) and we have to make sure that where they want to have their voice, where they want to part of this, this is not denied from them" and whilst this was the view of many of the group, they also raised the reality they face; that meaningful, safe engagement with children requires a package of support and that getting that in place is often out of their hands and sphere of influence and often takes more time than DHR timelines allow.

DHR Chairs also shared many of the other very real challenges that they face when attempting to engage children in reviews. The issue that came up again and again in the survey responses, was that of access. Often, where Chairs have tried to invite children into reviews they have not been able to secure consent from the child's parent/carer/guardian – actual access to the children has been a significant barrier. Another clear theme (highlighted above in the focus group discussion) was concerns over re-traumatising children who families and professionals might feel "have already suffered enough" (DHR Chair 3) and are "too vulnerable to participate" (DHR Chair 8). One Chair relayed their experience in a recent review "The fear of re-traumatising children and protecting them and their identity is the greatest hurdle to child engagement. Most professional agencies want all information relating to children to be removed, leaving a sanitised or redacted version of events in a report that they cannot relate to as adults. I often find that some professionals talk on behalf of the child victims and what they think the child wants and needs, but when you speak to the child/ren, they can often have very different views and want their voice(s) heard. We recently met with a young person (12) who adamantly protested to be consulted in the DHR because he was not given the chance during the trial or criminal investigation. He was never interviewed, yet when we met him, he had such powerful memories and contextual information to add, and he felt so empowered and heard when his words were eventually added to the report. We should not assume that seemingly well-meaning professional perceptions are what the child wants and needs." (DHR Chair 4).

Some good practice was identified and highlighted by the focus group and in the survey responses such as using specialist child advocates to work with children, engaging an adult who already has a positive and trusting relationship with the child (for example a social worker or a teacher), meeting children where they are and where is comfortable for them and giving them the opportunity to contribute in the way that best suits them.

Chairs also considered how they might include the 'voice of the child' and gather learning about their experiences even where they were unable to speak or engage directly with the children themselves. One Chair highlighted how they draw on other work that has been done to bring children's voices into reviews, for example life story and therapeutic work, another wanted to "share the value of having children's schools safeguarding leads as panel members for DHRs. A recent review I chaired involved three children in the family who all attended different schools. We were able to identify some opportunities to improve safeguarding in local schools and development for education professionals. We also were able to hear the impact on the children from a social and educational perspective, and the relationships the schools had with the victim, perpetrator and family" (DHR Chair 7).

A number of Chairs felt that clear, best practice guidance from the Home Office would better support Chairs and panel members to give children a voice in DHRs and one Chair, again looking to the future, recommends routinely in their DHRs that a copy of the published review is attached to a child's social work file, offering them the opportunity to access the DHR in the future should they wish.

> *"he had such powerful memories and contextual information to add"*
>
> DHR Chair 4

> *"A number of Chairs felt that clear, best practice guidance from the Home Office would better support Chairs and panel members to give children a voice in DHRs"*

Timescales

Paragraph 46 of the Home Office Statutory Guidance for the Conduct of DHRs states that "The overview report should be completed within a further six months of the date of the decision to proceed unless the review panel formally agrees an alternative timescale with the CSP. It is acknowedged that some DHRs will necessarily go beyond this further six-month timescale due to the complex scope of the DHR and/or due to on-going criminal justice proceedings". This timescale presents significant challenges for all stakeholders in the DHR process, with very few reviews being completed within this timeframe – a point highlighted by families in the reference group. The focus group participants and survey respondents offered a range of reasons why we might see (significant) delays in the process that takes the review process well beyond six months. Notably they highlighted: criminal proceedings, challenges for CSPs in recruiting Chairs, delays in Individual Management Reviews being submitted by agencies, additional information being required as a result of IMRs, family information or panel meetings, the quality of Chairs, the complexity of some reviews, delays caused by parallel processes, difficulty in engaging family members, CSP sign off and the Home Office Quality Assurance process.

