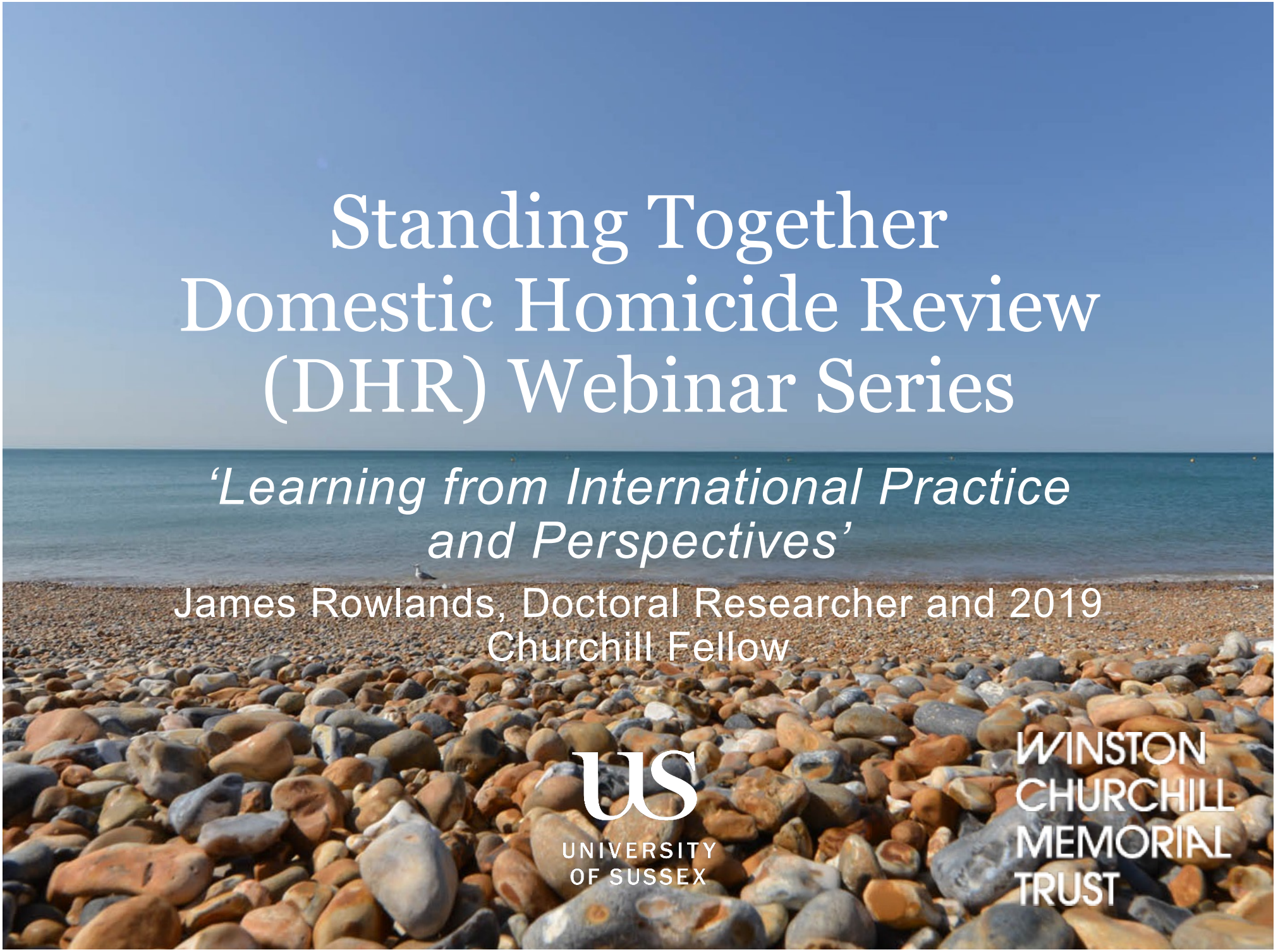
Standing Together
Domestic Homicide Review
(DHR) Webinar Series
'Learning from International Practice and Perspectives'
James Rowlands, Doctoral Researcher and 2019 Churchill Fellow
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WINSTON CHURCHILL MEMORIAL TRUST

Overview

- About me – my professional background, research, and recent Churchill Fellowship
- Reflections on international approaches to domestic / family violence death reviews ('fatality review')
- Learning for and from Domestic Homicide Reviews (DHRs) in England and Wales
- Implications for the delivery and further development of DHRs

