



LEARNING LEGACIES: AN ANALYSIS OF DOMESTIC HOMICIDE REVIEWS IN CASES OF DOMESTIC ABUSE SUICIDE

FULL REPORT

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July 2022

Acknowledgments

This research was funded by the Home Office under the Domestic Abuse Perpetrator Research Fund 2021/22. The authors are indebted to the Home Office for funding this research, and to AAFDA and Warwick Law School for their support in the management and administration of the award. Views expressed in this report regarding research findings result from independent analysis and reflection by the research team and may not correspond to views held by the Home Office. The researchers have benefitted throughout this project from input from members of our Stakeholder Advisory Group, which included Bereaved Family Members as well as academic experts (Professor John Delaney, University of Edinburgh, and Dr Ravi Thiara, University of Warwick), and we are immensely grateful to them for their time, insight and reflections.

We would also like to thank AAFDA for their assistance in recruiting and supporting Family Members who participated in the research and the Community Safety Partnerships that shared reports with us when approached. Most importantly, we would like to thank all those who took part in interviews with us – their professional and personal experiences have significantly enhanced our understanding of and learning from the DHRs – and we are mindful that for Family Members giving those accounts was at times distressing. Lastly, we would like to acknowledge the individuals whose deaths prompted these DHRs and those whose experiences were documented or referenced by interviewees. We hope that, by learning more through this research about the abuse that they suffered, we can prompt strides in improving understanding and safeguarding, and in preventing future deaths in this context.

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Executive Summary

Background to, and Aims of, the Research

Though implemented in 2011, a robust research base exploring the findings and processes of Domestic Homicide Reviews in England and Wales has been slow to develop (Rowlands & Bracewell, 2022). There are several reasons for this, including the lack of consistent processes across Community Safety Partnerships (CSPs) in regard to the publication and retention of reports, the current absence of a central repository or oversight mechanism at the national level, and the existence of substantial divergence in reports, both across and within local areas, in terms of their format and remit. Localised or smaller scale studies have, however, yielded important insight (e.g. Neville & Sanders-McDonagh, 2014; Sharp-Jeffs & Kelly, 2016; Montique, 2019; Hope et al, 2021; Bracewell et al, 2021) and larger datasets are now more commonly being used in order to explore wider patterns in terms of demographics and dynamics (e.g. Chantler et al, 2020; Potter, 2022). Despite an extension of DHRs to include domestic abuse related suicides in 2016, the majority of research to date - reflecting the dominant focus of DHR commissioning - has been on cases where perpetrators directly inflict fatal violence. However, the Government's recent Domestic Abuse Plan has rightly expressed "concern" about the effects of domestic abuse on suicides (2022:7). The scale of this problem remains largely unknown, and the nature of the causal, aggravating and mitigating connections involved are often complicated (Bates et al, 2021; Munro & Aitken, 2020). Likewise, the ways in which DHRs might develop understanding of the experiences of those who take their own lives and illuminate pathways to improved suicide prevention in the context of domestic abuse are yet to be fully explored (Monckton-Smith, 2022). Against that background, this study is the first of its kind to undertake a systematic review of DHRs that have been commissioned, completed and published in cases of domestic abuse suicide in England and Wales. Broadly speaking, it aimed to contribute to knowledge across two related areas - first, in respect of learning from *within* the DHR process about domestic abuse related suicide, and second in respect of learning *around* the DHR process in this context.

Methodology

The study used a mixed methods approach to collecting and analysing data, drawing on conceptual frameworks from across law, psychiatry, psychology, social policy, gender studies and criminology. Data collection was undertaken across 3 incremental but iterative phases: (1) reviewing academic and policy literature to refine key research questions and maximise the import of findings; (2) collating and anonymising, ready for detailed qualitative and quantitative analysis, our sample of 32 suicide DHRs; and (3) undertaking a series of 36 semi-structured interviews with stakeholders (professionals and family members) involved in the commissioning and running of, or participation in, suicide DHRs, alongside holding a further family member focus group discussion, which involved 8 participants. Resultant data was coded and analysed using a variety of approaches to capture key insights, including thematic content analysis via Nvivo, case file extraction to spreadsheets for SPSS analysis and reflective narrative notes. Though the sample size of 32 is small, we believe it captures most if not all of the DHRs that have been commissioned, completed and published in suicide cases to date; and while some caution is required in drawing on these reports for research purposes, their analysis - particularly in conjunction with the stakeholder interviews - has yielded a rich dataset. In what follows, we provide a brief summary of the key themes that we have identified, which are then developed in further detail within the main report.

Theme 1: Parties' Profiles, Vulnerabilities and Needs

One overarching observation is the peculiarly one-sided nature of many of the suicide DHRs, reflected in the 'absent presence' of partners and a predominant focus on the deceased. In that latter regard, our sample reveals a profile not dissimilar to previous studies of DHRs. The majority of victims were female (n=25) and in the 27 cases where the sex of the perpetrator was identified, the majority were male (n=22), most commonly partners and ex-partners or husbands. Victim ethnicity data was missing from 20% of DHRs, but where it was noted, the majority of victims were classified as 'White' or 'White British' (n=20). Ages varied across the sample but 40% of victims were aged between 25 - 34 years at the time of death, and there was a broadly even split in terms of their relationship status as indicated in the report. Almost two-thirds had dependent children, half of whom were living with them in the same household at the time of the death. In 12 of the DHRs, concerns over custody of children, and in particular the threat or actuality of social services intervention, was evident. The presence of financial or housing precarity in the lives of victims was also a prominent theme, identified in 65% of cases. Almost half of victims (47%) had prior experience of abuse as an adult, often in domestic settings. In 94% of cases, there was a documented record of victim mental health issues and in almost half of cases, evidence of a history of self-harm. In almost two-thirds of the cases, there was evidence of previous suicidal ideation or attempts. There was also evidence that the victim had difficulties with drug or alcohol misuse in half of the DHRs.

Theme 2: Agency Engagements and Responses

Notwithstanding substantial barriers to disclosure and known under-reporting in domestic abuse cases, within our sample, there was often clear evidence of victims navigating complex needs in plain sight of statutory agencies. Just over half of victims had engaged with specialist domestic abuse services, almost two-thirds with mental health or counselling support, and similar proportions had attended hospital or A&E services in conjunction with their abuse. Three-quarters were known to have regular contact with their GPs, 90% had a history of police contact, 30% had accessed specialist addiction services, more than half were in ongoing contact with housing services and 47% had been referred at least once for a MARAC intervention. Across these interactions, however, we identified many cases in which the DHR chronologies documented a lack of professional curiosity to ask questions about domestic abuse, about suicidality, or about the connection between the two. There was also evidence of inadequate risk assessment training and tools to appropriately identify risks of self-harm and suicidality, and a tendency towards siloed responses within agencies, with indicators in several DHRs of responses from professionals that lacked empathy for the complex needs that victims were navigating and associated barriers to their help-seeking.

Theme 3: Context and Aftermath of Death

Information regarding the mode of death was not recorded in 5 of the DHRs, but in the remainder, in line with previous research (Bates et al, 2021), the most common method was hanging (n=16), followed by poisoning/drug-related (n=3), stab wounds/lacerations (n=3), or self-immolation (n=2). In 8 of the 32 cases, there was mention made in the DHR of the presence of a suicide note at the scene, though this rarely divulged a direct causal link to abuse. In terms of chronologies immediately prior to death, in many of the DHRs, suicide seemed to reflect the end point of a gradual process of being 'ground down' and isolated, both by the domestic abuse and by the failures of systems and professionals to help. At the same time, there were also several cases in which an acute stressor could be identified in this period, often tied to interactions with services (in particular, criminal justice or social services). Despite this, it was apparent that family members and professionals alike were concerned about the prospect that police might close investigations too quickly in the aftermath of suicide, resulting in a failure to identify or act upon links to domestic abuse.

Family members spoke powerfully about the challenges they faced in trying to open up space for this to be considered, and about the additional ways in which the absence of dedicated family liaison officers and trauma-informed practice made communications with police (and other agencies) more difficult. The need for well-resourced and professional support for bereaved family members in suicide cases was clearly illustrated throughout our interviews, in particular in terms of access to specialist bereavement counselling, advocacy and accessible legal advice - not only to assist families in navigating the inquest and DHR, but in dealing with legacies left by the death, for example around child custody.

Theme 4: Commissioning and Commencing DHRs

While our sample - by definition - was comprised of cases in which domestic abuse was identified as a relevant feature for the purposes of triggering a DHR, there are clearly challenges to applying such thresholds for identification and commissioning with confidence and consistency. Indeed, in the absence of guidance, we found that ad hoc and localised interpretations have developed, which tend to adopt differential approaches to the types and levels of evidence of abuse required; and concerns were also expressed by several professionals about the lack of associated training and resource around this. In addition, where DHRs were commissioned, our findings highlighted specific challenges posed to their commencement in suicide cases, including - in particular - the availability of a sufficiently broad and diverse pool of Chairs and the scope for misunderstanding, distress or family / agency disengagement that professionals suggested may arise as a consequence of the terminology of 'homicide' in this context. Further challenges were also apparent in the interaction between DHR and coronial processes, since there is currently no clear mechanism for ensuring they work effectively as parallel processes in suicide cases.

Theme 5: Running Successful DHRs

Running suicide DHRs can also generate specific issues not adequately recognised or addressed in existing guidance. Chairs recounted, for example, difficulties around language choice in the absence of a confirmed criminal justice outcome, reflective of a wider anxiety about exposure to complaints from partners about breach of privacy or reputational damage. Concerns were also expressed about how to navigate safety risks posed to panel and family members when partners were still at liberty. Highlighting the importance of specialist knowledge in suicide DHRs, questions were raised about the appropriate composition of panels and the need for Chairs to have different skills to those required in other DHRs.

DHR reports in our sample varied significantly in remit and size. While the vast majority received Independent Management Reviews (IMRs) from 5-10 or 10-15 agencies (45% and 39% respectively), 2 had IMRs from less than 5 sources whilst, at the other end of the spectrum, 2 had reports from as many as 22 agencies. There was also variance in the length of time considered relevant: in approximately two-thirds of cases where it was articulated, the panel restricted their focus to the 5 years prior to the victim's death, and in half of those they focussed only on the previous 2 years. Full Overview Reports ranged from 18 to 185 pages, with the durations from commencement to completion ranging from 5 to 39 months. Action plans similarly varied in scale and ambition - the average number of recommendations per DHR was 18, but almost one-third had 10 recommendations or fewer. Recommendations were overwhelmingly targeted at the local rather than national level, moreover, with GP and health services being the most common recipients (25%), followed by policing and criminal justice (17%) and multi-agency forums (15%). Change priorities were most often tied to improved training and professional development / curiosity (31%), better policies for engaging and supporting victims (19%), more robust and consistent risk assessment (17%), and more effective information sharing (15%). Notably, improvements to,

and better engagement with, suicide prevention strategies accounted for less than 3% of all recommendations.

While the involvement of bereaved family members should be a priority - in principle and in practice - across all DHRs, this was also variable in our sample and family interviewees relayed mixed personal experiences. In some cases, this appeared to impact upon the panel's ability to ensure that the voice of the deceased was heard in a trauma-informed way that avoided victim-blaming. Professionals also intimated that, in suicide cases, some agencies might be less open to critical self-reflection for fear that family members harbour expectations of the DHR process that extended beyond a focus on 'illuminating the past to make the future safer' to blame attribution. While the accuracy of that assumption about family members' motivations emerged as questionable, it was clear that starting from a premise of hesitancy or superficiality in the inquiry process was apt to generate a mutual distrust and to reduce the prospects for probing reflections that could yield ambitious reforms and truly transformative lessons.

Final Reflections for Policy and Practice

Recent commitments from the Government in respect of increasing evidence of, and awareness about, the links between domestic abuse and suicide are clearly welcome, as are its undertakings to improve the Domestic Homicide Review process. The current lack of tailored guidance precludes the identification and timely referral of domestic abuse suicides and creates inconsistency in the DHR commissioning process. A failure to acknowledge and attend to the ways in which suicide cases can generate distinctive challenges to the running of DHRs leads to increased uncertainty amongst professionals that can undermine the tone of agency engagements, the ambition of DHR recommendations, and the involvement of family members. Increased use of mechanisms to maximise and share learning about best practice (for example, through Coroner's Prevention of Future Death reports or the planned development of a national DHR repository) is key, but it must be supplemented with robust oversight and ownership of recommendations and effective feedback loops to agencies and professionals, who are appropriately resourced and trained. In the context of suicide DHRs, moreover, there must be consideration given to the need for specialist knowledge and greater engagement with, and synergies to, public health suicide prevention strategies. Families bereaved by domestic abuse suicide are currently inadequately supported in respect of their emotional, practical and legal needs. The involvement of advocates in the DHR process to assist families was widely acknowledged to be valuable, but its provision should be routine and sustainably resourced. All of this and more is owed to the legacies of those who have lost their lives to, or been impacted by, suicide in the context of domestic abuse, and is vital to our ambitions to prevent such deaths in future.

Setting the Scene: Background to, and Aims of, the Research

Domestic Homicide Reviews (hereafter 'DHRs') were first implemented in England and Wales in 2011, having been established under section 9 of the Domestic Violence, Crime and Victims Act 2004. Distinct from a criminal justice investigation, which focusses on the retrospective attribution of responsibility and, where appropriate, imposition of punishment on a perpetrator of abuse, DHRs involve a contextual exploration of the broad circumstances in which the death occurred, with a view to learning lessons that can facilitate improved safeguarding, agency engagement and support provision. As Home Office guidance puts it, DHRs "should illuminate the past to make the future safer" (2016a: 6). Reviews should be undertaken with a commitment to professional curiosity, both in understanding the dynamics and effects of domestic abuse from the perspective of those impacted and in reflecting critically on agencies' involvement and interventions. In furtherance of this objective, each review should investigate "with an open mind" the scope and nature of agency interactions, professional training, and organisational cultures; whilst ensuring that the narrative "articulates the life through the eyes of the victim" (Home Office, 2016a: 7) and treats bereaved family members as "key stakeholders" (Home Office, 2016a: 17).

Across its iterations, the Government's 'Ending Violence Against Women and Girls Strategy' has consistently underscored the importance of prevention and early intervention, increasingly also noting the role that an effective DHR system can play in learning lessons to ensure improved service responses. Indeed, in its recent 'Tackling Violence Against Women and Girls' report, the Government specifically earmarked investment to strengthen DHRs in England & Wales, alongside funding to "target perpetrators" (2021: 84). Individually and collectively, then, the purpose of DHRs is multi-faceted, reflecting the fact that - as Rowlands has put it - "DHRs are both a process and a product" (2022: 2). Amongst other things, they aim to learn lessons about agencies' safeguarding and support practices; identify the improvements required to those practices for them to fulfil their potential; develop more effectively integrated and coordinated multi-partner responses to domestic abuse; use experience arising at the local level to inform regional and national approaches, including by highlighting and sharing examples of good practice; and contribute more broadly to improved understanding of the nature and effects of domestic abuse.

Domestic Homicide Reviews: What Do We Know So Far?

The practice of conducting DHRs in England and Wales is now relatively well-established, but there has been surprising little research to date that has explored overarching findings arising across and within resultant reports, or in respect of the DHR process more widely. There are several reasons for this, including, in particular, the lack of consistent processes across the local Community Safety Partnerships (CSPs) who typically commission DHRs in regard to the publication and retention of reports, the absence of any central repository or oversight mechanism at the national level, and the existence of substantial divergence in reports, both across and within local CSP areas, in terms of their format, remit, and ambition. The wider limitations of DHRs as a form of data, and the associated politics of their production, have also been acknowledged by researchers (Rowlands & Bracewell, 2022; Chantler et al, 2020), and this is something that we will discuss further in the context of our study in the Methodology section below.

DHRs thus remain somewhat of an under-explored "black box" (Rowlands & Bracewell, 2022), even in respect of cases where perpetrators directly inflict fatal violence upon victims, which were clearly the paradigm when the regime was first designed and have continued to dominate the work of DHR panels since. The significant (and gendered) loss of life in these circumstances is certainly well-documented: the Office for National Statistics has reported,

for example, that 114 domestic abuse homicides were recorded in England and Wales in 2020-21, with almost half of all adult women homicide victims being killed in a domestic setting (76% by a partner or ex-partner) (ONS, 2022). In this context, it is unsurprising that the Government's most recent Domestic Abuse Plan has again identified domestic homicides as a major problem to be tackled (2022: 10), including by improvement to DHR processes.

To date, work that has sought to collate and explore the content of DHRs in England and Wales has yielded important – and generally consistent – findings in respect of key lessons to be learnt. In 2013 and 2016, for example, two swift analyses were conducted of samples of 54 and 40 DHRs respectively (Home Office, 2013; Home Office, 2016b). Recommendations across these studies focussed on the need for increased training for healthcare professionals, improved risk assessment measures, more effective responses to those with complex needs, better record-keeping within and across agencies, and the need to identify and act upon missed opportunities for child safeguarding. Meanwhile, Neville & Sanders-McDonagh (2014) reported on an in-depth analysis of 13 DHRs in the West Midlands, supplemented by 8 stakeholder interviews. This study likewise identified key themes around effective risk assessment, use of multi-agency risk assessment conferences for those with complex needs and / or high-risk circumstances, and the need for better and more consistent information sharing across agencies. Similarly, Sharp-Jeffs & Kelly's analysis for Standing Together (2016), which looked at 32 DHRs across England - 24 of which involved intimate partner homicide (IPH) and the rest adult family homicides - identified key themes around missed opportunities associated with GP contact, mental health interventions, safeguarding adults, safeguarding children, disclosures to and from informal networks, and effective risk assessment.

Importantly, this Standing Together research also provided deeper insight into the profiles, needs and vulnerabilities of those whose lives (and deaths) were the focal point of DHRs. 22 of the 24 IPH victims in this study were women, 71% had children (the majority of whom were under 10 years old), and in 23 of the 24 cases the perpetrator was male (overwhelmingly either the victim's husband / partner, or ex-partner) (2016: 23-4). 15 of the IPH victims had documented support needs related to their mental health, including, in particular, depression and panic attacks, with similarly high rates of mental health need recorded in relation to perpetrators, and often exhibited in conjunction with drug or alcohol dependency (2016: 31-3). Contact between victims and children's services was noted in 6 of the 24 IPH cases, and the researchers acknowledged the complex dynamics at stake in these engagements, with concerns expressed variously in relation to the risk to children from intimate partner violence, the impact that fear of losing custody may have on victims' disclosure and engagement, and the appropriateness of interventions in the name of child protection (citing, for example, a DHR in which a child was removed due to the deceased's alcoholism but placed with an abusive partner: Sharp-Jeffs & Kelly, 2016: 45).

A subsequent study, also conducted for Standing Together, which analysed 59 Intimate Partner Homicide DHRs and 25 Adult Family Homicide DHRs, alongside data from questionnaires completed by 28 London Boroughs and 18 follow up interviews exploring the DHR commissioning and review process with stakeholders, revealed similar outcomes to the above in respect of the content and lessons emerging from reviews (Montique, 2019). Specifically, in 39% of IPH cases analysed, there was evidence of a lack of understanding about the dynamics and impact of domestic abuse; with agencies lacking professional curiosity to ask about possible abuse or failing to appropriately share information in almost half of cases. In 56% of cases, risk assessments were either not done or done in a manner that was subsequently found, after the victim's death, to have been inadequate. Notably, the study also observed that while 'disengagement with services' was often reported by agencies it was rarely followed up to establish *why* the victim had disengaged and or to determine whether barriers could be overcome to continue support. In addition, the report identified acute difficulties in relation to funding of reviews and appointment of suitably qualified Chairs, as well as record keeping and oversight to ensure implementation of action plans.

Working with a larger dataset than in previous studies, Chantler et al (2020) raised similar concerns. Drawing on a sample of 141 DHRs available on CSP websites in June 2016, Chantler et al provided further quantitative insight into the demographics, and risk and need profiles, of the parties involved. In particular, they reported that 81% of victims were female and 86% of perpetrators were male, most often being husbands or ex-husbands (38%), followed by partners / boyfriends (36%) and sons (19%). 29% of victims were identified as having mental health issues, 29% physical health difficulties, and 25% issues with alcohol misuse. 26% also had a prior recorded history of domestic abuse, largely as victims. Meanwhile, some 70% of perpetrators had a history of previous violent behaviour, 64% were identified as having mental health problems, 48% problems with alcohol misuse, 37% drug problems and 18% physical health difficulties. Prior to the homicide, 33% of perpetrators had allegations made against them of physical violence to a previous partner, and 32% had allegations of prior violence towards the deceased. In half of the cases, Chantler et al reported that key agencies - such as police, health, housing, education or social care - were aware that domestic abuse was present in the relationship, but specialist support was only provided to 10% of victims; and in almost half of the cases where the domestic abuse was known, it was reported that the victim had not received any formal risk assessment at the time of death.

Alongside this quantitative analysis, Chantler et al also undertook an in-depth qualitative exploration of a sub-sample of 54 DHR reports, illuminating important insights about the dynamics of domestic homicide and the adequacy of statutory services' involvement - both in identifying and responding to risk, and in supporting prevention and protection. Highlighting the value of that more textured analysis, the authors emphasised in particular the importance of context-specific insight that focusses on the challenges faced by distinctive cohorts. Indeed, they concluded that "detailed research is required which not only illuminates general patterns of domestic homicide, but which also employs a more granular and finely tuned analysis, in relation to sub-sets of domestic homicide victims and perpetrators" (2020: 491).

Building on this, Hope et al (2021) have recently explored the gendered dynamics at play in a sample of 22 DHRs, spanning the period from 2015 to 2020, in which a male victim was murdered by his female partner. Though aspects of their analysis and conclusions have prompted critical reflection (Rowlands, 2022), their assessment that too often there may be a tendency amongst informal networks and agencies alike to trivialise the impacts of abuse upon male victims, and to start from a presumption that their injuries arise from reciprocal violence in which they are positioned as the primary aggressors, is important. Meanwhile, Bracewell et al (2021) have focussed dedicated attention on Adult Family Homicide cases, as distinct from the Intimate Partner Homicides that have been the primary focus of much previous research. Analysing 66 such DHRs (drawn from within a wider cohort of 317 publicly available DHRs hosted on CSP websites), the researchers identified interlinked themes as key factors in perpetration, namely mental health issues, alcohol or substance misuse, a history of criminal behaviour, experience of childhood trauma, financial difficulties and perpetrators' involvement in a dynamic of care with victims. In line with previous studies of intimate partner DHRs, Bracewell et al concluded that, amongst the most frequent recommendations within adult family cases, were calls for more specialist training, greater professional curiosity, improved risk assessment, and better understanding of the relevance of historic abuse.

Most recently, Potter has conducted a review on behalf of the Home Office, of a sample of 124 DHRs which had received Home Office quality assurance approval during the period from October 2019-20. In keeping with previous studies, Potter reports that 80% of victims were female and 83% of perpetrators were male, with 73% of those perpetrators being the partner or ex-partner of the victim. In households where the victim was aged under 60, 52% had dependent children living with them at the time of death. 61% of victims were recognised as having at least one vulnerability, with many having multiple and complex needs, including,

in particular, mental ill-health or problems with drugs or alcohol misuse. 16% of those with a mental health vulnerability had suicidal thoughts and 14% had attempted to take their life by suicide. In 46% of cases, there was evidence to suggest that victims had also been the target of domestic abuse by a previous partner or partners. Meanwhile, in respect of perpetrators within the sample, 71% were considered to have at least one vulnerability, with drug and alcohol misuse and mental ill-health again being the most common. Of those with mental health issues, 21% were known to have experienced suicidal thoughts (with 11 perpetrators dying by suicide following the death of the victim). Approximately 60% of perpetrators were known to have a history of offending, and in three-quarters of cases this included abuse of a previous partner. Akin to Chantler et al (2020), Potter triangulated this more quantitative overview with in-depth, qualitative analysis of a smaller sub-set: in this case, of 50 DHRs. In respect of these, it was reported that, in 42 cases, there were references to victims having been in contact with agencies, with the most frequent - in descending order - being health, police, housing, children's social care, adult social care, or domestic abuse support. Echoing preceding studies, Potter concluded that key areas identified for improvement across the DHRs were - again - better understanding of the ways in which abusive partners can control victims' engagement with agencies, mechanisms for risk assessment, information sharing between agencies, support for staff working with victims of domestic abuse, protocols for making referrals appropriately, and better provision of updated and accessible training (2022: 2).

While research on the processes, content and efficacy of DHRs is thus still evolving in England and Wales, across the studies that have been conducted in the past decade there have clearly been broadly consistent findings regarding the profiles of parties, as well as the key recommendations for continuing improvement around agencies' risk-assessment, engagement and support provision. It is noteworthy, moreover, that this also resonates internationally: indeed, Jones et al concluded, based on a systematic analysis of studies to date across England and Wales, and states in the US, Australia and Canada that have review procedures designed to fulfil a similar function to DHRs, that overarching themes arising included the need for increased training and awareness about links between domestic abuse and homicide, improved provision and coordination of services, greater attention to the impact on children of domestic abuse, and more resourcing to enhance service provision and victim support (2022: 9). What is more, there are substantial parallels between these findings and those of previous studies looking at other inquiries designed to learn lessons about agency action or inaction. In relation to child death reviews, for example, Devaney et al (2011: 246) note that evaluations have consistently raised concerns about inter-professional communication, the quality of agency assessments, and the adequacy of review outcomes (Ofsted, 2008). Meanwhile, in a recent exploration across domestic homicide, mental health homicide and adult practice reviews, Robinson et al conclude that consistent themes can be identified - including in respect of difficulties in managing transitions between services or localities; limited assessments that focussed too singularly on particular aspects of behaviour or risk; difficulties in dealing with 'aloof' or disengaged service-users; a 'tunnel-visioned' approach to understanding people's experiences; and hierarchies of knowledge that tended to privilege professional accounts over those of family members (2019: 19-22).

Domestic Abuse Suicide: A Known Unknown

The scale of domestic abuse related suicide in England and Wales, and the underlying links between domestic abuse and suicidality, have been acknowledged as a 'known unknown' for some time by academics, third sector experts and policy-makers alike. The issue was, however, brought to the fore by the Court of Appeal case of *R v Dhaliwal* ([2006] EWCA Crim 1139), in which there was a failed attempt by the Crown Prosecution Service to bring manslaughter charges against an abusive husband who had subjected his wife to sustained psychological abuse prior to her suicide. Though the case fell at the first hurdle with bodily harm being defined to exclude psychological forms of injury, the court observed that if the CPS had relied instead on the husband's less frequent but nonetheless extant acts of physical violence, this could have been overcome; and that the court would then have been open to hearing arguments seeking to establish the necessary causal link between the husband's behaviour and the victim's death.

At that time, though there was research elsewhere which indicated that women who had experienced physical or sexual violence were nearly four times more likely to attempt suicide than non-victimised counterparts in the general population (see, further, Devries et al, 2011), there had been little sustained exploration in the UK of the connections between domestic abuse – in all its manifestations – and suicidality. In 2001, a report by Chantler et al, based on data within one locality, had estimated that as many as half of all women in Asian communities living in the UK, who had attempted suicide or self-harmed, may have suffered domestic abuse (2001). And in 2004, Walby extrapolated from wider data sources to suggest that more than one-third of all female suicides in England and Wales may have been caused by women being subjected to domestic abuse (2004). Both of these studies were speculative, however; and the need for further research was acknowledged. In the aftermath of the *Dhaliwal* case, Siddiqui & Patel produced the 'Safe and Sane Report' for Southall Black Sisters (2011). It documented that – across a sample of 409 domestically abused women that the organisation had worked with – some 44% had contemplated suicide or self-harm and a further 18% had made attempts to do so. In addition, during the 8-year period reviewed in this research, a further 8 women had ended their lives by suicide.

Subsequent to this, Aitken & Munro produced a further report, analysing data across a cohort of 3,519 clients who had interacted with REFUGE between April 2015 and March 2017, all of whom were aged 18 or over, had completed a CORE-10 psychological well-being questionnaire and had provided a history of abuse to caseworkers which had been documented on their files (2018). Though the researchers acknowledged that the measures used to capture clients' suicidality were apt to be under-inclusive, they reported that 24% responded positively to one or more of these measures. 18.9% reported feeling suicidal currently or recently, and 18.3% confirmed having made plans to end their lives, with 3.1% declaring that they had made at least one failed attempt to do so previously. Suicidality was present across clients with a diverse range of types of abuse experienced, but the correlation was heightened, in particular, where the abuse was cumulative, sustained over a long period of time, or perpetrated by more than one person. In addition, the researchers reported that clients who expressed suicidality scored significantly higher than peers in the CORE-10 questionnaire, with measures tied to feeling despairing and hopeless, or depressed and isolated, being particularly prominent; and often intersecting in complicated ways with an increased prevalence of issues in relation to the misuse of drugs or alcohol (Munro & Aitken, 2020).

More recently, Bates et al have reported, within a wider Home Office funded Domestic Homicide Project, that there were 39 victim suicides following domestic abuse in England and Wales in the year to March 2021. Whilst noting that this figure is likely to be an underestimate, given its reliance on police identification and referral, the authors suggested that the scale of this should not be exaggerated, since in interviews with 8 police leads "overall,

police reported that they were relatively confident in their ability to identify suspected victim suicides linked to domestic abuse" (2021: 23). As we discuss further below, however, the testimonies provided to us by several family members and other professionals in this study, alongside recent work exploring the adequacy of lines of communication and information sharing between police domestic abuse specialists and those officers who typically attend suicide scenes (Bettinson et al, forthcoming), suggests that this assessment may be rather optimistic.

Recent collaborative work between Kent and Medway Suicide Prevention Programme and Kent Police has found that 20% of all suspected suicides in their region between 2019 to 2021 were linked to domestic abuse (2021). Meanwhile, McManus et al, based on an analysis of the 2014 Adult Psychiatric Morbidity Survey, which involved interviews with over 7,500 participants forming a national cross-sectional sample of the general population in England, have reported that - after adjusting for other variables - past year suicide attempts were almost three times more common in victims of intimate partner abuse, and almost four times more common amongst those victimised in the previous year (2022: 6). Indeed, amongst those who reported having attempted suicide in the past year in that Morbidity Survey, 58.4% of the women had experienced intimate partner violence over their lifetime, as had 39.6% of the men (McManus et al, 2022: 6). In line with the REFUGE research, this study also indicated the existence of a 'dose-response' relationship between domestic abuse and suicidality, with those who experienced two or more types of abuse having higher odds of suicidality or suicide attempts within their sample (McManus et al, 2022: 7).

Though, in this context, the knowledge base is thus also still evolving, these studies collectively attest to the scale and complexity of the connections between domestic abuse and suicidality, and lend support to the warning raised by campaigners that the number of deaths through suicide in domestic abuse contexts may substantially exceed those directly caused at the hands of violent perpetrators. It is as a consequence of this that the Government's most recent Domestic Abuse plan has expressed "concern" about the effects of domestic abuse on suicides (2022: 7), noting that "in too many cases, these harms [inflicted by domestic abuse perpetrators] can result in a victim taking their own life" (2022: 11). That Plan is right to acknowledge the centrality of feelings of hopelessness and isolation to victims' suicidality (O'Connor 2003; Munro & Aitken, 2020; Monckton-Smith et al, 2022) in its observation that "it is devastating to know that those trapped by domestic abuse can feel so hopeless that they believe the only way out is suicide" (2022: 60). But it is equally important to underscore that this is not an inevitability, and there is much that can be done through improved training, risk assessment and support provision tailored to this context.

Bates et al's analysis of the 39 domestic abuse suicides identified to them by police in 2020/21 is instructive here. It reveals continuities with previous research regarding the profiles of those involved in fatal domestic violence. For example, 90% of the victims were female and in almost all cases where the relationship was known, the domestic abuse that preceded suicide was perpetrated by an intimate partner or ex-partner (94%) (2021: 50). At the same time, their findings in relation to this cohort also point to some important specificities. Indeed, while there is often a strong theme in domestic abuse related deaths of prior awareness amongst agencies of the perpetrator's abusive behaviour, Bates et al suggest that this may manifest in distinctive ways in suicide cases. More specifically, while the victim was known to agencies prior to death (most commonly MARACs, mental health teams, domestic abuse services or children's social services) in over half of the homicides reviewed, levels of agency contact were higher in domestic abuse suicide cases where there was known involvement with 74% of victims. Moreover, the perpetrators of abuse in suicide cases were three times more likely to have engaged in coercive and controlling behaviour than those in intimate partner homicides (2021: 58), and a history of non-fatal strangulation was four times more common in suicide cases, with 10 of the 18 cases in which the victim died by hanging having involved a record of non-fatal strangulation by a suspect (2021: 54). Suicide prevention is

clearly not a simple matter: for one thing, as we will discuss further below, those with pre-existing vulnerabilities and mental health issues may be at heightened risk of experiencing domestic abuse, which complicates causal pathways and interventions. At the same time, however, as Bates et al conclude, “the relatively high number of suspected victim suicide cases already known to mental health and / or domestic abuse services suggests that for some of these victims there were, or could have been, opportunities to offer support” (2021: 68). And in this context, the critical reflection and learning that the DHR regime is designed to encourage amongst statutory agencies may be particularly important.