Despite these acknowledged delays, many of the Chairs that contributed to this report did not feel that this was a significant issue for families – a view directly contradicted by the views expressed by families in the reference group. One said "My experience is that families are NEVER concerned about the timeliness of the reports if they are involved and know precisely what is happening and when. They are only concerned when they are kept out on a limb. Families always say they would rather have a thorough, accurate report than a rushed tick-box exercise.", and DHR Chair 5 appears to agree saying "I don't agree families generally dislike the length Reviews can take, my experience is that they much prefer a proper job than a rushed job".

DHR Chair 8 however strongly disagreed and was concerned about the impact of significant delays in the process on families "The long delays are very detrimental to families. DHRs take time for the report to be produced which means contacting the family a while after the death. Then they need to read the report and then the Home Office can take 9 months or more to QA the report so the family then need to be contacted again sometimes a year after the report is completed to tell them it is to be published - again causing upset and re-opening wounds and sadness.". Regardless of their views on the impact on delays for families, there was a real sense that the Quality Assurance process was in need of reform in order to better support timely reports and indeed the entire DHR process and those working within it.

Recommendations and action plans

Families often do not see how (and when) action plans (that are borne of report recommendations) are implemented and the subsequent change as a result of the review into the death of their loved one – this was a point of significant discussion in the Findaway Project Family Reference Group. We asked Chairs and CSP representatives what the best mechanism might be to feedback progress on action plans to families that is both realistic and achievable for CSPs. The was broad agreement that CSPs should be re-engaging with families six months after publication with updates on the progress of actions within the plan and indeed should be updating all contributors to the review on progress made. However, despite this being felt to be best practice, one Chair acknowledged that "this aspect of DHRs is crucially lacking systemically" (DHR Chair 4) and CSP representatives highlight the challenge of capacity to achieve this (particularly in areas with a high number of reviews). Another Chair highlighted that this should and would be part of the Domestic Abuse Commissioner's DHR oversight mechanism and that some pilot work[35] is imminent to better track action plans that come from DHR recommendations.

35 More information on this pilot will be available at domesticabusecommissioner.uk

Reflections

The 123 reviews analysed here, alongside the reflections and views of the families and DHR network members, offered significant learning that better helps us to understand the role of families in reviews and how the learning from them can be better heard and harnessed to develop recommendations. This learning can also directly support the future design and delivery of the Findaway project. The themes identified in this report speak to the specialisms amongst the partners involved and will enable the development of practice, training, influencing and the future strategy of Findaway.

Beyond this learning, there are four key observations.

Firstly, this report has highlighted that despite families contributing to reviews and sharing their own experiences and aspirations for others like them, their contributions are not being developed by panels into robust recommendations that might support families in the future who are grappling with supporting a loved one who is being abused. This minimises their expertise and ultimately narrows our learning, it speaks to a hierarchy of testimony where the information from agencies holds more weight than the voices and knowledge of families. It demonstrates the significance and urgency of bridging the gap between these families' experiences and the translation of their insights into meaningful recommendations.

> ***"This minimises their expertise and ultimately narrows our learning, it speaks to a hierarchy of testimony where the information from agencies holds more weight than the voice and knowledge of families."***

Secondly, the views of families gathered through the Findaway Project Family Reference Group and the DHR Network (through the Focus Group and survey responses), highlight an apparent disconnect between what professionals and DHRs Chairs think they are doing well and families' real experiences of the process. Reflection is needed to bridge that gap and mediate between the two perspectives.

Thirdly, it is clear from this project that where there are recommendations in reviews that are a result of family contributions, there is a lack of visibility of how this then translates into actions and indeed if identified actions are completed and what outcomes are achieved. The Statutory Guidance for the Conduct of Domestic Homicide Reviews is clear that "Completing the action plan and publishing the DHR is only the beginning of the process. To derive value from the DHR process and prevent further abuse and homicide, CSPs should satisfy themselves that there are appropriate governance mechanisms in place for monitoring delivery against DHR action plans." Without sight of this governance, it remains challenging to see that DHR action plans are being delivered.

