AAFDA response to the open consultation on updating the domestic homicide review statutory guidance

Statement

No-one knows how many people's lives are ruined by domestic abuse; no-one knows how many people are killed or caused to die from domestic abuse. Each year we become more knowing of the likely scale of the problem, and then new information indicates that the problem is bigger than we thought. There have been significant, laudable and innovative investments and attempts to curtail this sickening affliction but it's still with us. In setting this new statutory guidance, we have the chance to shine the brightest light possible to illuminate the past to make the future safer. In AAFDA, we hope that Government will seize this chance to both ensure that Domestic Abuse Related Death Reviews are fully funded and bring the necessary will, skills and adequate resources to act on their recommendations so that Government fulfils its first duty – protect its citizens, so many of whom are battered and diminished by domestic abuse, killed by domestic abuse or caused to die by domestic abuse. We dedicate this response to all victims of domestic abuse.

Frank Mullane CEO, AAFDA

Acknowledgement

With thanks to my colleagues in AAFDA, the bereaved families and others in the sector whose views helped inform this response including: Sarah Dangar, Dr James Rowlands, Dr Elizabeth Cook, Surviving Economic Abuse, Centre for Women's Justice, Domestic Abuse Commissioner.

Questionnaire

https://www.homeofficesurveys.homeoffice.gov.uk/s/dhr-guidance/

We would welcome responses to the following questions set out in this consultation paper.

1. Are you responding as an individual or on behalf of an organisation?

☐ Individual

✓ ☐ Organisation

[if 'Individual then Q2, if Organisation then Q3]

2. If you are responding as an individual, please select the option which best describes your status.

☐ Family member or friend bereaved by domestic homicide

☐ Family member or friend bereaved by another type of domestic abuse related death (not a homicide)

☐ DHR Chair or Panel member

☐ Academic / researcher / student

☐ Other (please specify):

3. If you are responding on behalf of an organisation, please select the option which best describes the type of organisation.

☐ Law enforcement agency (police, policing body, Crown Prosecution Service)

☐ Healthcare organisation

☐ Local Authority

☐ Community Safety Partnership

☐ Educational institution or student body

☐ Violence against women and girls charity / service provider

✓ ☐ Other (please specify): Charity supporting families following fatal domestic abuse

4. What is the name of the organisation?

Advocacy After Fatal Domestic Abuse (AAFDA)

5. From the list below, where are you or your organisation based?

✓ ☐ National

☐ South West

☐ South East

☐ North West

☐ North East

☐ Yorkshire and the Humber

☐ East of England

☐ West Midlands

☐ East Midlands

☐ London

☐ Wales

☐ Another part of the UK

6. Do you have any comments on 'Section 1.1 Purpose of a DHR' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

The process of going through a DARDR may be traumatic but it can also be cathartic. The latter experience is made more likely if the behaviours of reviewers is welcoming, kind, courteous, respectful, empathetic and professional. This section should include as part of the purpose, that reviewers should consider their behaviours when conducting the review so that those behaviours do not cause secondary trauma.

Behaviours causing families great difficulty can include being: obtuse, rude, jarring (crude and aggressive communications), shoddy, superior, officious, condescending and unhelpful.

Para 1.1 –

- After the word "national learning", it might be helpful to insert the words 'including in the community'.
- Whilst the text provided is helpful, the loss of the following purpose in the 2016 Guidance is unfortunate as this provides a simple and helpful clarity regarding the purpose of a DHR:

"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 safeguard 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) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice."

Para 1.2 –

- This infers that the DARDR will follow the inquest. However, AAFDA's experience strongly points to the need for inquests to come after DARDRs. Inquests often rely on the evidence provided by police which may exclude examination of the circumstances leading up to the death. The DARDR usually includes a rich and detailed examination of any domestic abuse and the actions and inactions of agencies.

Para 1.3

- DARDRs are not just about "the way in which local professionals and agencies work", they should also be about the role communities (families, friends, employers, clergy, club members, public transport, pubs, cafes, nightclubs and leisure companies) can play in preventing domestic abuse. That is, they do more than just help identify barriers.
- Finding the 'trail of abuse' has been lost from the 2016 Guidance. This phrase was there to remind CSPs that perfunctory and summary reviews of cases will often not reveal the abuse. This can lead to mistaken conclusions such as 'came out of the blue'. AAFDA recommends that this be re-inserted as it requires the Chair and the Panel to look thoroughly at the lives of the deceased and the alleged perpetrator.

