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Advocacy After Fatal Domestic Abuse

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

EXECUTIVE SUMMARY

Sarah Dangar (AAFDA)
Vanessa E. Munro (Warwick Law School)
Lotte Young Andrade (Warwick Law School)

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.

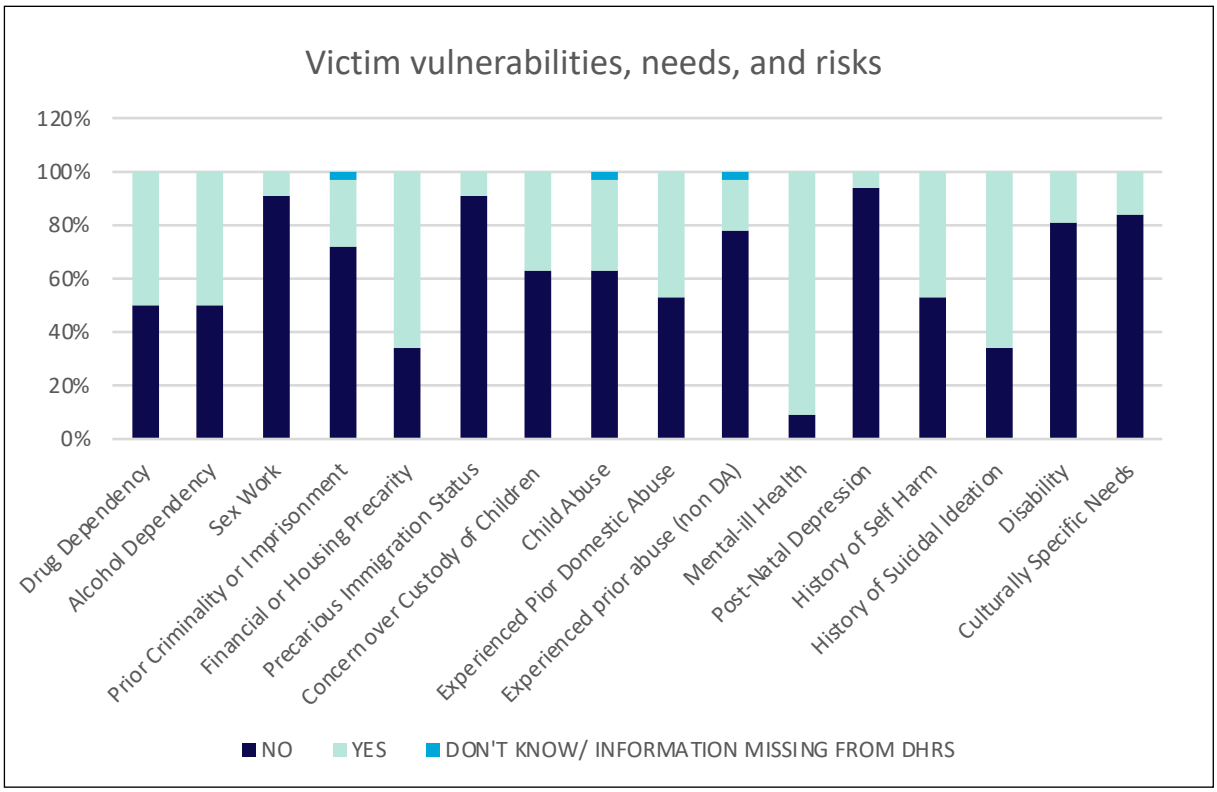
Methodology

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 identified, which are developed in the full report (available at **https://warwick.ac.uk/fac/soc/law/research/projects/**).