Though, as noted above, the paradigm case when the DHR regime was first designed involved direct infliction by a perpetrator of fatal violence upon a victim, growing concern about domestic abuse and suicidality led the Home Office to extend the statutory guidance and create a duty for all CSPs to commission DHRs into any death that “has or appears to have” resulted from domestic abuse (2016a: 5). Thus, the guidance now states: “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” (2016a: 6). To the extent that DHRs can play an important role in increasing understanding of the relationship between domestic abuse and suicidality, as well as in interrogating the adequacy of existing protocols and practices within statutory agencies to identify and respond to victims at risk of suicide, this is welcome. However, we currently know remarkably little about this category of DHRs and their outcomes. Though suicide cases are forming a more sizeable proportion of DHR activity, there is clearly regional variation in this picture. To date, there has been no systematic analysis of the frequency with which suicide DHRs are commissioned, the contexts that typically give rise to them, or their handling and resultant findings. The first of the Standing Together reports mentioned above, which provided crucial insight into DHRs in homicide cases, pre-dated the extension of the statutory duty to suicide cases (Sharp-Jeffs & Kelly, 2016), and the more recent study focussing on London Boroughs also did not include any suicide cases (Montique, 2019). Likewise, suicide cases were not the focus of analysis in Chantler et al’s study (2020); and in Potter’s study, although he identifies the existence of 14 suicide cases within the overall sample of 124 DHRs, there is no dedicated discussion of them in the report and it does not appear that any of these were included in the sub-sample of 50 that he subjected to more detailed, qualitative review (2022). Thus, while there may be good reason to think that at least some of the patterns in respect of vulnerabilities and agency engagement, which have emerged in those previous studies, may also resonate across suicide scenarios, the evidence base for reaching this conclusion is limited and we currently have little insight into the peculiar ways in which this might manifest in the specific context of death by suicide, or into the additional challenges and complexities that might arise within these cases.

Monckton-Smith et al’s recent extension of her ‘homicide timeline’ to suicide cases is thus an important development. Though suggesting, based on what is described in the report as “anecdotal” knowledge, that some 70 DHRs have been commissioned to date in England and Wales focussing on intimate partner suicide, Monckton-Smith et al note that not many of these have been completed, published and made searchable (2022:10). Thus, the researchers supplemented their documentary analysis with interviews with family members and homicide advocates, in order to make observations in regard to 40 cases of intimate partner suicide and 6 cases of honour suicide. Their discussion of those cases provides a powerful account of victims (the vast majority of whom were female) with complicated needs, including in relation to drug or alcohol misuse, who had interacted - often repeatedly - with agencies (in particular, police and mental health services), and had disclosed prior suicidality often tied to feelings of entrapment and hopelessness. However, it is not always clear in the underpinning analysis whether this information comes from documented evidence, DHR reports, or family / advocate accounts, nor how these sources might have been triangulated

to strengthen conclusions both within and across cases. At times, this makes it challenging to assess clearly the ramifications of that data and analysis. For example, while Monckton-Smith et al report that the perpetrator had a history of coercive and controlling behaviour in 23 of the 40 intimate partner suicide cases, it is unclear whether this was documented in the 23 cases through agency records or personal testimonies, and whether the latter were provided before or after the victim's death. Of course, such behaviour often occurs without any formal report, and uncritically privileging agency documentation as a source of evidence should be resisted, but at the same time, insight in this regard is needed to inform understanding of victims' engagement with agencies and their responses. Similarly, the finding in Monckton-Smith et al's study that early disclosure to friends or family was more common in suicide cases (n=33 of 40) compared to homicide cases is potentially significant: but it is unclear whether the balance in data collection between documented evidence vs. family testimony was the same across these cohorts of cases, and without this knowledge extrapolating meaningful comparisons in relation to matters such as early disclosure is difficult. In addition, acknowledging a limitation on identification akin to Bates et al (2021), Monckton-Smith et al note that their "sample was drawn mainly from cases that were known to have domestic abuse in the antecedents, and this was visible enough to attract media attention and / or the commissioning of a DHR" (2022: 10). Though there is no doubt that many suicide cases which have not to date resulted in a DHR may merit being commissioned - indeed, this is a theme we reflect on in more detail in our discussion below - this statement suggests that, across the 40 cases drawn upon in the study, only some generated a DHR. It is unclear, however, in what proportion, which makes relying on that data to reflect specifically on DHR processes or outcomes in suicide cases difficult.

Thus, as Jones et al have also recently observed, there remains a significant need for further research, in the context of DHR processes and outcomes, into the relationship between suicide and domestic abuse, as well as into the impact of involvement in DHRs on family members (2022: 17). Against this context, and building on - but hoping to also reach beyond existing understandings - this study set out to explore in detail the commissioning, contexts, and findings of DHRs in suicide cases, consolidating knowledge across the DHRs that have been undertaken in England and Wales to date and triangulating that analysis with input from key stakeholders (including DHR Chairs, CSP Leads, Advocates and Other Professionals, as well as bereaved family members) regarding their experiences of the process and its outcomes. Broadly speaking, the study aimed to contribute to existing knowledge across two related areas - first in respect of learning from *within* the DHR process about domestic abuse related suicide, and second in respect of learning *around* the DHR process in this specific context. To guide our investigation and reflection in these regards, we thus identified a number of key research questions under each 'limb' of the project:

Learning from within the DHR Process

- » What patterns, if any, can be identified in terms of the circumstances that surround the suicide, including types and duration of abuse, victim and partner demographics, situational and personal risk factors, and prior engagement with services?
- » Based on those patterns, what lessons can be learned in terms of support for victims, including in relation to risk assessment mechanisms, overcoming barriers to disclosure, and ensuring effective multi-agency communication and interventions?
- » Based on those patterns, what lessons can be learned in terms of prevention, including in relation to perpetrators' *modus operandi* and intentions to precipitate suicidality, and engagement with courts, counselling, and behavioural change programmes?

Learning around the DHR Process

- » What are the challenges and opportunities faced in commissioning and conducting DHRs in domestic abuse related suicide cases, including in relation to threshold triggers, reporting mechanisms, evidence-gathering, and appropriate expertise?
- » Based on those challenges and opportunities, what changes are needed to policies, procedures and personnel in order to ensure consistency and best practice?
- » How do families bereaved by domestic abuse related suicide experience the DHR and how can they best be supported to participate in and navigate this and other related processes?

After giving an account of the methodology that we used in the study to gather and analyse our data, we will set out our key findings in response to these research questions by framing discussion around five themes - namely, (1) parties' profiles, vulnerabilities and needs; (2) agency engagements and responses; (3) context and aftermath of death; (4) commissioning and commencing DHRs; and (5) running successful DHRs. Thereafter, we will conclude with some reflections on how best to ensure that we learn lessons from the legacies in suicide DHRs, and how to enable those ambitions to be achieved in policy and practice.

As noted above, the 2022 Domestic Abuse Plan has underscored the need to improve knowledge through better data on domestic homicides and suicides following domestic abuse. In this project, we share the Government's ambition that this analysis can be "fed back into the system to tailor and refine" - and we would add, crucially, to *improve* - "responses to domestic abuse" (2022: 11), particularly in respect of prevention, safeguarding, and victim support. Our hope is also that our findings can inform emerging initiatives, including Home Office reform of the DHR process with a particular focus on developing best practice in relation to the police identification, investigation and referral of domestic abuse suicides (2022: 22 & 69), and the review of wider Suicide Prevention Strategy and institutional practices (2022: 69).

Methodology

This study used a mixed methods approach to collecting and analysing data, drawing on conceptual frameworks from across law, psychiatry, psychology, social policy, gender studies and criminology. It is grounded in a feminist ethos that is sensitive, in particular, to power dynamics and recognises the importance of situational forms of knowledge. The report draws on the expertise of its authors – Sarah Dangar has worked for some time in the domestic abuse sector, including in her role as Deputy CEO of AAFDA, to campaign for improved responses to those bereaved by domestic abuse including in the context of suicide; Vanessa Munro is a Professor of Law who has researched extensively on legal and social responses to gender-based violence, including domestic abuse, and been involved previously in projects exploring the relationship between domestic abuse and suicidality, and criminal justice responses to deaths that arise in this circumstance; Lotte Young Andrade is a PhD researcher at the University of Warwick, exploring challenges in providing legal advice to victims of domestic abuse following legal aid restrictions, who has previously worked at a domestic abuse charity supporting Latin-American women.

We approached the data collection for this study in three incremental but iterative phases: (1) reviewing existing academic and policy literature to refine key research questions and ensure that findings are appropriately situated within a wider evidence base to maximise their significance and import; (2) collating and anonymising, ready for detailed qualitative and quantitative analysis, our sample of suicide DHRs; and (3) undertaking a series of semi-structured interviews (and 1 focus group) with key stakeholders (professionals and family members) involved in the commissioning and running of, or participation in, suicide DHRs. Here, it is important to give further detail, in particular, in relation to phases (2) and (3), so that the findings that we will report based on this data can be most effectively evaluated and assessed.

Local CSPs have variable practice in relation to the publication and retention on their websites of completed DHRs, and in the current absence of any national repository, this can make the process of identifying and collating DHRs for analysis difficult. In some previous studies, researchers have sought to address this by making Freedom of Information requests to local boroughs. This is a laborious process that often does not yield comprehensive disclosure and would, in any event, not have been feasible within the timescales required for conducting and completing the present study. In other studies, researchers have relied simply on a snapshot at the time of data collection of what is available on CSP websites. Given the relatively low frequency with which DHRs in suicide cases have been commissioned since the statutory guidance was extended, and the fact that the process for compiling and reviewing reports is often a lengthy one, attenuated for much of the period since 2016 by delays linked to the Covid-19 pandemic, such a temporal snapshot would have been unlikely to yield an adequate sample for current purposes.

As a result, in our Phase 2 data collection, we adopted a more purposive approach. We were considerably assisted in this respect by the fact that one of the research team, as a consequence of her AAFDA role, had already collated a rolling database of DHRs in suicide cases that had been completed and published on (and in many cases since removed from) CSP websites from 2016 onwards. This database extended to n=28 DHRs. It was augmented further through requests to specific CSPs where we had knowledge that suicide DHRs had recently been completed and quality assured, but were not yet published. In anticipation of their soon being made publicly available, we asked those CSPs to share the DHR reports with us for the purposes of the research, and this secured 3 additional reports. Finally, we approached CSPs where we were aware that suicide DHRs had previously been completed and quality assured but a decision had been taken – which might have been for a range of reasons – not to publish on their website. We asked them to consider whether it might be

appropriate nonetheless to make the report available for the purposes of this anonymised research. This yielded one further DHR, which although unpublished was included in the study with the explicit consent of the bereaved family. In total, then, this generated a sample of 32 DHRs commissioned and completed in suicide cases, across a time period ranging from 2015 to 2021, and involving 21 local CSPs. 23 of these were Full Overview Reports and 9 were Executive Summaries (we were unable in these latter cases to secure Full Overview Reports, despite making a request to the relevant CSPs for access). As a consequence of this purposive and targeted approach to data collection, while we do not, and cannot, claim to have been able to include all suicide DHRs that have been conducted, completed and published between 2016 to 2021 in our study, we do believe that we have managed to include the overwhelming majority, and so are able to provide the most systematic analysis to date.

Alongside the DHR reports collated in Phase 2, we also collected data in Phase 3 by conducting a series of 36 semi-structured interviews - with DHR Chairs (n=13), Local CSP Leads (n=7), Advocates or Other Professionals involved in the DHR process (n = 7), and Family Members bereaved by domestic abuse suicide who had been involved in, or were in the process of involvement in, a DHR (n = 9). These interview participants were identified largely through a purposive and snowballing method, involving targeted approaches to professionals known to have expertise in commissioning, running or otherwise being involved in suicide DHRs to date, with a supplementary request for participants made via a mailshot to the national DHR Network (which currently has a membership of more than 250 professionals). In respect of family members, participants were identified with AAFDA acting as an intermediary, in order to ensure that they were given adequate opportunity to understand the parameters of their involvement and had access to specialist support both in the run up to and after the interview if needed. All the interviews for the study were conducted over Teams and were audio recorded for subsequent transcription and analysis.

Though they engaged with diverse stakeholders, the interviews followed a largely similar schedule, with a series of open questions designed to prompt reflections from participants. For professionals, the interview began by asking them about any patterns they might have identified through being involved in suicide DHRs in terms of parties' needs or vulnerabilities, and their engagement with services, before asking them to reflect on the hallmarks of a good DHR process and report, and on whether there were additional or unique challenges to this that arose in suicide cases. Towards the end of the interview, they were also asked to reflect on commissioning thresholds for suicide DHRs and navigation of parallel review processes, before having an opportunity to add any further thoughts or reflections that they considered important in the context of the research. For bereaved family members, the interview began in a more unstructured way with participants sharing - to the extent that they felt comfortable to do so - information about their loved one, and the circumstances and relationships prior to their death that interviewees felt were important. Interviewers carefully followed up on prompts provided in this way to ask about family members' knowledge and assessment of their loved one's engagement with statutory agencies during their lives, and thereafter participants were also asked to reflect on their own interactions with police and other services in the aftermath of the death, as well as being asked about the process by which a DHR came to be commissioned in their case. From here, the structure fell back in line more closely with the professional interviewee schedule: family members were asked to reflect on the hallmarks of a good DHR process and report, on their experiences of being involved in a DHR and any relevant parallel processes, and on what recommendations they would make for reform, or advice they would offer to other families. The interviews varied in duration, since participants from all categories were empowered to provide as much or as little detail in their responses as they wished. The vast majority of professional interviews lasted approximately one hour while family interviews tended to run between one to two hours, but mostly not more than 90 minutes. This longer duration for family interviews was built into

the study design following discussion with family members on our Stakeholder Advisory Group, who underscored the importance of rapport building and enabling interviewees to 'tell the stories' of their loved ones at their own pace. In addition to these interviews, an in person focus group involving 8 family members (3 of whom had previously participated in interviews) was also undertaken. Again, participants for this were identified and approached through AAFDA, and the aim of that discussion was to draw out - in a collective, discursive environment - family members' views about how to ensure best practice in conducting the DHR process and supporting those bereaved by suicide against a background of abuse.

It is important to note that, although there was some overlap between DHRs contained in our sample and the bereaved family members who participated in interviews or the focus group, it was very limited - only in one case were we able to triangulate a completed DHR with participation of a key family member in the study [DHR03 / Family Member 2]. This was because the family members with whom AAFDA had most immediate contact in the recruitment phase were often those who were either still in the DHR process or who had relatively recently completed it, with a report having been issued in draft form or concluded but awaiting Quality Assurance and Home Office approvals. This meant that reports in these cases were not yet available in a format that enabled their inclusion within our Phase 2 sample. In regard to other triangulations between Phase 2 and Phase 3 data, it is also important to note that six of the DHR Chairs that we interviewed in the study had overseen reports that ultimately formed part of the sample. Three of them had been involved as Chairs or co-Chairs on one report in the sample, two had chaired or acted as Deputy Chairs in a further two reports each, and one had acted as Chair in five of the DHRs in the sample. Since Chairs and Deputy Chairs are named in reports, we have not provided information about which DHRs the professionals were involved with so as to avoid the risk of jigsaw identification.

In analysing the data, we adopted a mix of qualitative and quantitative techniques. From each DHR within our sample, we extracted some key information into an excel spreadsheet, which captured basic demographic details about the deceased and their partner; any vulnerability, need or risk factors in respect of either party (including mental health issues, drug / alcohol misuse, housing precarity, prior experience or perpetration of domestic abuse) that had been identified in the DHR; the agencies with whom either party had engaged prior to the victim's death; and some basic information about the immediate circumstances of the death (including mode and presence of a suicide note), as well as about the DHR process and report itself (for example, timeframe, length, or nature of family involvement). We then utilised this spreadsheet to undertake analysis using SPSS, both to create descriptive statistics that enabled us to better understand the broad contours of the sample and to undertake cross-tabulation checks that identified key correlations between variables. For each DHR, we also produced a 'free narrative' report which provided a space to record a very brief summary of key facts and findings from within the DHR, and to capture the researchers' reflections on the broader tone of the report, language used, processes undertaken as part of the review, composition of the panel, and selection of the Chair.

This was then situated alongside a detailed thematic coding and qualitative exploration of both the DHR sample and fieldwork interviews, facilitated by use of Nvivo for data management purposes. We applied an inductive approach to our coding frame, informed by the Phase 1 literature review. As a team, we undertook a sample of coding which we then compared for consistency, and identified additional nodes to be added to our initial coding frame. We proceeded incrementally with coding thereafter, ensuring that the coding of DHRs from Phase 2 was completed before embarking on the coding of interviews from Phase 3, so that we could collectively review the frame at key points, and ensure the flexibility to refine existing or introduce emergent nodes on a grounded basis. Broadly, our coding frame centred around 9 overarching nodes relating to (1) nature of and language used to describe the vulnerabilities, needs or risks faced by the deceased; (2) nature of and language used to describe the vulnerabilities, needs or risks faced by their partner;

(3) nature of and language used to describe the parties' relationship and personalities; (4) nature of and language used to describe the domestic abuse suffered; (5) nature of and language used to describe the deceased's engagement with services before the death; (6) nature of and language used to describe their partner's engagement with services before the death; (7) nature of and language used to describe the circumstances of the death; (8) nature of evidence relied upon in the DHR and its influence; and (9) key findings within DHRs and wider recommendations identified in relation to their conduct, drafting and implementation. Within each of these overarching nodes, we also identified a range of sub-nodes which allowed more fine-grained coding - for example, to capture engagement with different types of services under nodes (3) and (4) above, or to group insights regarding good and bad practice under node (9) into themes associated with risk-management, multi-agency cooperation, recognising and responding to barriers to access, approaches to commissioning, and training issues.

Having coded the sample of DHRs and interview transcripts in this way, we reviewed the data to identify themes and organised them into the key findings that provide the structure to the remainder of this report. In respect of Themes 1 and 2 below, which explore the profiles, needs and vulnerabilities of the parties and their engagement with statutory services respectively, the findings map quite directly onto our original coding nodes. In respect of the remaining Themes, however, we have extracted material across nodes to narrate our findings in the most accessible and effective manner, working chronologically from the moment of suicide through its immediate aftermath, the commissioning and commencement of the DHR, and the running and outcomes of that process. Throughout our analysis, we have focussed not only on documenting the information contained in the DHRs but applying a critical lens to that information to reflect on how knowledge is constructed and organised, how the boundaries of relevant evidence are established, how language choice and perspective influence the depiction of facts, and how absences and silences can be as illuminating as content. We have been further assisted in this critical approach through the insights gathered during the interviews, which have provided a wider context to understanding the mechanics of DHRs in suicide cases, the complexities and challenges that can be encountered, and the experiences of those who participate in them, as professionals and as family members. By adopting this broader frame, we have sought to avoid what Rowlands & Bracewell have criticised as a tendency to treat DHR reports simply as "information containers" (Flick, 2018: 380) and to move towards an understanding of them as "contextually specific, constructed accounts of DVA-related deaths" (2022: 7). As Rowlands & Bracewell note, this is challenging: it requires "ongoing dialogue about everyday work practices associated with the knowledge production in and by DHRs" and "critical reflection about the layers of interpretation and complex interplay involved" in order to increase transparency and rigorous assessment (2022: 12).

Before moving on to present our findings, it is necessary to make some further comments on the limits of our data and the linguistic choices we have been required to navigate. First, and perhaps most obviously, it is necessary to bear in mind that the primary focus of this report is on DHRs that *were* commissioned and completed in cases of domestic abuse suicide. As we will discuss below, it is widely recognised that these represent only a proportion of deaths by suicide in which domestic abuse was a significant factor, and in many of these cases the triggering of a DHR was tied to the presence of a particularly substantial history of documented agency engagement in relation to domestic abuse or local variabilities in the identification and commissioning process itself. While this data can certainly tell us valuable things about the experiences of victims, and the links between domestic abuse, service engagement and suicidality in these cases, we should not presume uncritically that these accounts reflect the experiences of others who took their own lives without provoking a DHR. Secondly, and somewhat relatedly, though DHRs can provide a rich source of information, as others have noted, "they are not produced for research purposes...(and) the variable

quality of DHRs also impacts on what data can be extracted” (Chantler et al, 2020: 491; Rowlands, 2022). We have tried to reflect this, amongst other things, through our conscious acknowledgement of areas in which there is a lack of information - particularly in relation to partners in suicide cases, but also in terms of culturally specific needs that the victim might have had, for example - and through drawing attention to differential approaches to the handling and recording of data across DHRs. Finally, we also need to address the question of terminology. A recurrent finding we discuss below was the difficulty that language posed for those involved in chairing and producing DHRs in suicide cases, particularly where there was no conviction secured for abuse against the deceased during their lifetime. In this context, the labelling of ‘victim’ and ‘perpetrator’ may become more contentious, but attaching the preface ‘alleged’ to either label as a form of mitigation risks connoting scepticism in relation to the abuse that is not only narrated by family members but often corroborated within the records of statutory agencies. Referring instead to the ‘deceased’ and their ‘partner’ or ‘ex-partner’ might be seen to provide a more neutral tone, but that neutrality can also efface the power dynamics that were central to their lived experiences in the crucial moments that the DHR is designed to investigate and better understand. This was also a dilemma that we were required to navigate in the framing of our project and the drafting of our report. In the discussion that follows, we do not adopt a consistent approach but have instead tended to reflect the language choices made within the DHR or by participants during their interviews.

It is also important in closing to note that the research was conducted with full ethical approval from the University of Warwick’s Humanities and Social Sciences Research Ethics Committee, and was completed in line with recognised professional standards regarding informed consent and confidentiality. Particular care was taken in discussions with bereaved family members to ensure a supportive environment - specifically, the researchers took advice from lived experience experts on our Stakeholder Advisory Group in framing the protocol and, as noted above, participants were linked to AAFDA support in the run up to and after the interview, with one family member - at her request - having her advocate present during. These interviews were conducted solely by Sarah Dangar and Vanessa Munro, both of whom have extensive experience engaging in difficult conversations on sensitive topics in a trauma-informed way.

Theme 1: Parties' Profiles, Vulnerabilities and Needs

Perhaps the most striking thing to note from the outset in respect of our findings around the profiles, vulnerabilities and needs of the parties is the peculiarly one-sided nature of this focus within the sample of suicide DHRs. Partly because of challenges tied to the fact that there was often no formally charged and convicted abuser, let alone a perpetrator recognised as 'responsible' for the death, there was generally a narrower focus within this sample - relative to the other types of DHRs that have formed the primary data source of prior research - exclusively upon the victims. As such, partners or ex-partners were often a very absent presence within the pages of the review, making it difficult to learn more about their profiles, behaviours, needs, and what routes to prevention might have been tried or made available.

In line with previous studies, the majority of victims in our DHR sample were female (n=25 of 32). In 4 of the cases, the sex of the alleged perpetrator was not specified, but in the remainder, they were most commonly male (n=22). In 3 of the DHRs, no information was provided about the victim's relationship status at the time of death, but in the remainder, there was a roughly even split: with 10 being married or cohabiting, 11 being separated or divorced, and 8 being either single or living alone. In 15 cases, the alleged perpetrator was a male partner or ex-partner and in a further 7 cases it was a husband, with one further DHR in the sample involving a male deceased who was represented as the primary perpetrator in a marriage involving allegations of reciprocal abuse. In only one case within our sample was the relationship in question a familial one, with the abuse in question attributed to an aunt and uncle.

While the age range of victims across our sample was 20-55 years old, the most common age group, which accounted for over 40%, were aged between 25 and 34 years old at the time of their death. This was also the age range most commonly represented amongst deceased's partners within the sample, but since this age information was missing from 61% of DHRs, it is not possible to identify any clear patterns.

Victim age at time of death

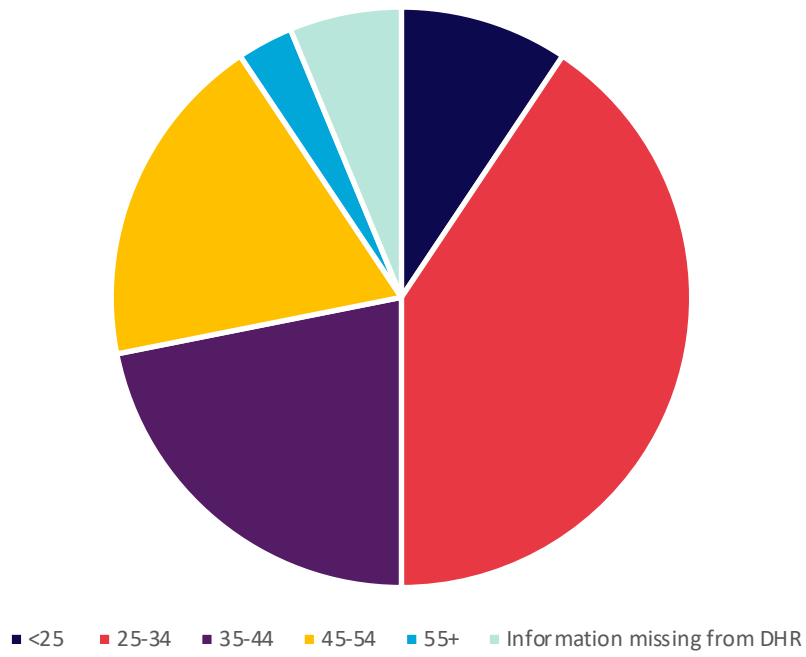


Figure 1: Victim age at time of death

Partner Age at time of DHR

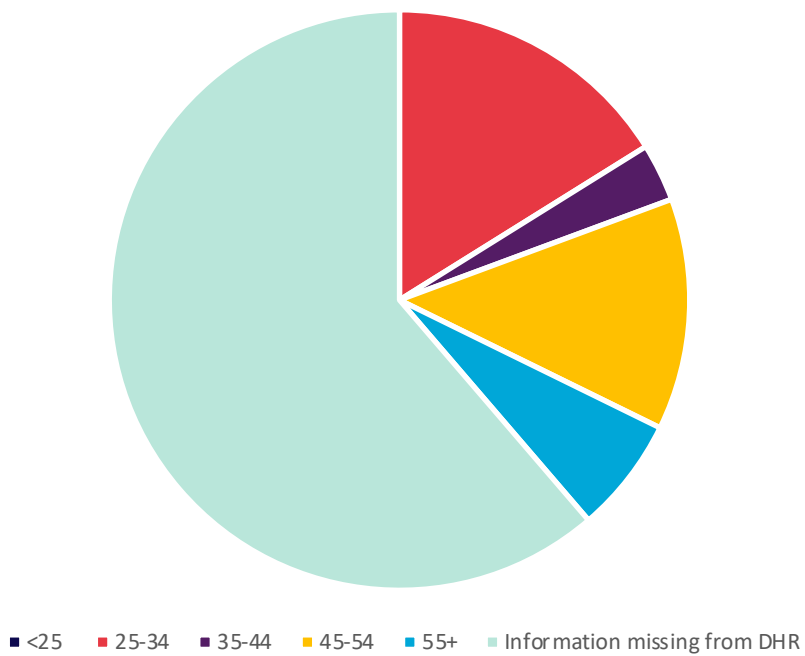


Figure 2: Partner Age at time of DHR

As with age, ethnicity data was absent in respect of deceased's partners in the majority of DHRs (n=18). Moreover, notwithstanding the fact that failure to record victim ethnicity data in DHRs has been recognised as a problem by the Home Office (2016b: 6; 2016a), reducing scope to understand the complex ways in which culturally specific practices and needs infuse experiences of and responses to domestic abuse (Sharp-Jeffs & Kelly, 2016: 77; Imkaan, 2017; Imkaan, 2020), this information was also missing in almost 20% of our sample. Where ethnicity information was available, the victim was most commonly identified as White (n=20 of 32, of whom 17 were recorded as White British), with the next most frequent category being Indian (n=3). The preponderance of White / White British victims in our sample is broadly in line with previous research involving cohorts of DHRs. Sharp-Jeffs & Kelly found, for example, that 14 of the 24 IPH victims in their sample were White British (2016: 23); and while Montique's follow-up analysis of London DHRs identified a more diverse spread, over one-third of IPH victims (n=20 of 59) were recorded as White, with the vast majority being White British. Likewise, Bates et al (2021: 39) reported that over three-quarters of the victims in their sample of domestic homicides and suicides were recorded as White, and Potter's most recent analysis concluded that 80% of DHR victims were recorded as White (against a benchmark of 74% of all homicide victims). Across these studies, the next most common categories have been Asian / Asian British or Black / African / Caribbean / Black British, with these each accounting for 10% of victims in Bates et al's study (2021: 39), and 8% and 5% respectively of the DHRs in Potter's sample (2022: Table 3). Bates et al observe that this reflects an over-representation of white ethnic groups in IPH and suspected victim suicide cases relative to the population, noting that BAME victims were less likely to be previously known to police or other agencies, compared to their white counterparts (2021: 45). As we reflect on below, in the small number of minority ethnic cases in our sample, there was evidence that victims' culturally specific needs were not always adequately identified or addressed. This supports concerns previously expressed regarding the additional barriers to disclosure and engagement, which require to be navigated and overcome (Gill & Day, 2020; Anitha & Gill, 2021).

Ethnicity of victims

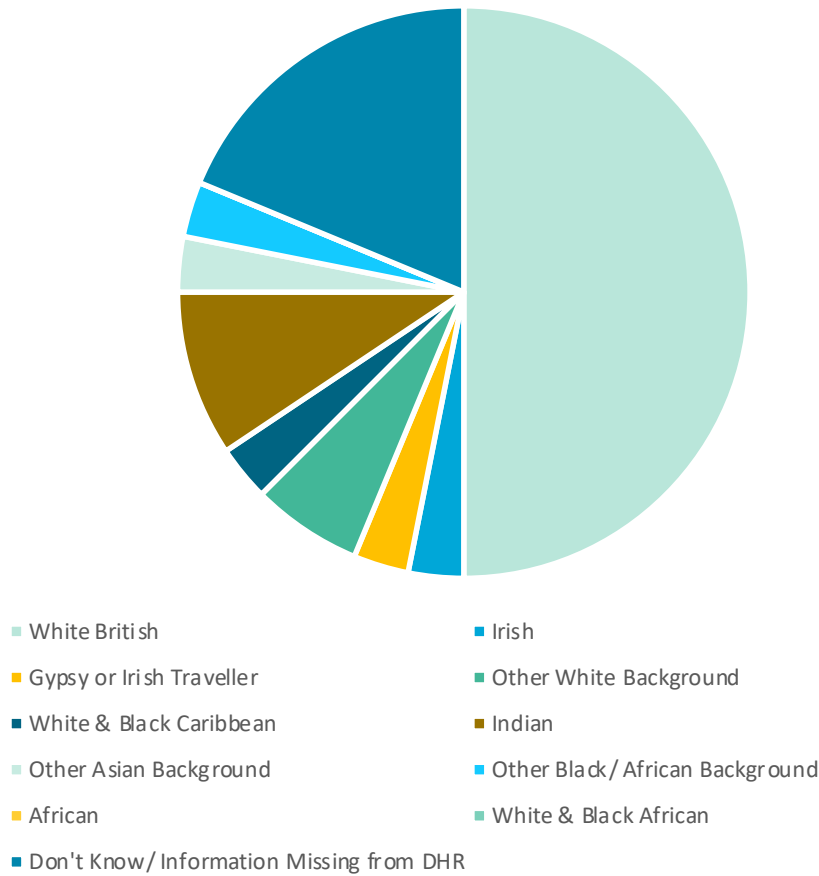


Figure 3: Ethnicity of victims across DHR sample

In cases where the information was available (it was absent in 2 DHRs), 63% of victims had dependent children, and in half of those cases the children were living in the same household at the time of death. In 12 of the DHRs, concerns over custody of children, and in particular the threat or actuality of social services intervention, was evident. The presence of financial or housing precarity was also a prominent theme, identified in 65% of cases. As noted above, the causal and compounding relationship between mental-ill health and domestic abuse can be difficult to disentangle, but in 72% of cases, there was recorded medical evidence in the DHR which indicated that the victim had long-standing challenges with mental health prior to the domestic abuse they experienced before their death. Moreover, though there were victims in our sample who had little to no agency engagement in this respect (for example, in DHR10), it is striking that, in 94% of cases, there was a record of known victim mental health issues provided by agencies; and in almost half of cases, a documented history of self-harm. Though in some cases, deteriorating mental health was evidenced more by withdrawal from service engagement and increased social isolation, in 88% of the cases where victims were being supported with mental health conditions, there was a trajectory of deteriorating mental health documented in agency records in the lead up to their death, and in almost two-thirds of cases, there was also evidence of previous suicidal ideation or attempts by the deceased. Furthermore, many victims exhibited intersecting vulnerabilities also recognised to have contributed to their mental-ill health, such as difficulties with drugs and alcohol misuse (n=16), a history of child abuse (n=11) or prior adult domestic abuse (n=15). Where there was evidence of previous abuse, moreover, it was clear that the cumulative impact of

this, alongside current abuse, had significant implications in the timing and effectiveness of service intervention, which will be discussed in further detail in Theme 2.

