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

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In partnership with

**A Domestic Homicide Review (DHR), 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.**

Families, friends and communities have a vital role to play in tackling domestic abuse. Findaway is a learning project exploring how to best support families, friends and communities worried about someone they know. Findaway offers an anonymous phoneline, information, resources, training and awareness raising within agencies and the community.

To inform the development of the Findaway project, research was commissioned by WWIN Specialist Domestic Abuse Service, in partnership with Advocacy After Fatal Domestic Abuse (AAFDA), into learning from family contributions and engagement with DHRs, both to understand recommendations from reviews but also families' experiences of the DHR process.

## AIMS

The overall aim was to understand the scale and scope of recommendations from published Domestic Homicide Reviews [1] (DHRs) relating to communities and testimonial networks. From this, the intention was 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.

## METHOD

123 published DHRs concerning deaths in 2018, 2019 and 2020 were collated and initial analysis highlighted reviews with recommendations made in relation to communities and testimonial networks, which were further analysed to identify themes.

Through the Findaway Project Family Reference Group, bereaved families were consulted on the report findings and the draft recommendations. DHR Chairs and representatives from Community Safety Partnerships were consulted via the AAFDA DHR Network [2] . These discussions helped to shape the final report and its recommendations. All responses, from both the Family Reference Group and the DHR Network, were anonymised and all quotes are shared with consent.

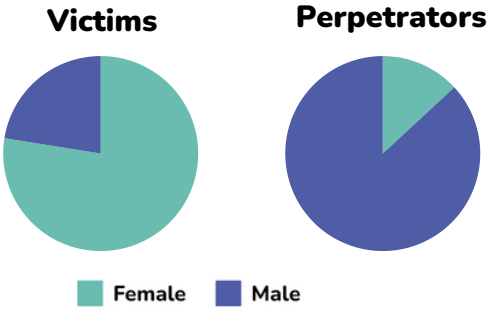
1 Further information on Domestic Homicide Reviews can be found at www.gov.uk/government/collections/domestic-homicide-review.
2 The DHR Network was established by AAFDA in 2021with the aim of raising the standard of DHRs nationally. More information is available at: www.aafda.org.uk/dhr-network.

# VICTIM AND PERPETRATOR CHARACTERISTICS AND CONTEXT

Of the 123 DHRs analysed, 100 related to domestic homicides, 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. Of the 100 domestic homicides covered by the sample, 71 were Intimate Partner Homicides[3], 25 were Adult Family Homicides, specifically parricides[4], and the remaining four were other deaths (for example individuals living in the same household but not related or intimate partners). The 126 adult victims represented in the reviews were survived by over 165 children[5].

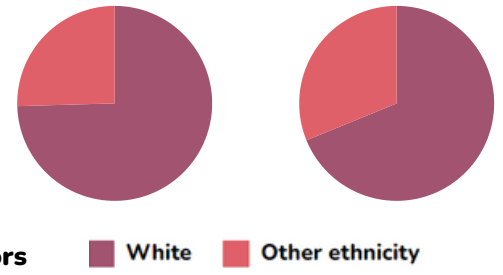
## Sex

**Most victims were female (100/129, 77.5%) and most perpetrators were male (106/122, 87%), with 16 being female.** The sex of the perpetrator was not stated for three individuals.




## Ethnicity

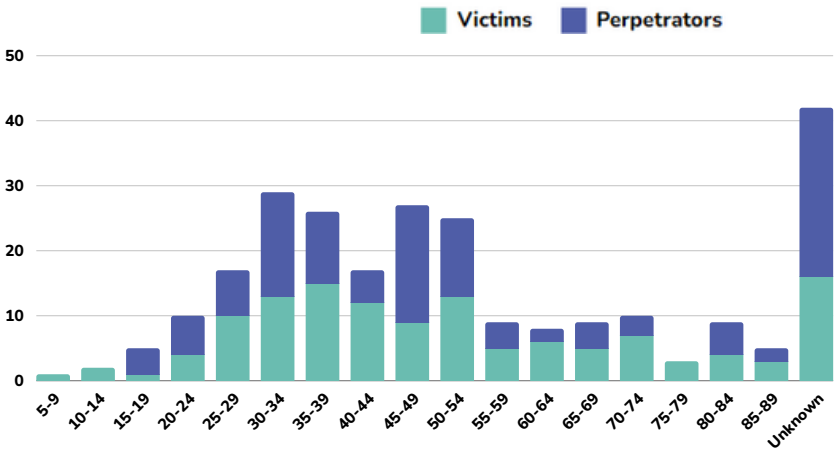
**Victims (82/110, 74.5%) and perpetrators (64/93, 69%) were in the majority White.** 19 victims and 32 perpetrators had missing ethnicity data. Where ethnicity was stated, reviews did not offer consistent recording of ethnicity. With the caveat above, the following ethnicities were reported in relation to victims and perpetrators:




| | Victims | Perpetrators |
|---|---|---|
| Asian, Asian British or Asian Welsh | 10 | 11 |
| Black, Black British, Welsh, Caribbean or African | 4 | 9 |
| Mixed or Multiple Ethnic groups | 5 | 1 |
| White | 82 | 64 |
| Other ethnic groups | 9 | 8 |

