

# HALT Briefing Paper

## Professionals' Perspectives about Domestic Homicide Review Processes

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### Introduction

Domestic Homicide Reviews (DHRs) are a statutory requirement in England and Wales, conducted when somebody aged 16 and over dies from violence, abuse or neglect by a relative, intimate partner or member of the same household. The key aims of DHRs are to identify recommendations and lessons learned to eventually prevent further domestic homicides, there is limited evidence globally regarding the extent to which these are followed up or make a difference.

### Aims

To explore professionals' experiences and views about the DHR process to better understand the opportunities and challenges to the conduct and impact of DHRs to enhance their learning potential.

### Methods

19 qualitative semi-structured interviews with senior managers within statutory, third sector/independent organisations with a key role in safeguarding boards/community safety partnerships and with experience of involvement in the DHR process. Participants were recruited from 5 Safeguarding Boards in Gwent and 14 Community Safety Partnerships (CSPs) in Lancashire.

### Results

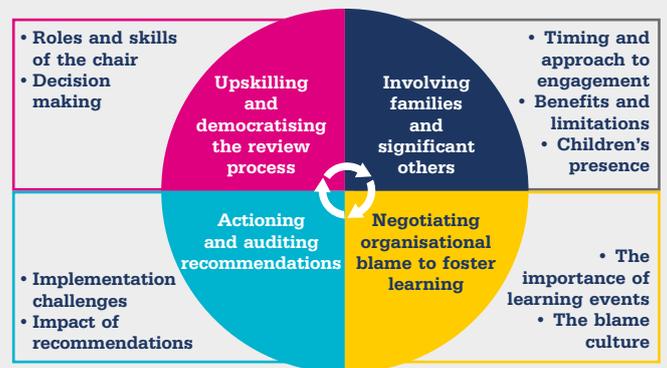
Four key themes emerged



#### Theme 1: UPSKILLING AND DEMOCRATISING THE REVIEW PROCESS

##### Decision making

- Despite guidance, participants highlighted grey areas regarding whether to conduct a DHR. Not conducting a DHR raises questions about the impact on the family.
- The DHR review process is perceived as limited by a lack of diversity and valuable input from third sector specialist domestic violence and abuse (DVA) agencies.
- Decision-making within the conduct and writing of the review, including recommendations, is heavily influenced by a Chair who may not always consider the expertise and input of the panel members.
- Democratising the DHR process is about meaningful involvement of families, and significant others.



#### The role and skills of the Chair:

- Good Chairs enable learning, engender honesty and ask difficult and pertinent questions. They empower professionals to question practice, challenge entrenched attitudes and prejudice.
- An independent Chair is seen as advantageous but is counterbalanced by funding issues and insufficient knowledge of the local area.
- There was disappointment with poor quality reviews, particularly when Chairs failed to question their own assumptions which sometimes contributed to victim-blaming and compromised objectivity.



## Theme 2: INVOLVING FAMILIES AND SIGNIFICANT OTHERS

### Timing & approach

- Professionals recognised the increasing importance of involving friends and relatives.
- They reported being cautious about approaching or managing expectations. Timing is key and requires sensitivity.
- Levels of involvement vary and views on participation can change over time. Early involvement of specialist support organisations is recommended.
- Participation of families is managed at the Chair's discretion.
- Children were less likely to be involved in DHRs due to concerns about traumatisation and future impact.

### Benefits & limitations

- The involvement of significant others enhanced the quality, impact and learning from the review. It provided the victim with a 'voice'; made them 'real'.
- There were challenges where relatives were unaware of hidden aspects of the victim's life, where there were difficult family dynamics, family disagreement regarding participation, and geographical distances.
- Friends were consistently perceived as likely to have greater awareness of DVA. More work to involve wider networks such as employers, neighbours, and communities would be beneficial.
- DHRs may help family members manage their grief. However, families may feel disappointed or frustrated where learning has not helped prevent another domestic homicide.

## Theme 3: NEGOTIATING ORGANISATIONAL BLAME TO FOSTER LEARNING



### The 'blame culture'

- DHRs are required by statute and oversight sits with the Home Office, therefore organisations might be more guarded and mistrust the process.
- In a 'blame' culture, it is difficult for those involved in the DHR process to be open, challenging of self and others and challenge organisational practices.
- The corporate role creates a tension for representatives from organisations between what their organisation will allow them to say, the shifting of responsibility and the Chair's final report.

### The importance of learning events

- Learning events were perceived by participants as a key mechanism to embed learning, share good practice and take recommendations forward; identify failings and ways to improve practice without "finger pointing".
- To be successful, the events need to be well managed by good moderators.

## Theme 4: ACTIONING AND AUDITING RECOMMENDATIONS



### Implementation Challenges & Impact

- Actioning recommendations frequently occurred during the DHR process.
- Action plans should be (organisation) specific, tangible, achievable, and realistic.
- Broad/vague recommendations disperses responsibility and causes monitoring and implementation difficulties.

### Barriers

- Covid-19, austerity, commissioning, data protection, or referral pathways.
- Lack of legal accountability for taking recommendations forward or national strategic oversight.
- Suggestion for a national library/repository with large-scale analysis.
- A DHR should be a continual process of 'evolving practice', including an audit to demonstrate how recommendations have been delivered, monitored and evaluated.



## Key Messages

**DHRs are a complex process. The skills of the Chair, meaningful involvement of families and survivor networks and openness to learning are key.**

**To maximise learning and action from DHR findings, participants called for a greater role for national bodies (e.g., the Home Office); monitoring implementation of recommendations would enable more meaningful engagement in the DHR process from all parties.**

**Organisational learning cannot be achieved without accepting organisational responsibility, which could be perceived as blame - a way forward is to have skillful leaders/Chairs, a 'learning' organisation and well managed learning events.**

**Producing DHR recommendations requires careful management by enabling a safe open environment for all stakeholders.**

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