In the remainder of this section, we will explore the contours and implications of these profiles, vulnerabilities and needs in more detail, and reflect on how they were presented within the DHRs. The overall breakdown across the sample - for victims and partners respectively - is provided in Figures 4 and 5 below. What these illustrate is both the scale and complexity of the needs exhibited by victims and the profound lack of knowledge within the DHRs in respect of risks and needs associated with partners. It is also important to note, however, that while we have separated strands for the purposes of our analysis, this is not intended to suggest a one-dimensional understanding of these needs and vulnerabilities as singular phenomenon, nor to minimise the complex ways in which they will intersect with and often compound one another, in all their multiplicity, within the life experiences of the individuals involved. The aim here, however, is to emphasise how vulnerabilities identified in DHRs - particularly in respect of victims - originated from and were often exacerbated by experiences of domestic (and other) abuse.

Crucially, this discussion also does not take an uncritical approach to the identification and labelling of 'vulnerability' - indeed, we recognise the ways in which what counts as vulnerability is itself the outcome of power dynamics, positionality, and policy agendas. Inhabiting or being allocated a position of vulnerability can be both a lever for redress as well as a mechanism for entrenching disempowerment (Munro, 2017), but in a context in which it is increasingly the frame through which needs and risks are measured and prioritised by statutory agencies, there are strategic benefits to not abandoning it here.

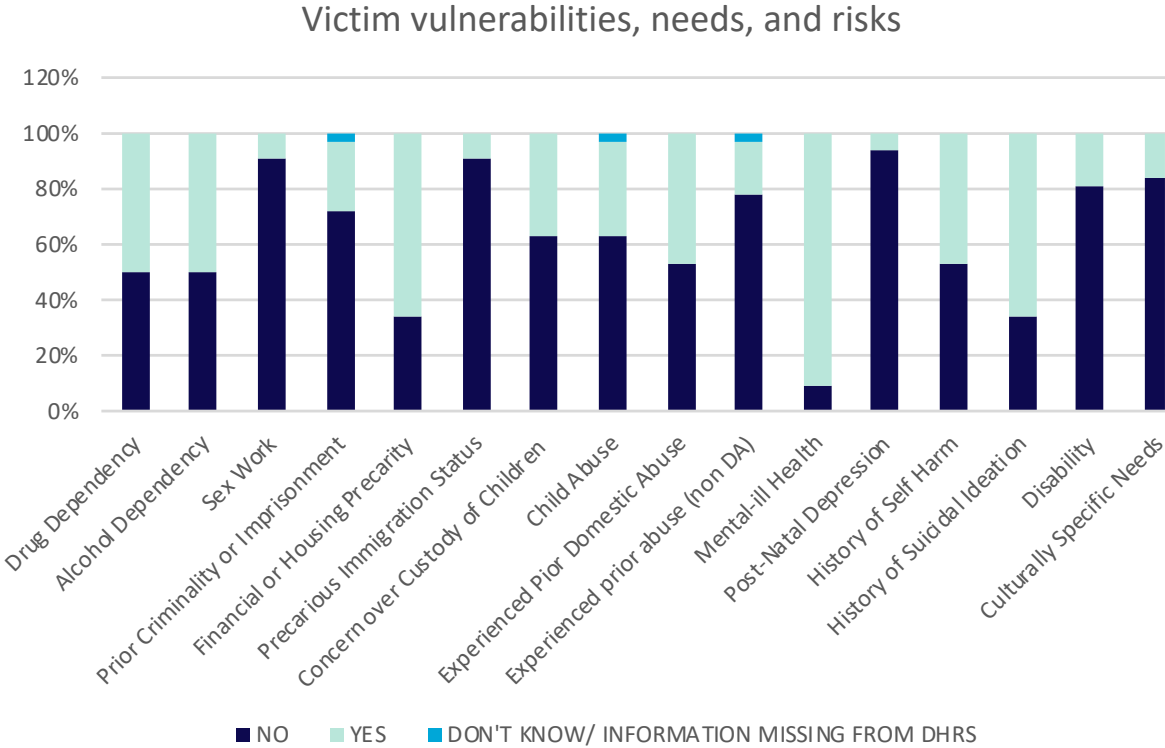


Figure 4: Victim vulnerabilities, needs, and risks

Partner vulnerabilities, needs, and risks

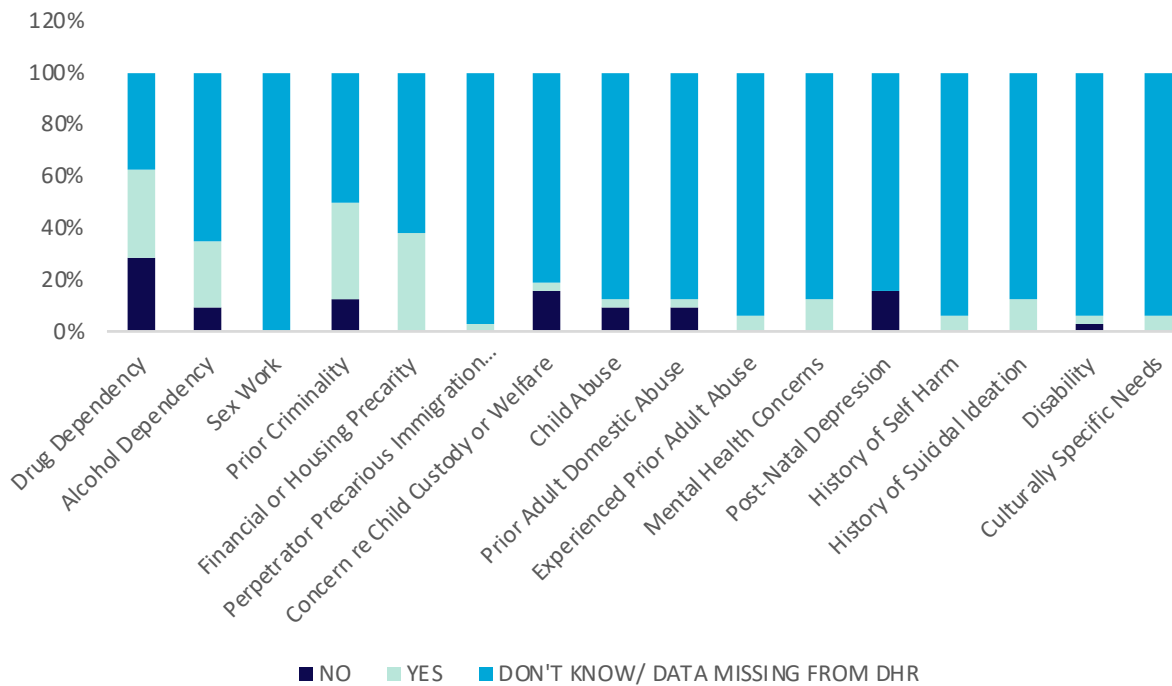


Figure 5: Partner vulnerabilities, needs, and risks

Historical Abuse and Its Complex Legacies

Previous research has documented, in various contexts, that victims' experiences of prior abuse can increase the risk of them being targeted by perpetrators in the future (Graham-Kevan et al, 2015; Scottish Government, 2019). The trajectories tied to this can manifest in a diversity of ways, but it was clear in our DHR sample that a number of those who died by suicide had documented experiences of historic abuse, either as children or previously in adulthood, which had significantly impacted upon their well-being.

Childhood Sexual Abuse

In a context in which, often betrayed by those in a position of trust, many children and teenagers will not disclose crimes committed against them until much later in life, and some may never feel safe to do so, we cannot know how many of the deceased in our sample had been victims of child sexual abuse. What we do know, however, is that of those who did disclose crimes committed against them to family members or agencies (n=7), none saw their complaint result in a successful conviction. For some, the suggestion in the DHR was that this was because they did not wish to pursue the allegation further - for example, in DHR09, where the victim was prompted to share with police that she had been sexually assaulted by her father when she was 10 years old because she was concerned about the risk posed by his having access to his grandchildren. At the same time, what this demonstrates is the complex legacies of that abuse, particularly in situations where perpetrators may still be involved in the victim's life in some capacity. In DHR02, for example, it was disclosed to a caseworker that before she had reached the age of 15, the victim had been raped by three men, one of whom had also domestically abused her mother. As she was disclosing this information to her caseworker, it became apparent that another of the perpetrators was still involved in her life, and had continued to sexually exploit her: indeed, her father indicated during the DHR that he was of the view that this person had continued to abuse the victim up until her death.

For others, it was apparent that they had wished to pursue the complaint but a decision not to take further action had been made by criminal justice professionals. This was reflected, for example, in the account that Family Member 8 gave of her daughter having been sexually abused as a teenager by an adult who had assumed a paternal role. She reflected that this “had a very big negative impact on her mental health” but she “didn’t want to press charges straightaway...And then when she did finally press charges, they didn’t take it any further. I will never understand that; they completely let her down”. The significant ways in which this undermined victims’ confidence in those agencies’ ability to protect them against future abuse is something we return to consider below, but there is little doubt that this increased the risk of repeated and routinised victimisation. In addition, in some DHRs, there was evidence of unidentified or unidentifiable child sexual exploitation. In DHR20, for example, the victim had been referred to Children and Adolescent Mental Health Services for incidents of self-harm. The DHR identified that the assessment, which recorded the victim as being sexually active and “inappropriate with men”, should have flagged an investigation of grooming and child sexual exploitation. Similarly, in DHR05, the victim had been regularly found by police in the home of a registered sex offender, but no action was taken since she was over 16.

A failure to recognise such indicators of childhood sexual abuse and / or to respond effectively when complaints were made can have lasting implications that map to subsequent experiences of domestic abuse and suicidality. Indeed, as Advocate 1 put it, when reflecting on the profiles, needs and risks experienced by victims in the suicide DHRs that they had been involved in, “we’re seeing a lot of adverse childhood experiences...lots of the victims who end up taking their life, perhaps there has been something, so perhaps they’ve been sexually abused when they were children. That feels like quite a common theme and also, sadly, perhaps linked to that, having vulnerabilities around their own mental health as well”.

Childhood Exposure to Domestic Abuse

Where there was evidence that the victim had been exposed to domestic abuse as a child, there were also often patterns of childhood neglect that could lead to complex trauma as an adult. Though reflecting on this more in the context of harms experienced by the children of those who died by suicide, DHR Chair 13 noted: “it’s a constant battle to get the appropriate resource at childhood level on the basis that, you know, children who witness domestic abuse...children who see the most horrendous things, are likely, not in every case but are likely to really suffer long term enduring problems.” One of the key issues that appeared to impact victims in our DHR sample was witnessing domestic abuse against a parent. This not only increased their risk of being abused themselves but may have also prompted them to be removed from the family home and placed into temporary or permanent care. In DHR17, for example, the victim had spent time in a domestic violence refuge due to his father’s violence against his mother. Meanwhile, in DHR28, the victim and her brothers had been placed into local authority care for a period until it was safe to return home as a result of her father’s violence towards her mother and herself as a child.

In DHR05, the victim kept running away from home and not turning up to school due to the violence she was experiencing in her home. Evidence on her file from that time stated “[the victim] describes violence in the family home, that she and her sister would be hit and their parents would put hands over their mouths to stop them screaming... [the victim] feels rejected and blamed”. There was further evidence to suggest that she was experiencing emotional and physical neglect, which made her vulnerable to abuse and exploitation from older people. Meanwhile, in other cases, there was evidence of child neglect and witnessing abuse in the family home that led to early exposure to harmful substances, which subsequently developed into drug and alcohol abuse in adult life. In DHR11, for example, there were clear warning signs of child exploitation by criminal groups that were missed by social services. The victim’s mother described her daughter as “going off the rails” at the

age of 11, and by the age of 14 there were strong suspicions that she was injecting drugs. As a result, the victim was described as having had a “difficult and complex life which had been compounded by years of domestic abuse, substance abuse, low level criminality, anti-social behaviour, and increasing vulnerability through these factors impacting on her mental health”.

Such patterns of criminality or risky behaviour, reflected in victims’ involvement with police during their formative years, were described by social services in DHR05 as examples of “acting out” in response to abuse experienced at home between parents. Suffice to say that this language choice betrays the danger of underestimating the negative effects associated with being exposed to domestic abuse as a child, both in relation to immediate behaviours and longer-term mental health and vulnerability to abuse. It also raises questions about whether more could have been done by agencies to understand why children were engaging in problematic behaviours and to intervene in order to avoid escalation or entrenchment.

Prior Domestic Abuse as an Adult

Across our DHR sample, just under half of victims had prior relationships that were documented as involving domestic abuse before their final known relationship (n=15 out of 32). This was also a common theme raised by family members who, during interviews, described their loved ones as falling into cycles of harmful relationships. As Family Member 1 put it, her daughter “seemed to fall into the trap of another perpetrator. I don’t think they choose them; I think these perpetrators seem to choose the victims, that somebody is vulnerable to their attention, love, and emotion”. Similarly, Family Member 2 shared that her daughter “had contact with the police previously because there was a lot going on. I mean it was very toxic, the ex-husband, the boyfriend, and the three of them were just, all of them were behaving absolutely appallingly.” It was clear that in these cases, although victims had ultimately been able to leave those prior abusive relationships, intersecting issues such as housing and financial precarity, mental health concerns, substance addiction or family pressures meant they were at risk of being targeted by new abusive partners. In DHR18, for example, the victim left an arranged marriage, as a consequence of which she lost contact with her children and wider family. It was noted in the DHR report that she shared with friends that “in order to be with [new partner], she had to give up her family due to the controlling role of her previous culture.” What this left unstated, however, was the extent to which, in relinquishing that network of support, she was at increased risk of isolation and abuse via the control of her new partner.

It is also important to highlight that, in several of the DHRs, previous perpetrators were also parents of dependent children, which often entailed the necessity of an ongoing relationship with the victim and the increased risk of further abuse regarding or in the context of managing child contact. In DHR32, for example, three out of five known perpetrators were also the fathers of the deceased’s children, meaning that, as she entered new relationships with partners who in due course also proved to be abusive, she would receive additional abuse from ex-partners. There was evidence of such ex-partners using the victim’s deteriorating mental health, co-dependent substance misuse and / or new abusive relationships to maintain control over her, for example, through threats of calling child social services. In DHR20, the victim disclosed how her ex-partner (the father of her child) would force her to take drugs as a form of control: “I could not breast feed as he kept putting coke in front of my face, said that if I told social services, they would take the children away...I have been trying to keep the children safe, but he is not letting [me]”. Meanwhile, in DHR30, the victim’s ex-partner told professionals and family members, including their child, that the deceased was “not capable of looking after the child” and was a “useless mother”, alongside making repeated threats to call the police on her. In DHR02, the victim’s ex-partner took matters further and commenced legal proceedings against the deceased in order to seek custody of their child, stating that she was “unable to cope with the child” due to her mental health.

Though there were many contributing factors which led to the death of the victim in DHR02, there was clear evidence that the risk and eventual loss of contact with her child was a significant marker in her deteriorating mental health.

Partners' Prior Domestic Abuse Convictions

As noted above, there are substantial gaps in our data in respect of partner's vulnerabilities, needs, and risks. Often, the lens for gathering this information was restricted to whatever information the deceased was known to have shared with agencies about their partner(s). For example, DHR09 contained the most detail surrounding the partner's personality, needs and vulnerabilities, but this was primarily due to the fact that much of the deceased's engagement with services involved making inquiries about complications her partner had with his mental and physical disabilities. On rare occasions, information about partners was also made available to the DHR panel as a consequence of direct agency involvement, but this was typically only with the partner's consent: which was often denied or given only subject to restrictions. In DHR02, for example, the previous partner and father of the deceased's child, contributed to the DHR process only insofar as to deny any allegations made about a violent incident perpetrated by him. Thus, our data is largely limited here to discussion of suspected perpetrators whose vulnerabilities affected the *victim's* needs rather than a detailed understanding of the partner's profile on its own terms.

One area where we had a higher level of references to partners' profiles related, however, to their prior domestic abuse convictions, or allegations of abuse made against them by previous partners. Advocate 1 observed, "lots of them have been abusive before, whether or not they've got a criminal history." And certainly, there were numerous references in the data to police involvement in incidents perpetrated by the deceased's partner (n=10). In DHR13, for example, the panel accessed information that the victim's partner had been arrested for a domestic abuse related assault in a different relationship. Though no further action had been taken following that arrest, a pattern of abusive behaviour was able to be identified within that relationship which provided additional understanding of what the victim may have experienced before her death. In some DHRs, perpetrators were shown to have a consistent history of violence against women, documented in one case (DHR26) by over twenty years of criminal convictions. In such cases, the modes and patterns of abuse demonstrated were often indistinguishable from those documented in homicide cases, where the perpetrator's role in causing death is not in question.

This is reflected, for example, in the timeline overleaf of police involvement in the case of DHR32:

Table 2: Timeline of police involvement in the case of DHR32

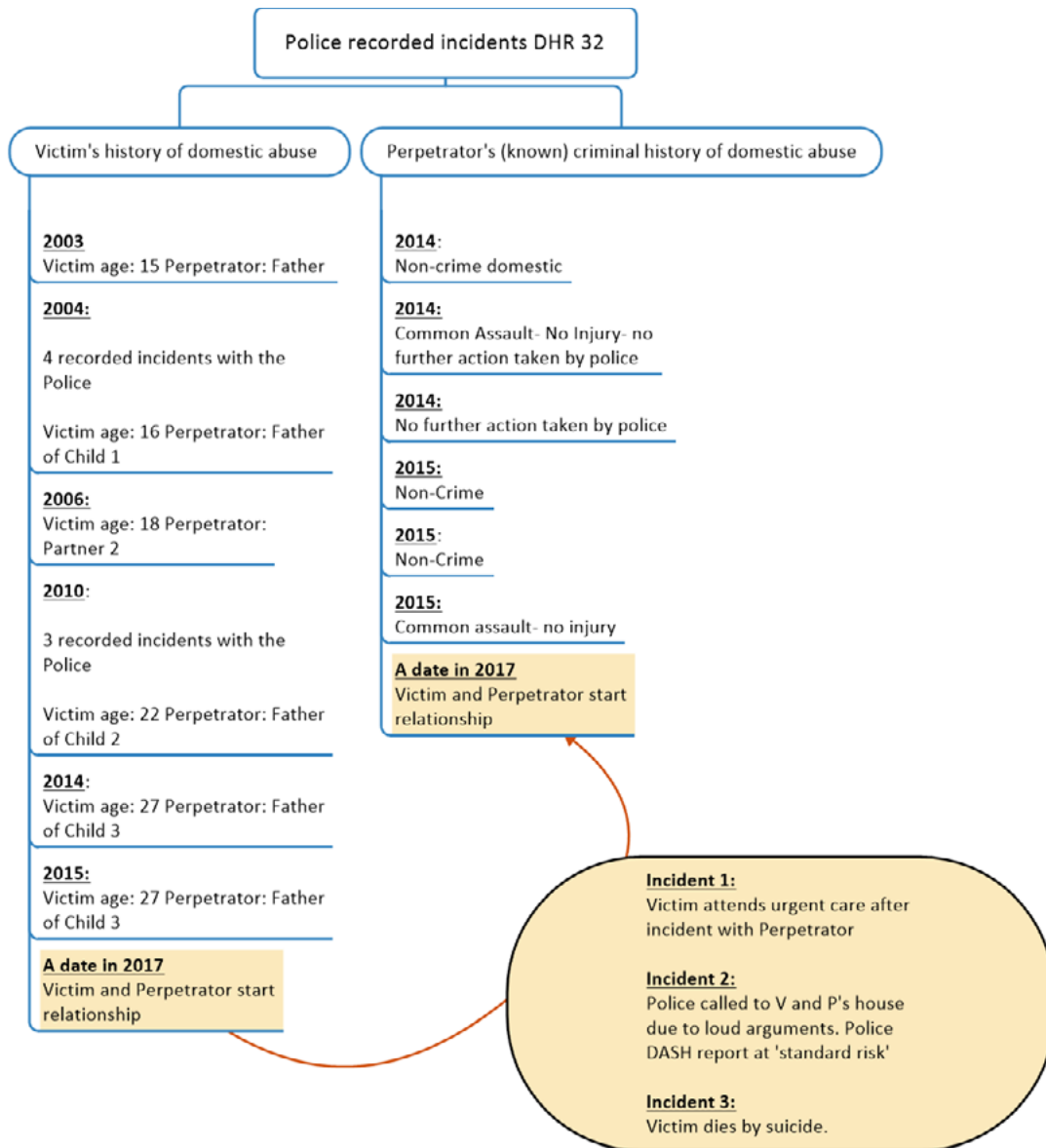


Figure 6: Police recorded incidents in DHR32

Despite this, in only one of the DHRs in our sample was a classification of Domestic Abuse and Serious Perpetrator (DASSP) made in relation to the perpetrator, and only two cases resulted in a restraining order being made against partners in respect of prior allegations or abuse. Though the Domestic Violence Disclosure Scheme (often referred to as 'Clare's Law') is intended to improve intelligence-led safeguarding in respect of serial domestic abusers, it was unclear from our dataset that it was being utilised effectively or consistently in suicide cases. In the aftermath of victims' deaths, family members often reported to us that they had been unable to obtain information as to partners' history in this respect. As Family Member 9 put it: "we have been given the head nod that there is a pattern to his behaviour but we're not sure... whether that pattern of behaviour is domestic abuse, coercive control or whether it's something else."

Evidence of Complex Needs

The discussion above highlights the ways in which historical experiences of abuse can generate complex needs and vulnerabilities that not only leave victims more susceptible to perpetrators of abuse, but diminish the practical and personal resources they have available to extricate themselves from future abusive relationships. Across the DHRs in our sample, there were examples of victims navigating complex needs, some of which – due to barriers to disclosure and siloed working – were unknown to all agencies with whom the victim engaged until after their death. In this section, we focus particularly on needs tied to victims’ mental health, other disability, alcohol and / or substance misuse, housing and / or financial precarity, immigration precarity, and culturally specific needs. Some of these needs predated victims’ exposure to domestic abuse and would have generated risks and vulnerabilities regardless of this factor. However, it was also clear that a number of these needs were created or exacerbated by the experience of abuse, for example, with substance misuse often acting as a coping mechanism and factors tied to financial, housing or immigration precarity operating to diminish victims’ prospects for escape.

Mental Health

In many of the DHRs, there was evidence of long-term mental health diagnoses, but there was a tendency for this to be deployed less to present a holistic understanding of the victim’s experience and needs, and more to offer an explanation for their suicidality. This resulted often in missed opportunities – both amongst the services that supported victims during their lifetimes, which we discuss below, and in the DHR itself – to recognise the ways in which domestic abuse can cause and aggravate mental ill-health. In DHR15, for example, the victim was reported to have been consistently stalked and harassed by her ex-partner, with evidence of breach of multiple restraining orders. Living with a diagnosis of Bipolar Affective Disorder and Emotionally Unstable Personality Disorder, comments were raised by service providers suggesting that the victim’s challenging behaviour had placed barriers to their engagement with her. But no opportunity was taken in the DHR to question whether agencies were in fact required to do more to meet their anticipatory duty to make reasonable adjustments – for example, by providing aids to communication that would better facilitate their engagement with, and support provision to, victims.

Meanwhile, in other DHRs, there was inadequate attention paid to the ways in which partners may have targeted the victims *as a consequence* of vulnerabilities tied to their mental health diagnoses. In DHR01, for example, the victim had a history of prior domestic abuse perpetrated by her father and ex-husband, which resulted in complications in relation to her Bipolar Affective Disorder. This led to her having to spend time in psychiatric care on several occasions. She met her final partner just after being discharged from hospital. She reported to services that he pressured her to make substantial purchases for his benefit, which the evidence suggested he continued to do until her death, despite their separation. This idea that abusive partners deliberately targeted victims’ mental health vulnerabilities was reflected in Family Member 6’s account of the origins of her daughter’s relationship with the perpetrator: “she didn’t have an ounce of confidence and he picked her out because she was vulnerable. He picked her out when she was diagnosed with post-traumatic stress disorder [after rape] and she never recovered.”

There was also no discussion across the DHRs about the particular challenges that neurodiverse victims may have faced. Family Member 1 shared, for example, how her daughter’s dyslexia affected her chances of receiving appropriate support. She described how her daughter struggled to read letters from agencies, maintain a job, and make sense of bus timetables: “she’d obviously been offered alcohol support, but then they do it through certain agencies where they send letters, send appointments, which she actually couldn’t read half the letters because she was so severely dyslexic and had learning disabilities”. Again, this raises the

question of whether more could be done to understand what reasonable adjustments are needed for those in domestically abusive relationships facing additional barriers due to neurodiversity.

Disability

Of course, mental ill-health falls under the wider banner of disability and as such should be acknowledged in DHRs as engaging issues under the Equality Act 2010. Not only was it not clear that this occurred in a systematic manner, but there was also not a consistent approach to this in relation to physical disability. In DHR16, for example, the victim suffered serious injuries which had left her physically disabled and with limited mobility. After divorcing her husband of 30-years, she faced financial challenges in accessing support from social services. It was noted that the family would provide support when they could, but after her separation, she felt like she was alone. The perpetrator had just left prison when he got in contact with the victim, and within 6-months had moved into her home. After an incident of physical violence, the victim disclosed to police that the perpetrator had physically, psychologically, and financially abused her. There was also evidence in this case to indicate that he had deliberately targeted the victim and taken advantage of her physical disabilities not only to have accommodation after prison release, but to access funds for his drug habit. Despite this, the DHR concluded that “there is very little evidence that [the deceased’s] vulnerability due to her physical disability formed part of professionals’ considerations. As well as the practical consideration that it made her less able to resist physical abuse, her reliance on care in her home day to night might have made her reluctant to report abuse at an early stage”.

In instances where victims were caring for partners with long-term disabilities, there was also evidence of an increased vulnerability to coercive and controlling behaviour. In DHR09, for example, the deceased’s husband had various complications with his physical and mental health, which resulted in the majority of the couple’s service engagement focusing on his needs. On the day of her death, the deceased called the police to disclose her suicidal intentions explaining that she had experienced years of emotional abuse which she described as “mental torture”. It emerged that service providers had not previously spoken to the deceased separately to identify any risks associated with undertaking a full-time caring role, which might have created an opportunity for earlier disclosure of, and support provision in response to, the abuse. A related concern was also raised in relation to the burden of caring roles on elderly couples. DHR Chair 4 observed that this group are often hard to reach: “with an elderly couple, what I find is that there are some vows that they took years ago and...they are precious to that generation...you’ve got these old-fashioned principles of wedding vows and old-fashioned principles of I can look after her, and it’s quite obvious to agencies that they can’t”. As noted, the age of victims in our sample tended to cluster in a younger bracket, and we did not see cases of elder abuse, but it is impossible to know if this is reflective of the concern raised about elderly victims of domestic abuse being less visible to statutory services.

Suicidal Ideation and Self-Harm

Across our DHR sample, 67% of victims who had presented signs of suicidal ideation and / or made prior suicide attempts before their death, also had a history of self-harm. DHR Chair 4 was clear that “very often self-harm is an indication of the want of need and support” and, though not always recognised as such by agencies, it ought to precipitate a high-risk response in relation to suicidality. In DHR22, for example, the victim’s clinical history showed that his self-harming and suicidal ideation was a central focus of his engagement with health services throughout his life. Nonetheless, the DHR concluded that suicide risk assessments undertaken fell below acceptable standards with a lack of compassion reflected in the treatment of the deceased and a failure to properly recognise and respond to his trauma. In

some cases, there was also evidently a lengthy history of prior suicide attempts. In DHR25, for example, it was reported by the victim's GP that they were aware of four previous overdoses, one of which was described as a "serious suicide attempt". Though self-harm, suicidal ideation and / or previous suicide attempts were thus often documented, it was clear that the scale of these sometimes only came to be known about in a haphazard way, suggesting that under-recording may also be common. In DHR15, for example, the deceased was taken to hospital after disclosing that she had taken an overdose. It was only after a 'Concern and Vulnerability Form' was completed that it emerged she in fact had a long history of self-harm, including three prior suicide attempts that had not been properly recorded in her medical notes.

Alcohol and Substance Misuse

Where there was alcohol and / or substance abuse documented on the part of the deceased within the DHRs, there were also often signs of consistent self-neglect and deteriorating mental health. 50% of victims in our sample (n=16) had experienced challenges associated with drug and alcohol misuse, and in all cases, this served - in different and sometimes complex ways - to aggravate other vulnerabilities. For example, 43% of those who had disclosed issues with alcohol or drug misuse also reported a history of childhood abuse and trauma. The implications of that were clear in the case of DHR11, where - as mentioned above - the victim reported a history of child exploitation during which she was exposed to substances from a young age. As a result of subsequent years of misuse, agency reports documented that she had drug-induced psychosis which often resulted in episodes of severe self-harm and which made it difficult for professionals to conduct a full mental health assessment to determine her risks and needs.

In many of the cases, there was also evidence of a pattern whereby previous or current partners had introduced victims to different drugs and used this as a form of control. In DHR20, for example, the couple were described as having a co-dependent relationship with drugs: "information indicated that [the victim] and [her partner] were both involved in substance misuse and that drugs appeared to be a dynamic in their relationship." There was also frequent evidence of the involvement of alcohol and / or drugs in incidents where violence or abuse was directed at the victim, and in several cases the deceased was established to have taken substances before or during prior suicide attempts, or its presence in the deceased's system was confirmed at their post-mortem, even where it was not the cause of death.

The complex interplay between domestic abuse and alcohol or drug misuse was not always appropriately recognised within DHRs, but in DHR13, the panel did emphasise that evidence of alcohol misuse in the victim's life should be understood not "as causal factors for domestic abuse" but rather as "symptoms of those who are being abused". This is an important distinction, echoed in contributions from family members who identified substance use as a form of "self-medication" (Family Member 3) or "a crutch" (Family Member 4) for their loved ones experiencing abuse. As we discuss below, however, it was not always clear that this nuance was taken on board adequately within victim's service interactions.

Financial and Housing Precarity

Financial and housing instability created difficult conditions for victims to leave abusive relationships in many of the cases in our sample, and particularly so where victims were living with dependent children. Other Professional 5 explained that, in their local area, many victims who were homeowners had struggled to leave their abusive partners since "there's a lot of pressures on people that are homeowners, so asset rich but cash poor...and lots of victims really don't want to go back to the property where all the abuse happened, you know, they wouldn't feel safe there, and actually, their options are really limited". The

implications of this were reflected upon by Family Member 8 who recounted how her daughter, “after years and years of ongoing abuse and just horrific circumstances” left her ex-partner to move in with her mother: “her and the three children moved in with us, in our two-bedroom house, with my younger daughter and my partner”. Though clearly not an ideal housing solution, Family Member 8 noted that they “managed to get through that and we found her a flat”. But when her daughter had her children removed by social services as a consequence of abuse in a subsequent relationship, this lack of housing resource again became key since the family had no capacity to assume custody and the children had to be placed in local authority care. Family Member 8 felt this was a key factor in precipitating her daughter’s suicide. Meanwhile, in DHR17, financial constraints on both sides resulted in the deceased living at the same home as his estranged partner; and it is reported that these living arrangements not only contributed to tensions within their relationship but also played a significant role in the deterioration of his mental health.

The provision of specialist and structured housing support for victims of domestic abuse was identified in several DHRs to be crucial, with some examples of good practice available. In DHR12, for example, staff identified that the deceased required specialist domestic abuse support and aimed to collaborate with other agencies, including housing, to ensure that her needs were met. At the same time, it was clear that victims who struggled with substance misuse and addiction often encountered greater challenges in securing stable accommodation via housing associations. In addition, conditions imposed on the receipt of housing lacked understanding of the dynamics of domestic abuse: in both DHR05 and DHR15, for example, tenancy agreements explicitly stated that the victim’s partner would not be permitted on the premises as a response to reports of abuse. In both instances, the deceased was reported to have breached these requirements resulting in withdrawal of support from housing associations, but no consideration was given in either case to the possibility that the partner’s presence may in fact have been an indicator of their coercive control and thus the victim’s ongoing abuse. The consequence of this is that victims become more vulnerable to homelessness or staying with abusive partners. In DHR11, for example, after various failed attempts to secure supported accommodation, the deceased was deemed ‘intentionally homeless’ which reduced her priority for housing, and reports of the deceased’s non-engagement with her tenancy key worker meant she did not receive the support that she required in relation to budgeting and benefit applications, as well as in respect of registering with her local GP.