## Age

**Victims ranged in age from 7 to 89 years. Perpetrators ranged in age from 18 to 88 years.** In 16 of the reviews, the age of the victim was not stated or was stated in a range. The age of the perpetrator was not stated in 26 of the cases analysed. The majority of victims (49/129) were in their 30s and 40s. 28 victims were over the age of 60 years old.




3 Intimate partner homicide (IPH) refers to the killing of a person by their current or former intimate partner.
4 Parricide is the killing of a parent or other near relative.
5 In 30 cases, it was either not stated if the victim had children or how many children they had.

## KEY FINDINGS

### Themes arising from analysis of DHRs

Across the 123 DHRs in the sample, there were 1602 recommendations made, of which 117 recommendations (7%) related to Findaway themes, despite the fact that testimonial networks were involved in 92 of the 123 reviews in the sample.

**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.**
**~ DHR107**

In many of the cases analysed, 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. 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.

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

**1) Public awareness:**
This area attracted the most recommendations covering a wide range of public awareness activity. Many of which 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.

**2) 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, listening to families' expertise on their loved one to improve responses.

**3) Support for families/carers/wider communities:**
There were a number of recommendations around support for families and wider communities; particularly where families are dealing with multiple and intersecting needs.

**4) Involving families in risk assessment:**
Closely linked to the theme above, there emerged a theme focused on risk, risk assessment and involving families in planning around risk, acknowledging the potential danger to family members and the important information they may hold.

**5) Post-death recommendations:**
Some recommendations 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.

**"It was very important that I had my say [...] 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"**
**~ Family Member 5**

## KEY FINDINGS

# Themes arising from consultation with the Findaway Project Family Reference Group

The concerns of family members bereaved by fatal domestic abuse fell broadly into the following themes:

- The importance of the role of the DHR Chair in making the DHR a positive process for families.
- Concerns about DHR panels and their composition, authority and engagement with families.
- The importance of being regularly updated about the DHR process.
- The critical nature of independent advocacy to support them through the process.
- The importance of giving children a voice in the process and believing them.
- The impact of media reporting causing distress to families who are already managing traumatic grief.
- The disconnect between what families are reporting into reviews and how their testimony is being translated into recommendations and real action.
- Concerns at the length of time reviews can take.

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

**"The whole process takes too long, far too long for families because you can't move on"**
**~ Family Member 5**

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

**"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**

## KEY FINDINGS

### Themes arising from consultation with DHR Network members

Consultation and discussion with DHR Network members concerned the following themes:

- Best practice and challenges in engaging with families and friends.
- The tensions between wanting to engage with wider testimonial networks and the barriers to this.

**"The testimony of friends and family MUST be given the same weight, value and worth as professional testimony [...] Without their voice, the review risks being dominated by professional perceptions"**
**~ DHR Chair 4**

- The value that meaningful engagement with family, friends and wider networks brought to a review and to the learning that can arise from the review.
- The tension between Chairs' commitment to family and wider network testimonies being of equal value to other testimony not being reflected amongst other professionals and panel members.
- There are some opposing views around the involvement of children in DHRs amongst the professionals involved in DHRs.
- The need for reform of the DHR Quality Assurance process in order to better support timely reports.
- Good practice in re-engaging with families six months after publication with updates on the progress of actions within the plan but with challenges to achieving this.

**"(a DHR should not) discount one set of voices because the other shouts loudest"**
**~ CSP Representative 1**

**"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**

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

**"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"**
**~ DHR Chair 13**

## REFLECTIONS

The 123 reviews analysed, 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.

**"Families need 'the right to reply with proper advocacy' "**
**~ Family Member 3**

## Key observations:

1) In many of the cases analysed, 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. This minimises their expertise and ultimately narrows our learning, it speaks to a hierarchy of testimony where the views of agencies are given more weight than the experiences, knowledge and reporting from victims' wider testimonial networks.

2) 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 DHR Chairs think they are doing well and families' real experiences of the process.

3) 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.

**"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**

**" 'Ongoing' means 'we are never going to do that' "**
**~ Family Member 5**

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

**"How are we going to improve or move forward unless we have that level of scrutiny?"**
**~ Family Member 4**

# 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[6]. 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[7] 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 any one time.

6 Domestic Abuse Act: www.legislation.gov.uk/ukpga/2021/17/section/3/enacted
7 Guidance on how to support children in DHRs available at: www.aafda.org.uk/public/resource-categories/children-in-dhrs