Para 1.5

- It is also important to see life through the eyes of those who were trying to help the victim. This includes, family, friends, communities and professionals. This paragraph states that it is important to work with those who were close to the victim, but it should go further than that and gather the perspectives of these people too, i.e. what were their opinions and conclusions.

7. Do you have any comments on 'Section 1.2 Criteria and definitions for a DHR' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

Para 2.1.

- Deaths abroad from domestic abuse but where the deceased lived in England or Wales, should be included. The death abroad will likely have been preceded by domestic abuse in England and Wales and this is where most of the learning will come from.
- The definition of which deaths should be reviewed should be changed to reflect the intention of the Home Office to review domestic abuse related deaths rather than just domestic homicide. The guidance should consider utilising the definition of Dr. Neil Websdale who in personal communication to me, shared this many times – ''caused by, related to, or somehow traceable to domestic abuse".

- This section would benefit from clarifying definitions of domestic abuse related suicide and sudden deaths and when these are considered to have met the criteria for a DARDR. This criteria needs to be expressed in more detail, so that we learn more about the totality and range of deaths from domestic abuse and so that commissioners and those seeking reviews, know the types of death that should be reviewed. Sub-Section 8e lists information about reviewing suicides, but it might be better to list those here, plus add other information, for example:
    - Deaths by suicide
    - Deaths due to neglect
    - Deaths due to unexplained circumstances
    - Bystander deaths
    - Killings of new partners of the victim, by the former partner.

Para 2.2.

- This wording appears to negate the need for a Scoping Review, something later described in paragraphs 5.1 to 5.5.

  This is currently extremely limited. The information provided on pages 10 and 11 section 3, is relevant to and would be better placed in section 2.

Paras 3.9 to 3.12 seem as if they are part of the SUSR. Perhaps they need a separate section.

Para 3.10

- The heading "Factors to consider when commissioning a DHR" needs to be clearer. One of the bullet points below this header states "the victim had no prior contract with any relevant agencies." Taken together, i.e. the header and the bullet point, might lead some commissioners to deduce that the guidance is implying that if this factor is present, a DHR is not necessary. The header should make clear that the presence of any of the listed factors should trigger a DHR, but also that these are simply examples. A better header might be "Here are only some factors which indicate that a DHR should be commissioned. It is not an exhaustive list".
- The first bullet point may lead to misinterpretation. At this stage, the CSP may not know how much domestic abuse there has been and a later bullet point makes clear that it is irrelevant if the deceased had, had any contact with agencies. We know that most domestic abuse is not reported, so making a point about 'multiple incidents of domestic abuse being reported' feels unhelpful.

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

✓ ☐ Yes

☐ No

Please provide explanation for your answer in the text box below.

AAFDA Response

Overall, the process map is helpful, but:

- AAFDA is concerned that there no longer appears to be a requirement, where the CSP determines that a death does not meet the DARDR criteria, to inform the HO QA Board of their decision not to undertake a DARDR. This means a CSP could decide that all deaths brought to them as potentially requiring a DARDR, did not meet the criteria, and nobody would know as there appears to be no requirement for the CSP to tell anyone. We are already aware of some CSPs avoiding progressing a DARDR when one would be appropriate. In the current guidance, a CSP must tell the Home Office (Para 24) "...of a decision to review, as well as a decision not to review a homicide..." (Para 24) and the CSP should at the same time also inform the victim's family, in writing, of its decision as well as send the family relevant correspondence from the Quality Assurance Panel regarding its position (see section 6 of this guidance on how to engage families) or advise the Home Office of its rationale in not doing so. (Para 25). The checks and balances in paragraphs 24 and 25 of the current statutory guidance have been removed.
- The following element is unclear - What decision leads from 'CSP conduct scoping review' directly to 'Deliver local action plan'?
- The map lacks information on resubmissions and family involvement.
- The word 'fatality' is used and this should be changed to domestic abuse related death.
- The map feels a little underdeveloped and would benefit from input from bereaved families, review commissioners and chairs.