There were other cases in the sample of DHRs in which agencies also failed to recognise and respond to risk in the context of housing provision adequately. In DHR26, for example, the victim was subjected by a partner that she had tried to leave on numerous occasions to a sustained campaign of stalking and harassment, resulting in several non-molestation orders being made against him. As a consequence of her relocation to a refuge in a different part of the country, she was assessed to be at reduced risk and, at a time when new non-molestation orders were being issued and immediately breached, she was threatened with eviction from the refuge because of an inability to pay rent, while police and domestic abuse services advised they would not be able to provide enhanced security in other accommodation.

Immigration Status Precarity

Across our sample, there was only one DHR in which the deceased appeared to have faced immigration challenges (DHR10). There was little evidence here of any service engagement with this victim, and no family involvement, so the DHR report could only paint a brief picture of her life. The main timeline of her activity in the UK is thus formulated by several immigration applications which were later refused.

Despite there being so little agency involvement, there is much to learn from this DHR. It was also the only case in our sample which involved domestic abuse and exploitation between family members rather than partners or ex-partners. The victim came to the UK from India to live with her aunt and uncle while she studied. However, her entitlement to an education visa subsequently lapsed, rendering her stay illegal. Friends reported that the victim had to take on a considerable amount of household duties, was restricted on who she could see, and had limited access to her finances and mobile phone. The only contact she had with agencies during her time in the UK was with her GP who described her as a “happy traditional India girl,” notwithstanding the fact that she had asked the GP to write a sick note to her family saying she should not do any housework because of backpain. Though this was an indicator of the abuse, the GP did not probe further, despite acknowledging during the DHR that the possibility of honour-based violence crossed her mind. The GP reflected that, because the deceased was a certain age and from the same cultural and religious background as herself, she did not feel that this was likely to have been a risk. Though the DHR rightly identifies amongst its recommendations that GPs should receive more training on honour-based violence and exploitation, and not be driven by their own assumptions when identifying risk, it does not go further to interrogate the cultural biases that influence engagement with such victims and the safety that victims might feel in disclosing abuse where their immigration status is precarious.

Culturally Specific Needs / Risks

DHR10 is instructive not only in respect of the question of immigration precarity, but also the wider issue of identifying and responding to victims’ culturally specific needs or risks. Across our sample, there was a lack of representation amongst victims from minority ethnic backgrounds. The purposive nature of our sample, its relatively small scale, and the fact that the process of commissioning DHRs is dependent on agency recognition of abuse and referral may all be significant factors here. But two things are particularly noteworthy: first, there were several DHRs where the race or ethnicity of the victim was not properly recorded (missing in 20%); and second, various interviewees intimated concerns about the extent to which suicides in minority communities were being adequately investigated. When asked about diversity in the suicide DHRs that they had worked on, DHR Chair 12 replied, for example, that “no most of them are White British of the ones I’ve looked at.” They then went on to reflect particularly about a case they had been aware of in which a partner “did all those bits of, they’ll never believe you, you are from abroad, I will have the children” but the police failed to situate this within a frame of coercive control and instead purely “saw it as an escalation in her violence against him”. More broadly, DHR Chair 7 observed that: “people who are furthest from services are often people who are in some way marginalised...some communities, because of the stereotyping that’s happened, we know that Black people have got...much poorer results from mental health services...[that] is knowledge that we need to use in order to understand the complexity of what’s happening with people” in respect of domestic abuse suicide.

This lack of diversity (reflected also in the composition of DHR Chairs) clearly merits further exploration, particularly in a context in which previous research with organisations supporting victims in minority ethnic communities has indicated a correlation between abuse and suicidality (Chantler et al, 2001; Siddiqui & Patel, 2011). It raises crucial questions about the work that specialist and statutory services are doing to identify and respond to suicide risk factors in diverse communities, and how they are engaging with individuals who may have culturally specific needs and anxieties in respect of disclosure. In DHR02, for example, the deceased had shared that it was very important to her that she received specialist support from an organisation that was sensitive to, and familiar with, her minority ethnic community background. However, the opportunities for such access are often limited, and particularly so where victims are isolated from major cities. Meanwhile, in DHR18, the victim who was of

Sikh origin was noted to have contravened the cultural norms of her community by leaving her family and marrying a white man, with whom she led an isolated life marked by abuse until she took her life. On the one hand, this DHR acknowledged the additional risks that being ostracised from networks of support may have posed to the victim, and highlighted the need for agencies to better explore the significance of her cultural background. On the other hand, however, the tone of the report tended to presumptively 'other' her as a result of her heritage. It noted, for example, that "culturally, some in Sikh society have struggled" with the concept of sex equality and suggested "it is a fair assumption that [the deceased's] thoughts and actions...will mirror this." As a consequence, it concluded that, whether "by design or by cultural influence", the victim's assertion during a Crisis Team assessment that she wanted to be a "typical Indian wife" was apt to make her "minimise her well-being" and place her partner's needs ahead of her own.

In a context in which, as noted above, information regarding partners is generally lacking in our sample, this also applies in respect to their ethnicity profiles where it was missing from DHRs in 56% of cases. It is important to note, however, that some of the considerations raised here in relation to victims may also apply, however, to agencies' involvement with suspected perpetrators who are not White British, and the extent to which cultural or racial bias informs their assessments of 'acceptable' relationship norms.

Theme 2: Agency Engagements and Responses

Amongst the findings that our sample of DHRs most clearly reveals, then, is that victims were often navigating a variety of complex vulnerabilities and needs, and frequently doing so, moreover, in the plain sight of statutory services. Just over half of the victims had engaged with specialist domestic abuse services, almost two-thirds had engaged with mental health and / or counselling services, and similar proportions had attended hospital or A&E services in conjunction with their abuse, with three-quarters known to have also been in at least relatively regular contact with their GPs. Notwithstanding the higher rates of drug and / or alcohol dependency indicated in the DHRs, less than 30% of victims had accessed support from specialist addiction services. However, over 90% had a history of contact with the police, often as a result of domestic abuse reports, and more than half had prior or ongoing contact with housing services, often due to being in a precarious housing situation. 47% had been involved at some time or another with a MARAC intervention. In respect of partners' service engagement, there continues to be a dearth of information available in the DHRs - indeed, only 2 of them included any information about whether they had previously been referred to or attended a perpetrator programme. It was more common for information to be recorded in relation to partners' broader engagement with police or probation, but even here there was no mention of it in approximately one-third of cases, and it was often included through the lens of providing context to victims' service engagements rather than on its own terms. This leaves us unable to conclude whether the absence of such interaction in any given case reflects the reality of the documentary evidence or the constrained parameters of suicide DHR investigations.

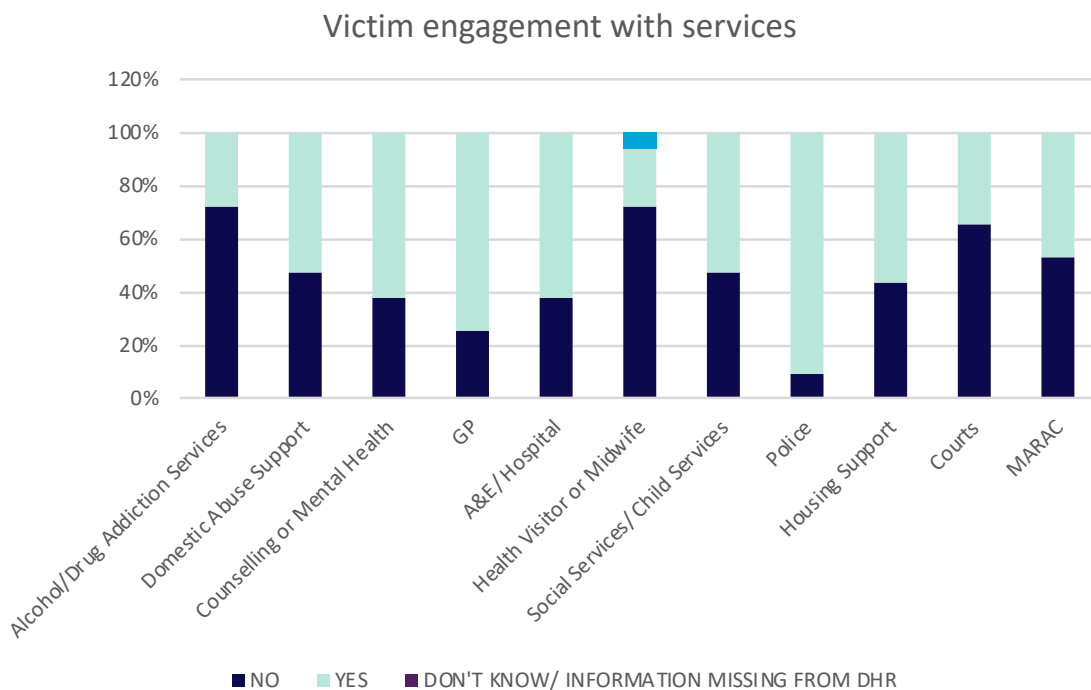


Figure 7: Victim engagement with services

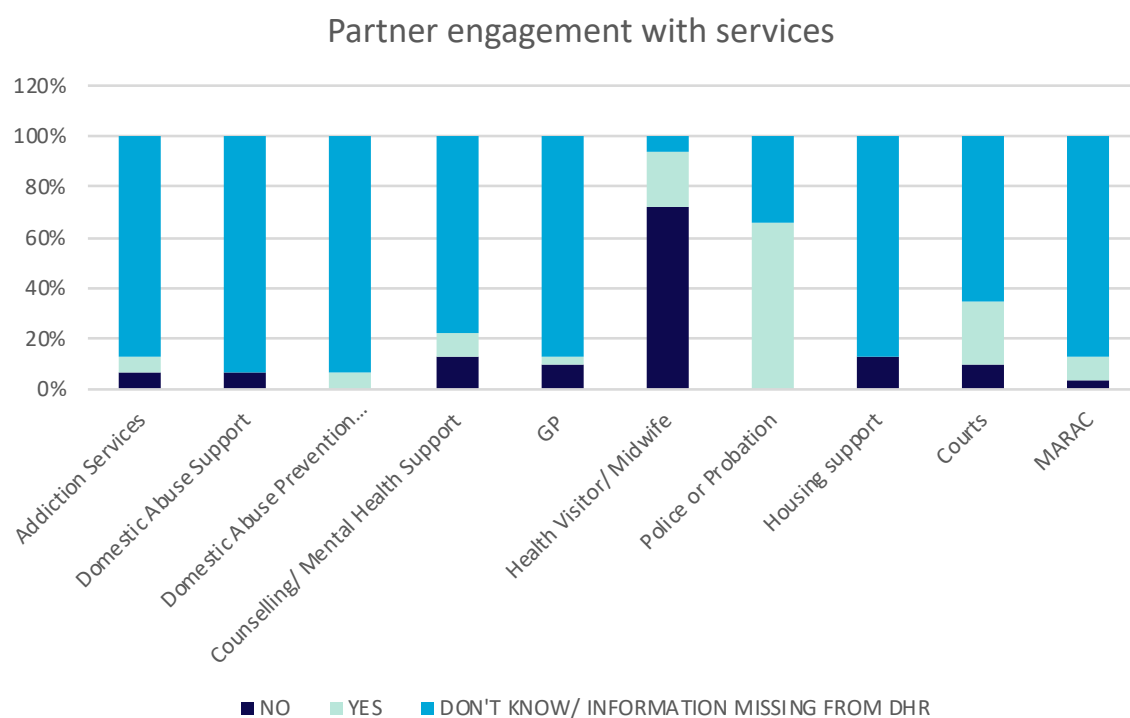


Figure 8: Partner engagement with services

There is much to unpick in our data regarding parties' engagement with statutory services, which was documented both through the DHRs and reflected upon via the stakeholder interviews. In line with previous research on DHRs in other contexts, and indeed wider research on domestic abuse disclosure and risk assessment, there was a recurring theme of lack of confidence and curiosity amongst professionals in asking questions: whether about domestic abuse, about suicidality, or about the possible inter-relation between the two. As we will expand upon below, there was also a basis for some concern regarding the suitability of risk assessment tools to properly identify and measure risks associated with controlling behaviour, hopelessness, and suicidality. Reliance on professional judgment to mitigate these shortcomings in risk assessment is particularly problematic where training around suicidality is partial and resourcing is limited, with many responders who administer these tools being inexperienced and overwhelmed. As CSP Lead 3 articulated it: "I think people understand...that a high risk is high risk of serious harm or homicide...I don't know if they necessarily understand the potential suicide risk that sits alongside that. I think that is a bit more of an unknown for agencies...And I don't know if the risk assessment tools themselves are specific enough around the potential for suicide."

Across the DHRs, there was considerable evidence of agencies approaching the complex and intersecting needs of victims - which we reflected upon in Theme 1 - with too 'singular' a focus, failing as a result to respond holistically to the person before them and to initiate cross-agency collaboration adequately. There was also evidence of failures to properly acknowledge or devote resources to overcoming the barriers to access that victims of domestic abuse might be required to navigate, and evidence that this led to cases being closed prematurely by agencies and / or their personnel encountering compassion fatigue. As CSP Lead 1 put it, there's "a lack of appreciation for the impact of the trauma, a lack of sort of curiosity to follow up on things when people may have dropped out of contact with

agencies or seem to be spiralling, in terms of other issues, whether that's mental health or substance use issues." There was also evidence across the DHRs of victims being let down - often repeatedly and in significant ways - by agencies, as a result of which they lacked trust in their capacity to offer assistance, which compounded feelings of isolation and helplessness tied to abuse. More generally, in line with previous research, we also found concerns regarding the effectiveness of multi-agency partnerships: though there were some examples of good practice in this respect, there were many instances where information was not shared when it ought to have been, sometimes complicated by parties' movement across regional borders.

Of course, parties' interactions with statutory services are rarely singular or linear, but tend instead to involve a cross-cutting engagement with multiple points of contact that fluctuate over time and context. Whilst acknowledging that complexity, and returning to it below in relation to multi-agency partnerships, in what follows we have primarily structured our discussion around parties' engagement with specific services, which better enables some critical reflection around how the institutional policies, operational procedures, and resourcing constraints specific to each agency might influence service interactions.

Criminal Justice System

Across the DHRs and interviews, it was clear that the deceased's engagement with police during their lifetime was a particularly prominent factor. Indeed, it was the most frequently referenced node across all types of service engagement. In Theme 3, we reflect further on the parameters and stakeholders' experiences of police engagement in relation to the suicide investigation, but here we reflect specifically on patterns in terms of the identification and management of risk for victims of domestic abuse.

In a context in which over 90% of the victims in our sample had a history of prior engagement with the police, it is important to note that this high level of interaction is not typical across all victims of domestic abuse, given well-established barriers to disclosure and reporting. Our study focuses on cases where a DHR was commissioned, and as we reflect on elsewhere, decision-making around identification and referral of suicide cases often currently relies on the existence of a documented case history, located primarily in the presence of engagement with police. It is not possible, however, given the current evidence base, to know what proportion of victims' high levels of police engagement in this sample reflects this filtering through DHR commissioning as opposed to indicating something distinctive about victims who die by suicide, given that previous research has suggested that this cohort may be acutely associated with prolonged abuse, often by consecutive partners (Bates et al, 2021; McManus et al, 2022).

There was certainly evidence across the sample of inconsistent police practices in respect of the recording of complaints, the seriousness and priority with which those complaints were investigated, the handling of victims who subsequently intimated that they wished to withdraw their support for proceedings, and the resultant criminal justice outcomes. There was also evidence in some DHRs that police were uncertain regarding the boundaries of their role and responsibility in cases where complaints made were deemed - appropriately or otherwise - not to meet the threshold for further action, but where they might be well-placed to support safeguarding. There was evidence too of some uncertainty regarding how best to respond to complaints in which there was evidence of situational reciprocal abuse: in DHR17, for example, police were called to the home in relation to both partners. The deceased's partner, amongst other things, was reported to have removed the thermostat from the house so that the deceased could not turn on the heating or hot water in her absence. Whilst the attending police officer focussed the response primarily on the deceased's mental state, missing opportunities to investigate potential coercive and controlling behaviours,

the reaction was markedly different during another incident in which the deceased's partner reported a verbal altercation, after which police suggested that she put a lock on her room to protect her from the deceased. It can only be speculated whether this more singular focus on the deceased's behaviour may have increased his sense of isolation and lack of confidence in being taken seriously by agencies when disclosing abuse. This was not the only case in which a male victim failed to be readily recognised by agencies, reflecting a wider concern raised by some interviewees, including CSP Lead 7 who observed: "once a woman has called the police, regardless of what happened, people will look at it and go, he must be a perpetrator and now he is calling the police...[But] actually there is more nuance there."

At the same time, indicators of prior criminality by victims in our sample were also often the result of failures by police in identifying the primary aggressor in domestically abusive incidents. In DHR03, for example, the police were called to the victim's home after neighbours raised concern. No further action was taken; however, the deceased was labelled as the perpetrator. During the DHR, questions were raised about this assessment and it was noted that, despite this positioning, no DASH risk assessment was carried out on the deceased's partner. The repercussions of being positioned as an aggressor can clearly be substantial for victims and yet there was evidence in the DHRs of partners taking advantage of misidentifications to dissuade victims from making complaints and a suggestion that some had deliberately lodged false accusations to build a negative profile of the victim. The impact of this on her daughter was powerfully recounted by Family Member 4: "the IDVA rang me up and she was really concerned about my daughter that she was going to [die by suicide]. She was in a dreadful state, hysterical. And she said, 'this is what he's done, mum'. He pressed charges against her...he said I'm going to make sure you end up in [name of] prison." Family Member 4 described how this experience was not only acutely distressing for her daughter at the time, but entailed that she would not engage again with police or other services thereafter: "the police believed him...so she stopped reporting to the police."

In cases where police were able to confidently identify the victim and felt assured that the threshold for their involvement had been reached, there were examples across the DHRs of good practice in respect to the carrying out of DASH risk assessments. In DHR15, for example, the perpetrator was charged with breaching his restraining order and consequently remanded in custody to appear before the Magistrates Court. Following this, the police attempted to carry out a DASH risk assessment which the victim declined. Despite this, officers used their professional judgement to grade her case as high-risk and on this basis made a MARAC referral. This was undermined a year later, however, after the victim reported to police that she had seen the perpetrator in a road adjacent to where she lived. The officer missed a key opportunity to carry out a DASH risk assessment at this stage, with a family member reporting to the DHR panel that: "the officer who dealt with [the victim] had an 'awful attitude', had accused her of 'facilitating the breach' and told her that lots of aggrieved ex-partners called the police to get ex-partners 'into trouble'." This illustrates the scale of variance in police response, but also highlights a further challenge identified in the DHRs, which related to officers ensuring that DASH risk assessments, once completed, were updated appropriately after changes in circumstance (for example, where perpetrators were released from custody) or that procedures were in place to join up historical and current risk assessments.

As discussed in Theme 1, there were several instances in which victims' partners had a known criminal history of domestic abuse, but there were issues in how these risks were managed by police. In DHR32, for example, the perpetrator was known for his involvement in other criminal incidents as well as for being a serial domestic abuser. In his probation interview in respect of drugs and firearm possession charges, there was a failure to include his history of domestic abuse within his report, and the DHR Chair opined that, if this had been included, the court may have been more likely to put a Community Order in place with requirements

in relation to domestic abuse and safeguarding. This maps to wider considerations in relation to the functioning of the Domestic Violence and Disclosure Scheme ('Clare's Law') as a mechanism for safety planning. In DHR13, for example, the Chair noted that despite the launch of this scheme, there was no evidence of disclosure on a 'right to know' basis being offered by police to the victim. Meanwhile, in DHR26, while the disclosure requested by the victim was processed by the police, revealing a long history of domestic abuse convictions as a consequence of which the police advised her to secure a non-molestation order, the DHR indicates that more could and should have been done by police to recognise the patterns of harassment that the perpetrator was subjecting the victim to, and to respond to that with greater urgency and severity, particularly as threats to her and her family progressively intensified.

Social Services

Over half of the victims in our DHR sample (n=17) had a history of engagement with social services. As discussed above, victims' adverse childhood experiences in several DHRs meant that Chairs were able to draw on agency involvement with the deceased from their childhood or teenage years. The most regular engagement that we saw in this respect was in DHR05, where the victim had weekly interactions with her social workers until her death at aged 21. The victim had developed a strong bond with her social workers and even invited them to her wedding. The main issue raised in this DHR, however, was lack of multi-agency involvement, with recommendations made to children's social services that more should have been done to refer the victim to appropriate mechanisms of support as she became an adult. Relatedly, the DHR found that the victim's pathway planning did not include an accurate assessment of her risks, both as a survivor of historic domestic and sexual abuse and as an adult in a new, abusive relationship.

The other key area of engagement between victims and social services documented in the DHRs revolved around agency concerns over the welfare of children living in domestically abusive homes. DHR Chair 7 reflected that for many victims, their "greatest fear" was that social services would get involved and remove their children. Despite this, concerns were expressed regarding the extent to which social services worked proactively with victims to enable them to "get the help they need" rather than thinking "anyone who's suicidal, they just have to put the kids on child protection" (Family Member 5). Irrespective of the safeguarding merits of any decision in relation to child removal, our data certainly provided several examples where such interventions had significant effects on the deceased. In DHR30, for example, after an incident of alleged assault against her son, a mother who was otherwise recognised to be devoted to her children, experienced a sharp deterioration in her mental health, amplified by her abusive ex-partner's insistence that he would now win the dispute over custody in which they were engaged. Similarly, in DHR25, the victim had a brief phone call with a charity specialising in supporting individuals from minority ethnic backgrounds, during which the caseworker sought to refer her to a domestic abuse service. It is reported that, at this, the victim withdrew "as she was afraid she would never see her sons again".

Advocate 1 emphasised that this was a common theme: "most of the women...who end up taking their lives, it's when partners are taking away the children or threatening to take away the children". It was also apparent that, in several of the cases where children were removed from victims, an ongoing relationship - and contact if not custody - was often preserved between the children and abusive partners or ex-partners, which was not only felt to be unfair by victims but placed them at additional risk of harm. A particularly pronounced example of this was provided by Family Member 8 who relayed that Social Services had asked her daughter to pass messages on to an abusive ex-partner on their behalf and to take responsibility for facilitating his 'garden-gate' contact with their children at her home:

something that Family Member 8 described as “so goddamn wrong” in the context of his abuse towards her.

Resolving disputes over child contact or custody where it is sought by a domestically abusive parent continues to be a significant challenge within the family courts, and an experience that compounds the trauma and vulnerabilities of victims; and potentially also of the children themselves. It was clear in our research, moreover, that this was a matter on which there was still disagreement between professionals. For example, DHR Chair 9 relayed a case in which “the lady’s children were taken into care, were taken from her, and given to her abusive partner” and she took her life very shortly thereafter. In panel discussions, the Chair remarked with some dismay that, in discussing the perpetrator, the children’s social worker had said “just because he’s a domestic abuser doesn’t mean he’s a bad father,” reflecting - in the Chair’s view - an inadequate understanding of the harmful effects on children of witnessing abuse.

Family interviewees were also particularly powerful in sharing the impact that losing custody of children had on their loved ones. Family Member 8 recounted, for example, how her daughter had been looking forward to being with her children for Mother’s Day contact and had gone to great lengths to make the day “really special”. 10 minutes prior to meeting with her children, Family Member 8 reported that:

“she was told by this social worker that social services recommendations were that the children [were] not [to] be returned to her care...and in their wisdom, they turned around and decided that she wasn’t well enough to see the children...so I got a phone call, I’d literally just got back home, asking me to go pick [name of victim] up...the children were sat in the next room waiting for their mum with flowers and chocolates...the family worker had to literally, not carry her but have her arms around her and support her because she was broken”.

It was clear that in many cases these interactions, though always apt to be difficult, were managed by social services with insufficient regard for the psychological impact that child removal would have on victims, and in particular the ways in which it might amplify their sense of hopelessness and attendant suicidality. Similar experiences were echoed across the DHR reports with patterns of missed opportunities to ensure that victims were referred to other services after children were removed or when developments in their case meant that they would be faced with delays in regaining custody. In DHR32, for example, the Chair concluded that the support that the victim had received from children’s social services fell “below the threshold” for specialist services. Cumulatively, these examples indicate that greater training in understanding the links between domestic abuse and suicidality, and in recognising the increased vulnerability of victims when children are removed from their care, is likely to be particularly key.

Emergency Hospital and General Medical Services

Across the sample, there was a significant amount of data provided in respect of victims’ engagement with GPs, hospitals, health visitors, and A&E (though comparable information about partners was almost never available due to privacy concerns, which we discuss further below). In line with previous research, a particularly common theme that we identified was the need to improve GP’s alertness to and understanding of domestic abuse, particularly including more subtle manifestations of coercive control.

Important strides have been made in this respect, with CSP Lead 1 reflecting that “we have the IRIS programme that we utilise in our GP surgeries, as a way of identifying and making referrals...that works very well, in terms of health.” The positive effects of this were demonstrated in DHR27, where the victim’s GP identified warning signs of domestic abuse in the victim’s low-mood and anxiety, which prompted her to examine injuries that proved to be consistent with physical and sexual abuse. The GP maintained regular communication with the victim’s IDVA, and was the primary source of support to the victim in the final years of her life. This, however, was a relatively rare example and the DHRs continued to provide evidence of crucial opportunities being missed. In DHR13, for example, the Chair noted the absence of any evidence that the GP had conducted a domestic abuse risk assessment despite the victim’s ongoing use of anti-depressant medication and the fact that her partner was known to have prior convictions of domestic abuse. Meanwhile, in DHR16, the victim lost 5 stones in weight in the two-month period after she married the perpetrator (a marriage that she subsequently suggested she had not wanted to enter). The GP with whom she was in contact during this time was aware of her abuse in her previous marriage, as well as her current relationship; and had noted in her file both that there had been recent call outs from the police and victim support, and that she appeared to be in “acute distress” during a consultation. Despite this, rather than probing further, he noted that “she was a large lady” and so her dramatic weight loss was to be welcomed. Of course, as professional interviewees noted, a key issue here is not just training but also the resource constraints of general practice. As CSP Lead 5 put it, “one of the key agencies that our individuals who [die by suicide] had contact with was their GPs. However, if they’re presenting at the GP... you’ve got 7 minutes..., you’re down, you’re up, you’re gone. If you’re presenting with a bad back or presenting with being tired, is the GP going to actually relate to that and think, domestic abuse?”.

Similar challenges were also identified in victims’ engagement with hospital Accident & Emergency departments, where resource pressures often resulted in rushed decision-making that missed opportunities to identify and respond to suicidal ideation or abuse. A striking example of this was recounted by Family Member 6: her daughter, following a violent attack, phoned for an ambulance and was taken to hospital where it was recorded that “she was in a very vulnerable state” and staff “were concerned for her safety and welfare”. Having expressed reluctance in response to the hospital’s suggestion that she report the incident to the police, staff placed a cannula in her arm pending further examination, and then left her unattended. When the team returned to top up her fluids, she had gone - her partner had arrived at the hospital and she had left with the cannula still in her arm. The staff called and asked her to come back to have the cannula removed, which she initially agreed to do; but when they followed up some 30 minutes later, she said “she wasn’t coming back...she was with him.” The DHR in this case is pending, but Family Member 6 - who had accessed many of the relevant medical records - understood that there was no further follow up from the medical team on that occasion, notwithstanding clear indicators of risk. Meanwhile, in DHR18, the deceased was taken to A&E by police officers after he appeared to have a mental health crisis. Though he communicated his suicidal ideation in an initial assessment, pressures on the Psychiatry Liaison Team meant he was discharged from hospital after being further assessed as not suicidal, with a plan to self-refer for psychological therapy and inform his GP for further support. In other cases, such experiences of a lack of follow-up through healthcare services clearly contributed to victims’ withdrawal from support. In DHR25, for example, the victim was taken to hospital and asked for a psychiatric assessment. Though hospital staff completed a DASH risk assessment, there was a lack of understanding as to how the victim’s experiences of domestic abuse had been an aggravating factor in the deterioration of her mental health. Indeed, ultimately, the psychiatric assessment concluded that “the husband may need some extra support as he is not coping with the patient having psychotic behaviour”. The DHR report emphasised that this outcome was likely to have had a “profound impact on the victim”, reflected in the fact that she never sought medical support for her mental health again.

Counselling or Mental Health Services

Over 60% of victims had accessed counselling or mental health support services across the DHRs. In addition, there was evidence in 5 cases of partners accessing this support, often as a result of encouragement to do so from the deceased. In both DHR18 and DHR09, the panel were only aware of the partner's access to mental health services through evidence gathered in the context of the victims' disclosures. In DHR18, however, suspicions were raised about the extent to which the perpetrator relied on mental health concerns to control the victim: "the review author is keen to emphasise 'alleged' PTSD as there is no provenance within the records examined and agency reports that can verify or identify this as a matter of fact. As the review author has already stated this would appear to be untrue and most probably a way that he used to coerce and control [the deceased]". Similarly, in DHR06, there was evidence that the convicted perpetrator had used her access to mental health support services as a method to financially and emotionally control the victim. Despite the fact she disclosed to mental-health services that she had the tendency to attack her partner when she was angry, there was no evidence of this information being passed on to other agencies. As a result of this, opportunities were missed for sharing information between services to identify potential abusive behaviour from partners.

In most cases involving victim engagement with counselling and mental health services, referrals were either made through disclosures of low mood to GPs or self-referrals. In some cases, they were only made after suicide attempts or incidents of serious self-harm. In DHR12, for example, the victim made a dozen attempts to die by suicide in under a year, after which she was referred to specialist mental health housing support, but due to errors in processing the referral her placement was delayed: she stopped responding to calls from the support team and took her own life within the month. Periods of uncertainty in accessing long term mental health support after speaking with GPs often resulted in a faster deterioration of victim's mental health, and long waiting lists for services were common. The implications of this were often reflected upon by family members. As Family Member 6 put it, for example, "by the time she got to see the psychologist, she had taken four overdoses. They put her on a waiting list".

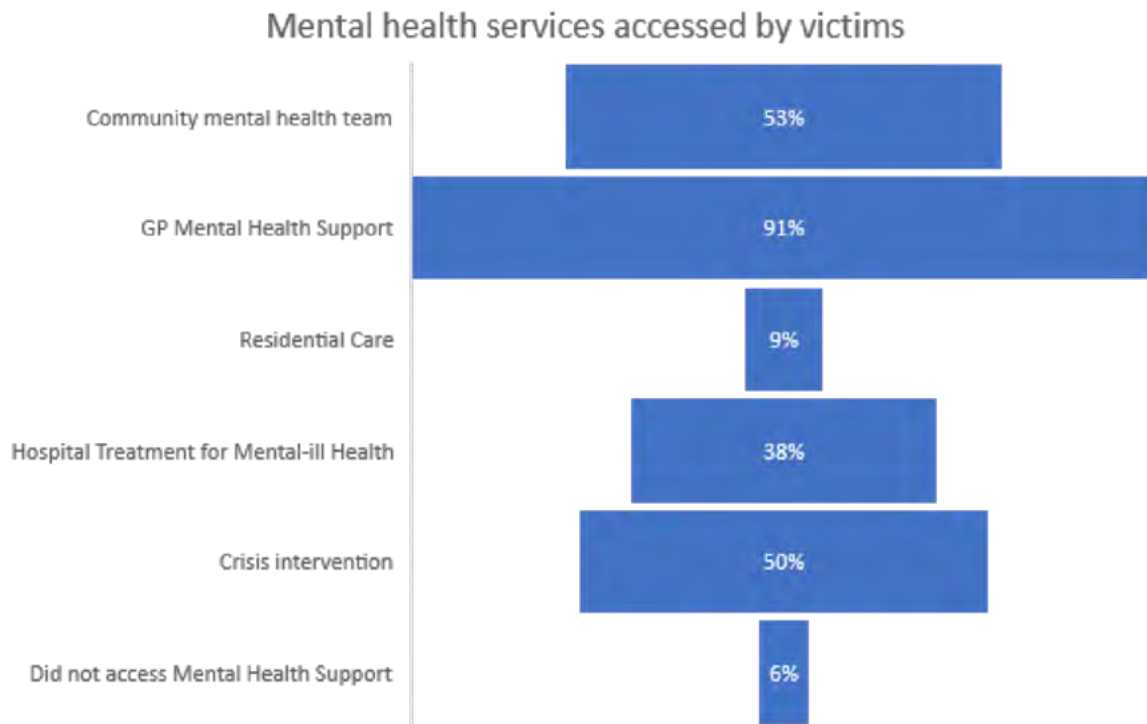


Figure 9: Mental health services accessed by victims

Figure 9 above illustrates the types of mental health service accessed by victims across our sample, and gives a good indication both of the scale of that engagement across the cohort and the extent to which this spanned local GP support through to specialist treatment and crisis interventions. In terms of victims' experiences of counselling support, once initiated, there was evidence that this tended to fluctuate in intensity depending on perceived engagement, often with a lack of 'joined up thinking' in anticipating crises. For example, in DHR19, the victim had been informed of a decision by police not to take further action in respect of two historic rape allegations. Despite evident vulnerability, no anticipatory provision was put in place to help her, and she took her life 5 days after attempting to restart mental health support. More broadly, there was, in some cases, evidence of proactive and trauma-informed practice, which helped to maintain engagement often despite victims' chaotic lives. In DHR02, for example, it was recorded that, despite difficulties in engaging with services overall, the victim had developed a particularly positive relationship with a named counsellor. At the same time, there was also often evidence of failures to empathise with the barriers to engagement that victims might encounter or to work creatively to overcome them, even where that non-engagement was reflective of worsening mental health or the entrenchment of pre-existing vulnerabilities or abuse. Family Member 1 recounted, for example, that though her daughter's non-engagement with support for her anxiety, depression and alcoholism stemmed from the control she was experiencing from her partner, it was an "automatic strike off" when she failed to attend an appointment. She underscored the profound inadequacy of that approach: "you know, to somebody with a problem like that, where they can't get of the house, the perpetrator doesn't allow them out of the house to know where they're going, and then you don't support them."