Finally, the report demonstrates that the Findaway project is needed beyond its current geographical remit. Families around the country are struggling to navigate the best way to support someone they know who is suffering abuse and would benefit from a service that could support, guide and signpost them. This, in turn, would better support services to improve their responses to victim survivors being subjected to abuse.

Recommendations

The following recommendations are a result of the findings from the 123 Domestic Homicide Reviews analysed, the family focus group session and the DHR Chair/CSP representative survey responses and focus group session. The Findaway Project Family Reference Group were consulted on the final recommendations below.

1. Domestic Homicide Review Chairs and panel members must hear the voices of families, friends and wider testimonial networks. Where these networks are actively participating in reviews, learning from them should translate into robust recommendations with SMART actions identified.
2. The Home Office should consider strengthening the Statutory Guidance for the Conduct of Domestic Homicide Reviews to include the publication of action plans alongside the Overview and Executive Summary. This would ensure that action plans, as described in the guidance, "set out who will do what, by when, with what intended outcome and clearly describe how improvements in practice and systems will be monitored and reviewed" and would ensure that there is accountability and oversight around the implementation and audit of actions within that plan. A feedback loop must also be developed to ensure that families can see change.
3. Domestic Homicide Review Chairs and panel members should be clear in communicating their expectations/aspirations for contributions from family members/ friends/wider testimonial members before the review starts to enable families to prepare their contribution and reflect on how they might best wish to contribute to the review.
4. Domestic Homicide Review Chairs and panel members should commit to removing the hierarchy of testimony that exists in reviews, recognising the expertise of families and friends and ensuring that this testimony holds the same weight as information from agencies and organisations (the 'professionals')
5. Domestic Homicide Review Chairs and panel members must reach beyond families and better engage wider testimonial networks including friends, colleagues, employers, faith leaders/groups and community groups in order to better understand the knowledge and understanding around domestic abuse within these networks.
6. Domestic Homicide Review recommendations should continue to highlight the need to raise understanding, awareness and education (as widely and through all means and media possible) of what to do if a loved one is being abused, how to report it and how to access support but critically, this must be supported by robust action and the continued consultation of families and friends.
7. Children were recognised as victims in their own right in the Domestic Abuse Act[36]. There is little consideration or discussion of them and their needs (both before and after the death of their loved one) in Domestic Homicide Reviews. Domestic Homicide Reviews Chairs and panel members should commit to ensuring the voices of children are heard in reviews, that they have the opportunity to contribute[37] and that children are signposted to specialist and expert trauma informed support.
8. Community Safety Partnerships (with the support of the Domestic Abuse Commissioner's Office) should develop a consistent model of commissioning for Domestic Homicide Review Chairs in order to ensure a high standard, this should include consideration of the number of reviews a Chair is undertaking at one time.

36 www.legislation.gov.uk/ukpga/2021/17/section/3/enacted
37 Guidance to support children in DHRs available at: aafda.org.uk/public/resource-categories/children-in-dhrs

Appendix 1

The Findaway project and project partners

Findaway is a project created by WWIN, together with Advocacy After Fatal Domestic Abuse and five other organisations. The project is based in Sunderland, supporting people across Sunderland and the surrounding area. The project was made possible due to support and funding from Comic Relief.

More information about the project can be found at:

www.wefindaway.org.uk

Or on social media at:

@wefindawaytosupport

@wefindaway.org.uk

@we_findaway

You can contact the Findaway phoneline on

0300 140 0061

Or e-mail at

hello@wefindaway.org.uk

WWIN:

(Wearside Women in Need) is a women-led, specialist domestic abuse service that delivers highly respected, trauma-informed victim support services across Sunderland and Wearside. They deliver training for community members and professionals on responding and supporting survivors of domestic abuse.