9. Do you have any comments on 'Section 2.4 Notification of a death to the Community Safety Partnership' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

Overall, this section is clear.

Para 4.2.

- There should be a sentence added at the end – When agencies become aware of a domestic abuse related death, they must refer it to the CSP without delay.

Para 4.3

- The following statement, however, would benefit from being clarified - *A friend or family member may find it useful to contact a statutory agency or specialist support service who had contact with the deceased individual for support when contacting the CSP*. Perhaps replacing the last four words with 'when building a representation to the CSP', would help.
- The guidance should oblige the commissioning authority to make a referral to a specialist agency when it receives a representation from a family or friend.
- The CSP should be required to advertise how to make a referral of a domestic abuse related death to the CSP.
- This Section should make clear that where a victim lived in many CSP areas, the area where the victim lived most of their time during any abusive period, should be the area

commissioning the review. This section should also make clear that other CSPs have a duty to collaborate.

10. Do you have any comments on 'Section 2.5 Scoping Review process' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

- There is a lack of guidance on the circumstances which might cause a CSP to decide **not** to hold a scoping review. We know from paragraph 3.10 that the victim having no prior contact with any relevant agencies is not a reason to dismiss the call for a DARDR. And, when a case is referred to a CSP for a DARDR, it has already been established by the referring body that the case is likely to meet the criteria for a DARDR.
- It is unclear, therefore, under what circumstances a CSP might conclude that a DARDR is not required following the scoping exercise. We are already aware of some CSPs avoiding progressing a DARDR when one would be appropriate.
- To ensure that the scoping review process is not used inappropriately as a reason to not undertake a full review, further guidance on what the scoping review would look like and its potential outcomes would be helpful.
- The guidance should include a mechanism for the family to supply the CSP with relevant information, which was not known to them at the time of the Scoping Review, which may render a Scoping Review decision incorrect, with a view to the CSP reversing that decision.
- The guidance should include a process whereby families can appeal to the Home Office Quality Assurance Board if they disagree with decisions reached by the Scoping Review and information on who they should appeal to if they disagree with a decision not to conduct a review, taken by the Home Office Quality Assurance Board.
- Taking paragraphs 2.1 and 5.1 together leads to a little conflict in one's mind. If the deliberations undertaken because of the requirements in paragraph 2.1, lead to the conclusion that a DARDR is merited, the purpose described in paragraph 5.1 becomes challenging. Paragraph 5.1 needs further development.

Para 5.2

- Should also provide guidance on first, how family members can be consulted around the scoping review (including its conclusions) and second, how family members can be consulted if a criminal investigation is ongoing.
- We recommend replacing the word "should" (appears four times) with 'must', each time the word "should" appears.
- It would be a good idea to oblige the commissioning authority to make a referral to a specialist agency (i.e. not just offer the service) when it notifies the family that a Scoping Review is being undertaken and to repeat this offer along the journey.
- Should refer the reader to the list of organisations on the final page. And wherever specialist advocacy is mentioned, there should be a link to this list.

Para 5.4

- This should also include representations from family, friends and wider networks.

Para 5.5

- The list of who the Scoping Review should be sent to, needs to include the family of the deceased.
- The family should be treated as a key stakeholder throughout the process, including the Scoping Review. That would mean that the family should be told that the Home Office Quality Assurance Panel will review the decision not to carry out a DARDR.

11. Do you have any comments on 'Section 2.6 Coordinating a Domestic Homicide Review at a local level' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

Para 6.2.

- We think responsibility for the final composition of the Panel should sit with the Independent Chair and the Panel.

Para 6.3.

- We think that, to ensure access to expertise from specialist domestic abuse and by and-for services that the new guidance includes a requirement for local commissioners to resource their participation.

Para 6.3.

- We think there should be some guidance around what constitutes an appropriate expert.

Para 6.5.

- This section relieves, in our view inappropriately, the Panel a little, of the extent of responsibility it had as per the current DHR guidance – "On being presented with the overview report and executive summary the review panel should:

  a) ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the reports;

  b) be satisfied that the reports accurately reflect the review panel's findings;

  c) ensure that the reports have been written in accordance with this guidance; and

  d) be satisfied that the reports are of a sufficiently high standard for them to be submitted to the Home Office." (Para 74). Paragraphs c) and d) Current statutory guidance.