Part of the problem in these cases lay not only in a tendency to separate mental health concerns from other vulnerabilities, but to demand a particular state of 'readiness' for mental health treatment - reflected, for example, in being drug-free, having stable accommodation or capable of reliably attending meetings at specific times or venues, which was often difficult

for victims to achieve. As DHR Chair 13 put it, “mental health services may want to deal with a mental health issue but won’t engage until the person has dealt with their substance misuse issue. But they can’t deal with their substance misuse issue because they’ve got some underlying mental health issues that drive them back to it”. In this context, and particularly where there is a history of domestic abuse, withdrawal from specialist mental health services ought to be treated with caution, as a trigger for exploration, action and engagement, rather than interpreted as an autonomous decision representing victim disinterest or a lack of pressing need.

Alcohol and Drug Addiction Services

Of the 16 DHRs in our sample where there was evidence of drug or alcohol misuse, the victim had contact with specialist addiction services in only 9 cases. Moreover, engagement with these services was often described as “sporadic and of varying quality” (DHR07). In only one case was it noted that addiction services had a more prominent role in the victim’s life (DHR11). Again, though previous research has suggested a high prevalence of addiction issues amongst perpetrators of abuse, there were only 2 DHRs in which reference was made to partners having accessed specialist services, with minimal information as to the nature of support provided. In DHR23, the only information presented to the panel was that the suspected perpetrator was ‘known’ by addiction services as it was a condition of their suspended sentence order. Meanwhile, in DHR30, the deceased had shared with service workers that her partner had been attending Alcoholics Anonymous (AA), though this was neither confirmed nor denied by her partner.

DHRs typically provided no information regarding how victims became aware of specialist addiction services or their referral pathways towards them. The only exception to this was DHR23 in which it was reported that the victim was referred after attending the Accident & Emergency department in the wake of a road traffic accident where he had taken heroin and consequently been knocked off his bike. This lack of information makes it impossible to draw any conclusions in this study regarding practice across different agencies with whom victims might interact in terms of methods or frequency of referrals.

There was, however, evidence of robust suicide prevention policies and risk assessments across addiction services in our sample, often tied to an appreciation that those navigating substance misuse are at a higher risk of taking their own lives. In-depth understanding of how different drugs affected mood and mental-health risks also meant – as evidenced in DHR11 – that addiction services could be especially useful in supporting victims through times of crisis. There were challenges identified, however, in relation to the handling of disclosures of domestic abuse and the ways in which this fed into risk assessments, as well as how such information was shared. In DHR20, for example, the addiction support worker saw that the victim had reported coercive and controlling behaviour by their partner, but there was no evidence to suggest that this information was shared with other agencies; meanwhile in DHR11, the Panel concluded that there were missed opportunities to fully explore the victim’s disclosures of domestic abuse, due to confusion regarding who held responsibility for such investigation after a MARAC referral was made.

Addiction support services often reported to DHRs that they had experienced challenges in engaging victims, with occasions of difficult behaviour preventing support workers from progressing with treatment. The language used to describe these challenges in the DHR reports was often problematic. In DHR07, for example, the victim’s engagement with addiction services was described as driven by her self-interest: “looking across all the separate reviews and the records of each agency it is reasonable to say that [the deceased] approached, and worked with, agencies when she saw personal benefit.” The Chair highlighted that support services went above and beyond to provide support despite her “challenging” behaviour,

including “the social worker who put so much time and effort to support [the deceased] despite her inability or unwillingness to receive help, and her well recorded aggressive and combative behaviour” (emphasis added). Rather than seeing her addiction as a health issue, the victim is attributed with considerable agency over her ‘choice’ to continue treatment, and there is a failure to consider appropriately the effects that her partner’s behaviour towards her had on her mood and addiction.

This in turn maps on to a further concern, raised by one family member during an interview, regarding the ways in which victims’ engagement with addiction services can paradoxically also work against them in the eyes of others. Specifically, Family Member 3 shared that it was in an alcohol support group that the victim first came to appreciate that the trigger for his drinking was the abuse to which he was being subjected: “the only people he got any kind of escapism from was going to this group.” Though Family Member 3 suggested that attending was primarily performing a “social” function, offering him community and understanding, she noted that agencies were quick to attribute his suicide to his challenges with alcohol - “because he had alcohol and a small amount of cocaine in his system on the night he died, that was it” - and this made it far more difficult to secure recognition of the abusive context or trigger a DHR.

Domestic Abuse Charities and Independent Domestic Violence Advisors

Just over 50% of victims in our sample had accessed specialist domestic abuse services, with support most commonly being provided by Independent Domestic Violence Advisors (IDVAs). Considering that these were cases with sufficient (documented) evidence of abuse to meet the criteria for DHR commissioning, it is perhaps surprising that, despite an overall profile of agency visibility, more victims had not in fact engaged with this support. Reasons for this will vary but are likely to include barriers to disclosure, failures by other services to make referrals, and restricted access to or availability of specialist services. Some interviewees intimated that the time pressures and lack of resources under which professionals are working entail that, even though “sharing the load” (via referral to an IDVA) is likely - in the longer term - to make interactions with the victim more manageable and improve support provision, it can feel like an extra thing and there is a “siege mentality” that “I’m really busy so I need to just focus on what I’m doing” (DHR Chair 3). In addition, there was also an evident appreciation amongst professionals of the increasing capacity challenges on IDVA services themselves, which might disincline them from making a referral. As DHR Chair 10 put it, “our ability to confidently ask about and...respond to trauma is limited, so we kind of wrap it up into anxiety and depression, and then let’s send it to IAPT [psychological therapy] because that’s probably the only service we’ve got anyway.” Though the pressures on domestic abuse services are indeed often acute, this reflects a tendency to discount the expertise that they can bring and the capacity of IDVAs to work holistically with victims, in a trauma-informed way, to support and safeguard.

At the same time, there was also evidence across the sample of cases in which the service provided to victims by IDVAs fell short of expected standards. For example, failures in appropriately triaging and communicating with those who self-referred for support meant that, in some cases, victims withdrew from the engagement before it had ever properly been initiated and were more hesitant to make a repeat attempt since the response was interpreted as indicating a lack of concern or priority. In DHR25, for example, the victim was reported to have contacted a specialist service, but due to delays between the referral and the contact with an IDVA, the victim was reported to have withdrawn from support. Similarly, in DHR26, the deceased expressed frustration that - due to a four-month waiting list for counselling support - at times of crisis, she was only able to speak with caseworkers on the phone. It was suggested that, while there are pros and cons to in-person meetings with some victims being more inclined to disclose and seek support through phone calls or

online mediums, in the case of the victim in DHR26, this impacted negatively on the ability of case workers to make informed decisions as to best possible actions.

In a context in which competitive commissioning models and insecure funding arrangements, as well as increased demand on services as a result of the Covid-19 pandemic and associated lockdowns, entail that IDVAs are now routinely managing extensive caseloads, it is perhaps unsurprising that such difficulties will arise – and that IDVAs themselves will be at increased risk of compassion fatigue or burn out. In DHR16, for example, it was noted that “the caseload that IDVAs have is such that it is not possible to meet every client” demonstrating the pressures that the domestic abuse service was experiencing. There was also, across our sample, evidence of variable practice amongst IDVAs, and occasions on which their interactions with the victim suggested a level of frustration at their perceived reluctance to engage. In DHR27, for example, it was acknowledged that the victim’s refusal to report abuse to the police and her reluctance to leave her partner, though “identifiably common behaviours for a victim of domestic abuse”, was potentially “frustrating” for agencies keen to support her. After working with the victim for a significant period of time, in this case, it was reported that the IDVA withdrew support and informed her GP that, if she needed specialist domestic abuse advice, the victim could seek it via the helpline. The reasons behind this decision are not detailed, but there is an implication that the IDVA had reached a level of burn-out without support from other agencies. Meanwhile, in DHR19, the victim agreed to be referred to an IDVA after reporting to the police that her abusive ex-partner had begun to contact her again. When she did not attend the first appointment, however, her case was closed. It is now understood that the victim also contacted a Crisis Team around this time, disclosing heightened anxiety and suicidal thoughts, and there was evidence of her increasing withdrawal from social settings. By closing her case after one missed appointment, the IDVA service here missed the opportunity to provide support, and to recognise that her perceived lack of engagement was in fact potentially an indicator of increased risk of harm. This was also raised as a concern by DHR Chair 3, who suggested that after referral has been made to an IDVA, there should still be “some form of escalation” because otherwise “it’s just like, no, we’ve got X number of clients...I’ve made three phone calls to this one, if they don’t want to engage then I can’t force them.”

Moreover, there was evidence in the DHRs of some IDVAs being potentially hesitant to use the fullest extent of the professional discretion afforded to them within the DASH risk assessment framework in order to escalate the priority of risks associated with a victim’s harm to self or suicidality, as distinct from harm by the perpetrator. In DHR15, for example, despite the victim stating that she did not have suicidal intentions in her DASH risk assessments, her history of suicidal ideation and self-harm should have been an indicator that, as her ex-partner’s harassment and stalking intensified, her risk of suicide also increased. That said, overall, it is important to note that – often due to the rapport that IDVAs and domestic abuse practitioners can create with service users – DASH risk assessments undertaken by them tended to be more thorough in recognising warning signs than those completed by other agencies or professionals.

Multi-Agency Cooperation

One of the recurring themes across the discussion above, reflected also in the findings of numerous prior studies exploring DHR outcomes, is the importance of – but also challenges to – effective multi-agency cooperation. Several interviewees highlighted that there have been improvements over time in this regard, with more proactive work taking place within CSPs, particularly once an individual is identified as high risk, and more effective protocols for sharing of information. Other Professional 3 intimated that increasingly they were seeing situations in which agencies “have really just made sure everything that could be done has been done...they’re already ahead of you”, which was attributed in part to better coordinated

effort. Certainly, in DHR08, for example, the panel commended evidence of good linking between Health Visitors, GPs, Social Workers and a CAMHS worker in assessing the risks that the victim's children were experiencing. Their sharing of summaries and notes around what future input would be necessary was significant in ensuring that agencies could work together to find the best possible safeguarding routes. Meanwhile, in DHR16, the more 'unorchestrated' benefits of service co-location were apparent when the victim's IDVA, who had been working in a multi-agency Community Safety Unit, happened to overhear police officers talking about the deceased's partner. Upon doing so, she disclosed that she was supporting the victim in her IDVA role, which led to a sharing of information that identified the perpetrator as in breach of his bail conditions, in turn providing the evidence for his subsequent arrest.

There were also positive examples where agencies opted to continue involvement, notwithstanding the victim's withdrawal. In DHR27, for example, the victim did not consent to information being shared with police but was willing to disclose to her GP, who continued in turn to share that information with her IDVA to maximise their ability to support her. In the year leading up to her death, the victim disclosed escalating physical and sexual violence, which prompted three referrals to the regional MARAC. Though DHR27 involved a victim who was widely acknowledged by those involved to be high-risk, there was also evidence to suggest improved coordination and communication amongst agencies in respect of those considered to be lower risk. Other Professional 6, for example, observed that this was a natural extension of having put processes in place that have been shown to assist with higher risk clients: "we have really good mechanisms in place to all work together and share information, and we have all of those partnerships already worked out, whether that person has a suicidal ideation or not, or mental health difficulties or not, we're still able to work together really well and we do all of that information sharing anyway."

Despite this, there were also cases where it was clear that, after an initial period in which there may have been good information sharing across agencies, there was a risk that developments in victims' cases were not similarly cascaded, even where they had a significant impact on risk assessment. In DHR16, for example, despite good initial information sharing between the IDVA, housing support and police, there was no record of the IDVA passing on information disclosed to her by the victim that after the perpetrator's arrest, she feared that he had moved in next door and was staying with her neighbour. This was a missed opportunity to not only address the risk that the perpetrator was putting on the victim's safety, but also to assess the psychological impact that this threat would have had upon the victim.

In terms of improving multi-agency practice, key themes identified related to more accurate identification of risk (and consistent application of risk assessments across partner agencies); greater training and appreciation across agencies of the benefits of sharing responsibility and in particular of making use of the MARAC referral process; and addressing capacity issues in MARACs to ensure adequate resources to manage referrals and ensure adequate follow-up of identified actions. But concerns were also expressed by interviewees about the need to ensure that initiatives to strengthen multi-agency communication do not increase the workload pressures on already overstretched professional cohorts. Expressing this concern, Other Professional 1 said: "in the main, it's just workload. It's just, I've got 15 cases on my case-load and I need to file various reports. And if I've got to share this information with six different agencies each time I see someone....Yes, I wouldn't put it down to anything other than capacity." Thus, as was also the case with respect to individual agency engagements, while there are certainly obstacles tied to a lack of understanding about the value of multi-agency partnership in this context, so too there are acute challenges linked to pragmatic issues of time, resource and capacity that must equally be addressed.

Theme 3: Context and Aftermath of Death

Mode of Death

Information regarding the mode of death was not recorded in 5 of the DHRs, but across the remainder of our sample, the most common method was hanging (n=16), followed by poisoning / drug-related deaths (n=3), deaths by stab wounds / lacerations (n=3), or self-immolation (n=2). In most DHRs, the language used to detail this was primarily factual, and often perfunctory. However, there were some examples in which the scene was described far more vividly. A particularly striking example of this was in DHR20, where it was noted that “the purpose of this review is to examine the circumstances surrounding [the deceased’s] tragic death, whose lifeless body was discovered by police officers late November 2017.”

In some DHRs, the way in which mode of death was described provided a window onto wider considerations about its causes. In DHR05, for example, the deceased was found face down in the bath, with her death attributed to drowning. It was noted that, due to signs of disturbance at the scene, her husband had been arrested on suspicion of murder but that the charges had not been pursued and the Coroner returned a finding of suicide. In setting this context, the DHR noted that, had it been a homicide case, “a perpetrator can be viewed as having caused the death, and situations leading to that event can be analysed and evaluated”; but, since it was not, “it is difficult to get to the absolute cause of death and therefore to look at contributing factors, as there is obviously some doubt as to what happened.” This uncertainty about questions of intention and cause was also apparent in the language used to describe the mode of death in other reviews. In DHR01, for example, it was noted that “the conclusion of the coroner was that the deceased died from a self-inflicted stab wound...at the time, the balance of her mind was disturbed, however her intentions were unknown.” Similarly, DHR20 noted that “the official cause of death was confirmed at the inquest...that [the deceased] died by hanging, but it was not possible to determine whether she intended to take her own life or she had hoped to be found in time.” This can be contrasted with the language used in DHR06, where the deceased died by euthanasia in another country after a violent attack by his partner. Here, the review author had “no hesitation in saying that the injuries inflicted...directly led to [the victim’s] decision to end his life...that is a natural conclusion to arrive at; there can be no other.”

Occasionally, the way in which mode of death was described also raised concerns about victim-blaming. In DHR18, for example, the chair noted that “the immediate and associated circumstances of [the victim’s] death were of concern”, but provided little detail about the scene, noting simply that “the circumstances of the discovery of the deceased, which are not needed to be repeated in this report, led the attending agencies to conclude that the facts of her death appeared to be suspicious.” This prompted a homicide investigation to be launched against her husband but it was not pursued further after a pathology examination confirmed suicide. Notably, in recounting these facts, the DHR quoted directly from the Inquest report which observed the deceased “was not shy about contacting [agencies] for help. She was not forgotten by mental health services - they did all they could to help her”. Though, on the one hand this analysis of service engagement was pertinent to the DHR, positioning of the victim as ‘not shy about contacting’ services implied she may have been seen as overly-demanding. As we discuss below, this sets a perilous path for victims between being deemed ‘unresponsive’ or ‘a nuisance’ in agency engagements.

Suicide Notes

In 8 of the DHRs, there was mention of the presence of a suicide note at the scene. Often these were directed to partners or ex-partners, but occasionally to the deceased’s children or wider family. In some cases, the deceased had also sent texts or left voice messages in the

immediate period prior to death. It was rare that these linked the suicide directly to any abuse experienced, with a more common focus being to explain the pain they were suffering. In DHR12, for example, the note explained: "I don't want to keep trying to somehow deal with and cope with my own mind. It's torturous;" while in DHR27, the victim articulated that: "I just couldn't take it anymore...I just can't explain the dark cloud that is over me."

It goes without saying that the fact these notes did not explicitly link the suicide to the impact of domestic abuse does not mean this was not a significant factor, and the chronologies contained in the DHRs often indicated the need to read these notes through that lens. The importance of this was also reflected on by family members, who highlighted that while such notes can, on the surface, say nothing directly about abuse, when understood and interpreted contextually, they can give a strong indication of the ways in which it impacted on victims' well-being and agency. Family Member 9 reported, for example, in a context in which she had been unable to see her sister's suicide note because it was addressed to her partner and as such was deemed by police to be his property, that "the Coroner, when we went to the inquest, said that on the note...she very much highly indicated that the reason for her suicide was the relationship she was in at the time." When asked later why she thought that this note had not then prompted a more substantial investigation by police into the death, Family Member 9 clarified "because she didn't put on it that you are doing this or you are doing that...it was just, I don't want to be here, I don't want to be living this way". She went on to reflect "it's one of those, you read it and go, we know exactly what's been going on here, but...there's nothing black and white in evidence, so they haven't been able to take it forward."

Events Immediately Prior to Death

Factors can interact - in diverse and complex ways - to precipitate or mitigate the risk of suicide, and the aim of the DHR process is clearly not to identify linear causal trajectories. At the same time, as earlier discussion indicated, there were clear patterns in the victims' life experiences contained within our sample of DHRs that merit exploration. This was also the case in relation to events immediately prior to death.

Many of the DHR chronologies reflected an incremental worsening of the victim's mental health, accompanied by heightened insecurity, isolation and hopelessness. In DHR27, for example, the victim telephoned '111' on the morning she took her life reporting that she was having suicidal thoughts after having made two prior attempts to die in the preceding weeks. Following an assessment over the phone, the Health Assessor offered to call her an ambulance, but she declined saying others needed it more and that she would make her own way to the hospital. A clinical advisor, after contacting the Crisis Team and being advised that the victim was not currently on their caseload and so would need to be referred back to her GP, made contact to explain the situation. In response, the victim commented that she "got that a lot" and said "I'm not phoning anyone else. Everyone turns me away... What's the point?...The GP refers me every time. Crisis contact me and tell me I'm not a suicide risk." A few hours later, she called the police to say she was having suicidal thoughts and did not want her family to find her body. The call handler asked her to hold while they got help, but she replied that "it was too late". These final conversations reflect powerfully the victim's experience of being 'ground down' both by the abuse to which she was subjected and by the systemic failures to address her associated mental health vulnerabilities. Indeed, the DHR noted the deceased "had a complete sense of powerlessness and resignation that it was inevitable that her husband would kill her or she would take her own life." Meanwhile, in DHR32, the 'grinding down' of the victim arose in a different way. Having experienced a friend and family member take their own lives, the deceased texted her partner on the day of her death to say: "you keep saying I will do everyone a favour [by killing myself]", "you hurt me inside" and "I hope your life is better without me".

In these situations, there was a tendency in the DHRs to position victims in polarised categories. Either those in respect of whom there were no 'warning signs' nor anything particularly out of the ordinary - against a background of abuse, depression or addiction - that would have alerted agencies to an escalating risk; or those in respect of whom their mental health had 'spiralled' in such a dramatic way that there was little any agency intervention would have been realistically able to achieve in respect of suicide prevention. In either category, there was, moreover, a risk of victim-blaming. In DHR07, for example, it was noted, in relation to a victim who had major physical health difficulties as well as addiction issues, that "her situation was driven by choices she had made in earlier life and then driven by her drugs and alcohol misuse". The review concluded that, while her death was not "surprising" to agency staff, the fact that she took her own life was, since "there was no indication that suicide was a possibility". A similar narrative was presented in DHR11, where a 27-year-old woman who had been in a succession of abusive relationships, with a history of addiction and intermittent rough-sleeping, took her own life after having repeatedly reported psychosis and engaging in frequent self-harm. The DHR concluded that, although a full mental health assessment was never completed, there was "nothing in the review to provide a rationale for why she took her life on that day". These observations can be contrasted with the approach Family Member 6 recounted having been taken towards daughter who, in medical records made available after her suicide, was described as "well-kempt" and "articulate". Family Member 6 suggested this was relied upon in the DHR to evidence that her daughter was not in urgent need, despite sustained physical and psychological abuse in respect of which there was a long record of police and medical intervention.

In some other cases, however, this incremental 'grinding down' of the victim was also accompanied by specific life events or agency engagements in the immediate period running up to suicide, which were particularly significant: and which, in many reviews, the DHR panel indicated were likely to have played a contributory role. As DHR Chair 12 put it, "usually, it's been a protracted, ongoing wearing down...but often something happens that triggers it". These triggers clustered particularly around engagement with the criminal justice system (often but not exclusively the discontinuance of complaints or release of perpetrators) or social services in relation to removal of children, or other disputes over child custody.

In respect of criminal justice interaction, DHR19 provides a striking illustration. The deceased was a 20-year-old woman who made two reports of rape against an ex-partner (alongside other abuse). Despite her engagement with sexual violence and domestic abuse support services, documented prior suicide attempts, and the fact that when she gave her police interview she told the officer in charge that she "could not cope" and had made an attempt on her life the previous evening, she was offered no additional support in respect of the decision not to take further action over her allegations, in part because of evidence that she had ongoing contact with the accused. Less than one month later, she took her own life. So too, in several other cases, though the temporal proximity may have been less acute, the impact of prior 'no further action' decisions was pertinent, making victims substantially less likely to make further reports or have confidence that the justice system would protect them. Other experiences with the criminal justice system also provided bases for concern. In DHR16, for example, a woman who agreed to support the prosecution of her husband for violent behaviour towards her was not only not referred as appropriate by the police to a MARAC, but was informed in error by court staff that her husband had been released when in fact he had been remanded in custody. She was so fearful of his retaliation that she responded by telling her IDVA that "it was as though the magistrates had signed her death warrant", and she took her life two days later. Meanwhile, in DHR26, a victim who had been under the impression that her perpetrator had conditions attached to bail that prevented him from being in the town where she resided, experienced a substantial deterioration in her mental state when she discovered this was not the case. Two days after a failed attempt

via a Victim's Right of Review to challenge the police's decision not to prosecute his breach of a non-molestation order, she took her own life. There was also evidence in some cases that being accused by police, for example where there was a suggestion of reciprocal abuse, could be a significant trigger. In DHR17, the deceased took his own life the morning he was due to attend the police station in respect of complaints of harassment made against him by his estranged wife. Meanwhile, in DHR30, the deceased took her life three days after an incident in which she was alleged, whilst intoxicated, to have assaulted her child. Although the DHR did not draw a conclusion, it noted that this police intervention would have provoked acute anxiety in respect of an ongoing battle for custody.

This last example maps to other engagements with agencies in respect of children that were also prominent across the DHRs. Irrespective of the substantive merits or demerits of social service intervention, it was clear, as we discussed above, that this was not always managed in a trauma-informed way, and that it had a profound effect on victims. Indeed, family members were in no doubt that this loss of their children – or “their anchor” (Family Member 5) – was often a key factor in compounding their loved one's feelings of hopelessness. Family Member 7 commented, for example, that at the point at which her sister's children were placed on a plan under an interim care order, “the writing was on the wall.” In that case, the care order was imposed on the Thursday and the victim took her life on the Monday. In other cases, the trigger appeared to relate not to the prospect of local authority intervention but rather to the removal of children by ex-partners, or custody disputes with other family members. In DHR20, for example, a social worker advised the perpetrator (against whom restraining orders were in place) that the local authority would not be recommending the return of the children to the victim or her family, and then provided him with information regarding the process for his seeking custody. Although the DHR was unable to draw a conclusion, it noted that the deceased was in his company the day before she died and hypothesised that he may have divulged this information, precipitating the crisis during which she took her life. Meanwhile, in DHR08, a woman whose children were residing with her mother whilst she was required by the local authority to render an excessively cluttered home safely habitable for them, took her own life two days after a communication with the council in which it was implied, if not explicitly stated, that her failure to clear the property sufficiently to enable necessary works to be undertaken would jeopardise the prospects of her children being returned to her in the longer-term.

These chronologies suggest that, though the abuse experienced by, and vulnerabilities of, the deceased often had a long and grinding history, there were also several cases in which there were acute stressors in the immediate period before death, frequently related to agency interactions, which could have been responded to more effectively; and had this happened, it may have reduced the risk of suicide. At the same time, it is important to bear in mind that there were cases which did not fit neatly with this trajectory – where victims took their lives apparently ‘against the tide’ of circumstances. In these situations, it was suggested that the suicide occurred at a point when they appeared, and were assessed by others, to be more optimistic about their prospects for safety and recovery. Family Member 4, for example, recounted how, only a few days before her daughter's death, she had been excitedly decorating her new home including bedrooms for her children. She recalled a conversation they had in which she said to her daughter: “it's been a long coming but at last you're on that pathway...things are moving forward” and reflected that “it really did feel like things were moving forward.” It was clear that suicide in those moments was less expected by family members, and professionals hypothesised that a possible explanation might lie in the fact that recovery was precarious and so any set-back could be experienced profoundly as an indicator of the impossibility of change. Indeed, this was a pattern observed by DHR Chair 6, who commented that, in quality assuring DHRs: “one of the things I have noticed... [is] a theme of women being that close. That close. And that's the point at which they just run out of hope”.

Agency Responses in the Aftermath of Death

In the aftermath of death, there was evidence of agencies positioning the victim's suicide as a reaction to pre-existing mental health or dependency issues, often echoing the lack of reflection discussed above over the extent to which such factors might more appropriately be understood as symptoms of, or coping mechanisms for, domestic abuse. This manifested itself in language that positioned that victim as 'difficult' or 'chaotic', a narrative that was in some situations bolstered further by partners' accounts. In other cases, it was reflected more in the pace at which deaths were determined to be non-suspicious, with initial investigations being cursory even where there was a documented history of abuse. In DHR21, for example, it was noted that "the nature of the police investigation, as an unexplained death and not a homicide, meant that the breadth and depth of their enquiries was less...and so no witnesses to the death or with knowledge of the family history were identified". Of course, the remit of the DHRs in our sample did not typically extend beyond the death of the victim and so - although perhaps a missed opportunity for learning - agency responses (including in respect of the police investigation) in the aftermath was not a focus. Nonetheless, in interviews with professionals and family members, this was an area of concern.

As we reflect on further below, it is ultimately for the Coroner to determine the cause of death, and to make an official finding of suicide. However, as the College of Policing guidelines express it, "to allow for an effective and fast, intelligence-led response...there is often a requirement for an initial judgment to be made on whether a case is potentially suicide." In making this determination, police officers should use their professional judgment to determine whether a death was more likely than not to have been suicide, but with this judgment amenable to review on the basis of any further evidence. Information on the College of Policing website also indicates that this assessment is to be guided by the so-called 'Ovenstone' criteria, which suggest that each of the following, on its own, may be treated as sufficient evidence of suspected suicide, unless there is a positive indication that the fatality was accidental or due to homicide - presence of a suicide note or prior statement of suicidal intent, behaviours demonstrating suicidal intent (e.g. seeking lethal means), previous suicide attempts, "a marked emotional reaction to a recent stress situation" or "failure to adapt to a more remote stress" which may be characterised by mood swings into depression or withdrawal, and may include resorting to alcohol or drugs (Ovenstone, 1973:16; see also <https://www.college.police.uk/app/mental-health/suicide-and-bereavement-response>).

When developed, in the early 1970s, this Ovenstone approach was innovative. In contrast to the then-dominant legal approach, which required evidence of manifest intent, it opened scope for recognition of suicide by applying a 'psychiatric approach' that allowed intent - defined to include "clearly formulated legal intent through ambivalent behaviour and appeals for help" - to be inferred from surrounding factors (1973: 18). It is striking, however, that almost 50 years later, and notwithstanding huge advances in academic and popular understanding the complexities of suicidality, as well as significant shifts in the boundaries of psychiatric and psychological approaches, this remains a touchstone of College of Policing guidance. It is even more concerning in the current context, given the absence of any gendered analysis of power dynamics within the Ovenstone criteria, and the fact that - as clearly documented above as well as in previous research - the links between domestic abuse, depression, social or agency withdrawal, drug and alcohol misuse and suicidality is unlikely to be captured in these criteria. By adopting an approach to what constitute indicators of suicidality that is likely over-simplistic, if not in general then certainly in the context of domestic abuse, and requiring that this assessment is undertaken by often inexperienced frontline officers with stretched resources, there is a risk that police will fail to "see the bigger picture" and "add the dots up" (Family Member 4). This has significant ramifications not only for the prospects of seeking and securing criminal redress against abusers for their behaviour and / or the death, but also - as we discuss further below - for the commissioning of DHRs and associated opportunities for learning.

Concerns about the robustness of police investigations were often raised by professionals. Advocate 1 observed: “my biggest issue that I see over and over again...it’s the police not linking a death to domestic abuse and therefore everything is built on a house of sand, you know, you lose everything. There’s no DHR, there’s no investigation, you know, there’s no justice at all.” Meanwhile, DHR Chair 1 noted that, in contrast to the substantial resources allocated to homicide enquiries, suicide investigations are “low level” and “quite quickly, it’s established that there’s no third-party involvement”, whilst DHR Chair 13, a former police officer, observed more candidly that “in the aftermath of a death, the police don’t investigate it properly”. More specifically, DHR Chair 13 suggested “the police will not routinely interrogate mobile phones following a suicide” even though the deceased is often on their phone immediately before they take their life. This means “there’s no record ever been recovered of these messages” so “a basic understanding of what happened in the last minutes, hours of their life” is lost, which “may show a completely different complexion on what actually happened”. DHR Chair 2, also a former police officer, discussed the ramifications of this in one case: “no one took her mobile phone, no one took her computer, no one searched the house...by the time a detective came round...he looked, saw there was a note, it didn’t mention domestic abuse, although he knew that there was a marker on the house saying this is a known address for domestic abuse...He knew about that, but he said, there was no mention, I read the note and realised it was just a suicide, so nothing happened. That’s when the case was destroyed.”

Family members also often recounted underwhelming experiences in this regard, even where police knew or had been made aware of a history of domestic abuse. When asked about the investigation in the aftermath of her sister’s death, Family Member 7 remarked, for example: “there wasn’t one...I mean, you know, there was, but it was open and closed, they didn’t even take statements...they literally only asked about the last four days...they were told about how abusive [X] was...they didn’t take anything, nobody even signed a statement...they took her phone. Well, initially, they actually gave us everything and I said to them, you’ll need her phone, you’ll not be able to give her phone”. For those family members who accepted that their loved ones had taken their own lives, these perceived failures to interrogate the surrounding context, identify the role of domestic abuse within it, and take action against the perpetrator were extremely distressing. They were perhaps even more so for family members who suspected that the perpetrator had a more direct hand in their loved one’s death, potentially having set up the scene as a suicide to hide a homicidal act or to hide their presence and direct encouragement in respect of the death. Family Member 1, who was in this position, recounted how - despite the back door to her daughter’s house being ‘wide open’, there being damage to the garage roof indicative of someone having climbed over it, panic alarms being missing and a note next to her daughter’s bed indicating that her partner had been abusing her - “none of that was used in evidence, none of that was found” since “within an hour and a half, two hours, they decided that there was no question to answer, it was straightforward suicide.”