Advocacy After Fatal Domestic Abuse:

Advocacy After Fatal Domestic Abuse (AAFDA) is a national charity working across England and Wales, providing specialist and expert advocacy and practical and emotional help for families after fatal domestic abuse. AAFDA is also a centre of excellence for reviews into domestic homicides, suicides and unexplained deaths following domestic abuse. We are particularly skilled in Domestic Homicide Review (DHR) methodology and best practice having been closely involved in developing the model with the Home Office since 2008, three years before they became law.

Using our specialist knowledge and collective insights we help agencies to refine their services for victims and to review domestic abuse related deaths more effectively. We provide a unique national voice for the learning that each DHR generates. While no two cases are the same, we believe that each DHR is an opportunity to end domestic abuse.

The Angelou Centre:

The Angelou Centre is one of the few surviving black-led women's organisations in the North East, having been in operation for over 25 years. Critically, the Angelou Centre provides a specialist integrative programme of support for black and minoritised women and children who have been subject to domestic and sexual violence, face multiple forms of discrimination and often have associative complex needs. The Angelou Centre's holistic violence against women and girls' services comprise of refuge accommodation (including provision for women without recourse to funds), specialist advocacy, outreach, therapeutic support and recovery programmes for survivors.

Respect:

Respect is a pioneering UK membership organisation in the domestic abuse sector. The charity leads on the development of safe, effective work with perpetrators, male victims, and young people using violence in their close relationships.

The Alice Ruggles Trust:

The Alice Ruggles Trust was established in 2017 following the murder of Alice by her ex-partner after a relentless stalking campaign. We aim to raise awareness of stalking and coercive control, to ensure that relevant legislation is effective and adhered to, and to bring about lasting improvements in the management of perpetrators and the protection of victims. Stalking is a horrific crime that affects 1 in 5 women and 1 in 10 men across the course of their lifetime. It is a psychological crime leading to Post-Traumatic Stress Disorder in almost 78% of victims, and, in the worst cases such as Alice's, is also a violent crime potentially leading to murder.

Office of the Northumbria Police and Crime Commissioner - Violence Reduction Unit

The Northumbria Violence Reduction Unit (VRU) is built on the belief that if we improve lives, we can prevent crime, so that we can all live, learn and work free from a fear of violence. We take a public health approach to tackle violent crime, including domestic abuse. This includes recognising symptoms, understanding causes, stopping it from happening and giving people tools they need to tackle it. We work closely with many services like Findaway.

SEA:

Surviving Economic Abuse (SEA) is the only charity in the UK dedicated to raising awareness of economic abuse and transforming responses to it. Economic abuse occurs when someone's partner controls (through restriction, exploitation and/or sabotage) how they acquire, use and maintain economic resources such as accommodation, food, clothing and transportation. All our work is informed by Experts by Experience – a group of women who speak about what they have gone through so that they can be a force for change. Find out more on our website.

Appendix 2

Survey questions – DHR Network members

1. What do you consider to be best practice in engaging with families, friends, employers and wider testimonial networks?

2. What are you looking for family members to bring to the process? Are there examples where family members have brought a view that has changed the context and thinking of the DHR panel?

3. There are examples where wider testimonial networks (for example faith groups and employers) hold vital information, are reviews too heavily focussed on statutory/voluntary sector services?

4. What are the challenges for Chairs and panel members in engaging with:
   - families/friends and
   - wider testimonial networks (for example faith groups, community groups, employers etc)?

5. Children are now considered victims in their own right but seldom have their voices heard in DHRs. How can their voices be captured and heard within this process?