  We would like paragraph 6.5 to be strengthened as regards the responsibilities of the Panel and the current 2016 guidance is a good template.

- The Panel should ensure that at the outset of the review, a mapping is created of just who the family and friends are. This is because there may be families in dispute or family members who had some culpability in the death.
- We fully support mandatory training for DARDR Chairs going forward. This will go a long way to ensuring an increase in the quality of DARDRs.

Para 6.11

- We think that Chairs should be informed as to how to work with perpetrators, whether convicted, alleged or suspected.

12. Do you have any comments on 'Section 2.7 Conducting the Domestic Homicide Review' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

We note the loss of the six month timeframe within which a DARDR should be completed. Whist this is welcome, as it was unrealistic, the complete lack of guidance may cause issues (we note one year is referenced in the review template). Some guidance here would be helpful.

This section does not include the need for individual agency chronologies enabling the reviewers to create a combined chronology. The chronology is a critical component of a review illuminating the past to make the future safer.

This section could be very helpfully enhanced by stating the significant role that first hand evidence from the victim (diaries, social media posts) can play. Included in this section could be the good practice of obtaining a photograph of the victim and attaching it to papers seen at each panel meeting. This can help reviewers focus and more deeply appreciate the potential price of poor service provision.

Para 7.1.

- We think that the sentence about sharing the Terms of Reference with the family should be suffixed with "giving them the opportunity to affect the Terms of Reference." Without this addition, the family may be given the Terms of Reference as a fait accompli.

Para 7.3.4.

- We think the word "specialist" should be added when describing the advocate.
- "…can be utilised.", should be changed to – must be utilised wherever possible and with family agreement.

Para 7.4.

- Given the Home Office is expecting reviews to take place following certain deaths not deemed as homicide, it may be better to use the term domestic abuse related deaths (see penultimate sentence).

Para 7.6.2.

- The word 'integral' is no longer being used to describe the status of the family as regards the review. We feel this should be re-inserted.
- This list should be extended to include children (and the specialist help they should receive). AAFDA has long campaigned for the voice of children to be heard in DARDRs and the guidance needs to make very clear that genuine efforts are made to ensure they are given the chance to contribute. Hand in hand with that goes ensuring they receive preparation care, care while contributing and post contribution care. AAFDA has specialist competence in this work. A common response from professionals when asked if a child might be approached to take part in a DARDR, is to reject the approach claiming that it would traumatise the child. It is unclear on what basis the professional has concluded this effect and it feels as if sometimes, it is a stock response. Causing some children trauma may be a possibility when involving them in a review, but nobody seems to be considering the possibility of positive benefits and no-one seems to be measuring the trauma of excluding children from participation.
- This list should give other examples of community members such as religious ministers and social contacts. Where religious ministers are used, it would be helpful for a 'by and for' expert to assess their input as many religious ministers and institutions do not have a good understanding of domestic abuse.
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13. Do you have any comments on 'Section 2.8 Compiling the Domestic Homicide Review' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

Para 8.1.

- Using the language "…how and why the death occurred…" makes the review sound similar to an inquest which often confines its assessment to a very limited part of the life of the victim. A DARDR is taking a much broader approach to determining why this happened and will be identifying:
- Actual and potential intervention opportunities along a much longer life trajectory, right up to the death.
- Relevant post death learning, for example safeguarding issues and treatment of family.

Paras 8.3 and 8.8.

- We think something needs to be added to ensure that those conducting the review know what trauma-informed and victim-centred approaches are and how they should be practiced.

Section 8c

This section would benefit from words that help the CSP and reviewers avoid causing secondary trauma to family and / or friends. Perhaps the following words would be helpful –

"Those commissioning and conducting the review should maintain the highest standards of courtesy and respect." Or "Avoiding causing secondary trauma to family and / or friends is

made more likely if the behaviours of reviewers are welcoming, kind, courteous, respectful, empathetic and professional."

Para 8.11.

- We think that words should be added which reflect that families may give vital information on agency responses.

Para 8.12.

- AAFDA is pleased to see that the warning about ascribing a hierarchy of testimony is retained in the draft guidance. AAFDA successfully lobbied for this warning to be in the 2016 guidance.
- The reference to panels having an awareness of the risk of ascribing a hierarchy of testimony should be amended to say that panel members should commit to ensuring there is no hierarchy of testimony within reviews.