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About me

- Trained as a Social Worker and an Independent Domestic Advisor (IDVA) in Wales
- 15 years experience in the Domestic Violence and Abuse (DVA) and wider Violence against Women and Girls (VAWG) sector
- Currently work as a consultant, principally as an Independent Chair for DHRs
- Undertaking an Economic and Social Research Council (ESRC) funded PhD looking at DHRs

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Churchill Fellowship

- Travel grant to spend four to eight weeks overseas
- Awarded a 2019 Churchill Fellowship as part of the ‘Emergency Services’ category
- Explored domestic / family violence death reviews in countries with establish processes - Australia, Canada, Aotearoa New Zealand and the United States

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Section 9 of the Domestic Violence, Crime and Victims (DVCV) Act 2004

"means 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 was or had been in an intimate personal relationship, or

(b) a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death"

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DHR purpose

- Establish what lessons are to be learned about the way in which local professionals and organisations work individually and together to safeguard victims
- Identify what is expected to change as a result
- Apply these lessons to service responses (including changes policies and procedures)
- Improve service responses to ensure that domestic abuse is identified and responded to effectively
- Improved understanding
- Highlight good practice

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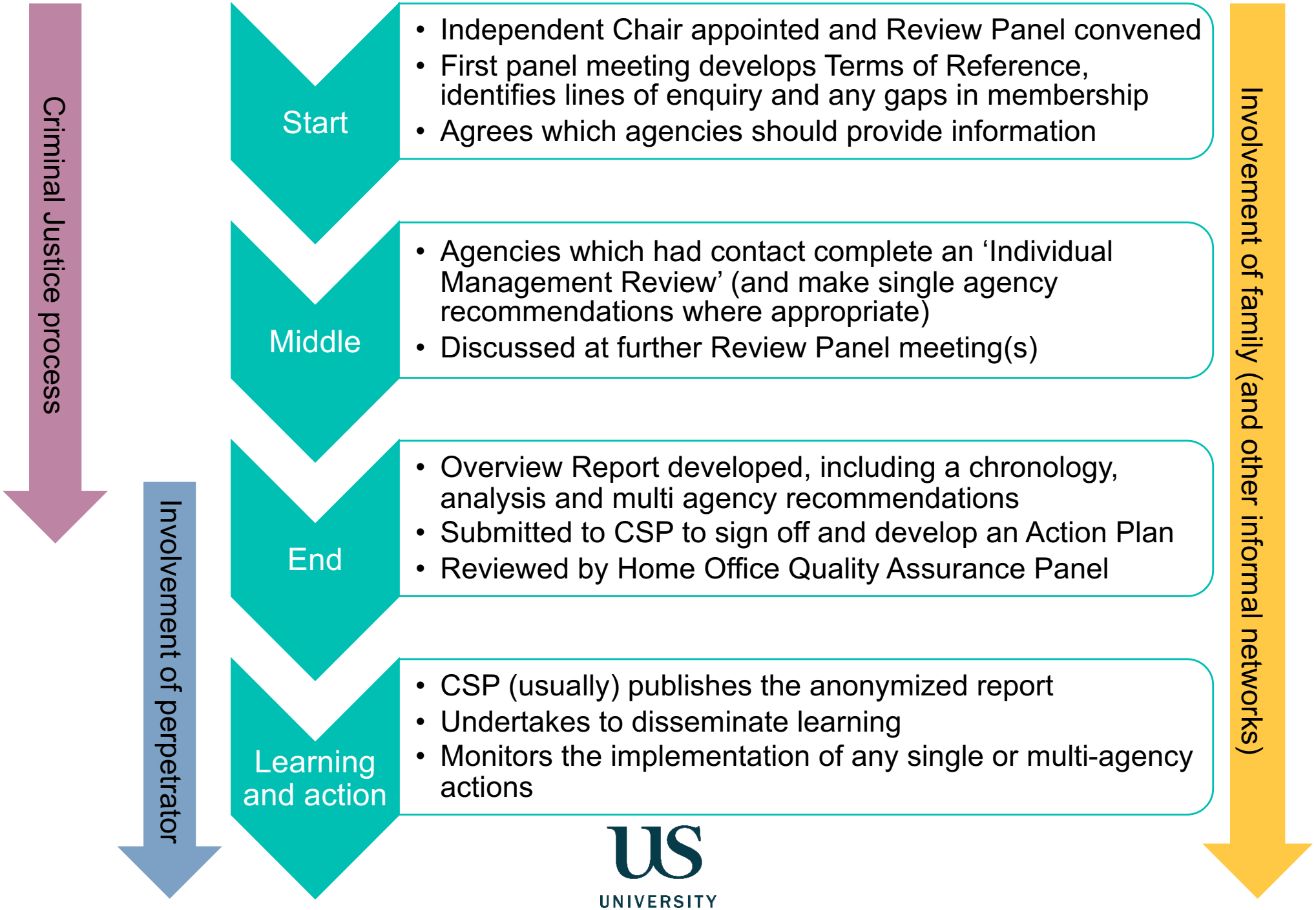
DHRs are commissioned by the local Community Safety Partnerships (CSP)