Several family members also spoke about the challenges they faced in trying to re-open space for investigating the possibility that the death was a staged suicide or suicide precipitated by another’s abuse. Often positioned as ‘too emotional’, they recounted repeated interactions with agencies that were “deflective...patronising and condescending” (Family Member 5). Family Member 3 reflected, for example: “you are completely disadvantaged by being family...he told me that I couldn’t be objective and that no one would listen. My evidence and my opinion counted for nothing because I was his sister.” Several also recounted having undertaken their own ‘detective work’ in the hope this would prompt more investigation. Family Member 8 said: “I begged the police to speak to the neighbours. They said they spoke to some but when I’ve asked neighbours, they’ve said they’ve not spoken to anybody”. This bereaved mother wrote and distributed letters to all the houses in the local vicinity asking residents to get in touch with police if they had information to share but was told

by the police that nobody reached out, which she said “I don’t believe”. Meanwhile, Family Member 3 submitted 74 exhibits of screenshots and photographs in the aftermath of her daughter’s death but felt dismissed out of hand by the officer in charge when she presented them: “I said to him, I’ve brought this because I think it’s important information. Every time he took a piece of paper off me...[he] slammed it on the desk. I said to him, are you not going to look at them? He said, there’s no point. He said, ‘it’s irrelevant...your daughter took her own life’...It was like she wasn’t important when she was alive and...she’s not important now she’s dead.”

Family members often likened the dynamics of these exchanges to abusive relationships. One put it: “we’re being abused by all these systems. Our loved ones have died in an abusive relationship and now all the agencies are abusive to us...you’re trying to be a voice but then you’re fearful and then you’ll get stabbed in the back with a nasty letter or a patronising sentence in a message” (Family Member Focus Group). Another observed that “it makes it really stressful not knowing what’s going on because I feel like I’m working really hard to gather as much information as I can and nothing’s coming back...it feels like you’re sort of trying to run the whole thing without being allowed to be involved” (Family Member Focus Group). This was also reflective, for many, of a wider sense of not being responded to in a trauma-informed way by police (and other agencies), particularly given the grief they were navigating. Family Member 8 recounted how, whilst waiting in a police car outside the property where her daughter had taken her life, she watched as two male officers at the front door chatted and laughed with one another: “my daughter’s lying dead on the stairs behind and they’re having a private joke...that is part of my flashbacks. It was like the disrespect and the abuse that my daughter suffered all these years from these men, and...it was like a continuation of the abuse all over again.” She also spoke of how, after “pleading with [police] to keep hold of her [daughter’s] phone and go through all the messages”, it was returned to her five months later without the SIM card. The officer said it must have been loose in the plastic bag where the phone had been stored. Though he apologised, he advised that it was “not his responsibility” to assist her in obtaining a replacement from the mobile phone provider (who would not automatically do so due to data protection), leaving her to go to the bin outside the police station, at 9:30 at night in the rain, with the intention of looking for the SIM, since it had “all her [daughter’s] photographs” on it.

Though these are particularly striking examples, they are indicative of wider difficulties in terms of the communication between police and bereaved family members, and the ways in which distrust can develop as positions become entrenched. It is possible, and several participants suggested it, that this might have been assisted, at least in some cases, by the involvement of family liaison officers. Family Member 2, for example, recounted that she had to give her account of the abuse experienced by her daughter to three different officers from the same police force in the weeks after her suicide, because of a failure to coordinate internally, and suggested that a dedicated liaison point might have prevented this. Meanwhile, Family Member 9 spoke about how the two community officers sent by the police to inform her parents of her sister’s death “had no idea what was going on” and were unable to answer questions about what had happened to the body, etc. This compounded her family’s distress at an already immensely difficult time and led her to conclude: “there definitely needs to be a process when the police are called out to any death that they have a single point of contact...it needs to fall within that family liaison department that is actually connected to the police force...who can get those answers.”

Allied to this, others pointed out that communications might have been improved if clearer protocols were in place in relation to data protection and disclosing information to next of kin where domestic abuse was identified. In some cases, the difficulty here lay in the fact that the deceased’s next of kin was a parent who was so distressed in the aftermath of the death that they were not in a position to be able to engage with agencies or push for robust investigations. As Family Member 9 articulated this: “I really, really wanted to speak to them

and just say, look, there is something more here” but “it took me four days to contact him and when I did finally contact him, I got told that because I wasn’t next of kin he couldn’t tell me anything. My parents weren’t in a position to be able to speak to the police, not even a quick call to say, you know, we give you permission to speak to me about it”. In other cases, the next of kin was designated as the deceased’s father who was now estranged from the deceased’s mother meaning that “even to see my own daughter in the undertakers I had to get permission from my ex-husband” (Family Member 2). Sometimes, the next of kin was determined to be the deceased’s partner or ex-partner, in respect of whom allegations of abuse had been made and, in several cases, proven. Family Member 9, who was struggling to liaise with police on behalf of her parents, went on to recount, for example, how her sister’s partner rather than her parents had been called upon to identify the body, and when she and her parents accessed her sister’s residence after her death, they found that her phone had also been handed over by the police to him - “four days after my sister had died, I was having to pick up the phone to the person that I blame and still blame to this day blame for her death, to ask for her stuff back.”

Additional Support for Families After Domestic Abuse Suicide

Interviews with family members indicated a range of other ways in which they felt they had been inadequately supported in the aftermath of their loved one’s death. The need for specialist bereavement counselling was often highlighted, particularly where the family were unaware of the extent of the abuse or where there was a child bereaved by the suicide. As Other Professional 1 put it, “being bereaved by suicide in any sense is horrific but when domestic abuse is involved as well, it’s just a whole other layer of complexity and different emotions,” including for children who “have lost their parent and then seen the other parent accused or convicted of abuse.” For family members who had suffered loss, the emotional demands to then be responsible for communicating that death to affected children were, understandably, significant. As Family Member 5 put it, “my husband really dealt with all the police and interactions with agencies...I just remember him showing me a bunch of leaflets...And then our first port of call was phoning Winston’s Wish to find out how we tell a three-year-old his mother is dead.” Another recounted how she had asked for support from the police, via a Family Liaison Officer, but was told that they didn’t have any officers available for this, “so the next morning, I was over in [XXX] with the children’s father telling them their mother was dead” and “that was probably one of the hardest things to do...And we could get no help from anybody” (Family Member 2). The lasting legacy of that loss for all concerned was also often highlighted. Family Member 8 explained that they were “not the person” they used to be, while Family Member 2 spoke of a family unit “devastated”, such that “a piece of music, the smell of her perfume, the sight of a mother and daughter... for us that is a torture.” Participants reflected on their sense that the magnitude of this was rarely acknowledged by the agencies with whom they interacted. As Family Member 4 put it, “after the death, it’s almost like you’re on another traumatic journey. There is no respite from it. And people just sit on the outside, they go, well it’s nearly two years now. They just don’t get it. They don’t realise what comes next.” The jarring effects of this were clear in an example she provided of how, after notifying the benefits agency about her daughter’s death, she received a letter informing her that her daughter had been overpaid, since they calculated payment on an annual basis, and needed to pay arrears. Though Family Member 4 reported that the agency contact was “livid” when he discovered this letter had been sent in the circumstances, that did little to address her distress at having received it.

Another area where additional support needs were identified related to legal and advocacy assistance, both in respect of engaging with police about investigations and navigating coronial and DHR processes. Legal aid funding is not available for families in most contexts, creating substantial differentials in terms of understanding and representation, which have material effects on how processes are experienced and their substantive outcomes. Family

Member 2 explained: “you’re thrust, in a nanosecond your life flips on its axis, and not only are you dealing with the impact of losing someone so precious, especially in circumstances like this,...you have to learn a whole new language...and then there’s timeframes, you’ve got to have this done by that...you’ve got this agency asking you for that, you’ve got someone questioning you, the police are calling you up”. In respect of the DHR process itself, which we will discuss in more detail below, family members often reflected on this power imbalance: “you’ve got every one of those professionals sat in these meetings...who have got legal representation, yet they expect the family to sit there and represent themselves with no knowledge or no idea....they’re as much of an abuser and controller to the family as the perpetrator was to our family member because they know they’ve got the gift of talk, they can pull what you say to pieces and take advantage,...it is abusive...that they don’t entitle us to that representation” (Family Member 1). In this respect, it is important to note that family members who had access to advocacy support, specifically in our sample via AAFDA, were overwhelmingly positive about its impact. Family Member 2 remarked that “my advocate was amazing. I wouldn’t have survived it without her” while Family Member 1 discussed how her advocate “empowered” her, and Family Member 7 reflected that her advocate is “like the comfiest cushion in the world...it just softens the blows. They still come...[but] if you didn’t have that advocacy there at all, then you’d be left in a very vulnerable place.” At the same time, it was also striking that many suggested that their contact with AAFDA had been the result of either serendipity or lengthy, concerted effort on their part to research routes to support, rather than due to any routine referrals by agencies that acted as first responders in the aftermath of the death.

Finally, it is worth noting that the need for advocacy and legal advice that might be encountered by family members in the aftermath of a loved one’s suicide can clearly extend well beyond the parameters of the initial investigation, inquest, and DHR process. Indeed, many family members recounted ongoing concerns about contact with, and care of, the deceased’s children, for example. One interviewee spoke about it being “horrific” to have to go to court to be able to see her grandchildren who were “living with the abuser” (Family Member 7), whilst another commented “I don’t have parental responsibility for [deceased’s son], so therefore the man that’s responsible for her wanting to kill herself has all the control in life and in death; and I just find that sickening” (Family Member 5). Meanwhile, another recounted how her daughter’s former partner, though not the primary perpetrator of the abuse that precipitated her death, has “stopped me seeing the boys...He’s taking me to court now for full custody... He’s not a nice man and he’s got more nasty since my daughter died...And this isn’t about the children, it is about him wanting to punish us...He’s angry that [X] done this to herself” (Family Member 4). Others also recounted continuing anxiety about their own personal safety and fear of retaliation from perpetrators, with one commenting that she “had the police on standby” at her daughter’s funeral due to the potential threat of violence (Family Member 2) and another noting she had obtained a three-year restraining order against her daughter’s partner after the death “because he was abusive and hounding me constantly” (Family Member 1). While Family Member 1 felt she “had to move to be safe...he knew where I lived...[and] I feared he might do something to the house”, Family Member 2 did not relocate but remarked “my house is like Fort Knox....That’s how we live, for us, that’s the reality that you’re left with. It’s not only the absence, the not having somebody there, it’s the legacy that’s left behind”. These legacies often require grieving families to navigate further unfamiliar terrain within the legal system, often still without adequate access to affordable advice and representation. They may do so, moreover, in situations where their prior interactions with key agencies – including police, courts or social services – have often already been tarnished, both by disappointing engagements with the victim during their lifetimes and by difficult interactions with themselves in the aftermath of death or in subsequent inquest and DHR processes.

Theme 4: Commissioning and Commencing DHRs

By virtue of the focus in this study on DHRs that were commissioned in suicide cases, we are, of course, limited in what we can say more broadly about the scale and characteristics of domestic abuse suicides that go unrecognised and / or that do not precipitate any DHR. However, our interviews revealed a number of concerns amongst professional stakeholders and family members regarding current practice on this issue and the adequacy of existing statutory guidelines to ensure a consistent and robust approach. As Other Professional 6 put it, this matters because “a decent DHR starts with you identifying the right case, the right sort of cases. I do think that that’s really difficult in relation to suicide.”

From the outset, professionals questioned whether cases of suicide where domestic abuse was present were being identified and referred, as appropriate, into Community Safety Partnerships (CSPs) to be considered for a DHR. CSP Lead 6 reflected, for example: “I wonder whether we get advised of all the suicides...I’m sort of wondering whether there is actually a whole load more that could come if you scratched beneath the surface”. This concern was shared by Other Professional 1: “I think there are many more victims dying, many more DA victims dying by suicide than result in a DHR. So understanding that disconnect or whatever it is, whatever you want to phrase it, that’s key for me because this is much bigger than is currently being... captured by the DHR process.” Police were often identified as the most likely agency to refer a DHR, and in this context the concern raised above regarding initial investigations re-emerged. CSP Lead 6, for example, said: “I would be interested on the police side as to how they get to us or, you know, if they’ve got very good guidelines as to when they would tell us. Because at the end of the day, if they don’t tell us, we’re never going to know”. Meanwhile, DHR Chair 13 observed: “I think the messaging around when cases should form a DHR in cases of suicide needs to be reinforced...police will go to ostensibly a suicide and unless they do the research to recognise that there has been domestic abuse in the past, and sometimes they don’t, then it won’t ever get flagged up as a DHR until somebody from an agency perhaps recognises and does flag it up. But the police are the biggest referrer, so they need to be aware of that.”

Despite these concerns, some stakeholders also felt that there was, more recently, evidence of improved practice. DHR Chair 6 asserted, for example, that “it’s getting better, the identification”; and DHR Chair 3 noted that “there is an awareness, and some CSPs are really good at it, and once they’ve picked up one then they get another one, you know...it’s almost like once you get told how important it is, then they do recognise it.” There was also an acknowledgement that this increased awareness meant other agencies - in addition to police - were beginning to identify deaths and refer them for DHRs more often. Other Professional 3 noted: “most of our DHR notifications used to come via the police, but they don’t always come from the police now...one of our hospitals is really proactive in reporting potential DHRs now and that’s really good...lots of suicides of late we’ve had, it’s not necessarily been the police, or the police maybe do it a bit later on, but...quite a few recently we’ve had have been the local hospital and the NHS Trust has forwarded on to us.” Meanwhile, Other Professional 5 highlighted the role that Coroners have in identifying suicide cases for DHRs: “it might only be as a result of the Coroner’s hearing that perhaps additional information has come out that people might not have known about before, enough to kind of pull everything together. ..One of the key things is the Coroners being alert and thinking that through”.

At the same time, whilst there may be indicators of improved identification and referral, DHR Chair 10 underscored that challenges remain in terms of the clarity and confidence with which decisions around commissioning are made when cases are referred: “it’s just not clear what is the threshold for a suicide DHR, to put it crassly. And the statutory guidance says cause for concern. But there’s so many questions around that...I think the issue is identification and then because the statutory guidance is so unclear in terms of what it defines as a suicide DHR, I’m confident different areas will make different decisions”.

To Commission or Not to Commission?

Current practice on commissioning appears to involve regionally and sometimes organisationally specific approaches, often leading to divergent interpretations of Home Office criteria. CSP Lead 3 acknowledged: “statutory guidance isn’t particularly helpful around identifying which suicide cases need to proceed to a DHR. So in the absence of very specific guidance, we’ve got our own localised criteria and localised process around discussing these cases for a suicide DHR, with kind of an expert panel of local people to help the CSP decide.” Meanwhile, Other Professional 6 added that additional guidance around commissioning would be valuable, “perhaps saying that, you know, domestic abuse may have been a factor maybe in the six months prior to the death, as opposed to just leaving that very general.” Though they went on to underscore the importance of “not making it an absolute - must have been six months - but just something for agencies to consider when we’re considering it”, Other Professional 6 thus indicated that putting “a bit of a limit on it as a suggestion” would be helpful. This idea of requiring a temporal connection between the abuse and death also featured in other interviews, often identified as a key consideration in local decision-making over DHR commissioning. CSP Lead 3 reflected, for example, that some kind of temporal criteria was useful since “we’re very well aware that if we reviewed every single suicide where there’s an element of domestic abuse, we potentially could be doing DHRs constantly, which isn’t something that anybody would be able to facilitate.” This was echoed by CSP Lead 1: “How far back do you go? Is it about the last relationship they were in, or does it go all the way back to how they’ve experienced life?”

Other interviewees placed less emphasis on temporal connection but pointed to other factors that would help them to determine whether and when a DHR ought to be commissioned in suicide cases. More specifically, these factors often looked for evidence of a causal link or connection between the suicide and the abuse. As CSP Lead 1 put it: “when it comes to the suspected suicide ones, that initial conversation is usually around, how confident are we that there was domestic abuse happening and that that was likely to have had an impact on their decision to take their life.” In support of that initial conversation, they explained that: “we look for indicators, like were they known to MARAC, was there evidence in GP records or police records? Were they known to our local domestic abuse service? Those sorts of things. We look to sort of triangulate our decision...if we have that sort of evidence, then we would seek to do a domestic homicide review”. For other professionals too, this search for ‘evidence’ was important as a precursor to DHR commissioning. CSP Lead 4 explained, for example, that under their local process, “we do a bit more evidence finding before committing to the review”, whilst CSP Lead 7 spoke of doing “a quick scoping exercise amongst key partners” and CSP Lead 3 talked of “having to do a little bit more exploratory work before a decision is made to understand the case in a little bit more detail, as to not only does it fit the criteria for a DHR but is the domestic abuse enough of a feature in that individual’s life to warrant a DHR?”

Of course, significant difficulties lie here in the fact that domestic abuse can often go unreported to agencies, and the evidence that is documented and accessible posthumously is likely to be partial in nature. Moreover, the agencies most likely to document abuse - in particular, police and hospital or GP services - may be prompted to do so more routinely by reports of physical violence, resulting in a skewing of the evidence base in cases where abuse typically involved the kinds of emotional or psychological control that Bates et al indicate may be more prominent in domestic abuse suicide cases (2001). Though CSP Lead 4 was keen to underscore that - in looking for evidence of abuse as part of decision-making regarding the commission process - “it doesn’t need to be like a direct cause of the death. It doesn’t need to be, you know, there was a suicide note that says this is because of domestic abuse,” other professionals continued to urge greater caution in this respect. DHR Chair 10 reflected: “sometimes there’s a really problematic view, no agency contact, not worth doing a DHR, which I fundamentally disagree with...suicide DHRs may be perhaps a little more

likely to have less immediate agency contact...[T]hose two things combined, a lack of clarity about when and how the suicide is linked to domestic abuse, plus perhaps a presumption of the importance of agency contact in commissioning decisions, might together and separately mean that some CSPs just don't commission....I would always argue for a wider lens".

One suggestion for what might assist with that wider lens was to focus less on individual case characteristics and more on whether there were likely to be effective learnings from the review that could inform future practice. But in a context in which learnings often emerge through the process of *doing* the DHR rather than in advance, using this to refine commissioning decision-making is difficult. Moreover, it is likely to be impacted by funding challenges, particularly where resource allocation is devolved to the local level. As CSP Lead 1 noted: "without guidance I think it's a real challenge for local authorities...you will get local authorities trying to come up with their own best practice...to come up with something that feels like a rational way of making a decision, but my sense is it will look different everywhere". And this is a problem not only of consistency and rigour of approach, but also a threat to the very commissioning of suicide DHRs when set in a wider austerity landscape. Indeed, as CSP Lead 1 went on to reflect: "we do need some clarity because the danger is...reviews still cost councils a lot of money...if they think...we don't need to do any more reviews, in an effort to save money fundamentally...it's sort of at risk if we're not being clear about it in the guidance." Allied to this, CSP Lead 7 observed: "funding is so difficult because everyone's budgets are smashed...I think if there was a national pot that paid for DHRs, I think more people would be saying yes to doing them. When they're costing about eight, ten grand each, it just makes it really tricky when there's no identified funding for that". This can compound, moreover, a wider sense of ambivalence about the costs and benefits of DHRs that was highlighted by Other Professional 2: "particularly over the last year, with DHRs in general, there is a sense of people don't like them, you know. The willingness I think to do them has decreased and I think there are lots of reasons for that, around the length of the process and how long it takes to get the feedback from the Home Office. I think there is just a bit of fatigue in agencies and I think there it still that underlying like, yes, we have to do the right thing, but there is very much that sense of, is this the right way to do it?"

In suicide cases in particular, some interviewees suggested this might also impact on the levels of engagement that agencies would commit to any DHR undertaken. In the absence of "really clear criteria" (CSP Lead 3) for commissioning, it was suggested that agencies might be less motivated to participate since they may see less benefits in terms of learning compared to other deaths. Indeed, Other Professional 3 observed: "it's interesting because when we do, before we even get to commission a DHR, obviously the guidance says we should contact agencies to see if they've had contact, so the CSP Chair can decide whether they should do a DHR. And even at that point you get some of the comments from agencies who say, oh we shouldn't do a DHR because of, blar, blar, blar, you know". Reflecting on this, CSP Lead 3 commented: "I suppose for us we have had the support in the main of most agencies. And I think because, for the suicide DHRs that we're doing at the moment, there's clear evidence of domestic abuse quite close to the time that someone took their own life, so it's much more clear cut. The ones where we have had some pushback from, it tends to be where it's a little bit more unclear. And perhaps the mental health issues for those individuals were so significant that some agencies feel that maybe a DHR isn't appropriate."

Families that we spoke to often highlighted the importance of advocates in pushing for the commissioning of a DHR that would otherwise, in their view, often have been unlikely to have taken place, particularly due to reluctance from police to refer suicide cases after their initial investigation. One reflected, for example: "we found out about the DHR through AAFDA. We didn't have any information from Coroners or police or anything like that. And then our advocate contacted the CSP to request a DHR" (Family Member Focus Group). Another relayed a similar experience: "we found out...about nine months...after my sister

had died – the police were pushing for an adult safeguarding review, trying to completely ignore all of the domestic abuse...my advocate had to work extremely hard to make the CSP understand and see that there was domestic abuse” (Family Member Focus Group).

Commissioning the DHR Chair

This lack of guidance, and attendant regional inconsistencies, in respect of commissioning suicide DHRs themselves was mirrored, moreover, in the commissioning and procurement of the individuals that serve as independent DHR Chairs. The implications of this were repeatedly reflected upon by interviewees. Some recounted ‘informal’ processes that involved asking for recommendations from neighbouring areas and / or contacting individuals they knew to have previously chaired reviews, whilst others spoke of using formal procurement portals to recruit Chairs. In all cases, participants reflected on the challenges of locating suitably qualified Chairs and the additional difficulties that this could pose in suicide cases.

Other Professional 1 reflected, for example, that “you need a good Chair to bring everyone on board...A Chair who’s not afraid to ask awkward questions and keep challenging, not take the first response from an agency or an official.” Other Professional 5 agreed that “having the right Chair I think is really important, you know, because it’s sort of, then you can really encourage that openness and the sharing, rather than making, because sometimes the agencies can end up being quite defensive, they fear for attack, which isn’t really the point of it at all.” At the same time, those responsible for commissioning DHR Chairs also spoke of the difficulties in making appointments, let alone recruiting those with experience and expertise in suicide DHRs specifically. CSP Lead 6 reflected: “good Chairs, you know, I say they are hard to come by but you know what I mean, they’re all booked up, so we’ve never actually got our first choice”; and CSP Lead 7 noted difficulties associated with the fact that “even if I do find a good Chair”, “you’re not supposed to have the same Chairs over and over again, so...how do I maintain independence and new Chairs when there’s so little availability.” In navigating this tension between experience and availability specifically, CSP Lead 7 commented: “where we come unstuck is expecting someone to have done a DHR before...sometimes you just have to take a chance...because otherwise the pool is too small”. At the same time, it was clear that participants felt that suicide DHRs may require a specific skillset that reduced this pool further. DHR Chair 7 observed that “there probably aren’t enough people who are Chairs, because often they’re looking for somebody who’s got some experience of dealing with suicide cases” while CSP Lead 5 confirmed that in commissioning a Chair, “I didn’t want someone who had never dealt with a suicide. I wanted someone who had that experience, so that they could bring that experience to the partnership table and start making the partners think as well”.

Relatedly, several professionals also raised questions around the training that DHR Chairs undertake. There is currently no national requirement for Chairs to undertake any formal enhanced training or accreditation process before commencing DHRs. The Home Office Statutory Guidance offers a guide for commissioning a DHR Chair that includes “completion of the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports” (Para 39, Home Office, 2016). However, this on-line learning amounts to a non-interactive web page that offers a relatively simplistic overview and certainly does not consider the complexities of domestic abuse suicide ([Conducting a domestic homicide review: online learning - GOV.UK](#)). As part of their tendering process, some local areas have developed additional requirements for applicants to have completed a 3-day accredited programme in ‘DHR Chair Training’ provided by AAFDA, but this is not a national requirement and there is currently no quality mark for individuals that wish to set up as DHR Chairs. On the one hand, as Other Professional 5 observed: “you don’t want to put people off being Chairs by making it too arduous and the accreditation too difficult. But on the other hand, a lot of the CSPs are going into it a little

bit blind”, and DHR Chair 7 confirmed that “there’s probably more training needed. I think probably Chairs need some specific training, not just going along to a two-hour seminar”. Certainly, in respect of suicide cases, this process of training and the specialism of Chairs was understandably important to family members. Indeed, as Family Member 1 reflected: “we need more specialised DHR Chairs in suicide, so they actually understand where you’re coming from in the first place”. As we will discuss further below, the success with which family members felt that DHR Chairs managed the process and its outcomes was indeed often influenced by their perception of the adequacy of their understanding about the dynamics of domestic abuse and its relationship to suicidality, as well as their ability to engage with victims’ narratives and families’ contributions in a respectful, inclusive and trauma-informed way.

Early Engagement with and Support for Families

A key principle of the current Home Office Guidance is that families are ‘integral’ and ‘key stakeholders’ in the DHR process. However, a number of CSP leads and DHR Chairs highlighted early notification of the DHR and engagement with families as being challenging and, at times, problematic, especially in suicide cases. As CSP Lead 4 put it: “for the suicide cases it has been slightly more difficult to make that relationship with the family. Because we usually go through the police FLO, so family liaison officers, who are usually in place for a murder investigation, but with suicides there’s not always that kind of police involvement. So...it isn’t impossible but it’s sometimes harder to get in touch with the family and...harder to engage with them right at the beginning.” This lack of a Family Liaison Officer, reflected on from the point of view of families above, was also raised as an obstacle by several Chairs. DHR Chair 5 reflected, for example: “the fact that there’s no FLO involved...the way that you would approach the family needs to be different”, while DHR Chair 3 noted: “you judge how you make your contact, your letter usually goes through the FLO. Whereas, this, unless they’ve taken on AAFDA early, and in my case that was only 25% of them, then you’re basically cold calling them and saying, here’s a letter or here’s an email saying, hello, this is me, this is what’s going on.” For many professionals, this was part of a wider problem with the current lack of early support afforded to families bereaved by domestic abuse related suicide. Indeed, echoing the concerns raised by family members about the paucity of that support, DHR Chair 2 observed that: “families of the deceased get...no support at all for suicide. If it’s a murder the police will appoint a family liaison officer and...victim support will provide someone to help them through..., but it has to be a murder for them to get involved. And I’ve raised that on a number of occasions as well, that families do not get any support unless you go to organisations like AAFDA to provide that support”.

The process of navigating that initial contact with families at the outset of suicide DHRs was made more difficult, according to many interviewees, by the language of ‘Domestic Homicide Reviews’. DHR Chair 13 described the terminology as “an absolute blocker,” while DHR Chair 9 suggested that a different name would “change the landscape” in terms of those early engagements. The implication of this was illustrated by DHR Chair 2 who recounted: “often the family don’t even know that their daughter or son was being abused and it is quite shocking when you’ve got to tell them...I had one where, when I wrote to the family, their son-in-law was actually living with them, and he moved in because he was so distraught over his wife, or apparently so distraught over his wife’s death. And the family were quite belligerent to me and were criticising the agencies that were suggesting this review in the first place. That took a while and the family totally changed their views when they found out how he was treating their daughter.” As a consequence of such experiences, DHR Chair 2 reported that, in initial approach letters to families, they now adopted a different approach where instead they “write a letter where you say, because of your relative’s death we are undertaking a statutory review...I never mention the words ‘Domestic Homicide Review’

until I actually meet the family and meet the partner and then I explain it.”

Similarly, though concerned as much about agency as family or partner engagement, CSP Lead 5 spoke of how they tended to refer to ‘Domestic Suicide Reviews’ - although they also expressed concern about whether this fit with Home Office Guidance, and in particular any implication that they were “demoting it from a homicide to a suicide”. Meanwhile, Other Professional 3 explained that they sometimes called them ‘domestic abuse death reviews’ to “appease the homicide bit” while DHR Chair 3 reflected that, though they continued to use the language of Domestic Homicide Reviews in correspondence, they always “have to do that explaining” to help people “recognise what it is really.” And DHR Chair 1 recounted a suicide case in which agencies initially refused to take part because they did not consider the frames of the DHR process appropriate, and it required concerted effort to “get them back on board”, including by rebranding it as a ‘statutory review’. The ways in which such manoeuvring in the setting up of suicide DHRs might impact upon agencies’ subsequent participation and engagement is explored further below.

The Coronial Process

Before turning to the running of DHR processes, it is important to reflect here also on the coronial process which emerged as a key theme sitting across both the commissioning and the commencing of DHRs. In both the DHR sample and interviews, the scope, outcomes and experience of the Inquest, and role of the Coroner, were raised, although it emerged as a more prominent feature in the latter. In 23 of the 32 DHRs, the Inquest had been completed at the time of DHR publication: it remained open in 2 cases, whilst in 3 there was no discussion at all of the Inquest, and in 4 there were exceptions that applied (either because an Inquest had been opened and subsequently adjourned, or the death fell outside the Coroner’s jurisdiction). In 11 DHRs, the panel used information gathered from the Inquest to guide and inform the review, though in only 1 case was HM Coroner included in the dissemination list for the DHR. The extent of discussion of the Inquest varied across the reviews, with some simply noting that it had occurred whilst others quoted directly from its conclusions. While this variability of engagement with the Inquest as a parallel process was surprising, it may be at least partly attributable to the early nature of some of the DHRs in the sample and the fact that they were thus conducted at a time when the practice of reviews relating to domestic abuse suicide was more nascent. Certainly, interviews with those involved in more recent or current DHRs suggested a greater interest in the operation of the coronial process, albeit often accompanied by lingering concern or confusion regarding how it ought best to operate alongside the DHR.

A number of those interviewed raised concerns, for example, over a lack of consistency across these parallel processes and suggested that the DHR and Inquest could, at times, pull in different directions. CSP Lead 3 noted, for example: “we’ve got lots of debates locally at the moment about whether the Coroner should do their inquest before we do the DHR or vice versa.” They went on to suggest that, in suicide cases in particular, “that is a bit more complicated to navigate because, in theory, we cannot really refer to it as a suicide until the Inquest has confirmed some of that detail. But then in some instances,...the Coroners will wait for a DHR to conclude, so that can feed into the Inquest.” For CSP Lead 3, this provided another example of an issue in regard to which, in the absence of clear guidance regarding suicide cases, “it tends to be something that the Chair of the DHR is navigating with the Coroner and having those conversations.” A similar concern was raised by CSP Lead 7, who emphasised the lack of national consistency in approach: “quite often, the Coroner will wait for our report first and then they’ll do theirs. But it seems to be different in different parts of the country.” Meanwhile, DHR Chair 13 said: “with a Coroner, it’s not that straightforward... thankfully, we’ve only had it once, but one Coroner, on a currently live case, is demanding all of the paperwork to do with the DHR. And we’ve only just started the DHR...so there’s

real legal issues.” The legal issues alluded to here were addressed more candidly by Other Professional 1, who observed that adjourning the Inquest pending the DHR process could act as a barrier to agency contributions: “if the Coroner process is still ongoing, you will get some who are concerned that they might be asked to give evidence in a Coroner’s Inquest, and they are therefore mindful of that fact when they are preparing anything that they give to a DHR process.” DHR Chair 13 contrasted this coronial approach to others they had encountered: “other Coroners will take a far more pragmatic view and say, okay, well, I will halt the Inquest until the DHR has been completed”. For him, ultimately, the preferred approach was where “Coroners will say, what we’ll do is we’ll hold the Inquest,...the short form of Inquest, and we’ll deal with the who, what, when and how. But we’ll make it clear that there is a DHR. And if that DHR raises issues that I should be aware of as a Coroner, I will reserve my right to reopen the Inquest.”

Procedures for notifying Coroners of the commissioning of DHRs in suspected suicide cases, and working with them as both processes progressed, clearly felt uncertain for many professionals. CSP Lead 3 reflected: “we don’t really have any kind of set criteria...I’m aware of some areas that have developed a really kind of clear process with their local Coroners but for us...because the suicide cases have just started for us and they’ve come out of nowhere...we haven’t really got to that stage of having a really robust process.” Meanwhile, DHR Chair 1, who had experienced challenges to date in working with Coroners in suicide cases, indicated that something beyond localised procedures was needed: “an agreement between maybe the Home Office and the Coroner’s office, to say your reviews into suicide will be, should be, made available to a subsequent inquest” would be helpful and offer clarity to all parties involved.