Theme 1: Parties' Profiles, Vulnerabilities and Needs

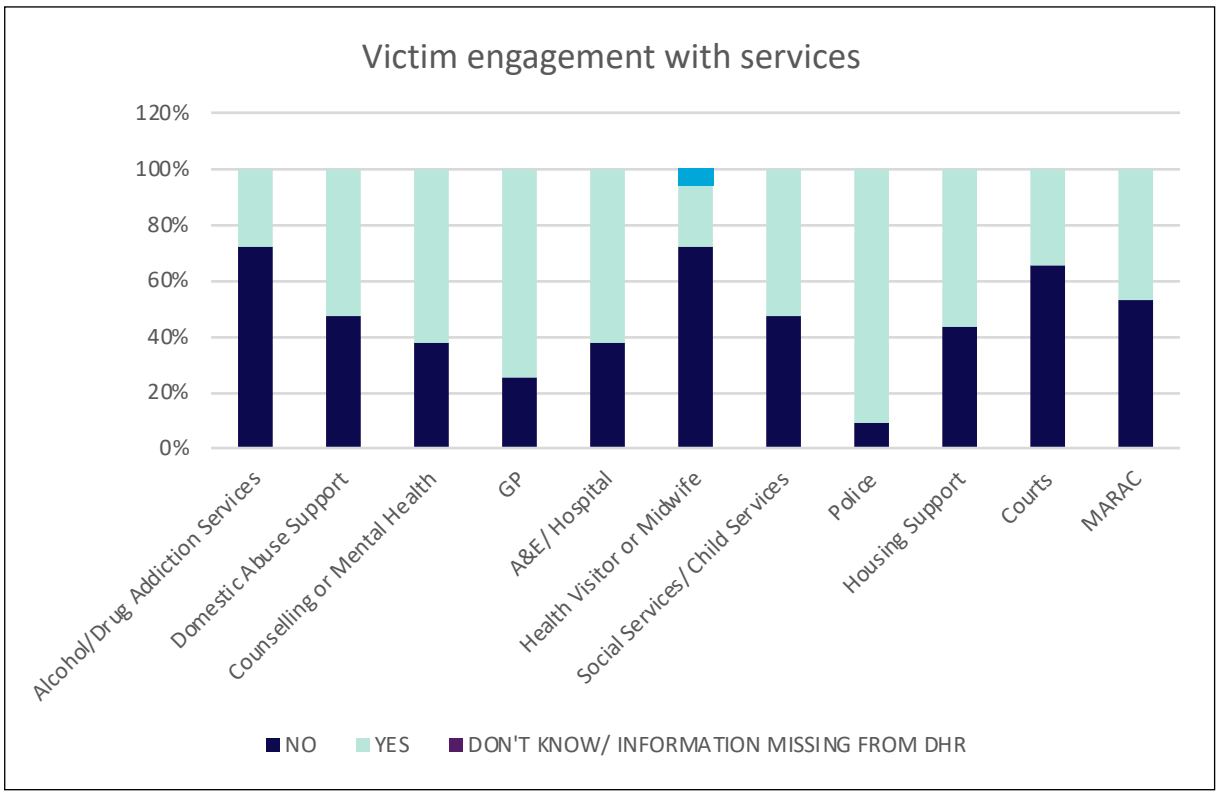
One overarching observation is the peculiarly one-sided nature of many of the suicide DHRs, reflected in the 'absent presence' of partners and a predominant focus on the deceased. In that latter regard, our sample reveals a profile not dissimilar to previous studies. The majority of victims were female (n=26) and in the 28 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 noted, the majority were classified as 'White' or 'White British' (n=20). Ages varied across the sample but 40% of victims were aged 25 – 34 years at the time of death.

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 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 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

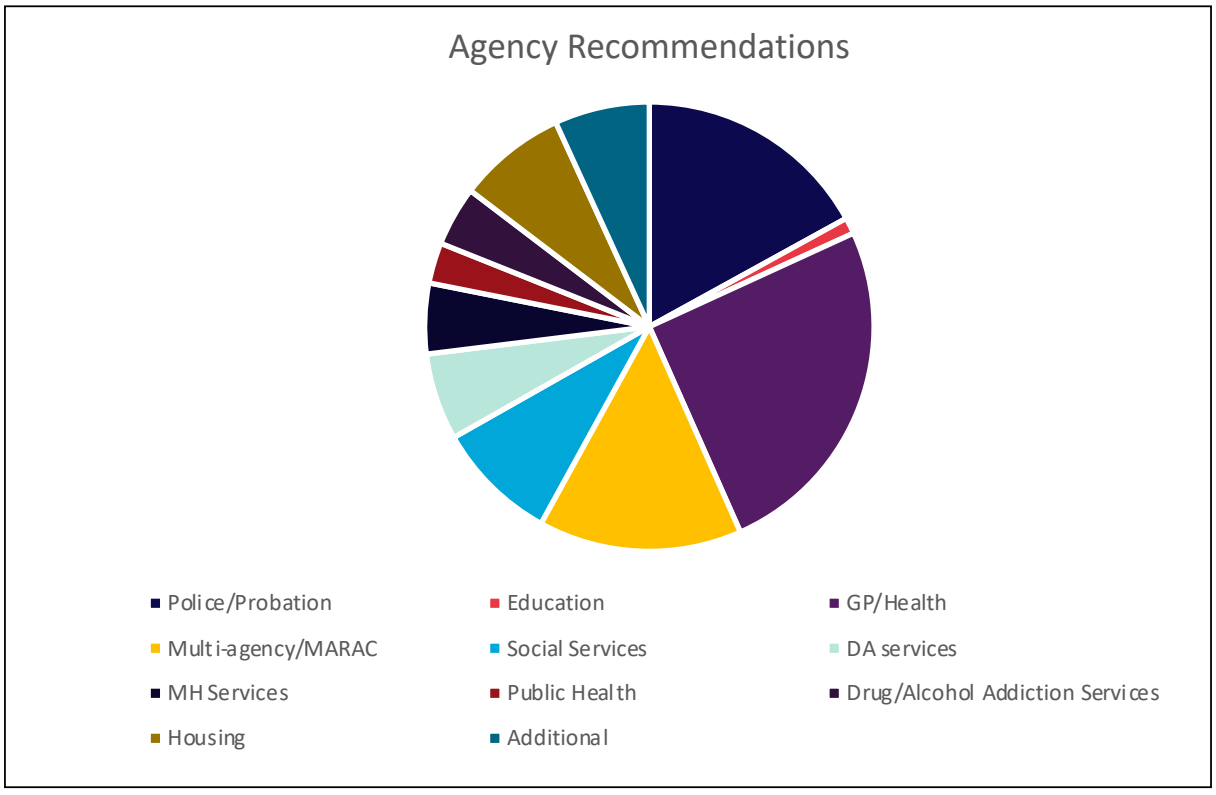
While our sample – by definition – was comprised of cases in which domestic abuse was identified as a relevant feature for the purposes of triggering a DHR, there are clearly challenges to applying such thresholds for identification and commissioning with confidence and consistency. Indeed, in the absence 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.