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Key differences between DHRs and international models of fatality review

Timeframe (commencement, milestones and duration)

Information sharing (what is collected / how it is used)

Publication (DHRs are published as individual case reviews. Raises specific issues in terms of anonymity and the narratives produced)

Family and community involvement (aspiration for equal status and model of expert and specialist advocacy)

Issues with reporting, data collection and no repository

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There are some significant strengths to the DHR system – but also some real challenges

Elements of fatality review

- Principles
- Establishment
- Identifying cases for review
- Membership
- Making sense of homicides
- Identifying learning and making recommendations

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Principles

- Identifying, reviewing & reporting on homicides
- Aim to build profiles & identify gaps in service responses (Wilson and Websdale 2006; Bugeja et al. 2015)
- Collaborative enquiry, ‘no blame/no shame’, accountability (Websdale 1999)
- Common thread of hearing and / or honouring victims

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Principles cont.

‘While it is an honour to bring a greater voice to those who have lost their lives to domestic and family violence, our sympathies extend to the families and friends left behind, forever changed by their loss’.

Australian Domestic and Family Violence Death Review Network (2018, p.v)

‘Speaking for the Dead to Protect the Living’

[Canada] Campbell, M. et al. (2016, p.1).

‘Creating a culture of safety in order to review domestic violence deaths effectively, honestly, and openly’.

[United States] (Websdale et al. 1999, p. 71)

‘’We partner with others, and learn and share together. We use consumer experience, expert knowledge and current information to come up with new ways of thinking and better ways of doing things’

(New Zealand) (HQSC 2017)

Learning from England and Wales

- In England and Wales, principles are to ‘illuminate the past to make the future safer’ (Mullane 2007, p. 261)
- Purposes are set out in statutory guidance but:
  - Unclear how these are understood
  - Also, in the doing and use of DHRs, the ‘push factors’ may be greater than ‘pull factors’
- Arguably there is superficial unit to the DHR system (i.e. appears to be a single system but is a localised endeavour)
- Range of operational implications e.g. shared concepts and memorialisation

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1. How can we develop and sustain a shared understanding of the purposes of DHRs?

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Establishment

- Emphasis on having a clear mandate, but this has operational impact (e.g. membership, confidentiality and disclosure, reporting)
- 38 ‘jurisdiction wide’ death reviews identified (Bugeja et al. 2017), although this has likely changed
- Manner of establishment affects operation, as does capacity and resource
- Difference degrees of independence

Establishment often linked to an ‘instigating’ case

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Learning from England and Wales

- In England and Wales, DHRs had a curious trajectory, from legislation in 2004 to implementation in 2011
- Another feature is the split between the national (statutory guidance and quality assurance but little else) and local (including decisions about whether to conduct a review, and then delivery)
- There is relatively little regional work (where this has happened, it has often been led by Police & Crime Commissioners)

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2. How can we ensure that there is effective oversight of the DHR system at a local, regional and national level? In answering this question, what constitutes effective oversight and what is its purpose?

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Case identification

- Generally consider cases of intimate partner homicide (Dale et al. 2017)
- Differences in what constitutes a ‘domestic homicide’ (Albright et al. 2013; Fairbairn et al. 2017)
- Raises questions about ‘what counts’ (e.g. suicide, dating violence, as well as communities that might be excluded e.g. LGBT+)

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Learning from England and Wales

- Relatively low threshold ('…has, or appears to have…')
- Some requirements on CSPs (e.g. timeframe, family involvement, notification to Home Office)
- But no obligation to report on decision making
- Not clear how decisions are made (inc. on cost, perceived learning benefit, or in cases that do not 'fit')
- Current model is 'one size fits all' – yet perhaps DHRs could be flexible without loosing wider goals (e.g. memorialisation, family, changing the narrative)

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3. What is the best way to commission and deliver DHRs, while continuing to recognise the unique significance of each homicide?