Para 8.13.

- This paragraph needs to include that when the Chair reaches back out to the family/friends before the DARDR is finalised, that specialist advocacy is again offered.

Figure 2: AAFDA is pleased to see that its 7-step model for working with families in DARDRs (then DHRs) first accepted by the Home Office for integration into the 2016 statutory guidance has been retained in this draft guidance.

- Nine requirements…This should become **ten** with the final one being - That the Community Safety Partnership must agree appropriate feedback mechanisms for family, friends and communities on the progress of actions.
- The requirement to refer to a specialist and independent advocacy service is noted at the point of commissioning a DARDR. Given the intention is to inform and involve family at the point of a scoping review, this should also be included in the first of the Nine requirements.
- Although the input of lawyers to DARDRs is minimal, some families wish to share draft DARDRs with their lawyers. Some CSPs have tried to forbid the families from doing this. This section should make clear that any family is allowed to share information with their lawyer. AAFDA has seen legal advice making it very clear that to deny a family this right, is unlawful.
- The 'Nine requirements for engaging family and friends in the DHR' only briefly refer to engaging children and young people. Section 8e would benefit from explicit reference to this and associated good practice.
- No.6 of the Nine requirements – The sentence very clearly means that the CSP does not have to offer a meeting with the panel as long as it offers a meeting with the Chair alone. This is repeated in Annex I on page 60. This is a downgrade on the current guidance. We think the family must be offered a chance to meet the DARDR Panel unless there are truly exceptional circumstances.

- The list of Nine requirements excludes encouraging the CSP to give the family opportunity to help create change after the review.

Section 8d – Should include words to assist reviewers when the perpetrator of the death may also be a victim of abuse from the person they killed or who took their own life.

Para 8.18.

- We think it would be helpful to include a specific warning – that the reviewers must not include in the report the convicted perpetrator's repeat of his or her defence in Court as the conviction has proven that defence as dis-credited.
- Reviewers must consider the negative effects on the family of including the perpetrator's comments in the DARDR.
- The family should always be consulted on the proposed input to the DARDR report from the perpetrator and to have their request for redaction before publication, respected.

Section 8e. We think this section needs considerable development to include, for example:

- This could go further in clarifying the circumstances within which a suicide following domestic abuse meets the criteria for a DARDR. It would also be beneficial to reference other types of sudden deaths following domestic abuse that may be appropriate for a DARDR, for example,
    - Those from neglect
    - Those which are unexplained.
    - Bystander deaths
    - Killings of new partners of the victim, by the former partner.
- The CSP being required to undertake a risk assessment and to manage risks associated with conducting reviews where a suspect is not convicted or is not being held by Police.
    - Risks to children
    - Risks to other family
    - Risks to professionals
    - Risks to the suspect
- The Chair understanding the higher risk of suicide present in the family of the person who took their own life.
- The Chair working out who the family is given that a partner, ex-partner, or family member such as, but not limited to, a sibling, child, parent or grandparent may have been the cause or part cause of the suicide.

14. Do you have any comments on 'Section 2.9 Parallel Reviews' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

- The review should expect access to relevant information including individual reviews conducted by any single agency.
- There is rich information which may inform the review from the Family Courts and the Criminal Justice System. It will likely require input from the Home Office and the

Ministry of Justice to ensure access to these sources is given to the reviewers. Further guidance on this would be helpful.

15. Do you have any comments on 'Section 2.10 Criminal investigations' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

Para 10.1.

This section should include that families are engaged in discussions with regards to whether they are pursuing a criminal investigation which may not have been opened, as this can have evidential implications later.

Para 10.6.

- We think that it could be made clearer that preliminary work can be carried out even if the panel has agreed to delay progressing the review (Para 10.5). In other words, only part of the review is delayed. Linking paragraphs 10.5 and 10.6 in this way, would be helpful.
- We don't think it is right to say that the DARDR Chair must avoid speaking to potential witnesses. The Chair could describe the review process. That would not in any way compromise a criminal investigation. However, we are open to hearing the views of police and the CPS on this.