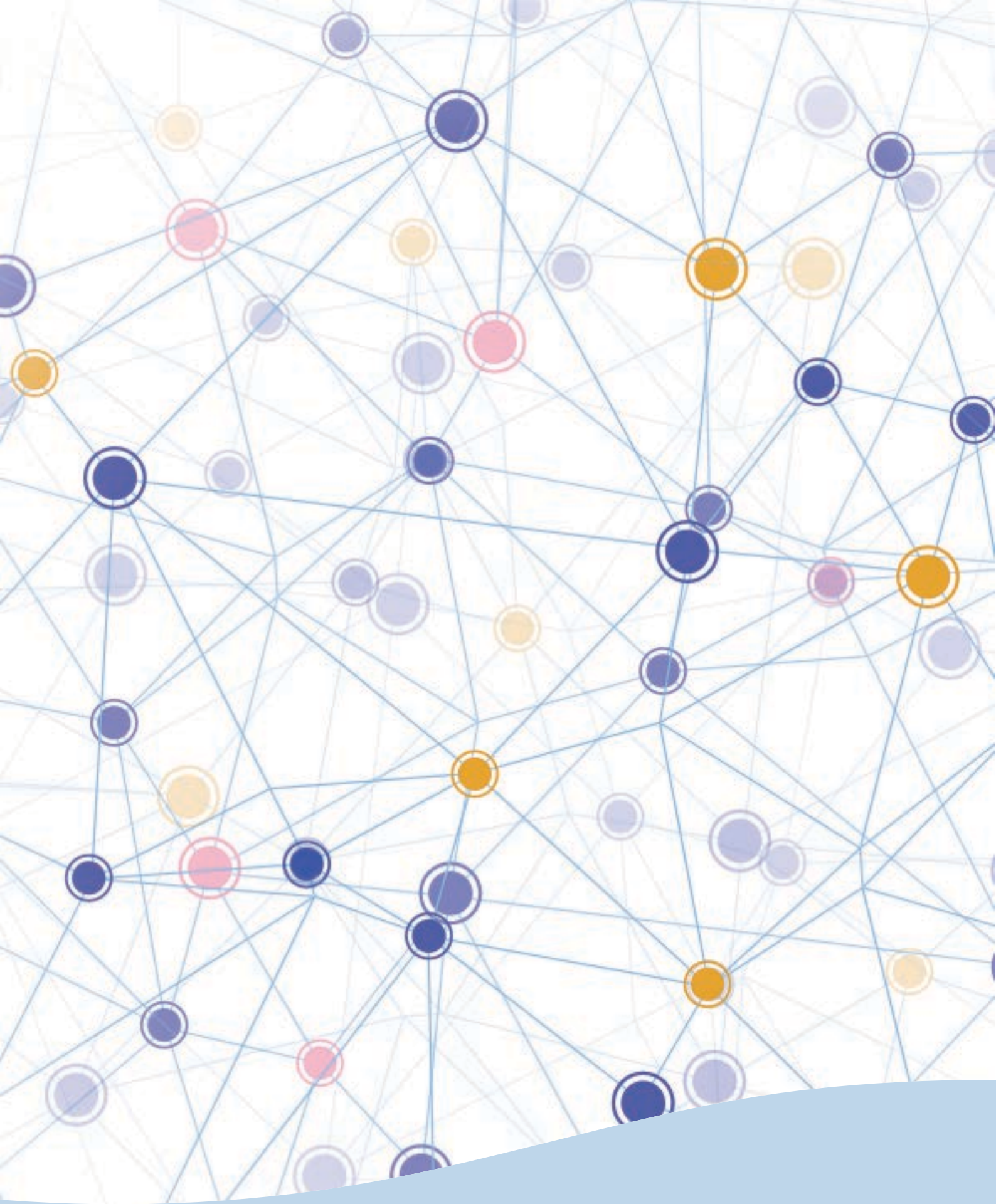
6. What practice have you used or seen to engage children or hear the voices of children in DHRs?

7. What are the challenges for you as DHR Chairs in engaging with children in the DHR process?

8. What might help you to facilitate the engagement of children or to hear their voices and perspectives?

9. Timescales for the production and publication of reports are often longer than families would expect and like. Where or what are the barriers to timely, relevant reports?

10. Families often do not see how (and when) action plans are implemented and the subsequent change. What might be the best mechanism to feedback progress on action plans to families that is realistic and achievable for CSPs?



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