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Membership

- Emphasis on inclusive membership (Websdale 2020)
- However, ‘state’ agencies tend to predominate
- Hence, focus on how to bring specific knowledge (e.g. DVA specialist, community members, experts by experience, cultural competence, academics)
- Also focus on how to build a team culture

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Learning from England and Wales

- Panels are commonly ‘bespoke’ e.g. London, at least half of panels are convened in this way (Montique 2019)
- May lead to challenges in panel formation, including selection/nomination, knowledge & skills of participants, and team dynamics (and impact on participants)
- Non-governmental organisations may need additional support to be involved (Benbow et al. 2018)
- DHRs are unusually dependent on a single individual in the person of the Independent Chair / Report Author

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4. How can multi-agency review panel members be supported to take part in DHRs?

5. What is the best way to ensure that Independent Chairs have the right skills to lead DHRs?

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Sense making

- Information drawn from criminal justice process (Walklate et al. 2020) and other sources (Websdale et al. 2019)
- Toolkit includes chronologies; risk factors; agency contact; family & informal networks; evaluation of information sharing & collaboration (Websdale 2020)
- Other ideas: 'unique trajectories' of cases (Websdale et al. 2019), identification of 'mis matched' responses (FVDRC 2016) or 'social entrapment' (Tolmie et al. 2018)
- Focus on aggregation of case data and learning

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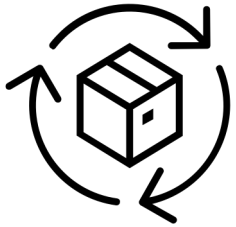

Learning from England and Wales

- DHRs access a range of information – this raises the question of how information is collected (from whom & how much is enough?) & used (including publication)
- DHRs are in-depth biographical case reviews
- But it is unclear what factors shape DHRs, including how review panels make sense of a homicide, the story that is told and the learning that is generated
- Much of this hinges on 'decision-making moments' (Albright et al. 2013)

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- Limited data collection (Home Office 2013b, 2016a), albeit with an increasing body of research by NGOs (e.g. Sharp-Jeffs and Kelly 2016), regional summaries (SCIE 2020) & academic research (Chantler el. 2019)

6. What have we learnt after nearly a decade of DHRs about best practices around methodology?

7. How can the DHR system ensure it can ‘see the big picture?’

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Learning from England and Wales

- Home Office's quality assurance process (Home Office 2013a, 2013c, 2016b) does not have equivalent in other fatality review systems
- Quality assurance 'bookends' the DHR process
  - Oversight of decisions to conduct DHRs – little is known
  - Individual DHRs require approval before publication – issues include timeliness, broader impact (on individual DHRs and overall system integrity) and little consolidation of learning & recommendations
- Limited national leadership or technical guidance

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8. What is the best way to deliver an oversight function to ensure the quality of individual DHRs and system integrity?

9. What is the most consistent and cost-effective way to support best practice?

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Learning / recommendations

- Routinely report on learning
- Reporting is usually in aggregate, identifying common risk factors, trends and pattern and system system learning (Campbell et al. 2016)

Challenges in evidencing impact (Bugeja et al. 2015). It may be more useful to focus on systemic change (Payton et al. 2017) or other intermediate impacts

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Learning from England and Wales

- Fragmented and inadequate reporting system, reflecting:
  - Delegation to CSPs
  - Absence of a standardised reporting mechanism
  - Issues with the publication and accessibility of individual DHRs
- At a national level, the absence of a national repository means the capacity to routinely produce aggregate data and learning is limited

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10. How can learning be shared across the DHR system?

11. How can the impact of the DHR system be evidenced and sustained?

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Learning from other fatality review

- Wales – Single Unified Safeguarding Review process and Central Repository for all public sector reviews
- Northern Ireland – In process of being introduced, using a single pool of chairs

International examples:

- New Zealand is a similar ‘national’ jurisdiction albeit a different model, but there is also valuable learning from other fatality review systems

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12. What are the opportunities presented by international collaboration?

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Final reflection

- DHRs can make a difference
- To quote AAFDA's Frank Mullane, they 'illuminate the past to make the future safer'
- At their best, DHRs can honour a victim, be of value to family, challenge narratives, improve our understanding, and drive change (as well as promote good practice) and hopefully prevent future homicides
- But DHRs are a tool, how we **understand**, **do** and **use** them matters

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Further information and contact details

Rowlands, J. (2020) *Reviewing domestic homicide – International practice and perspectives*. London: Winston Churchill Memorial Trust. Available at: https://www.wcmt.org.uk/users/jamesrowlands2019

(Email) J.Rowlands@sussex.ac.uk

(Twitter) @jh_Rowlands

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References

Albright, D. et al. 2013. Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation. *Homicide Studies* 17(4), pp. 436–456.