16. Do you have any comments on 'Section 2.11 Coronial Inquests' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

- The scoping review process is not referenced in this section but is highly relevant to the inquest. The Supreme Court decision (Maughan) increases the probability of suicides that follow domestic abuse, being concluded as unlawful killing in the inquest and this has already happened in the inquest of Kellie Sutton. It means that notifications of any scoping review must be made to the coroner at the earliest opportunity to ensure that regardless of the scoping review decision, the coroner has received all of the information relevant to the death. The presence of domestic abuse can be a significant factor in determining the conclusion of an inquest. This has been further highlighted in the recent High Court ruling which stated 'emotional abuse' led to Roisin Hunter Bennett taking her own life in March 2022. The DARDR and inquest should work in parallel to ensure the coroner has access to as much information as possible for the inquest.
- The guidance should be amended to include a requirement for CSPs to inform Coroners when a scoping review is taking place.

17. Do you have any comments on Section 1.3 and Section 2.12 'Conducting a DHR in Wales: The Single Unified Safeguarding Review (SUSR)' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

- There are references in this section to departures from the DARDR guidance, and that these have been agreed with the Home Office. It may be helpful to include a brief summary of these here.
- How will DARDRs from Wales be assessed by the Quality Assurance Board?

18. Do you have any comments on 'Section 2.13 Anonymisation' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

- Whilst welcoming that panel members names should not be stated to avoid unnecessary risks to them, we propose that their roles should still be stated to give confidence in the appropriateness of their inclusion.
- We think that in circumstances of unacceptable risk, as defined by the CSP and the Chair and agreed by the Quality Assurance Panel, the name of the Chair could be removed from some reviews.
- The statement – 'Exact dates should not be used, only the month and year are required' – does not account for the fact that exact dates will be used within the Chronology in the report.
- Some guidance on the process for selecting pseudonyms would be helpful. These should never be chosen by the reviewers except as a last resort, for example where the reviewers were unable to identify any family or friends.
- The guidance could include that DARDRs would be published on fora which do not reveal the CSP.

19. Do you have any comments on 'Section 2.14 Data Protection' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

- We are aware that many CSPs and Chairs are unclear about access to and the management of alleged perpetrator's data, where a crime has not been confirmed. Further guidance on the inclusion and use of an alleged perpetrator's data would be welcomed.

20. Do you have any comments on 'Section 2.15 Home Office Quality Assurance Board' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

Para 15.2.

- The bullet point about families, friends and community should include a checklist of the Nine (we recommended a tenth one) requirements in Figure 2 and should be strengthened to require that their testimony has been given equal weight to statutory agencies, and learning from them has been translated into robust recommendations and actions.
- Where testimony from family has not resulted in any recommendations and actions a bullet point should be added to require the review to include a rationale as to why.
- The list should also include reference to children so that the QA panel can be satisfied that where there are children, they have been given the opportunity to contribute and their voices are reflected in the review, where this was appropriate.

21. Do you have any comments on 'Section 2.16 Publication' in terms of content or clarity?

☐ Yes

✓ ☐ No

22. Do you have any comments on 'Section 3: Implementation of Learning – Making the Future Safer' in terms of content or clarity? Please specify which subsection you are referring to or enter 'No' if no further comment.

✓ ☐ Yes

☐ No

AAFDA Response

Section 3 – Sub Section 19 –

- The CSP responsibilities should include feeding back to the family, friends and community, progress of actions.
- The guidance should include the family, friends and community members, being offered an opportunity to attend a part of a CSP meeting.

Section 3 – Sub Section 20 –

- The role of PCCs relating to the DARDR is not described in enough detail.

23. Do you think the DHR Toolkit is useful?

✓ ☐ Yes

☐ No

24. Do you have any comments on the 'DHR Toolkit' in terms of content or clarity?

✓ ☐ Yes

☐ No

AAFDA Response

Annex A –

- The Terms of Reference should include Key Lines of Enquiry.
- Input from family, beyond a pen portrait is missing. There is nothing about input from friends and community. Families, friends and community members may supply critical empirical information about the victim's life including about their interaction with agencies and about red flags which may be unknown by agencies. Including this will demonstrate commitment to there being no hierarchy of testimony.
- Lessons learnt and recommendations should include remarking on whether they include those stemming from family, friends and community input.
- Non-fatal strangulation and suffocation should be added to the list of aggravating factors in section 10.
- Childhood sexual abuse as well as ACEs should be included in relation to Previous abuse in section 10.
- Extent of engagement with family, friends and community should be specified in Contributors to the DARDR, section 14

Annex B –

- A column should be added to the Action Plan template headed "Evidence that the outcome was achieved".