A wider concern that was raised centred around the scope of, and attitudes exhibited by, Coroners within the Inquest process in relation to cases involving domestic abuse suicide in particular. The technicalities associated with whether and when a Coroner could formally declare death by suicide, and their ability currently to record the context of domestic abuse in respect of that suicide, was suggested by several interviewees, and particularly bereaved family members, to be confusing and limiting. Family Member 2, for example, noted: “although the Coroner was...sensitive, gave time to listen to all the arguments, I felt his scope for the conclusion as to how she died is failing in the ability to distinguish suicide in the context of a coercive controlling relationship...Despite the fact my barrister presented plenty of evidence of coercive control and abusive behaviour, it didn’t feel as if this was acknowledged or even understood...in Coroner’s courts, there needs to be a lot more education and an embedded understanding.” Meanwhile, Family Member 3 reflected that: “the ultimate thing we wanted was domestic abuse - suicide contributed to, or potentially contributed to by domestic abuse - on his death certificate or in the Inquest.” And for some family members, this Coroner declaration was identified as even more important than any criminal justice outcome, since it made it clear that “yes, [the deceased] chose their death... but they aren’t to blame for the circumstances they found themselves in” (Family Member 7).

Naftalin and Munro have highlighted the duty of the Coroner to investigate a sudden or unexplained death and to “ensure that the relevant facts are exposed to public scrutiny” (2022: in press). In that context, they posit that Coroner’s courts “have an essential role to play” and that Coroners can, perhaps uniquely, “cast light not only on the role of the perpetrator in the death, but on the extent to which agencies understand, and are appropriately equipped to respond to, the risk of suicide amongst victims of abuse” (2022: in press). Coroners also have the power to make Reports to Prevent Future Deaths if they hear evidence during the inquest which causes them concern about the risk of future deaths occurring unless action is taken (para 7, schedule 5, Coroners & Justice Act 2009). Indeed, in a recent inquest before Hull and the East Riding Coroner’s Court, which involved a domestic abuse suicide, the Coroner made a series of factual findings on the circumstances that gave rise to the death, including that “agencies had institutional blinkers and a ‘not my agency, not my problem’ approach

to parts of the deceased's care." The Coroner exercised her power to make a Prevention of Future Death Report to the Secretaries of State for the Home Office, Justice, and Health and Social Care outlining a number of issues that had caused her concern, including in relation to police training on domestic abuse, risk assessment and information sharing in complex cases, and underscoring the need to recognise "the link between domestic abuse and suicide" since "processes and policies do not seem to include this serious area to the extent that is required" (Bhatt Murphy, 2022). Though this has the potential to become a significant turning point, Naftalin and Munro note that "as things currently stand, such interrogation is not the norm" (2022: in press). Moreover, although the Supreme Court's judgment in *R (Maughan) v. HM Senior Coroner for Oxfordshire* ([2020] UKSC 46) also "opens up the possibility of conclusions of unlawful killings for suicides that follow domestic abuse, if it can be shown on the balance of probabilities that the elements of the offence of unlawful act manslaughter is made out...and that it was reasonably foreseeable that the dangerous act would cause harm to the victim" (2022: in press), Naftalin and Munro observe that this too remains largely uncharted terrain within Inquests: notwithstanding recent guidance from the Chief Coroner as to how unlawful killing verdicts should operate in the wake of this decision (2021). Whilst these indicators of more expansive and flexible powers being available for use by Coroners might thus offer hope to families seeking recognition of the impact of the domestic abuse their loved one suffered upon their death, Naftalin and Munro suggest that the reality of these powers being used widely and consistently still remains rather remote (2022: in press). This is likely to be especially so for families that, as is currently often the case, do not have the benefit of access to legal advice and representation.

Concern regarding Coroners' views about, and understanding of, domestic abuse was also raised by professional participants. It was starkly reflected in DHR18, for example, where the Assistant Coroner was quoted as stating, whilst recording the suicide verdict, that the deceased "was not shy about contacting [Mental Health Services] for help. She was not forgotten by [them]". In response, the DHR author rightly underscored the importance of listening to the views of the deceased about the quality of service they received, but stopped short of directly addressing the Coroner's language which at the least connoted a lack of empathy with the challenges faced by victims in making disclosures and navigating the mental health impacts of abuse. As a corollary to this, DHR Chair 12 reflected that, in their experience, "Coroners often see...women as kind of weak, they're so misguided and they take their own lives, and they should have stood up for themselves and left...So you get that kind of reference to, you know, extreme attention-seeking. And it's not that. It's that you're utterly worn down by someone who often is so cleverly manipulative...I don't think Coroners understand that at all and the barriers to leaving and all those sorts of things...I don't think they have an understanding of how all these little things are really damaging."

As the number of DHRs being commissioned for domestic abuse suicides continues to increase, this tension with the coronial process is likely to become more challenging for CSPs, DHR Chairs and families. It is clear that, in their current operation, these are processes that are often not working in parallel, and may at times pull in opposite directions. Though, as was the case in relation to DHR commissioning in suicide cases, it is clear that some areas have managed to navigate these difficulties by developing local protocols and practices, it is also unsatisfactory that they are required to do so due to the absence of adequate guidance at the national level to inform the successful running of DHRs alongside Inquests.

Theme 5: Running Successful DHRs

In this section, we raise the question of what constitutes a 'successful' DHR in suicide cases, where one has been commissioned. We first consider additional challenges that may be posed by a potential lack of fit to the existing DHR regime, particularly in terms of data protection and risk assessment. We then consider some ways in which achieving the hallmarks of a good DHR may require specialist consideration in suicide contexts. Finally, we turn to the outcomes of the process, exploring the adequacy of reports produced, and considering the extent to which they enabled the voice of the deceased to be heard, avoided victim-blaming, and identified learnings that hold agencies to account in their future practice.

When One Size May Not Fit All: Process Challenges in Suicide DHRs

When the Home Office extended the remit of DHRs to include domestic abuse suicides, it is not clear that this was accompanied by significant reflection as to the appropriateness of that process - designed initially for situations involving fatal infliction of violence upon a victim - to scenarios in which there may be no confirmed perpetrator and no uncontroversial causal link between the abuse and death. As discussed above in relation to commissioning, interviewees often lamented this absence of guidance in respect of running suicide DHRs. Though few were as strident as CSP Lead 2, who suggested that "the Home Office guidance is just abysmal", there was a broad consensus that, as CSP Lead 5 put it: "the DHR guidance nationally doesn't really help in suicides, it's a bit woolly on suicides"; or in the words of DHR Chair 1, that "using the domestic homicide review process to review suicides with a history of domestic abuse is incredibly clunky." Part of the difficulty here, CSP Lead 3 suggested, is that the additional challenges that arise in this context had not been anticipated: "prior to the suicide cases, it's not really something that we had to think about because it was very structured and very clear. It's only once you start doing the suicide DHRs that you start realising some of the complexities that you might not have thought about".

Having become cognisant of those challenges, CSP Lead 3 was confident that "more guidance would certainly be welcomed by anybody who was doing DHRs" and "it is definitely something...we need to develop" at national and local levels. Although there were mixed views as to whether an entirely separate regime was necessary, it was widely acknowledged that "there needs to be a bit more thought...have different sections within them for how to deal with suicides" (DHR Chair 12). We discussed above the potential barriers to engagement posed by the terminology of 'Domestic Homicide Reviews', but participants also highlighted the ways in which language mattered beyond those questions of 'fit' in the initial approach. More specifically, DHR Chair 2 noted: "language is important because you can't talk about the victim as a victim. You've got to talk about them as the deceased. You can't talk about the partner as being the perpetrator, you have to talk about them as being the partner. And that's sometimes difficult for people on reviews to understand." Meanwhile, DHR Chair 9 commented: "when we write to families, we start the letter calling it a multiagency review and only part way down do we tell them this is established under the Domestic Violence Crime and Victims Act", noting that otherwise when writing to partners, "I am accusing him of something that he hasn't been charged with, that nobody's even probably questioned him about." Though this hesitancy in using the terms 'victim' and 'perpetrator' may - in some cases - be understandable, as we reflected upon in our methodology discussion, it also risks distorting the experience of the deceased that is optimally at the core of the DHR process, and overriding the perspectives of family members. Indeed, in the Family Member Focus Group, participants commented: "it was such a shock" when, after a "very supportive" discussion with a DHR Chair which indicated that they "could see all the abuse", the language used in the report is "about the alleged perpetrator" which "read different to how that conversation felt". At the same time, this reflects the reality, as DHR Chair 2 candidly

put it, that “you don’t want to be sued”. That is an important consideration, moreover, not only in the self-interest of individual Chairs but because: “it is an inverted pyramid, that if one organisation got sued, they would all start running for cover and saying we’re not participating unless we have our lawyers present”. This too was something family members could appreciate - “it talks about alleged perpetrator, [but]...I understand the reasoning why they say it like that” (Family Member Focus Group).

Nonetheless, there was a suggestion amongst some interviewees that the process had become too risk-averse in this respect in suicide cases. Other Professional 3 commented, for example, about how “panel members get really concerned” about labelling someone as a perpetrator where there has been no conviction; and, indeed, even in cases where there was a conviction against a partner for domestic abuse during the victim’s lifetime, they have encountered hesitancy about using the language of perpetrator because “even though he’s been convicted, he wasn’t convicted for her death.” There was a recurring sense too that the Home Office guidance did not assist Chairs in navigating these “complexities” (CSP Lead 3), and that this “feels more precarious” (CSP Lead 2) in suicide cases, in a way that impacts not only language choice but the wider participation of partners within reviews, as well as panel’s access to, use and publication of, data about partners’ risks, needs and agency engagement. As DHR Chair 11 put it: “in a homicide situation, you’ve got a victim and you have a perpetrator. And that creates a lot of clarity, and it really helps with information collection” but this does not transfer over to the suicide context where “we need a different platform”. As noted previously, one consequence of this is that the suicide DHRs we reviewed were one-sided in their focus on the deceased, often with little detail about partners. This risks a partial understanding of the dynamics at play, limited learning in relation to future interventions, and a propensity to responsabilise victims for their suicidality whilst the perpetrators’ role is eclipsed.

It was clear, however, that professionals were unsure of the extent to which it was permissible - legally or ethically - for panels to request and receive information about partners within suicide DHRs, and in the absence of authoritative guidance giving clarity in respect of how to navigate the boundaries of data protection and privacy, many adopted a cautious approach. For example, while DHR Chair 6 emphasised that DHRs “need to make the perpetrator visible...a lot of victim-blaming comes from the fact that the perpetrator isn’t in the sentence”, they went on to recount a suicide case they had chaired in which it had been questioned during the quality assurance process, unfairly in their view, whether the report had done enough to hold to account a husband whom the Chair described as “devastated by the death of his wife”. Though there was one documented incident of physical violence a decade prior to her death, DHR Chair 6 emphasised that there “was no evidence to support” disclosures by the deceased that “she was experiencing ongoing abuse”, and he reflected that raising this allegation with her husband “was really difficult...I felt awful, I really felt like I was making someone’s nightmare worse...for this poor guy.” This reflects the difficulties that arise in all homicide reviews where the deceased is no longer able to give their own account, and it may also raise questions about how - in abusive relationships - allegations can be repackaged by abusers and professionals as fabrications reflective of mental health vulnerabilities. In addition, though, it reflects a hesitancy by professionals to “wade into” the grief that partners might exhibit in the wake of suicide, even where there has been a history of domestic abuse that merits exploration. And that hesitancy is compounded by uncertainty about the permissibility of probing further, particularly where doing so requires seeking disclosure of private information about that partner. As DHR Chair 6 went on to comment: “I have no right, and I don’t think I should have the right either, to the perpetrator’s details, or the alleged perpetrator’s details. You know, why should I have access to his medical records because his wife committed suicide. He’s not actually a perpetrator, you know.”

These challenges were also sometimes raised explicitly in the DHRs. In DHR07, for example, it was noted that the deceased “died at her own hands” and “was the perpetrator of her own death”. As such, the question arose as to whether Home Office DHR guidance indicating that approaches should be made to the ‘perpetrator’ applied to her partner. The Chair noted that “this has caused some confusion” since “whilst the Data Protection Act allows for disclosure between agencies to ‘prevent crime’...concerns were raised about the release of information identifying [his] new address”, in order for the Chair to make contact. Meanwhile, in DHR26, when a partner against whom non-molestation orders had been made, refused his consent for the panel to access his health care records, the Chair obtained release through the Clinical Commissioning Group (CCG) which reported: “despite the national DHR guidance, there remains reluctance for the release of the perpetrators’ records without consent” which “could potentially delay lessons learnt being utilised to change practice and reduce the risks to others.” The difficulties that arise in such situations were reflected upon by DHR Chair 3, who noted: “there could be a lot of argument at the beginning where you’ll get CCGs saying, ‘we can’t go into his medical records’...I can understand that and I think some people get too wrapped up in that, trying to push to get access to a perpetrator’s medical records when they’ve not been charged with anything...I really want to focus on the history of the victim because I think you could get yourself tied up too much in the legalities of accessing his medical records.”

At the same time, failure to obtain this information can undermine the benefits of conducting DHRs in suicide cases, in terms of learning robust lessons. As DHR Chair 11 put it “there needs to be an acceptance now from the Home Office that that information [about a surviving partner] is probably unlikely to exist in those [suicide] reviews, or some clarity to Chairs as to how we access it if it’s expected to be in there...If you go for the former,...suicide reviews will naturally be really limited...we would miss out on 75% of the information, and that doesn’t feel like an effective review.” Similarly, DHR Chair 4 observed: “let’s say there’s a suicide of a young lady and there’s a partner. If he says, no, you’re not having mine [my data], there’s not a lot we can do about it. The guidance...says that we can have the perpetrator’s details, the medical details, if it’s in the public interest to do so. And I’ve written umpteen times, until I’m blue in the face, and said ‘what does that mean?’...So, in my report I will say that the perpetrator didn’t engage, didn’t give us permission to examine his medical records, but nonetheless the QA panel still write back and say, we’re disappointed the author hasn’t done more. Like what, tell me what more I can do...For me that’s the main area of the guidance that really needs a shake-up because we miss so much.”

The dynamics of this negotiation over data access, and its impact on the balance of the DHR, was also a concern to family members: “our loved ones aren’t there to give their own side of it and they’re so scared of relying on hearsay or third-hand information...they’ve gone too far the other way” [Family Member Focus Group]. Family Member 9 noted, for example, that there was a range of information about the deceased’s partner, including whether there was a prior pattern of domestic abuse, that police indicated “they’ve looked into but can’t tell us about because of data protection.” She reflected that this was frustrating not only in the parameters of the DHR process but also because “I would really, really like to see what his life has been like because maybe he needs a little bit of help”. Some professionals suggested that this lack of transparency only created more scope for difficulty with bereaved families during the DHR process since “the family have the view that this person is in some way culpable for the death, and that they haven’t engaged and haven’t given permission to access their medical records just adds fuel to that fire really...it’s a wholly unsatisfactory situation...a homicide is much clearer” (DHR Chair 11).

Allied to these concerns about the appropriateness and legality of seeking private information about partners in suicide DHRs was a related concern about the risks to safety that might be posed by the fact an alleged perpetrator remained at liberty. As DHR Chair 12 put it: “how much information you can put in about someone who is not in prison,

who has not been convicted of anything...I think it's really difficult. And, you know, it puts others at a lot of danger." The dilemma that DHR Chair 12 points to here is that the more intrusive the panel is in seeking information about and from partners, the greater the risk they will become defensive or react negatively; and since they remain in the community, this can manifest itself in retaliation against the deceased's family (or children), as well as potentially against panel members or other professionals in agencies contributing to the DHR process. This concern was echoed by CSP Lead 2: "all the things that are good practice with DHRs, if your perpetrator is still there, ...how does this look? How do you do it safely?... the lens that we need to be using has to be around risk - it should be risk to the children, risk to my team, risk to other family members. But the guidance is completely absent... it doesn't feel safe for families, and it doesn't feel safe for the panel or the team really." Meanwhile, DHR Chair 6 reflected on the practice of naming panel members which "does make it easier for people to be tracked down and identified if somebody is particularly vengeful". The potential ramifications of this for review contributors was also highlighted by DHR30 in which the headteacher at the school where the deceased's youngest child was in attendance "provided a significant amount of written documentation which has informed the facts, analysis and lessons learnt within the DHR report". In a context in which there is nothing in the report to indicate that contact between the deceased's partner and his son was severed after the suicide, or that the child had been relocated, this raises questions about the impact of participation on that headteacher's future relationship with the alleged perpetrator, and - potentially - the risk to personal safety as they are required to maintain that professional interaction.

Some interviewees indicated they had made conscious decisions in suicide cases not to approach people to participate in DHRs precisely because of a mindfulness of these risks. DHR Chair 12, for example, recounted a case in which they decided not to approach children to participate since they determined "the kids were in danger if they spoke against [their father] and told some narrative apart from the one that he's decided has to be told". Meanwhile, others suggested they tried to manage these risks by providing opportunities for participation but combining that with a liberal use of redaction in final reports, or with decisions not to make reports public. CSP Lead 3, for example, noted a practice in other areas only to publish a learning summary in suicide cases rather than full reports, which they were likely to consider in future, since "it's very difficult to put that out in the public sphere for the individual that still remains in our community". Though such decisions are often prompted by concern about the risks posed by publication for family members, it was clear that some found this decision frustrating: "it's almost like [the Panel Chair] is guarded in what she says and she talks about being protective. Why? It's an open document, it's a legal document, and to know that they're open and transparent, and it's fair, the truth needs to be documented there, whoever said it" (Family Member Focus Group). Moreover, in terms of reviews fulfilling their purpose in terms of learning lessons, others queried whether concerns about safety resulted in "so many redactions that the report's not worth the paper it's written on" (CSP Lead 2).

Achieving Best Practice in Suicide DHRs: The Importance of Specialist Knowledges

As this discussion demonstrates, there were challenges identified in suicide DHRs in respect of terminology, data access and risk management where no perpetrator had been confirmed and partners retained contact with children, family members or agencies, and professionals felt they were required to navigate these challenges on an ad hoc basis. So too, the distinctive characteristics of domestic abuse suicide highlighted ways in which specialist and expert knowledge, combined with a receptivity to and appreciation of the unique perspectives offered by family members or friends of the deceased, were required to ensure best practice in the running of DHR processes and the production of reports.

In terms of specialist knowledge, this was often tied to the need for better understanding of the links between domestic abuse and suicidality, as well as the ways in which suicide can be understood as a response to hopelessness. As CPS Lead 7 put it: “we did a briefing for staff to try and get that across because quite often, all the suicide messaging has come across as if everyone’s got really severe mental health problems. It’s saying no, it’s because they feel completely hopeless in that situation.” Across the DHRs, there were certainly reports where Chairs referred directly to research that documented the links between domestic abuse, hopelessness and suicidality and made concerted efforts to understand the experiences of the deceased in this frame. But this was not common. There was often a lack of reliance on expert knowledge and an associated tendency to emphasise mental health or addiction issues as the dominant features generating suicidality. As we discuss below, this often led to a tendency to blame, or responsabilise, victims and to diminish the contributory role that agencies and other individuals might have played in affirming their sense of hopelessness through their behaviour towards them. On the one hand, this led participants to suggest that it would be appropriate to consider the composition of the panel to ensure specialist knowledge in relation, for example, to suicide prevention. As DHR Chair 10 noted: “there’s something about the knowledge around the table that’s really important, that ability to draw on expertise, which is not necessarily the same as the services involved...and that includes specialist expertise in terms of particular communities...because suicidality doesn’t just tend to appear out of nowhere, there’s a pathway to that and...and it’s not linear.” Likewise, DHR Chair 10 considered whether “how you frame the question and the knowledge you have around that table...will change the lens and particularly the width of the lens through which you look”, noting that this may be particularly pertinent in suicide DHRs “because they’re not anchored within the criminal justice system in the same way.”

Meanwhile, others extended this logic to suggest that Chairs in suicide cases might also require distinctive skillsets from those often exhibited in homicide cases. CSP Lead 2 observed that “quite a lot of DHR Chairs are ex-police...which can be an amazing skillset, but it isn’t necessarily what you need in a suicide DHR.” Though those DHR Chairs we spoke to who had a policing background suggested, to the contrary, that they may be peculiarly well-suited, since they have a confidence regarding investigative procedures that enables them to challenge agencies in suicide DHRs, several family members shared concerns about their capacity to be independent. One commented: “I think most of the police ones who chair them are...by the wording, you can see they’re actually focussed from a policeman’s point of view”, whilst another reflected that “my Chair was an ex-policeman and they just accept blindly, absolutely without scrutiny” (Family Member Focus Group). Irrespective of this debate, family members and professionals alike recognised that good chairing required a trauma-informed approach, meeting family members where they were in the process and taking seriously the commitment to value their contributions. As DHR Chair 13 put it, “DHRs are a million times better” where there is family involvement. CSP Lead 3 suggested this may be all the more important with suicides where “we need to

understand a little bit more about the individual and what was happening for them, and how they were responding to that in their day to day lives”.

At the same time, questions were raised about the extent to which the current process really supported that involvement, particularly because of unrealistic timescales for engagement. As CSP Lead 3 put it: “if we truly want to allow family to contribute in a meaningful way, placing a six-month deadline on something can make it completely impossible...in order to facilitate that we need to be more flexible.” This was also identified as a barrier by family members. As one put it: “they only put timeframes on us, you know, I want this done in so many weeks” but “I don’t think they get where we are in the grieving process. At that point, we don’t have the knowledge or able to think logically or sensibly at that time” (Family Member Focus Group). So too, family members remarked that they felt meetings with the panel were often too truncated to be meaningful. Family Member 2 commented that “there wasn’t enough involvement. I had that one meeting which was cut short and a couple of telephone calls”, while Family Member 5 said “we did have a zoom call with agencies...we got about 45 minutes and that was it. What can you say... and comments were made about, well you’re in grief...I went, you’re damn right...I said, you’re not listening, you’re not listening.” This final comment mapped to concerns, also evidenced in respect of agency engagements in the aftermath of death, about the difficulty of being required in the DHR process to participate with a level of detachment, in order to be seen as ‘reasonable’ in engaging the panel and ‘intelligible’ in one’s account. Though professionals were cognisant of the distress felt by family members and the ways in which this might be particularly heightened in suicide cases, it was not clear that this consistently informed their engagements with them during the DHR process. As DHR Chair 9 put it: “sometimes families don’t help themselves” when “coming from a place of emotion”; and the implications of this approach were not lost on family members – as Family Member 9 put it, “I’m naturally quite calm and...can put my emotions aside, which I think probably helped in that I wasn’t this distraught, crying, bereaved sister who couldn’t believe that, you know, her sister had killed herself.”

Across our sample, though in many respects a rough indicator, we coded DHRs in terms of levels of family involvement (based on information within the report about its process and meeting schedules, as well as the range of evidence drawn upon and apparent priority afforded to the content of family input within the narratives) as either ‘none’, ‘limited’ or ‘significant’. We found a broadly even spread across these three levels in the 32 DHRs. Of course, there may be a range of reasons for no or limited family involvement, including where family members chose not to participate or where panels decided not to approach them due to safety concerns. Nonetheless, it was clear from interviews with family members that their experiences had similarly been mixed. Some recounted a broadly positive experience in which they felt that they had an opportunity to be heard and had ensured that the voice of the deceased was captured in the DHR. Meanwhile, others felt that they had been misled by a process that purported to include them, but which ultimately produced reports that failed to recognise their input, or that reached conclusions that they felt were under-critical of agencies or generated action plans that lacked ambition. In the next section, we explore in more detail the outcomes of the DHRs with these considerations in mind, but one thing that was clear in this study was the extent to which involvement of an advocate in the DHR process appeared to increase the likelihood of meaningful, trauma-informed family engagement; and so we close this section with some remarks about the value of advocacy in the suicide DHR process.

We highlighted above the ways in which family members positively experienced the involvement of an advocate as part of a wider package of support in the aftermath of a loved one’s death. But it was clear that professionals involved in DHRs also valued advocates’ participation, especially in suicide cases. Several DHR Chairs reflected on how the involvement of an advocate facilitated constructive dialogue: “I might say something in that report that upsets the family and then our relationship’s doomed and they’ve got no one supporting

them...So I always say to them, really, try to have an advocate because it's actually better for our relationship moving forward if we do that because then there's a buffer" (DHR Chair 5). DHR Chair 9 noted that "a review is always better if they're being supported...from our perspective there is somebody else to help manage the expectations of the family", while DHR Chair 12 underscored the importance of this role-division: "as a Chair, you can't be an advocate and you have to have someone else there to take that on, you can't take on all the emotion and all the paper because it is too much." Meanwhile, CSP Leads also identified the benefits of this advocacy role from their perspective: "good advocacy helps the family feel safe and it means that I have someone so I'm not having to go direct to family...with the advocate, I'll talk about the letters that I write, making sure that the tone is right, that I understand if there's any learning needs, I understand their language needs. So I've got almost an intermediary who can help me make sure that everything we're doing feels safe and supportive with that family" (CSP Lead 2). The benefits of this intermediary 'buffer' were also confirmed by family members who spoke of how their AAFDA advocates had "shielded" them by "fielding the emails from the DHR" and liaising with the panel in respect of dates that might coincide with particularly difficult stages in the grieving process [Family Member Focus Group], or had gone "above and beyond...in helping get the answers" from the various agencies that the family were required to engage with [Family Member 5].

These observations from DHR Chairs about the value of an advocate in supporting them to engage with family members also resonate with a final theme pertinent to the question of specialist training, namely the risk of vicarious trauma. The extent to which the DHR process and its outcome was grounded in a thorough appreciation of the complex links between domestic abuse, hopelessness and suicide varied, but interviews indicated that where Chairs had more experience in undertaking suicide reviews, they had become increasingly cognisant of this connection, at least to the extent that it had impacted on their levels of emotional labour. As DHR Chair 13 put it: "dealing with suicides I would say is particularly stressful...the last ten years I've been doing this...but the first time I had clinical supervision was in the last couple of years [after taking on suicide reviews], just because...it seems the cases feel even more hopeless...to think they've been driven to taking their own life is just a different sort of element for me...it's really, really stressful...quite traumatising in a way that maybe dealing with homicides isn't." An advance appreciation of this was also identified by some as a possible barrier to others coming forward to undertake suicide reviews: as DHR Chair 7 put it: "a lot of people are a bit worried about doing it as well because of the emotional aspect of it...people who are new to DHR chairing would be more reluctant probably".

Reviewing the Review in Suicide DHRs

DHRs in our sample varied significantly in remit and size. Although most involved contributions from a relatively broad range of agencies, some worked within more narrowly circumscribed limits. Independent Management Reviews (IMRs) are reports provided to the panel by relevant agencies, designed to reflect their open and critical account of service engagement and operational practice. 45% of the DHRs received IMRs from between 5-10 agencies and 39% received them from 10-15, but 2 DHRs involved IMRs from less than 5 sources whilst, at the other end of the spectrum, 2 had reports from as many as 22 agencies. There was also variance in the time period considered relevant. Though the review's temporal scope was not explicitly stated in all DHRs, in approximately two-thirds of those where it was articulated, the panel restricted their focus to the 5 years prior to the victim's death, and in half of those cases they focussed only on the last 2 years of life. The shortest time span in the sample was 5 months prior to death, while in 11% of cases, the panel considered a period that stretched beyond the previous decade of the victim's life. Although the remit of the review in these senses did not always neatly map onto the ultimate length of report, in this respect too there was considerable divergence. Full Overview Reports ranged from 18 to

185 pages, with the durations from their commencement to completion ranging from 5 to 39 months.

Action Plans were also variable in their scale and ambition. Discounting DHR28, which was published without a clear set of recommendations capable of being extracted from wider 'lessons learned' in the report, we subjected recommendations across the sample to further analysis. In particular, we explored the origin and scope of recommendations, the change priorities they identified and the agencies to whom they attributed responsibility for change. It was difficult to map this neatly, since recommendations were sometimes written with insufficient precision: for example, it was not always clear whether a recommendation had been carried forward from an agency IMR or arisen during DHR analysis and review; it was common for recommendations to combine one or more substantive suggestions for different change priorities; and recommendations did not always clearly articulate which agency was responsible for actioning the change, or they identified a list of agencies in the same recommendation to whom its substance applied. In our analysis, therefore, we looked at information regarding the profile of recommendations across our sample (n=558), grouping change priorities and agencies as discussed below, and where a recommendation identified multiple change priorities or multiple responsible agencies, we coded it under each heading rather than trying to attribute it solely to one 'primary' priority or agency.

One thing that was immediately clear was that, while the average across the sample was approximately 18 per DHR, there was considerable range in the number of recommendations being identified. DHR03, for example, had only 3 recommendations, with almost one third of the sample (n=10) having 10 or fewer, whilst DHR 32 identified 41 recommendations and 3 further DHRs in the sample had more than 30. Though, as noted, it was not possible in several of the DHRs to clearly differentiate the origins of recommendations, where these were distinguished, there was also considerable variability apparent. In DHR25, for example, 26 of the 27 recommendations were identified by single agencies during their IMRs, whilst in DHR17, only 1 of the 14 recommendations arose in this manner. What was more consistent, however, was the significantly localised nature of recommendations. Less than 5% of all recommendations (n=25 of 558) were directed toward national policy or practice, the vast majority of these being addressed to the Home Office with a focus on improved guidance for running suicide DHRs or better support for bereaved family members / children in this circumstance. In terms of the local agencies towards whom recommendations were addressed, in line with previous research on other cohorts of DHRs, we found a prominent focus on GPs and health services (accounting for 25% of agency identifications, n=129 of 512), followed by policing and criminal justice agencies (17%, n=87 of 512) and multi-agency forums, including MARACs (15%, n=75 of 512). Recommendations targeting social services, housing, domestic abuse services, mental health services and addiction services were the next most frequent, in descending order from 9% (n=45 of 512) for social services to 4% (n=22 of 512) for drug / alcohol addiction services. Far more rarely, there were also recommendations addressed to public health services (n=15 of 512) or education services (n=6 of 512), as well as occasional targeting of ambulance services or benefits teams.

Agency Recommendations

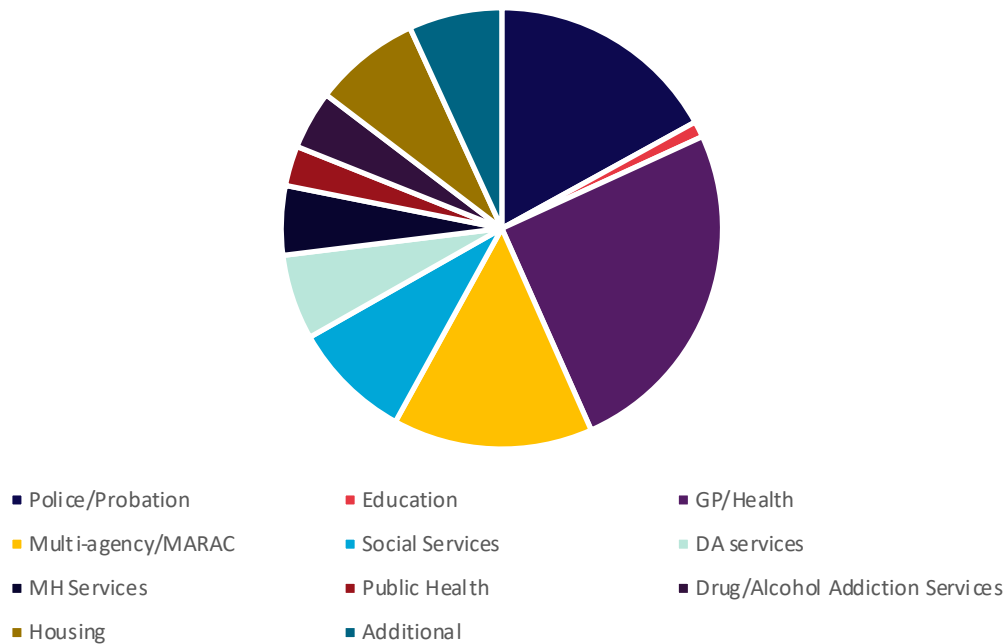


Figure 10: Agency Recommendations

In terms of change priorities, previous research has identified themes around professional curiosity, risk assessment, information sharing and multi-agency cooperation. These were also prominent in our sample. Indeed, improved training and professional development, including in respect of professional curiosity to ask questions that might facilitate disclosure and risk identification, featured in almost one-third of suggestions made (n=178 of 568). This was followed by a focus on improved policies for engaging victims and practices designed to support service-users (19%, n=107 of 568) and recommendations designed to achieve more effective and robust risk assessment (17%, n=95 of 568) or better protocols for information sharing within and between agencies (15%, n=87 of 568). Less frequent, but still apparent, themes also related to resourcing and capacity building (8%, n=46 of 568) and public awareness-raising about domestic abuse, its forms and effects (7%, n=40 of 568). But perhaps the most striking finding was the lack of prominence across the DHRs of recommendations tied to suicide prevention strategies. This accounted for only 15 of the 568 suggestions made (less than 3%). Given the subject matter of these DHRs, this is both surprising and concerning. Though, as noted above, there was evidence that some panels had taken account of the existing evidence regarding links between domestic abuse and suicidality, the failure in resulting DHR reports to make recommendations drawing on those connections in the spheres of suicide prevention and public health is disappointing; and may also reflect difficulties discussed above regarding the composition of panels, and the need for specialist knowledge to ensure holistic recommendations.