Australian Domestic and Family Violence Death Review Network 2018. *Australian Domestic and Family Violence Death Review Network: 2018 Data Report*. Available at: http://www.coroners.justice.nsw.gov.au/Pages/Publications/dv_annual_reports.aspx [Accessed: 10 December 2019].

Benbow, S.M. et al. 2018. Older adults and violence: an analysis of Domestic Homicide Reviews in England involving adults over 60 years of age. *Ageing and Society* , pp. 1–25.

Bugeja, L. et al. 2015. Domestic/Family Violence Death Reviews: An International Comparison. *Trauma, Violence, and Abuse* 16(2), pp. 179–187.

Bugeja, L. et al. 2017. Domestic/Family Violence Death Reviews: An International Comparison. In: Dawson, M. ed. *Domestic Homicides and Death Reviews: An International Perspective*. London: Palgrave Macmillan, pp. 3–26.

Campbell, M. et al. 2016. *Domestic Violence Death Review Committees: Speaking for the Dead to Protect the Living. Domestic Homicide Brief (1)*. London, ON, Canada: Canadian Domestic Homicide Prevention Initiative.

Chantler, K. et al. 2019. Learning from domestic homicide reviews in England and Wales. *Health & Social Care in the Community* , p. hsc.12881.

Dale, M. et al. 2017. Ethical Conundrums in the Establishment and Operation of Domestic/Family Violence Fatality Reviews. In: Dawson, M. ed. *Domestic Homicides and Death Reviews: An International Perspective*. London: Palgrave Macmillan, pp. 229–256.

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Fairbairn, J. et al. 2017. Challenges in Defining Domestic Homicide: Considerations for Research and Practice. In: Dawson, M. ed. *Domestic Homicides and Death Reviews: An International Perspective*. London: Palgrave Macmillan, pp. 201–228.

Home Office 2013a. *Criteria for considering domestic homicide review reports*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/207602/criteria-DHR-web-v2.pdf [Accessed: 10 April 2020].

Home Office 2013b. *Domestic Homicide Reviews: Common Themes Identified as Lessons to be Learned*. Available at: https://webarchive.nationalarchives.gov.uk/20150512003318/https://www.gov.uk/governmen t/publications/domestic-homicide-review-lessons-learned [Accessed: 28 November 2018].

Home Office 2013c. *Terms Of Reference (June 2013): Domestic Homicide Review Quality Assurance Panel*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/208143/terms-of-reference-june-2013.pdf [Accessed: 10 April 2020].

Home Office 2016a. *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide REviews*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf [Accessed: 28 November 2018].

Home Office 2016b. *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf [Accessed: 28 November 2018].

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HQSC [2017]. *Our vision & values*. Available at: https://www.hqsc.govt.nz/about-us/our-vision-and-values/ [Accessed: 23 April 2020].

Mullane, F. 2017. The Impact of Family Members' Involvement in the Domestic Violence Death Review Process. In: Dawson, M. ed. *Domestic Homicides and Death Reviews: An International Perspective*. London: Palgrave Macmillan UK, pp. 257–286.

Montique, B. 2019. *London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process*. Unpublished report. London: Standing Together Against Domestic Violence.

Payton, J. et al. 2017. United Kingdom. In: Dawson, M. ed. *Domestic Homicides and Death Reviews: An International Perspective*. London: Palgrave Macmillan UK, pp. 91–123.

Social Care Institute for Excellence 2020. *Analysis of statutory reviews of homicides and violent incidents*. Available at: https://www.scie.org.uk/files/safeguarding/homicide- reviews/Analysis-of-reviews-of-homicides-and-violent-incidents.pdf [Accessed: 20 April 2020].

Sharp-Jeffs, N. and Kelly, L. 2016. *Domestic Homicide Review (DHR) Case Analysis*. London: Standing Together Against Domestic Violence and London Metropolitan University. Available at: http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf [Accessed: 28 November 2018].

Walklate, S. et al. 2020. *Towards a global femicide index: counting the costs*. New York: Routledge.

Websdale, N. 1999. *Understanding domestic homicide*. Boston: Northeastern University Press.

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Websdale, N. et al. 2019. The domestic violence fatality review clearinghouse: introduction to a new National Data System with a focus on firearms. *Injury Epidemiology* 6, 6.

Websdale, N. 2020a. Domestic Violence Fatality Review: The State of the Art. In: Geffner, R. et al. eds. *Handbook of Interpersonal Violence Across the Lifespan*. Cham: Springer International Publishing, pp. 1–23.

Wilson, J.S. and Websdale, N. 2006. Domestic violence fatality review teams: An interprofessional model to reduce deaths. *Journal of Interprofessional Care* 20(5), pp. 535–544.

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