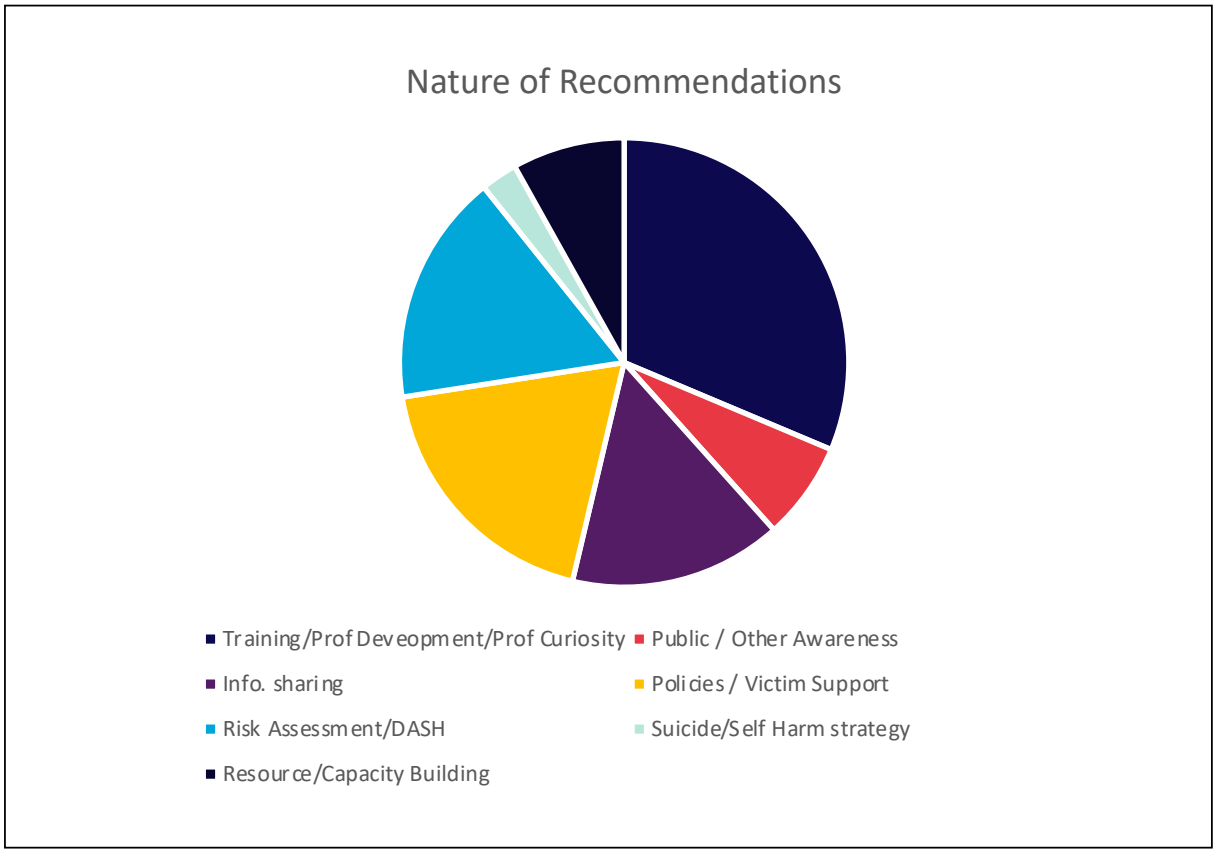
Theme 5: Running Successful DHRs

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%), 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.

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v.munro@warwick.ac.uk
aafda.org.uk
warwick.ac.uk/fac/soc/law

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