Nature of Recommendations

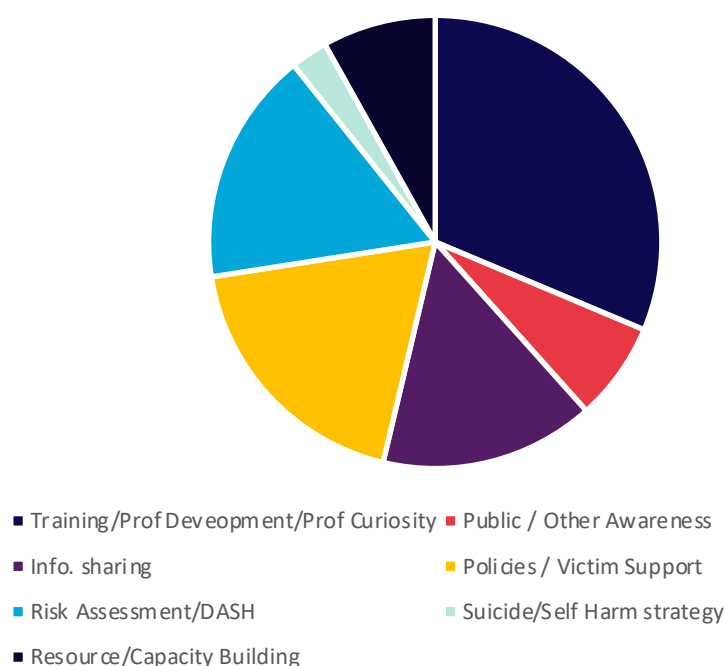


Figure 11: Nature of Recommendations

In the remainder of this section, we focus on three key facets that were identified by interviewees as hallmarks of a 'successful' DHR process, all of which are also prioritised as core objectives within the current Home Office guidance. We explore the extent to which the specific contexts and dynamics of suicide cases might impact upon achieving success in these respects, and reflect on the implications of that for victims, participants, professionals, and the DHR process overall. More specifically, the three facets that we focus on here are - (i) ensuring that the voice of the victim is heard; (ii) maintaining a trauma-informed approach that avoids victim-blaming; and (iii) engaging in critical reflection and ensuring that appropriate lessons are learned in order to improve practice and protocols for the future.

Ensuring the Voice of the Victim is Heard

In any DHR, there are obviously evidential challenges, arising from the sheer fact of death, to ensuring that the voice of the victim is properly heard. Diaries may be instructive where they are available, as can suicide notes (although as discussed above, in the current sample, these were relatively rare, typically brief and often not particularly specific about the factors precipitating suicide). For the most part, however, panels will need to rely on the testimonies of third parties to piece together the picture of the deceased's experiences and to try to give voice to their perspective. Documentation provided by agencies with whom the deceased interacted - for example, GP or counselling notes - can, of course, play an important role here; but these are typically forged for their own operational purposes, applying their own criteria of relevance and functionality. In addition, reliance only on formal interactions and documentation would be to ignore the reality that much domestic abuse goes undisclosed to agencies. Family members and friends thus perform a vital function in providing a more textured account of the victim and their experiences. In that respect, there is substantial overlap here with our observations above about facilitating family involvement within the DHR and the importance of being sensitive to the power dynamics, emotionality, and knowledge hierarchies that require to be navigated in that process.

In homicide and suicide contexts alike, there can be contested ground in relation to what constitutes the 'voice' of the victim: not least because victims will speak in a variety of registers across time, space, and context. In suicide cases, however, this can be attenuated by the fact that there may be no formally confirmed perpetrator, since it may become more likely that approaches will be made to partners to contribute their reflections on the 'voice of the victim'. Where this occurs, it brings unique challenges. DHR Chair 2 reflected on this in respect of one review he had conducted where a partner, who maintained that the death was an accident arising from consensual BDSM activity, was charged but released by police. He said: "I always tell the perpetrator, the partner, this is not about you, it's not about blame... That said, you will very often see in the report what your wife has told them [agencies] which you might not agree with, and you will have the opportunity to say your piece, which I will put in the report." Reflecting that it was important "to give him or her their voice...so it balances", DHR Chair 2 noted that, in his opinion, that "is what a good Chair should be doing, just setting out the facts, be they ones that the family support or the perpetrator supports, you've got to be honest." This kind of approach was reflected too, for example, in DHR27, where the Chair included the testimonies of family members and friends, alongside excerpts from the deceased's diary, and what were described as "comments and corrections" by her husband.

At the same time, of course, what constitute 'facts' is not always self-evident, and for many family members, there was an acute sense that - in death as in life - giving this platform to the perpetrator had silenced the victim. Family Member 1 reflected that she had to "battle" for her daughter's voice to be heard in the DHR. Indeed, on its publication, she reflected: "the perpetrator got more of a stand in the DHR than [the deceased] got. I didn't hear [the victim's voice], it [the DHR] didn't even comprehend the abuse, the analysis was poor. I did sixteen pages of comments and nobody [read it], they didn't even share it with the panel or the CSP." Meanwhile, other family members recounted how they felt that, through their involvement in the DHR process, partners had been able to manipulate and control the victim's legacy as well as the lives of those left behind: "it's given the perpetrator a bit more control back in the sense that she's been dodging calls from the agency, just putting it off... that's been for several months" [Family Member Focus Group].

Even where partners were not directly involved, moreover, anxieties about data protection, respect for privacy, risk management and causing reputational damage, which were discussed above, entailed that there was often a marked tendency in the reviews to 'counter-balance' the voice of the victim that was narrated by others. This typically took the form of reminders about the subjectivity or one-sidedness of that perspective, in a way that was perhaps less likely to arise in homicide DHRs where the conclusions of a criminal investigation are often positioned as obvious corroboration. In DHR03, for example, the Chair reported that the testimonies of the family could not be included directly: "due to the nature of this DHR, there are some elements of [the victim's] life that cannot be described fully. This is because they would identify people in [the victim's] life, and therefore breach confidentiality." As a result, family feedback was instead incorporated where deemed "appropriate". Although not explicitly stated, it can be assumed the Chair's concern here was with including information that would identify the victim's partner. As a result, however, important details, such as the circumstances leading up to the deceased's suicide were missing. Family Member 2 shared that, on publication of this report, she felt her daughter's voice was not present: "everything was about protecting him [the partner]...everything revolved around him."

Furthermore, even where Chairs and family members went to concerted efforts to bring the voice of the victim into proceedings, there was often a lingering sense of one-dimensionality. Intersectional identities were poorly represented, with relatively little engagement, for example, regarding victim's culturally specific needs, even in cases where it appeared directly relevant to the abuse experienced, avenues for disclosure and support, and ultimate mode of death. More broadly, it was rare - other than where partners and family members provided oppositional accounts - to triangulate narrations of the victim's voice to generate a

richer soundscape that might have more fully reflected the complexity of lived experiences. It was common in DHRs for the same form of language to appear, indicating that ‘the story of X’s life was told by Y’. Resources – in terms of time, personnel, intellect and emotion – are not unlimited, of course, and that inevitably has an impact. Equally, as was reflected in DHR11, there can be logistical challenges in identifying sources – there, it was noted that “the Chair looked at the viability of approaching those individuals who could be classed as the friends of Adult A. Due to the chaotic and transient lifestyle of these individuals this was not deemed to be a viable option...The family were also asked about others that could be contacted as part of the Review but were unable to provide any details.” Nonetheless, there is also something jarring in the implication both that there is only one story of a person’s life and that it is self-evidently unproblematic for that story to be told by only one person. In some cases, it appeared, moreover, that this more contained narrative approach was often adopted in DHRs, notwithstanding efforts by family members to encourage a wider engagement. Family Member 2, for example, recounted that the DHR Chair had failed to make contact with any of the individuals suggested by her as well-positioned and willing to give an account of the changes in the victim as a result of her relationship with the perpetrator, including siblings and life-long friends in whom the victim was likely to have confided.

Though articulating the life through the eyes of the victim is a laudable aim and one that ought, rightly, to infuse the DHR process, it is often a complicated task. It is, moreover, not necessarily one in the immediate skillset of DHR Chairs, and efforts at it can be frustrated by the frameworks of final reports. This was a recurrent theme in discussions with family members, where they queried “if some of these professionals understand how to document the voice of that person” (Family Member Focus Group) and suggested “if you put them all around the table and asked them to write down how you think you present the voice of the person being heard, I don’t think they understand that...when the chronologies come, I don’t think they come across from the voice of the victim” (Family Member 1). Echoing wider concerns about family engagement, Family Member 7 observed that one of the key barriers here lies in professionals’ discomfort with emotionality: “automatically you’re viewed as somebody who’s grieving, so you don’t know what you’re saying...I’ve got services reporting on [X] who never met her, didn’t know who she was...I could put 20 people in front of them and they wouldn’t pick her out...yet they’re the expert”. Similarly, participants in the Family Member Focus Group expressed frustration that listening to the family was too often “just a tick-box” in the DHR process, an exercise in “listening but not hearing” because “they keep saying they want to hear the voice of the victim, but the voice of the victim would be emotional, saying all the things that we’re saying. That’s what they’re hearing from us and they’re dismissing [it]”. As a consequence, they suggested that the resultant report is “very cold, very clinical in how it’s written, there’s no...you’re not seeing a human” (Family Member Focus Group), notwithstanding claims or efforts to the contrary.

Trauma-Informed Engagement & Avoiding Victim-Blaming

Though not unrelated to the goal of ensuring that the voice of the victim is heard, a specific indicator of a successful DHR that was also often identified by interviewees was that it should not only articulate life through the eyes of the victim but do so with compassion, empathy and an appreciation of the barriers to engagement they may have encountered. Key to this was maintaining a trauma-informed approach to understanding victims’ experiences and interactions, and avoiding victim-blaming language or logics that focus on what victims could or ‘should’ have done differently rather than on what agencies can learn.

The scale of this challenge was repeatedly highlighted. DHR Chair 6 observed: “it’s just so ubiquitous, the victim-blaming...I do try and head it off at the pass now...I do say, you know, please think about your language and ask yourself whose behaviour am I expecting to change and why.” Likewise, Advocate 1 suggested: “there’s often a lot of victim blaming

in DHRs, full stop. And there is still far too much onus on the victim to be asking for that help or not failing to attend,” whilst CSP Lead 2 confirmed: “that’s something we still fall foul of as agencies when we’re talking about people’s lifestyles and experiences, is victim-blaming.” For DHR Chair 6, at the root of this is a tendency to focus on the emotional or relational rather than practical or structural dynamics of domestic abuse: “every time I do domestic violence 101 training, we do a little exercise about I’m going to answer that question you all want to ask me...why does she stay...I absolutely guarantee the first ten things they say are all about something to do with how her brain works...it’s always something about a character flaw in her. It’s not I’m going to lose my house, my children, my finances, my job...it’s always if only she could change the way she thinks she could sail out of there with no problems. Every single time, and I must have run that exercise with over 10,000 professionals by now.” And it is the failure to properly appreciate this reality that, according to DHR Chair 10, makes victim-blaming often a “default” position: “we tend to expect the victim to change their behaviour, particularly if there’s children involved...when a victim starts behaving in ways which are challenging for agencies to recognise, respond and dealt with...agencies tend to make someone the problem...someone becomes ‘difficult to engage with’...whatever euphemistic language is used...because they’re not being the good square peg and fitting into the good square hole.”

As discussed above, there was certainly evidence across DHRs of this victim-blaming language in agency IMRs. In some cases, this prompted Chairs to be explicit in their condemnation and to use such instances as an opportunity for learning. In DHR20, for example, the victim struggled to maintain her home appropriately for her children or to ensure their attendance at school. In respect of this, the DHR Chair noted critically that: “in reviewing the IMRs and in discussion with some professionals, either consciously or not, there were some moral judgements made about [X]’s way of living, which was seen in some cases as a lifestyle choice, rather than as a result of living with abuse affecting her parenting capacity”. At the same time, it was clear that a considerable amount of such victim-blaming remained uncontested. In DHR11, for example, a 27-year-old woman who had been in a succession of abusive relationships, and had a history of drug and alcohol dependency alongside intermittent periods of rough sleeping and sex work, had repeatedly reported suffering from psychosis and had frequently presented to A&E services after acts of severe self-harm. Despite this, she never secured a proper mental health assessment because agencies were unable to engage with her for appointments or her drug use made diagnosis difficult. Though the Chair noted a siloed approach as a result of which “the issue of substance use became the focus along with the view that services needed to wait for the adult to be ready to engage”, the DHR action plan stopped short of interrogating the judgements underlying this, suggesting that “professionals may need to think more laterally” whilst noting that “interventions are complex and would have required cooperation”. Meanwhile, in DHR07, a victim who took her own life after being subjected to sustained domestic abuse and control, was described by the Chair as being in a situation driven by “choices she had made in earlier life” and thus, as also referred to above, being “the perpetrator of her own death”.

In other cases, the lingering influence of victim-blaming in the DHR process was more subtly expressed. In the Family Member Focus Group, participants picked up on terminology often used, and perhaps on the face of it thought to be neutral in tone, for example, that the deceased “moved to another area”. One family member recounted that she had to push to get the DHR Chair to change that language to “she fled” instead, since - although he seemed to indicate that it was not material - “there’s a difference in your wording there” and it matters in terms of the connotations it sends about the deceased’s agency at the time. Indeed, family members often suggested that it was in their challenge to such victim-blaming terminology within DHR processes and reports that they encountered greatest resistance from Chairs. In this context, one reflected on how “I felt my Chair was a perpetrator in his own right. That’s just how I felt. I thought, I’ve just seen my daughter go through all this bullying with the

perpetrator but yet you're trying to control and bully...and that's how I felt he was bullying me and controlling me" (Family Member Focus Group). Some other family members did recount more positive experiences of the DHR process and of the ways in which they felt that their Chairs had listened carefully and sensitively to their accounts. Nonetheless, this highlights the challenges in ensuring a trauma-informed engagement, both in relation to the deceased and those they have left behind, which requires appreciation of the power dynamics within the DHR process and the ways in which expectations of the "good square peg" can persist.

Engaging in Critical Reflection and Learning Lessons

Hearing the victim's voice and avoiding victim-blaming, though important in their own right, are also fundamental to achieving the final hallmark of success identified by many interviewees, namely engaging in critical reflection about agency responses and learning lessons to make the future safer. As DHR Chair 5 put it, the key indicator of a good process "is engagement from the panel, like straightaway, it's that non-judgmental, open, safe environment...a space for us to learn together". Similarly, DHR Chair 6 suggested it was vital that the process be "honest and transparent" and "lacking in defensiveness" - without this, it would never be able to affirmatively answer the crucial question: "if the same set of circumstances were to occur again tomorrow, would we get a different outcome." At the same time, respondents underscored that this was not always easy, and especially so in suicide cases. Other Professional 5 observed that it requires "having the right people involved, having the right Chair" because "you've got it at the back of your mind, how's this going to reflect on my team, on my own work, my team's work, the organisation"; and concern about how a colleague might be impacted by a death that arises in circumstances where they "missed all those warning signs which they shouldn't have missed" may make agencies "protective when presenting that information" or when interrogating other agencies.

As noted above, the remit of the DHRs in our sample was variable, and so too was the ambition reflected in their action plans. Though reports were largely complementary about the levels of agency engagement during the DHR process, our interviews indicated mixed views amongst professionals as to the thresholds for, and value of, undertaking reviews in these cases, and it is possible that this might have impacted on how information was provided, or panel meetings were conducted. Some respondents were candid about the fact that suicide cases can generate complexities around, or barriers to, open and self-reflective agency learning. CSP Lead 3 noted that while "a good DHR is very much where we get really open and honest conversations amongst agencies...everybody acknowledges that it's not about blame but it is about learning", "in suicide DHRs, it is much more complicated, it's very, very difficult." Part of the challenge here can lie in the range of complex needs that victims might navigate, reflected through our discussion in Themes 1 and 2. This relates in turn to difficulties with identifying neat, linear causes of suicidality, and the ways in which this can dislocate responsibility to other agencies, often by maintaining a narrow focus on one's own areas of specialism. In DHR 20, for example, the Chair concluded that the death was "unexpected" though it followed a decision to take the deceased's children into care at a point when she was - in the Chair's words - "seeking help for substance abuse, attending the Children's Centre and doing what professionals asked". This review drew more extensively than many others on research highlighting the links between domestic abuse and suicide, and the extent to which retaining contact with, or care of, children can be a protective factor. It also acknowledged that agencies had failed to adequately consider the "bigger picture" of the issues the deceased was experiencing, and had they done so it might have prompted more support when her children were removed. But still, it distanced her death from these systemic factors, highlighting relational and personal vulnerabilities: "the review has highlighted the tragic cost of domestic abuse, including coercive control, mental health issues and substance abuse".

More broadly, there was a suggestion amongst interviewees that DHRs undertaken in the shadow of a criminal justice process in which a violent perpetrator has been convicted of directly causing the victim's death will be different in substance and tone than suicide cases. In the knowledge, in homicide cases, that there is - as one put it - a "baddie" ultimately "to blame" (DHR Chair 6), there may be greater freedom for agencies to be more candid about their interactions and shortcomings. This was contrasted with suicide cases where it was suggested that "there's a culpability potentially, and it's an unspoken culpability" in regard to agencies' role, which impacts on the process and its outcomes: "the whole way that [agencies] approach the review is very, very different, much more defensive...I've noticed the IMRs are different, the way they're written is slightly different" (DHR Chair 5). One example of this in our sample arose in DHR10 where the police justified their lack of knowledge about the abuse experienced by the deceased on the basis that "the definition of family for domestic abuse would not have extended as far as the family members that [the deceased] lived with [her aunt and uncle]. Had the police been called...this would not have been recorded as a domestic incident *unless the officer reporting was particularly alert, as the relationship was very extended*" (emphasis added). Across our sample, there were certainly DHRs in which recommendations could have been more demanding of agencies and interrogated more deeply their organisational cultures and protocols. As noted above, there was a regular focus in Action Plans on improved information sharing, more professional curiosity, or better record-keeping, often articulated in vague ways and without clearly expressed expectations regarding timescales or accountability. By contrast, there was relatively little in the way of more ambitious challenge to barriers to engagement, responding holistically to the victim, or addressing systemic issues around inadequate resourcing (or prioritising of resource) and restrictive commissioning models. In DHR03, for example, one of the - three - recommendations made was for police "to address the learning in relation to categorisation in non-crime domestic incidents". Meanwhile, in DHR07, in which the deceased had been positioned, as noted above, as the "perpetrator of her own death", a rare example of a national level recommendation was provided amongst the seven listed by the panel: it is notable, though, that while it involved a request for more Home Office guidance in relation to suicide DHRs, the drive appeared to be to reduce the expectation of their being conducted. It was recommended that "greater flexibility could be given to CSPs to only review those suicides where Domestic Abuse appears to have been a significant and primary influence on the decision of the person to take their own life." As we discussed above, while resourcing is a concern and more guidance would be welcome, restricting commissioning by demanding evidence of such a causal connection particularly at an early stage in the process is only apt to undermine learning.

This was reflected too in family members often feeling underwhelmed by the outcomes of DHRs. Family Member 5 commented: "I'm really pleased...there is this process that absolutely holds everyone to account, except you don't get that from them...it's all lip-service." Meanwhile, Family Member 2 reflected that her daughter's DHR had been "lacklustre" with "no ability to challenge any agencies involved", and that, overall, she felt "it was not robust or probing." In the Family Members Focus Group, participants also variously reflected that the panel "only see what the agencies tell them, and the agencies can manipulate that"; and they raised concerns about how that information may then be "cherry-picked" and "selectively interpreted" by Chairs, without enough scrutiny of conflicting accounts. They expressed frustration too at learning outcomes that lacked specificity or clear accountability. As one interviewee put it: "the learning has got to be really clear...not wrapped up in pointless words that mean nothing... the things that we've read about for 20 years about agencies working together" (Family Member 7). Meanwhile, Family Member 4 observed that "it's all the same recommendations, all the same learning outcomes, isn't it, working together, sharing information, you know, it's all the same old, same old, same old."

A particular difficulty that it was suggested might impact on assessments of the success of DHRs in suicide cases was the existence of divergent expectations of, and aspirations for, that process between professionals and family members: or at least a sense in which family members may have additional hopes for the DHR that are less easy to accommodate within its current frame. In a context in which avenues for justice and redress in the criminal justice arena are more restricted, and they may have been fighting for some time to secure any recognition from agencies of the abuse experienced by their loved ones and its life-changing effects, it was suggested that families in suicide cases can be “in a very different space” (DHR Chair 6). One interviewee suggested, for example: “some families perhaps feel a little guilty...so can then be looking for someone to blame, you know, ideally an agency, a nameless agency that they can blame” (Other Professional 5). Meanwhile, DHR Chair 8 observed: “I think [families] struggle to understand that it’s the story of the victim and what agencies could have done. They expect it to be an assassination case of the perpetrator and...that’s not the case of the DHR, it’s got to be balanced.” Echoing this, CSP Lead 2 reflected that such aspirations were at odds with DHRs’ purpose: “we’re there for interagency learning and we’re not going to be able to deliver what that family want...there’s only going to be disappointment because we can’t deliver justice, we’re not investigative”. Though this is true in relation to the parameters of the DHR process, operating from this starting point risks embedding too simplistic an understanding of family members’ aspirations and too restrictive an understanding of what ‘delivering justice’ might mean.

There was certainly evidence in our study that, in some cases, families were seeking something *additional* from the process – perhaps a vindication for their sense that an agency performed poorly, or a confirmation of the pivotal role of the perpetrator of abuse, or both. And for some family members, it was also clear that they did harbour some hope that the DHR might prompt a reconsideration of the perpetrator’s criminal liability. As Family Member 9 put it: “for us the damage is done. No one can fix it. Even at this stage, if we were to get to the point where they did find a bit of evidence and could go forward with the prosecution, it would be amazing for us as a family, it would give us some closure”. Meanwhile, Family Member 3 commented in relation to what they wanted from the process: “learnings, yes, but...what I want to be able to do us to use it to go to the police and the coroners and say, you need to relook, you need to reopen the investigation, or you need to give us an apology.” But, at the same time, it is important to note that these family members were typically aware that the prospect of these outcomes was extremely remote, and it was clearly far from being their sole motivation for involvement in the process. In other cases, moreover, family members were self-reflective and explicit about the fact that, for them, the DHR was less about reopening investigations or attributing blame and more about securing a legacy that made it clear – for example, to surviving children – that the deceased took their life by compulsion rather than choice. As Family Member 7, put it, she hoped the DHR would “take blame away from the victim” and clearly articulate that “this person isn’t to blame for their death.”

For other family members, moreover, their participation was primarily about looking forward to improve others’ safety. Family Member 2, for example, who was deeply disappointed by the DHR produced in respect of her daughter’s death, commented: “we understand the report isn’t meant to point the finger, it is to learn lessons, but I don’t feel this was achieved.” Meanwhile, Family Member 9 was circumspect about what would come from the DHR process for her: “I’m on the fence with the DHR. I think it’s really good that it’s going ahead... and hopefully the outcome of that will be that other families don’t have to go through what we’ve been through. In regards to what it’s going to do for us in our situation, I don’t think it is going to do a lot...it’s about helping future families.” To this extent, professionals’ projections onto family members about how they approach, and what they desire from, suicide DHRs may be at best partial and at worst mistaken. At the same time, the existence of such projections risks generating a self-fulfilling prophecy, with agencies displaying “a lot more defensiveness” (DHR Chair 6) from the outset and setting a tone for engagement that

makes family members more likely to become suspicious, confrontational or disillusioned. This was reflected in the following exchange in our Family Member Focus Group:

"R2: I think sometimes the agencies, the impression I get is that...everyone thinks that we're trying to blame them. And I don't think anyone that I've spoken to started out their journey looking to blame the police or to blame the healthcare system or to blame anyone. But the way the system sort of makes us feel, like we end up angry at them as well. And we didn't start off that way. And if they made a mistake, I don't think anyone would be...I think we'd probably be annoyed but we wouldn't be out for their blood, we would just want to know the truth.

R1: That's a self-fulfilling prophecy, isn't it, it's an angry family...but it's because you've been ignoring me.

R4: I always say, I'll sign any paper you want, I'm not going to sue, but what I do want is changes to happen and lessons learnt...I want nothing more than that because nothing will bring my daughter back but then this will help the next person. But I think it is this sue culture which puts us on a backfoot to some of these professionals."

Running successful DHRs in suicide cases requires overcoming several distinctive challenges, including in relation to specialist knowledge and understanding, data protection and risk, evidence-gathering, and publication. The ability to navigate these effectively has been hampered by minimalist statutory guidance and poor infrastructure for sharing good practice, locally and nationally. There are, no doubt, different motivations and hopes being harboured by all participants in these reviews, but to attribute family members' dissatisfaction with their outcomes exclusively to that fact sets a foundation grounded in defensiveness and suspicion, and misses vital opportunities to do at the macro level in relation to its own processes what DHRs are set up to do at the micro level in relation to individual deaths, that is, to interrogate interactions, evaluate protocols, and learn lessons, in a spirit of empathy and openness, that will improve future performance. There are parallels here, moreover, to findings of previous studies that have explored the processes and outcomes of other types of agency learning: in relation to non-accidental child death reviews, Devaney et al concluded, for example, that whilst professionals recognised the importance of family involvement to ensure "a more holistic overview of the situation", there was concern that it could have "the less desirable consequence of...discouraging some professionals from engaging" (2011: 254). To the extent that this points to what Devaney et al suggest is a wider tension in the multi-agency review process - between "being able to reflect on the learning from a given situation" and ensuring that "individuals and institutions are held to account if their actions have fallen below the expected level" (2011: 257) - it is clear in the context of domestic abuse suicide that greater guidance is needed to support professionals in the commissioning and conducting of reviews, as well as in their making single agency contributions thereto, and that engagement with bereaved family members should be approached with respect and the kind of open-mindedness intended to be at the core of all DHRs.

Final Reflections for Policy and Practice

Throughout this report, we have documented key findings - drawn from within the DHRs themselves as well as the wider perspectives provided by those with experience of their underlying processes - that have significance for the future development (and improvement) of policy and practice in this area. In this closing section, we take the opportunity to briefly underscore some of the most urgent of these, and to highlight the extent to which they require building upon, and going beyond, recent commitments made by the Government as part of its refreshed Domestic Abuse Plan and associated strategic undertakings.

One issue raised repeatedly by interviewees was the lack of adequate guidance and training to inform professionals in identifying domestic abuse related suicides in a timely and consistent manner, and in referring them appropriately to CSPs for DHRs and / or to investigative teams for criminal charging. This speaks to a significant and concerning gap in existing understandings about the causes and culpabilities of domestic abuse suicide, and the priority afforded in policy and practice to addressing the behaviour of perpetrators and securing justice for the deceased. While there have, to date, been successful prosecutions for offences following deaths by suicide, these remain the exception rather than the rule. The Government's recent Violence Against Women and Girls Strategy commits to pursuing perpetrators, observing that "it is essential that police officers investigate all evidential possibilities in order to build a successful evidence-led case, including other witness testimony, evidence from social media and cyber sources, medical reports and photographs or physical evidence, 999 call recordings, evidence from police body-worn cameras, and circumstantial evidence" (Home Office, 2021: 58). Though the hope is clearly that interventions can be made, and support offered, during the lifetime of the victim to protect them from abuse, where victims take their lives within abusive relationships, this commitment must also hold true. Ensuring that first responders to the death undertake rigorous enquiries to establish any indicators of abuse, consider its potential connection to suicide, and engage constructively with families is key.

Where domestic abuse suicides are identified and referred to CSPs, moreover, the paucity of current statutory guidance on the commissioning, commencing and running of suicide DHRs was another evident and justified area of concern, the implications of which were also apparent within the DHR sample. Though domestic abuse suicides may share several of the characteristics of domestic homicides - particularly in terms of victims' vulnerabilities and perpetrators' modus operandi in respect of the abuse - there are also distinctive considerations involved that require specialist knowledge, including in applying commissioning thresholds; and additional challenges posed within the DHR process itself in terms of data protection and risk assessment where partners have not been prosecuted for the abuse. Our study highlighted the ways in which, in the absence of guidance, professionals are navigating these complex considerations in an ad hoc manner, anxious about the exposure of those involved in DHR processes as a result. We also highlighted the extent to which an over-cautious approach can generate imbalanced learning from the DHR itself, and prompt disproportionate focus only on the behaviour and engagement of the victim. In light of this, we urge the Home Office to push forward as a priority with initiatives to improve and extend its statutory guidance on running DHRs, including tailored reflections around best practice in suicide cases.

The coronial process and its intersection with DHRs in suicide cases was also a clear point of concern. For the professionals navigating the process, there was a lack of clarity and consistency regarding how the DHR and Inquest sit together, particularly temporally. This is something that should also be addressed within revised Home Office guidance to ensure a coherent and effective approach. Concerns expressed about the willingness and ability of Coroners to make links between domestic abuse and suicide also indicate the need for

additional training and greater use of mechanisms already at Coroners' disposal, including through the verdicts available to them and their use of Prevention of Future Death Reports.

In terms of DHR learning outcomes, there is clearly a pressing need for a more effective mechanism, with national oversight, to ensure that DHRs are collated in a way that will maximise the potential for sharing best practice. We are pleased to see that this has been acknowledged in the Government's recent Domestic Abuse Plan (Home Office 2022). It is important to underscore, however, that the need identified here will not be addressed simply by the planned repository: it also requires greater consistency in the approach taken within, and the recording of, DHRs, as well as robust oversight of the completed reviews and the recommendations and actions that are at the heart of the purpose of DHRs 'to make the future safer'. Professionals raised frequent concerns about the adequacy of current mechanisms to ensure that action plans are taken forward, and reflected that practice across areas is variable in terms of ownership of actions, measurements of success, and feedback processes. This also permeated family member interviews where participants expressed concern that DHR action plans risked being perpetually marked on gant charts as 'in progress' or 'achieved' in tokenistic ways that both did an injustice to the legacy of their loved ones and missed the opportunity for real and sustained change: "I'm fighting for my daughter to be heard...[she] hasn't just gone in vain, something has to come out of it" (Family Member 1).

In many of the DHRs, notwithstanding the circumstances under which they had been commissioned, there was a concerning lack of consideration of the links between domestic abuse and suicide. Across many of the chronologies and conclusions, as well as the stakeholder interviews, there was a tendency to position the dynamics between domestic abuse and suicide as peculiarly complicated: victims with complex needs who take their own lives as a consequence of interconnecting factors, with any reliable connection - either to their abusers or agency engagements - being contested and consequently out of reach. Though this was a cohort of victims who exhibited notably high levels of agency engagement and disclosure in respect of the abuse experienced during their lifetimes, risk assessments were often viewed through a narrow lens that focussed on the risk from the perpetrator rather than on the risk to themselves. Siloed agency interactions, inadequate information sharing, and shortages of resource or inclination to understand and overcome barriers to victim engagement were also common themes. Though DHR recommendations varied significantly in their ambition, a clear omission in the majority of the reviews was any form of link, or indeed, response from Public Health relating to domestic abuse suicide and suicide prevention. Despite some positive progress at local level (for example, Kent & Medway Suicide Prevention Programme, 2021), there continues to be a peculiar lack of connection between criminal justice, safeguarding and public health bodies in this arena. Community Safety Partnerships should routinely ensure input into suicide DHRs from experts in suicide prevention, and DHR Chairs should be encouraged to reflect specifically in their recommendations around links to Public Health, to ensure more holistic and effective learnings.

Families bereaved by domestic abuse suicide currently lack adequate support. They do not routinely benefit from the provision afforded to those bereaved by domestic homicide in terms of counselling support or police family liaisons. They are often required, in the midst of acute grief, to advocate for their loved ones in post-death investigations and to navigate complex Inquest and DHR processes without emotional, practical or legal support. Those family members who secured advocacy support and / or legal representation consistently underscored its value, and professionals within the DHR process also welcomed advocates' involvement in proceedings which they felt assisted family engagement. This should not be a matter of chance, however: such provision should be made available as a matter of course, and should be underpinned by commitments to sustainable and adequate resourcing in order to support this.

The moving testimonies provided by family members in this study have painted a clear picture of a cohort navigating a system created with domestic homicide in mind, often without the offer of support, advocacy or guidance. It is these human stories, these human legacies, that must remain at the heart of any policy and process improvement. DHRs are not just about learning and change, they are and should remain a lasting narrative of someone's life, their experiences of abuse, their death and the impact on those left behind. Looking beyond process to honour the lives impacted by domestic abuse suicide is key: it requires engagement and empathy, it calls for innovation and courage, and it demands our urgent attention.

"There's got to be change. I wouldn't wish this pain on anybody. I can't do anything for my darling [name of victim] but I'd like to think in her name, I can save other young women." (Family member 6)

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