Annex C –

- There should be a question such as "Was the family referred to a specialist advocacy unit"?

Annex G –

- There should be added the question "Were children invited to participate and were they given specialist advocacy?".
- This should be developed to include guidance for DARDR Chairs, Panels and CSPs on best practice for engaging families, friends and communities.

Annex I

- This checklist indicates that the family does not have to be offered a meeting with the Panel. This should be altered to make it clear that the family must be offered a chance to meet the panel except in truly exceptional circumstances.

25. Do you think there are any ways that the guidance could be improved overall?

✓ ☐ Yes

☐ No

<u>AAFDA Response</u>

- It should be checked for consistency and clarity.

26. Is there anything missing in the guidance that you would like to see included?

✓ ☐ Yes

☐ No

AAFDA Response

- Families should be offered the chance to help the CSP make change to domestic abuse services after the DARDR.
- The current guidance includes a comment about reviews not being about blame. That does not appear in the draft guidance. A key aspect of DARDRs is that the focus is on learning not blame. It would be helpful if the guidance encouraged agencies and their Chief Executives/Directors to free their people up to be forthcoming. AAFDA has long held the ambition that these reviews rise above the blaming and game playing nature of many previous reviews and strive to be models of how adults should behave and should be helped to behave, when learning from the past to make the future safer. Anecdotally, there are reports of professionals suffering greatly in, and after some reviews because of inappropriate behaviours from their own organisation. In another part of this response, we have laid out the behaviours that we feel should be expected of professionals towards families. It is also fair that professionals should be treated respectfully.
- CSPs should have to retain information on file (for a period of time specified by the Home Office) about the processes around DARDRs including but not limited to decisions not to commission a DARDR, Scoping Review and reasons for reacting names of professionals.
- On the final page there is no heading for “Suicide and unexplained deaths support”. AAFDA is the only organisation offering specialist advocacy and peer support across the currently known forms of fatal domestic abuse.
- AAFDA is aware of the difficulties and inconsistency of resourcing of the DARDR process and would welcome guidance being made available to those commissioning DARDRs on expectations and good practice approaches to resourcing DARDRs.
- The telephone number given for AAFDA should be 07887 488 464 as per the website.
- Intersectionality needs to be described in the guidance and its importance in the DARDR championed. It impacts across the commissioning and undertaking of the review.
- The Home Office might consider that the Minister in the Home Office should send national recommendations to the relevant Minister in the department expected to consider implementing the recommendation.
- There should be funding from the Home Office to ensure that these reviews take place, are effective and follow the statutory guidance. The detail of this should be described in the statutory guidance.
- To ensure that families are treated as equal partners in the process and for the process to remain trauma informed will require greater and sustained investment in specialist support.
- The Home Office should provide funding for the team managing DARDRs to grow to reflect the seriousness and extent of this work. The current team works extremely hard but there is not enough of them. Currently, the system has regular backlogs and delays across all the functions, for example, conducting the review, quality assurance and implementation of actions. These system delays do cause secondary trauma to some families and conceivably may lead to acts of domestic abuse and fatal domestic abuse occurring which otherwise would not have happened.

Thank you for participating in this consultation.

About you

Please use this section to tell us about yourself.

Full name: Frank Mullane

Job title or capacity in which you are responding to this consultation exercise (for example, member of the public): CEO

Date: 28 July 2024

Company name/organisation (if applicable): Advocacy After Fatal Domestic Abuse Ltd (AAFDA)

Address: Suppressed.

Charity Number: 1185078 Company Number: 9527065

Postcode: Suppressed.

If you would like us to acknowledge receipt of your response, please tick this box: ✓☐

Address to which the acknowledgement should be sent, if different from above
INFO@AAFDA.ORG.UK

If you are a representative of a group, please tell us the name of the group and give a summary of the people or organisations that you represent.

Contact details and how to respond

Please complete your response online
via https://www.homeofficesurveys.homeoffice.gov.uk/s/dhr-guidance/

OR send your response by 01/07/24 to:

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